"You Can't Just Get Up in the Morning and Do It":
Bridging the Partner Violence and Substance Use Services Fields

by

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AA – Alcoholism Anonymous

ADAMHA – Alcohol, Drug Abuse, and Mental Health Administration, established in 1972; housed NIDA, NIAAA, and NIMH

ARI – Access to Recovery Initiative (2004)

ATTCs – Addiction Technology Transfer Centers

CMBWN – Chicago Metropolitan Battered Women's Network (founded 1980)

CSAT – Center for Substance Abuse Treatment, part of SAMHSA (founded 1992)

DASA – Division of Alcoholism and Substance Abuse

DATA – Drug Abuse Treatment Act (2000)

EAPs – Employee Assistance Programs, employment-based addictions services

GRPA – Government Performance and Results Act (1993)

IADDA – Illinois Alcohol and Drug Dependence Association

ICADV – Illinois Coalition Against Domestic Violence (founded 1978)

ICASA – Illinois Coalition Against Sexual Assault

IDAP – Illinois Drug Abuse Project

IDVA – Illinois Domestic Violence Act (1982)

ILDHS – Illinois Department of Human Services

LEAA – Law Enforcement Assistance Administration, part of the Department of Justice

LEAA – Law Enforcement Assistance Administration; part of the US Department of Justice and an early source of funding for partner violence programs

NA – Narcotics Anonymous

NCA – National Council on Alcoholism (formerly the National Committee for Education on Alcoholism)

NCADV – National Coalition Against Domestic Violence (founded 1978)

NCEA – National Committee for Education on Alcoholism, the advocacy arm of Alcoholics Anonymous (founded in 1944)

ROSC – Recovery Oriented Systems of Care

SAMHSA – Substance Abuse and Mental Health Services Administration

SAODAP – Special Office for Drug Abuse Prevention, established in 1972

TASC – Treatment Alternatives to Street Crimes (TASC); established within the LEAA in 1972

ABSTRACT

This project addresses three questions: Why, despite need and available models, do so few organizations address both partner violence and substance use? What allows some organizations to address these issues together when most do not? And, when organizations address both partner violence and substance use, what strategies do they use? My answers draw on field theory and multiple kinds of data, including key informant interviews; exploratory, quantitative analysis of organizational practices; and archival research into the histories of both fields. Focused on metropolitan Chicago, a region with a history of support for approaches drawing from both fields, I find very few organizations address both partner violence and substance use. This is due to incompatibilities between the central logics of the two fields at the time of their emergence in the 1970s. Due to ongoing efforts to bring the two fields into greater alignment since the early 1980s, the degree of incapability between their logics has been reduced, although regulatory and funding barriers remain. Despite this, some organizations address both issues together, a practice more common amongst those in the partner violence field, organizations offering services for trauma, and organizations in lower status positions in their primary field. However, most organizations with services for both issues do not actually address them together. Instead, services for both issues exist as separate tracks within the same larger organization. This pattern is the combined results of funding pressures and regulatory barriers, which stem from differences in field-level logics. Organizations addressing both issues together in a substantive way tend to be higher status, underscoring the high level of resources needed to bridge both fields. This

suggests the need to ask not just whether organizations address both issues but how they accomplish this work. The success of efforts to support people experiencing both partner violence and substance use hinges on careful navigation of convergences and tensions between fields. Through specifying attention to barriers stemming from field-level logics, resources, regulations, and networks, this dissertation provides a blue print for future efforts in this direction.

CHAPTER I

Why Partner Violence and Substance Use?

> Very early, very early, a woman came into the program who shared with me that she was a late-stage alcoholic, and she was having trouble, she was having difficulty making it through the night. […] I wrote in [the log], "Late Stage Alcoholic, needs some support," and it didn't occur to me that that one advocate on site at the shelter had never had any training in substance use, just like I hadn't really had anything but two hours of training in domestic violence while working in the substance abuse program, my counterpart in the shelter knew very little about alcohol and drugs. And I wrote "Late-Stage Alcoholic, needs some support," she came upstairs after I left, asked for a bottle of Nyquil, drank it down, got loaded, came upstairs, stole the shelter programmer manager's purse, called the shelter director a "big fat dyke," threw a fit, they called the community police, rather than the ones with guns, to try to get her out of there, and she tried to strangle the CSO officer, the community service officer, which caused a horrible shock, and a terrible scene at the shelter and they wound up having to call the [police department] to haul her out, I remember that. I remember that because not long after, she passed away. (Judy, 2010 interview).

Partner violence and substance use are both serious issues with devastating consequences for individuals and society. In the United States, 35.6% of women and 28.5% of men will experience some form of partner violence—physical or emotional abuse, sexual assault, or stalking—over the course of their lifetime, with many victims disproportionately experiencing a range of negative physical and mental health outcomes (Black et al., 2011). While the prevalence of problem substance use—whether alcohol or other drugs—remains lower, consequences are high. Alcohol is the fourth leading cause of preventable death in the United States (Centers for Disease Control and Prevention, 2013; Mokdad et al., 2005) and there have been significant increases in overdose death between 2002 and 2015, with the sharpest increase for deaths from heroin overdose (National Institute on Drug Abuse, 2017). Services for both issues are underutilized but

for different reasons. In 2015, an estimated 10.8% of individuals in need of substance use treatment actually received it, which suggests the individuals with substance use issue face barriers to entering treatment (Lipari, Park-Lee & Van Horn, 2016). On the partner violence side, the need for services often outpaces organizational capacity to provide them: In 2017, 14.6% of requests for assistance from partner violence shelters were unmet because of funding and staffing limitations (National Network to End Domestic Violence, 2017).

Since the early 1990s, research has demonstrated that individuals affected by partner violence or substance use have needs related to the other issue at much higher rates than the general population and that the co-occurrence of these issues places affected individuals at increased risk. Despite this, few social service organizations address both issues. My dissertation is addressed to understanding the nature and causes of barriers to the development of combined approaches—instances where partner violence and substance use are addressed in a single intervention—and the contextual and organizational factors that allow them to be addressed together.

Below, I provide an overview of the literature on individual level co-occurrence of partner violence and substance use as well as the effectiveness and incidence of combined approaches. I tend turn to field analysis—an integrated set of theory and methods drawn from sociology and organizational studies—to offer preliminary insights into barriers to addressing partner violence and substance together and the types of organizations that may be best equipped to overcome them.

Co-occurrence of Partner Violence and Substance Use

Research suggests that partner violence and substance use co-occur at rates between 50 and 90% (Easton, Swan, & Sinha, 2000; El-Bassel, Gilbert, Schilling, & Wada, 2000; Rothman et al.,

2008). Half of partnered men entering substance use treatment have battered in the past year (Chermack et. al., 2000), and men are 11 times more likely to be violence towards a partner on a day they have used alcohol (Fals-Stewart, 2003). More than half of women in treatment for substance use issues have been victimized at some point in their life (Cohen, Field, Campbell & Hien, 2014; Downs, 2001; Liebschutz et al., 2002; Moses, Reed, Mazelis, & D'Ambrosio, 2003).

Available evidence suggests relationships between partner violence victimization and substance are complex and multi-directional. For female partner violence victims, alcohol and other drug use may increase odds of subsequent victimization and previous victimization may increase the odds of subsequent alcohol and other drug use (El-Bassel et al., 2005; Kilpatrick et al., 1997; Lewis et al., 2015; Nowonty & Graves, 2013). Available evidence suggests the relationship between partner violence perpetration and substance abuse is complex and may vary by intoxicant (Bennett & Williams, 2003; Foran & O'Leary, 2008; Moore et al., 2008; Schumacher et al., 2001; Stith, Smith, Penn, Ward & Tritt, 2004; Testa, 2004).

Individuals affected by both partner violence alcohol and other drug use face increased risks. In one study, men who perpetrated partner violence and had co-occurring disorders, including substance use, were more likely to have been arrested in the prior year than those without co-occurring disorders and women currently experiencing partner violence were 25% less likely to complete treatment (Lipsky et al., 2010). Relapse has been found to increase odds of partner violence recurrence for both survivors and perpetrators (Mignone, Klostermann, & Chen, 2009; Murphy & Ting, 2010). Other research has linked intoxication while participating in a partner abuse intervention programs (PAIP) to increased risk for future episodes of violence (Gondolf, 1999).

Effectiveness of Combined Approaches

Most often, partner violence and substance use are addressed separately, with services offered serially (e.g., one after the other) or in parallel, but with no links between them (Bennett & Bland, 2008). Given evidence that co-occurring partner violence and substance use may create additional challenges, some attention has been devoted to studying the effectiveness of combined interventions, which address both issues together as well as relationships between them.[1] I use the term "combined approaches" to describe any effort to address both partner violence and substance use together regardless of the specific organizational arrangements or strategies that make the program possible.

Studies have examined the effectiveness of combined interventions for partner violence and substance use, both among women who are victims of partner violence and have substance use issues (Cocozza et al., 2005; Fowler & Faulkner, 2011; Morrissey et al., 2005) and among men who are perpetrators and have substance use issues (Easton et al., 2007; Goldkamp et al., 1996; Kraanen et al., 2013). Results suggest addressing partner violence and substance use together may improve outcomes and that failing to address both issues when both are present may exacerbate risks.

A recent meta-analysis by Fowler and Faulkner (2011) considered the effectiveness of combined interventions for women with substance use and partner violence victimization. They find combined interventions are most effective with women currently experiencing intimate partner violence, younger women who have experienced less cumulative trauma, and women of color. The positive effects of combined interventions were also more pronounced in studies with smaller sample sizes, which Fowler and Faulkner suggest may be due to the more individualized approaches possible in these settings, lower attrition rates, or differences in study design. In a

[1] Bennett and Bland (2008) distinguish between two types of combined approach: coordinated and integrated. The former refers to approaches to partner violence and substance use that involve collaboration between discrete organizations and the latter to instances where both services are offered at a single location.

study comparing the effectiveness of combined approaches that also include attention to mental health and trauma to "usual care" (e.g., separate interventions for each issue), Cocozza et al. (2005) found that participation in combined programs led to greater reductions in post-trauma symptoms and the severity of drug problems. Effects were more pronounced when a combined approach was used across services (e.g., in individual and group counseling versus in one or the other) (Cocozza et al., 2005; Morrissey et al., 2005). Subsequent analysis of data from the same project suggests combined approaches may be particularly beneficial for participants who enter treatment with more severe alcohol use issues (Morrissey et al., 2005). Taken together, these studies underscore the benefits of addressing substance use and partner violence victimization through combined approaches and in multiple types of services.

Research has also considered the effectiveness of combined substance abuse and partner violence interventions for perpetrators. Results from the Dade County Court experiment, which compared outcomes of a combined substance use-partner violence program to a partner abuse intervention program and simultaneous referral to substance abuse treatment, support a combined approach (Goldkamp et al., 1996). Participants in the combined intervention had higher attendance and completion rates and lower recidivism rates than those receiving separate services for partner violence and substance use. A second study, housed within the Yale University Substance Abuse Treatment Unit, compared outcomes for men in a combined program using cognitive behavior approaches to those in a 12-step based substance use group (Easton et al., 2007). Participants in the combined program reported significantly fewer days of alcohol use and marginally fewer episodes of partner violence following the intervention than did those in who participated in the substance use group. A third study compared the effectiveness of a combined intervention to a substance use intervention with a single session on partner violence (Kraanen et

al., 2013). Both interventions were found to reduce substance use and partner violence, with no significant differences in their effectiveness.

Prevalence of Combined Approaches

Studies of intimate partner violence and alcohol and other drug use organizations in the mid- to late-1990s suggested that organizations rarely engaged the other issue beyond basic screening, assessment and out-referral (Bennett & Lawson, 1994; Collins & Spencer, 2002). More recent research has produced widely variable results largely due to differences in study design, sample, and measures used to assess combined services. Taken together, these studies suggest most partner violence and substance use organizations pay relatively little attention to the other issue.

One of the earliest known surveys of partner violence and substance use programs, conducted in 1994, found only a minority of programs (1 in 10) screened for the other issue (Bennett & Lawson, 1994). While most programs reported referral relationships with providers of the other type of service, it was unclear how often such relationships were activated. A nationally representative survey of partner and substance use programs found, in the early 2000s, that 58-72% of programs reported screening for the other issue (Spencer & Collins, 2002). Neither study, however, identified predictors of screening for both issues nor was any other type of combined approach studied. Similar rates of screening were found in a more recent study of substance use treatment organizations (Bennett, Prabhugate & Gallagher, 2016), with rates of screening higher in organizations with greater awareness of links between the two issues.

The only recent study to include both partner violence and substance use organizations focused on combined services for partner violence perpetrators and substance use (Timko et al., 2012). Results suggest a minority (16%) of substance use organizations systematically address partner violence perpetration at intake or over the course of treatment. In roughly one-third of

substance use programs, clients may be barred from admission or terminated for partner violence perpetration. Higher rates of screening were found in partner violence intervention programs (PAIPs): roughly 50% report screening for and/or monitoring participant substance use throughout the program. Consistent with Timko and colleagues (2012) findings, studies of partner abuse intervention organizations suggest that the majority include attention to substance use. Results of a 2009 survey of 276 programs found 55% include content on substance use (Price & Rosenbaum, 2009). In their survey of 238 PAIPs, Cannon and colleagues (2016) find a similar incidence of combined programs: 50.7% offer substance abuse counseling, although the extent to which this is integrated into the PAIP is unclear.

Studies of substance use treatment organizations suggest a substantial minority of programs report some attention to partner violence (Cohn & Najavits, 2014; Capezza et al., 2015). Using data from the National Survey on Substance Abuse Treatment Services (NSSTS), these studies find nearly 40% of substance use organizations report offering services for "domestic violence—family or partner violence services (physical, sexual, and emotional abuse)" (Cohn & Najavits, 505). Predictors of offering partner violence services include working exclusively with women, ownership by a tribal government, a general health focus (rather than mental health or substance use focus), ongoing staff training (opportunities for ongoing supervision and continuing education), and accreditation by the state health or mental health department (Capezza et al., 2015).

Research on combined programs in victim services organizations has been more limited. An unpublished study of 60 partner violence shelters found that many had policies restricting shelter access by women with active substance use issues (Wells, 2010 cited in Schumacher & Holt, 2012): more than two thirds of programs reported refusing to admit women who were

intoxicated at intake and nearly half stated they would ask an intoxicated shelter resident to leave. Few shelters (10%) indicated a willingness to admit and maintain victims with current substance use issues in residence, although 22.1% had substance use counselors on staff, 17.6% offered safety and sobriety groups, and 11.8% had both. Based on their survey of 71 domestic violence programs in North Carolina, Martin et al. (2008) found that 25% would refuse shelter to a woman who was actively intoxicated. Of those programs who would refuse admission, half indicated they would refer the participant to a substance abuse treatment program but only two programs had formal agreements in place to facilitate this.

These studies suggest that, with the exception of PAIP, relatively few programs working on substance use or partner violence include attention to the other issue. Thus, there appears to be some variation by program type, with studies suggesting women-specific substance use programs may be more likely to address partner violence (Capezza et al., 2015). In general, however, these studies provide limited insight into how programs address both issues (although Martin et al., 2008 is an exception). In larger studies—particularly those using National Survey on Substance Abuse Treatment Services data—it is often unclear which populations are included in the combined program (e.g., combined victim services and substance use or combined PAIP and substance use) as well as the particular services involved.

Barriers to Combined Approaches

Given high rates of co-occurrence, it is surprising so few organizations offer combined services for partner violence and substance use. Research suggests a combination of structural and philosophical differences pose barriers. While Collins and Spencer were unable to identify factors associated with lower levels of screening, assessment, and referral, they note that substance use organizations were, in the aggregate, larger and better-resourced, with greater

access to professional staff and a variety of revenue streams than were partner violence organizations (Collins & Spencer, 2002). These differences mirror earlier findings by Bennett and Lawson (1994). There also appear to be differences in how organizations structure combined programs, with substance use organizations more likely to address partner violence in-house than through collaboration with another organization despite low rates of training on partner violence (Collins & Spencer, 2002). Partner violence organizations more often reported address substance use through collaborative means (Collins & Spencer, 2002).

Conflicting philosophies also appear to play a role in limiting the prevalence of combined approaches. Over half of the respondents in Bennett and Lawson's survey described differences in beliefs about responsibility for behavior ("issue of control versus surrender") as a barrier to combined approaches. For respondents in partner violence programs, 12 step programs were also described as a barrier. Nearly half of partner violence programs and one-third of substance use programs either expected or had experienced "difference[s] in treatment philosophy" as a barrier to combined approaches (Collins & Spencer, 2002, p. 12).

Even amongst organizations committed to providing services for both partner violence and substance use, differences in resources and philosophies can be challenging to negotiate. In their study of 19 organizations in the United States and Canada with combined services for partner violence victims with substance use needs, Reed at al. (2004) identified three strategies organizations used to accomplish this work, each with distinct benefits and challenges. In the "exchange model," organizations combined services through a collaborative model. Partnerships between a partner violence and substance use organizations often involved cross-training staff and shared case conferencing. These often developed in response to changes in funding or policy. Organizations using this model reported conflicts based on differences in size and resources.

In the "expanded model," an organization focused on either partner violence or substance use integrated attention to the other issue into one or more existing program, which remaining primarily focused on its original issue. This strategy was most common in instances where distance, lack of resources, or other types of incompatibility precluded collaboration with a program of the other type. As organizations using this model expanded services to include the other issue, they often reported encountering suspicion from other partner violence or substance use organizations.

The "combined model" included organizations founded to address both partner violence and substance use and that devoted significant attention to both issues and their intersection. Organizations using this method reported challenges related to the incompatibility of funding sources for each issue and difficulty hiring staff with appropriate credentials and dispositions for work on both issues. Like expanded programs, combined programs reported difficulties stemming from their questionable legitimacy amongst single-issue organizations, funders, and regulatory systems associated with either area. Thus, the greater degree of integration, the more challenges organizations faced with respect to legitimacy in both fields.

These findings suggest differences in philosophy and structure present barriers to the development of combined approaches to substance use and partner violence. Existing research reveals little, however, about why or how much these differences matter. In my own research, participants often describe differences between the social systems for partner violence and substance use through metaphors of language or culture. Colleen, an expert in gender-sensitive substance use treatment, told me "the fields just grew up separate from each other, you know, and as I said, there's a lot of mythology about what they thought was happening" (2010 interview). Similarly, Judy described learning to work with partner violence victims after having

been trained in substance use as becoming bilingual: "I was speaking domestic violence with an accent, a very heavy accent, like almost not understandable, but as time passed, I became fluent […] I understand it and I get mixed up sometimes because I'll forget what field I'm in and I'll have to stop and search for a word because I'm thinking so fast that I can't translate fast enough" (2010 interview). Understanding barriers to combined approaches to substance use and partner violence require exploration of the belief systems—as Colleen put it "the mythology"—of both areas and how these have shaped organizational forms and practices.

A Field Theory of Social Service Provision

To better understand the philosophies associated with partner violence and substance use treatment and how these in turn shape practices and limited combined approaches, I turn to field analysis. An interrelated set of theories and methods, field analysis, at its core, is directed towards understanding relationships between macro-level phenomena and the actors—whether organizations or individuals—that shape and are shaped by these phenomena.

Fields cohere around a central logic: a set of common symbols, material practices, underlying rationales, and rules related to the distribution and valuation of resources (Friedland & Alford, 1991). While a field's logic references the larger institutions or broader fields in which it is embedded, a field's logic is unique and not reducible to that of any other field (Bourdieu & Wacquant, 1991; Thorton & Ocaisio, 2006). Some perspectives, like institutional analysis, emphasize formal rules—often rooted in the state and largely figured as external to the field itself—to which actors are subjected, normative forces assumed to generate pressure towards similar or isomorphic practices, and the common cognitive systems or cultural schemas actors draw upon (Scott, 1995).

Despite common adherence to the field's central logic, actors within a field are not all the same. Bourdieu emphasizes the dynamic nature of fields, with analysis focused on describing the different positions—dominant and subordinate—what make up a field and the principles of division that shape action and determine the allocation of resources in the field (Bourdieu & Wacquant, 1999). Fligstein and McAdam's (2012) more recent work on strategic action fields shares this emphasis. They divide actors into incumbents and challengers. Incumbents are actors with the power to shape the way a field is organized at a specific time—the specific approaches and perspectives regarded as best. Challengers often act in conforming with the field's central logic, but do not fully share it. When conditions shift, they may act to disrupt the current order and, in shifting the fields logic to favor themselves, become the next set of incumbents. Fligstein and McAdam's framework also includes a third type of actor—internal governance units—whose role is to maintain order in the field. Specifically, these bodies "legitimize and naturalize" the field's logic and rules, collect and provide information about the field to members, and mediate between actors within the field and other external fields (p. 14).

Some studies of fields focus on describing differences between positions. Emirbayer and Williams (2005), for example, use field analysis to describe dynamics amongst New York City homeless shelters. They emphasize competition for status based on pursuit of two seemingly contradictory goals: working with the most disadvantaged clients and producing order, both within the shelters and as an outcome of intervention with individual residents. Emirbayer and Wiliams argue, rather than simply a matter of size, age, or revenue, the highest status shelters are those able to achieve the best outcomes for the most challenging cases. As organizations pursue these goals, they also attempt to shift field-level dynamics—funding decisions and policies—to favor their approach to homelessness.

In applying the concept of field to social service domains, work on so-called "problem-centered fields" is particularly relevant (Hoffman, 1999). Problem-centered fields coalesce around issues or problems and bring together different types of actors—not just organizations whose day-to-day work concerns said problem, but also funding and regulatory agencies, scholars committed to the development of formal knowledge, and individual activists—all those with a legitimate stake in the target issue (Hoffman, 1999). Because these fields are tied to social movements, positions within them represent deep affiliations: they are "not simple constellations of ideas, frames, cognitions and identities. Rather, they [are efforts to] enact, embody, emote and articulate (visually and verbally) particular visions of what is and what ought to be" (Klawiter, 2008, p. 44).

Tracing the history of a field is often part—if not the central focus—of field-analytic studies. Research focused on identifying a field's logic tends to use an inductive approach, building up a conception of the field's logic—and shifts in that logic over time—based on analysis of textual materials, whether academic sources (Reuf, 1999, 2000), organizational descriptions (Armstrong, 2002; Mohr & Duquenne, 1997), or the legislative record and field-specific publications (Hoffman, 1999). Other research focuses more on understanding the range of logics in play at a particular moment in a particular field and the implications for actors Emirbayer & Williams, 2005; Garrow & Grusky, 2012). A third set of studies occupy a middle position, first developing an account of shifts in the fields logic and then situating the activities of a discrete set of organizations within it (Klawiter, 2008; Scott et al., 2000).

Though methodologically distinct, both Scott et al.'s (2000) analysis of the healthcare field and Klawiter's analysis of social movement organizations focused on breast cancer are similar in scope. In both pieces, efforts are made to document changing logics and situate the

activities of a discrete population of organizations against them. Scott et al. (2000) identify three eras relevant to their analysis of Bay Area healthcare organizations. Eras differ in terms of their governance structures, logic, and the types and relative influence of involved actors, though they emphasize the role of legislative shifts in bounding each era. While Scott et al. (2000) provide a clear description of their techniques for identifying governance structures and key actors, their approach to the field's logic is less clear.[2] As in Armstrong's (2002) analysis, Scott et al. are attentive to the shifts in the numbers of different kinds of healthcare organizations across eras.

In making sense of different understandings of and approaches to breast cancer by a set of Bay Area organizations in the late 1990s, Klawiter (2008) highlights the role different "regimes of practice" play in shaping organizational practices. These regimes are bundles of cultural material—"institutionalized practices, authoritative discourse, emotional vocabularies, visual images, and social scripts through which [phenomena] are socially constructed… managed…administered, and subjectively experienced" (Klawiter, p. 33)—that, as the result of advocacy by specific actors, gain prominence in specific historical moments. In tracing responses to breast cancer over the course of the 20th century, Klawiter focuses on the regime of medicalization and the shift from conceptualizations of breast cancer as a shameful, private problem to a popular cause.[3] Her account traces the declining hegemony of professional medicine in responding to the disease. Whereas knowledge of the disease was once tightly regulated and women had minimal influence over their course of treatment, today there are multiple perspectives on the causes, nature, and ideal treatment for breast cancer. In detailing the

[2] They note that they "employ a variety of indicators, all of which serve to assess changes in underlying belief systems. Shifts in the content of professional journals, in the circulation of popular magazines, in the ways financing is arranged, in who is regarded as a legitimate leader—these are some of the markers employed to capture changing institutional logics" (p. 171). Their process for selecting and analyzing these source materials is not detailed.

[3] Medicalization represents one regime of practice: the social world is comprised of a "radical multiplicity" of regimes (Klawiter, 2008, p. 34).

activities of three organizations, Klawiter shows that differences between them, which she describes as "cultures of action," cannot be meaningfully understood without reference to the broader history of the disease. Each culture of action represents a different perspective on what breast cancer is and how it should be addressed. Her analysis shows how particular ideas about the nature of social problems are structured into organizations, thus shaping all aspects of their practice.

Klawiter's historical analysis of shifting regimes of practice primarily serves to contextualize her ethnographic work three Bay Area organizations. In contrast, Epstein (1996, 2007) places greater emphasis on the role of formal knowledge. His 1996 analysis of the AIDS epidemic is intimately "concerned with the construction of facts, [and]…assumes that the dynamics of fact-making become apparent only through a…thoroughgoing examination of power, meaning, and social organization" (p. 5). Emphasizing the dynamics of knowledge production, Epstein's analysis centers on moments within the early stages of the epidemic in which science was enlisted to settle political disputes. In particular, he focuses on debates over the issues of causation and treatment. Though activists, researchers, and government officials largely function as discrete communities, it is only "out of their intersection [that] there emerges a field that generates knowledge about AIDS" (p. 18). It is in tracing the patterns of interaction between these groups that an understanding of the dynamics of the field of AIDS interventions becomes possible.

Epstein's analysis traces the establishment of dominant theories of causation and treatment protocols through exploration of "credibility struggles" that gave rise to them (p. 331). Dominant approaches gained credence only through the protracted struggles of different stakeholder groups, each with a different set of tools and interests related to the outcome.

Epstein's analysis shows that while scientists and activists pursued different pathways to credibility, the incorporation of medical terminology was critical to the success of both. Forms of treatment emerged through the selective combination of these scientific symbols and "moral (or political) and methodological (or epistemological) arguments" (p. 336) but gained credibility only with the sanction of biomedical authorities. Thus, while facts do matter, it is only through a careful mapping of the conditions of their production that one can trace how some facts come to matter more than others.

Understanding the characteristics and behavior of the organizational actors within a social service field thus requires unpacking the field's history. This history shapes the contents of what Clemens (1993) refers to as organizational repertoires: "the set of…models that are culturally or experientially available" (p. 758). While attempts to shift field-level logics are sometimes explicit, more often they are not. They include "resources that can be strategically mobilized but also…schemas and discourses whose workings may go unrecognized by the actors in question" (Johnson, 2007, p. 118). Building on Stinchcombe's notion of "organizational imprinting" (1965), Johnson argues that organizations are "shaped by historically specific resources upon which their founders draw," including influences of which actors are not fully conscious (2007, p. 98). A complete understanding of the actions of particular organizations would thus includes "assessment of the organizational and other repertoires on which founders draw or by which they are unconsciously influenced as they construct new organizations" (Johnson, 2007, p. 103).

Field-Level Logics and Organizational Practices

Research linking field-level logics to organizational practices has generally used an inductive approach. Studies have draw on descriptions in organizational directories (Armstrong, 2002;

Mohr & Duquenne, 1997) or mission statements (Garrow & Grusky, 2012; Garrow & Hasenfeld, 2014), treating these as types of as position-takings, "works services, acts, arguments, and products" organizations use to reference the field's logic and attempt to differentiate themselves from others (Emirbayer & Johnson, 2008).

Focusing on Los Angeles-area HIV-testing organizations, Garrow & Grusky (2012) begin with CDC guidelines for HIV testing and counseling—the field's logic—and proceed to consider the degree to which actual organizational practices conform to them. Based on analysis of organizations' mission statements and interviews with staff, they identify four variations of this logic—a medical logic, a public health logic, a social movement logic, and a multi-service logic. Each is distinct in terms of target population, conceptualization of the problem, desired outcomes, and proposed solutions. To consider how logics shape practices, the authors examine differences in staff background (medical or nonmedical), organizational formalization (use of the LSA Health and Human Service Information Resources System, a computerized system for tracking clients), and several other characteristics of organizations.[4] They find differences in the comprehensiveness of counseling sessions based on logic, with organizations adhering to a social movement logic covering a greater number of topics per counseling session than those using a medical logic. Thus, while all organizations in the study work on HIV, how they do this work is subject to considerable variation.

Other studies, in addition to using directories to identify field members, have analyzed directory descriptions rather than mission statements to conceptualize practices and, ultimately, logics. Mohr and Duquenne (1997) attempt to uncover the logic of social relief at the turn of the 20th century by systemically examining links between categories of aid recipients and relief

[4] These other organizational characteristics include the numbers of hours per week spent on client care, number of clients seen per week, number of employees, whether organizations were founded before or after 1980, and ownership status.

practices in organizational descriptions in the New York City Directory of Charitable Organizations. Their analysis centers on understanding which populations were understood as deserving of particular kinds of aid (e.g., indoor versus outdoor) and how this shifted over time. Armstrong (2002), also concerned with shifts in field-level logics, analyzes entries in organizational directories published between 1950 and 1994 to identify three political logics associated with the field of sexuality-focused organizations: an interest group political logic, a redistributive political logic, and an identity political logic. These logics are distinct in terms of their conceptualization of the problem, goals, and acceptable strategies, organizational characteristics, and conceptualizations of identity (Armstrong, 2002).

These studies suggest, for organizations engaged in human services or social change work, the kinds of descriptions found in directories and mission statements about target populations and services are symbolically and practically meaningful. Pursuing an inductive approach allows analysts to identify groups of organizations that approach the field's work in similar ways. This research suggests that critical areas for attention include problem definitions, target populations, goals or mission, and the specific services provided.

Relationships Between Fields

Pierre Bourdieu once described the relationship between fields as "extremely complex," a question he "would normally not answer because it is too difficult" (Bourdieu & Wacquant, 1991, 109). Since the time of that writing, numerous frameworks have developed that treat society as a space of hierarchically organized and potentially overlapping sectors (Friedland & Alford, 1991; Sewell, 1992; Fligstein, 2001; Klawiter, 2008). In each of these, the spaces between sectors are depicted as sites of radical potential, where change emerges through borrowing elements from one area and using them in another (Sewell, 1992; Armstrong, 2002; Armstrong & Bernstein,

2008). Actors able to adapt elements from one field to another are conceptualized as innovators or entrepreneurs (Fligstein, 2001; Armstrong & Bernstein, 2008; Binder, 2009).

Evans and Kay's (2008) work on mechanisms for field overlap offers a promising set of tools for identifying areas of convergence between fields. Based on their study of the relationship between four fields[5] involved in role of environmental groups in trade negotiations, Evans and Kay (2008) identify four mechanisms through which fields may overlap: rule linkage, network intersection, resource interdependence, frame concordance. The first mechanism, rule linkage, relates to institutional connections between fields and the ability of actors in one field to make rules that bind actors in another field. Network intersection refers to connections between actors across fields through which resources from one field may be deployed in the other. Similarly, resource interdependence refers to the degree to which resources valued in one are recognized as meaningful in the other. Lastly, frame concordance entails the ability of actors to transpose concepts and narratives from one field to transform the discursive parameters of another. Though focused on areas of overlap between fields, this framework also points to the kinds of conflicts that may arise between adjacent fields.

While Evans and Kay focus on dynamics at the field level, other scholars have focused on how organizations and individuals navigate multiple logics. Those drawing on logics from multiple fields are conceptualized as hybrids (Battilana & Dorado, 2010; Cooney, 2006; Skelcher & Smith, 2015). Cooney's (2006) account of a hybrid human service organization that includes elements from what she called the "social service organizational field" and the "technical business organizational field" (p. 148) suggests negotiating multiple logics may present challenges. Based on ethnographic work in a social service organization that provides welfare-to-

[5] These are the U.S. trade policy field, the legislative field, grassroots politics and transnational trade negotiating fields (Evans & Kay).

work job training through a for profit arm, Cooney finds that while the organization's hybridity enables it to access a broader variety of funding than traditional organizations of either type, it has negative consequences as well. Efforts to achieve legitimacy in each field simultaneously may compromise its ability to compete adequately in either. Specifically, the need to support participants on the social service side conflicted with the need to maintain production standards on the business side.

Status and Innovation in Fields

The literature on dynamics surrounding innovation and change in organizational fields offers some insight into the kinds of organizations likely to adopt hybrid approaches. Several studies have considered the relationship between status and innovation. Across studies, status refers to the prestige, honor, or esteem associated with a particular position (Weber ([1922], 1946)—in field terms, whether actors fall into incumbent or challenger positions. Findings suggest that change emerges from either high or low status actors (Leblebici et al., 1991; Rao, Monin & Durand, 2005) rather than those occupying middle positions in field-specific hierarchies (Philips & Zuckerman, 2001).

In their study of the US radio broadcasting industry, Leblebici et al. (1991) define status in terms of access to resources in the radio broadcasting field. In the first period they identify, they define as high status those that were, in 1921, already "established players in this industry"—founders of the Radio Corporation of America and their primary competitors, intercontinental cable networks used for private communication. Low status players are amateur radio enthusiasts who were "building their own makeshift home receivers and broadcasting from their attics and garages" (p. 343). In subsequent periods, high status players are those who able capitalize on innovations introduced by marginal players in the prior era. They find that in each

of the three historical periods, innovative practices were most often introduced by actors who were either new to the field or in low status position within it. High status actors, with a vested interested in maintaining the status quo, initially resisted innovations. Over time, however, competition amongst elite actors led to the adoption of previously marginal innovations, a revaluation of resources within the field, and an altered hierarchy in the subsequent period.

In their study of the hybridization of French classical and nouvelle cuisines, Rao, Monin and Durand (2005) find the opposite. In their analysis, status is defined using Michelin stars, where high status chefs are those with one or more stars. They find high status actors were more likely to adopt techniques from the other schools and were less likely to be penalized for doing so (in the form of a downgrade in Michelin ratings) than were lower status actors. As the number of high status actors bridging cuisine types increased, penalties diminished for the field and lower status actors began to emulate their higher status peers. Thus, innovation was introduced by elite actors and, over time, diffused to the margins of the field.

Philips and Zuckerman's (2001) analysis of middle status conformity offers something of a compromise. Based on their analysis of the market for legal services in Silicon Valley and the investment advice market, findings underscore the notion that innovative practices are unlikely to emerge from middle status actors. Philips and Zuckerman argue that fields divide into three categories: insiders (high status), outsiders (low status) and those on the dividing line (middle status). In their study of law firms, status hinges on the proportion of attorneys with degrees from a set of six elite law schools while the study of securities analysts uses rankings in a prominent publication in the field to determine status. In both fields, middle status actors, neither securely at the top or bottom, "work feverishly to solidify their social standing by demonstrating their conformity with accepted practice" (p. 382). Elite actors innovate because they possess the

resources—both material and reputational—to do so at minimal cost, whereas marginal actors innovate because they have nothing to lose and, potentially, everything to gain.

What is means to be high or low status in a field thus depends on the field itself. Status reflects how actors embody the field's logic, which changes over time as the result of internal competitions and external forces. The consensus that emerges on the relationship between status and innovation, however, is that change is most likely to be introduced by either marginal or elite actors.

Hybridity Strategies

Other research suggests that organizations combining logics from separate fields may do so in different ways. Based on their efforts to integrate literatures on organizational hybridity and the institutional logics approach, Skelcher and Smith (2014) theorize five types of hybrids, distinguished by the degree of separation between components. In the first two types, logics remain compartmentalized in discrete units within a single organizations. In the first of these types—segregated hybrids—activities associated with distinct logics are divided into discrete organizations. This approach, then, may describe what previous studies of combined services for partner violence and substance use refer to as exchange (Reed et al., 2004) or coordinated approaches (Bennett & Bland, 2008).

The second approach, segmentation, describes hybrids where activities associated with different logics remain separate but with a higher degree of coordination than in segregated hybrids. For example, a large human service organization might have one department focused on partner and another focused on substance use, connected only at the highest administrative levels. Though part of the same organization, these units might have separate management, wholly separate funding streams, and perhaps even be housed in different sites. In segregated and

segmented hybrids, organizations are, to a large extent, insulated from potentially negative effects of incompatibilities between the two logics. Skelcher and Smith suggest that this form of hybrid will be most common in environments with strong normative pressures.

In assimilated and blended hybrids, the two logics within a hybrid organization are brought into a higher degree of coordination. In assimilated hybrids, the organization's core logic remains the same although elements associated with a new logic are selectively incorporated. For example, a substance use program might begin to include safety planning—a routine practice with partner violence victims—into its counseling services for women without changing the overall framework for services. Alternately, a partner violence program committed to "meeting participants where they are at" might begin to offer support groups for substance use within its shelter. In both cases, the organization's core identity as either substance use or partner violence organization remains unchanged, although practices associated with the other field are incorporated. In assimilated hybrids, tensions between logics are minimized through the selective incorporation of elements from the other field. Skelcher and Smith suggest organizations that begin with a segmented approach may shift to assimilation as they become increasingly adept and navigating both logics.

Skelcher and Smith use the term blended to refer to organizations in which two formerly separate logics merge to such an extent as to form a third category. A blended hybrid's identity thus incorporates synergist elements from both original logics. For example, an organization committed to providing services for both partner violence and substance use might refocus on trauma-informed care for both and, within all services offered by the organization, begin incorporating attention to partner violence, substance use, and the relationship between them.

The fifth type of hybrid identified by Skelcher and Smith is the blocked hybrid. In this type of organization, the two logics are sufficiently incompatible that the organization cannot function and either gives up on hybridity or fails. Existing literature on organizational efforts to address partner violence and substance use suggests that this outcome may be quite common.

In theorizing why organizations use particular hybridity strategies, Skelcher and Smith suggest that different combinations of logics may result in different forms. Thus, understanding how individual organizations are situated in their primary field in terms of how they embody its core logic and their relative status potentially shapes the likelihood of their engaging in hybridity and the strategies they use to do so.

Outline of Dissertation

My dissertation seeks to answer two interrelated questions. First, why, despite evidence of need, availability of models and, in some cases funding, do so few organizations address both substance use and intimate partner violence? Second, what distinguishes organizations who address both issues together from those that do not? To answer these questions, I draw on multiple kinds of data to conceptualize partner violence and substance use as discrete fields, each with its own logic, practices, and actors, and draw on literature on relationships between status and hybridity to understand which organizations are likely address these issues together.

In the following chapter, I describe the data and methods used in this dissertation. Conceptualizing partner violence and substance use as fields requires attention to both their histories and current configuration. This chapter details the process of gathering data on the histories of both fields—and the relationships between them—using interviews with key informants in both fields and archival data as well as the process of developing a dataset on the

characteristics and practices of contemporary organizations involved in either type of work in metropolitan Chicago.

Chapter III focuses on the history of the substance use field, which, though rooted in earlier models like Alcoholics Anonymous, emerged in the early 1970s with the passage of several major pieces of federal legislature that established early infrastructure for community-based treatment programs and research on their effectiveness. Drawing on interviews with key informants, archival materials, and the secondary literature on policy and treatment, I trace the increasing medicalization of the field and chart the emergence of specialized forms of treatment—notably, women specific programs. Yet, as funding models have shifted to favor a medical logic, approaches to the complex needs many participants have are increasingly constrained. I end by describing the current configuration of the field, using interview data to elucidate its status hierarchy.

In Chapter IV, I turn to the history of the partner violence field. Rooted in feminist social movements of the late 1970s, there are longstanding tensions between approaches that root partner violence in patriarchal social structures and those that place greater emphasis on individual and family characteristics. As the field developed, policy and funding changes came largely through alliances with the criminal justice system. I describe tensions over professionalization and the proper place of partner abuse intervention programs, both sources of ongoing tension. The chapter ends with attention to the current configuration of the field, pointing to likely bases for status.

The following chapter, Chapter V, looks to the history of both fields to develop a deep understanding of barriers to combined services. I show how definitions of alcoholism as a family illness and partner violence as a social-structural problem led to early tensions. Tracing efforts to

address both issues together in metropolitan Chicago, this chapter shows how the specific kinds of tensions and convergences at various time points have allowed for the development of hybrids.

Chapter VI considers the activities of contemporary partner violence and substance use organizations in metropolitan Chicago. Using data from organizational directories and websites, I describe contemporary positions in both fields, as well as showing how the two fields differ in organizational characteristics and practices.

In Chapter VII, I consider the relationship between status and hybridity for both fields. Consistent with existing literature, this analysis suggests that hybridity is most common amongst lower status organizations in both fields. Through attention to hybridity strategies, my findings suggest most hybrids do little to address both issues together, despite the presence of services for both within a single organization. More substantive approaches to hybridity are found disproportionately amongst higher status organizations in both fields, pointing to the role of resources in mitigating barriers.

The conclusion, Chapter VIII, offers an overview of key findings with implications for future research, policy, and practice. While awareness of the need for combined services has increased in the last several decades, with staff in both types of organizations increasingly receptive to the development of these approaches, regulatory and funding systems have been less amenable to change. Mitigation of tensions between field-level logics has made implementation of combined approaches more possible but, without changes to regulatory and funding system, they are likely to remain rare.

CHAPTER II

A Field Analytic Approach to Services for Partner Violence and Substance Use

The purpose of this dissertation is to show how differences in the ways the partner violence and substance use fields developed shape current organizational practice and, more specifically, the development of combined approaches at the level of individual social services organizations. To do so, the project employs a mixed-methods design. More than simply being complementary, the different kinds of data and different phases of the project are interwoven, with unexpected insights emerging from moving back and forth from historical to contemporary materials and from data on organizational characteristics to key informant-generated narratives about the overall structure of the fields. This chapter describes collection of that data and analytic process used in the remainder of the dissertation.

Conceptualizing Fields

Field analysis favors the use of multiple kinds of data and methods. Emirbayer and Johnson describe collection of the necessary data as an iterative process, which should draw on existing histories but also include primary data collection, whether in the form of surveys, interviews, archival research, or some combination (2008). Historical analysis is foundational to field analysis and Emirbayer and Johnson argue that constructing appropriate measures for primary data collection depends on insights developed from in-depth, ethnographic and historical research.

Thus, most studies using field analysis have used multiple kinds of data. Crossley (2006), for example, draws on records from social movement organizations, newspaper articles, and records from Parliamentary debates, existing publications, and key informant interviews to conceptualize the field of psychiatric contention in Great Britain. Epstein's research on the AIDS epidemic draws on a rich variety of sources, including "published instances of claimsmaking" in academic, popular, and alternative journals and newspapers, interviews with "researchers, activists, and government officials" and observations at "conferences, meetings, forums, demonstrations, and other public events" (p. 355). Similarly, Klawiter (2008) combines multi-sited ethnography with historical research focused on portrayals of breast cancer in public health campaigns. Each of these accounts layer together analysis of historical documents, including academic and popular texts, with observations and interviews. In so doing, they offer insights into the processes by which contending groups "sketch out a different blueprint from…the same terminology and the same essential set of concepts" (Sewell, 1985, p. 74 & 76 cited in Emirbayer & Goodwin, 1994, p. 1440).

Sample, Data, and Analytic Strategies: Key Informant Interviews and Archival Work

I rely on primary, secondary, and archival sources to describe the history and development of the fields of substance use and partner violence services in the United States from the 1960s to the present. Data were collected and analyzed in several waves. This approach allowed me to refine my focus and research questions over time. Themes identified in earlier waves of interviews shaped lines of questioning in subsequent waves.

Key Informant Interviews, 2010

I collected an initial set of 16 semi-structured, qualitative interviews with experts on partner violence and/or substance use in 2010. For the purposes of eligibility, expertise was defined as

ten or more years of involvement in work on either issue in federal or state government, research, and/or direct service provision. Interviews focused primarily on perceptions of the field's history—major victories and setbacks, players, theories and approaches—and current configuration. Questions on the field's current configuration centered on identifying the basic set of services an organization needed to provide to "count" as a partner violence or substance use organization, criteria for successful work on substance use and partner violence, and services and approaches interviewees' characterized as especially innovative or cutting edge. Interviews were semi-structured, which allowed me to tailor questions to respondents' circumstances and expertise.[6] All study procedures and materials were approved by the University of Michigan's institutional review board (IRB) prior to the beginning of data collection. As the project developed, this initial IRB application was amended to reflect shifts in focus and procedures.

I developed an initial list of potential interviewees through academic networks at the University of Michigan and responses to a survey on organizational efforts to address both partner violence and substance use.[7] Subsequent interviewees were identified using snowball sampling. At the end of each interview, I asked participants to identify three or more other individuals whose perspectives on the fields should, in their estimation, be included in the project. To maximize the variety of perspectives included, I encouraged participants to recommend others who they thought might have a different perspective on the history or current state of the field than their own and who also met criteria for inclusion based on years of experience. With participants' permission, I used these recommendations to recruit others, explaining that the

[6] The semi-structured interview guide for the 2010 interviews is included in Appendix B.

[7] This survey, led by Beth Glover Reed and Larry Bennett, was targeted towards direct service organizations but was sent via listservs—including one maintained by a regional coalition of batterers programs—that included people working in a variety of kinds of positions. An initial screening section included a question asking whether respondents might be willing to participate in a follow up interview "regarding activities and organizing related to partner violence and/or substance use services in the United States." When I began recruiting interviewees, I drew on this pool of potential participants.

potential participants had been recommended as someone with a valuable perspective on the field's history and approaches.

During this phase of data collection, I contacted 26 individuals to request interviews and completed interviews with the 16 who responded.[8] These interviews are listed in Table II.i. This set of interviews include seven interviewees whose primary areas of expertise is substance use and nine whose primary area of expertise is partner violence. Of the sixteen interviewees, seven has expertise on both issues, having worked in both fields or been involved in efforts to develop, implement, or otherwise promote combined approaches.

Table II.i – Key Informant Interviews, 2010

Pseudonym	Primary field	Population	Dual Expertise	Position	Tenure (years)	Illinois based
Gail	Substance use	Women	Yes	Direct service	20+	No
Joan	Substance use	Women	Yes	Research	30+	No
Virginia	Substance use		No	Direct service	20+	No
Ian	Partner violence	PAIP	No	Policy	20+	No
Nathan	Partner violence	VS*	Yes	Research	20+	No
Diana	Substance use	Women	Yes	Direct service	10+	Yes
Steven	Partner violence	PAIP	No	Direct service	20+	No
Paul	Partner violence	PAIP	Yes	Research	30+	Yes
Judy	Substance use	Women/VS	Yes	Arservice	20+	No
Roger	Partner violence	PAIP	No	Research	30+	No
Julie	Partner violence	VS	Yes	Direst service	20+	No
Doug	Partner violence	PAIP/VS	No	Funding	20+	No
Gene	Substance use	Men	No	Research	40+	No
Gloria	Partner	PAIP/VS	No	Direct service	30+	No

[8] Nonresponders were disproportionately from the substance use field. This is partly because my initial list of contacts skewed towards the partner violence field.

	violence					
Colleen	Substance use	Women	No	Research	25+	No
Ken	Partner violence	PAIP	No	Direct service	25+	No

* victim services

Because interviewees were based across the United States, all but two interviews were completed via telephone or Skype. Interviews ranged in length from 45 minutes to three hours. After each interview, I developed field notes to encapsulate major themes and explore relationships between interview content and emergent ideas about field-level dynamics. A secondary purpose of these interviews was to identify a geographic focus for subsequent rounds of primary data collection. All interviews were audio-recorded and professionally transcribed. To protect confidentiality, interviewees were assigned pseudonyms.

These first-hand narratives were supplemented by review of the secondary literature, which I conducted between 2011 and 2012. To identify relevant articles, I drew on both recommendations embedded in the 2010 interviews and searches in *Social Service Abstracts.* The review focused on four areas: federal policy and funding, theories and conceptualizations of partner violence or substance use, approaches and interventions, organizational and staff characteristics, and strategies for evaluating intervention effectiveness. Examples of search terms include phrases like "federal policy AND domestic violence" and "substance use treatment effectiveness." In selecting literature, I emphasized peer-reviewed literature—and often review articles describing policy and/or intervention approaches—but also included popular, agenda-setting texts that impacted public perceptions and popular discourse.[9] This research also included attention to documented efforts to facilitate work on both partner violence and substance use,

[9] Examples of these kinds of texts include *The Twelve Steps and Twelve Traditions,* which codified the twelve steps and traditions associated with Alcoholics Anonymous, and, on the partner violence side, Del Martin's *Battered Wives* and Susan Schechter's *Women and Male Violence: Visions and Struggles of the Battered Women's Movement.* The latter are both associated with feminist approaches to partner violence.

whether sponsored by the federal government, state governments, or private organizations. These pieces were most often identified based on the 2010 expert interviews. Though not exhaustive, this search strategy allowed me to develop basic timelines for each field in the four areas identified above. These were then used to structure subsequent rounds of analysis and data collection.

Site Selection and Organizational Interviews, 2011

While the 2010 key informant interviews and secondary literature review allowed me to develop rough timeline of events in both fields and some sense of their logics, they provided little insight into organizational practices and, specifically, differences between organizations that work on both substance use and partner violence and those focused on one or the other issue. Expanding the project to consider the activities of organizations required making decisions about where to focus data collection, which were shaped by both theoretical and practical considerations.

Chicago—and Illinois more generally—was a compelling choice for several additional reasons. In the late 1960s, Chicago was home to one of the first federal demonstration projects related to substance use—the Illinois Drug Abuse Project—which focused on bridging what were often rigid distinctions between different treatment modalities. On the partner violence side, Illinois is home to one of the oldest state coalitions, so has a rich history of feminist advocacy work on this issue. Illinois is also unique in that, in the 1990s, there was a state-led effort to facilitate the development of combined approaches through the Domestic Violence/Substance Abuse Interdisciplinary Taskforce, which sponsored a series of conferences, developed a best practices manual, and offered pilot funds for designing and implemented combined programs.

To understand why some organizations use a combined approach to partner violence and substance use when most do not, I needed to compare hybrid and non-hybrid organizations while

controlling—at least to some extent—for differences in regulatory and funding environments and, potentially, participant demographics. I focused subsequent primary data collection on metropolitan Chicago, a region with multiple organizations working on both partner violence and substance use and a history of state-level support for these endeavors. Though directories of state-licensed substance use programs, state-licensed partner abuse intervention programs, and the membership list for the Illinois Coalition Against Domestic Violence, I identified a preliminary list of 20 hybrid organizations—15 licensed to provide substance use services and licensed to provide PAIP and an additional 5 that had been part of the Domestic Violence/Substance Use Pilot Project.[10] I also solicited recommendations from a Chicago-based contact with long-standing ties to both fields.[11]

Based on nominations from contacts in Chicago, I planned to recruit 10 organizations: 5 focused entirely or primarily on substance and 5 focused entirely or primarily on partner violence. I found it much easier to recruit partner violence organizations than substance use ones. Calls and emails to substance use organizations more often went unreturned and, when I contacted potential participants, they were more likely to decline participation. When I followed up with the CEO at one large substance use organization to better understand the circumstances under which they might have been willing to participate, I asked whether providing an incentive of $200 or $300 in compensation for their time would have made a difference and was told that it likely would have.[12] While that it unknowable, the contrast in the accessibility of key informants

[10] Entries in these same directories—supplemented with several others--formed the basis for the organizational dataset described below and used in Chapters VI and VII.

[11] Having this contact was an additional motivated to focus on metropolitan Chicago. Because of their work with many of the organizations in the study, being able to say this contact had suggested I interview potential participants opened doors that likely otherwise would have been closed to me as an outsider.

[12] This is a known issue with expert interviews. Because interviewees are people in professional positions with significant resources, the kinds of incentives researchers ordinarily offer—like $20 Target gift cards—have little

in both fields speaks to differences between the two fields. My sense is that narrating the history of the field or their organization for a younger woman interested in partner violence had meaning beyond the encounter itself. Several informants in the partner violence field raised concerns about the loss of institutional memory as activists associated with the field's early history retired or passed away.

Table II.ii - Organizational Interviews, 2011

Organization Pseudonym	Founding Year	Primary field	Hybrid	Interviewee Pseudonym	Tenure
Women's Advocacy Center	1976	Partner violence	Yes	Constance	20+
Solutions for Health	1972	Substance use	Yes	Carla	20+
			Yes	Mark	30+
Wellness Support Organization	1984	Substance use	Yes	Sheila	4
				Tammy	27
				Eleanor	7
Safe Space	1981	Partner violence	No	Laura	9
Sunrise Place	1982	Partner violence	No	Bridget	10+
Center for Wellbeing	1967	Substance use	No	Silvio	26
Lifeline Services	1975	Partner violence	No	Wendy	30+
Transitions	1928	Substance use	Yes	Ruth	25+

In 2011, I traveled to Chicago and collected semi-structured interviews with representatives of six organizations, three focused primarily on partner violence and three primarily on substance use. Of these six organizations, three were currently using combined approaches to substance use and partner violence and three were not, although one had in the past. All interviews were conducted at the organization, which afforded an opportunity to observe program spaces and collect agency documents, when interviewees made these available. Geared more towards the characteristics and practices of organizations, these interviews in many

meaning for participants while the level of incentive that might tip the balance is sufficiently high to be out of reach for most researchers.

cases afforded unexpected insights into field-level histories. The semi-structured interview guide is included in Appendix B.

As with the earlier set of interviews, I created field notes after each interview to summarize content and track themes. Two additional interviews with direct service organizations in metropolitan Chicago which were also collected in 2011, are included in this wave of data collection.[13] These organizations were both primarily in the partner violence field, though one also addresses substance use. These interviews were conducted by phone. All interviews were audio-recorded and professionally transcribed. Table II.ii describes the organizational interviews conducted in 2011. To protect the confidentiality of participants' responses, each participant—and each organization—was assigned a pseudonym.

Key Informant Interviews, 2014

The final wave of data collection occurred in 2014. During the summer and fall of that year, I spent five weeks in Chicago, conducting interviews with 26 experts in partner violence and/or substance use in metropolitan Chicago. As with previous waves of interviews, I began with a discrete number of contacts. These initial contacts had either been recommended by a colleague with longstanding involvement in work on both issues in the region or identified during earlier waves on data collection. Additional participants were identified using snowball methods. Over the course of this wave of data collection, I contacted 40 individuals to request interviews and completed interviews with 26.[14] Of those I contacted but did not complete, only one declined, citing limited availability. Others failed to respond to multiple recruitment emails and phone

[13] These interviews, though collected for a separate project led by Beth Glover Reed and Larry Bennett, include sections on the organization's history, current approach to partner and/or substance use, and relationships with other area service providers and related institutions.

[14] In several instances, the person I initially contacted was not available but referred me to someone else in the same organization who went on the complete an interview. Because the focus of the project was on organizationally-situated perspectives rather than individuals per se, I do not count these as refusals to participate.

calls. Most of the individuals I contacted who did not participate were in the substance use field; the remaining five were in the partner violence field. This sample of interviewees is described in Table II.iii.

Interviews were conducted at a time and location of the interviewee's choosing. To accommodate interviewee schedules, four interviews were conducted over the phone. When interviews were conducted in person, all but one took place at the interviewee's place of employment during regular working hours; the other interview was conducted at a restaurant during the interviewee's lunch break. All interviews focused on interviewees' perceptions of the field's history, including turning points with regards to policy, funding, services, and overall approaches; debates and areas of consensus; and the current services landscape. Questions regarding the current services landscape included common services and approaches and well as the identification of organizations interviewees saw as involved in particularly high-quality work on their target issue. All interviews were audio-recorded and professionally transcribed.

Table II.iii - Key Informant Interviews, 2014

Pseudonym	Primary field	Dual expertise	Position	Tenure (years)
Yvonne	SU	No	Research	23
Gabriel	SU	No	Research	24
Angela	PV (VS)	No	Funding	26
Hannah	SU	No	Policy	20
Greg	PV (VS)	No	Funding	9
Marcia	PV (VS)	No	Policy	34
Susan	PV (VS)	No	Research	34
Cheryl	PV (VS)	No	Service	33
Lucille	PV (VS)	No	Policy	36
Vivian	PV (VS)	No	Policy	30
Sharon	PV (PAIP)	No	Policy	17
Irene	PV (VS)	No	Policy	34
Donna	SU	No	Service	29
Tom	PV (PAIP)	No	Research	22
Angelo	SU	Yes	Service	31
Anne	SU	No	Service	33
Anthony	SU	No	Service	29
April	SU	No	Policy	22

Richard	SU	No	Research	47
Janet	PV (VS)	No	Policy	30
Joyce	PV (PAIP)	No	Service	32
James	PV (PAIP)	Yes	Service	22
Kevin	SU	Yes	Policy	17
Cynthia	PV (PAIP)	No	Service	15
Phyllis	SU	No	Policy	47
Pete	PV (PAIP)	No	Service	23
Pam	PV (VS)	No	Policy	13

Archival Data Collection, 2014

While in Chicago collecting key informant interviews, I spent several days working with DePaul University's Special Collections and Archives records for the Illinois Coalition Against Domestic Violence (ICADV).[15] DePaul University's records, which were donated by the Coalition, are comprised of 43 linear feet of materials, divided across 85 standard size boxes, each organized chronologically with contents further divided into meticulously labeled manila folders. Described in detail in the associated finding aid, holdings span from 1975 to 2009. Materials included the Coalition's monthly newsletter *For Better Times*, other brochures and publications, membership files including original applications and supporting documents, board and committee meeting minutes, financial information, program records and statistics (DePaul University, 2017). Because the archive is closed—meaning I had to request specific boxes in order to examine their contents rather—the finding aid proved invaluable. I focused on organizational documents such as ICADV's articles of incorporation and bylaws, newsletters and other materials meant for public consumption, and minutes from the committees on abuser treatment, services, and strategic planning. Archives materials were in excellent condition and meticulously organized. As I perused materials, I kept notes on my observations. I returned from the field with over 200 pages of reproduced materials, the 100 photocopies pages to which I was

[15] I had not originally planned to include archival data. However, during my first week in the field, an interviewee mentioned the DePaul Archive. This is one example of the interdependencies between different phases and kinds of data that characterize this project.

limited by library policy and an additional 109 images I produced, with library permission, using a digital camera.

Seeking a parallel source of data about policies and services in the substance use field, in July 2014, I made a trip to Springfield, IL to visit the Illinois State Archives. These include records of the Department of Alcoholism and Substance Abuse (DASA). DASA records comprise 61.5 cubic feet of material, spanning from 1971 to 1993. They include records from the Illinois Dangerous Drugs Commission, which operated from 1974 until 1984 when it was consolidated into the Department of Alcoholism and Substance Abuse, as well as the Division of Alcoholism, which was part of the larger Department of Mental Health until 1984, when it too became part of the Department of Alcoholism and Substance Abuse. Discrete collections within this larger set of records include strategic plan report files; commission meeting minutes; administrative files for the director, the deputy director, the field services division, the prevention and education division, and the toxicology laboratory; prevention and education program files; and rules and regulations files. In requesting boxes from the archives, which are closed, I focused on Annual Strategic Plans Report Files (series 233/009), which include materials from 1971 to 1993 and comprise 17 cubic feet. Individual file boxes were several feet long, with materials arranged "somewhat chronological[ly] by report period" (University of Illinois at Urbana-Champaign, 2010a). In practice, reports were often in three-ring binders in various states of deterioration packed so tightly into the larger boxes that some were wedged in sideways.[16] While boxes themselves were numbered, the folders contained therein were not. I also examined materials from the Field Services Division (series 233/007), 2.25 cubic feet of material from

[16] For example, I located an incomplete copy of the 1972 Illinois State Plan for the Prevention, Treatment, and Control of Alcohol Abuse and Alcoholism in box 1 of the Annual Strategic Plan Report Files and a complete copy wedged sideways into box 7 of the same series. Similarly, I unearthed a copy of the 1980 State Plan for Drug Abuse Prevention in records for the Field Services Division rather than in the Annual Strategic Plan Report Files.

1976 to 1983, that includes copies of grant applications from individual facilities, reports from state grants, and annual reports back to legislature on drug and alcohol-related expenditures (University of Illinois at Urbana-Champaign, 2010b.) As I read through materials, I kept notes on my observations and returned from the archive with over 200 pages of photocopied materials.

Analytic Strategies

Following other scholars (Hoffman, 1999; Mohr & Duquenne, 1997; Reuf, 1999), my initial analytic approach involved developing a timeline of significant developments in the field. Areas of interest included shifts in legislation, funding, and interventions related to alcohol and other drug use, such as emerging "best" or "evidence-based practices" championed by federal or state officials and field-salient events such as moral panics over specific substances or substance-using populations. While the secondary literature provided the initial scaffolding for the timeline, interview data, which was analyzed using Atlas.ti, provided perspective on the meaning of these shifts—how events, particularly at the federal level, were received by people in the field. Interviews with Chicago-based participants allowed for rich insights into developments in the region.

In addition to identifying key events in the history of the field, Fligstein and McAdam's framework for studying strategic action fields provided an additional set of sensitizing concepts. They argue attention to field emergence is particularly critical, stating analytic energies should be directed towards identifying key actors or positions and the material, political, and ideological resources associated with them; competing conceptions; roles of external actors; the rise of any internal governance units—bodies within the field that "legitimize and naturalize the logic and rules of the field" and ensure compliance of actors within it (p. 13); and, finally, the terms of

settlement, or the conditions under which the field stabilized. Essentially, attention to field emergence is critical for identifying the core assumptions structuring the field.

Fligstein and McAdam argue, following emergence, fields alternate between period of settlement and crisis. In period of settlement, the power structure of the field is relatively stable, allowing an analyst to identify incumbents (high status actors) and challengers (low status actors), the practices associated with each position, and to delineate the role of overlapping fields in shaping action. Periods of crisis potentially restructure power relations, as challengers mobilize to alter the field's logic to favor their own approaches. An understanding of crisis periods requires attention to precipitating factors, the role of internal governance units and external actors during the crisis, and the conditions under which the field restabilizes. As the result of a crisis, which actors are incumbents and challengers may shift as may the practices associated with these positions. Evans and Kay's work on field overlap provided an additional set of concepts for considering changes in the structure and configuration of each field individually over time as well as thinking about areas of tension and convergence.

As described above, after the completion of each interview, I developed a case summary (Padgett, 2017) detailing content in the interview and my initial observations on themes. These memos were crucial in capturing the context of the interview—particularly when it took place in a substance use or partner violence organization—and allowed me to take preliminary steps towards analyzing the data while conducting additional interviews. They formed a sort of index to the interview transcript, cataloging the events, organizations, and perspectives described therein.

Once interviews were transcribed, I read each transcript line-by-line. Many of my initial, open codes were sensitizing concepts drawn from field theory. These included interviewee

statements about definitions of partner violence and substance use, the characteristics of high quality service provision in each area, and statements about resources, networks, regulations, and discursive frameworks associated with each field. I also coded comments about relevant internal governance units, for example, the Department of Alcoholism and Substance Abuse in the substance use field and the Illinois Coalition Against Domestic Violence in the partner violence field, and paid careful attention to how interviewees characterized these entities. However, I also remained open to new and emergent themes. In moving from analysis to writing, I focused on adding an Illinois-specific dimension to the working timelines of events in both fields. Having already developed the basic scaffolding of the events in both fields, I focused on coding interviews for meanings and implications these had for participants with different perspectives on the field.

Sample, Data, and Analytic Strategy: The Organizational Dataset

Field-level logics are assumed to be the dominant force shaping organizational activities, functioning as a common container for cultural tools with which organizational actors do their work (Swidler, 1986). Logics are meaningful only insofar as they shape practices and any study of fields is incomplete without attention to how actors negotiate field-level dynamics. Linking logics to practices in a meaningful way requires the introduction of a clear set of criteria for defining members.

There are several different approaches determining a field's boundaries and identifying its members.[17] While some commentators have suggested actor's subjective sense of

[17] This discussion is shaped by Laumann, Marsden and Prensky's (1989) review of approaches to parallel issues in network analysis. While fields and institutions share some of the same features as networks – all are a set of actors unified by some common interest or identify – they diverge significantly in terms of methods. While a number of authors suggest network analysis as an important method in a toolkit of techniques for undertaking field analysis

membership should be privileged (Emirbayer & Johnson, 2008), this is empirically cumbersome. As a result, most analysts pursue a nominalist definition where the boundaries are set based on the conceptual framework employed, choosing include organizations identified using some objective criteria. Many studies of organizational fields have used directories or other pre-existing lists to define the set of actors involved and, depending on the nature of the field, have also limited their analysis to a specific geographic area, such as a city or region (Armstrong, 2002; Garrow & Grusky, 2012; Mohr & Duquenne, 1997; Scott et al., 2000). The integrity of the analysis that results depends on inclusion of all possible actors, however peripherally involved or marginal they may be.

Sample: Identifying Actors

The dataset includes all known organizations providing services for either partner violence or substance use in the Chicago metropolitan statistical area in 2012.[18] To identify a complete list of organizations in either field, I relied on directories provided by internal governance units within the fields. Organizations were identified by combining entries in five existing directories, two focused on substance use and three focused on partner violence. Substance use organizations were identified from a list of state licensed treatment programs (Division of Alcoholism and Substance Abuse, 2012) and from county-specific records in the Substance Abuse and Mental Health Services Administration's (SAMHSA) online *Treatment*

(Emirbayer & Johnson, 2008; Thorton & Ocaisio, 2006), its use is limited by the dearth of complete network data on many phenomena (and the practical difficulty of its collection). Missing data is particularly problematic in network analysis such that a rigorous study of an organizational field would require participation from all involved actors. And, while there have been some recent efforts to better capture the meaning of ties within networks (c.f. MacLean, 2007), this remains underdeveloped.

[18] This includes Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, McHenry, and Will counties.

Locator.[19] Partner violence organizations were identified from the state coalition's list of member programs (Illinois Coalition Against Domestic Violence, 2009), the Chicago Metropolitan Battered Women's Network's list of member programs (Chicago Metropolitan Battered Women's Network, 2012), and a list of state licensed partner abuse intervention programs (PAIPs) (Department of Human Services, 2012).

This initial list includes all organizations officially authorized by the two fields' internal governance units to work on either issue. To ensure inclusion of more peripheral organizations, after construction of the initial dataset, I searched for additional organizations in the target region in GuideStar, a directory of nonprofit organizations, using National Taxonomy of Exempt Entity (NTEE) designations commonly associated with partner violence or substance use organizations.[20] 27 additional organizations were identified using this strategy; the final dataset includes 379 organizations.

Data Sources

Information on organizational characteristics and services was coded from several sources. For substance use organizations, directory entries provided basic information about types of treatment offered, the provision of specialized services for different populations, and forms of payment accepted. Parallel information on partner violence organizations was less readily available in directories. While the list of licensed PAIP organizations contained some information about types of services—for example, whether PAIP groups are for men or women

[19] Records in the Treatment Locator contain information from the 2011 National Survey of Substance Abuse Treatment Services (N-SSATS). Because of the need to preserve information on organizational identities and combine multiple data sources, I hand coded records from the Treatment Locator rather than using N-SSATS data.
[20] The NTEE is limited to nonprofit organizations, so smaller for profit entities may still be missing. Relevant codes the partner violence field include P43 (Family Violence Services & Shelters), P62 (Victim Services), and I71 (Spouse Abuse Prevention). Codes used to identify substance use organizations are F20 (Alcohol, Drug and Substance Abuse, Dependency Prevention and Treatment), F21 (Alcohol, Drug Abuse (Prevention Only)), and F22 (Alcohol, Drug Abuse (Treatment Only).

and the languages in which PAIPs are offered—directories of victim services organizations included only the organizations' names and contact information.

In an effort to gather parallel information on all organizations in either field, I turned to organizational websites. Websites, which I located for 288 organizations (75.9% of the sample) were archived and coded information on organizational characteristics, approaches, and services.[21] Of particularly interest were organizational mission statements or mission statement like explanations of their purpose, philosophy, or focus; descriptions of their history; and pages describing services for partner abuse and/or substance use.

Additional information on organizational characteristics such as total revenue and number of employees was coded from GuideStar, and ReferenceUSA, a database housing information on US businesses.[22] A final search of the Illinois Secretary of State's database of corporate "certificates of good standing" was used to verify organizational founding dates.

Measures: Conceptualizing Logics, Practices, and Positions

Primary field. Organizations were assigned a field based on the source through which they were identified. Organizations identified using one of the three partner violence directories were coded as primarily partner violence organizations and organizations identified through sources specific to substance use were identified as primarily substance use organizations. The small set of organizations (n=22) listed in directories associated with both fields were assigned a primary field based on the area of services they began providing first and/or their predominant

[21] To locate organizational websites, I relied on URLs in directory entries and simple searches by organizational name and location. When a URL was available but the target website was not, I searched the WayBack Machine, an internet archive with records of webpages of previously active webpages.

[22] This data source was added in 2014 to limit missing data for for profit organizations. While GuideStar profiles most often contained information on founding dates, numbers of employees, total revenue, and focal issues (e.g., NTEE designations) for nonprofit organizations, these were missing for for profit organizations. One consequence of the late addition of ReferenceUSA as a source is that it was not used to identify organizations based on partner violence or substance use related NAICS or SIC codes. Thus, smaller for profit organizations may have been missed if they were not licensed by DASA or included in the Treatment Locator.

area of service provision. This coding was possible because there were no organizations in the region that had worked on both issues since their founding.

Tenure. This variable was calculated by subtracting organizational founding dates from 2012, the year directories used to identify organizations were published.

Founding era (partner violence field). Organizations in partner violence field were grouped into three categories based on founding date. These categories are before 1982, which corresponds to the passage of the Illinois Domestic Violence Act, between 1983 and 1994, after the passage of ILDVA but before funding associated with the 1994 Violence Against Women Act (VAWA) would have gone into effect, and after 1995, when VAWA would have been implemented.

Founding era (substance use field). For substance use organizations, these categories are before 1972, which corresponds to the passage of the federal Treatment Alternatives for Safer Communities, between 1973 and 1996, and 1997 or later, when Illinois adopted ASAM patient placement criteria, which were intended to standardize criteria for admission to and discharge from treatment programs.[23]

Size (partner violence field). Field-specific measures of size were developed based on the total revenues and numbers of employees of organizations in each field. These were recoded into three-category ordinal variables based on frequency distributions for the original variables (total revenue and number of employees), such that each category included roughly one-third of organizations in the field. Because of a higher incidence missing data on number of employees,

[23] I originally defined the earliest founding era in the field as before 1965, a date corresponding to the passage of the Narcotics Addict Rehabilitation Act (NARA), which shifted federal dollars from incarceration to community-based treatment thus resulting in a significant expansion of the numbers of federally-funded treatment programs from the early 1960s to mid-1970s. This produced unbalanced categories, however, with only 13.5% (37) organizations founded before 1965.

total revenue was taken as the primary indication of size. In instances where total revenue was missing, values were imputed from number of employees, as early analysis showed these variables were high correlated.[24] For the partner violence field, small refers to organizations with 14 or fewer employees and/or less than $600,000 in total revenue, medium organizations are those with between 15 and 51 employees and/or between $600,001 and $2.3 million in total revenue, and large organizations are those with 52 or more employees or total revenue above $2.3 million.

Size (substance use field). The same strategy described above was used to create a size variable for organizations in the substance use field. Here, small organizations are those with fewer than 6 employees and/or less than $470,000 in total revenue; medium organizations are those with between 7 and 31 employees and/or between $470,000 and $5.6 million in total revenue; large organizations have 32 or more employees and total revenues of more than $5.6 million.

Size (cross field). For the cross-field measure, organizations were coded as small if had 6 or fewer employees and/or less than $515,000 in total revenue, medium if they had between 6 and 30 employees and/or between $515,001 and $3.5 million in total revenue, and large if they had 31 or more employees and/or more than $3.6 million in total revenue.

Ownership status. This measure describes whether organizations are private or public nonprofits or for profit entities and was coded based on organizational websites and the presence or absence of organizations in GuideStar, a directory of nonprofit organizations.

[24] For organizations in the partner violence field, the correlation between the number of employees (n=60) and total revenue (n=52) was 0.78. For organizations in the substance use field, the correlation between number of employees (n=262) and total revenue (n=186) was 0.98. The correlation between total revenue (n=248) and number of employees (n=238) for the dataset as a whole is 0.99.

Focal issue. As a measure of organizational focus or identity, I created a set of variables for focal issue based on primary codes assigned to organizations through the North American Industry Classification System codes (NAICS), Standard Industrial Classification codes (SIC), and National Taxonomy of Exempt Entities designations (NTEE). These were used to create a series of dichotomous variables describing organizations' focal issue. Each taxonomy assigns primary, secondary, and tertiary codes to describe the specific areas of their work. To create a single measure, I clustered similar codes into broad, thematic categories.[25] Because of inconsistencies primary codes across taxonomies, I created a series of dichotomous variables to describe focal issue clusters: children and youth, criminal justice, educational or vocational services, faith-based, health, homelessness, human services[26], identity-based services, mental health, partner violence, substance use, and other. Two additional dichotomous variables were created to indicate whether organizations had a secondary or tertiary code that included partner violence or substance use.

Salience of target issue. Two three-point indices (0-3), one for the partner violence field and one for the substance use field, were developed to measure the salience of the field's target issue (partner violence or substance use) to organizations' identities. Three aspects of organizations were considered: first, whether the target issue is one of the organization's focal issues, whether the target issue is mentioned in the organization's mission statement, and whether the organization's name references the target issue. Organizations were coded absent (0) if the target issue was not present in any of these areas, peripheral (1) if the target issue was

[25] This coding process is described in Appendix C, Table C.i.

[26] The existence of this category reflects in part, the limited ability of the NAICS and SIC codes to capture differences between social service organizations, and a disappointing lack of specificity in the NTEE, which includes categories like P20 (Human Service Organizations) and P99 (Human Services – Multipurpose and Other N.E.C.)

included as focal issue but neither referenced in their name nor mission statement, and salient (2) if the target issue was included as a focal issue and referenced in the organization's name or mission statement.

Medicalization (substance use). This measure considers whether substance use organizations are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or accept Medicaid. Organizations were coded as low (0) they were neither accredited nor able to accept Medicaid, medium (1), if they accepted Medicaid but were not accredited, and high (2), if they accepted Medcaid and were accredited by JCAHO.

Index services (substance use). This set of variables describe formal services offered for substance use: detox, DUI/DWI, medication-assisted treatment (MAT), outpatient, and residential. Coded primarily from directory listings and supplemented with information from organizational websites, these reflect the broad categories of services organizations may be licensed to provide.

Service comprehensiveness (substance use). This measure indicates whether organizations offer comprehensive services for substance use, defined as three or more of the index services described below.

Specialized services (substance use). On the basis of information coded from Treatment Locator profiles, a series of dichotomous variables indicates whether organizations provide "specialized services" to any of eleven groups: adolescents, children (beds for clients' children), criminal justice, co-occurring mental health issues, DUI/DWI, gay and lesbian, HIV/AIDS, men, women, pregnant/postpartum women, and seniors. When Treatment Locator profiles were not available, this information was coded from organizational websites.

Service specialization (substance use). Organizations were coded as offering service specialization to the extent that they offer specialized services for three or more of the above-listed groups. This variable represents a dichotomized version of an index created by summing the eleven specialized services variables. The decision to define service specialization as services for three or more group is based on the distribution of index scores.

Engagement in advocacy (partner violence). To capture organizational involvement in advocacy work, I considered membership in local and state-level coalitions focused on partner violence: The Illinois Coalition Against Domestic Violence (ICADV) and the Chicago Metropolitan Battered Women's Network (CMBWN). Organizations were coded as not engaged (0) if they were members of neither coalition, local only (1) if they were members of CMBWN but not ICADV, and state (2) if members of ICADV (and potentially, CMBWN as well). Because of the historic importance of the state-level coalition in determining funding priorities and engaging in legislative advocacy, involvement at the state level was treated as a higher level of engagement than was membership at the local level only.

Service populations (partner violence). This variable indicates whether organizations provide services to partner violence victims only, partner violence perpetrators only, or both. It was coded based on directory listing patterns and organizational websites.

Provides any victim services (partner violence). Organizations were coded as providing any victim services if they offered any services specifically for victims regardless of whether or not they also offered PAIP.

Index services for partner violence (partner violence). This set of dichotomous variables describes the presence or absence of core services for partner violence, including group counseling (victims), individual counseling (victims), legal advocacy, any PAIP services,

children's programming, emergency shelter, and 40-hour training. Selected from a list of 12 services for partner violence coded from organizational websites (described below), these services are the activities key informants most commonly mentioned when asked to describe core programs in partner violence organizations.

Service comprehensiveness (partner violence). A 12 point index (0-12) measures the number of services organizations provide for partner violence. It includes individual counseling (victims); group counseling (victims); PAIP (men); PAIP (women); PAIP (youth); PAIP (LBGTQ); emergency shelter; children's programming; legal advocacy; emergency response; transitional housing; and training. The index was simplified into a dichotomous variable, service comprehensiveness. Organizations offer comprehensive services to the extent that they offer six or more of the services listed above. The cut point is based on the distribution of scores on the index.

Gender sensitive. This measure considers whether organizations use participant gender to organize services. Organizations were coded as gender sensitive if they indicated working exclusively with either men or women in their mission statement; referenced gender specificity in their name;[27] provided specialized substance use services for men, women, or pregnant/postpartum women; or have a specialized PAIP for women.[28]

Trauma services. Organizations were coded as having trauma services if their websites indicated that they offered groups, individual counseling, or other supportive services focused on trauma or PTSD.

[27] Examples of organization names coded as referencing gender include Stepping Stones for Women and Woman2Woman Community Services.

[28] The existence of specialized PAIP groups for women is the outgrowth of debates in the field regarding "gender symmetry" and intimate partner violence (see DeKeseredy & Dragiewicz, 2007 for an example of this debate, though their position is not a disinterested one). While it is beyond the scope of this chapter to rehash those arguments, the existence of specialized PAIPs for women is an outgrowth of the position that when women use violence against intimate partners it is often for different reasons and thus requires a different intervention.

Anger management. Organizations were coded as offering anger management if their websites indicated that they offered anger management groups, classes or treatment.

Couple counseling. Organizations were coded as offering couples counseling if their websites indicated that they offered couples or marriage counseling or therapy.

Position in Substance Use Field. Based theoretical considerations and themes from key informant interviews, I developed a measure of position in the substance use field that considers the centrality of substance use to organizations' identities and degree of medicalization. I assumed how focused organizations were on substance use indicated their degree of affiliation with the field's central issue, following from Hoffman's (1999) conceptualization of problem-centered fields. Medicalization was included as well based on statements from key informants regarding increasing emphasis Medicaid billing and integration with primary care. [29]

Table II.iv – Positions in the Substance Use Field

		Medicalization		
		Low	Medium	High
Salience of target issue	Absent	Outsider	Peripheral	Peripheral
	Peripheral	Peripheral	Contender	Core
	Central	Contender	Core	Core

The coding strategy for this variable is described in Table II.iv. For the contemporary field, I defined the lowest status position—outsider—based on the absence of substance use from organization's identities and a low degree of medicalization. The highest status position—core—was defined by centrality of substance use to organization's identities and a high degree of medicalization (or centrality of substance use and medium level of medicalization or vice versa). The contender position—middle/high status—was defined as centrally focused on substance use but with a low level of medicalization or in a middle position on both variables. The peripheral

[29] The full context for these choices is provided in Chapter III.

position—low/middle status—is defined by peripheral focus on substance use and a medium or high level of medicalization.

Position in Partner Violence Field. A measure of position in the partner violence field was developed using a similar strategy, but considers the salience of partner violence to organization's identities and their involvement in advocacy work.[30] This second point of emphasis was chosen based on the continued emphasis placed on the social movement roots of the partner violence field. The coding strategy is described in Table II.v.

Table II.v – Positions in the Partner Violence Field

		Engagement in advocacy		
		None	Local only	State (and local)
Salience of target issue	Absent	Outsiders	Peripheral	Contender
	Peripheral	Peripheral	Contender	Core
	Salient	Contender	Core	Core

Hybridity. Organizations with services for both issues were identified using several strategies. I identified an initial list of 20 hybrid organizations based on directory listings and information about participation in the pilot project associated with Domestic Violence/Substance Abuse Interdisciplinary Taskforce. As I coded organizational websites, I identified 2 additional organizations that mentioned both issues in their mission statements and an additional 34 that indicates some level of services for both issues beyond it being a possible topic in individual counseling sessions.

Hybridity strategy. Based on Skelcher & Smith's (2015) framework describing the arrangements that allow organizations to incorporate multiple logics, I grouped hybrids into four categories. Organizations were coded as taking a segregated approach to the extent that they address both issues through a partnership or collaboration with another organization. They were

[30] Additional context on these choices is provided in Chapter IV.

coded as segmented when they had programs for both partner violence and substance use with no evidence of connections between them. Organizations that included attention to their non-primary issue within the context of services for the primary issue were coded as assimilated.[31] The code blended was applied to organizations that addressed both partner violence and substance use in multiple programs or with multiple populations, regardless of their primary field. To code hybridity strategies, I relied on information from organizational websites describing how they addressed their secondary issue as well as information about organizational practices from the 2011 and 2014 interviews.

Analytic Strategy

In Chapter VI, univariate statistics are used to describe the dataset in terms of basic characteristics like ownership status, size, and organizational tenure. I also use univariate statistics to describe each field with regards to organizational characteristics, approaches, and services. Bivariate statistics are used to show how field position shapes organization's characteristics and practices as well as to show differences between the two fields.

In Chapter VII, bivariate statistics are used to examine differences between hybrid and non-hybrid experiences across fields and within each field in terms of characteristics, approaches, and services profiles. I also consider relationships between organizational status and hybridity and between field position and hybridity strategies.

[31] Examples include a victim service organization with a substance use counselor on staff or a substance use organization with an ongoing support group for partner violence victims.

CHAPTER III

The Substance Use Services Field

Most scholars trace the emergence of the modern system of treatment for alcohol and other drug use in the United States to federal legislative changes in the late 1960s and 1970s. These efforts took place against the backdrop of earlier ones, both public and private. I begin by describing major approaches of the earlier era. These reflect a split between activities meant to address alcohol use and activities meant to address the use of other drugs, a bifurcation that continues to shape policy and services.

A key tension in the field of alcohol and other drug use services in the last fifty years involves the relative emphasis on criminalization and medicalization—two strategies for addressing deviant behavior (Conrad & Schneider, 1992). Scholars of social problems have generally argued that medicalization, which treats the target issue as an illness whose etiology and symptoms are beyond individual control, results is less stigma than criminalization, which roots the target issue in individual morality or choices (Conrad & Schneider, 1992). Moreover, these approaches have different implications for intervention. While medicalization holds problems are potentially treatable through therapeutic means, criminalization instead produces interventions geared towards containment. Ultimately, I argue that the medicalization of alcohol and other drug use is uneven, with the pendulum swinging from criminalization towards medicalization at some time points for some populations using some substances. These patterns

have implications for organizational forms and practices, which are shaped by cultural attitudes and more tangible issues like funding and scholarly evidence.

Historical Precursors – 1930s-1962

For much of the 20th century, alcohol and drug use were viewed as discrete phenomena with distinct causes necessitating different kinds of interventions (White, 1998.) Understanding the cultural building blocks for the modern treatment system that emerged in the late 1960s and early 70s thus requires unpacking what might be best considered separate fields of alcohol use services and drug use services that had developed previously.

Efforts to address alcohol use coalesced around two basic approaches: the self-help tradition most associated with Alcoholics Anonymous and a more clinical approach rooted in The Yale Center for Alcohol Studies and associated Yale Plan Clinics. Both were formed in contrast to ad hoc care that was then the norm (White, 1998). While medical or psychiatric hospitals did admit and monitor people with alcoholism during an acute detoxification episodes, no specialized short or long term care—or after care—were available (White, 1998).

Alcoholics Anonymous (AA), which was founded in the 1930s and with its approach formalized with the 1939 publication of an eponymous book, known as the "big book" or "blue book" and still widely used today (Alcoholics Anonymous World Services, 2017a; White, 1998)[32]. AA's core philosophy holds that alcoholism is an incurable, fatal illness; it can be managed through total abstinence; abstinence requires personal, lifestyle, and spiritual changes and will result in benefits beyond sobriety (White, 1998). AA emphasizes participants' identities as people with alcoholism, but also as members of the AA fellowship. Thus, regular attendance

[32] In terms of the mythology of AA, the origins of the group itself are traced to a 1934 "spiritual awakening" by its primary founder, known as Bill W (Alcoholics Anonymous, 2017a). The approach that developed is also rooted in the earlier Oxford Group, an early 1900s, Christian self-help organization (see Archibald, 2007; White, 2005; White, 2014 for more complete accounts of AA's origins).

at meetings is strongly encouraged, as is having a sponsor—an individual who has worked the steps themselves and maintained sobriety for a longer period than the sponsee—sponsoring others, and service work within the fellowship (White, 1998). None of these are requirements for participation; the only requirement for AA membership is a desire to stop drinking (Alcoholics Anonymous World Services, 2017b). Relapse is understood as part of the process of recovery and members who have gone "out" of the group are often part of targeted outreach efforts and are welcomed back when they decide to return (White, 1998). Reflective of the deep division between alcohol and drug use, early groups deliberately blocked discussion of drug use, categorizing it as an "outside issue" (White, 1998).[33]

Throughout the 1940s and 1950s, the organizational character of AA was codified through the development and adoption of the Twelve Traditions, meant as solutions to some of the early issues faced by groups (White, 1998). The Traditions emphasize the non-professional nature of the group (tradition 8) and bar groups from taking public positions on "outside controversial issues—particularly those of politics, alcohol reform, or sectarian religion" (Alocholics Anonymous World Services, 2017b). Mechanisms, such as the *AA Grapevine* newsletter, were put in place to coordinate groups; by the early 1950s, AA had 90,000 members (White, 1998). AA members were important carriers of the disease model of alcoholism, with members engaged in outreach efforts to major institutions—medical and psychiatric hospitals—providing services to people with alocholism (White, 1998). Though efforts focused on individual people with alcoholism within these settings rather than the institutions themselves,

[33] In response to the limited availability of formal addictions treatment and exclusion from AA, addiction focused 12 Step fellowships were established in the late 1940s and early 1950s (White, 1998). Several AA-style groups—Addicts Anonymous in Lexington, KY, Narcotics Anonymous in New York, and a distinct Narcotics Anonymous in California—emerged with similar models and missions. White (1998) attributes the slow growth of these groups to several factors, including the infiltration of meetings by both law enforcement and drug dealers and few models for long-term abstinence from drugs due to high relapse rates amongst members. Ultimately, these groups merged in the 1970s to form what is today called Narcotics Anonymous.

the presence of AA members likely impacted the perceptions of facility staff they encountered (White, 1998).

This approach to alcoholism was further promulgated by the National Council on Alcoholism (NCA), which was founded in 1944 as the National Committee for Education on Alcoholism (NCEA) as the advocacy arm of AA (Schneider, 2003). In contrast to the intentionally anonymous, apolitical stance of AA, the goal of the NCA was to influence policy decisions:

> The NCA is set up with slots for recovering people on their board and slots for nonrecovering people and they were always very anxious to recruit, you know, well respected professionals who weren't recovering but who were going to be advocates for recovering people. And so NCA—it was just alcohol when I first got involved in the field. Somewhere along the line, they added the DD. So it's now NCADD and again, the DD is dangerous drugs…And they had an office in DC, they had an office in New York. They—they had a fair amount of political clout. (Joan, 2010, interview).

Thus, the NCA's mission was to carry the disease model of alcoholism into the political arena. The NCA, for example, pushed for the establishment of employment-based supports for people with alcoholisms—often a single counselor who was themselves in recovery hired as a support for problem drinkers within the company—which became the basis for employee assistance programs or EAPs that became increasingly common in the 1970s and 1980s (White, 1998).

The 12-step approach to alcoholism was, by the late 1940s, prominent enough to shape residential programs like the Hazelton Foundation, which was founded in 1949, and Wilmar State Hospital, a psychiatric hospital that began incorporating 12 step approaches in the 1950s (White, 1998). These facilities, both in Minnesota, embraced the notion of people with alcoholism helping other people with alcoholism by hiring people in recovery as staff and hosting AA meetings as part of treatment (White, 1998). The facilities marked an important shift in treatment by providing specialized services for people with alcoholism. However, recognition

that people with alcoholism had unique needs was far from widespread in conventional, medical settings. Phyllis, trained as a psychiatric nurse in the 1960s, recalled requesting to work with a patient with alocholism: "I was told I couldn't take this person because he was just an alcoholic. There's nothing you could do for them. And that is number two school, you know, in the country. I don't want to say their name but that is where we were at that point" (Phyllis, 2014, interview).

A more clinical, research-based approach to alcoholism was also emerging through the Yale Center for Alcohol Studies, which was founded in 1942 (Schneider, 2003). The Center's work included education for medical professionals through the Summer School of Alcohol Studies, the production of scholarly knowledge disseminated through *The Quarterly Journal of Studies on Alcohol*, and, beginning in 1944, outpatient treatment through the Yale Plan Clinics (Schneider, 2003; White, 1998). Though originally meant to provide assessment, diagnostic and referral services for people with alcoholism, the lack of dedicated treatment facilities at the time pushed the clinics into direct service provision. Treatment was based on the psychoanalytic model, included both individual and group counseling as well participation in AA, and was facilitated by a professionalized staff that included psychiatrics, internists, psychologists and social workers (White, 1998). The Summer School was as a critical site for information exchange regarding extant models of alcoholism treatment (White, 1998) and had close ties to the NCA (Schneider, 2003). This work included the development of the "Yale Plan for Business and Industry" in 1950, which sought to educate employers about impact of employee alcoholism on workplace productivity and safety and provide guidance about the creation of workplace-based support programs (White, 1998). The combined efforts of individual 12-step groups, the NCEA, and the Yale Center were pivotal popularizing the notion that alcoholism as a disease and treatment as part of the public health agenda (Chafetz & Demone, 1962).

While the medicalization of alcohol use was already underway by the 1960s, drug use remained wholly criminalized, with one commentator describing the period from the 1930s to the 1960s as the "Law Enforcement Era" (Moore, 1993). The federal government had a role in shaping research and treatment through the Committee on Drug Addiction and Narcotics, which was established in 1947 as part of the National Research Council and replaced the earlier Committee on Drug Addiction (Musto, 1996), but this was minimal in comparison with later programs. The Committee oversaw the work of the federal public health hospitals in Lexington and Forth Worth which were, at the time, the primary cites for the treatment of drug addiction in the United States (Campbell, 2007; Campbell, Olsen & Walden, 2008; Musto, 1996; White, 1998). Both facilities were tasked with housing and rehabilitating individuals charged with federal drug crimes. A psychiatrist, who was assigned to Lexington in the early 1960s, recalled

> Well, it was unique in the United States. It was a prison and a hospital. We had 1,000 people there, of whom two-thirds were inmates doing 1 to 10 years. And about 300 of the 1,000 were volunteers who were really what we call pressure volunteers. They were there under pressure from licensure boards, probation officer, judges. So we had a lot of doctors, lawyers, pharmacists, dentists as well as some of the best jazz players in the United States, all of them ended up at some time or other at Lexington. It was also the only co-ed prison I've ever heard about. So it was really a very unique place. And in those years, it was really one of the only places in the United States that provided treatment for narcotic addiction. (Gene, 2010, interview).

Stays were divided into three phases: detoxification, which lasted approximately two weeks; convalescence, an extended period devote to therapeutic and recreational activities; and rehabilitation (White, 1998). Through the late 1960s, the dominant approach was "milieu therapy," with patients holding each other accountable for participation and adherence to rules (Campbell, Olsen & Walden, 2008). Work on the farm comprised most of patients' daily activities; only one-quarter of the time spent on "vocational rehabilitation" was devoted to

therapeutic activities (White, 1998). Patients had minimal contact with their families and little was done to support their reintegration into the home communities post-release.

The prison-hospital at Lexington also housed the Addiction Research Center (ARC), which sought to expand knowledge about the nature of addiction. Amongst other topics, ARC researchers explored individual differences in the propensity towards addiction, the causes of relapse, physical and subjective effects of various substances, and the addictive potential of new pharmacological compounds (Campbell, 1997; Campbell, Olsen & Walden, 2008). For example, ARC researchers hoped to find a compound as effective as morphine in relieving pain but without its addictive potential. Though unsuccessful, pursuit of this goal led to early research on methadone, including the establishment of therapeutic dosages for opiate detoxification (Campbell, 2007; Campbell, Olsen & Walden, 2008; White, 1998).

Table III.i – Historical Precursors – 1930s-1962

Logic (frames)	Dominant: Moral failing Competing: Spiritual disease (alcoholism)
Internal governance units (rule-making)	Alcoholics Anonymous Yale Center for Alcohol Studies Committee on Drug Addiction and Narcotics
Networks	Nonprofessional (AA) Professional psychiatry (Yale Center)
Resources	Self-help (AA)

Field Emergence – 1963-1969

Federal involvement in research and treatment for alcoholism began in the early 1960s with the formation of the Cooperative Commission of the Study of Alcoholism (CCSA) within the National Institute of Mental Health. In 1967, the CCSA released a report on the current state of services for alcoholism calling for greater federal support for research and community-based interventions, training on alcoholism for medical and helping professionals, the development of workplace policies for identifying and aiding people with alcoholism, and increased coverage of

alcohol treatment by private insurance companies (White, 1998). Commentators attribute federal interest in treatment to the convergence of several factors: the success of public education campaigns—particularly on the alcohol side—in the preceding decades, increased support and advocacy around the disease model by professional groups, t he growing presence of 12 step programs, a documented increase in drug use amongst middle- and upper-middle class youth, opiate use among veterans returning from Vietnam, and the emergence and popularization of new treatment approaches (McBride et al., 2009; Moore, 1993; White, 1998).

The legislative acts that, between 1963 and 1966, created comprehensive community mental health centers also impacted the services landscape for people with alcoholism (White, 1998). As mental institutions closed, communities struggled to find appropriate services for people with alcoholism as well as for people with serious mental illnesses. Richard, who began his work in the alcohol and other drug use field in Illinois in this context, described early work on the ground connecting people to the scattered services that existed at the time:

> I actually started in 1967 as a student screening people with substance use disorders who were in state psychiatric hospitals in Illinois and I was screening them for potential re-entry into the community, in some cases following prolonged institutionalized in the state psychiatric hospitals. And then I went to – my first role in the community was as kind of a community organizer in what was then called street worker. Today we call them an outreach worker. Basically there weren't treatment programs in the community that I was working in so I was doing basically sort of detached street work, a lot of crisis intervention work, and getting people into hospitals, driving them to what would be two and three hours to the closest addiction treatment program at that point in time. (2014, interview).

He went on to note that, in many communities, there were no supports for people with alcoholism other than AA meetings. There was, however, political will to develop alternatives: "So when I say I was a community organizer, part of my role was really to sort of assess that vacuum and start writing grants and proposals and agitating and doing what I could to—to develop specialized treatment services" (Richard, 2014, interview).

To influence this process, treatment providers began to organize themselves, as reflected by the 1967 founding of the Illinois Alcohol and Drug Dependence Association (IADDA), which was formed as a grassroots group of people in recovery (Phyllis, 2014 interview). At the time, there was also a separate organization of providers—the Chicago Detox Directors Association (Phyllis, 2014 interview). These groups subsequently merged:

> We created a separate provider organization and then basically, in order to really make it workable, we merged with IADDA. I think today, there are still some issues regarding the community behavioral health organization and IADDA and so forth, or perceived loyalties and so forth. But it was kind of interesting because it was the Allertons [informal group of treatment providers] and that kind of movement that we had to be strong together in order to have the influence we needed to get the funding we needed to do the things we needed. […] And at the Allertons, I can remember because I had to stand up and present them and get them voted on. And they were passed without a no vote, which meant that we created a provider organization which then merged with IADDA. And those bylaws were changed to accept ours, and so it was—the one thing I feel a little bit badly about was IADDA may have lost a little bit of its identity as a—a recovering person organization and so forth. (Phyllis, 2014, interview).

The existence of separate groups for people in recovery and non-recovery professionals reflects division that became increasingly prominent as the field professionalized.

Efforts were also underway to shift interventions for drug use from a criminal to a medical approach. This is evidenced by the 1961 publication of a joint report by the American Bar Association and American Medical Association titled *Drug Addiction: Crime or Disease*, which called for a shift from institutionalization in correctional facilities towards treatment in community settings (White, 1998). That report was the first in a spate of similar publications throughout the early 1960s, which also include a 1962 report by the President's Commission on Narcotics and Drug Use and similarly called for a shift towards a medicalized approach emphasizing treatment rather than social control (Musto, 1996).

Reflecting this push for the medicalization of drug use, the Narcotics Addict Rehabilitation Act (NARA), which was passed in 1966, established treatment as an alternative to

incarceration. The act greatly increased the involvement of the federal government in interventions for drug use and channeled funds towards community-based treatment and prevention efforts (Moore, 1993; White, 1998). Additional funds were allocated towards the creation of community-based treatment programs in 1968, with the passage of the Alcoholic and Narcotic Rehabilitation Act. The impact of this legislation on community-based services was not immediate, however. Richard noted that "it took—in our community, for example, I—you know, I started organizing in '69 and we didn't open the first residential program until 1973. It took that long to get—the—to connect with state and federal monies to build that first program" (2014, interview).

As funding for alcohol and other drug treatment began to flow to the states in the late 1960s, several approaches that shaped emergent services. As described earlier, apart from AA, most work with people with alcoholism occurred through medical or psychiatric hospitals. Neither the short, term, AA-based residential approach later known as the Minnesota Model nor the outpatient approach associated with the Yale Plan Clinics were yet widespread. On the drug side, there were four major approaches: therapeutic communities, outpatient methadone maintenance programs, drug-free outpatient programs; and outpatient detoxification[34] (Fraser & Kohlert, 1998; Hubbard, Simpson & Woody, 2009; White, 1998). Newly formed crisis centers were an emergent form in the 1960s founded to support the growing number of young people experimenting—and sometimes reacting negatively to—psychedelic drugs.

The late 1950s saw the beginnings of non-carceral approaches to addiction through the rise of therapeutic communities like Synanon, which was founded in 1958 in California by a

[34] Outpatient detox programs were organizations that supported drug users—at the time, heroin addicts—during active detoxification but did not offer additional or ongoing support (White, 1998). Early research on treatment effectiveness suggested that these programs in isolated tended not produce lasting sobriety (Fraser & Kohlert, 1998). Detoxification thus came to be seen as a necessary first step to towards treatment rather than a stand-alone intervention.

person in recovery from drug addiction (White, 1998). Therapeutic communities, like 12 step programs, promoted a holistic model of change that focused an addict's entire lifestyles and identity; total immersion in the community was thought to be critical to the change process (White, 1998). Many programs required periods of residence between 18 months and 3 years and employed a confrontational approach intended to break down addicts' resistance to change (White, 1998). But unlike 12 step fellowships, therapeutic communities did not wholly embrace medicalization, instead viewing addiction as a "socially induced…symptom of an underlying characterological disturbance" (White, 1998, p. 246). In its first decade, Synanon shifted from a program of three meetings a week to a commune-like residential facility and, by 1969, housed 1400 residents (White, 1998). While therapeutic communities could be transformative, the model was also prone to abuse; one interviewee described them as "wonders when they worked well and monsters when they didn't" (Joan, 2010, interview). Synanon's success fostered the emergence of similar programs nationally.[35] By the 1970s, many therapeutic communities had begun incorporating professional staff and facilitating additional training for staff who were former addicts, expanding therapeutic approaches, and encouraging a less authoritarian atmosphere (White, 1998).

In the late 1960s, outpatient approaches to addiction—notably methadone maintenance clinics—were founded as an alternative to incarceration and residential models like therapeutic communities. Though methadone had been used for detoxification purposes since the late 1940s, by the mid-1960s, research suggested it was effective as a long-term treatment for heroin addiction because of its ability to prevent withdrawal symptoms without producing "highs" or noticeable side effects (White, 1998). Treatment regimens included either gradual withdrawal

[35] Gateway Foundation, founded as Gateway House in Chicago in 1968, was originally a therapeutic community although they now incorporate a wide variety of approaches (White, 1998; Gateway Foundation, 2017).

(outpatient detoxification) or potentially indefinite monitored use, often accompanied by other outpatient counseling services (Schilling, Dornig, & Lungren, 2006). Methadone maintenance programs were—and are—controversial despite robust research on their effectiveness in reducing harms associated with illicit opiate use (White, 1998; Schilling, Dornig, & Lungren, 2006). According to Gene,

> Methadone maintenance was begun in 1966 by Dolan Nisewonder in New York. It was very controversial. I remember when I was at Lexington, inviting a speaker down who was the head of a therapeutic community in New York City and one of the inmates asked him about this new program called methadone maintenance. What was his opinion? And he said I think methadone's a great idea. I think we should give money to bank robbers, women to rapists and methadone to addicts. So that may give you some idea of what the viewpoint on methadone was at the time. And it hasn't changed I think for many people. (2010 interview)

While research supported use of methadone in treatment, popular opinion did not.

Drug-free outpatient programs, similar in philosophy to the Yale Plan Clinics, were in some ways a response to methadone maintenance programs (White, 1998). In these programs, treatment relied on individual and group counseling and often included some participation in 12-step programs. However, the use of medications such as methadone was seen as a breach of sobriety rather than a necessary support for it (White, 1998).

Crisis centers, a distinct approach that attempt to mitigate harms associated with drug use without necessarily reducing drug use itself, emerged in response to use of psychedelic drugs by young people in the late 1960s.[36] As Joan explained, "A lot of the people that were doing these crisis centers were using and they would run classes on how to use, you know, safely. So you know, they weren't particularly anti-drugs whereas the therapeutic committees thought you had to stay totally clean except they tended not to pay much attention to alcohol." (Joan, 2010, interview). These programs prioritized accessibility and offered supports like emergency help

[36] These programs were modeled on the Haight Ashbury Free Clinic, which was founded in San Francisco in 1967.

lines and tents at music festivals where attendees could access support if needed or have drugs tested to assist in making decisions about safer use (Richard, 2014, interview). White (2014) observes that relatively few of these programs remained in existence beyond the 1970s.

Regardless of modality, most facilities were staffed primarily or entirely by people who were in recovery themselves (White, 1998). With increased federal funding came a push for greater professionalization but there were few formal training programs available. Phyllis recalled

> You had to have counselors. Okay, so now we have peer counselors but we also have to get them certified. So now you have to do this and now you have to do this. And so it was kind of funny because we had no college programs and the—what happened was members of the Chicago Detox Directors Association started the program at National Louis, but we didn't have any instructors. So we had to go teach. […] I was also the only medical professional and for many years, people outside of a certain group did not know I was a nurse because medical professionals were frowned on by recovering people. (2014 interview).

Early on, then, there were some tensions between professionalized staff—without or without medical credentials—and those whose expertise stemmed solely from lived experience with alcoholism, addiction, and recovery.

As the federal and state governments sought to fund treatment, this handful of modalities formed the basic building blocks. Their effectiveness, however, had not yet been established. In describing the various residential and outpatient approaches to alcohol and other drug use in the late 1960s, Joan stressed "There really weren't any clinical models. I mean, the—what we had was all these different modalities" (2010 interview). Along with extending funding for alcohol and drug treatment programs, the federal government established a program of research on treatment effectiveness. In some cases, these agendas were explicitly linked, with the availability of research funds tied to the development and provision of services. Gene recalled applying for NIH funding to study the therapeutic potential of LSD in addictions treatment and receiving

> a letter back or a phone call back saying well, since you have no treatment program, we don't know that you're going to be able to recruit addicts. Start a treatment program and we might be willing to fund the LSD research. So I wrote a grant for a small treatment program and they called up again and said well, we have a little money this year. If you were to design the model treatment program, including everything that we know about treating addicts, design it, include research, I did. (2010 interview).

In this way, the federal impulse to address alcoholism and addiction fostered an environment of creativity, where funding for treatment and research were readily available to those with expertise to develop concrete programs.

Some of the earliest federally sponsored research on treatment effectiveness began in 1968. The Drug Abuse Reporting Program, which sponsored by NIMH, focused on evaluating the effectiveness of what were, at the time, the major treatment modalities: outpatient methadone maintenance, outpatient detoxification, therapeutic communities, and drug-free outpatient programs (Fletcher, Tims & Brown, 1997; Fraser & Kohlert, 1998; Hubbard, Kohlert & Simpson, 2009; White, 1998). The purpose of this study was to determine which modality most reliably produced abstinence from illicit opiate use and it included follow up for three to twelve years following treatment. Results suggested that detox alone had no discernable impact on illicit opiate use and that, assuming treatment duration of at least 90 days, methadone maintenance, therapeutic communities, and drug-free outpatient programs were commensurate in effectiveness, with slightly more than half of participants abstinent from daily opiate use one year after completion (Fraser & Kohlert, 1988). Longitudinal findings underscored the relapsing nature of addiction: while three-quarters of participants had ceased daily opiate use at the 12-year follow-up point, they reported, on average, 6 admissions to treatment in the intervening period (Fraser & Kohlert, 1988).

There remained a deep division between work on and with people with alcoholism and work on and with people with drug addiction. Most researchers and practitioners were involved

in work in only one of these areas. Joan, relatively unique in the late 1960s for her involvement in both, told me

> There were also national conferences on the alcohol side, some of which was research and treatment models and things and I don't really—you know, I went to some. And again, they were culturally very different. So on the alcohol one, people would be dressed in suits and dresses, mostly men, or at least heavily men, middle aged. Totally dry. The drug conferences would be people in—much more racially mixed, people in dashikis and beads and—and a lot of drinking. So I mean, culturally, they were just vastly different. (Joan, 2010, interview).

Amongst experts at the time, there was no unified concept of substance use that include both alcoholism and addiction. Thus, some therapeutic communities encouraged alcohol use just as some treatment programs for alcoholism readily prescribed sedatives and tranquilizers (White, 1998).

Just as there were deep division between work on alcohol and other drugs, so to were there deep divisions between treatment modalities. An early exception was that Illinois Drug Abuse Program (IDAP), which grew out of a Department of Mental Health sponsored demonstration project (White, 1998). The program's first clinic opened in 1968 and Chicago and served as Illinois's primary drug treatment program until 1974 (White, 1998). IDAP's counselors were primarily people in recovery, though the program was run by the University of Chicago's Psychiatry Department and included physicians and nurses in addition to counselors (White, 1998). IDAP was unique for its use of multiple modalities; following completion of centralized intake and assessment procedures, clients were referred to specific treatment program based on the results (White, 1998). Researchers there

> really pushed this sort of multi-modality treatment system that was a balance of some – many of those services that I talk about on the – on the addiction side which were methadone maintenance, therapeutic communities, outpatient drug free programs. And then there was a separate division of alcoholism in the state that was really pushing the expansion of residential services in social setting detox programs in those years. So – so

> fairly quickly, Illinois became – really looked to sort of create these local continuums of care where people had choices across modalities. (Richard, 2014, interview).

These decisions about the configuration of treatment were based on the growing body of research on treatment effectiveness:

> They began to look very quickly at the early science evaluating methadone and therapeutic companies and outpatient and decided that all of them had a potentially important role to play. And that was not always the case because in other places, you had people who came out of one particular modality and sort of wanted to imprint that on the whole state as they got into positions of leadership. (Richard, 2014, interview).

Between 1968 and 1973, IDAP grew from single clinic with 75 clients to a network of 55 programs serving 5000 clients (White, 1998). As with other early treatment programs, IDAP served as a site for early research on treatment effectiveness, generating findings underscoring the relationship between treatment duration and outcomes (White, 1998). Because of its early prominence, IDAP served as a model for addictions treatment as federal money became available for the development of new community-based programs.

Table III.ii – Field Emergence – 1963-1969

Logic (frames)	Spiritual disease
Internal governance units (rule-making)	Alcoholics Anonymous Cooperative Commission of the Study of Alcoholism Illinois Alcohol and Drug Dependence Association (Illinois)
Networks	Nonprofessional (AA)
Resources	Community-based treatment

Institutionalization – 1970-1980

At the federal level, the early 1970s saw both the reorganization of existing governmental apparatus related to alcohol and drug use and the passage of new legislation further shifting the locus of treatment towards community-based organizations (White, 1998). In 1970, the Cooperative Commission of the Study of Alcoholism was granted divisional status within the National Institute of Health (NIH) and renamed the National Institute on Alcohol Abuse and

Alcoholism (NIAAA). According to White, the establishment of NIAAA was a political victory, reflecting the new status of alcoholism as a disease in its own right rather than a variety of mental illness. Funding also increased dramatically. While in 1960, federal spending on alcoholism totaled 6 million annually, by the end of the 1970s, the federal government devoted 468 million to alcohol-related grants to the states and an addition 654 million in direct project grants (White, 1998).

On the drug side, the 1972 establishment of Treatment Alternatives to Street Crimes (TASC) within the federal Law Enforcement Assistance Administration reallocated efforts from criminalization towards community based treatment. According to Joan "all of that stuff was part of this big push, this war on drugs and trying to really create some alternatives. That was when the first serious funding for crisis centers came along, even though they'd existed before that and sometimes with federal money" (2010 interview). TASC strengthened existing mechanisms for screening offenders for addiction issues, deferring them from incarceration and into treatment, and establishing a system of case management to link offenders, the courts, and community-based treatment providers (White, 1998).

The same year, the Drug Abuse Treatment Act (DATA) established the Special Action Office for Drug Abuse Prevention (SAODAP) and reconstituted NIMH's Division of Narcotic Addiction and Drug Abuse as the National Institute of Drug Abuse (NIDA), placing it on equal footing with the NIAAA and NIMH under the newly created Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) (Brown & Flynn, 2002; White, 1998). These reconfigurations were symbolically significant in their separation of alcohol and drug abuse from mental health. Rather than being symptom of underlying mental health issues or varieties of mental health issues, alcoholism and addiction were, instead, discrete issues requiring unique

interventions. They also remained separate from each other at the federal level, which had the consequence of creating separate funding streams for research and treatment for the two issues (Metlay, 2013).

These federal shifts also had implications for the organization of state-level activities related to alcohol and other drug use. Joan related

> one of SAODAP's earlier charges was to get this federal system set up and the same legislation that established SAODAP also mandated that every state had to merge their alcohol and drug agencies into a single state agencies... whoever the—public health officer was for a county would be in charge of whatever alcohol funding they had. […] And then on the drug side, it was in mental health. So one of the challenges at the state level was that alcohol and drugs had been located in very different places. So they had to essentially—so there was a big fight at the state level and at every county level as to where the money was going to come for these combined substance abuse programs, because it was a fair amount of money. And—and you know, they merged the funding stream—they merged the policy stuff at the state level but then kept it separate at the federal level. (2010, interview).

Thus, the emerging treatment system varied considerably from state to state.

Under this system, receipt of federal funds was contingent on states' submission of plans specifying which intervention activities were planned and mechanisms for evaluation and monitoring (Brown & Flynn, 2002). In Illinois, initial funding largely went towards strengthening existing health and mental health facilities. At the time, there were ten programs in Region 2—all mental health centers or state hospitals (Department of Mental Health, 1972). While most existing programs were part of medical or mental health facilities, the state's priorities were shifting. According to the 1972 State Plan:

> The primary emphasis of our state-run alcoholism activities will be on intensive treatment and a shortened period of hospitalization geared towards complete rehabilitation. We are reevaluating the costly program of purchasing care of emergency hospitalization for this purpose with an eye towards more fully utilizing the alcoholism units already in operation at our mental hospitals and zone centers. (Department of Mental Health, 1972, pp. 1-2).

While the Illinois Department of Mental Health spent $4,523,200 on alcoholism programs in 1971, only $650,000 was allocated towards community programs (Department of Mental Health, 1972). Expansion was a priority, with the governor recommending allocation of $6.8 million for alcohol programs in the 1972 fiscal year.

In the state system of treatment for alcoholism, Illinois emphasized the development of five kinds of programs: medically-supervised detoxification; outpatient services, including individual and family counseling; inpatient care "for those requiring more intensive care in their rehabilitation"; half-way or three-quarter houses; public education programs with the goal of preventing alcohol abuse (Department of Mental Health, 1972, pp. 51-52). As part of the State Plan, the Department of Mental Health called for a survey of needs and existing resource, whose results would inform the development of regional action plans (p. 53). It also called for the development of "model demonstration programs" for "alcoholic employees" and the "inner city" or near west side of Chicago (pp. 57-58). The plan also includes more detailed descriptions of four "model programs" involved in work with people with alcoholism in Illinois, including a "Chicago private hospital…[with] a well developed rehabilitation center providing not only detoxification, but a myriad of services to alcoholics of both sexes" (p. 107) and research and training activities. Treatment was overseen by a team that included a counselor who was in recovery, a social worker, a "clergyman," and a nurse, "one of whom is his [the patient or client's] primary therapist" (p. 107). The approach described is primarily didactic, with lectures, films, and discussion groups as well as group and individual therapy, "weekly discussion-lecture groups…with spouses," and AA and Al-Anon meetings.[37]

[37] Al-Anon are 12-step based meetings for family members of people with alcoholism, who are thought to benefit from working through a parallel set of step through work with a sponsor.

State level legislative shifts, like the decriminalization of public intoxication, furthered trends towards the development of a community based treatment system. Phyllis argued that the impact of this change is underappreciated, telling me "they could not, you know, just arrest everybody. So they had to put together a statewide network of detox centers or something, emergency intakes. With that, the division begins to build the statewide system of care" (2014 interview). She attributed decriminalization with the development of a statewide system of community treatment for alcoholism, contrasting it with the smaller, Chicago-based system then emerging for addictions treatment through IDAP. As federal dollars began to flow into Illinois for treatment, however, Phyllis observed that they disproportionately went to support treatment programs for other drug use rather than alcoholism. While she attributed this to the need for the addictions side to "play catch up" relative the comparatively well-established system of supports for alcohol use, other commentators have pointed to the role of public discourse on crime and public safety in channeling funding towards the addictions side (Metlay, 2013).

Alongside general support for research on both the etiologies of drug and alcohol abuse and treatment effectiveness, the federal government also sponsored research on women's experiences with drugs in the early 1970s. Most programs were based on an implicitly—or explicitly—male model of alcoholism and addiction. Joan described this ethos in alcohol treatment programs by saying "the most common image of the alcoholic was kind of a middle aged White man who had, you know, been functioning reasonably well and eventually, their body gives out or they have some huge crisis" (2010 interview); another interviewee described the field in the 1970s as a "good 'ole boy network" (Gail, 2010 interview). Four demonstration projects, including one focused on pregnant women, were funded in 1973 with the goal of producing a more accurate understanding of women's needs and participation in treatment

(Campbell & Ettore, 2011). Findings underscored the need for more comprehensive health services within treatment settings, better tools for identifying women with substance abuse issues, and greater sensitivity on the part of medical professionals, particularly towards pregnant women. They also found "women were more socially isolated, more often primary caretakers of children, and more commonly suffered depression, anxiety, and low self-esteem before entering treatment" than their male counterparts (Reed, 1987). Campbell and Ettore observe that findings led women's treatment advocates to emphasize differences between women and men with alcohol and other drug issues and argue for greater equality in program funding and access to treatment.

As with treatment for other populations, there was no consensus on what women's treatment should look like. Gail, who worked on a SAMHSA grant in the late 1970s for work with pregnant and postpartum women—one of the special populations for whom treatment was prioritized—recalled having a great deal of freedom in terms of design because there was no existing research to structure interventions (2010 interview). At the time, theories of women's addiction emphasized gender role transgression as causative such that many early treatment programs focused on helping women learn to fulfill their roles within the family and the home (Campbell & Ettore, 2011). Campbell and Ettore describe this framing as intentional on the part of advocates, arguing analysis of early women's programs "offer[s] a set of historical case studies in how a form of 'strategic essentialism' was used in order to gain a toehold for women's drug treatment within medical institutions" (2011, pp. 52-53). They also had a coercive element: early programs used contact with children whom women feared losing to incentivize compliance. Overall, though, the development of curricula focused on mothering was innovative, and part of a larger effort to destigmatize women's alcohol and other drug use by showing that women with

alcoholism and/or drug addiction looked more like "normal" women than like men with alcoholism or drug addiction (Campbell & Ettore, 2011).

Conceptions of alcoholism and addiction began to merge in parts of the field in the mid 1970s (White, 1998).[38] Interestingly, one of the major factors contributing to their consolidation into the unified concept of "substance abuse" or "chemical dependency" was the insurance industry. Some private insurances began covering treatment for alcoholism in accredited hospital programs as early as the 1960s. This practice spread throughout the 1970s as part of the "War on Drugs" and successful advocacy efforts by groups like the NCA:

> One of the things that happened again as part of the war on drugs is they succeeded in getting insurance coverage for substance abuse treatment. That was a very big deal. [I: Was that a hard battle?] Hard, hard, hard, hard battle. And I think it was mostly the alcohol people that were mounting that battle. And a lot of the real argument about alcohol being a disease had to do with trying to get it into the health arena and get insurance coverage because you know, there was public money for some people but—but you either had to have money and be able to pay for treatment or you had to qualify for some of these public clinics and a lot of the middle class people wouldn't go to the public clinics and they couldn't afford the high end ones. So you had this huge group of people who just weren't—you know, the only thing they had was AA. (Joan, 2010, interview)

Initially treatment was reimbursable only in medical facilities, but by the early 1970s, some insurers had loosened requirements to allow treatment in select, non-accredited facilities and, by the mid-1970s, for drug addiction (White, 1998). In 1972, the Joint Commission on Accreditation of Hospitals developed accreditation procedures for alcohol and drug programs, further contributing to their status as healthcare organizations and the status of alcohol and other drug use as diseases (White, 1998).

By the late 1970s, funding increases had impacted the numbers of treatment organizations. White (1998) observes that in 1973, there were 500 treatment programs for alcoholism in the United States. By 1977, there were 2400 and by 1980, 4,219. Similarly, in

[38] While in 1982, alcohol- or drug-only made up 51% of all providers, by 1990, these single-issue agencies made up only 13% of all treatment providers (White, 1998).

1971, there were 54 communities in the United States with federally funded drug treatment programs. By 1973, there were 241 and 1,800 by 1977 (White, 1998). Most providers continued to specialize in a single modality and treatment for alcohol or drug use (White, 1998).

Expanding treatment required increases in staff and staff training. Previously, most employees in organizations that saw people with alcoholism and/or drug addiction either lacked specialized training for working with these populations, as would have been the case in medical and psychiatric hospitals, or, as would have been the case in therapeutic communities and crisis centers, had few if any formal credentials, despite lived experience using alcohol and or other drugs. Groups like IADDA pushed for professionalization of the existing workforce. Phyllis recalled using limited travels funds to keep a colleague in Springfield while the legislature was in session:

> I used all my travel money to keep him down there... And we were able to get these upgrades. So the system, you know, was able to develop—add equipment, add facility enhancements, to again upgrade, you know, staff salaries. I did some budget initiatives where again, you know, we were supporting that career ladder. And so what you really have is a professional development going on. The—one of the drug program directors said the best thing that ever happened to the drug programs were the alcohol people, because that was not done in that system. (Phyllis, 2014, interview).

Even while treatment for alcohol and drug use remained separate in most facilities and at the state level, developments in the two domains were often interdependent.

The Department of Mental Health's Annual Report for Fiscal Year 1972 to 1973 describes an "aggressive reorganization" of the Department by the incoming Governor (Walker), intended to bring "Illinois to the forefront in the treatment and care of the mentally disabled" (Department of Mental Health, 1973, p. 3). included the elimination of over one thousand "unneeded positions" and delegation of responsibility to regional administrators. At the time, more than 90% of the Department's budget continued to go towards "upgrading and renovating"

State Hospitals. However, the Department had the largest budget in its history—$337 million—and sought to develop outpatient and aftercare programs. Detailing developments in the Chicago area, this report notes that "Alcoholism programs have tripled in number and dollar amounts in the last three years to give $1 million to agencies" (Department of Mental Health, 1973, p. 14).

In 1974, Illinois established the Dangerous Drugs Commission (DDC), which replaced IDAP as the central coordinating body for other drug use services in the state (White, 1998). The DDC, which was created through the passage of the Dangerous Drug Abuse Act, had the mandate of establishing and implementing an array of activities related to prevention, research, and "provid[ing] diagnosis, treatment, care and rehabilitation for controlled substance addicts to the end that these unfortunate individuals…be restored to good health and again become useful citizens in the community" (Dangerous Drugs Commission, 1979, p. 1). Its governing board included directors or superintendents from agencies across state government including mental health, education, corrections, law enforcement, public health, vocational rehabilitation, public aid, children and family services, and spots for three political appointees. It also included a 30-member advisory council with membership that included representation from various professional groups—the Illinois Public Defender's Association and City of Chicago Board of Health, for example—as well as representations from across state government. The DDC's work included shaping policy, overseeing treatment research, and awarding funding.

The Dangerous Drug Commission's 1979 State Plan for Drug Abuse Prevention describes accomplishments from the previous fiscal year that include increasing treatment capacity to 9,000 individuals, providing technical assistance and training to workers in drug abuse programs, and efforts to meet the "unique treatment needs of minority youth, women, rural drug abusers, and drug abusers in the criminal justice system" (p. 10). During 1978, the state

made specific gains in women's treatment, funding six specialized programs and increasing the percent of admissions by female clients from 22.6% in 1976 to 32.2% in 1977. As of June 1978, 29 organizations were licensed by the DDC to provide outpatient and residential methadone and drug free services; 29 operated through subcontracts with NIDA, most of which also received matching funds from the state; 16 were funded through Drug Abuse Treatment Act formula grants for treatment services and an additional 17 were funded through the same mechanism for prevention work. Reflecting the work of IDAP, DDC emphasized the need for multi-modality treatment and the creation of "a geographically decentralized drug abuse treatment network across the State…[to provide] services on a local basis, using program designs which reflect local need" (p. 90).

Table III.iii – Institutionalization – 1970-1980

Logic (frames)	Dominant: Disease (singular approach) Competing: Disease (differentiated approaches)
Internal governance units (rule-making)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) Treatment Alternatives to Street Crimes National Institute of Drug Abuse (NIDA) Joint Commission on Accreditation of Hospitals Department of Mental Health (Illinois) Dangerous Drugs Commission (Illinois)
Networks	Increasingly professional
Resources	Grant-based Research-contingent Insurance reimbursement

The 1970s were an era marked by tremendous federal will to use community-based treatment address alcoholism and addiction. Back by commensurate levels of funding, this was a period of enormous creativity. Phyllis, working in state government at the time, recalled writing multiple initiatives per day: "there was one day we had—my boss was over there and I was supposed to write a funding initiative every nine minutes. I said no, okay, I just can't do that. But we—we had been told that we were the governor's priority and so we, you know, put the

initiatives together" and observed "you don't see that happen very often where all of these doors are opening and if you can bill it, then you can create the change" (2014 interview). This allowed for a tremendous growth in the number of facilities and creation of research infrastructure. The same legislative shifts solidified conceptions of alcohol and drug use as problems in their own right rather than symptoms of some other mental illness. The push for medicalization of both issues was supported by a variety of actors, including the federal government and private groups like the insurance industry. Older distinctions between modalities of drug treatment—and between alcoholism and addiction—were beginning to recede. By 1980, most programs used multiple modalities and offered treatment for both alcohol and other drug use (White, 1998). Federal and state infrastructure—at least in Illinois—were well developed for both alcoholism and drug use services.

Strategic Expansion – 1981-1993

By the 1980s, the field of alcohol and other drug intervention had grown considerably, both in terms of the allocated funds and the sheer number of organizations. However, the momentum that had characterized the 1970s began to wane. Commentators describe the 1980s as a turning point, in which the public will and levels of funding that enabled the prior decades' growth gave way to skepticism and fiscal restraint (Brown & Flynn, 2002; McBride et al., 2009; White, 1998; White, 2005). This shift has been attributed to several trends, some related to the cost, availability, and purity of drugs like heroin and cocaine, but also to the effectiveness of the push for treatment in the 1970s (Brown & Flynn, 2002). In any case, federal funding for alcohol, drug use, and mental health treatment was reduced by one-quarter under the Omnibus Budget Reconciliation Act of 1981 with the effect that total public funds were reduced by roughly 30 percent between 1976 and 1982 (Brown & Flynn, 2002). There was also a shift towards formal

research—often on individual-level etiology and physiological responses—and away from treatment (Brown & Flynn, 2002).

The federal approach to drug use shifted away from treatment and towards criminal justice centered approaches and arrests for drug-related offenses increased from 19 per capita in 1980 to 104 per capita 1992 (White, 1998). Renewed criminalization efforts focused largely on drug addiction—and crack cocaine specifically. Commentators often link the resurgence of punitive approaches to alcohol and other drug use to the racial demographics of the so-called "crack epidemic," which was concentrated in urban areas and communities of color. The emerging "tough on crime" approach found resonance with extant "culture of poverty" rhetoric. In contrast, new law enforcement efforts related to drunk driving prompted a different approach. Despite a spate of public attention towards and new legislation concerning public intoxication and drunk driving, resultant interventions emphasized deferral to an emerging set of organizations offering evaluations, classes, and specialized treatment (White, 1998). Organizations able to work with these court-mandated clients were well-positioned. According to Phyllis, "in terms of treatment initiatives, you have the money going only to criminal justice patients. And you know, you look at some criminal justice organizations and you can just see their increase in size" (2014 interview). In the 1980s, attention was increasingly devoted to youth-focused prevention activities, in part, because of advocacy by parents' groups (Fraser & Kohlert, 1988; Moore, 1993).

Under the Reagan administration, block grants became the primary mechanism for distributing funds for treatment to the states, a move facilitated by the consolidation of state apparatus into single state agencies. As part of this larger trend, in 1984, the Dangerous Drugs Commission and the Division of Alcoholism were reconstituted as the Department of

Alcoholism and Substance Abuse (DASA). Though prompted by federal shifts, repositioning the Dangerous Drugs Commission and Division of Alcoholism were also consonant with IADDA's goals. According to Phyllis

> [The goal was to] pull it out of criminal justice, pull it out of mental health, which is where you land up with some of the issues again when you do MISA [mental illness and substance abuse] initiatives for the mentally ill and you do criminal justice initiatives, you're going right back again. (Phyllis, 2014, interview).

On a symbolic level, the creation of DASA represented state recognition of alcoholism and drug abuse as distinct from mental illness and requiring specialized interventions.

DASA assumed responsibility for block grants for both alcohol and other drug services in Illinois. In comparison with earlier funding, block grants were less generous and relationships between ongoing state-level activities and payments were less tightly coupled with research and evaluation plans (Brown & Flynn, 2002). Funding was also increasingly tied to the expansion of services for specific populations. Because total funds levels were stagnant through much of the 1980s, requiring the development of programs for special populations translated into funding cuts for many existing programs (Phyllis, 2014, interview).

Specialized treatment for women thus continued to expand during the 1980s. The 1984 Alcohol Abuse, Drug Abuse and Mental Health Amendments, for example, contained a provision known as the Women's Set-Aside, which mandated that at least five percent of total block grant funds be devoted to new women-specific treatment and prevention programs (Campbell & Ettore, 2011). Though only a small portion of overall block grant funds, Campbell and Ettore (2011) argue that the set-aside represented a major victory for women's treatment advocates given the era's restrained attitudes towards social spending and hostility towards overtly feminist causes. Yet, as Colleen—an expert in women's treatment—resulting programs did not necessarily put women's needs first: "often they're designed by people whose primary

interest is actually the children. Now that's not a bad thing but it's a bad thing if you see the mothers as the problem and treat them that way" (Colleen, 2010, interview).

Under this system, states diverged—sometimes sharply—in how and how much they supported women's treatment. Illinois was amongst the states at the forefront of women's treatment and the first to develop a specialized women's plan (Phyllis, 2014, interview). Richard, remarked that the initial spike in interest in women's treatment in the 1970s was influenced by research on fetal alcohol syndrome "but it was really the 1980s and the emergence of sort of the moral panic around cocaine exposed infants that really triggered the funds to create probably the—one of the largest networks of gender specific programs in the country [in Illinois]" (2014 interview). As elsewhere, the initial impetus for developing women's programming was motivated by concerns for children.

In 1985, the Illinois Department of Children and Family Services (DCFS) commissioned a study on the role of mother's alcohol and drug use in neglect cases (White, Woll & Weber, 2002). This resulted in the developed of a model treatment program—Project SAFE—by DCFS and DASA and, in 1986, funding to pilot it in three communities, chosen for their commitment to development gender-sensitive treatment (Richard, 2014, interview). As originally envisioned, the program focused primarily on alcohol use. An intensive, outpatient program, it included participation in a formal parenting course, in-home work with a peer outreach worker in support of both sobriety and parenting goals, and self-help groups during and after completion of the program (White, Woll, & Weber, 2002). Perhaps most significantly, the specific services and supports offered as part of Project SAFE were based on a detailed assessment of early participants' needs, which included transportation, case management, safe and affordable housing and child care, and education around parenting. As Richard explained

> To be perfectly honest, once we started those programs, we started them with the idea that what we had was a concept and a commitment more than a program and I—I think that was really critical because there really weren't that many clearly defined gender specific programs in the country at that point. So what we said was we're going to assess the needs of these women and their children and their partners and their extended families and we're going to respond to those needs and let those needs drive where the model goes. And believe me, the model we ended with was far different than the one that we originally conceived and wrote grants for. (2014 interview).

By 1989, DASA funded expansion of Project SAFE in the additional sites, two of which were in Chicago (White, Woll, & Weber, 2002). Its growth was facilitated by research on its effectiveness in the original pilot sites as well as by federal increases in funding for women's treatment. In 1988, the women's set-aside was raised to ten percent (Campbell & Ettore, 2011).

The renewed federal emphasis on criminalization was, to some extent, counterbalanced by continued pressure for medicalization by professional groups in medicine (White, 1998). In 1983, the American Society on Alcoholism and Other Drug Dependencies was established within the American Medical Association (AMA). Later renamed the American Society for Addiction Medicine (ASAM), this group played a major role in professionalizing the alcohol and other drug use services workforce, by creating an addiction medicine certification and providing education on addictions (White, 1998). A parallel group, the American Academy of Addiction Psychiatry, was founded within the American Psychiatric Association in 1985. Significantly, these groups focused on both alcoholism and drug addiction, reflecting and further contributing to the consolidation of these previously distinct issues. Payments from insurance companies were, by the early 1980s, a major source of revenue for alcohol programs and, by the late 1980s, for drug treatment programs as well (White, 1998).

With the increased role of insurance companies in paying for treatment, approaches began to shift in ways that were not always supported by research on treatment effectiveness.

Donna, who began working in the field in the 1980s, described treatment decisions as increasingly driven by cost considerations:

> People ask me all the time, where did the 28 day model come from? You know, it came from—it was called the Minnesota model and I believe it was Hazelton that brought it to the table. And how do they come up with 28 days? Insurance companies were willing to pay 28 days so then they figured well, what can we do in 28 days kind of a thing and that's kind of where the 28 day model came from. (2014 interview).

While the state was still willing to fund longer term treatment, many individuals were not willing to remain in residential care for the full 90 days. To the extent that a person left treatment prior to completion, the were discharged against medical advice, which constituted a treatment failure regardless of their actual post-intervention outcomes (Donna, 2014, interview).

By the late 1980s, the early successes of Project SAFE, combined with increases in federal support for women's programs—particularly for pregnant and postpartum women[39]—led to the development of a dedicated plan for women's treatment in Illinois. Ongoing evaluation efforts of Project SAFE suggested that women often left treatment because of a lack of concrete supports for issues like transportation and childcare as well as deeper issues like histories of trauma and current partner violence (Richard, 2014, interview). The state sponsored research that identified childcare and pregnancy as the major barriers women faced in entering and remaining in treatment (Donna, 2014, interview). Phyllis, who was involved in drafting the women's plan, described it as another moment when political will and funding came together to allow for the development of new services:

> When we did the women's plan and we had the women's committee, I finished printing it about midnight. We loaded my car up and I drove to Springfield. I was about ready to walk into a wall because we had all the women legislators there and so forth and we distributed the plan. I went back to the hotel and collapsed. But we had those

[39] The 1988 Set Aside prioritized work with this population through the creation of the Pregnant and Postpartum Women and Infants Program (PPWI), which had led to the creation of 200 programs by 1991 (Campbell & Ettorre, 2011).

> opportunities. And now, you know, I think it's just a different phase. (Phyllis, 2014, interview).

The Women's Plan specified the need for child care, transportation, and case management, with the later focused on linking clients with services for partner violence and sexual assault, health care, basic needs like food, clothing, and shelter, and educational or vocational services (Subcommittee on Women's Alcohol and Substance Abuse Treatment, 1992).

Early activity related to women's treatment included the establishment of a dedicated facility—Orchid Place—in Chicago in 1990. Located in a former hospital on the west side of the city, the state purchased the facility with the intention of developing programming for pregnant and postpartum women. The program had been in development for some time: the 1980 State Plan for Drug Abuse Prevention describes plans for a specialized, multi-modality facility in Chicago geared towards pregnant and/or parenting women and formerly incarcerated women (Dangerous Drugs Commission, 1980). Although the State had been working on women's treatment for well over a decade, it was not until the end of the 1980s that this plan was realized.

Table III.iv – Strategic Expansion – 1981-1993

Logic (frames)	Dominant: Disease Competing: Crime
Internal governance units (rule-making)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) Treatment Alternatives to Street Crimes National Institute of Drug Abuse (NIDA) Joint Commission on Accreditation of Hospitals American Society for Addiction Medicine (ASAM) Department of Alcoholism and Substance Abuse (Illinois)
Networks	Professional (psychiatry)
Resources	Criminal-justice approaches Insurance reimbursement

Medicalization and Individualization – 1994-2003

Building on earlier scientific research on the neuroscience of addiction, in the 1990s, addiction was increasingly conceptualized as "a chronic relapsing brain disease" (Campbell,

2007, p. 204). While the new emphasis on its status as a brain disease prompted shifts in research priorities away from behaviorist approaches and towards neuroscientific ones, the notion of addiction as chronic and relapsing found resonance with established traditions emphasizing the need for holistic lifestyle changes to support recovery. However, links between research and interventions became more tenuous (Campbell, 2007). There is also considerable push back against a vision of addiction where the emphasis on the brain crowds out other factors. When asked about definition of addiction, Colleen remarked "I think right now, people are very focused on brain disease and I think that's the major focus is brain disease. And I would say certainly their brain changes, the brain's involved but I think it's—a more complicated issue than that. […It] includes the physiological but there are political issues at stake, there's environmental issues at stake, there are emotional-social issues" (2010 interview). Other interviewees were similarly skeptical; Paul told me "going to the grocery store changes the brain and most of the interactions that we have in the environment change the brain, so saying that something changes the brain does not make it a disease and that – so for me, it's a definitional issue" (2010 interview).

The passage of managed care legislation in the 1990s, as part of broader healthcare reform efforts, effectively established a separate system of regulation and reimbursement for alcohol, drug, and mental health interventions relative to other types of medical care (Sosin, 2002). Advocates for managed care argued that it would streamline costs by limited unnecessary and ineffective treatments and expand access; opponents charged that it would limit provider discretion and, ultimately, the quality of treatment (Alexander & Lemark, 1997). New regulations, which emerged within the insurance industry, required programs to develop and adhere to criteria for admission, continued participation, discharge, and procedures for case

review at each point to receive reimbursements (White, 1998). These often also limited treatment modalities available to particular beneficiaries and set criteria for repeat admissions (White, 1998). To the extent that someone sought treatment in a specific facility using a particularly modality, this had to be justified:

> All public addiction money got moved into a managed care model so you had managed care that the insurance companies were doing but you also had all the states moving to a managed care model for public funding. And that then meant that you had to, you know, justify why your kind of addiction required an 18 month program and you know, because you had Minnesota model which was three weeks, hospital based no matter what. (Joan, 2010, interview).

While managed care facilitated access by setting up centralized assessment and intake facilities in many communities, decisions were "driven by the people who were worried about saving money" (Joan, 2010, interview). While managed care allowed for the greater individualization of treatment through linking it to initial and ongoing assessments, decisions were also shaped by cost containment. One area where these concerns became particularly attenuated related to treatment duration. As Phyllis noted "when we start to interfere with someone's stay in treatment for reimbursement reasons, then we're interfering with their treatment progress" (2014 interview). Similarly, older group-based models of care became more difficult to fund under managed care (Joan, 2010, interview).

Programs also came under increasing pressure to demonstrate the effectiveness of their services. With the passage of the Government Performance and Results Act (GRPA) in 1993, receipt of federal funds was increasing tied to outcomes. April described GRPA reporting, saying "it's a way to keep us all very accountable for understanding that we—there's scarce resources and we want to be able to not just say well, we spent all the money or we served a bunch of people, but we want to know what the impact of those services were too" (2014 interview). With these changes, the system of funding for substance use shifted from a grant-based model where

funds were provided up front for various categories of expenses to a fee-for-service model. Under the latter system, the state contacted with individual organizations to provide specific services and offered reimbursement with proof of service (Phyllis 2014 interview). Phyllis characterized the fee-for-service model as much less flexible, noting that in a grant based system, providers were able to renegotiate service levels: "In the grant, if we don't increase your grant over 10 years, then we could negotiate you would have to do less. Fee-for-service, you don't get to do less." (2014 interview). Under the fee-for-service system, activities like outreach, case management, and wrap-around services became very difficult (Richard, 2014, interview; Anne, 2014, interview).

The combined changes that came with managed care and the shift to a fee-for-service model created challenges for programs offering a range of supportive services. Anne described this combination of factors as having effectively shifted substance use treatment from a social service model to a medical model (2014 interview). Programs that, like Project SAFE, included a range of supportive services in addition to treatment, were particularly vulnerable. By the late 1990s, the program had expanded to 24 or 25 communities across Illinois (Richard, 2014, interview). In the scaling up process, key elements were modified or eliminated in many sites:

> We developed this sort of vibrant, dynamic model and then when you get into the state politics of wanting to replicate this, what you began to—and then the dollars that were available, what began to happen was they began to really sort of strip the model down so it kept the Project SAFE name but to replicate it, they basically started striping components out of it, lowering intensity, minimizing transportation services, reducing the level of childcare services, eliminating the length of time an outreach worker could stay involved trying to engage somebody in treatment. (Richard, 2014, interview).

In some instances, decisions further undermined the model. In one program, the Project SAFE group met next door to a men's prison re-entry group, which resulted in the formation of problematic romantic ties across groups; in another, the program was placed under the guidance

of a man therapist —the original model used exclusively women therapists—who was "an incredibly incompetent clinician" (Richard, 2014, interview). Evaluation results from many of the replication sites were less promising than earlier research had led planners to believe and by the early 2000s, the state cut funding for the program. In some sites, Project SAFE was eliminated entirely while in others its core elements were selectively absorbed into other gender-sensitive programs (Richard, 2014, interview).

In 1992, SAMHSA established the Center for Substance Abuse Treatment (CSAT) as a means of both enhancing treatment quality and promoting the use of scientific evidence in shaping treatment. Its primary goals include increasing access to treatment, encouraging the use of evidence-based practices,[40] and strengthening substance use treatment organizations (SAMHSA, 2016). Amongst other activities, it oversees the publication of the Treatment Improvement Protocol series, topic best practices manuals geared towards treatment providers. CSAT also funded the creation of 11 regional Addiction Training Centers in 1993 (Addiction Technology Transfer Center Network, 2014a). Subsequently renamed Addiction Technology Transfer Centers (ATTCs), these centers were reconfigured at a unified network in 1997 with the primary goal of promoting use of evidence-based practices in treatment organizations through providing ongoing training and support (Addiction Technology Transfer Center Network, 2014b).

By 1995, though, the number of programs offering specialized services for women had doubled from 1982 figures and women's treatment remained a federal priority (White, 1998). In 1993, the Center for Substance Abuse Treatment funded 65 demonstration project related to women's treatment and oversaw production of several best practices manuals related to gender-

[40] The classification of interventions as evidence-based depends on the rigor of the methods used to assess its effectiveness, with randomized clinical trials as the highest standard, and the amount of evidence that supports it (Miller et al., 2005). SAMHSA's National Registry of Evidence Based Practices considers both quality of research and the availability of materials to support implementation (e.g., "readiness for dissemination") when categorizing an intervention as evidence-based (Substance Abuse and Mental Health Services Administration, 2016).

specific care (White, 1998). However, funds did not necessarily go to programs with existing expertise. According to Colleen,

> Many of the people who got the grant money were not the people providing women's services. They were hospitals and universities who wrote better grants, which created a split in the field. So we have some of these programs for pregnant parenting women that I would also say are not very good programs for women because they didn't use the knowledge base that was already there on women's services and then expand it to include or think about this population and their specific issues. (2010 interview).

Increasingly, there was the sense that what was being rewarded was technical proficiency with bureaucratic processes like grant-writing or Medicaid billing rather than the provision of comprehensive, high-quality treatment for alcohol and other drug use.

By the late 1990s, the field had become increasingly professionalized at the level of individual staff as well. Surveys of the workforce suggest that nearly 80% of program staff had four-year college degrees and nearly 50% had graduate degrees (Mulvey, Hubbard & Hayashi, 2003). Whereas in earlier eras, most staff were in recovery themselves with few formal credentials, licensure increasingly required that programs hire people with professional credentials (Diana, 2010, interview). Many interviewees described a sense of loss for the character of the field while recognizing they were often direct beneficiaries of new preferences for formally-credentialed staff. Anne, who entered the field with an MSW in the mid 1980s explained "part of what we really lost in that process [of professionalization] has been some of the really rich traditions in this field that were people in recovery kind of reaching out and helping other people" (2014 interview). Angelo, who had worked in substance use treatment since in 1970s told me "the field has also, as you know—it has evolved and it's become so professionalized now so that this is—it's scary in some way. You know, the more professionalized a field is, the more probably—more into—I don't say lack of commitment but the passion might not be there, just a clinician, just you do your work and you know, you're just

totally detached" (2014 interview). Thus, while professionalization and medicalization might have improved the status of the field, many felt these trends had negatively impacted program's abilities to engage with clients, an experiential skill on which treatment success ultimately depended.

Table III.v – Medicalization and Individualization – 1994-2003

Logic (frames)	Chronic relapsing brain disease
Internal governance units (rule-making)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) Treatment Alternatives to Street Crimes National Institute of Drug Abuse (NIDA) Joint Commission on Accreditation of Hospitals American Society for Addiction Medicine (ASAM) Insurance industry (managed care) Center for Substance Abuse Treatment Addiction Technology Transfer Centers
Networks	Professional
Resources	Insurance reimbursement Fee-for-service (medicalized) Evidence-based treatment

Strategic Expansion – 2004-2010

In the early 2000s, changing legislation and funding priorities shifted the composition of the field further. The development of new forms of medication-assisted treatment and changing prescribing laws meant that these forms of care could be provided by private physicians rather than in dedicated clinics (White, 2014). The federal government also began to encourage a shift from an acute model of treatment in which individuals were seen primarily in periods of crisis to an expanded model with greater funding for early engagement and long term supports.

The Drug Abuse Treatment Act (DATA), which passed in 2000, allowed doctors to prescribe schedule III narcotics. In 2002, two additional opioids—Suboxone (buprenorphine and naloxone) and Subutex (buprenorphine) were approved as schedule III narcotics. Gene, whose work centered in part on supporting medically-assisted addiction, regarded this shift as

significant in increasing the accessibility of these forms of therapy. He noted that, because methadone is schedule II, it remains much more tightly regulated. While clients are eventually allowed to bring doses home for self-administration, the number of days they must be seen in clinic decreased over the course of several years of successful treatment. The need to be seen in clinic "made it hard to keep up, you know, a—a job and it discouraged a lot of people from seeking that kind of treatment" (Gene, 2010, interview). In allowing primary care physicians to offer medication-assisted treatment, Gene felt this legislative shift had the potential to destigmatize this modality in ways that had been difficult for advocate of methadone therapies.

Gene's optimism was not necessarily shared. While interviewees were unilaterally positive about the safety and effectiveness of medication-assisted therapy, they also described the stigma around long term use of these medications as deep and pervasive. TASC, for example, was working to educate judges, who sometimes gave directives that went against clients' treatment plans. Hannah explained "our clients get stuck in some very uncomfortable situations where if you don't want to go to jail and your judge is saying get off this medicine, yet you have a referral that's been made based on your—you know, your needs and your treatment provider's saying, you know, you're on the right dose" (2014, interview). This antipathy towards medication-assisted therapy is rooted in 12-step traditions and pervasive in the field. According to Angelo "Something that we grew up in the field not believing in [is] medication. We have to keep them drug free, right?" (2014, interview). As much as interviewees often worried about professionalization altering the character of the field, they also saw it as a necessary corrective to older models, like 12-step programs, that promoted a narrow vision of recovery.

Beginning with the Access to Recovery Initiative (ARI), which was launched in 2004, the federal government made efforts to broaden the kinds of interventions available to individuals

with alcoholism and other addictions. ARI program increased funding for treatment and client choice of facilities by, amongst other things, expanding funding eligibility to include faith-based organizations (SAMHSA, 2007; White, 2005). Through creation of a voucher system, ARI also expanded the kinds of services that were billable. According to April, "it's also providing other recovery support services that have traditionally not been funded by the state, so including things like vocational services, spiritual counseling, peer-to-peer counseling. Things that have traditionally fallen outside of our ability to pay for that kinds of stuff" (2014 interview). Essentially, ARI re-expanded the range of support services available, with the catch that these were most often provided by organizations not already licensed to provide substance use treatment. In describing ARI, April remarked that it was a way to bring additional providers into substance abuse treatment without the burden associated with formal licensure and to allow participants the option of receiving ongoing support services in organizations less explicitly focused on alcoholism and addictions. Yvonne worried, however, about the sustainability of these organizations' involvement in recovery support work in the absence of dedicated funding (2014 interview).

Federal commitment to broadening the range of treatment options were deepened with the push for Recovery Oriented Systems of Care (ROSC), which emerged a National Summit on Recovery sponsored by the Center for Substance Abuse Treatment (SAMHSA, 2010). Like ARI, ROSC is meant to expand the range of community-based treatment opportunities from early, pre-treatment engagement to after care and long-term recovery support though the use of self-help and peer-based models. Unlike ARI, ROSC was directed towards systems rather than individual treatment organizations and was meant to foster greater collaboration between providers (SAMHSA, 2010). Federal grants for ROSC initiatives were distributed to states and thus

programs are subject to considerable geographic variation. Paul explained the impetus behind ROSC by saying

> We've been living under this notion that it's a sort of my way or the highway mentality addictions counselors sort of somewhere have. I think is being now directly challenged. There's lots of ways of recovering, there are – including not getting treatment. I think that is a radical idea and completely unacceptable to the status quo, the idea that people could actually fix themselves through a variety of, you know, things that they could do on their own and in their communities through faith groups, through other kinds of things that have nothing to do with AA or treatment. (2010 interview).

In some ways, ROSC represented the evolution of the notion of multi-modality care that gained prominence in the 1980s and 1990s—that no single approach will work for everyone and individuals should be allowed some choice in the kind of treatment they receive.

In Illinois, ROSC was supported by the Great Lakes Addiction Technology Transfer Center. While the experts I spoke with were generally supportive of ROSC's goals, most felt its impact was not fully realized. Yvonne attributed this, in part, to the structure of the relationship between DASA and individual treatment organizations, noting that in nearby states, the DASA contracts with counties to fund treatment (2014 interview). Counties then distribute funds to organizations and, in the case of ROSC, often mandate coordination between individual treatment organizations. Consequently, incentivizing coordination is more difficult. She noted with chagrin that, in seeking funds, some of the larger organizations tried to characterize themselves as recovery oriented systems of care. Hannah similarly noted feeling like individual organizations were trying to take on too much rather than making use of local social service networks (2014 interview). Like others, Donna—the director of a treatment organization—was supportive of ROSC in principle but concerned about how cost-containment had shaped implementation in the region. She described organizations expanding the role of peer recovery coaches to fill other gaps in services like court accompaniment as a way of maximizing services

while minimizing staffing costs. With these expanded roles, the nature of the positions shifted, with programs seeking certified counselors with basic clinical training rather than emphasizing the peer component of the original model (Donna, 2014, interview).

Along with the new emphasis on ROSC, the earlier emphasis on gender-specific treatment was gradually replaced with a broader agenda related to "family focused" programming. As Colleen explained "it used to be women and children or gender responsive services, pregnant and parenting women, women and the kids. Now they're even changing language to being family focused programs. Now we all say well, that sounds good until you look underneath that and realize now they're becoming less focused on women. (Colleen, 2010, interview). She described this as part of a broader trend towards de-gendering treatment:

> The Substance Abuse Mental Health Services Administration puts out their sort of core areas of focus every four to eight years when there's an administration change. And the interesting thing is that [beginning in the early 2000s], the word woman came out of any of the areas of focus. They even had an area of focus that was domestic violence and somehow could describe that without using the word woman. So figure out how complicated that is. So the whole—that language started changing then but it's still there now with them now talking about family focused services, them being SAMHSA. And then when you talk to people in the field who are required because of the grants they get to become family focused and you begin to see how complicated this is and how potentially it could unravel women's services. Because now people are saying well if we're family focused, maybe we should really stop being just women's services. Maybe we need to serve families by having men and women. Now we're back to co-ed services again. So it's very bizarre. (2010 interview)

In 2006, the funding model for substance abuse treatment shifting from the fee-for-service model adopted in the 1990s to a performance based system. April, tasked with monitoring compliance for DASA, explained that this was part of a larger trend in Illinois and nationally: "we're turning away from—from looking to see—from reporting how many people we serve and how much money we spend, because those kinds of things are very empty in terms of understanding what it is that we're actually doing with those resources" (2014, interview).

Instead, the state works with providers to build language into contracts that describes goals for clients so that reporting describes "actual impacts." From the State's perspective, ""we don't want to just buy services, we want to buy outcomes" (April, 2014, interview). Performance indicators used by DASA are shaped by SAMHSA's national outcome measures[41] and include treatment completion rates, which April describes an important indicator of engagement and effectiveness.

Part of the broader trend towards using research evidence to drive services and funding, others worried about the pressures this might create for organizations. Phyllis speculated that this model has created disincentives for working with more difficult clients, saying if you want your performance to be stellar, you are probably not going to pick some of the state's clients. […] It's sort of like when you look at surgical outcomes and some hospitals, they will take a risk and try to help somebody and maybe the outcome is not as good." (Phyllis 2014 interview). Similarly, Anne worried it might jeopardize treatment relationships by creating resentments against struggling clients.

Others pointed to the role of performance based contracting and the establishment of national outcome measures in flattening differences between programs. Donna told me

> When you talk about philosophical differences, I mean once upon a time, there were treatment programs that used to make clients wear signs, shave their heads, do all those kinds of things. You don't see that too much anymore and I think part of the reason is we all have the same outcomes that we have to meet. You don't get to do whatever you want any more as a treatment program. The other thing is you have to have customers that want to come to you. It's gotten very competitive. And now everybody has medical

[41] For substance abuse programs, these standards were established under a 2010 reauthorization of the GRPA. They include "(1) abstinence from drug use and alcohol abuse, or decreased mental illness symptomatology; (2) increased or retained employment and school enrollment; (3) decreased involvement with the criminal justice system; (4) increased stability in family and living conditions; (5) increased access to services; (6) increased retention in services for substance abuse treatment or decreased utilization of psychiatric inpatient beds for mental health treatment; and (7) increased social connectedness to family, friends, co-workers and classmates" (Center for Substance Abuse Treatment, 2015).

> insurance. […] This isn't like aren't you lucky you get a bed in my place anymore, right? So it's very customer service driven, it's very outcome driven. (Donna, 2014, interview).

While greater oversight has helped curb the abuses to which earlier models like therapeutic communities were sometimes prone, it also means that programs offer many of the same services in similar ways. For example, many programs describe themselves as using cognitive-behavior therapy, although it is unclear to what extent they truly do (Silvio, 2011, interview; Miller et al., 2006).

Through the Center for Substance Abuse Treatment and the Addiction Technology Transfer Centers, the federal government has also ought to promote the use of evidence-based practices. While interviewees were overall positive about incorporating approaches supported by research, this was coupled with a sense that the supports to implement these practices well are often lacking.[42] Gabriel, a provider of technical assistance to treatment organizations, attributed implementation issues to continued investment in 12 step models by direct service staff and an unwillingness to invest in ongoing training. He simultaneously recognized the resource limitations that prevent this and underscored the choice to prioritize other things:

> Now, are there funds to do that type of stuff, you know, how do you pay a trainer within the organization that's actually not producing—you know, those—but again, if you really wanted to do it, then you would start looking for the financial means to support what you want to do. And I think that's where, you know, there's some lack. (Gabriel 2014 interview).

Others described tensions between assumptions about the modularity of evidence based practices and work with a primarily Latino or Black clientele. Angelo observed that most of the research on evidence-based practices like CBT is generally done with white clients so, while they

[42] The push for evidence based practices is ubiquitous in social more generally and, across domains of practice, there are issues with uptake by direct practitioners. This challenges has fostered the development of an entire subfield—implementation science—to explore the conditions under which the translation of research into practice occurs successfully.

incorporate these approaches, they also adapt them to better fit clients' cultural frameworks (2014 interview).

The passage of the Patient Protection and Affordable Care Act, in 2010, represented a major change in funding for substance abuse treatment. April described ACA as "the biggest thing in the whole world" and characterized the early phases of implantation as "literally standing on a cliff watching like what's—like this is changing the landscape of how substance abuse and mental health services are going to be provided" (2014 interview) and Hannah enthused "it's the most exciting time I have ever had in my professional life" (Hannah, 2014, interview). She went on to describe what she saw as ACA's profoundly stigma-reducing potential:

> I think the terminology can change. These aren't going to be the uninsured, you know, the quote societal perceptions, low life, junkie, releasee, ex-con, offender. You know, all of the different horrific stigmas that are attached to this population, you know, this is someone showing up at a clinic or a doctor's office or a primary medical home or a community mental health or substance abuse provider with insurance and you're going to treat them, because that's what you're supposed to do and they're coming with funding attached to them. (Hannah, 2014, interview).

Others were less sanguine and worried about the consequences for providers not already adept at the complex process of billing for Medicaid reimbursement. Kevin explained

> with DASA the way it works is provider provides a service, they send in a voucher for the service. Unless there's some administrative issue with that voucher, that service is paid for. Provider knows how much money they're allocated for the year, they don't provide any more services than that contract allows them to. Under managed care, the provider needs to get authorization for the service, they need to provide the service, they need to submit the bill but if ultimately the managed care company denies the claim, there's no way for the provider to get paid for that service. And the denial of claim could be as simple as it—the claims issues related to errors in the billing which when longer than the 90 day time frame for submitting claims, so then managed care doesn't have to pay for the claim. Doesn't have anything to do with the clinical side but administratively, there's more—there's more investment needed for providers.

There was little ACA represents the more medicalization of treatment. In explaining the kinds of changes programs would need to make in billing practice, April summed this perspective "so some of the things that they're going to need to be doing are—it really is—on one hand, it really is how the rest of the whole health care world works" (2014 interview).

ACA further trends, which began in the early 2000s, to increase the involvement of primary care physicians in substance use treatment. Paul, involved in technical assistance to treatment organizations, told me

> We were told in no uncertain terms last week by the director of CSAT that primary health care is going to be the new criminal justice system. It's the new paradigm that everybody is going to have to get on board with and—and that's where we're headed as a field. So if you—you need to go out and find yourself some GP, family practitioner type people to be at your agency, not so much psychiatrists anymore, family practitioners are going to be the new psychiatrists. (2010 interview).

In describing potential impacts of the ACA, Phyllis told me "The Affordable Care Act is supposed to integrate everything into primary care. My concern with that is the—the reviews or research done on primary care is they're not very good at it. […] So it's—my concern is it's going to go back to he's just an alcoholic, there's nothing you can do for him. I will never forget that" (2014 interview).

Concerns about funding were paramount. Colleen, for example, described "doing more for less" as a "sort of mantra" in the field (2010 interview). Gene, who had worked in the field for 40 years, saw little chance of the situation improving, noting "there was a doubling of the NIH budget I think in the early 2000 years and then that's been flat the last couple years. And given the current budget deficit problems, I see no reason to think that that's going to get better" (2010 interview).

Illinois was particularly hard hit by the 2008 recession and Hannah noted that in the previous ten years, DASA's budget had been reduced multiple times (2014 interview). In 2014,

the Division had somewhere between 45 and 50 staff statewide, down from over 200 in the mid 1990s (Phyllis, 2014, interview). Hannah worried that the effects of diminished funding were likely to be interpreted as, instead, diminished treatment effectiveness:

> I don't think it's any secret, the state of the state's budget has impacted services across behavioral health for the nine years that I've lived in the state. Multiple years being direct impact to DASA, other years being direct impact to DMH [Department of Mental Health] with—which of course affects our clients across the board, you know, whichever side takes the hit, which impacts our providers, which impacts our ability to be able to refer to people, which impacts the court's perception of, you know, does treatment work or not? You know, from the bench, it could be just as easy as oh my goodness, this person is, you know, in my courtroom four different times for the same charge of possession, treatment doesn't work… (Hannah, 2014, interview).

Kevin explained that treatment funding had been cut by roughly forty percent since 2008, with the largest reductions in prevention programs. He related that "that's 80% reduction in your funding for prevention during the same exact time that now we have an increase in kids using prescription drugs…" (2014 interview).

Increasingly, substance use and mental health services have been unified under the broader category of behavioral health. Paul described this as the result of substance use trading on the higher status of mental health

> At this conference I was at last week in Cincinnati, you did not hear the word substance abuse agency spoken very often at this conference which I thought was a substance abuse conference. It's not. It's a behavioral health conference, even though all of the people there were substance abuse people. There were no mental health people who didn't provide substance abuse services there, but they never used the term substance abuse. They call themselves behavioral health agencies and they feel like you're limiting them if you use the term substance abuse because they do oh so much more than that. They have credentialed people, they give diagnoses, every substance abuse person has a mental health issue that go along with that and therefore, we need to be able to treat those issues. And if we can treat those issues, we're behavioral health agencies, we're not substance abuse agencies. (2010 interview)

There were concerns that, in Illinois as elsewhere, state divisions associated with substance use and mental health would be consolidated. Kevin, for example, stressed the importance of

substance use retaining a unique identity: Any of the states that have merged their systems where there were two separate systems, usually what – majority of the time what would happen is the addictions treatment, because it's a smaller system, is absorbed into the mental health system and then it loses its identity." (2014 interview). Phyllis echoed this sentiment, saying "when substance use disorders get combined, they often go unseen" (2014 interview).

Treating substance use and mental health as the same was also seen as consequential for the implementation of ACA. While I was in the field, a recent New York Times article (Goodnough, 2014) had generated a flurry of attention to the Medicaid Institutions for Mental Disease Rule and its consequences for larger, residential substance use programs. This provision was meant to prevent the warehousing of mentally ill clients that had occurred prior to deinstitutionalization in the 1960s and prohibited Medicaid reimbursement for care in facilities with more than 16 beds. While residential programs for women—who had long been eligible for Medicaid provided they were pregnant or parenting—were intentionally designed on a smaller scale, men's programs were not. Kevin offered this as an example of the problems of trying to fit substance use—which has evolved into an independent system in the last five decades—back into a mental health focused model (2014 interview).

Table III.vi – Strategic Expansion – 2004-2010

Logic (frames)	Chronic relapsing brain disease
Internal governance units (rule-making)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) Treatment Alternatives to Street Crimes National Institute of Drug Abuse (NIDA) Joint Commission on Accreditation of Hospitals American Society for Addiction Medicine (ASAM) Insurance industry (managed care) Center for Substance Abuse Treatment Addiction Technology Transfer Centers
Networks	Professionalized
Resources	Insurance reimbursement Performance-based Evidence-based treatment

Current Configuration – The 2010s

Given the history of the field, a broad array of organizations are involved in work on alcohol and other drug use. The field includes hospitals whose involvement in treatment for alcoholism predates the emergence of the modern treatment system and an array of organizations not explicitly focused on substance use at all, drawn in through initiatives like Access to Recovery in the early 2000s. While identifying the specific kinds of organizations and approaches currently animating the field is an empirical question best answered by discerning patterns amongst the current population of organizations involved in this work, there was some degree of consensus about the markers of high quality care—or at least the characteristics of organizations likely to survive the sea-change represented by ACA.

With the passage of ACA, providers with infrastructure to bill for Medicaid reimbursement were seen as relatively advantaged. April explained "right now, it's their ability to understand and navigate what's going to be happening with Medicaid expansion in Illinois and how they're going to—how they're going to work with the managed care entities that are going to oversee the care of all of the individuals who are going to be Medicaid eligible" (2014 interview). This tended to favor larger programs with more financial resources and those that were more medicalized: "the ones that are most at risk are the ones that don't have the capital to sustain the change. If you don't have the financial resources to invest, your best option is to merge with someone. Otherwise you just go out of business" (Kevin, 2014, interview).

While the field included organizations with a variety of forms—public agencies as well as private non-profits and for profit corporations—there is a sense that substance abuse treatment should not be provided on a for profit basis. At a pivotal moment in her career, Gail described

not taking position in a program for homeless women with mental illnesses because "the money of [the organization] ultimately goes to [its owner] who, you know, drives a Porsche. You know, I mean, I just couldn't put that—I had a lot of trouble with it just integrity wise and so I chose not to do it" (2010 interview). Similarly, Gene related with pride that he had managed to keep for profit methadone programs out of the state where he worked, suggesting a profit motive diminishes service quality "some of these guys make millions. One—one person or one company owns over 50 methadone clinics. The way you make money is you cut down the professionalism of your staff" (2010 interview). In his own psychiatric practice, counseling was a necessary piece of medication-assisted treatment and any other model was irresponsible.

Despite the field's emphasis on evidence-based practices, most described methadone programs as highly stigmatized. Support for evidence-based practices starts to break down, however, where the use of methadone is concerned. Though well supported by federal research, methadone programs are not eligible for Medicaid reimbursement (Anne, 2014, interview). Paul explained,

> There's a lot of evidence that this is one of the evidence based practices that really says a lot of money and helps the welfare of the country so that's what we're going to do, man, that would be 180 degrees in the direction of where the substance abuse field is headed. Those all—you know, methadone maintenance has—has never sat well in the substance abuse field, even though the federal government identifies it as a—a really good thing to do. (2010 interview).

This sentiment was widely shared. Donna related "the methadone thing still—still have some people that really have a problem with that. And yet it—it—the research will show that it works and there's no other drug I don't think anywhere that's been researched as long and as hard as methadone" (2014 interview). Gabriel felt that greater incorporation of staff with mental health training who were generally more accepting of the use of medications would ultimately lead to changed attitudes towards methadone:

> We're starting to accept that medication should be part of our arsenal but we're not even – we're not really there yet, while mental health kind of accepted that and kind of went too far the other way, you know, where they thought medication was going to cure everything. So I think there's some of that distinction, like the mental health field I think is a little bit more mature than the substance abuse field (2014 interview).

Most interviewees were ambivalent about the incorporation of approaches associated with mental health. All felt that recognition of co-occurring disorders—relationships between substance use and mental health issues like depression and bipolar disorder—had enhanced providers' abilities to meet clients' needs. The ability to address co-occurring mental illness—or at least not stigmatize clients for taking prescribed medications—was also important and an area to which the state had devoted some training (Phyllis 2014 interview). Most were positive about adaptation of specific practices, like CBT or trauma-informed care, but, as described above, concerned that the overall embrace of mental health might dilute the field's focus on substance use.

Another marker of quality relates to the range of services programs provide. In identifying high-quality alcohol and other drug programs, Hannah emphasized those offering the "full continuum" of services. Kevin's terminology was similar, prioritizing programs with a "kind of a spectrum" of treatment options. He saw this as crucial in offering flexibility to clients—being able to move them to different levels of care within the same larger organization rather than referring them to another provider.

In addition to the range of services offered, interviewees described the provision of specialized services—those tailored to the needs of specific populations such as women, criminal justice clients, or members of specific racial or ethnic groups—as a marker of program quality. Paul's remarks suggest that these programs are seen as being less entrenched in old models:

> the sort of specialty approaches, like women specific treatment and culturally competent treatment, those kinds of things I think have taken what was clearly the old boys club of

> AA and made it much more useful for women, for minorities and you know, if we could do the same thing for poor people, if we could have treatment that recognized social class as an important variable, I think we'd really have something. (2010 interview).

Kevin described this as offering "different treatment approaches" based on client needs (2014, interview). Gabriel explained "I think providers like that that do gender specific treatment, even just doing that I think is—is evidence-based. Now, what do you do with people once you separate them by gender, that's—yeah. But at least having an understanding that women's needs for addiction treatment, that their needs are different than men. I think that's a great step" (2014 interview). These sentiments echo the much earlier idea of multi-modality care—the notion that a single approach to treatment will not work for everyone—and that it is providers who must be flexible.

Organizations that were described as "community based" were viewed as particularly responsive to the needs of clients. Phyllis explained, "you have the older community based programs and then you have – and that's where they are very committed to the area they're located in and their staff may be very committed" (2014, interview). These are programs who emphasis is on serving a specific community—whether defined in geographic terms or identity-based terms—and thus as more willing to pivot emphasis in response to changing client needs.

On this basis, status in the substance use field in the 2010s hinges on medicalization and, specifically, organization's abilities to navigate the complex system of Medicaid billing. While this capacity was presumed to be more likely amongst larger organizations, there were other considerations as well. While there was recognition of the presence of for profit organizations in the field, there remained a sense that obligations to generate a profit potentially conflicted with providing high-quality treatment. Informants felt that high quality treatment hinged on attention

to how issues like mental health, gender, and trauma shaped substance use as well as providers' ability to offer range of approaches.

Table III.vii – Current Configuration – The 2010s

Logic (frames)	Behavioral health
Internal governance units (rule-making)	National Institute on Alcohol Abuse and Alcoholism (NIAAA) Treatment Alternatives to Street Crimes National Institute of Drug Abuse (NIDA) Joint Commission on Accreditation of Hospitals American Society for Addiction Medicine (ASAM) Insurance industry (managed care) Center for Substance Abuse Treatment Addiction Technology Transfer Centers
Networks	Professionalized (psychiatry, primary care medicine)
Resources	Insurance reimbursement (Medicaid) Performance-based Evidence-based treatment

Discussion

In the narratives about the field's history that I collected through interviews—as well as the synthetic version above—there is a sense of having come full circle. In the early 1960s, alcoholism and other drug use services were pulled out of mental health treatment and, for much of the last fifty years, addressed through a largely discrete system of providers. Trends surrounding professionalization, the incorporation of evidence-based practices, and changing funding patterns can all be viewed through this lens.

There are other stories as well. What is clear is that the core infrastructure of the field developed in a period of enormous creativity in the 1970s where there was a historically anomalous about of will—and funding—to develop a system of community-based treatment. These were sufficiently strong that the treatment system was relatively well-established by the early 1980s when funding levels were sharply reduced and public discourse turned back towards criminalization.

Though hardly a novel insight, it seems clear that the increasing emphasis on cost effectiveness and performance based funding as had negative consequences for the quality of services. With the shift towards fee-for-service models in the 1990s, many programs were forced to drop ancillary services—transportation, health services, employment support—that were not easy to fit within a managed care framework. A decade later, these are some of the same supports funder sought to enhance access to—albeit through a voucher-based system—through the Access to Recovery Initiative (ARI) and Recovery Oriented Systems of Care (ROSC).

As an outsider, the field appears perplexingly selective in its approach to evidence. The push for adaptation of evidence-based approaches has been accompanied by a systematic unwillingness to provide financial support for some of the best supported approaches. While support for methadone programs are a casualty of entrenched notions that recovery necessarily means abstinence from all mind-altering substances, insurers pushed for ever shorter treatment stays, despite robust evidence regarding the relationship between treatment duration and outcomes.

CHAPTER IV

The Partner Violence Services Field

Scholars of partner violence root the contemporary set of approaches and interventions in feminist activism in the 1970s. A full understanding of this work requires some attention to the cultural frameworks then available for thinking about and intervening in instances of violence in the home, as these form the backdrop and building blocks for subsequent efforts. Discussion of developments in the field is shaped by attention to relationships between what Cramer (2005) refers to as three paradigms of partner violence: the feminist model advanced by the battered women's movement, a clinical model emphasizing the role of individual characteristics in placing some individuals at risk for violence, and a criminal justice model where law enforcement and the courts central to interventions.

In describing the field, I use the term partner violence to describe the phenomena more commonly known as domestic violence. As described below, the latter is a legal term often used to describe a broader category of behavior that includes all violence in the home. Partner violence is specific to abuse between people in an affectional or sexual relationship, regardless of whether they currently or have ever shared a home. It thus included people who are or have dated and excludes violence between siblings or between parents and children. To describe the two broad categories of intervention for partner violence, I follow the conventions of advocates and policymakers in Illinois and use the term "victims services" to describe efforts directed at supporting those against whom partner violence has been perpetrated—"victims"—and "partner

abuse intervention programs" or "PAIP" to describe efforts meant to transform individuals—"perpetrators" or "batterers"—who have perpetrated acts of partner violence.

Historical precursors – 1925-1972

Prior to the 1970s, there was little public awareness of—and essentially no resources—for women experiencing partner violence. This absence is well-documented in the literature but was underscored by the experts I conducted interviewed, several of whom had been involved in work on partner violence since the earliest phase of organizing in the 1970s and 1980s. Joan, a community psychologist by training who was doing clinical work in the 1960s, recalled the details of her work with a client who would today be described as a victim of partner violence

> I had one client that was absolutely sane and in this hugely violent relationship with this totally charming man in public, three kids, no money. And she would periodically act crazy and break up everything in the house and get arrested so she could go—and then she'd be sent to the psychiatric hospital and she said I just—A, to be safe for a little while and B, because it was the only way she could stay sane. So she literally got herself mandated into mental health treatment at least three times while I worked with her to try and stay alive. And she also said he's nicer to the kids when he's escalating with me, if I can get myself out of there, the kids are less at risk than if I'm still there because they get caught in the crossfire, because she would fight back. And you know, she finally moved in with her mother. So she and her kids were in this one bedroom apartment for a while and she finally got a job. That would have been '69 maybe. And there were just no resources for her. So I mean, that—that—I still remember—I mean, I could tell you—her name was Dorothy. I mean, I can still remember in vivid detail what she looks like and her kids were adorable. And I was just horrified that there wasn't anything I could do to help her. I mean, there was nothing I could do to help her except to make sure that all of her records didn't say she was crazy. Because the problem is, she would have to act crazy and then she'd get labeled crazy in order to get herself admitted to the hospital and then I would get her coming out of the hospital. And there was nothing for her except what her mother would do. And you know, because she was married to this sort of charming guy, everybody thought she was crazy.

Even for highly trained individuals in the helping professions in the late 1960s, there were no resources that provided assistance and few frameworks for even helping victims understand their experiences.

To the extent that models for understanding partner violence existed, at best, they depicted it as a problem for which both parties were partially responsible. At worst, following the psychoanalytic tradition rooted in the work of Helene Deutsch, whose initial work on the psychology of women was published in 1925, it was attributed to innate, masochistic drive that formed the basis for women's psychological experience (Pleck, 1987). This framework held that women entered and remained in abusive relationships because "they derived psychic and sexual gratification from being beaten and humiliated" (Pleck, 1987, p. 159). The notion that women were somehow to blame for the violence they experienced thus came to permeate literature in psychology and marriage and family therapy on violence in the home, as well as the way partner violence cases were received in the rare instances they made it to court (Schechter, 1982).

Perspectives on violence in the home began to shift in the early 1960s, at least in instances where the victim was a child. In 1962, a pediatrician named C. Henry Kempe presented a paper on what he called "battered child syndrome" at a conference organized by the U.S. Children's Bureau. Subsequently published in the *Journal of the American Medical Association,* the research was based on a survey of hospitals and district attorneys that asked about inflicted trauma in children, estimating that 6 in 1000 children were victims of intentional harm (Krugman & Korbin, 2013). Although what we now term child abuse had been previously described by scholars, Kempe's work—combined the recent passage of a California law requiring medical professions to notify police in instances of suspected child abuse—generated a flurry of attention in the press (Krugman & Korbin, 2013; Pleck, 1987).

Throughout the 1960s and early 1970s, emerging interest in child abuse thus laid the groundwork for subsequent conversations about violence in the home and potential roles for the government in addressing what had previously been considered a private issue. Pleck (1987)

argues for the significance of several aspects of "battered child syndrome" in shaping subsequent attention to partner violence: the blamelessness of the victim, medicalization of the issue through use of the term "syndrome," and characterization of the phenomena as equally prevalent across the socioeconomic spectrum. Each of these factors was seen as necessary for generating sufficient sympathy for victims to produce policy change.

Table IV.i – Historical precursors – 1925-1972

Logic (frames)	Private issue
Internal governance units (rule-making)	None
Networks	None
Resources	None

Field Emergence – 1973-1979

The so-called "Battered Women's Movement" emerged around the same time as the "Women's Liberation Movement," albeit with distinct agendas (Pleck, 1987). The former arose in part because of the latter's predominant focus on sexual assault and access to safe and legal abortion. These movements are necessarily linked, with "the antirape movement provid[ing] the ideology, methods, and public acceptance necessary for the emergence of the battered women's movement" (Pleck, 1987, p. 185). In addition, the infrastructure provided by existing feminist organizations proved crucial.

At the national level, the earliest organizing around partner violence was through the National Organization for Women. The group, organized by a formerly battered woman, began as a self-help group and subsequently became the Pennsylvania Taskforce on Household Violence (Pleck, 1987). At the individual level, members encouraged women to leave and seek prosecution of abusive husbands and, at the community level, they pushed for increased police responsiveness to partner violence-related calls. They provided supports such as court

accompaniment. Groups like the Pennsylvania Taskforce became models for early state-level coalitions, which provided opportunities for those working in otherwise isolated organizations to network and begin pushing for broader policy change.

The first shelter specifically for partner violence victims—known as Women's House—was founded in 1973 by Women's Advocates, feminist collective, in St. Paul, Minnesota (Martin, 1981; Pleck, 1987). Previously, victims in need of emergency housing had either sought assistance from homeless shelters or, when available, with the assistance of feminist organizations who, in some areas, offered housing in offices or in members' homes (Schechter, 1982). Early shelters, which often grew out of existing women's movement organizations, were often co-located in existing social service organizations, such as the YWCA or in run-down buildings (Pleck, 1987; Schechter, 1982). Most were small, taking five or ten families at a time, and ran as collectives with the tasks of daily living—cleaning, cooking, and childcare—shared on a rotating basis (Schechter, 1982). These facilities, like their contemporary counterparts, had clear systems of rules, which established guidelines for things like childcare, curfews, alcohol and drug use, and length of stay. Staff support often took the form of informal conversations that drew on consciousness-raising approaches. Largely staffed by volunteers who often had personal experience with partner violence, boundaries between staff and residents were fuzzy. According to Gloria, who worked in one of the earliest shelters, "as women came in, some of the women who were working with them weren't in much better shape than the women who were coming in and that caused its own set of problems" (2010 interview). As awareness of and funding for partner violence activities increased, these early shelters served as models for new ones.

There were no established models for working with partner violence victims or liaising with other institutions. Multiple interviewees described having the sense that they were simply

making things up as they went along. Thus, part of the early work of advocates involved developing guidelines and manuals regarding resources strategies that had been effective in particular communities and disseminating them through coalition networks (Schechter, 1982). These groups were often critical in marshaling public will and funds towards their creation. Other common coalition activities included establishing and staffing call centers, providing crisis counseling, legal advocacy, community education, and support services such as transportation (Schechter, 1982). By bringing together staff and volunteers associated with a variety of community organizations, coalitions served as important networking sites for broader social change efforts, such as revising existing state laws.

Yet, as much as early organizations provided concrete support to women experiencing partner violence, this individual-level work was seen as inseparable from broader social change goals. Gloria explained the interdependence of these activities, saying

> there is a way of having individual service always feed into advocacy and always inform advocacy but also that individual work with women is done in a politicizing way for women that recruits women into a social movement. And that has been a dilemma is that some people have a political agenda that it's perfectly legitimate to bring—as women come in for help, to say this is the work of the movement, join us, come in with us and organize your work in a way that would get women to join and to help out. And then there's—and then there's other people that say that's exploiting women for a political purpose and we're here to provide a service for them and that—and that has been the—the early years of the movement was much more when you came in, you got recruited. (2010 interview).

While subsequent participation in political organizing work was never a precondition of involvement in support services, individual-level work was seen as part of building the movement in feminist-aligned partner violence organizations.

The earliest organizations in Illinois focused on partner violence were the Women's Center in Carbondale, the Women's Fund in Urbana-Champagne, and Lifeline Services in the

Chicago suburbs (Lucille, 2011 interview).[43] Though none of these programs were intentionally founded to work with battered women, all shifted focus to this work in the early to mid-1970s. Lifeline Services, for example, was founded in 1975 with the broader mission of working with families in crisis but pivoted to focus on partner violence based on the needs of one of its first clients. As Wendy, who began working at Lifeline a few years later, recalled that there were few available models to guide their work: "This field was so new that literally we would go to the, readers guide periodicals literature and try to look it up and there were no articles, there was no research, you could find some articles on masochism and we said, "Oh, that is not what's going on here." This is new and we literally developed our program as we went along" (2011 interview). To support each other and build a broader change agenda, staff from these three organizations began meeting once per month on Saturday in Springfield to share knowledge and resources (Lucille, 2014 interview).

In Chicago, the earliest work on domestic violence occurred through the Women's Advocacy Center, which was founded in 1976. This group developed and disseminated an early resource guide for victims, which in 1976, included three shelters (Schechter, 1982). None were specific to partner violence victims and, being religiously based, all stipulated residents attend Bible classes as a condition of residence (Schechter, 1982). Women's Advocacy Center was responsible for setting up the first partner violence hotline in the region in 1977 and, in 1979, establishing the city's first domestic violence shelter. Constance, the associate director of Women's Advocacy Center, described their goals as broader than service provision saying,

> these were a lot of really wonderful women in the movement of domestic violence who were very strong advocates to try to eliminate all of those things that I mentioned by creating a set of services to respond to those needs. But also to help inform and educate the community at large and legislators on why there needs to be funding, why there needs

[43] The Women's Center, which was founded in 1972, describes itself as "one of the first domestic violence centers in the country" (The Women's Center, Inc., n.d.).

> to be appropriate laws and legislation around the issue of domestic violence. (2011 interview).

Thus, in Chicago as elsewhere, providing support to victims and engaging in broader social change were inseparably linked.

Feminist advocates found support for their perspectives on partner violence through several early books. These include texts like Del Martin's *Battered Wives* (1976) and, in more academic circles, Dobash and Dobash's *Violence Against Wives* (1979). The feminist position held that partner violence is the result of gender socialization and patriarchal social relations. Martin argued that partner violence occurs because of men's continued property rights over women. Dobash and Dobash similarly conceptualized partner violence as an extension of male dominance, arguing that it was rooted in the normal process of male socialization. Like Martin, Dobash and Dobash saw marriage as an inherently patriarchal institution that authorized violence against women and children. Critical to related conceptions of partner violence was the notion that all women—not just those of specific ethnic, racial, or socioeconomic groups—were potential victims, a point that was supported by early incidence studies (Pleck, 1987). The narrative was a relatively simple one: "within the shelter movement, there wasn't a lot of ambiguity about what they were dealing with. They were dealing with battered women who were being oppressed in their relationships and in their marriages with men and they were battered and the men were batterers and that was it" (Gloria, 2010 interview). Partner violence was a problem that potentially united all women against a universal system of male dominance.

By 1976, fifteen states had laws in place that allowed them to fund shelters specific to partner violence (Pleck, 1987). In many municipalities, civil restrictions preventing suits between spouses had been removed and attempts were being made to increase reporting rates by improving policing and court practices (Pleck, 1987). Gloria partly rooted these early successes

in the absence of partner violence from the agenda of groups who might have otherwise pushed back. She told me

> women would show up at the—you know, we would take busloads of women down to the state legislature and they would tell their stories and the people would go oh my god and they would pass these laws that we wanted, you know? There was no organized resistance against us. […] So we were able to in the late 70s, early 80s, kind of take claim to and define the issue in a much more powerful way than we are today. (2010 interview).

The narratives promulgated by the movement tended to emphasize the blamelessness of victims. The absence of competing narratives and established interventions for partner violence thus allowed feminists a great deal of room to shape early policy and practice. However, with greater public attention, competing perspectives emerged.

In 1976, the federal government sponsored the first major study on the incidence of different types of domestic violence, led by a team of sociologists (Pleck, 1987). Findings showed that partner violence was common, occurred in a range of family situations, and was present in different ethnic/racial and socioeconomic groups. Early activists saw these findings as critical to marshaling public support for increased intervention (Mears & Visher, 2005). In 1977, Law Enforcement Assistance Administration,[44] part of the US Department of Justice, was given $700,000 in discretionary funds to distribute to local organizations; "family violence" became an agency priority at this time (Pleck, 1987; Schechter, 1982). There were concerns within the battered women's movement about how these monies were being distributed and used: all required collaborative efforts to increase prosecution rates. Some felt that organizations without explicit feminist commitments were being favored and that funds were being diverted from organizations focused on aiding victims of violence and towards efforts to improve the police and criminal justice system responses (Pleck, 1987).

[44] LEAA was established under the Omnibus Crime Control and Safe Streets Act (1968) and abolished in 1982, when it was replaced by the Office of Justice Assistance, Research, and Statistics and, later, the Office of Justice Programs.

Early federal interventions, as much as they were a response to organizing by feminist advocates, thus also created a foothold for a resurgence of more clinically-oriented approaches that rooted partner violence in the larger family system (Pleck, 1987). Subsequent research by Straus, Steinmetz, and Gelles, the research team that conducted the 1976 national study, would treat partner violence as the outgrowth of patterns of conflict between couples, much to the consternation of feminist advocates (Schechter, 1982). Later research in this vein suggested that women engaged in violent behaviors towards male partners as or more frequently than men did towards female partners—a finding that dramatically undercut the critique of patriarchy central to feminist conceptions of partner violence (Saunders, 2002; Schechter, 1982). These studies were thoroughly critiqued on methodological grounds, with critics noting that focusing on the incidence of specific behaviors like slapping and pushing failed to capture the context of that behavior. Valid measures of partner violence needed, instead, to capture the motivations underlying violent acts (e.g., to produce fear, control the partner's behavior, self-defense) and emotional and physical consequences for the victim, such as fear and degree of injury (Saunders, 2002; Schechter, 1982).

LEAA funds were also used to divert perpetrators from the courts into counseling, which often occurred in mainstream social service settings without ties to the battered women's movement (Caesar & Hamberger, 1989; Pleck, 1987). Instead of conviction, offenders were mandated into counseling or education programs lasting between 6 months and 2 years (Caesar & Hamberger, 1989). Their emphasis was therapeutic and often focused on issues of "emotional stability" and/or substance abuse, which were treated as "underlying causes" for partner abuse (Caesar & Hamberger, 1989, xxix). One early model emerged in Seattle through Ann Ganely's

work with veterans with alcohol issues (Ganely & Harris, 1978). Gloria, who later become deeply involved in work with batterers, recalled

> She and this guy named Lance—I can't remember Lance's last name because he never really got involved in the movement—but Lance and Ann started this group and then from that, she started writing about anger management stuff and she designed this whole idea of having like anger logs for men and that you'd deal with them about their anger and how—you know, she started the whole notion of anger management group for batterers. (2010 interview).

Other programs, rooted in family systems theory, sought to address partner violence as a martial problem. Ken, involved in the founding of an early protofeminist batterers program described this orientation, saying

> Originally there were the family systems people, who felt that-some of them at least, not all of them, that wouldn't be fair-that it really should be done as a couples, or family systems approach, and that that was the best way to intervene, and that in fact people shouldn't be arrested for it because it was a family systems issue; it wasn't a crime, or at least, some of them said that. (2010 interview).

Other models drew on self-help approaches, with some groups modeled on 12 step fellowships and others focused on masculinity more generally (Schechter, 1982). What these approaches have in common is their attribution of partner violence to underlying psychological issues or tensions in the family system, thus undercutting feminist advocates' critiques of patriarchal culture (Bennett & Williams, 2001; Schechter, 1982).

Advocates in the battered women's movement recognized the need for intervention with perpetrators, but what this should look like and who should carry it out were sources of controversy. There were concerns that partner abuse intervention programs (PAIP)s would compete with victims organizations for funding, as well as deeper issues with philosophical orientation (Schechter, 1982). Yet advocates within the battered women's movement were generally unwilling to take this work on themselves. Instead, "most feminists assert[ed] that, ideally, men should provide separate counseling services for men" (Schechter, 1982, p. 263).

The "first wave" of batterers programs—beginning with Emerge in Boston in 1977 and RAVEN in St. Louis in 1979—were founded for this purpose. They were "developed at the request of battered women's advocates" to mitigate the absence of ideologically-compatible programs for male perpetrators (Aldarondo & Mederos, pp. 5-6). Their explicit proto-feminist orientation was reflected in their practices and organizational structures. Like feminist victim services organizations, they tended to be organized as collectives and employ consensus-decision making. Their goal was to hold participants accountable for ending violent and abusive behavior with the idea that this individual-level would foster greater equality between men and women. Participation in these programs was voluntary. Proto-feminist programs depended largely on relationships with women's groups as a source of legitimacy, as Aldarado and Mederos note that they often lacked ties to other organizations and institutions. Some commentators worried that proto-feminist programs—and particularly those affiliated with shelters—were not invested in the idea that partner-abusive individuals were capable of change or would not support reunification if this was what both partners desired (Geffner et al., 1989; Roberts, 1984b).

Federal attention to partner violence continued through the late 1970s, affording advocates new opportunities for organizing. In 1978, the Senate, House, and Civil Rights Commission held a series of hearings in on domestic violence which were modeled on an earlier set of hearings on battered child syndrome (Pleck, 1987). As with the hearings on battered child syndrome, the Civil Rights Commission hearings on partner violence led to increased public awareness and new streams of funding (Pleck, 1987). They also underscored the limits of using borrowed strategies—advocates were pressed for answers to questions about why women remained in abusive relationships in way that advocates for battered children had not been (Pleck, 1987). Feminist advocates also lacked allies in the professions. While child abuse awareness and

interventions had been led by medical professionals, representatives from this group were notably absent from the 1978 domestic violence hearings. Ultimately, the conception of domestic violence that emerged was rather different from that of the movement: "The preferred explanation, given by psychologists and sociologists, was that domestic violence arose from stress and frustration, compounded by alcoholism and drugs" (Pleck, 1987, p. 195). Thus, the federal approach to partner violence hewed more closely to the clinical paradigm than feminist advocates might have hoped.

By situating the issue of partner violence in the family system, this conceptualization sparked renewed interest in partner violence amongst helping professionals in social work and family therapy (Rothenberg, 2003). In her analysis of rise of the clinical paradigm, Rothenberg (2003) suggests that, in the late 1970s and 1980s, advocates ultimately faced a decision between taking an approach that was politically feasible but ideologically suspect or maintaining the feminist position and potentially jeopardizing needed resources. Lenore Walker's work on "battered woman syndrome" and the "cycle of violence" emerged in this context (Walker, 1979; Walker, 1984). Walker's work draws on social learning theory and specifically, the notion of learned helplessness, to theorize why women remain in abusive relationships. Though they may initially attempt to prevent or control their partner's violence in various ways, as the violence continues, victims become passive, having "learned" that their efforts are ineffective (Walker, 1984). Proponents cited research on the relationship between childhood exposure to partner violence and subsequent victimization or perpetration to support this perspective (Jasinski, 2001). Though Walker's model highlighted the lack of institutional responses to partner violence contributed to battered women's sense of helplessness, this aspect of her model was seldom emphasized in popular accounts (Walker, 1979, 1984; Rothenberg, 2003). Advocates responded

to Walker's work—and the attention it generated—with ambivalence. On the one hand, it proved useful in defending battered women who went on to kill their abusers (Susan, 2014, interview) but was, at the same time, often used to pathologize victims and underscore their helplessness (Julie, 2010, interview; Rosenberg, 2003).

The first national partner violence-focused organization—the National Coalition Against Domestic Violence (NCADV)—arose in response to the Civil Rights Commission Hearings with the goal of facilitating advocacy at the federal level (Pleck, 1987; Schechter, 1982). As described by Schechter, in preparation for the hearings, the Women's Legal Defense Fund was tasked with researching and locating potential experts: "two staff members…called women in every state, hunting for information about shelters, hotlines, model state and local legislation, and other law reform projects" and sought to get a cross-section with representation from different geographic areas, racial and ethnic groups, levels of urbanicity, and kinds of programs (e.g., shelter and non-residential) (1982, pp. 137-138). The group that formed to provide advocacy at the hearing became the basis for the National Coalition. NCADV built on the infrastructure of existing state and local coalitions, which were already were already publishing newsletters and forming policy working groups.

As a result of the Civil Rights Commission Hearings, the Carter Administration established an Office of Domestic Violence (ODV) as part of the Department of Health and Human Services. The office was provisioned with a small budget—$900,000—for "demonstration grants, research, and dissemination of materials" (Pleck, 196). It was also a center for advocacy on early federal domestic violence legislation—two bills that would have funneled $125 million into social programs for partner violence. Introduced in the 1977-78 and 1978-79 legislative sessions, neither bill was ultimately passed largely due to concerns over

federal reach into the private sphere (Pleck, 1987). ODV, however, remained to provide technical assistance through the ACTION program.[45] ACTION designated ten partner violence organizations as technical assistance centers and tasks them with organizing and hosting conferences and other training activities. Per Schechter, the goals of the ACTION Program became increasingly problematic for member organizations. During the second year of the program, collaboration with mainstream social service organization was expected and the fact "that traditional social service organizations offer totally different models of help and have different politics was insignificant to funders" (1982, p. 194). Feminist partner violence organizations worried that they were being asked to help strengthen organizations whose work undermined their own. Funding for direct work with victims came from two sources: HHS Title XX and the Comprehensive Employment Training Act (CETA). While the former most often supported shelter services and the purchase and renovation of buildings, the latter was often used to pay staff wages.

The same year, the initial conversations that led to the formation of the Illinois Coalition Against Domestic Violence (ICADV) began. By 1978, a group of advocates who had been meeting informally began to pull in others interested in doing work on partner violence. This group was an early resource for Lucille, then a clinical social worker, who had been seeing domestic violence victims in the course of practice and was considering starting a shelter:

> when I just—you know, I—I'm seeing things and I don't really have a—a framework to put it in, but what my intuition told me was I needed to see if I could find a safe place for these people and—and so my idea was to get a home where people could come when they were in crisis and where women could come when they were in crisis and with the aid of social workers, be able to figure out what they wanted to do and move on. And we were—when I was looking for this place, at the same time, I ran up against the domestic violence—the people who were working in the field of domestic violence and—and

[45] ACTION, a federal agency established by the Nixon Administration in 1971, coordinated government-sponsored volunteer activities such as VISTA (Volunteers in Service to America), the Peace Corps, and others.

> Susan Schechter was one of those people, I just heard her speak. But there were other people in the room who were working in the field. (2014 interview).

The "other people in the room" were the advocates who formed the Springfield Saturday group. Wendy explained, at the time

> there were six of us in the State, six shelters for women and children and the six shelters were experiencing battered women and we contacted one another and said, "Perhaps it would be good for us to meet and compare notes." And that was in 1978 after I had been [at Lifeline Services] for a year already and out of that meeting the Illinois Coalition Against Domestic Violence was born. (Wendy, 2011, interview).

According to its Bylaws, which were approved by consensus of the twelve existing members in 1978, ICADV's purpose was "to eliminate domestic abuse in the State of Illinois with primary focus on women and their dependent children" (ICADV, 1978). Membership was limited to non-profit organizations that provided shelter, counseling, "referral and/or advocacy" for partner violence victims and that were "committed to: 1. Providing services to victims of domestic violence and/or abuse, 2. Exposing the roots of violence, with primary emphasis on the institutionalized subservience of women, and 3. Providing quality service statewide through cooperative, non-competitive means" (ICADV, 1978). Each member organization was allowed one spot on the Board, which was tasked with approving new member organizations.

One of the earliest goals of ICADV was securing federal funding for partner violence work in Illinois. Specifically, the group sought funding under Title XX, a system of block grants to the states to support social services. ICADV members convened at a retreat center to prepare their materials: "and the instructions were that we were to bring a sleeping bag and a covered dish" (Lucille, 2014, interview). In comparison with other state coalitions, ICADV was relatively unique in its role in requesting and dispersing federal funds, establishing itself early on as a "pass-though" for federal funds (Vivian, 2014, interview). Operating expenses for the Coalition came out of these grants, which were then distributed to its members. In keeping with its

commitment to cooperative, non-competitive methods, the Coalition expanded its membership only when there was a commensurate increase in the total availability of funding for partner violence work (Vivian, 2014, interview).

The National Coalition continued to grow as well, with membership increasing from 26 organizations in 1979 to 123 in 1980 (Schechter, 1982). NCADV was also attempting to be increasingly response to the diversity of its membership. In 1981, the Coalition moved to create caucuses for women or color, lesbians, and women in rural communities (Schechter, 1982). Issues of identity became increasingly contentious at the national level (Yllö, 1988). Julie explained

> I was there in the thick of it in the 80s and—and it was so painful. And you know, being a white liberal woman, it was particularly shattering for me because I was so young and so naive, that all of it just came as a complete shock that anyone, you know, might be really angry with me. So that was all—that was huge. That was huge about not only not including women of color and lesbians in terms of who was hired within our programs, but also the extent to which we were just not adequately—adequately, that's not even the word. How we were just, you know, completely failing to serve the needs of women of color, battered women of color and lesbians and boy, were we failing.

While these debates had minimal impact on the services landscape in many communities, in metropolitan Chicago, they gave rise to a number of organizations addressed to partner violence in the diverse racial, ethnic, and religious communities comprising the region, which were founded throughout following decade. Irene described the emergence of these different "pockets of expertise" as an "organic development" in metropolitan Chicago (2014 interview) which generated little friction because of ICADV's role in distributing funds. Throughout the 1980s, ICADV prioritized the development of programs in areas it considered underserved through mechanisms like funding for satellite and special programs for "populations that [are] special because of geographic, cultural or special service need (e.g., advocacy for Spanish speaking women; support groups for minority women)" (ICADV, 1985).

Table IV.ii – Field Emergence – 1973-1979

Logic (frames)	Dominant: Private Issue Competing: Woman or Wife Abuse, Family Violence, Battered Woman Syndrome
Internal governance units (rule-making)	National Organization for Women Law Enforcement Assistance Administration (LEAA) Office of Domestic Violence National Coalition Against Domestic Violence Illinois Coalition Against Domestic Violence
Networks	Grassroots activists State coalitions
Resources	Policing and criminal justice system responses ACTION grants (through LEAA) HHS Title XX Comprehensive Employment Training Act (CETA)

Criminalizing Family Violence: 1980-1993

Successes in the late 1970s had, by the early 1980s, translated into an altered legal and service landscape. By 1980, 44 states had laws allowing civil suits between spouses (Pleck, 1987), 27 had laws allowing victims to apply for civil orders of protection (Caesar & Hamberger, 1998), and a number had removed the marital exception previously embedded in rape laws (Pleck, 1987). All but six states had laws in place that allowed funding for shelters by 1980 and two years later, Schechter (1982) estimates there were between 300 and 700 shelters in the United States. However, partner violence activities were targeted by the rising conservative movement as contributing to a breakdown in family values. In the context of this growing controversy over partner violence and diminished funding, the Office of Domestic Violence was shuttered and its staff reassigned to the National Council on Child Abuse and Neglect (Pleck, 1987).

Analysts have suggested that feminist advocates in the early 1980s faced a difficult choice: to maintain ideological purity at the cost of blocked progress or to make a series of

strategic compromises. This is the broader context for the emergence of what Cramer (2005) refers to as the criminal justice paradigm. Although rooted in the efforts of feminist advocates to increase legal protections for battered women and their children, critics like Cramer charge that the approaches that emerged did much more to strengthen and expand the criminal justice system itself with disastrous consequences for communities of color (Cramer, 2005; Richie, 1996). Gloria explained that advocates that the time "took advantage of a discourse that was available to us" (2010 interview). The goal of advocates continued to be ensuring the safety of battered women but the avenues for accomplishing that reinforced the status quo:

> By the time we go to the place where we really had an agenda with the criminal justice system, Ronald Reagan was coming in and […] was into increasing police and a whole kind of agenda of putting more money into the criminal justice system and building more prisons and putting more people in those prisons. And so there was money around—connected to that for victims services, etc., etc. And also there was an agenda of holding offenders accountable that—that whole—in that kind of 80s mentality took on, that these offenders are not being held accountable. And so we ended up being able to fit in with that bigger, larger social agenda of right-wing change unfortunately. […] So when we tried to criminalize this, we just happened to be articulating that at the same time, instead of fighting against the—the norm, we were kind of going with the flow. (Gloria, 2010, interview).

Thus, early evidence suggesting that the act of arrest alone often reduced subsequent violence incidents combined with public support for a "tough on crime" stance. Many states and localities enacted mandatory arrest laws, requiring that police responding to domestic violence calls identify and arrest whomever they determine to be the "primary aggressor" (Iovanni & Miller, 2001).

In Illinois, a group of battered women's advocates in Chicago formed a distinct coalition—The Chicago Metropolitan Battered Women's Network—in 1980 to shape policy and services in the city. It was founded "by 5 women from four different human service organizations that provided a variety of services for battered women and their children. […]

After several meetings, The Network structure was formalized to include, two co-chairs, four agencies belonging as official members, and 41 agencies joining as participating organizations" (Chicago Metropolitan Battered Women's Network, n.d.). Their membership thus included essentially all organizations then involved in any work on domestic violence in the metropolitan region. All the work they did—legislative, policy—was member-driven, mission-driven. They met monthly and created subcommittees and produced protocols for healthcare screening, amongst other things. In comparing CMBWN to ICADV, Irene, one of its early members characterized the former as "the truly stronger coalition," noting it had no staff of its own so "no one was getting paid" (2014, interview).

Many organizations were members of both CMBWN and ICADV, though the former tended to include more individual members whereas the latter's members were primarily organizations (Vivian, 2014, interview). According to one early member, CMBWN arose, in part, because of regional differences in organizations' needs between the more urban, northeastern part of the state and the more rural south and west (Cheryl, 2014, interview). For example, ICADV members in the south tended to favor mandatory arrest while those in the northeast were concerned that this would ultimately disempower victims, arguing instead arrest policies should be driven by local ordinance rather than state law to allow communities to make their own decision (Cheryl 2014 interview). There were also concerns that mandatory arrest policies would disproportionately impact communities of color, given existing patterns of over-policing (Marcia, 2014, interview).

Another early source of disagreement involvement shelter admissions for male children. This debate, centered in ICADV rather than CMBWN, involved push back against a common shelter policy barring admission for boys over the age of 12. Cheryl (2014) explained this

reasoning—which she strongly disagreed with—saying, “they’re a lost cause once they’re, you know, in their teens. I’m like what the – what do you mean they’re a lost cause? Well, they’re batterers probably by then because that’s what they’ve grown up with.” Others, like Cheryl, felt these policies placed victims at additional risk by creating unnecessary barriers to their entering shelter. In response, other shelters made the explicit decision to take children whenever necessary, regardless of age or gender. According to Constance

> I think the other thing that makes us stand out in our niche is we're one of only two shelters in the city that allows women to bring their male children into shelter up to the age of 18, the cut-off age. I know this shelter I used to work at, I think the cut-off age was 12, 11 or 12 or something like that. So when people ask that magical question, "Why doesn't she just leave?" It's because she has a 12, 13, 14, 15, 16, 17-year-old son that she doesn't wanna leave at home with the abuser. And so having that capability is a really big thing for us. (2011 interview).

In some ways, these policies represented two different takes on how feminist beliefs should shape practice, with the first position holding to a deterministic view of gender socialization and the second that services should be driven by women’s needs.

A separate group, with membership overlapping with both ICADV and CMBWN, began working on drafting domestic violence legislation in the early 1980s. In crafting the legislation, the group reached out to legal experts like the Illinois Bar Association and local judges (Marcia, 2014, interview). Marcia, who was involved in developing the Illinois Domestic Violence Act (IDVA), told me they had to work hard to convince the legislature that allowing for ex parte (emergency) orders of protection was necessary. The legislation also made civil orders of protection criminally enforceable. The IDVA also created the framework for domestic violence legal advocacy programs adding protections around confidentiality so advocates could not be subpoenaed (Marcia, 2014, interview). Cheryl, who was also involved in legislative work in the early 1980s, remarked that they could do some innovative things in those days because “no one

was paying attention" (2014 interview). There was not enough awareness about partner violence for there to be opposition. This allowed advocates to push for the development of a specialized domestic violence docket. Previously, partner violence cases were mixed up with all the other misdemeanors: bar fights, theft, etc. and it was traumatic for women to have to tell their stories in front of a bunch of unsympathetic stranger and a judge who did not care. The goal of creating a partner violence courtroom was that it would allow them to work with a particular judge, providing more training and education. Thus, IDVA strengthened the non-shelter component of many early partner violence organizations.

The legal advocacy positions that were created through the Illinois Domestic Violence Act, like other work in early partner violence organizations, blended individual and systems-level work. Just as the goal of support provides on an individual or group basis was to enhance the well-being of individual women while also recruiting them into the movement (Gloria, 2010, interview), legal advocates provided one-on-one support during court cases but also worked to identify systematic issues. Marcia explained that when advocates returned from a day in the courthouse, they sat down together to talk through cases and, in the process, identified larger challenges and strategies for addressing them (2014, interview).

At the national level, early concerns about batterers programs—and a preliminary set of strategies for their resolution —were crystallized in a 1980 set of guidelines issued by the Ms. Foundation. These stipulated that PAIPs were not to be established in areas without parallel programs for victims; that PAIPs must work collaboratively with victim services and "share the same philosophical understanding of the reasons for violence and…work in concert with the shelter movement to end violence against women" (Schechter, p. 261); and, in instances where programs might compete for limited funding, that support for victim services be prioritized.

While other models of PAIP existed then and continue to exist today, this framework established a basic model still used in many programs. At least as far as the movement was concerned, protofeminist programs were the only acceptable intervention with batterers.

The Duluth Model—which became the model for PAIP programs by the late 1980s and early 1990s—built on the legacy of early protofeminist programs but was much more reliant on the criminal justice system. This model, based on the work of Ellen Pence and Michael Paymar at the Domestic Abuse Intervention Project in Duluth, Minnesota, was, like earlier programs, group-based but differed in its emphasis on the criminal justice system. Ken explained "a pro-feminist approach would see the whole of family violence as men's attempt to reinforce the patriarchy over women and gain power, and the only way to change that would be to re-educate the men and tell them they could no longer use violence as a way of maintaining patriarchal domination over women" (2010 interview). Participants, rather than being voluntary, were court-mandated so the choice was essentially between completing the program and going to jail. Gloria explained the decision to structure participation this way, saying

> Our little claim to fame was that we were saying therapists and psychologists, people like that should not start groups with men that aren't attached to a criminal justice control of the men. So we started a whole thing about you always have them court mandated and you first set up your court relationship before you start your groups. […] You shouldn't do this without a coordinated community response and you've got to get all the criminal justice people behind you so that if he doesn't take to this treatment, he takes to jail. And you owe that to women, that you've got this alternative or you offer him this help but you stick him in jail if he doesn't do things. (Gloria, 2010, interview).

The prominence of the Duluth Model in shaping PAIP—and in the work of the Domestic Abuse Intervention Project on work with victims—cannot be understated.[46] While many programs have

[46] The Domestic Abuse Intervention Project also developed the "Power and Control Wheel," an iconic visual description of partner violence. Developed conversations with victims, the power and control wheel conceptualizes partner violence as an interrelated set of behaviors backed by physical and sexual violence that includes intimidation; emotional abuse; isolation; minimization, defiance, and blaming; using children; male privilege; economic abuse; and coercion and threats (Pence, 2002). It is paralleled by the Equality Wheel, which describes the characteristics of

moved away from strict adherence to the Duluth Model, elements of it remain in many programs commitment to co-facilitation by one man and one woman and the emphasis on the twinned goals of victim safety—often described as paramount—and perpetrator accountability.

An early survey of batterers programs suggests that, by the early 1980s, many programs incorporated feminist goals (Roberts, 1984a). Of the 44 included in the study—at the time, roughly half of known PAIPs—most listed eliminating partner violence as a goal and reported involved in community outreach and education activities with law enforcement and the larger social service community. Alongside systems-level goals and strategies, programs also reported more conventionally therapeutic goals like encouraging responsibility, effective communication, and educating participants about battering and anger management (Roberts, 1984a). Most programs used educational workshops or group sessions, although a substantial minority (25%) reported using individual or couples counseling. Programs received referrals from both victim services organizations and the court system. Only about one-third of programs received federal funding, most often from LEAA, CETA, or ACTION, with others funded by state or local governmental sources, community foundations, or participant fees.

In metropolitan Chicago, batterers programs were extremely rare in the early 1980s. While there were approximately 89 batterers programs in the United States in 1985 (Caeser & Hamberger, 1989), Joyce recalled a total of three programs in metropolitan Chicago in the mid-1980s (2014 interview). At the time, she was working in a victim service organization with a PAIP component. This model—a PAIP embedded in a larger victim service organization—was something of a rarity, both in Chicago and nationally. In describing the configuration of services

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gender-equitable relationships. The Power and Control Wheel has been widely adapted to reflect the experience of different ethnic, racial, and religious groups as well as the experiences of individuals in different life phases (National Center on Domestic and Sexual Violence, 2012) and is widely used for educational purposes with victims, perpetrators, and the public (Gondolf, 2010).

in Colorado at the time, Ken remarked that "most of the time the shelters didn't provide, or they were not involved in, treatment, certainly of any abusers at all" (2010 interview). Yet, to the extent that feminist victim services organizations ceded away responsibility for the development of PAIPs, the gap was filled by more clinically oriented programs. This, too, was problematic, particularly given the lack of oversight for PAIP. Julie explained "when people started calling it services, it's like excuse me. It was insane to me to even think about it in those terms and then, you know, people were hanging shingles and it was like excuse me, you know, mental health was taking it over, it was just—it was insane" (2010, interview). Still, victim services organizations, already strapped for funds, were unwilling to divert resources from what they saw as their primary mission of supporting victims.

Increased federal funding for domestic violence work came in 1984 from two sources. The first, the Family Violence and Services Prevention Act, allocated $6 million towards funding for shelters. Consistent with the federal focus on family violence, provisions for shelter funding were tacked onto a bill focused on issues of child abuse—infant protection in particular—and was thus viewed by advocates as something of a compromise (Pleck, 1987). Still, it was a flexible source of funding that could be used for basic operating costs so organizations "could have the lights on" (Vivian, 2014, interview). These early links to child welfare came with costs, however. Gloria recalled "[It was] really big was when social services started telling shelters you're mandatory reporters. You have to—you are like another social service provider like us and you've got to report when women aren't doing these things to protect their kids. That was a huge—and shelters did it" (2010 interview).[47]

[47] This shift coincided with the rise of so called "failure to protect" laws, which have been used to prosecute non-abusive partner violence victims whose children have been abused by their partners. For commentary on these laws see Enos (1996) and Magen (1999).

Additional funding came through the Victims of Crime Act (VOCA). In Illinois, 30% of VOCA funds were earmarked for victims services, with half going to ICADV and the other half to the Illinois Coalition Against Sexual Assault (Greg, 2014, interview). Combined funding from FVSPA and VOCA allowed ICADV—and partner violence services across the state—to expand considerably. The coalition grew from 12 organizations in the early 1980s to 48 by the early 1990s (Vivian, 2014, interview). ICADV's operational costs were rolled into these grants but at a relatively low level. In 1985, the ICADV Administrative Support Budget was set at 8.9% of the total budget for partner violence programs in the state (ICADV, 1985).

At the national level, as overall funding for partner violence interventions increased, organizations adapted more traditional, hierarchical forms, adding features like boards of directors and replacing volunteers with paid staff, which were seen as incompatible with feminist ideologies (Schechter, 1982). These issues were exacerbated in the most successful shelters, which expanded rapidly. Based on his study of 89 victim service organizations, Roberts (1984b) observes that the majority (65%) received federal funding under CETA. Other research suggests that by the mid- to late-1980s, victim services organizations had largely shifted towards more conventional organizational forms and philosophies. Wharton (1987) finds, for example, that of the 25 organizations in her study, 23 were bureaucratically rather than collectively organized. Only a minority (6 organizations) described themselves as "explicitly feminist," while the remaining 19 identified themselves as either "not explicitly feminist" (11 organizations) or "not feminist" (6 organizations) (Wharton, 1987). Organizations taking a more tempered approach to feminism were more likely to have arisen from an existing social service organization, such as a YWCA and were more likely to describe their surrounding communities as hostile towards feminism (Wharton, 1987).

Given the social movement roots of domestic violence work, it is hardly surprising that professionalization was greeted with suspicion by feminist advocates. Julie, for example, recognized that as staff in partner violence organizations became more professionalized, they were treated as more legitimate by other systems but generally regarded the process of one of co-optation. She saw it as a loss for the field when formal credentials gradually took precedence over lived experience in hiring decisions (2010 interview). Gloria similarly described the shift from a movement orientation where the work was based, on one hand, in the lived experience of battered women and, on the other, in feminist theory towards a "helping" model: "now you've got people still working towards social change but without the women with them… The rhetoric of social change is still there but the mechanism to get there is gone and the role of women coming into programs has been relegated to the notion of healing, personal healing only and not becoming a part of the social movement" (2010 interview).

How individuals and organizations responded to increasing professionalization in the field depended, in part, on their origins. Lucille, a clinical social worker, had initially found the absence of other mental health professionals in early partner violence work disconcerting. Describing the group that gathered to craft the proposal for Title XX funds in the late 1970s, she told me,

> We went to this house and we sat there in this room, living—you know, like it was kind of like a living room, dining room space. And I am sitting there listening to DHS talk about the forms, which was not a problem because I was running a social service agency. But I'm also listening to the people in the room and it dawns on me that I'm the only licensed social worker in the room and that many of the people in the room were very suspicious of professionals. And I thought oh god, I've got to sleep here on the floor [with all of them]. So I mean, it worked out fine and you know, I've developed a lot of really nice friends and a lot of people who were from that very grassroots have done—some of them are still in the field and some of them have done—I mean, you know, they've—they've done okay. (2014 interview).

People affiliated with PAIPs were also generally more positive about professionalization, seeing it as potentially opening new avenues for their work, both in terms of approaches and funding.

By the late 1980s, it was increasingly clear to Joyce, and other working in early PAIP programs, that there was need for greater coordination, both among existing programs and with victim services organizations. Joyce explained,

> We sort of formed this collaboration of partner abuse intervention program providers of—of victims service programs because there was a lot of dismay in the Coalition. The Illinois Coalition Against Domestic Violence was not happy that there were people providing services to perpetrators of domestic violence. And they felt— a lot of the discussion centered around the fact that they felt it was going to take money or was taking money away from victims and the few of us kept saying no, this is really important. We really need to offer these services. (Joyce, 2014, interview).

This group worked with ICADV's newly to organize a conference on PAIP, bringing in speakers from the Domestic Abuse Intervention Project, RAVEN, EMERGE, and other national leaders (Rhodes, 1986). Julie described this conference, which took place in June 1987, as critical in "getting things moving" and garnering support for PAIP from victim service organizations.

At the same time, ongoing discussions of the role of ICADV in shaping work with perpetrators were taking place. Initially, these occurred through with Abuser Intake Subcommittee, which was part of the larger Service Standards/Training Committee (Service Standards/Training Committee, 2 May 1986) before becoming the separate Ad Hoc Committee on Abuser Treatment/Abuser Services (Service Standards/Training Committee, 21 November 1986). The Ad Hoc Committee, in addition to planning the conference described above, also worked to develop a position paper, to be presented to ICADV's board on interventions with perpetrators (Service Standards/Training Committee, 21 November 1986). The resulting position paper, which include both majority and minority reports, stated that ICADV programs "who wish to provide abuser treatment/abuser services [should] be allowed to do so. [And t]hat no

program would ever be expected or required to provide an abuser treatment or abuser services program" (ICADV, 1986). The report stipulates that ICADV not fund perpetrator programs with "core service monies" and that the coalition work with "the Department of Corrections, the Department of Probation, or the Department of Mental Health for funds to be used for abuser services, as funds from these sources would never be earmarked for services for victims of domestic violence […] so that no portion of the funds from core services would be used for abuser's programs" (ICADV, 1986, p. 1). The minority report held that ICADV should avoid any role in providing funding, however indirectly, or oversight to perpetrator programs. At least until the development of state-wide standards for PAIP in the early 1990s, ICADV's Services Committee continue to have some role in monitoring these programs (Service Standards/Training Committee, 12 October 1990).

Table IV.iii – Criminalizing Family Violence – 1980-1993

Logic (frames)	Dominant: Domestic/Family Violence Competing: Woman or Wife Abuse, Battered Woman Syndrome
Internal governance units (rule-making)	National Coalition Against Domestic Violence Illinois Coalition Against Domestic Violence The Chicago Metropolitan Battered Women's Network Ms. Foundation
Networks	Professional, social services
Resources	Victim services (versus PAIP) ACTION grants (through LEAA) HHS Title XX Comprehensive Employment Training Act (CETA) Family Violence Services and Prevention Act funds Victims of Crime Act (VOCA)

At the national level, the organizations in the partner violence field had become increasingly professionalized by the early 1990s. Roberts' (1998) study of 176 victims services programs found that the majority were reliant on federal and state funds, with donations and

private grants accounting for a negligible portion of their total revenue.[48] Funding was listed as a concern for all organizations. All had assumed conventional, nonprofit structure, with boards of directors whose membership was drawn from health or mental health fields, corporations, or local businesses. Relatively few board members were identified as being victims, suggesting that the organizational emphasis on involving victims in staff and leadership roles had faded by the early 1990s.

By the early 1990s, ICADV's status as a pass through for federal funds had become increasingly controversial. Irene explained that many in the state felt it created conflicts of interest in that ICADV "became the folks that you actually applied to for funding. The tricky piece was that the membership was also the board which was also the allocation committee. So you had people who were divvying up the money that were the leadership, including the Coalition itself getting a percentage of the dollars, right?" (Irene, 2014, interview). Beginning in fiscal year 1992, the State of Illinois decided they would no longer allow ICADV to administer federal partner violence funds.[49] According to Vivian, the decision was the result of "a personality conflict between the state administrator [of the domestic violence program] and state Coalition" although the stated reason involved the conflict of interest posed by ICADV's board allocating funds of which they were also potential recipients. This decision had significant implications for ICADV, which went from having a staff of 24 to 3.5 (Vivian, 2014, interview). Vivian explained "nationally, we were seen as one of the primary leaders of the movement. And then all of a sudden, we didn't have any money." With this shift, membership in ICADV and participation in the training and technical assistance programs it provided were no longer

[48] Though published in 1998, the research is based on survey data collected in 1994.

[49] ICASA was allowed, however, to retain this status which underscores the role of "personality conflicts" in precipitating ICADV's status change (Vivian, 2014, interview).

requirements of receiving funding. Several organizations did leave ICADV at the time in part due to tensions around ICADV's requirements that programs maintain "24-hour accessibility" and also over differences in vision that came from members of ICADV's board also being executive directors of organizations.[50]

With these changes, ICADV came to refocus on two areas: advocacy around the development and passage of federal partner violence legislation and the development of a credentialing system for staff in partner violence programs. The credentialing program represented, in some respects, an effort by ICADV to shift from providing oversight at the program level to the individual level. According to Vivian, "we were concerned that since the state took this over, somehow the state or somebody was going to come in and say everybody has to have a master's degree or they have to have this or that or whatever. And so to counteract that, we really wanted to create—I think we also saw it as an opportunity to train others" (Vivian, 2014, interview). Over the course of several years, an informal committee developed to create a framework for what they considered to be essential knowledge in the field, working with local universities and an educational testing company to develop training materials and the test itself (Vivian, 2014, interview; Lucille, 2014, interview). In the process, this group also standardized the 40-hour training that had, since the passage of the Illinois Domestic Violence Act in 1982, been required to shield advocates from being subpoenaed. Developing the credentialing system took years; the first set of advocates were credentialed in 2002 (Lucille, 2014, interview). To be eligible, an advocate needed to have completed an approved 40-hour training,[51] have 150

[50] As ICADV reconfigured itself, all but one of the organizations who had left the coalition rejoined, as did a number of newly emerging organizations (Vivian, 2014, interview).

[51] Approved training adhere to a curriculum developed by ICADV specifying the areas to be covered in the training and amount of time devoted to each. For example, trainings are required to provide between 1 ½ and 2 hours on content on alcohol and other drug use. They must also cover cultural issues, partner violence history, power and

supervised (by someone within the ICDVP credential) hours working with victims, and pass the test. When they first created the credential in 2000, they approved all ICADV members as providers of training and supervision.

With ICADV's reduced role in program oversight, the State of Illinois became increasingly involved in regulating PAIPs. In 1993, the Department of Human Services convened a Domestic Violence Advisory Council to begin work on what became the State Protocol for PAIP, which created a set of standards for licensing these programs (Vivian, 2014, interview). The process of developing the protocol was "very intentional" and included close work with victim services organizations (Sharon, 2014, interview). They used the term "partner abuse" to de-emphasize physical violence, allow greater attention to emotional abuse, and specify the relationship between abuser and victim as partners (Sharon, 2014, interview). For programs to be protocol-approved, staff were required to complete both the 40-hour training on partner violence and an additional 20-hour training on PAIP (Sharon, 2014, interview). When the protocol was developed, the state did not offer any funding for programs. Several years later, however the state set allocated 10% of partner violence funds for PAIP (Tom, 2014, interview). With the development of the protocol and licensing system for PAIP, courts were encouraged but not required to refer to licensed programs. This was a matter of practicality as, in some areas of the state, requiring referrals to licensed programs would have meant "sending some guy 200 miles down the road" (Tom, 2014, interview). In practice, it meant that judges still referred to anger management programs in instances where PAIP would have been more appropriate but was not accessible (Tom, 2014, interview).

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control, special populations, mental health, suicide and safety planning, and other topics. For a program to provide the training, all supervisors of direct service staff must be certified (Lucille, 2014, interview).

Despite the development of some supportive infrastructure, the overall number of PAIPs remained small and knowledge about their availability was not widespread. Cynthia, who worked in a community mental health center in Chicago in the late 1990s before transitioning to part-time work as a PAIP facilitator, told me,

> Even working in the city, giving referrals to people, I don't remember giving domestic violence referrals at all to any of the individuals that I met with. But that wouldn't happen all that often but now that I reflect, now that I've been doing the work so long, I remember meeting clients who, you know, clearly were in domestic violence relationships and then had a mental illness on top of it. So—so yeah, but I mean, I hadn't even heard of it. (2014 interview).

Despite the development of the protocol and increasing state support for PAIP, without dedicated funding, the growth of programs was slow.

Institutionalization – 1994-2008

In 1994, the Violence Against Women Act (VAWA) passed. Though part of the larger Violent Crime Control and Law Enforcement Act, VAWA was significant in that it was the first piece of federal legislation focused on violence against women instead of the broader—and less gendered—family violence. Commentators note that VAWA's passage was the culmination of nearly two decades of advocacy and research (Boba & Lilley, 2009; Meyer-Emerick, 2002). In describing VAWA, Cheryl characterized it as "one of the biggest and best things that ever happened to victims of domestic violence in this country" (2014 interview). VAWA created a Violence Against Women Office, housed within the National Institute of Justice; it also increased criminal penalties related to partner violence, enacted prohibitions against stalking and acquaintance rape, and freed funding to promote further research on violence against women (Boba & Lilley, 2009). While VAWA increased penalties for acts already defined as felonies, less extreme forms of violence against women remained under state dominion (Meyer-Emerick, 2002). As drafted, VAWA also included the provision that conceptualized violence against

women as a civil rights issue and would have expanded options for civil court action but this portion was declared unconstitutional in a 2000 Supreme Court decision (Meyer-Emerick, 2002; Rutkow et al., 2009). VAWA created two streams of funding for partner violence interventions. The first, channeled through the Department of Justice (DOJ), focused on enhancing law enforcement efforts, establishing victim advocacy services within the court system, and otherwise strengthening legal responses to partner violence (Valente et al., 2001) in some cases, tying receipt of funds to the existence of mandatory arrest laws (Meyer-Emerick, 2002). Thus, in many respects, VAWA cemented the criminal justice paradigm by creating synergies between protections for victims, law enforcement, and the courts. The second funding stream, directed through the Department of Health and Human Services, established a national partner violence hotline, and created grants for shelters, community-based partner violence organizations, and rape awareness and prevention programs (Boba & Lilley, 2009).

In 1998, the Mayor of Chicago (Daly) established an Office on Domestic Violence. Initially staffed by a single advocate who had been involved in domestic violence work since the early 1980s. Over the course of the following decade, the Office grew to include an evaluation researcher, several community organizers, and a set of activities included grant writing and capacity building around partner violence with other kinds of social service organizations (Irene, 2014, interview). Though funded through a mix of monies earmarked for public health and community policing, the Office was an independent entity within city government. Marcia described it as part of the Mayor's agenda and noted that its staff had direct access to the mayor, which gave the office a great deal of leverage in working with groups like the police, health department, department of aging, businesses, and faith communities (2014 interview). In partnership with CMBWN, the Office on Domestic Violence created a city-wide domestic

violence hotline that eased tensions between metro Chicago programs and ICADV by allowing programs to meet criteria for 24-hour accessibility without having to run and staff this service independently. As Irene explained, they started the Help Line because there was no single point of access for DV resources—each program had to have its own help line—and this was putting a lot of strain on programs (2014, interview). The evaluation team within the Mayor's Office collected and analyzed data from Helpline calls and was also working on developing a universal screening for partner violence to be used in public health programs. The Office was also instrumental in developing domestic violence subcommittees within all Chicago police departments to provide ongoing training and support (Irene, 2014, interview).

VAWA was reauthorized in 2000 and two additional programs were established: Services, Training, Officers, and Prosecution (STOP) Grants and Grants to Encourage Arrest Policies and Enforcement of Protection Orders. The STOP grants specifically promoted training for law enforcement, the creation of units or officers specializing in violence against women, and otherwise developing new types of responses to this set of crimes (Boba & Lilley, 2009). The Grants to Encourage Arrest support the developed of coordinated community response teams, collaborative efforts between partner violence organizations, criminal justice system representatives and, in some cases, other types of community organizations (Boba & Lilley, 2009).

In 2000, the governor doubled general revenue funds for partner violence services (Vivian, 2014, interview). To access these funds, programs were asked to apply and emphasize new or different services areas. A number of programs opened outreach offices in underserved areas as a result. This initiative also provided funds for several large multiservice organizations to develop a partner violence component—most often non-residential services like legal

advocacy and individual or group counseling provided by a single staff person (Vivian, 2014, interview). This effort was part of a broader push for service "co-location"—an effort by the state to increase accessibility encouraging providers to allow staff from other organizations to provide basic, on-site services (Sharon, 2014, interview).

This opening of funds also had implications for PAIP, which was, for the first time, able to access state monies for service provision (Sharon, 2014, interview): roughly one million dollars was allocated towards PAIP. Around this same time, the state protocol on PAIP was formalized into an administrative rule (Sharon, 2014, interview). Program length was increased from 16 to 24 weeks. Many requirements remained the same: the intervention was framed as psychoeducation, not "therapy"; it is required that groups be co-facilitated, ideally by a man and a woman. Sharon noted, however, that some of the philosophy and history that were part of the protocol dropped out of the administrative rule. At the time of its development, one of the goals of the protocol had been to clarify the nature of PAIP and, in doing so, to establish clear differences from interventions like anger management. Much of this was dropped from the administrative rule:

> There were a lot of [best] practices, value philosophical statements and not really rule – when you bump something up to be a rule, it has to be something that can be enforced, can be measureable, can be monitored around, where a protocol, think of that more as a guideline, training. I mean, the protocols at one point were published and sent out with sample tools. Like here's a sample intake, here's a wheel, here's, you know, all of that. That's not administrative rule. You don't see, you know, power and control wheels in an administrative rule. (Sharon, 2014, interview).

Other elements of what were then considered best practices for PAIP were retained, such the mixed gender co-facilitation model and the emphasis on victim safety be the primary goal of programs (Tom, 2014, interview). Many co-facilitators were drawn from existing victim services

organizations, which further eased tension between victim services and PAIP by creating ongoing, direct links between the two.

In 2006, the group that had created the Illinois Certified Domestic Violence Professional (ICDVP) program launched a second credentialing program for PAIP. While the Credentialing Board had considered developing a PAIP certification process several years prior, there were only about 350 people throughout Illinois working in PAIP, many of whom were part-time, and the idea was shelved out of concern there would be insufficient demand (Lucille, 2014, interview). With the expansion of PAIP in the early 2000s, the group began work, drawing on existing models like Duluth, RAVEN, and Emerge (Lucille, 2014, interview). As with the ICDVP, the Illinois Certified Partner Abuse Intervention Professional credential requires professionals to have completed basic trainings on partner violence—both the 40-hour training on victim services and the additional 20-hour PAIP training—that supervisors for people working towards to credential be certified themselves, and that professionals complete a certain number of continuing education hours to maintain certification (Lucille, 2014, interview). There were efforts to carry over elements from victim service credentialing into the PAIP program, like limiting eligibility to staff in nonprofit organizations, that were problematic. According to Sharon,

> It was just simply a well, let's take this that's already established, cut and paste from the document and put it on PAIP, you know, consistency between—that makes perfect sense. But then when it came back and saw that it didn't—that you could not be a for profit, then I said we have lots of PAIPs that are for profits and that doesn't mean they're any less invested in victim safety and abuser accountability. It was like oh. That was very different. You don't see grants going to for profit victims service agencies if there's, you know, such a thing out there. I mean, there are agencies—for profit agencies that serve victims, but not what we would consider victims service agencies. (2014 interview).

When the program was launched in 2006, staff in existing PAIPs were "grandfathered in" so there would be a core group of certified professional to provide supervision. However, growth

has been slow in part, due to the small number of PAIPs across the state. While the Department of Human Services encourages protocol-approved programs to support staff certification, this is not required because of the burden it would impose on programs in the southern part of the state (Sharon, 2014, interview).

In 2008, there were major changes to the Chicago Mayor's Office on Domestic Violence. The Office was reconfigured as the Division of Domestic Violence and placed within the larger Division of Family Support Services. Advocates who had worked within the Mayor's Office saw this as a loss, with its effectiveness further diminished by the incoming governor's dismantling of community policing programs to which the Office provided ongoing training and support (Irene, 2014, interview). In its current capacity, the Division of Domestic Violence continues to serve as a link between advocacy groups like CMBWN and the City (Angela, 2014, interview). It remains the primary funder for the City Helpline and continues to collect and analyze data on calls. In addition, they provide funding to 25 of the 40 partner violence organizations located in Chicago along with ongoing training and technical assistance with issues like program evaluation (Angela, 2014, interview). As with the earlier Office on Domestic Violence, the head of the Division of Domestic Violence is former advocate, having come through CMBWN (Angela, 2014, interview).

Table IV.iv – Institutionalization – 1994-2008

Logic (frames)	Dominant: Domestic Violence
Internal governance units (rule-making)	Office of Violence Against Women (federal) National Coalition Against Domestic Violence Illinois Coalition Against Domestic Violence The Chicago Metropolitan Battered Women's Network Domestic Violence Advisory Council (Illinois Department of Human Services) Illinois Certified Domestic Violence Professionals Board Mayor's Office on Domestic Violence (Chicago)
Networks	Professional, social services
Resources	Victim services (versus PAIP)

	Victims of Crime Act (VOCA) Violence Against Women Act (VAWA)

Current Configuration – The 2010s

In metropolitan Chicago today, there is little variation in the kinds of services organizations provide for partner violence. Amongst victim services organizations, the same categories of services are funded in the 2010s as were funded in the 1980s: shelter, legal advocacy, individual and group counseling, children's services (Angela, 2014, interview; Vivian, 2014 interview; Greg, 2014, interview). Funding streams are, for the most part, noncompetitive. Greg, the state administrator for VAWA and VOCA funds, explained that this money nearly always fund the same programs to do the same things from cycle to cycle (2014 interview). While points of emphasis may shift slightly—as with the appearance and then disappearance of funds for financial literacy in the late 1990s and early 2000s—these have minimal impact on the services landscape (Angela, 2014, interview).

In recent years, many victims service organizations in metropolitan Chicago began to shift away from shelter as their primary service. This was at least partly motivated by funding considerations. Operating a shelter is hugely expensive and reallocating funds meant that other areas of programming could be strengthened. Simultaneously, many of the victims being seen in shelters had complex needs that could not be addressed in the 30-day stay allowed by most shelters: rather than being the primary issue they were experiencing, partner violence was part of a larger constellation of challenges (Cheryl, 2014, interview; Vivian, 2014, interview). Doug noted with regret that most funding for transitional housing—a longer-term form of housing support—is tied to federal programming for homelessness rather than domestic violence (2010 interview). He attributed this split, in part, to efforts by early advocates:

> If you go back to the beginning of the movement, you'll find the creation of two shelter systems, a domestic violence shelter system and a homeless shelter system. And the whole reason that you have two from what I understand—and I got this from people who were around—have been around a lot longer than I have who claim that they are part of the mothers of the movement, they said the whole rationale for this was that the folks in the domestic violence shelters did not want their folks labeled as being mental—needing mental and chemical health services. And that that's how the two systems formed. But they were not foresighted enough to realize that the dollars were going to further—follow the larger numbers, which was chemical and mental health services. (Doug, 2010, interview).

Several advocates noted with chagrin that the City had recently earmarked funds to build a new shelter for partner violence victims. While the organizations to whom the funds had been granted—a larger social service organization with a victim service component and a non-residential program focused on the South Asian community—were well regarded within the larger field, there was a palpable sense of frustration that funds would go to provide intensive services for a small number of victims. Pam, whose background was in a nonshelter program explained

> The city of Chicago here is—found money to open the first shelter that's been provided here in the last—you know, for 10 years. I mean, they haven't provided any money to upgrade this current—the shelters that are out there but yet they found money for a new shelter that's being built. Now granted, most of the shelters here stay pretty full so it will be well utilized, but the fact of the matter is is that, you know, when women are receiving services, what they really want is permanent housing, what they really want is a job to support themselves. And what they really want is therapy, you know, to help them, and legal services. So you know, there's all these other pieces out there that I don't know that we've spent enough time on figuring out how to—how to work together to complete the package of what survivors need. (2014 interview).

Pam was not the only one to express frustration about the seeming disconnect between the kinds of activities that were fundable and what she saw as the true needs of victims.

Another area of expansion for both victim services and PAIP involved ongoing evaluation of programs. While in the past, funders were largely content with process measures, which Angela described as "counting widgets," there has been increasing pressure to measure

outcomes (Angela, 2014, interview). The City of Chicago Division of Domestic Violence and CMBWN were engaged in ongoing work to developing measures for victim services programs (Angela, 2014, interview; Pam, 2014, interview). These focus primarily on how services impact victims' self-perceptions and knowledge about partner violence and, as with most evaluation efforts, are tied to the receipt of funds. This has generated some pushback from programs. Cheryl explained that the City was requiring participants in her program to complete pre- and post-tests with a series of likert-scales, one of which essentially asked

> I understand how domestic violence can fuck up my kids pretty much was it and I'm like I'm not asking clients that. What the fuck's the matter with you? I'm not going to ask a client who has, you know, just worked her ass off trying to get out of this situation to protect her kids, I'm not going to ask her does she understand that before she got out of the situation – Her kids are fucked up, I'm not – I'm just not going to. And so I crossed it off every single test and the commissioners call me on the phone saying what'd you do that for? And I said okay, here, put yourself in this woman's shoes. She goes everybody else asked the question. I said because everybody else is a fucking idiot, you know, they – all they want is the money. I want clients to be okay, that's what I want.

In this way, the technical requirements of funders were seen as at odds with what advocates felt was best for participants. This skepticism of research is deeply embedded in the culture of victim services work.[52]

In recent years, the partner violence field has also been impacted by the federal emphasis on trauma. Janet explained that, beginning in about 2011, "the whole core DV services now are supposed to be trauma-informed and we have to help make it happen" (Janet, 2014 interview). Reception has been variable: "sometimes there are organizations run by advocates fiercely opposed to anything trauma-informed because they think it's pathologizing and clinicalizing and others who it makes perfect sense once they hear it" (Janet, 2014, interview). Gloria summed by

[52] An early issue of ICADV's *For Better Times* newsletter includes an article titled "Feminist Research: Getting Closer to the Truth" that describes an early effort by ICADV to facilitate research on the experiences of participants in victim services and the resistance they encountered from program staff regarding, amongst other things, concerns about how data might be used and the sensitivity of the questions (O'Neal & Safman, 1981).

the former position, explaining that much of the resistance comes from the failure of clinically-oriented proponents to adequately root discussions of trauma in a framework recognizing the systemic nature of misogyny:

> Not only is there kind of—kind of an unequal balance of power between men and women, but that unequal balance of power over time has developed into a disdain for women and kind of a—a culturally supported disdain for women that men take up and it articulates itself in the form of not only sexually exploiting or abusing them, but doing it with a lot of hostility and hatred and violence. (2010 interview).

While advocates do not necessarily dispute to notion that partner violence is traumatic and that victims may benefit from support services specific to these needs, there remain concerns about any approach to partner violence that roots issues and consequences primarily in individuals rather than in broader cultural systems.

In comparison with victim services, the range of organization and approaches to PAIP is considerably more varied. As much as the form and philosophy of programs is shaped by protocol-approval at the organizational level and, ideally, certification at the level of individual staff, in the last decade there has been an opening up of approaches. While once, the model was basically "Dulth, Duluth, Duluth," (Sharon, 2104, interview) programs are now more likely to incorporate elements of CBT and attention to issues like parenting (Tom, 2014, interview). These changes have been driven, in part, by recognition that the only way to facilitate the kind of transformative change PAIP is meant to effect is by actively engaging participants—something that many facilitators found difficult under the accountability-focused, classroom-based structure of the Duluth Model (Cynthia, 2014, interview).

The diversity of organizational forms is driven by the limited availability of funding for PAIP. Of the 77 protocol-approved programs in 2014, only 26 receive any state funding (Sharon, 2014, interview). While some additional funds, in the form of fee-for-service arrangements are

available to Cook County programs through the Circuit Court, this is not enough the sustain most programs (Tom, 2014, interview). As a result, the majority of PAIPs are of a larger social service organizations (Sharon, 2014, interview), with only a minority embedded in victim services programs.[53] This can create tensions when staff view partner violence through the lens of some other issue. Cynthia, who has been involved in facilitating the 20-hour PAIP training for new providers explained

> Those agencies, say there's a substance abuse program and they want to start a protocol approved program, they have already their substance abuse background. So that's valuable but then they also go in with a different kind of—you know, this is not substance abuse either. It's not AA, it's not any of that. So I think it's just making sure that it's kept to PAIP, if that makes sense. (2014 interview).

Similarly, in her role tracking protocol compliance, Sharon described working with mental health and substance abuse organizations to ensure that, in the PAIP, the remain focused exclusively on issues of partner violence (2014 interview).

Table IV.v – Current Configuration – The 2010s

Logic (frames)	Dominant: Domestic Violence
Internal governance units (rule-making)	Office of Violence Against Women (federal) National Coalition Against Domestic Violence Illinois Coalition Against Domestic Violence The Chicago Metropolitan Battered Women's Network Domestic Violence Advisory Council (Illinois Department of Human Services) Illinois Certified Domestic Violence Professionals Board Division of Domestic Violence (Chicago)
Networks	Professional, social services
Resources	Victim services (versus PAIP) Victims of Crime Act (VOCA) Violence Against Women Act (VAWA)

[53] Among some victim services organizations, there is still a reticence to engage in work with perpetrators. When I asked about her organizations decision to support the development of an independent PAIP rather than forming their own, Constance characterized CAWC's work as "women working with women" (2011 interview).

Discussion

Any effort to understand dynamics in the partner violence services field must contend with its history. As the field continues to professionalize, its rootedness in feminist social movements of the 1970s has become even more important. At several points, interviewees expressed concerns that not enough was being done to preserve this history or inculcate a sense of institutional memory in the next generation of advocates. Marcia, for example, describe a conversation with two younger advocates about concerns about their collectively having failed to develop the next generation of leadership in the movement and yet, when she mentioned *Women and Male Violence* (Schechter, 1982), neither was at all familiar with it (2014 interview). The importance of history was also underscored by the rationales interviewees gave when suggesting other interviewees or organizations for inclusion in the project. Often, others were recommended on the basis of their having been one of the "founding mothers" or "mothers of the movement." A similar level of veneration was reserved for organizations that had been around "since beginning."

Attention to the field's history helps elucidate ongoing tensions between feminist and clinical models of intervention. This division has had unfortunate consequence for the ability of field to grapple with the complex, lived realities of its service population. Gloria suggested that the movement's insistence on patriarchy and patriarchy alone as the sole cause of partner violence has been limiting: "there's an element of—not truth to their theories but there's an element of us creating their reactions by being pretty dismissive, because we didn't see these other things as causal, we didn't—we dismissed that we should even deal with them at all" (Gloria, 2010, interview). In addition to shaping concrete aspects of practice like terminology, tensions between feminist and clinical traditions also impact the degree to which the partner violence field has been willing to engage with formal research.

The challenges faced by PAIP programs—though also inflected by tensions over gender and responsibility—are also shaped by this division. Ironically, by limiting the ability of PAIP to access partner violence funding, advocates may have inadvertently created a system that requires these services be provided in organizations without clear feminist commitments. While early feminist advocates were successful—to at least some extent—in movement building, efforts to engage men in social change work around violence against women have never been fully realized.

CHAPTER V

Growing Up Differently: Tensions and Convergences Between Fields

> I think it's hard to integrate because the fields grew up differently […] It's hard to kind of look at each other and understand each other because it's—you grew up differently. It's like you're from different parts of the city, different parts of the world and it takes a long time to, you know, get to know each other. (Gabriel, 2014 interview)

Emerging at different times through efforts of different kinds of actors, the fields of partner violence and substance use services "grew up differently." Interviews with practitioners who have attempted to work across fields are rich with metaphor—the two areas represent different neighborhoods, cultures, or languages. This chapter, which uses interview and archival materials, focuses on identifying areas of tension and convergence between the two fields since the 1960s. It includes attention to developments at the federal level and in metropolitan Chicago.

Metropolitan Chicago—and Illinois more broadly—represents something of a best-case scenario for the development of hybrid organizations—those addressing partner violence and substance abuse though a combined approach. The State has a history supporting boundary-crossing approaches to substance use through efforts like the Illinois Drug Abuse Project and, in comparison with other states, has a robust women's treatment system. On the partner violence side, Illinois has one of the oldest state coalitions and one that played a major role in shaping service priorities.

Most importantly, in the mid-1990s, the Department of Human Services sponsored a series of conferences on the intersection of substance use and partner violence, facilitated the developed of a best practices manual on the same topic, and provided pilot funding for several

organizations to develop programs. This effort—the Domestic Violence/Substance Abuse Interdisciplinary Taskforce—was neither the first nor the last attempt to bring the two fields together in metropolitan Chicago, though it may be the most widely known. In this chapter, I explore the reasons why the Taskforce emerged in the mid-1990s and consider its legacy for contemporary work on both partner violence and substance use.

Drawing on Evans and Kay's (2008) work on field overlap, this chapter considers the role of four mechanisms of field overlap in accounting for the Taskforce's emergence and consequences. Rulemaking, the ability of actors in one field to shape rules in another, emphasizes connections at the institutional level through formal and informal systems of regulation. The second mechanism, alliance brokerage, considers the degree of intersection between networks in each field and how much influence actors are likely to have in their own field and the other field. Resource brokerage refers to the extent that material and political resources in one field are valued or useful in the other. The fourth mechanism, frame adaptation, considers the ability of actors in one field to adopt and make use of discursive elements from the other field. Understanding the presence—and absence—of these different kinds of overlap at different points in the history of each field helps account for the emergence and impact of efforts to bridge the two fields.

A "Family Illness": Alcohol, 12 Step Approaches, and Partner Violence

As the federal government moved into funding treatment for and research on substance use, the absence of formal models and trained professionals meant early approaches were influenced by Alcoholics Anonymous. Even prior to the late 1960s, the twelve-step approach shaped more medicalized models at the Yale Plan Clinics and were further popularized through the Summer School for Alcohol Studies, which offered training for professionals, and the National Council

on Alcoholism (NCA), which has been described as AA's political wing, and, though the NCA, influenced employment-based treatment (White, 1998). As dedicated treatment facilities emerged, many incorporated 12 step approaches by offering meetings on site. More importantly, AA was carried into treatment facilities by staff, who were most often in recovery themselves. Both formally and informally, 12 step approaches were built into the structure of the emerging substance use services field.

Understanding the ethos of these early programs—and the organizations and approaches that came later—requires attention to the philosophy and structure of Alcoholics Anonymous. The core philosophy of AA is described in the twelve steps themselves—which are read aloud at the beginning of AA meetings—while the basic structure of twelve step groups is codified in the twelve traditions. Both evolved from early meetings. The steps were formalized in 1939 with the publication of *Alcoholics Anonymous.* The 12 traditions were formalized somewhat later, emerging from reflections of AA's founder, Bill Wilson, published in Alcoholics Anonymous monthly newsletter the *Grapevine*, throughout the 1940s. The traditions were formalized in 1952, when they were published as part of *The Twelve Steps and Twelve Traditions*.

The twelve steps, in both form and content, were borrowed from the earlier moral reform movement known as the Oxford Groups. These were founded by an evangelist and minister named Frank Buchman, who developed a series of six steps to guide the spiritual development of group members (Sack, 2009). For the purpose of AA, these six steps—along with other elements of the Oxford Groups—were adapted and amended to focus on alcoholism. While AA meetings are open to anyone wants to stop drinking regardless of current sobriety status, "working the program" requires more than attendance. An AA member must also "work the steps" by

engaging in a structured process of self-transformation through reading and discussing *Twelve Steps and Twelve Traditions* with their sponsor, who has already worked the steps themselves.

The twelve steps hinge on the notion of individual powerlessness in the face of alcoholism and the centrality of moral self-examination and spirituality in the process of recovery. The first step requires a participant to "admit…powerless[ness] over alcohol" and recognize that life has "become unmanageable" (Alcoholics Anonymous World Services, Inc., 217a). The second and third steps underscore the spiritual nature of AA, and involve profession of belief in a "Power greater than ourselves [that can] restore us to sanity" and the decision to "turn our will and our lives over to the care of God *as we understood him*" (emphasis in original, Alcoholics Anonymous World Services, Inc., 2017c). The fourth step entails engagement in "a searching and fearless moral inventory"—identifying all the participant's "defects of character," which, in the fifth step, are disclosed "to God, to ourselves, and to another human being [the sponsor]" in precise detail. In this way, alcoholism is explicitly linked to individual failings. In the sixth step, participants become "entirely ready to have God remove all these defects of character" and, in the seventh, ask that they be removed by the higher power. In the eight step, participants identify those harmed by their alcoholism, whether directly or indirectly and, in the subsequent step, offer apologies or restitution to them except when these amends might cause additional harm. The tenth step underscores the ongoing nature of spiritual self-reflection central to AA, stating the members continuously engage in moral self-examination and admit any wrongdoing promptly. Step eleven proscribes ongoing prayer and meditation to enhance participants' connections with their higher power. Finally, step twelve encourages practitioners to "carry this message to alcoholics, and to practice these principles in all our affairs." While the

earliest steps focus on alcoholism, the program emphasizes holistic moral and spiritual self-transformation.

The Twelve Traditions provide for the basic organizational structure of Alcoholics Anonymous Fellowships. The first tradition underscores the centrality of the group, stating that "each member of Alcoholics Anonymous is but a small part of a great whole…Our common welfare comes first. But individual welfare follows close afterward" (Alcoholics Anonymous World Services, Inc., 2017b). The second holds that the "a loving God as He may express Himself in our group conscience" is the "ultimate authority" for the group. The third tradition specifies the openness of membership to any person suffering from alcoholism and the status of "A.A. group" to any collectively of people with alcoholism, however small. The fourth specifies the grassroots nature of AA fellowship, stating that each group is to be self-governing and that groups are barred from making decisions that might affect AA as a whole without consulting the General Service Board. The fifth tradition emphasizes AA's purpose in reaching out to people with active alcoholism (e.g., "carrying its message to the alcoholic who still suffers.") The sixth tradition establishes AA's independence from the various institutions—hospitals, churches, community centers—where meetings might be held. Similarly, the seventh tradition holds that meetings be self-supporting via participant donations but that fundraising otherwise be avoided. The eight tradition establishes the nonprofessional nature of AA, stating

> Alcoholics Anonymous should remain forever nonprofessional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform those services for which we might otherwise to engage nonalcoholics. Such special services may be well recompensed. But our usual A.A. Twelfth Step work is never to be paid for.

The ninth tradition further specifies structure and leadership, stating that each group should have "the least possible organization" with "rotating leadership" at the local level. Nationally, it

delegates authority for public relations to the General Service Board. The tenth step prohibits involvement of AA in "controversial issues—particularly those of politics, alcohol reform, or sectarian religion" and of AA groups from expressing opinions on these kinds of matters. The eleventh step describes anonymity, insisting members avoid publicly associating their names or images with the program. The twelfth tradition reinforces the emphasis on anonymity by reaffirming the spiritual benefits of placing the group before individual members. Thus, while AA could be described as grass-roots in its emphasis on it was never activist in orientation. Although the steps themselves suggest openness to a variety of religious traditions by highlighting the subjective nature of the higher power (e.g., "God *as we understood Him*"), in practice, AA meetings often end in a collective recitation of the Lord's Prayer. As translated into practice, the Twelve Step approach is often characterized by practitioners in the substance use field as inflexible. Paul characterized the "very traditional kind of 12 step" approach as "damn the torpedoes […], you know, my way or the highway, 90 meetings in 90 days" (2010 interview).

Alcoholics Anonymous's explicit focus is the person with alcoholism. In response to needs of family members of people with alcoholism, additional twelve step groups were founded as offshoots of AA. In 1951, Al-Alon was established by Lois W., the wife of AA's founder, Bill W. (Al-Anon Family Groups, 2017a). Although family groups had existed since the late 1930s, the 1950s saw this group's formalization. There were, in 1951, 87 family groups worldwide.[54] In structure and philosophy, Al-Alon mirrors AA—the steps and traditions are essentially identical and much of the official literature is shared by both groups. The "suggested preamble" to the 12 steps in Al-Alon meetings states

> The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope in order to solve their common problems. We

[54] A second family group, Ala-Teen, was founded in 1957 to support the children of people with alcoholism. Ala-Teen also relies on the twelve steps and twelve traditions.

> believe alcoholism is a family illness and that changed attitudes can aid recovery. Al-Anon is not allied with any sect, denomination, political entity, organization, or institution; does not engage in any controversy; neither endorses nor opposes any cause. There are no dues for membership. Al-Anon is self-supporting through its own voluntary contributions. Al-Anon has but one purpose: to help families of alcoholics. We do this by practicing the Twelve Steps, by welcoming and giving comfort to families of alcoholics, and by giving understanding and encouragement to the alcoholic. (Al-Anon Family Groups, 2017b).

Alcoholism, though an illness, is one that affects all family members. The person with alcoholism's transformation through the twelve steps requires their spouse and children to undergo the parallel process of self-reflection and spiritual awakening. The person with alcoholism's recovery depends on their family member's "changed attitudes" and "understanding and encouragement."

This notion of alcoholism as a family disease to which all members contributed found resonance with family systems approaches, which treated conflict in the family as something all from which all members benefitted to which all contributed. This understanding of family problems—including violence—came to permeate a variety of helping professions, notably marriage and family therapy, as well as institutions like family courts, it was particularly prevalent in substance use programs (Roger, 201, interview). The idea of co-dependency, which emerged from Al-Anon, is one example. Joan explained:

> On the substance abuse side, the idea was that these women needed to enable, that there was something very psychological that was still—you know, still this notion that most women are masochists and—and so you know, a lot of their behavior got interpreted as being their own psychological condition and that—that—so they were—you know, the women's psychological problems were enabling the men's drinking. […] Most of the early family stuff was very much focused around having the family's support the recovery of the user. (2010 interview).

Co-dependency was also used as an explanation in substance use organizations for why women remained with abusive partners. According to Colleen "substance abuse people use this label of co-dependent, would say well, women are just so co-dependent. That's why they stay with

batterers" (2010 interview). Similarly, Judy, who worked in a women's substance use program in the 1980s, observed

> You [would] see people going out for a weekend, and they would come back and they would have a black eye or something, and it wouldn't be, I mean people might say something, but it wasn't looked at as a huge barrier to treatment, it was more like, "she needs to get rid of this person," or people would write case notes like, "she's a professional victim," or something along those lines. (2010, interview).

The logic of alcoholism as a spiritual illness manifesting at the family level meant practitioners had little empathy for partner violence victims, particularly those with substance use issues of their own. To the extent that staff recognized partner violence and sought to intervene, the earliest programs—those operating before the mid-1970s—faced practical issues: there were no resources to support victims and no models for understanding this issue other than family systems approaches.

As the substance use treatment field developed, evidence suggests groups working with the families of people with alcoholism—notably, Al-Anon—were aware of and working to mitigate the effects of partner violence. Nonprofessional in nature, in some communities these groups worked to develop a more formalized system of supports, which included provision of emergency shelter. Their work remained defined wholly in terms of alcoholism and largely as a support for preserving family units.

One of the earliest women's shelters in the United States—Haven House in Pasadena, California—was established by Al-Alon members in 1964 (Schechter, 1982).[55] Mentioned in passing in Schechter's history of the women's movement, a fuller description is provided in Del Martin's *Battered Wives* (1981). Martin dates the establishment of the shelter to 1974, suggesting that any services prior to that point were directed more towards treating men with alcoholism

[55] Schechter's discussion of Haven House, based on her interview with the founder, provides few additional details about its history or characteristics.

than supporting their wives and children. Once the shelter was established, requests tended to outpace availability, so assistances was limited to the wives of men with alcoholism.[56] In describing the program, Martin observes that wives' shelter stays often served as motivation for husbands with alcoholism to enter treatment, which was described as a success by program staff. In this way, Haven House's goal was less the immediate safety of partner violence victims and more the long term recovery of the spouse with alcoholism.

Del Martin describes a similar program, Rainbow Retreat in Phoenix, Arizona, which opened in 1973 and also focused on the wives of men with alcoholism (1981). Rainbow Retreat was, per Martin (1981), accredited by the Joint Commission on Accreditation of Hospitals and received both federal and state funds—something that would have made it quite unique among early 1970s women's shelters. Because of its funding, it was unable to house women who were not victims of men with alcoholism and was "necessarily more structured" than feminist partner violence shelters (Marin, 1981, p. 207). Residents at Rainbow Retreat were required to participate in both individual and group therapy, which, in the words of the founder,[57] were focused on "getting at the underlying problems" in the marriage (Martin, 1981, p. 207). As wth Haven House, the goal of services was less to precipitate permanent dissolution of marriages than to pressure spouses with alcoholism into seeking treatment (Martin, 1981).

Al-Anon members in Harrisburg, Pennsylvania opened a similar shelter in 1974. Like other early programs, the Harrisburg shelter was explicitly nonprofessional in orientation and unconnected to the growing women's movement. According to Schechter, "the women [founders]

[56] Today, Haven House's primary focus is intimate partner violence. There are no references to its basis in Al-Anon—or its history in general, aside from a brief note on the main page stating it was "the first domestic violence shelter of its kind in the country"—on the organization's website (Jewish Family Services, 2016).

[57] Martin quote Joanne Rhoades, the executive director of Rainbow Retreat, at multiple points in her description of the program.

did not see themselves as part of a feminist movement" (Schechter, 1982, p. 57). Quoting one of the founders, Susan Kelly-Dreiss,[58] who was later active in both state and national advocacy around partner violence, Schechter notes

> "A loving struggle developed between the feminists and the Al-Anon women." The feminist notion of "empowerment" and the analysis that blames male domination for violence were foreign to Al-Anon women, but self-help and treating women as adults, important concepts for the women's liberation movement, were central to their philosophy. (1982, p. 57).

Schechter suggests a shared commitment to nonprofessional self-help models allowed the shelter to thrive. While there was recognition that feminists and Al-Anon members had different understandings of partner violence, this was not the source of tension it would become for subsequent practitioners.[59] Yet both Schechter and Martin, writing from the center of the battered women's movement, depict these early shelters a different—albeit related—phenomenon from the feminist partner violence programs emerging in the late 1970s. Although shelters like Haven House and Rainbow Retreat served women the movement would have recognized as victims of domestic violence, they were not domestic violence shelters. Their work was important, however, for the role it played in raising awareness about the prevalence of partner violence. Descriptions suggest that requests for shelter far outpaced capacity to provide it, underscoring the need for a broader system of supports victims, whether or not their partners were people with alcoholism.

Gender Role Rehabilitation: Early Women's Programs

The first women's substance use programs emerged in the early 1970s. These programs arose, in part, because of early research on women's needs for and experiences with substance use treatment. Relatively little was known about women's experiences with alcohol and other

[58] See National Women's Hall of Fame (2017).

[59] Survey work with staff in partner violence and substance use organizations in the 1990s suggests that the empowerment models used by most partner violence agencies and twelve step approaches employed by substance use organizations were viewed as largely incompatible (Bennett & Lawson, 1994; Collins & Spencer, 2002).

drugs and studies that did exist suggested women were often sicker by the time they entered treatment, more likely to be involved in "deviant" behaviors like prostitution, and "less motivated" to enter treatment, which commentators have suggested may be due to the lack of supports most programs had for issues like childcare (Campbell & Ettore, 2011, p. 17). Research conducted as part of the first wave of women-specific demonstration projects underscored differences between men and women's treatment needs. Relative to men in need of treatment, women had fewer social connections, greater responsibility for the care of dependent children, and a unique set of emotional and psychological needs, such as depression, anxiety, and low self-esteem (Reed, 1987).

Early women's programs, however, remained focused on women's roles in traditional family units. In the early 1970s, theories of women's substance use often attributed it to broader challenges fulfilling conventional gender roles, which were themselves treated as largely unproblematic (Campbell & Ettorre, 2011). Early women's programs often sought to help women better fulfill their primary roles as wives and mothers though offering supports like couples counseling and parenting classes (Campbell & Ettorre, 2011). Unsurprisingly, this approach to gender and family roles conflicted with the feminist framework that animated early, grassroots work on partner violence.

As women's substance use programs developed, they recognized the need to address partner violence and related issues. Describing the beginnings of her own involvement in women's programs, Joan explained that in 1975, when the first demonstration project opened,

> I heard that there was a group of women trying to start a women's program and that's what got me into what became the women's drug research project and these first women's demonstration projects. And all of those projects early on had to deal with violence, because you know, you could not find a woman addict that hadn't been raped or wasn't an incest survivor or hadn't been a prostitute. So those were just on the—I mean,

> we were dealing with them all the time but again, with no resources in the community. (2010 interview)

As women's programs emerged and recognized the pervasiveness of partner violence amongst their clients, they often sought to establish partnerships with other organizations who might fill gaps in support services. Gail, who worked on an early demonstration project in New England, explained the importance of these networks: "She [the founder] created a coalition. So she invited you name them to the table. Every state agency, providers, you know, so it included sort of, you know, domestic violence providers. I mean, she invited everybody to the table to work on this issue and some people came and some didn't" (Gail, 2010 interview).

Though the mid-1980s, partner violence organizations and women's treatment organizations were both relatively rare. Schechter (1982) estimates the number of victim services organizations in the early 1980s as between 300 and 700 nationally while Campbell and Ettorre posit a few hundred women's treatment programs in the early 1990s. The limited number of both kinds of programs suggests early contacts were likely only rarely between dedicated women's programs and partner violence organizations. More often, when partner violence organizations encountered substance use organizations, they would have been generalist programs steeped in Twelve Step approaches.

The latter half of the 1980s, there was also growth in self-help approaches formed at alternatives to AA and NA (White, 1998)[60]. Specifically, Women for Sobriety (WFS) was founded by Jean Kilpatrick in 1976 on the premise that women's experiences with alcoholism and addiction are fundamentally different than those of men (Women For Sobriety, 2016a; White,

[60] Others include Secular Organizations for Sobriety—Save Ourselves (SOS, founded in 1985) and Rational Recovery (RR, founded in 1986 and disbanded in 1999). Both rejected AA's emphasis on spiritually and the latter also incorporated emerging therapeutic techniques like rational emotive therapy (White, 1998). A third group, SMART Recovery, emerged from Rational Recovery in 1994 (White, 2014). In the early 2010s, there were 450 SOS groups and 470 SMART groups in the United States (White, 2014).

2014). Like AA, WFS's structure and philosophy are codified in a series of statements—Thirteen Statements of Acceptance—that emphasize similar goals of abstinence and spiritual growth. WFS differs from 12 step programs in its acknowledge of participant's power over their lives and affairs. The first statement, for example, reads "I have a life-threatening problem that once had me. I now take charge of my life and my disease. I accept the responsibility" (Women For Sobriety, 2016b). Although membership in WFS has grown since its founding—there were 200 chapters in 2013 (White, 2014)—it has never achieved the ubiquity of Alcoholics Anonymous and related 12 step fellowships.

No Excuses: Early Partner Violence Programs Consider Substance Use

As the partner violence field emerged, feminist advocates pushed back against approaches to violence they considered potentially "victim-blaming," including family systems approaches. Julie, who worked as an advocate in a partner violence shelter in the early 1980s, summarized advocates' perspective on substance use in that era:

> One of the ways in which abused women are so traditionally pathologized is that they view a woman coming into their system as someone who enables, this whole enabling thing. Enables their partner to use, to use violence against them and to use substance abuse, if he's a substance abuser, and so on and so forth. Well, if you think about it from her perspective, if she did anything else, if she didn't buy him that 6 pack of beer, if she didn't cover up for him when he, you know, wanted to stay home with a hangover for work, what's going to happen to her? What are going to be the consequences for refusing to do his bidding? So rather than seeing that behavior as enabling and pathological because she can't say no, you can see it as an active protective strategy. (2010 interview).

At the individual level, empowering victims often meant actively countering the kinds of messages they received in conventional social service settings and early alcohol and drug treatment programs about their responsibility for perpetuating "family conflicts."

At the systems level, feminist advocates were also wary of acknowledging the influence of factors like alcohol and other drug use in shaping partner violence. Because of the prevalence

of the idea that alcoholism, mental illness, or poverty caused partner violence in a simplistic sense, galvanizing political will to create laws and services for partner violence victims meant insisting on its independence from other social issues. According to Gloria,

> When you focused on the alcohol—was the stance of the movement, when you saw it as causal and you didn't deal with the fact that he's battering her and he's going to—even sober, he's going to keep battering her, then you know, what was happening in those days back in the 70s is everybody was just getting sent off to treatment. And the treatment centers weren't—they don't have—they didn't tend at that time to deal with like associated problems with the alcohol, they just went right for the sobering up people with the idea that the social problems associated with the alcohol would go away, the battering, the incest or whatever, you know? Later in the alcohol field, some of those things—there were some changes in that. But at that time, they were pretty focused on just sober the person up, that's the first priority. And then—and then take on these other issues as secondary issues. Whereas with the violence people, they were saying the priority is the violence and alcohol is an associated factor. So the movement—the women were pretty emphatic that we didn't want alcohol to become the excuse because for so long in the court system, it had just been send them off to treatment and then she'll be fine. So the reaction to that was alcoholism does not cause battering and treating the alcoholism isn't going to help. So it almost became—I'm sure it was seen by the alcohol people as naive and you know, blah, blah, blah. But it was—it was reactionary, but accurate in that it was a critique of the more established alcohol treatment field, which had kind of started more in the 60s. So they were like 10 years ahead of the battered women's movement and fairly entrenched in the court systems, et cetera. (2010 interview).

How advocates approached relationships between partner violence and substance use was thus shaped by differences in how connected each field was to key institutions like the court system and differences in the level of resources available to actors in each. At the time the partner violence field emerged in the late 1970s, the substance use field had undergone nearly a decade of development, the passage of multiple pieces of federal legislation, and the establishment of dedicated federal and state entities to direct research, funding, and services.

AA also shaped the earliest partner abuse intervention programs (PAIPs), which focused on altering the beliefs and behaviors of partner violence perpetrators. As these programs were founded, they tended to draw in existing models like AA. Tom described an early Chicago PAIP modeled on twelve step approaches:

> I know in Chicago, there were a couple of organizations that formed early on, guys kind of like—kind of taking the AA model, guys who had been through—had done this and had maybe been through a program, started their own kind of self-help kind of process and turned out that at least—at least one of those was still abusing, right? So there was this real worry from a lot of the victims service providers about that. (Tom, 2014, interview)

As PAIPs were established, there was a great deal of concern among feminist advocates that programs would support batterers' efforts to rationalize away violent and controlling acts by attributing them to alcohol or other drug use or other factors. In structure and content, PAIP programs were similarly oriented against family systems approaches, eschewing strategies like couples counseling, and framing their work as re-education or re-socialization. As Steven explained:

> [PAIP] may be therapeutic for somebody. But going for a walk can be therapeutic. It's not something that you are necessarily going to bill to somebody's insurance company. So I'm also a therapist but in this I don't call it therapy, I don't describe it as therapy, I don't conceptualize it as therapy. It is more than education and different than therapy. (2010 interview).

Much as for victim services, the legitimacy of PAIP depended on establishing partner violence as an independent social issue requiring a discrete, dedicated intervention. While attention to other potentially related issues might have some effect, unless targeted towards partner abuse, violence would only continue:

> If you give a batterer anti-depression medication, you're going to have a better-adjusted batterer. If you sober up a batterer, you're going to have a sober batterer. If you teach yoga and all kinds of anti-stress things to a batterer, you're going to have a more relaxed batterer. And, you know, this isn't anything new, this has been around, the echoes of the AA community have said if you take a drunken horse, you can sober him up and you'll have a horse again. (Steven, 2010, interview)

PAIPs reticence to address substance use echoed early substance use programs concerns about addressing outside issues. Focusing on anything other than partner violence was a potentially dangerous diversion from the goals of the intervention.

In this way, conceptualizations of partner abuse intervention as "not therapy" were structured into programs. One of the ways this occurred is through payment mechanisms. Despite the majority of participants in PAIP being constrained in their ability to pay out of pocket, charging participants for groups is part of the larger ethic of accountability. As PAIP developed, there were deliberate efforts to ensure that services not be reimbursable via insurance. According to Paul,

> Taking insurance for batterers programs would mark the territory big time because you would be having to give them a diagnosis to get the insurance. […] And you know, they're looked at highly suspiciously because the question's how do you do that? How does that work? What – are you treating depression or are you intervening with domestic violence? What exactly are you doing? […] Yeah, because if they're—if you're treating them for depression, you're basically saying that depression is etiologically related to domestic violence. I mean, that's one argument. (2010 interview).

Like victims service programs, PAIPs selective attention to issues like substance use and mental health was driven by insistence that partner violence was an independent social problem.

Initial Dialogues: Cross-Training Efforts in the early 1980s

In the early 1980s, there was minimal attention to partner violence in most substance use programs—including those for women—and vice versa. Judy, who began working a residential substance use program for women explained "at the time we were a very strong-I mean, we did excellent programming at women's treatment issues-but at the time there wasn't a lot of talk about relationships with domestic violence. In fact, we kind of thought you should focus on your substance abuse and worry about relationships later, don't do anything for an amount of time, all this old-time philosophy" (2010 interview). For staff in the program, there was little awareness of how violent relationships might impact clients, despite staff having received some training on the issue. As Judy explained, "if somebody said to us, 'My husband won't let me go to AA,' or 'my partner won't let me go to a meeting,' we were thinking this person hasn't hit rock bottom,

we weren't thinking that this is a control issue and you have a possible offender that's, a person, a batterer, who's preventing this person from getting healthy, we weren't thinking about it..." (Judy, 2010, interview). In a framework where any reason for less than complete engagement with treatment was characterized as an excuse, there was no easy way to recognize partner violence as a serious issue or barrier to recovery.

Over time, Judy became increasingly concerned about how violence in relationships might impact women's abilities to remain in treatment:

> I remember, I wasn't working there very long when one of the residents of the program who was in treatment was getting repeated phone calls from her husband, and he was [inside, hollering], even though he was at [mumbled], and she wound up leaving treatment against medical advice, and part of it was because the thinking was 'Oh, she wasn't focusing on treatment, she was focusing on the partner.' And I remember thinking at the time, "How could she control this guy's phone calls?" We were getting it wrong, you know, maybe the partner was actually actively undermining the treatment, and I'd only had a couple hours' training through the internship, but something did seem kind of funky to me, I remember thinking that at that time, and so many people getting pulled out of treatment against medical advice were going on. (Judy, 2010, interview).

To develop a clearer understanding of partner violence, Judy sought employment in a victim service organization. At the time, she had "no analysis of gender or any kind of oppression stuff" and had trouble finding a victim service program that would hire her. Eventually, she found a job working the night shift at a shelter and experienced a certain amount of culture shock:

> I feel like I'm in "The Exorcist" because in this one field you're very directive, you tell people what to do, you kind of tell them act as if until, you get it, and we know what's best, and it's very kind of paternalistic. And all of a sudden I'm in this kind of movement where autonomy is highly valued and they're having conversations about anti-oppression stuff, you know, it was like a total shock to me when I first got there. (2010 interview)

Few practitioners were as willing to work across fields as Judy. Her sense of the partner violence field and substance use field as having radically different approaches, however, is hardly unique.

In Illinois, Coalition newsletters from the early 1980s suggest that the advocacy community was aware of links between partner violence and substance use and working to

promote attention to both issues (ICADV, 1981; Quinn, 1983). A piece in a 1981 newsletter, "Cooperation in Prevention of Abuse of People & Substances," lays out statistics on the co-occurrence—estimated at between 70 and 90%—and several competing explanations for the relationship (ICADV, 1981). These were first, that substances enable violence by lowering inhibitions against its use; second, that substances are used to cope with feelings of shame and guilt surrounding the use of violence; and last, "more commonly held by domestic violence advocates," that substance use and partner violence are independent problems "each sowing its own suffering, each demanding its own resolution" (ICADV, 1981, p. 4).

As early as 1982, the State of Illinois sought to develop coordinated response to partner violence and substance use and regarded both ICADV and the Division of Alcoholism as "identified players" in developing comprehensive solutions (ICADV, 1981, p. 5). According to ICADV, the 1982 State Health Plan outlined procedures for handling court cases involving partner violence and substance use: "in accordance with the Illinois Domestic Violence Act, civil or criminal cases in which there was been a finding of domestic violence and which in the court's opinion was associated with alcohol abuse will be referred by the court to an identified agency for screening and assessment with disposition report back to the court" (ICADV, 1981, p. 5). The article then describes the Prevention Resource Center, a state-funded entity charged with providing technical assistance to programs "whose efforts help reduce and prevent the abuse of alcohol and drugs" (p. 5). It ends by acknowledging the challenges such cooperative efforts might entail, quoting Janet Wright, the coordinator of a two-year pilot project at Advocates for Battered Women, a shelter in Dane County, Wisconsin:

> The roots of chemical dependency treatment are in medical practice and social service. Ours, on the other hand, are in social change. We are concerned with how society causes violence through shaping our perception of the inequality between men and women. They see alcoholism as a disease. That notion tends to exonerate the abuser from blame. That is

> one of the great differences between us. We know that battering men do not seek treatment because they do not acknowledge that what they do is wrong. We want them to take that responsibility for their actions because otherwise there will be no change. (ICDV, 1981, p. 5).

Description of the program itself is limited, but suggests efforts at creating ongoing dialogue across program types and the use of "women alcoholism volunteers" to raise awareness about needs related to alcoholism within the shelter (ICDV, 1981, p. 5). ICADV subsequently publicized efforts by the Prevention Resources Center to cross-training staff in partner violence and substance use organizations in a series of workshops that included a keynote address by Wright (Quinn, 1983). Quinn also refers to a cross-training manual, authored by Wright, *Chemical Dependency and Violence: Working with Dually Affected Families.*

This suggests that early advocates were well aware of overlap between client populations and conflicting field-level logics. In an effort to counteract these, programs like Advocates for Battered Women sought to foster frame adaptation—or at least to minimize frame conflict—by encouraging alliances between staff. In describing this approach to members, ICADV's impulse was likely similar. Lacking influence in the substance use field, ICADV's best attempt was to use information about network intersection at the participant level to push for greater intersection at the staff level.

There were further efforts to promote collaboration between women's substance use programs and partner violence organizations through Project SAFE. Project SAFE was an early women's outpatient alcoholism treatment program that began in the early 1980s and was widely replicated throughout the state during the 1990s and early 2000s. As the program developed, founders quickly realized that they lacked the expertise and, in many cases, the capacity to provide supports clients needed to remain in treatment. According to one of the founders, "we really wrapped gender specific clinical services around a home network of ancillary services

including transportation, case management, housing in some cases, a lot of focus on parent training, child care and on and on and on. Of course we had to deal with domestic violence as an inevitable part of that" (Gene, 2014 interview). Significantly, the Project SAFE planners modified programming to meet emergent client needs. As Gene explained,

> We very quickly figured out we—with—with the level of psychiatric comorbidity in this group, we definitely needed mental health agencies pulled in fairly early. And almost immediately beyond—behind that, we really began to—to reveal the level of trauma, not only historical trauma but present trauma and the incredible safety issues facing many of these women, because this was an intensive outpatient model so it's not like we were able to isolate these women from their environments. And we began very quickly to—to stumble into all of these kind of horrific violence and safety issues that these women were confronting as they moved back and forth from their environments into this treatment milieu daily. So that's a—that's the point at which we began to do a couple of things. We began to refer more women out to—for domestic violence services but we also began to build relationships with domestic violence—violence agencies and actually bring some of their staff in to do educational tracts and to do co-leading some of the—the trauma support groups. (2014 interview).

The victim services organizations, cognizant of unaddressed substance use amongst their participants, were initially very receptive to collaboration with Project SAFE. Tensions emerged over differences in ideas about the causes and likely course of partner violence:

> The historical view on the addiction side was well, you know, this—this—this male partner is clearly addicted and later as we got into more, you know, lesbian and bisexual relationships, you know, the—we had the same kind of issues. Well, the partner is addicted. He or she needs to go to treatment. If we can get them into stable recovery, the violence will take care of itself. And obviously the—you know, it took time to discover that the world of violence is—the etiology of violence is much, much more complex than that. And from the DV side, there was a kind of view that really viewed the—the perpetrator almost in terms of sort of evilness. That this is a person we need to expel from the life of this person and that none of them are salvageable. (Gene, 2014, interview).

In this way, ingrained ideas in the substance use field about the importance of the family system and the causal role of substance use conflicted with the partner violence field's stance on the traditional family. Simultaneously, the partner violence field's absolute rejection of both violent

acts and the people who commit them potentially contradicted efforts in the substance use field to build and maintain rapport with clients and their families.

As Project SAFE was replicated over the course of the following decade, additional challenges in collaborating with partner violence programs emerged. Some of these had to do with shelters' limited capacity, particularly for women with older children as well as "sabotage of treatment goals among some mission-based shelters" and the tendency of some shelters to restrict admission for women with substance use issues (White, Woll & Webber, 2002, p. 25). Thus, while participants were referred out to partner violence organizations in some instances, Project SAFE increasingly sough to build capacity amongst substance use organizations to address partner violence on their own. Gene explained that this approach—providing partner violence services in-house—reduced client attrition rates:

> One of the things that we discovered was the—the greater the number of connections, you know, the—the higher the attrition was. And these—these are for the most part women with horrific relational histories in their life. These are women with histories of victimization and abandonment and—who sort of enter relationships from a position that they're either going to get victimized or abandoned or both. So you know, the amount of distress they brought to relationships was just almost beyond comprehension. So every time we had to bring new players, particularly to take the woman into alien environments was extremely difficult. So to the greatest extent possible, we tried to bring those services into the framework of the setting that they were at. (2014 interview).

In this way, barriers to access, perceived incompatibilities between approaches, and client needs combined to promote efforts by substance use organizations to address partner violence in-house and, in some cases, without much assistance from victim services organizations.

At the state level, attention to partner violence—particularly as it related to women's treatment—continued to with the development of the Women's Plan. The Women's Plan specified "case management services are key to treating women, as they possess a variety of problems. […] Case management would assist in accessing: services for domestic

violence/sexual abuse issues, health care, basic survival issues (food, clothing, shelter), and educational/vocational guidance" (Subcommittee on Women's Alcohol and Substance Abuse Treatment, 1992, p. 2). More significantly, the director of the Illinois Coalition Against Domestic Violence was a member of the Subcommittee on Women's Alcohol and Substance Abuse Treatment, which authored the plan.

Formalizing Collaboration: The Illinois Domestic Violence/Substance Abuse Taskforce

At the federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA), through the Center for Substance Abuse Treatment (CSAT), continued to fund specialized women's substance use treatment in the 1990s, including for programs that addressed partner violence (White, 2014). According to White (2014), these differed from mainstream substance use programs in their use of targeted outreach, provision of supportive services like childcare, transportation, and case management, coordination with services like domestic violence and healthcare providers, attention to physical safety and trauma, attention to relationships (especially parenting), and linkages to gender-specific mutual aid groups like Women for Sobriety.

The Center for Substance Abuse Treatment also sponsored the development of a best practices manual, *Substance Abuse Treatment and Domestic Violence*, as part of their Treatment Improvement Protocol Series in 1997 (Fazzone, Holton & Reed, 1997). Like other publications in the series, TIP 25 was meant to provide a set of implementation-ready practices and strategies for substance use organizations and individual counselors. Intended for a substance use audience, the manual offers an overview of existing research on the relationship between partner violence and substance use, with authors concluding that the effectiveness of substance use treatment depends on recognition of co-occurring partner violence as a separate issue requiring targeted

intervention. The manual contains sample screening and assessment tools related to partner violence for immediate use in substance use organizations and additional information on relevant laws and resources related to partner violence.

Some the experts involved in the development of TIP 25 have suggested that the guidelines eventually published were a watered down version of the their original recommendations. In some cases, this led to subsequent state and grassroots efforts to develop additional guidelines. Paul, for example, contrasted his experiences working on the federal manual and leading a subsequent project at the state level:

> I'm always kind of happy to have been a part of that even though it really pissed me off, you know, the results of that. And I think being pissed off when I saw what the governor did with the earnest product of people who care about this stuff, what they actually produced pissed me off enough that—and I talked about it enough here […] that we set up our own taskforce […] and a much more—a much more community oriented group of people than what participated in TIP 25 and we were able to, over the period of a few years in the late 1990s, construct a best practices manual for [state] that I think is much more detailed and informative than the federal manual. And I've always been kind of happy about being involved in that. (Paul, 2010, interview).

While TIP 25 was the first published effort to promote attention to both partner violence and substance use in over a decade, it gave rise to several other efforts, including Illinois Domestic Violence/Substance Abuse Interdisciplinary Taskforce, which was convened by the Illinois Department of Human Services in 1997 (Domestic Violence/Substance Abuse Interdisciplinary Taskforce, 2000), the Iowa Integrated Service Project, which began at the University of Northern Iowa in 1997 (Integrated Services Project, 2014), and the Alaska Network on Domestic Violence and Sexual Assault, which published its own guidelines for facilitating groups attentive to partner violence and substance use—*Getting Safe and Sober: Real Tools You Can Use*—in 2005 (Edmund & Bland, 2005).

The formation of the Illinois Domestic Violence/Substance Abuse Interdisciplinary Taskforce was shaped by several factors, including interest at the community level by organizations in both fields and by changes in the state's role vis-à-vis partner violence funding. In the substance use field, there was growing awareness of unaddressed partner violence needs. Recovery House—one of the largest substance use treatment facilities in Chicago—implemented a new screening tool in the early 1990s that included items on domestic violence and discovered roughly 80% of women in treatment and between 74 and 94% of men, depending on the program, were either victims or perpetrators of partner violence (Joyce, 2014 interview; James, 2014 interview). Rates were particularly high in the DUI program. They were concerned about both clinical consequences—that relationship conflict made relapse more likely—and liability issues for the program. If they were going to assess for partner violence, they needed at minimum, to make referrals to appropriate services. Yet "when we started looking for places to refer, there weren't many" (James, 2014 interview).

The administration at Recovery House put James in touch with a researcher at a nearby University who was working with several victim services organizations around substance use issues. One of these organizations—Chicago Abused Women's Coalition—was in the process of applying for funds through the Violence Against Women Act to support a partnership with Recovery House's women's program (James, 2014 interview). There were two other victims services organizations in metro Chicago also working to establish collaborations with substance use organizations, Safe Passages and PHASE/WAVE in Rockford.[61]

[61] PHASE/WAVE, which was founded in 1955 as a substance use organization, began work on partner violence in 1979.

The Illinois Coalition Against Domestic Violence was also working to build relationships with substance use organizations. With its role as a funder unclear, ICADV sought to create partnerships around areas where it felt additional work was needed:

> [ICADV] tried to look at it as an opportunity of how do we build relationships with other kinds of organizations, with the state, with other kinds of organizations, what is it that victims are telling us they need? There was a significant focus on children's services. There was a significant focus turned towards developing appropriate abuser services. And I think there was a real attempt to have a better conversation with the community that was providing substance abuse services, because philosophically, we had a different approach. And it remains a struggle. (Vivian, 2014, interview).

In addition to wanting to improve access to services, ICADV reached out to the addictions credentialing board for guidance around setting up a parallel process for staff in partner violence organizations. According to Vivian, "in the early development of the certification process, we looked to the substance abuse field quite a bit and really tried to learn from them about how they develop their certification process for substance abuse counselors. And so I think that was one of the ways that really helped open the door to trying to figure out how we can work better together" (2014 interview). In addition to connections at the community level between individual victim service and substance abuse organizations, ICADV was simultaneously building connections with parallel internal governance units.

Other informants suggested that the substance use field played a somewhat different role in shaping the development of the credentialing system. Angela, who was also involved in work on the Certified Domestic Violence Professional certification recalled

> About the time that there was that task force and—and talk about the integration, you know, there was a rumor that the—the substance abuse people were going to create a domestic violence credential and they were just going to kind of slowly but surely block us out of our own work. And so the domestic violence services community retaliated by creating the Illinois Certified Domestic Violence Professional. (2014 interview).

The emergence of both the credentialing system and the Taskforce were also shaped by concerns about the future of the partner violence field, which were likely motivated by the changing role of the Illinois Coalition.

Perhaps most consequentially, with the transfer of responsibility for federal partner violence funding from ICADV to the Department of Human Services (DHS), decision-making for both issues occurred, for the first time, within the same larger Department.[62] Partner violence services were administered by the Division of Family & Community Services and substance use services by the Division of Alcoholism and Substance Abuse, both part of DHS. Thus, decisions about service priorities and funding were centralized. Rather than requiring cooperation by both state and non-state entities with potentially competing agendas, bringing these issues together became a bureaucratic issue.

In the mid-1990s, DHS was also encouraging the development of "co-location" projects, which entailed bringing specialized services for issues like mental health, substance use, and partner violence into existing DHS offices. Sharon explained

> At that time, and I'm going from memory, at that time, there was like 126 local offices. We're way under that at this point in time but 126 and of that 126, there was probably 62 offices that had a co-located substance abuse counselor. There were 11 offices that had a co-located mental health counselor and 11 that had domestic violence staff at a local DHS office. So the department was looking at the how do we blend, you know, how do we integrate services. (Sharon, 2014, interview).

Although the Taskforce would ultimately work to promote the co-location of services for partner violence and substance use within private organizations, this overall strategy and the goal of enhancing accessibility to both services resonated with DHS priorities.

Initially, DHS established a 30-member advisory group, with members draw from government, community-based and policy organizations in both fields, and academia. Their

[62] As described in Chapter 2, ICADV had established itself as a "pass-through" for federal partner violence funds in the early 1980s. This status was revoked by the state in the early 1990s.

initial task was to facilitate dialogue between service providers through a series of conferences. The first of these, *Better Practices in Substance Abuse and Domestic Violence*, was held in 1998 and drew almost 400 attendees (Domestic Violence/Substance Abuse Interdisciplinary Task Force (DVSAITF), 2000). A second conference was held the following year, with subsequent work on partner violence and substance use undertaken by the newly formed Domestic Violence/Substance Abuse Interdisciplinary Task Force.

The Domestic Violence/Substance Abuse Interdisciplinary Taskforce met for several years, with its work including conference facilitation and the development of its own best practices manual. Though its work was based on CSAT's *Substance Abuse Treatment and Domestic Violence*, the best practices manual resulting from its work—*Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse*—was meant to be "Illinois-specific" (DVSAITF, 2000, p. iv). Subsequently updated, with a revised version published in 2005, *Safety and Sobriety* provides an overview of research substantiating the need for attention to both partner violence and substance use and a set of best practices for working with partner violence victims, perpetrators, women with substance use issues, and men with substance use issues. Guidelines favored a co-location model where services for both issues were available in the same location, whether this was accomplished through a partnership model or not. Given the high rates of co-occurrence, it also recommended universal screening and education for both issues.

The Department of Human Services also provided funding, in 2000, to foster work combining partner violence victim services with substance use and insights from this project were incorporated into the 2005 revision of *Safety and Sobriety*. Funding went to six organizations, two providing both partner violence and substance use within a single organization and an additional four providing both services through a partnership between one

victim service organization and one substance use organization (Bennett & O'Brien, 2007). The pilot project had the dual purpose of evaluating the effectiveness of the programs that resulted and capturing the implementation process. While the former has been documented (see, for example, Bennett & O'Brien, 2007), the latter was more difficult to capture. In describing the challenges, Susan, who was involved in the evaluation, observed that the process was more difficult for partner violence programs that substance use programs, whether they employed a co-location model where both services already existed within the same larger organization or a partnership model. Specifically, one partner violence program—already overburdened-struggled with issues of capacity and struggled to keep up with the additional components required to evaluate the project. According to Susan, "I think there was a lot of support on the face of it from Solutions for Health, in particular. Again, some misunderstanding among the staff at Sunrise Place about what—what this integrated program required of them" (2014, interview).

Particularly in the mid- to late 1990s, evaluation and research were not standard activities for victim services organizations, which were generally funded through grants that focused primarily on outputs rather than outcomes. In another program, entrenched stigma around women's substance use presented barriers:

> [The shelter director] really felt like by the time women came to shelter, they should be clean and she really was very cynical about the need for substance abuse treatment kind of as a parallel process, never mind an integrated process. I mean, she wasn't even—even though she recognized that substance abuse was kind of part of domestic violence cycles or issues related to abuse, she wasn't very flexible in her thinking about the possibility of that integration. (Susan, 2014, interview).

The program Susan described as most successful in the pilot program was one that had been engaged in work on both issues since well before the pilot project, having undertaken this work on its own in the late 1970s.[63]

The most significant challenge came from the transient nature of the project. The overall level of funds provided to programs was modest and, particularly for the partner violence programs, inadequate to support the kinds of changes fully implementing combined programs for would have required. Susan explained,

> One of the things that I really felt was problematic in trying to do this intervention, it was driven by money. I mean, this was a demonstration project, right? So people got into it from the very—from the jump on the basis of this is another stream of funding, which is I think very often the wrong reason to kind of build out a program. So particularly in 24 hour shelters, as I'm sure you're aware, just staying alive day-to-day is sometimes so fragmented and challenging that I think to assume this new demonstration was really hard on them and then hard on those—both those urban programs had really a hard time with kind of involvement in the research and—because of course, [we] had a very specific protocol for the assessment, for the measures, for the—the focus groups and both of those programs had a really hard time with just managing it. And I think that's—you know, that's often the problem with research in the real world. It requires time and attention that people don't have, or they don't have the funding support to do, because the state had an expectation that they would participate in the research—without kind of the additional dollars that would have made that more possible for staff time in particular. So we were asking a lot of them without the—enough resources and without the training to really become very thoughtful. (2014 interview).

At the level of beliefs, others suggested that the Taskforce was highly successful. According to Paul, most practitioners recognize the need to address both issues:

> I think 25 years ago maybe, there was—there was a lot of well, you know, yeah, these—either these are the same issue but substance abuse is more important or these are completely different issues and they need to be dealt with completely differently. Those were the two attitudes that you have. You don't hear those much anymore but you—you hear a general acceptance of the fact that we need to deal with both of these issues along with things like depression and trauma, you need to deal with all these issues but when it—when you actually get down to crafting and inter-agency agreement and memorandum

[63] This is PHASE/WAVE in Rockford, Illinois, which has subsequently been renamed Remedies Renewing Lives (Kolkey, 2015). There is little information about the organization's founding and history on its website (Remedies Renewing Lives, 2016).

> of understanding about you do this and I do that, it becomes not so good at that point. (2010 interview).

What the Taskforce accomplished for victim services and substance use was considerable. With the locus for rulemaking in both fields centralized in the Department of Human Services, efforts focused on alliance brokerage—facilitating dialogue between staff in both fields through the Taskforce itself as well as the conferences it hosted. While dialogue between fields did not result in the development of shared frames per se, it mitigated tensions between the dominant frameworks, at least for feminist victim services organizations and women's substance use programs. As funding disappeared, the effects faded but did not disappear entirely. As Angela explained, "[The Domestic Violence/Substance Abuse Interdisciplinary Taskforce] was probably the first thing that sort of came in on the edges and it didn't transform the work but it significantly informed the work" (Angela, 2014, interview).

Taking Advantage of Mom and Dad Not Talking: Substance Use and PAIP

In contrast to victim service organizations and most substance use organizations, there are similarities between PAIP and substance use programs that seem, on the surface, as though they might facilitate attention to both issues. As Lucille observed "there's a very—there's a real similarity between the kind of discipline in working with addictions as there is in working with perpetrators, because denial is a big component and—and certainly this loss of control" (2014 interview). Both place strong emphasis on accountability or personal responsibility, use group formats for counseling, and rely on the criminal court system to recruit participants, who are often mandated to attend as a condition of probation or parole. Yet, for these organizations too, addressing both issues is fraught.

In Illinois, as interest in collaboration coalesced in the early 1990s through the Taskforce, the overall number of PAIP programs remained quite small. James, describing efforts to forge a

partnership between Recovery House, the substance abuse programs where he was working at the time, and a partner violence program for perpetrators, observed "We couldn't find any place to refer people who had been abusive. There were at that time I think only two programs inside the city" (2014 interview).

Throughout the 1990s, PAIP became more formalized and the number of organizations grew. However, during this period, the Duluth model, which focused on perpetrator accountability through the criminal justice system, was the dominant framework. Tom explained that when he first became involved in PAIP in the early 1990s, "everybody talked about the Duluth model" (2014 interview). Similarly, while the substance use field has become more professionalized, 12 step approaches remained ubiquitous. Gabriel recalled that "basically treatment was really about 12 step enhancement, you know, kind of talking patients through the 12 steps and teaching them about the 12 steps and so forth. So it was really dependent on that" (Gabriel, 2014, interview).

Practitioners in both fields saw these models as in direct contradiction. Steven, who ran a PAIP, felt strongly enough about these tensions that he developed and circulated a position paper, which took strong stand against 12 step approaches:

> We wrote a position paper and then circulated it to licensed drug and alcohol program in the state and even nationally to a certain extent. We got whatever mailing list we could and sent them this position paper which was, which had a searing analysis of domestic violence and substance abuse and really assailed the substance abuse field for not responding to domestic violence. Which I think was fair. But we also took some shots at 12 step programs which, as we later found out, wasn't the best way to do it. […] That is was a, like a clubhouse for white men, upper middle class white men. That it was, kind of a den of misogyny. This kind of stuff, I'm not, I really don't remember the exact quotes. […] And it came to a head when a person got referred to [the local treatment center] from the […] court, for substance abuse treatment and was also supposed to be coming here and they told the court that his involvement with us would un-do what they were doing, that they were that concerned about our program. Which was, that's a pretty serious concern, rightfully so. And we would say the same thing. So here's one of those points where the rubber hit the road. (Steven, 2010, interview).

In this instance, the conflict between programs led to an opportunity for dialogue—facilitated by a probation officer familiar with both organizations.

What first appeared as tensions between models may have had less to do with true contradictions between modal PAIP and substance use programs than with how participants presented them. As Steven explained, for much of the 1990s, shared participants were one of the more common sources of information about the other type of program:

> We were getting this from our clients who would come back and say I don't understand, you guys are telling me that I'm all powerful, you're telling me that in my house I'm god, I get to decide everything, and they're telling me that I'm powerless. I don't understand. So there were three things going on there. One is the substance abuse community taking that first step out of context. The second is our not thoroughly understanding what we needed to be doing about that. And the third is that to a certain extent, and in retrospect, I'm sure batterers were taking advantage of the fact that mom and dad weren't talking. Because batterers are really good at that. Mom and dad aren't talking and play on off the other. (Steven, 2010, interview).

The sense of PAIP and substance abuse as incompatible stemmed from a lack of direct familiarity with the interventions in question by practitioners in both field and was fueled by intentional misrepresentations by shared participants.

Yet, real barriers remained. In the substance use field, particularly amongst more therapeutically-inclined practitioners, there were concerns about PAIP's focus on accountability. Gail, who was involved in work to bridge both fields in Massachusetts in the early 2000s explained

> the issue was the fear of loss of the alliance. So—so if I identify you—if I ask you about your behavior and then I say to you I think you're a batterer and you should go to batterer's intervention, they're afraid that the person will get mad and leave substance abuse treatment because they won't like being confronted about the battering. And they feel like that's—would be a disservice because then you wouldn't even be addressing the substance use, so now the guy doesn't get any help at all. So that's their—that's one of the things I think that they're concerned about. I think the issue of how to balance the accountability piece with the therapeutic alliance piece is fairly complex for people. (2010 interview).

Similar concerns were also emerging within the partner violence field. Emphasizing accountability above developing a rapport with participants made it difficult to foster the transformation participation in PAIP was meant to effect. As Tom explained,

> I think there—when we started—so there's—there's been a shift and I think there's been a shift in—I would say we're in—in kind of the adolescence to young adulthood of this—of this work. That realizing that if you really want to engage men in the change, that you can't ignore other things that are impacting their lives in some way, that you can't—and so it's been really important for us to begin to talk about how past trauma might influence your behavioral choice. And part of what we—we really have done a lot of work in our program is to say yes, though—you—you may very well be a trauma survivor yourself, you may have experienced abuse, you may be a substance abuser, you may have mental illness, but those—those are not—those do not cause your violence. […] That those are—those are things that if they really are a serious issue, you need to address separately from our program and with additional services along with our program. But to really humanize the challenges that they may face and humanize them makes sense. (Tom, 2014, interview).

Practitioners in the substance use field described this broadening of perspectives as helpful. Mark, who facilitates a PAIP within a substance abuse program, remarked

> I've been in the field over 32 years and when I first started it was like everybody that got a DUI they got this many hours of education. Then they said there are different levels that people kinda need so then they came up with three and they did that for a while. Then they subdivided and went four and different hours. There are people that specialty trained to work with that. I am hoping at some point the DV offender field is going to go through a similar growth process instead of this one size fits all kind of a thing. That's what I'm hoping for, I don't know if it's going to happen anytime soon. (2011 interview).

For many substance use practitioners, effective work with PAIP requires a broadened perspective on the nature of partner violence and the range of possible interventions.

In Illinois, because of funding limitations, PAIP are increasingly provided in organizations that are not exclusively focused on partner violence. In describing licensing patterns and the growth of new programs, Sharon explained that in some parts of the state, the Department of Human Services asks organizations with strong ties to local courts to create

PAIPs (Sharon, 2014, interview). While this increases access to PAIP, it can also create challenges when organization's primary emphasis—whether on mental health, substance use, or some other issue—takes precedence. Sharon explained that she often encourages licensed PAIPs to limit attention to these other issues:

> I can't tell them they can't do those things but I'm saying you're not being very efficient and you're probably going to run out of money because you're spending time doing these things which aren't required for PAIP (partner abuse intervention programs), aren't billable back to your other source, so just do what you need to do, which is screen and say hm, I wonder if they shouldn't go for a full-blown assessment someplace else. (2014 interview).

While for reasons of funding, PAIP and substance use often exist within the same organization and are, in some cases, facilitated by the same staff, licensure requires they remain formally separate interventions. The Administrative Rule on PAIP sets clear boundaries between PAIP and "inappropriate intervention models," including couples counseling and anger management as well as "approaches that identify and treat intimate partner violence as an addiction or mental illness and the victim as enabling or co-dependent in the violence" and "models that fail to approach substance abuse and partner abuse as separate issues" (Illinois Joint Committee on Administrative Rules, Title 89, Part 501.90.c). The Rule goes on the state that "protocol approved programs must approach these two issues [substance use and partner abuse] as separate and distinct disciplines that involve separate accountability" (Illinois Joint Committee on Administrative Rules, Title 89 Part 501.90.c). The regulations for PAIP thus explicitly prohibit combined approaches to partner violence and substance use.

In practice, however, PAIP often share staff with mental health or substance use programs within the same organization. For staff trained in other areas of social service, the transition to work in PAIP was a challenge. Regardless of experience or credentials, the Administrative Rule on PAIP requires that staff attend a 40-hour training on victim services and

an additional 20 hours of training on PAIP. For members in a field that has increasingly staked legitimacy claims on education and formal credentials, requiring this additional training, particularly from people who often lack commensurate levels of education and experience, is problematic: "what I hear a lot of squawking about is substance abuse people finding out that to work in a domestic violence field, your graduate degree and license isn't enough. You're actually going to have to take this 40-hour training from people that you don't actually respect all that much" (Paul, 2010, interview). Mark, employed as PAIP facilitator in a substance use organization, embodied this perspective, saying that he is "not happy about the level of professionalism in the DV field. In fact I really think it's pathetic. […] They've got advocates, there are survivors that have done 40 hours of training, calling themselves counselors and it just peeves me off. There's just a lack of professionalism in the field" (2011 interview).

Mental Health as Intermediary: Trauma-Informed Approaches and Behavioral Health

In the late 1990s, both the partner violence and substance use fields were increasingly under pressure to incorporate attention to mental health. In the substance use field, this came largely through attention to "co-occurring disorders" while in the partner violence field, the focus was much more on how mental health issues might limit access to services. For both, the idea of trauma-informed care, which originated in the mental health field, became a new area of emphasis. In the simplest terms, a trauma informed services model infuses recognition of the impact of interpersonal violence victimization on participants and, when implemented, should shape all interactions participants have within an organization "so that every interaction is consistent with the recovery process and reduces the possibility of revictimization" (Elliot et al., 2005, p. 462).

SAMHSA, in 1998, provided funding for the Women Co-Occurring Disorders and Violence Study, which evaluated the development and effectiveness of services that integrated attention to mental health, substance use, and physical or sexual violence (McHugo et al., 2005). The study included fourteen treatment programs across the United States and produced several scholarly publications substantiating the effectiveness of simultaneous attention to mental health, substance use, and interpersonal violence through the broader framework of trauma-informed care (see McHugo et al., 2005; Morrissey et al., 2005; Cocozza et al., 2005). In terms of best practices, Moses et al. (2003) identify "knowledge about violence and victimization," a design that minimizes "the possibilities of victimization and revictimization," use of an empowerment model, respective for participants' choices and autonomy, and a collaborative approach to provider-participant relations as critical to trauma-informed services – all elements that resonate with common practices to work with survivors in the partner violence field (p. 24). The model also emphasizes efforts to "facilitate recovery" and "emphasize women's strengths" (p. 24), which seem akin to the language of motivational enhancement therapy within the substance use field. Additionally, this approach to trauma-informed services regards systems-change work as similarly critical, though the focus is on intra-organizational issues. As a model, trauma-informed care includes attention to practices at the individual and group levels but also to the structural and philosophical models underlying interventions.

According to Janet, efforts to create trauma-informed services models brought a new focus on safety, empowerment and choice into mental health programs. This was "really pretty liberatory for people who were being mistreated in the mental health system, who were not being seen or involved in trauma programs, whose trauma wasn't being attended to, that most—many of the practices were objectifying, pathologizing and you know, the antithesis of what people

would want" (Janet 2014 interview). These same ideas—safety, empowerment, and choice—were at the core of feminist victim services. For victim services, incorporating attention to trauma and other mental health issues was framed as a way of making programming accessible in much the way programs had previously grappled with accessibility issues for people with disabilities. Educational efforts with victim services hinged on showing how substance use or mental health issues could be used as a power and control tactic by perpetrators. Janet explained

> even if people are using it to self-medicate, then their partner ends up controlling their access and supply. And so that it becomes part of the abuse and part of the coercion and control so that you can't not—you know, both seeing it that way and seeing that everyone has a right to safety and access to advocacy that, you know, it changes people's stance so that they realize okay, we have to figure out how to do this, not reject people because they're using, it makes us uncomfortable or we don't know how to deal with it. So once people have that, then the work is trying to learn and understand how to create programs that allow you to do that well. (2014 interview).

For victim services programs and women's substance use programs, moving towards trauma-informed models had the potential to facilitate each kind of program's ability to address the other issue.

In 1999, formal efforts began in Chicago to increase the capacity of victim services programs to address mental health issues. The Violence & Mental Health Policy Initiative (DVMHPI) was established in Chicago to "address the unmet mental health needs of domestic violence survivors and their children and the traumatic effects of abuse across the lifespan" (National Center on Domestic Violence, Trauma & Mental Health, 2012a). DVMHPI's role was as a provider of training and technical assistance to "domestic violence, mental health, substance abuse, and social service agencies in the Chicago area, as well as city and state-level policymakers" (National Center on Domestic Violence, Trauma & Mental Health, 2012a). DVMHPI's work began with focus groups with providers on both sides:

> We did focus groups with 17 DV programs in Chicago and they—they had like—their concerns were they were seeing women with mental health needs that they didn't feel so comfortable addressing, nobody was talking about trauma, they could see depression then but they thought well, of course she's depressed, she's being abused and you know. But they identified philosophical barriers, you know, that people didn't get DV, they would pathologize women's experience and their survival strategies, they'd give them meds and not find out what was really going on. They didn't address safety concerns. 50% of the mental health centers at that time would involve batterers if—you know, for couples therapy. And then there was the practical strategies, like it was like six week wait, you had no control over who— Someone was assigned to, transportation and childcare, services weren't culturally competent. So there—both those levels and on the mental health side, people said we know we're seeing—that this is happening, we don't know what to do. We need help. We need training, we need, you know, referral relationships. We refer to shelter and people are turned away. So that—people then came together to really figure out what they could do better because they were I think people who cared and it was an opportunity and they had support from their leadership, so. (Janet, 2014, interview).

As with the earlier Domestic Violence/Substance Abuse Taskforce, there was interest from community based organizations on both sides. According to Janet, "I think people were just so hungry to learn and when we started doing the trauma-informed work, people were really excited because it made sense of things" (2014 interview).

Practitioners, funders, and policy makers in both fields were overall positive about trauma-informed care. Angela, a funder in the partner violence field, described it favorably as "a big change" (2014, interview). Paul singled out trauma-informed care when asked about innovations in the partner violence field:

> [It has] caused people to think very seriously about the effect of domestic violence on battered women and I think it's—it's caused feminists and people in the domestic violence movement who would never give a mental health practitioner the time of day 20 years ago, to really think about well, maybe we ought—to pay more attention to issues like substance abuse and mental health because obviously these women are suffering and they – you know, they do have disorders. We've said for a long time they don't have disorders, they are the victims of domestic violence. But now we have to admit, yeah, they do have disorders and that maybe a victim—maybe a trauma-informed response that paid attention to what kind of problems they were having and didn't blame them for the problems and didn't assume that professionals were needed to intervene in these problems, that these might be peers as well to intervene, that whole trauma-informed approach has been a godsend. It's really changed the field dramatically and it's brought—

> it's brought the mental health people and the domestic violence advocates closer than—than I ever thought that they would be. (2010 interview).

For practitioners in the substance use field, trauma-informed care was often linked with broader support for evidence-based practices—bringing on-the-ground approaches to substance use treatment in line with academic research.

On the partner violence side, there remains some skepticism about trauma-informed care. An additional concern raised by practitioners on the partner violence side is that, most often, efforts to address trauma focused more on past experiences than current safety needs. As Gail, whose work centered on helping organizations moved towards trauma-informed models of care explained,

> When I do what I do and I always mention domestic violence separately from the rest because I feel like people—hear trauma and don't hear domestic violence, you know what I mean? Like […] they immediately go to childhood sexual and physical abuse and they're not thinking about domestic violence. (2010 interview).

Nathan raised similar concerns, telling me "where I would come from on that [trauma] is yes, it's very good that you address past trauma but there's also ongoing current domestic violence that needs to be addressed too" (2010 interview).

As funding models in the substance use field shifted from grant-based to fee-for-service to performance-based contracts, it created a system of disincentives for organizations to send staff to the kinds of meetings and trainings movement towards a trauma-informed perspectives requires. While mental health and substance use organizations sometimes retained the capacity to send staff who worked primarily in administrative roles, getting information to those doing clinical work was more challenging. Janet explained that

> When we started in '99, there was more money in the system. People had more flexibility. And then it got tighter and for the mental health organizations, it got harder because everything was fee-for-service and people couldn't take time, when it switched to Medicaid fee-for-service from a grant, you know, contract, then people had much less

> ability to go to meetings and do other things. And the people in administrative positions had more ability to do that but—it just—more, it was just different. (2014 interview).

In terms of changing on-the-grounded practices, bringing together direct service staff on the partner violence side and administrative staff on the substance use side is limited.

On the perpetrator side, there is a similar sense of potential around mental health-related models and, specifically, the new emphasis on behavioral health. With the expansion of approaches to PAIP beyond the Duluth model, some practitioners, like Steven saw their work in behavioral terms:

> I started off as a clinician, grew into becoming a staunch pro-feminist approach which I think has grown into being a radical behavioralist. And I know the ideology of the social movement stuff and I think it's relevant but it also doesn't necessarily translate into sitting down and working with somebody who isn't necessarily told about sit in with you. So you have to find ways to make it appeal and real to that person. (2010 interview).

Joyce similarly described her organization's approach to PAIP as "a cognitive behavioral program" (2014 interview). Given the emphasis in substance use and mental health fields on rapport building and participant engagement, behavioral health offers models for PAIP providers to solve these problems. Sharon, tasked with PAIP compliance with state regulations, observed that increasingly, PAIP do use cognitive behavioral models:

> Now I don't see what I would call a straight Duluth model as compared to even nine years ago, and certainly before that. I see a lot of adaptations.[…] But with that has been a mapping on a cognitive behavioral approach and then many of the new applicants are coming in with that kind of cognitive behavioral approach. The challenge has been to make sure that that is not a general approach, that it is tied to intimate partner violence. (2014 interview).

For practitioners rooted in—or tasked with upholding—feminist approaches to PAIP, the newfound emphasis on cognitive behavioral approaches may be problematic.

Although PAIP models have shifted to emphasis more behavioral approaches, there has not been a commensurate shift in funding. Only a minority of licensed PAIP programs receive

funding from the state: most depend partially on participant fees with most funding coming from the larger organizations of which they are part. Tom saw potential in behavioral health as a way of increasing funding for PAIP while potentially working around objections to diagnostic labeling:

> Now with the emphasis on behavioral health is why can't we—I don't want to diagnose individuals but isn't this a behavioral health issue and couldn't—why couldn't we get a special classification that people could bill their insurance over? I mean, I—I can get my massage taken care of on my insurance and that's not—that's not a medical issue. That's—to me that's, you know, physical—you know, there's just different ways that I think we need to be thinking about this issue. […] This is another broader discussion. They—one of the things that they have never wanted us to do is diagnose these men, right? Well, is there some way that we don't have to diagnose them with a mental illness to get some pay out of their insurance companies. (2014 interview).

The increasingly behavioral approach to PAIP thus remains at odds with its roots in feminist approaches, which eschew applying individualized, mental health diagnoses to what is, for feminists, a structural problem with individual-level manifestations. While some in PAIP programs, like Tom, see defining partner abuse perpetration in behavior terms as attractive at least in part as a remedy for ongoing funding limitations, this would require policy changes. The Administrative Rule on partner abuse intervention, requires that participants pay fees (Illinois Joint Committee on Administrative Rules, Title 89 Part 501.155) and prohibits insurance reimbursement..

Lingering Barriers

While participants described relationships between the fields as less contentious than they had been during earlier eras, when asked about barriers, lingering concerns about stigma associated with substance use or the accessibility of treatment remained.

In describing challenges working with partner abuse victim services organizations, concerns over policies surrounding medications were often raised. Judy raised concerns about

the easy access to over the counter medications many shelters allow, observing that this was a real safety issue for victims who were also in recovery: "A third of the people in your program have alcohol issues and you're passing out Nyquil, and mouthwash with booze, do you know what I'm saying? It wasn't empowering, but we didn't see it, you just don't see it and you don't know" (2014 interview). At the same time, others noted shelters were sometimes unwilling to admit people engaged in medication-assisted treatment. This, for Anne, revealed the extent to which substance use was still stigmatized:

> I mean, to me, the DV programs that refuse to take somebody on Methadone or Buprenorphine or something. […] Because if somebody instead needed their chemotherapy and it was the same thing, like okay, he knows where your oncologist is and he knows that your regimen is every two weeks, on Tuesday you go for your chemo, are we going to say we're not taking somebody on chemo? No, we're not. We wouldn't say that. (2014 interview).

In this way, victim services organizations were perceived as simultaneously too lax and too restrictive in their handling of medication, both policy positions stemming from a lack of familiarity with the role of medication in recovery.

Policies surrounding minor children remain a flashpoint. In the substance use field, practitioners raised concerns about shelter policies restricting admission of older, male children, noting—as some practitioners in the partner violence field do—that this practice forces victims to make difficult decisions between their own safety and that of their children. Policies surrounding support for parents were also seen as limiting access within the substance use field. Very few residential substance use programs have the capacity to admit client's children[64] and those that do often have a limited capacity to do so. Donna explained that her program, one of the few able to do this, only takes children through the age of 5 or 6:

[64] My analysis of the substance use field in metropolitan Chicago suggests that, of the 314 organizations in the field, only 2.1% ($N = 5$) have the capacity to admit children with their mothers.

> It's [age] five unless—six if they're not in school already. Where it gets tricky is pulling—pulling kids, taking them out of their district. The other thing that we've found is that families are more willing to deal with or take care of the older kids because they're not as labor intensive as babies and toddlers and infants, so we've had much better luck with that. But the schooling thing gets really tricky. So that's—that was the original reason for the cut off. (2014, interview).

Children in domestic violence shelters are eligible for busing to their home districts under the McKinney-Vento Act, a 1987 federal law that funded a system of supports for individuals experiencing homelessness. Children whose primary caregivers are in residential substance use treatment do not fall under the Act's definition of homelessness. By the logic of the field, residential substance use treatment is medical care whose seriousness necessitates its being received outsider the home, much like hospital admission. In contrast, partner violence shelters become temporary homes for their residents who have been forced from their previous residence.

Field Overlap and Combined Approaches to Partner Violence and Substance Use

How and why the partner violence and substance use fields have conflicted—and come together—as they have can be explained through attention mechanisms for field overlap. Though these originate in Evans and Kay's (2008) work on areas of alignment between fields, they can also be used to illuminate area of tension and sites of outright contradiction. Figure V.1 describes each field's trajectory in terms of logics (discursive frameworks), rule-making (internal governance units), networks, and resources.

The story of the partner violence and substance use fields has largely been one of conflicting logics, rooted in incompatibilities between conceptions of substance use as a family illness and partner violence as the individual-level manifestation of the structural patriarchy. While practitioners in the substance use field were, from shortly after its emergence, aware of links between alcoholism and partner violence, the overall logic of the field—that of substance

use as a spiritual, family illness—meant that interventions were directed primarily towards encouraging the person with alcoholism to seek treatment and mitigating family supports for continued substance use. Prior to the emergence of the partner violence field in the mid-1970s, there were no alternative frameworks nor other supports. Assumptions about the nature of alcoholism as a family illness were built into the treatment infrastructure that emerged in the late 1960s and early 1970s. Efforts to develop specialized women's treatment in the 1970s focused, in a large part, on fulfillment of what were seen as women's primary roles as wives and mothers.

When the partner violence field emerged in the late 1970s, it was through the efforts of feminist activists who rooted the problem in patriarchal structures. In seeking to harness resources to create a system of supports, advocates sought to establish partner violence as an independent social issue requiring a unique, dedicated intervention. In this framework, discussions of substance use or mental health needs of victims were, at best, distractions and, at worst, potentially victim-blaming. With the emergence of interventions for partner abuse perpetrators, attention to substance use or mental health needs were similarly viewed as distractions, or worse, as excuses for continued violence behavior. At the time of their emergence, the dominant logics or framework in the partner violence and substance use services fields were in contradiction.

Early efforts to foster combined attention to partner violence and substance use focused primarily on alliance brokerage—bringing staff from organizations in both fields together for training. These efforts were largely piecemeal, with scattered efforts throughout the 1980s by the Illinois Coalition Against Domestic Violence and later through the substance use fields as part of Project SAFE and development of the Women's Plan. Women's treatment, though supported by specialized funding, remained a position within the substance use field but not a dominant one

Figure V.i – Dominant Approaches in the Substance Use (SU) and Partner Violence (PV) Fields

<table>
<tr><th></th><th></th><th>1950s</th><th>1960s</th><th>1970s</th><th>1980s</th><th>1990s</th><th>2000s</th><th>2010s</th></tr>
<tr><td rowspan="2">Logics (Frames)</td><td>SU</td><td colspan="3">Spiritual (family) illness</td><td colspan="2">Disease</td><td colspan="2">Brain disease</td><td>Behavioral Health</td></tr>
<tr><td>PV</td><td colspan="3">—</td><td>Woman Abuse</td><td>Family Violence</td><td colspan="3">Gendered Crime</td></tr>
<tr><td rowspan="2">Rules (IGUs)</td><td>SU</td><td colspan="2">AA</td><td colspan="3">Department of Mental Health</td><td colspan="3">Division of Alcoholism and Substance Abuse</td></tr>
<tr><td>PV</td><td colspan="3">—</td><td colspan="2">Illinois Coalition Against Domestic Violence</td><td colspan="3">Department of Human Services
Illinois Coalition Against Domestic Violence</td></tr>
<tr><td rowspan="2">Networks (Staff)</td><td>SU</td><td colspan="2">Grassroots (AA)</td><td colspan="2">Social service</td><td colspan="3">Clinical</td></tr>
<tr><td>PV</td><td colspan="3">—</td><td>Grassroots (feminist)</td><td colspan="3">Social service</td></tr>
<tr><td rowspan="2">Resources</td><td>SU</td><td colspan="2">Self-help</td><td colspan="2">Grant-based</td><td colspan="2">Fee-for-service</td><td>Performance-Based Contracting</td></tr>
<tr><td>PV</td><td colspan="3">—</td><td>Self-help</td><td colspan="4">Grant-based</td></tr>
</table>

and thus these early alliances were seldom supported by rulemaking or resource brokerage. Throughout the 1980s, the partner violence field was comparatively less established and, in general, still focused on securing dedicated resources for its core issue. Yet, the presence of dedicated women's treatment programs with an interest in addressing partner violence—and a history of outreach efforts to partner violence programs—reduced contradictions between the fields' logics. Without this baseline level of compatibility, it is difficult to image programs would have been as open to exploring assessment practices and referral relationships related to the other issue as they were in the early 1990s.

While the role of the state in funding and regulating substance use organizations was established in the late 1960s and early 1970s, in Illinois, the parallel role on the partner violence side was filled by the Illinois Coalition Against Domestic Violence until the early 1990s. In this way, the creation of the Domestic Violence/Substance Abuse Interdisciplinary Taskforce was made possible in the early 1990s when rule-making authority in the partner violence field shifted from the Illinois Coalition Against Domestic Violence to the Department of Human Services, which also houses the Division of Alcoholism and Substance Abuse. With the primary internal governance units in both fields housed within state government and responsible for funding, the Taskforce increased network overlap through ongoing meetings and annual conferences and worked to further minimize frame incompatibility through the development of the *Safety and Sobriety* best practices manual. Perhaps most consequentially, through the pilot project, the Taskforce made resource brokerage possible by offering funding for projects combining attention to partner violence and substance use. My research suggests that the Taskforce was ultimately successful in reducing incompatibilities between the dominant logics in both fields. Practitioners largely agree that partner violence and substance use are mutually exacerbating

social issues and that attention to both is necessary for either intervention to be fully effective. Trauma-informed approaches are seen by actors in both fields as a positive development and one that might further facilitate their ability to address the complex needs of their service populations.

Yet, barriers remain, in incompatibilities between resources and regulations across fields. Policies surrounding accompaniment by minor children may limit access to partner violence shelters for victims and residential substance use treatment for women, while victim services organizations' approaches to medication poses additional risks for those in recovery. For partner abuse intervention programs, the Administrative Rule explicitly prohibits attention to substance use even as funding limitations necessitate housing these programs within substance use and mental health organizations. In the substance use field, changing funding models have created disincentives for programs to address complex issues like partner violence or trauma as well creating barriers to cross-field dialogue through shared training or staff exchanges.

This case suggests that attention to what Evans and Kay (2008) described as mechanisms for field overlap can be used to identify not just areas of convergence but also sites of tension and contraction between fields. This is useful for identifying the kinds of policy and practice interventions that may be necessary to bring fields into greater overlap. This analysis, however, underscores the primacy of the discursive frameworks or logics the shape action in fields. Rather than operating according to their own independent logics, the kinds of resources, regulations, and networks within a field are shaped by its discursive parameters. In this way, the adaptation of a performance-based contract system of reimbursement in the substance use field is the result of the field's march towards medicalization. Similarly, prohibitions against addressing substance use as part of a partner abuse intervention program stem from that field's orientation against approaches that might otherwise undercut the field's dual emphasis on victim safety and

perpetrator accountability. Even as the overall incompatibility between the partner violence and substance use fields has decreased, earlier logics—and contradictions between them—remain embedded in practice.

CHAPTER VI

Logics in Practice:

The Substance Use and Partner Violence Services Fields in Metropolitan Chicago

This chapter, which builds on discussion of the histories of the partner violence and substance use services fields described in previous chapters, focuses on the characteristics and practices of contemporary organizations. Based on organizational descriptions, this analysis describes each field individually in terms of overall logic and associated practices. I also present findings on differences in organizational characteristics and approaches based on field-specific measures of status. Finally, I consider differences in logics and practices between the fields and the implications these have for prevalence of hybrid organizations—those that address both partner violence and substance use—in metropolitan Chicago.

The Partner Abuse and Substance Use Services Fields in Metropolitan Chicago

There are 379 organizations that address partner violence or substance use in Metropolitan Chicago. As shown in table 6.1, 314 are in the substance use field and 65 are in the partner violence field. The majority of organizations (55%, 210) are private nonprofits or public entities, though a substantial proportion are for profit enterprises (45%, 169). Across organizations, the average tenure is 26.1 years (N = 365, M = 26.1, SD = 25.6). There is considerable variation, with tenure ranging from 0 to 155 years. The median tenure for all organization is 18 years. The largest share of organizations in the sample are small: 42.2% (155) have 6 or fewer employees and/or less than $515,000 in total revenue.

Table VI.i – The Partner Violence and Substance Use Fields

	% (f)
Primary field (*N* = 379)	
Substance use	82.8% (314)
Partner violence	17.2% (65)
Ownership status (*N* = 379)	
For profit	44.6% (169)
Nonprofit/public	55.4% (210)
Size (*N* = 379)	
Small	42.2% (155)
Medium	31.9% (117)
Large	25.9% (95)
Organizational tenure (*N* = 379)	*M* = 26.1, *SD* = 25.6 Median = 18

The Substance Use Services Field

There are 314 organizations in the substance use services field. The field is evenly divided between nonprofit or public organizations and for profit companies, with 50% (*N* = 147) of organizations falling in each category as shown in Table 6.2. The mean organizational tenure is 24.5 years (*N* = 301, *SD* = 25.7), with a range from 145 to 0 years; median organizational tenure is 16.3 years. Thus, the largest group of organizations are relatively new, having been founded in the period since 1997 (47.5%, *N* = 143). Roughly one-third (33.6%, *N* = 101) were founded between 1972 and 1996, with the remaining 18.9% (*N* = 57) having been founded before 1972. The largest share (41.7%, *N* = 131) of organizations in the field are small, having fewer than 6 employees and/or less than $460,000 in total revenue. The most common focal issues within the substance use field are human services (48.9%, *N* = 149), alcohol or other drug use (46.2%, *N* = 141), mental health (24.3%, *N* = 74), health (21.6%, *N* = 66), and children and youth (13.1%, *N* = 40).

Alcohol or other drug use is absent from the identities of roughly one-third (33.1%, *N* = 104) of substance use organizations, peripheral to an additional third (30.9%, *N* = 97), and central to the identities of 36.0% (*N* = 113).

Table VI.ii – Characteristics of the Substance Use Field

	% (f)
Nonprofit/public (*N* = 314)	50.0% (157)
Founding era (*N* =301)	
Before 1972	18.9% (57)
1973-1996	33.6% (101)
1997 or later	47.5% (143)
Size (*N* =314)	
Small	41.7% (131)
Medium	33.4% (105)
Large	24.8% (78)
Focal Issue (*N* = 305)	
Alcohol/other drug use	46.2% (141)
Children and youth	13.1% (40)
Health	21.6% (66)
Human services	48.9% (149)
Mental health	24.3% (74)
Salience of target issue (*N* = 314)	
Absent	33.1% (104)
Peripheral	30.9% (97)
Central	36.0% (113)
Medicalization (*N* = 314)	
Low	70.4% (221)
Medium	21.7% (68)
High	8.0% (25)

Organizations vary in their degree of medicalization. The largest share of organizations in the field (70.4%, *N* = 221) are not medicalized: they neither accept Medicaid nor are they accredited by the Joint Commission on Healthcare Organizations (JCAHO). 21.7% (*N* = 68) are partially medicalized, meaning they accept Medicaid but lack accreditation. A small number of organizations—8.0% (*N* = 25)—are highly medicalized, meaning they accept Medicaid and are JCAHO-accredited.

Table VI.iii – Services in the Substance Use Field

	% (f)
Index services for substance use (*N* = 314)	
Outpatient treatment	87.3% (274)
DUI/DWI	60.8% (191)
Detox	19.1% (60)
MAT (non-detox)	22.6% (71)
Residential	15.9% (50)
Service comprehensiveness (*N* = 314)	19.7% (62)
Specialized programs	
DUI (*N* = 243)	64.6% (157)
Co-occurring mental health issues (*N* = 236)	38.6% (91)
Women (*N* = 241)	33.1% (78)
Men (*N* = 236)	31.4% (74)
Criminal justice (*N* = 236)	27.5% (65)
Service specialization (*N* = 314)	32.8% (103)
Trauma (*N* = 215)	13.5% (29)
Gender sensitive (*N* = 314)	30.9% (97)

The five most common services in the field are outpatient treatment (87.3%, *N* = 274), DUI/DWI classes (60.8%, *N* = 191), medication-assisted treatment (22.6%, *N* = 71), detox services (19.1%, *N* = 60), and residential treatment (15.9%, *N* = 50). Thus, the most common services in the field are non-residential modalities that can be provided at relatively low cost to organizations. Most organizations in the field offer a relatively limited range of services for substance use: 19.7% (*N* = 62) offer three or more of the five index services for substance use.

Roughly one-third of organizations (32.8%, *N* = 103) offer specialized programming for three or more of the eleven groups identified by the Substance Abuse and Mental Health Services Administration (SAMHSA). Organizations most frequently report provision of specialized services for clients with DUI/DWI cases (64.6%, *N* = 157), co-occurring mental health issues (38.6%, *N* = 91), women (33.1%, *N* = 78), men (31.4%, *N* = 74), and criminal justice-involved clients (27.5%, *N* = 65). One limitation of the N-SSATS data on which Treatment Locator profiles are based is its imprecision about the services offered to each of these

populations. Without analysis of other data sources, it is impossible to know whether the specialized service is a single weekly treatment group or a dedicated residential treatment program.

Within the field, there is substantial variation across organizations in characteristics like ownership status, age, and size, relative emphasis on substance abuse and other issues, and the concrete activities through which they do their work. Based on differences in degree of medicalization and the centrality of substance use to organization's identities, I divided organizations into four groups reflecting relative status based on the field's hierarchies. I expected that organizations in more central positions (core and contenders), relative those in other categories, would be larger in size, older, and more likely to offer comprehensive and specialized services for substance use.

As shown in Table VI.iv, organizations in each position differ along a number of domains. The core category includes a significantly higher proportion of nonprofit/public organizations (77.8%, $N = 28$) than the other three categories (χ^2 (3, $N = 314$) = 12.77, $p<0.01$). Core organizations are significantly more likely to have been founded before 1972 (40.0%, $N = 28$) than organizations in any other position. In each of the other positions, the largest share of organizations were founded in 1997 or later. Differences between the four groups are statistically significant (χ^2 (3, $N = 301$) = 24.07, $p<0.01$). The proportion of organizations in each size category also differs significantly (χ^2 (3, $N = 314$) = 30.32, $p<0.001$), with a higher proportion of core organizations than those in any other category falling into the medium or large size categories.

Table VI.iv – Characteristics of Positions in the Substance Use Field

	All	Outsider	Peripheral	Contender	Core	χ^2
Nonprofit/public (*N* = 314)	50.0% (157)	43.9% (29)	46.8% (52)	47.5% (48)	77.8% (28)	12.77**
Founding era (*N* = 301)						
Before 1972	18.9% (57)	11.1% (7)	22.9% (24)	12.2% (12)	40.0% (14)	24.07**
1973-1996	33.6% (101)	34.9% (22)	32.4% (34)	30.6% (30)	42.9% (15)	
1997 or later	47.5% (143)	54.0% (34)	44.8% (47)	57.1% (56)	17.1% (6)	
Size (*N* = 314)						
Small	41.7% (131)	53.0% (35)	31.5% (35)	55.4% (56)	13.9% (5)	30.32***
Medium	33.4% (105)	27.3% (18)	36.0% (40)	30.7% (31)	44.4% (16)	
Large	24.8% (78)	19.7% (13)	32.4% (36)	13.9% (14)	41.7% (15)	
Focal Issue (*N* = 305)						
Children and youth	13.1% (40)	27.0% (17)	8.1% (9)	11.5% (11)	8.6% (3)	13.94**
Health	21.6% (66)	25.4% (16)	33.3% (37)	6.3% (6)	20.0% (7)	22.94***
Human services	48.9% (149)	28.6% (18)	51.4% (57)	56.3% (54)	57.1% (20)	13.71**
Mental health	24.3% (74)	38.1% (24)	18.0% (20)	20.8% (20)	28.6% (10)	9.88*

* p < .05, ** p < .01, *** p < .001

Table VI.v – Mean Organizational Tenure by Position in the Substance Use Field

	All	Outsider	Peripheral	Contender	Core	F
Org. tenure (*N* = 301)	24.5 (*SD* = 25.7) Med. = 16.3	20.5 (*SD* = 22.3) Med. = 13.7	27.4 (*SD* = 29.3) Med. = 17.8	19.7 (*SD* = 23.9) Med. = 11.5	36.5 (*SD* = 19.6) Med. = 37	4.85*

* p <. 05

Groups also differ in the mix of focal issues they address and the proportion of organizations focused on each. Significant differences based on status position were found for each of the most common focal issues in the substance use field.[65] Amongst core organizations,

[65] Because the measure of position considered the extent to which organizations are focused on substance use, the variable denoting focus on alcohol and other drug use was not included in this analysis.

the most common focal issues are human services (57.1%, *N* = 20), mental health (28.6%, *N* = 10), and health (20.0%, *N* = 7). For those in the contender category, the most prevalent focal issues are human services (56.3%, *N* =54), mental health (20.8%, *N* =20), and children and youth (11.5%, *N* = 11). Peripheral organizations are most often focused on human services (51.4%, *N* = 57), health (33.3%, *N* = 37), or mental health (18.0%, *N* = 20). Outsiders are more focused on mental health (38.3%, N = 24) than the other issues included here; similar proportions of outsiders are focused on human services, health, and children and youth.

Organizations in the four status positions also differ significantly in the services and populations they work with, service comprehensiveness, and service specialization. Compared to organizations in the three other categories, core organizations are significantly more likely to offer detox, medication-assisted treatment (MAT), and residential treatment, as shown in Table VI.vi. Differences the four positions statically significant for provision of detox, with 47.2% (*N* = 17) core organizations and 18.9% (*N* = 21) of peripheral organizations (the category with the next highest proportion of organizations) offering this service (χ^2 (3, *N* = 314) = 22.3, p<0.001). 55.6% (N = 20) of core organizations and 24.3% (N = 27) peripheral organizations offer MAT (χ^2 (3, *N* = 314) = 29.03, p<0.001). While 41.7% (N = 15) core organizations offer residential treatment, 20.7% of peripheral organizations do (χ^2 (3, *N* = 314) = 31.87, p<0.001). Core organizations are significantly more likely to offer comprehensive services for substance use than organizations in any other group: 52.8% (*N* = 19) of core organizations versus 19.8% (*N* = 22) peripherals, 15.8% (*N* = 16) contenders, and 7.6% (*N* =5) outsiders offer three or more index services (χ^2 (3, *N* = 314) = 31.93, p<0.001).

There are also significant differences between status groups in terms of the proportions of organizations offering services for trauma and those offering gender sensitive treatment. Core

organizations are the most likely to offer trauma services (20.7%, $N = 6$) and contenders are the least likely (4.4%, $N = 3$) (χ^2 (3, $N = 215$) = 7.85, $p<0.05$). Core organizations offer gender sensitive treatment at significantly higher rates than organizations in other status positions: 55.6% ($N = 19$) core organizations, 19.8% ($N = 22$) peripherals, 15.8% ($N = 16$) contenders, and 7.6% ($N = 5$) outsiders offer this approach to treatment (χ^2 (3, $N = 314$) = 19.33, $p<0.001$).

Table VI.vi – Services by Position in the Substance Use Field

	All	Outsider	Peripheral	Contender	Core	χ^2
Index services for SU ($N = 314$)	87.3% (274)	86.4% (57)	86.5% (96)	84.2% (85)	100% (36)	*n.s.*
Outpatient treatment						
DUI/DWI	60.8% (191)	60.6% (40)	58.6% (65)	61.4% (62)	66.7% (24)	*n.s.*
Detox	19.1% (60)	12.1% (8)	18.9% (21)	13.9% (14)	47.2% (17)	22.3***
MAT (non-detox)	22.6% (71)	13.6% (9)	24.2% (27)	14.9% (15)	55.6% (20)	29.03***
Residential	15.9% (50)	1.5% (1)	20.7% (23)	10.9% (11)	41.7% (15)	31.87***
Service comprehensiveness ($N = 314$)	19.7% (62)	7.6% (5)	19.8% (22)	15.8% (16)	52.8% (19)	31.93***
Specialized programs DUI ($N = 243$)	64.6% (157)	73.7% (28)	56.3% (54)	73.0% (54)	60.0% (21)	*n.s.*
Co-occurring mental health issues ($N = 236$)	38.6% (91)	21.6% (8)	45.1% (41)	34.2% (25)	48.6% (17)	8.16*
Women ($N = 241$)	33.1% (78)	21.6% (8)	37.0% (34)	27.3% (21)	54.3% (19)	11.71**
Men ($N = 236$)	31.4% (74)	21.6% (8)	28.6% (26)	32.9% (24)	45.7% (16)	*n.s.*
Criminal justice ($N = 236$)	27.5% (65)	16.2% (6)	25.3% (23)	34.2% (25)	31.4% (11)	*n.s.*
Service specialization ($N = 314$)	32.8% (103)	21.2% (14)	31.5% (35)	27.7% (28)	72.2% (26)	30.67***
Trauma ($N = 215$)	13.5% (29)	13.5% (5)	18.5% (15)	4.4% (3)	20.7% (6)	7.85*
Gender sensitive ($N = 314$)	30.9% (97)	15.2% (10)	35.1% (39)	27.7% (28)	55.6% (20)	19.33***

* $p < .05$, ** $p < .01$, *** $p < .001$

The Partner Violence Services Field

The partner violence field includes 65 organizations, whose basic characteristics are shown in Table VI.vii. The majority (82%, *N* = 53) are nonprofit or public, with a smaller proportion of for profits (19%, *N* = 12). Roughly half (51%, *N* = 33) were founded prior to 1982, the year the Illinois Domestic Violence Act passed. Of the remaining organizations, 20% (*N* = 13) were founded between 1983 and 1994 and 29% (*N* = 19) were founded after 1995. The average organizational tenure is 33.7 years (*SD* = 29.5), with a range from 1 to 155 years; median organizational tenure is 28 years. The largest proportion of organizations are small (40%, *N* = 26), with 14 or fewer employees and/or less than $600,000 in total revenue. 30.8% (*N* = 20) are medium size and 29.2% (*N* = 19) are large.

Within the partner violence field, the most common focal issues are human services (50%, *N* = 32), mental health (29.7%, *N* = 19), partner violence (26.6%, *N* = 17), criminal justice (17.2%, *N* = 11), and children and youth (15.6%, *N* = 10). There is a high degree of variation in how salient partner violence is to organizations' identities. Partner violence is absent from the identities of nearly have of organizations in the field (46.2%, *N* = 30), peripheral to the identities of additional one-fifth (18.5%, *N* = 12), and central to the identities of one-third (35.4%, *N* = 23). There is also considerable variation on engagement in advocacy, with 40% (*N* = 26) of organizations not involved, 23.1% (*N* = 15) involved at the local level only, and 35.4% (*N* = 23) involved at the state level (and potentially the local level as well).

In terms of service populations and services, findings, shown in Table VI.vii, reflect the partner violence field's emphasis on victims. Nearly half of organizations work exclusively with victims (49.2%, *N* = 32) and an additional 24.6% (*N* = 16) work with both victims and perpetrators. Slightly more than one-quarter of organizations in the field work exclusively with

perpetrators of partner violence (26.2%, *N* = 17). Thus, nearly three-quarters of organizations offer at least some services for victims (73.8%, *N* = 48).

Table VI.vii – Characteristics of the Partner Violence Field

	% (f)
Nonprofit/public (*N* = 65)	81.5% (53)
Founding era (*N* = 65)	
Before 1982	50.8% (33)
1983-1994	20% (13)
1995 or later	29.2% (19)
Size (*N* = 65)	
Small	40.0% (26)
Medium	30.8% (20)
Large	29.2% (19)
Focal Issue (*N* = 64)	
Children and youth	15.6% (10)
Criminal justice	17.2% (11)
Human services	50.0% (32)
Mental health	29.7% (19)
Partner violence	26.6% (17)
Salience of target issue (*N* = 65)	
Absent	46.2% (30)
Peripheral	18.5% (12)
Central	35.4% (23)
Engagement in advocacy (*N* = 65)	
None	40.0% (26)
Local only	23.1% (15)
State (and local)	35.4% (23)

As shown in Table VI.viii, for organizations in the partner violence field, the five most prevalent services are group counseling for victims (63.5%, *N* = 40), individual counseling for victims (61.9%, *N* = 39), legal advocacy for victims (60.3%, *N* = 38), PAIP for men (47.7%, *N* = 31), and children's programs (44.4%, *N* = 28). Though less common, roughly one-third of organizations offer emergency shelter for victims (33.3%, *N* = 21) and the 40-hour training required for worker certification (31.7%, *N* = 20), included in this analysis because of the importance of shelter and community education for the field. Most organizations (58.5%, *N* = 38) offer comprehensive services for partner violence, defined as six or more of twelve services.

Roughly one-third of organizations use a gender sensitive approach (32.3%, *N* = 21) and 11.3% (*N* = 5) offer services for trauma. Nearly one-quarter of organizations offer couples counseling (22.6%, *N* = 14) and slightly fewer than one-fifth offer anger management services (16.1%, *N* = 10).

Table VI.viii – Services in the Partner Violence Field

	All PV
Service populations (*N* = 65)	
Victim services only	49.2% (32)
PAIP only	26.2% (17)
Victims services & PAIP	24.6% (16)
Provides any victim services (*N* = 65)	73.8% (48)
Index services for PV (*N* = 63)	
Group counseling (VS)	63.5% (40)
Individual counseling (VS)	61.9% (39)
Legal advocacy (VS)	60.3% (38)
Any PAIP	50.8% (33)
Children's program	44.4% (28)
Emergency shelter	33.3% (21)
40-hour training	31.7% (20)
Service comprehensiveness (*N* = 65)	58.5% (38)
Gender sensitive (*N* = 65)	32.3% (21)
Trauma services (*N* = 62)	11.3% (5)
Couples counseling (*N* = 62)	22.6% (14)
Anger management (*N* = 62)	16.1% (10)

As in the substance use field, organizations in the partner violence field appear to vary considerably in their involvement in core activities of the field. To consider the relationship between organizational status, characteristics, and activities, I grouped organizations into four categories—core, contender, peripheral, and outsider—based on how central partner violence is to their identities and their degree of involvement in advocacy. As a measure of status, I expect organizations in central positions (core and contender) will be larger and older than those in lower status positions and be more likely to offer comprehensive services for partner violence. I

expect that higher status organizations will offer victim services at a disproportionately high rate and be less likely to offer controversial services like couples counseling and anger management.

Table VI.ix – Characteristics of Positions in the Partner Violence Field

	All PV	Outsider	Peripheral	Contender	Core
Nonprofit/public (*N* = 65)	81.5% (53)	55.6% (10)	90.9% (10)	81.8% (9)	96.0% (24)
Founding era (*N* = 65)					
Before 1982	50.8% (33)	38.9% (7)	54.5% (6)	27.3% (3)	68.0% (17)
1983-1994	20% (13)	22.2% (4)	0.0% (0)	18.2% (2)	28.0% (7)
1995 or later	29.2% (19)	38.9% (7)	45.5% (5)	54.5% (6)	4.0% (1)
Size (*N* = 65)					
Small	40.0% (26)	55.6% (10)	36.4% (4)	63.6% (7)	20.0% (5)
Medium	30.8% (20)	22.2% (4)	27.3% (3)	9.1% (1)	48.0% (12)
Large	29.2% (19)	22.2% (4)	36.4% (4)	27.3% (3)	32.0% (8)
Focal Issue (*N* = 64)					
Children and youth	15.6% (10)	11.1% (2)	0.0% (0)	10.0% (1)	28.0% (7)
Criminal justice	17.2% (11)	11.1% (2)	36.4% (4)	0.0% (0)	20.0% (5)
Human services	50.0% (32)	55.6% (10)	45.5% (5)	40.0% (4)	52.0% (13)
Mental health	29.7% (19)	38.9% (7)	18.2% (2)	30.0% (3)	28.0% (7)

Table VI.ix describes differences in characteristics based on organizational status in the partner violence field. While core, contender, and peripheral organizations are nearly always nonprofit or public, this is true for fewer outsiders (55.6%, *N* = 10). These organizations may be outsiders in the partner violence field partly of their for profit nature, given the dominance of nonprofit form. It is also possible that they are for profit because they would be restricted from receiving partner violence-specific grant funding for other reasons.

Groups vary in terms of founding era, but only in the core position were most organizations (68.0%, *N* = 17) were founded before 1982. The position with the largest share of new organizations, those founded since 1995, are contenders (54.5%, *N* = 6) rather than peripherals (45.5%, *N* = 5), or outsiders (38.9%, *N* = 7). Differences in mean organizational tenure by position are shown in Table VI.x. Core organizations tend to be larger in size than those in the other three positions. The majority (80%, *N* = 20) of core organizations are either medium or large compared with roughly one-third (36.4%, *N* = 4) of contenders, two-thirds (63.7%, *N* = 7) of peripherals, and slightly less than half (44.4%, *N* = 6) of outsiders.

Table VI.x – Mean Organizational Tenure by Position in the Partner Violence Field

	All	Outsider	Peripheral	Contender	Core
Org. tenure (*N* = 65)	33.7 (*SD* = 29.5) Med. = 29	35.1 (*SD* = 35.1) Med. = 20	26.1 (*SD* = 15.1) Med. = 30	36.1 (*SD* = 48.3) Med. = 14	34.7 (*SD* = 19.1) Med. = 31

These groups differ in the mix of focal issues they address and the proportion of organizations focused on each. For organizations in the core position, the most common focal issues are human services (52.0%, *N* = 13) and children and youth or mental health (28.0%, *N* = 7). Contenders follow a similar pattern, with the largest proportion focused on human services (40.0%, *N* = 4) or mental health (30.0%, *N* =3). The most common focal areas for peripherals are either human services (45.5%, *N* = 5) or criminal justice (36.4%, *N* = 4). Outsiders most often focus on human services (55.6%, *N* = 10) or mental health (38.9%, *N* = 7).

As shown in Table VI.xi, groups differ the populations they serve, the range of services provided, and the proportion providing index services for partner violence. With regards to service populations, the majorities of core, contender, and peripheral organizations work exclusively with partner violence victims while no outsiders do. While most outsiders (61.1%, *N* = 11) offer PAIP as their only partner violence, this is true for no other position; the position

with the next largest share of PAIP-only organizations is contender (18.2%, *N* = 2). The positions with the largest proportion of organizations that offer both victim services and PAIP are core (36.0%, *N* = 9) and outsider (38.9%, *N* = 7). Thus, while organizations in core, contender, and peripheral positions nearly always offer victim services, a minority of outsiders (27.8%, *N* = 5) do.

The proportion of organizations offering each index service—except for PAIP—declines with status. Core organizations are the most likely—and outsiders the least likely—to offer group counseling for victims, individual counseling for victims, legal advocacy, children's programming, emergency shelter, and 40-hour training. All outsider offer PAIP (100%, *N* = 18), with the next largest proportion found among core organizations (36.0%, *N* = 9); contender and peripheral organizations are equally likely to offer PAIP (27.3%, *N* = 3 in each category). Consistent with this overall pattern, the majorities of core organizations (92.0%, *N* = 23) and contender organizations (63.6%, *N* = 7) offer comprehensive services for partner violence in comparison with roughly one-quarter of peripheral (27.3%, *N* = 3) and outsider organizations (27.8%, *N* = 5).

With regards to other services, peripherals are more likely than organizations in any other category to offer services for trauma (18.2%, *N* = 2 compared with 12.0%, *N* = 3 core organizations, the next highest proportion). Core organizations are more likely than those in other categories to provide gender sensitive services (52.0%, *N* = 13), although the position with the next largest share of organizations using this approach is outsider (27.8%, *N* = 5). The two controversial services included in this analysis—couples counseling and anger management—are disproportionately offer by outsider organizations (couples counseling: 68.8%, *N* = 11; anger management: 50.0%, *N* = 8) and only rarely offered by organizations in other positions.

Table VI.xi – Services by Position in the Partner Violence Field

	All PV	Outsider	Peripheral	Contender	Core
Service populations (*N* = 65)					
VS only	49.2% (32)	0% (0)	72.7% (8)	72.7% (8)	64.0% (16)
PAIP only	21.5% (14)	61.1% (11)	9.1% (1)	18.2% (2)	0% (0)
Victims services & PAIP	29.2% (19)	38.9% (7)	18.2% (2)	9.1% (1)	36.0% (9)
Provides victim services (*N* = 65)	75.4% (49)	27.8% (5)	90.9% (10)	81.8% (8)	96.0% (24)
Index services (*N* = 63)					
Group counseling (VS)	63.5% (40)	17.6% (3)	54.5% (6)	80.0% (8)	92.0% (23)
Individual counseling (VS)	61.9% (39)	23.5% (4)	45.5% (5)	80.0% (8)	88.0% (22)
Legal advocacy (VS)	60.3% (38)	11.8% (2)	36.4% (4)	80.0% (8)	96.0% (24)
Any PAIP	50.8% (33)	100.0% (18)	27.3% (3)	27.3% (3)	36.0% (9)
Children's program	44.4% (28)	11.8% (2)	18.2% (2)	40.0% (4)	80.0% (20)
Emergency shelter	33.3% (21)	5.9% (1)	0% (0)	40.0% (4)	64.0% (16)
Provides 40-hour training	31.7% (20)	5.9% (1)	9.1% (1)	10.0% (1)	68.0% (17)
Service comprehensiveness (*N* = 65)	58.5% (38)	27.8% (5)	27.3% (3)	63.6% (7)	92.0% (23)
Trauma services (*N* = 62)	11.3% (5)	6.3% (1)	18.2% (2)	10.0% (1)	12.0% (3)
Gender sensitive (*N* = 65)	32.3% (21)	27.8% (5)	9.1% (1)	18.2% (2)	52.0% (13)
Couples counseling (*N* = 65)	22.6% (14)	68.8% (11)	18.2% (2)	10.0% (1)	0.0% (0)
Anger management (*N* = 62)	16.1% (10)	50.0% (8)	9.1% (1)	10.0% (1)	0.0% (0)

Differences Between Fields

Consideration of differences between the partner violence and substance use fields shows that, in the aggregate, organizations in these fields differ in structural characteristics like ownership status, organizational tenure, and size, as well as focal issues other than partner violence or

substance use. These findings are reported in Tables VI.xii and VI.xiii. Organizations in the partner violence field are significantly more likely to be nonprofit or public (81.5%, $N = 53$) than those in the substance use field, which contains equal numbers of for- and nonprofit/public entities (50%, $N = 157$), χ^2 (1, $N = 210$) = 21.68, $p < 0.001$). Organizations in the partner violence field are significantly older, with mean organizational tenure of 33.7 years (SD = 29.5) in comparison with 24.5 (SD = 25.7) for organizations in the substance use field, t(84.5)= -2.31, p < .05. The largest share of substance use organizations (41.7%, N =131) are small, compared to roughly one-quarter (26.2%, $N = 17$) of partner violence organizations. These figures are reversed in the middle category (43.1%, $N = 28$ partner violence; 28.7%, $N = 90$ substance use) and roughly equal proportions of organizations fall in the largest category (30.8%, $N = 20$ partner violence; 29.6%, $N = 93$ substance use).

Analysis of focal issues reveals areas of overlap and divergence. Both fields have large shares of organizations for whom human services is a focal issue (50.0%, $N = 32$ partner violence organizations; 48.9%, $N = 149$ substance use organizations) and substantial proportions focused on mental health (partner violence: 29.7%, $N = 19$; substance use: 24.3%, $N = 74$) and children and youth (partner violence: 13.1%, $N = 40$; substance use: 12.4%, $N = 33$), respectively. It is striking that no organization in the partner violence field includes substance use (alcohol/other drug use) as a focal issue or vice versa. The fields diverge significantly in the proportions of organizations focused on criminal justice and health. Criminal justice is a significantly more common focus for partner violence organizations (17.2%, $N = 11$)—the fourth most prevalent focal issue in the field—than substance use organizations (2.6%, 8) (χ^2 (1, $N =$ 369) = 22.98, p<0.001). While slightly fewer than one-quarter (21.6%, $N = 66$) organizations in

the substance use field are health focused, making it the fourth most common focal issue, this figure drops to 4.7% (N = 3) in the partner violence field (χ^2 (1, N = 369) = 9.99, p<0.01).

Table VI.xii – Differences Between Fields

	All	Substance Use	Partner Violence	χ^2
Nonprofit/public (N = 379)	55.4% (210)	50% (157)	81.5% (53)	21.68***
Size (N = 367)				
Small	42.2% (155)	41.7% (131)	26.2% (17)	8.03*
Medium	31.9% (117)	28.7% (90)	43.1% (28)	
Large	25.9% (95)	29.6% (93)	30.8% (20)	
Focal Issue (N = 369)				
Alcohol/other drug use	38.2% (141)	46.2% (141)	0% (0)	47.88***
Children and youth	13.6% (50)	13.1% (40)	15.6% (10)	*n.s.*
Criminal justice	5.1% (19)	2.6% (8)	17.2% (11)	*n.s.*
Health	18.7% (69)	21.6% (66)	4.7% (3)	9.99**
Human services	49.1% (181)	48.9% (149)	50.0% (32)	*n.s.*
Intimate partner violence	4.6% (17)	0% (0)	26.6% (17)	*n.s.*
Mental health	25.2% (93)	24.3% (74)	29.7%(19)	*n.s.*
Salience of target issue (N = 379)				
Absent		33.1% (104)	46.2% (30)	
Peripheral		30.9% (97)	18.5% (12)	
Central		36.0% (113)	35.4% (23)	
Gender sensitive (N = 379)	31.3% (118)	30.9% (97)	32.3% (21)	*n.s.*
Trauma services (N = 277)	13.0% (36)	13.5% (29)	11.3% (29)	*n.s.*
Anger management (N = 270)	25.6% (69)	28.4% (59)	16.1% (10)	*n.s.*
Couples counseling (N = 277)	19.2% (53)	18.1% (39)	22.6% (14)	*n.s.*

* p < .05, ** p < .01, *** p < .001

Table VI.xiii – Mean Organizational Tenure by Field

	All	Substance Use	Partner Violence	t
Org. tenure (N = 301)		24.5 (SD = 25.7)	33.7 (SD = 29.5)	-2.31*

* p < .05

Analysis of focal issues reveals areas of overlap and divergence. Both fields have large shares of organizations for whom human services is a focal issue (50.0%, N = 32 partner violence organizations; 48.9%, N = 149 substance use organizations) and substantial proportions focused on mental health (partner violence: 29.7%, N = 19; substance use: 24.3%, N = 74) and children and youth (partner violence: 13.1%, N = 40; substance use: 12.4%, N = 33), respectively.

It is striking that no organization in the partner violence field includes substance use (alcohol/other drug use) as a focal issue or vice versa. The fields diverge significantly in the proportions of organizations focused on criminal justice and health. Criminal justice is a significantly more common focus for partner violence organizations (17.2%, $N = 11$)—the fourth most prevalent focal issue in the field—than substance use organizations (2.6%, 8) (χ^2 (1, $N = 369$) = 22.98, $p<0.001$). While slightly fewer than one-quarter (21.6%, $N = 66$) organizations in the substance use field are health focused, making it the fourth most common focal issue, this figure drops to 4.7% ($N = 3$) in the partner violence field (χ^2 (1, $N = 369$) = 9.99, $p<0.01$).

Differences emerge in how central partner violence or substance use are to the identities of organizations in each field. While both fields contain a similar proportion of organizations highly identified with their central issue (those in the central category)—meaning it is a primary focal issue and referenced in the organization's name or mission statement—the partner violence field includes a larger proportion for whom the central issue appears to be absent (46.2%, $N = 30$ versus 33.1%, $N = 104$ in the substance use field) and a lower proportion of organizations peripherally focused on its central issue (18.5%, $N = 12$ versus 30.9%, $N = 97$ in the substance use field).

With regards to approaches like gender sensitivity and the provision of services for trauma, the fields differ little. Roughly one-third of organizations in each field are gender sensitive and slightly more than one in ten offer services for trauma. Similar proportions offer couples counseling. There is a trend for organizations in the substance use field to offer anger management at high rates (28.4%, $N = 59$) than those in the partner violence field (16.1%, $N = 10$), though it does not reach the level of statistical significance (χ^2 (1, $N = 369$) = 3.76, $p = 0.053$).

Discussion

In this chapter, I have described characteristics and structure of the contemporary partner violence and substance use services fields in metropolitan Chicago. I took an inductive approach to each field, building up membership lists from directories, with the goal of creating a complete census of organizations in both fields. The resulting analysis shows differences between the fields in size and scope as well as approaches. There are roughly five times as many organizations in the substance use field as in the partner violence field. The scale and resource levels of organizations also differ. While the largest substance use organizations have 32 or more employees and revenues of $5.6 million or more, the largest partner violence organizations have 52 or more employees and $2.3 million or more in total revenue. This is consistent with previous research, suggesting that partner violence organizations are comparatively under-resourced (Bennett & Lawson, 1994; Collins et al., 2002).

No organization in the partner violence field includes substance use as a focal issue, just as no organization in the substance use field includes partner violence as a focal issue, underscoring the contention that they have different logics. While both fields include a number of organizations focused on more generalist social service provision (e.g., human services) or mental health, it remains to be seen whether this commonality promotes hybridity.

Both fields are also internally diverse, with variation in how focused organizations are on their field's central issue, the services they provide, and the populations with whom they work. In addition to a description of the characteristics and practices of organizations in the partner violence and substance use fields in metropolitan Chicago in the early 2010s, I have sought to capture the contemporary status hierarchies in each field.

In the substance use field, I conceptualized status in terms of degree of medicalization and the centrality of substance use to organization's identities, based on themes in key informant interviews. This analysis shows that, in general, organizations in core positions—those that are both highly medicalized and highly focused on substance use—also tend to be older, larger, and are more likely to offer comprehensive and specialized services for substance use. They are also more likely to be nonprofit and include services associated with high-quality service provision, such as gender-sensitive approaches and attention to trauma.

Similar patterns hold for the partner violence field, though their clarity is limited by the small number of organizations in the field. Here, the clearest contrast is between outsiders and higher status organizations. Outsiders are disproportionately for profit in a field that is heavily weights towards nonprofits; they tend to be both newer and smaller. No outsider organization offers victim services and many offer services like couples counseling and anger management that have historically been controversial.

Though this analysis offers insight into dynamics and status hierarchies within each field and points towards some areas of commonality between them, it has not answered one of this project's central questions: what allows some organizations to address partner violence and substance use together when most do not? In the next chapter, I consider the characteristics, practices, and strategies that allow hybrid organizations to their work.

CHAPTER VII

Hybridity, Status & Strategy:

How Organizations Address Substance Use and Partner Violence

What differentiates hybrid organizations from non-hybrid organizations in the substance use and partner violence fields? This chapter uses quantitative data on the characteristics and practices of organizations in metropolitan Chicago to identify factors associated with hybridity—the provision of service for both partner violence and substance use. The relationships considered are drawn from analysis of areas of tension and convergence between the two fields presented in Chapter 5 as well as from the literature on status and innovation in fields, which suggests that innovative practice emerge from the lowest or highest status actors in a field (Leblebici et al., 1991; Rao, Monin & Durand, 2005) rather than from the middle (Phillips & Zuckerman, 2001). Drawing on recent work conflicting logics and organizational hybridity (Skelcher & Smith, 2015), I also examine relationships between organizational status and hybridity strategies—how organizations combined attention to both partner violence and substance use. Exploration of relationship between status and hybridity strategy draw on a set of interviews with six hybrid organizations—three in the partner violence field and three in the substance use field—as well as quantitative data.

Hypotheses

Tensions between the partner violence and substance use fields stem, in part, from differences in beliefs about violence in each field at the time of their emergence. On this basis, I expect

hybridity to be less common amongst older organizations in both fields, as these organizations are likely to retain elements of these founding beliefs even as staffing patterns and services have shifted to reflect newer approaches. I also expect tensions to shape the form hybridity takes. Based on key informant perspectives on trauma-informed approaches, I anticipate hybridity will be more common amongst organizations with services for trauma. Because of perceived incompatibilities between approaches, across fields, most hybrids will be segregated (combine services using a collaborative or partnership model) or segmented (offer both services but which limited to no internal connections between them).

Because of differences between the two fields, I expect that there will be different predictors of hybridity in each. I anticipate a higher incidence of hybrid organizations in the substance use field, particularly among organizations using gender-sensitive approaches to treatment. Qualitative analyses in the previous chapters suggest that substance use organizations with specialized programs for women have a longstanding awareness of partner violence needs of their clients. I also expect that these organizations will be more likely to address partner violence on their own, using an assimilated approach (where some services or attention to the non-primary issue in the context of a program focused primarily on the other issue), than through segregated means (e.g., partnership model) for two reasons. First, tensions between feminist models and the family systems approach more common in the substance use field have historically complicated relationships between the fields, making it more likely that substance use organizations finds ways of addressing partner violence on their own. Second, informants in substance use programs raised concerns about the accessibility of partner violence programs for their participants.

For organizations in the partner violence field, I expect that hybridity will be more common amongst those that are less feminist in orientation. Specifically, engagement in advocacy and hybridity will be inversely related. I also expect that hybridity will be more common amongst organizations with a mental health focus, which are likely to be less resistant to the individually-focused approaches common in the substance use field.

Based on literature on organizational status and innovation (Leblebici et al., 1991; Phillips & Zuckerman, 2001; Rao, Monin & Durand, 2005), I expect that, in both fields, hybridity will be most common amongst organizations in either outsider or core positions and less common amongst those in middle positions within field-specific status hierarchies.

Hybrid Organizations in Metropolitan Chicago

Of the 379 organizations providing services for partner violence or substance use in metropolitan Chicago, 14.8% (N = 56) include attention to both issues. Contrary to expectations, hybrids are significantly more prevalent in the partner violence field than the substance use field (see Table VII.i). Hybrids account for 12.4% (N = 39) of organization in the substance use field and 26.2% (N = 17) of organizations in the partner violence field (χ^2 (1, N = 379) = 8.07, $p<0.01$). There is no relationship between ownership status and hybridity or size and hybridity. While hybrids have a slightly longer mean organization tenure (M = 32.9, SD = 35.1) than non-hybrids (M = 24.9, SD = 24.6), these differences are not statistically significant. Results do not support the hypothesis hybridity is less common among older organizations.

Focal issue does not appear to be related to hybridity either. Similar proportions of organizations focused on children and youth, criminal justice, health, human services, and mental health are hybrid as are non-hybrids. While a higher proportion of organizations with a focus on alcohol or other drug use are non-hybrid (40.3%, N = 126) than are hybrid (26.8%, N = 15), this

trend does not reach the level of statistical significance (χ^2 (1, N = 369) = 3.65, p=.056). A slightly higher proportion of hybrids (41.4%, N = 23) than non-hybrids (29.4%, N = 95) are gender-sensitive, a relationship that approaches but does not reach statistical significance (χ^2 (1, N = 379) = 3.03, p=.082). Consistent with expectations, organizations with services for trauma are significantly more likely than those without trauma services to be hybrid: 22.6% (N = 12) of hybrids compared to 10.7% (24) of non-hybrids offer trauma services (χ^2 (1, N = 277) = 5.39, p<.05).

Table VII.i – Characteristics of Hybrid Organizations

	Hybrids	Non-hybrids	χ^2
Primary field			
Substance use	12.4% (39)	87.6% (275)	8.07**
Partner violence	26.2% (17)	73.8% (48)	
Ownership status (N = 379)			
For profit	14.8% (25)	85.2% (144)	*n.s.*
Nonprofit/public	14.8% (31)	85.2% (179)	
Size (N = 379)			
Small	11.6% (18)	88.4% (137)	*n.s.*
Medium	14.5% (17)	85.5% (100)	
Large	22.1% (21)	77.9% (74)	
Organizational tenure (N = 379)	M = 32.9 (SD = 35.1) Median = 21	M = 24.9 (SD = 24.6) Median = 17	
Focal Issue (N = 369)			
Alcohol/other drug use	26.8% (15)	40.3% (126)	*n.s.*
Children and youth	16.1% (9)	13.1% (41)	*n.s.*
Criminal justice	3.6% (2)	5.4% (17)	*n.s.*
Health	21.4% (12)	18.2% (57)	*n.s.*
Human services	46.4% (26)	49.5% (155)	*n.s.*
Mental health	26.8% (15)	24.9% (78)	*n.s.*
Partner violence	5.4% (3)	4.5% (14)	*n.s.*
Gender-sensitive (N = 379)	41.4% (23)	29.2% (95)	*n.s.*
Trauma (N = 277)	22.6% (12)	10.7% (24)	5.39*
Hybridity strategy (N = 56)			
Segregated	3.6% (2)		
Segmented	73.2% (41)		
Assimilated	21.4% (11)		
Blended	1.8% (1)		

* p < .05, ** p < .01

Consistent with expectations, across fields, the most common form of hybridity is segmentation (69.6%, *N* = 39), which describes organizations offering services for both issues but with few connections between them. In combination with organizations using a segregated or partnership approach (8.9%, *N* = 5), these strategies account for 78.6% (*N* = 44) of all hybrids. Taken individually, the second most common strategy is assimilation, which is used by 19.6% (*N* = 11) hybrid organizations. A blended approach, defined as attention to both issue across multiple service areas, was used by only one organization.

Table VII.ii – Characteristics of Hybrids and Non-Hybrids in the Substance Use Field

	Hybrids	Non-hybrids	χ^2
Nonprofit/public (*N* = 314)	44.7% (17)	50.7% (140)	*n.s.*
Founding era (*N* =301)			
Before 1972	18.4% (7)	19.0% (50)	*n.s.*
1973-1996	42.1% (16)	33.2% (85)	
1997 or later	39.5% (15)	48.7% (128)	
Organizational tenure (*N* =301)	M = 26.9, SD = 30.1 Median = 20	M = 24.1, SD = 25.0 Median = 16	*n.s.*
Size (*N* =314)			
Small	28.9% (11)	43.5% (120)	7.14*
Medium	28.9% (11)	34.1% (94)	
Large	42.1% (16)	22.5% (62)	
Focal Issue (*N* = 305)			*n.s.*
Alcohol/other drug use	36.8% (14)	47.6% (127)	
Children and youth	18.4% (7)	12.4% (33)	*n.s.*
Health	26.3% (10)	21.0% (56)	*n.s.*
Human services	42.1% (16)	49.8% (133)	*n.s.*
Mental health	23.7% (9)	24.3% (65)	*n.s.*
Salience of target issue (*N* = 314)			
Absent	34.2% (13)	33.0% (91)	*n.s.*
Peripheral	42.1% (16)	29.3% (81)	
Central	23.7% (9)	37.7% (104)	
Medicalization (*N* = 314)			
Low	65.8% (25)	71.0% (196)	*n.s.*
Medium	23.7% (9)	21.4% (59)	
High	10.5% (4)	7.6% (21)	
Gender sensitive (*N* = 314)	36.8% (14)	30.1% (83)	*n.s.*

* $p < .05$

Hybrids in the Substance Use Field

Table VII.ii compares the characteristics of hybrid and non-hybrid organizations in the substance use field. Hybrids are significantly more likely to fall into the largest size category (42.1%, *N* = 16) than are non-hybrids (22.5%, *N* = 62) (χ^2 (2, N=314) = 7.14, p<.05). They do not differ significantly from non-hybrids in terms of any other characteristic. While difference do not reach the level of statistical significance, hybrids are somewhat less likely to have alcohol or other drugs as a focal issue than non-hybrids (36.8%, *N* = 14 hybrids versus 47.6%, *N* = 127 non-hybrids) and it is less likely for substance use to be central to their identities (23.7%, *N* = 9 hybrids versus 37.7%, *N* = 104 non-hybrids). Hybrids and non-hybrids are similar in degree of medicalization and, contrary to expectations, hybridity is no more common among organizations with a gender-sensitive approach to treatment than those without.

Table VII.iii – Service Profiles of Hybrid and Non-Hybrid Substance Use Organizations

	Hybrids	Non-Hybrids	χ^2
Index services for substance use (*N* = 314)			
Outpatient treatment	94.7% (36)	86.2% (274)	n.s.
DUI/DWI	76.3% (29)	60.8% (191)	4.35*
Detox	23.7% (9)	18.5% (51)	n.s.
MAT (non-detox)	26.3% (10)	22.1% (61)	n.s.
Residential	13.2% (5)	16.3% (45)	n.s.
Service comprehensiveness (*N* = 314)	19.2% (53)	23.7% (9)	*n.s.*
Specialized programs			
DUI (*N* = 243)	76.5% (26)	62.7% (131)	*n.s.*
Co-occurring mental health issues (*N* = 236)	32.4% (11)	39.6% (80)	*n.s.*
Women (*N* = 241)	37.1% (13)	33.5% (69)	*n.s.*
Men (*N* = 236)	38.2% (13)	30.2% (61)	*n.s.*
Criminal justice (*N* = 236)	38.2% (13)	25.7% (52	*n.s.*
Service specialization (*N* = 314)	39.5% (15)	31.9% (88)	*n.s.*
Trauma (*N* = 215)	25.7% (9)	11.1% (20)	5.355*
Partner abuse service populations (*N* = 35)			
PAIP	74.4% (19)		
Only victim services	25.6% (10)		

* p < .05

As shown in Table VII.iii, with regards to discrete services for substance use, hybrids are significantly more likely to offer DUI programming (76.3%, $N = 29$) than are non-hybrids (60.8%, $N = 191$) (χ^2 (1, $N = 314$) = 4.35, p<.05). The two groups do not differ in their likelihood of offering any other index service for substance use nor do they differ in terms of service comprehensiveness. Hybrids and non-hybrids offer specialized programming at similar rates. Hybrids, however, are significantly more likely to offer trauma services (25.7%, $N = 9$) than are non-hybrids (11.1%, $N = 20$) (χ^2 (1, $N = 215$) = 5.355, p<.05), suggesting a field-specific relationship between trauma services and hybridity. With regards to services for partner violence, hybrids in the substance use field are more likely to offer PAIP (74.4%, $N = 19$) than they are to work exclusively with victims (25.6%, $N = 10$).

While the small number of hybrid organizations warrants caution in interpreting findings regarding relationships between position in the substance use field and hybridity, results (shown in Table VII.iv) suggest hybrids are more likely to occupy the peripheral position (52.6%, $N = 20$) than non-hybrids (21.7%, $N = 60$). When treated as a dummy variable, differences in the proportion of hybrids versus non-hybrids in the peripheral category are statistically significant (χ^2 (1, $N = 314$) = 4.95, p<.05).

Table VII.iv – Status and Hybridity in the Substance Use Field

	Hybrids	Non-Hybrids	χ^2
Position ($N = 314$)			
Outsider	15.8% (6)	21.7% (60)	*n.s.*
Peripheral	52.6% (20)	33.0% (91)	
Contender	23.7% (9)	33.3% (92)	
Core	7.9% (3)	12.0% (33)	
Peripheral (dummy)	18.0% (20)	9.4% (19)	4.95*

* p < .05

As shown in Table VII.v, the most common form hybrid organizations in the substance use field take is segmented, meaning both substance use and partner violence programs exist

within the same larger organization (69.2%, *N* =27) but with minimal connections between them. The second most common form, segregation (12.8%, *N* = 5) refers to organizations that address partner violence through collaboration with another organization. Assimilation is less common (15.4%, *N* = 6) and refers to substance use organizations that, on their own, have expanded programs to address the other issue. The least common strategy, blending, was used by only one organization (2.6% of hybrids) and refers to organizations that address both issues in multiple areas of programming. Except for organizations in the core position, hybrids are most often segregated in form. In contrast, organizations in the core position are most often assimilated hybrids (75%, *N* = 3).

Table VII.v – Status and Strategy in Hybrid Substance Use Organizations

	Segregated	Segmented	Assimilated	Blended
All hybrids (*N* = 39)	2.6% (1)	76.9% (30)	17.9% (7)	2.6% (1)
Position (*N* = 39)				
Outsider	0% (0)	100% (6)	0% (0)	0% (0)
Peripheral	0% (0)	85% (17)	15% (3)	0% (0)
Contender	0% (0)	78% (7)	11% (1)	11% (1)
Core	25% (1)	0% (0)	75% (3)	0% (0)

Hybrids in the Partner Violence Field

As shown in Table VII.vi, in the partner violence field, hybrids and non-hybrids do not differ significantly in any of the characteristics studies. They are similar in terms of ownership status, founding era, and organizational tenure. Hybrids are significantly more likely to have identities from which partner violence is absent (29.4%, *N* = 5) than non-hybrids (62.5%, *N* = 30) (χ^2 (1, *N* = 65) = 5.53, p<.05).[66] There is a trend for hybrids to be less engaged in advocacy than non-hybrids: 58.8% (*N* = 10) hybrids and 33.3% (*N* = 16) non-hybrids are not engaged in

[66] For the purposes of this analysis, the identity variable was recoded as a dummy variable, with the absent and peripheral categories collapsed.

advocacy at either the local or state level (χ^2 (2, N = 65) = 2.83, p=.092).[67] In descriptive terms, a smaller proportion of hybrids (23.5%, N = 4) fall into the smallest size category than do non-hybrids (45.8%, N = 22). Hybrids are also less likely to include criminal justice as a focal issue (5.9%, N = 1) than non-hybrids (21.3%, N = 10).

Table VII.vi – Characteristics of Hybrids in the Partner Violence Field

	Hybrids	Non-hybrids	χ^2
Nonprofit/public (N = 65)	76.5% (13)	83.3% (40)	*n.s*
Founding era (N = 65)			
Before 1982	58.8% (10)	47.9% (23)	*n.s*
1983-1994	17.6% (3)	20.8% (10)	
1995 or later	23.5% (4)	31.3% (15)	
Organizational tenure (N = 64)	M = 47.7, SD = 42.7 Median = 31.5	M = 29.0, SD = 22.3 Median = 27.5	
Size (N = 65)			
Small	23.5% (4)	45.8% (22)	*n.s*
Medium	41.2% (7)	27.1% (13)	
Large	35.3% (6)	27.1% (13)	
Focal Issue (N = 64)			*n.s*
Children and youth	11.8% (2)	17.0% (8)	
Criminal justice	5.9% (1)	21.3% (10)	*n.s*
Human services	58.8% (10)	46.8% (22)	*n.s*
Mental health	35.3% (6)	27.7% (13)	*n.s*
Partner violence	17.6% (3)	29.8% (14)	*n.s*
Salience of target issue			*n.s*
Absent	70.6% (12)	37.5% (18)	
Peripheral	11.8% (2)	20.8% (10)	*n.s*
Central	17.6% (3)	41.7% (20)	*n.s*
Target issue absent from identity (N = 65)	70.6% (12)	37.5% (18)	5.53*
Engagement in advocacy (N = 65)			
None	58.8% (10)	33.3% (16)	
Local only	5.9% (1)	29.2% (14)	*n.s*
State (and local)	35.3% (6)	37.5% (18)	

* $p < .05$

[67] This statistic was calculated for a dichotomized version of the engagement in advocacy variable, where categories were "none" and "local or state."

With regards to services for partner violence (shown in Table VII.vii), hybrids and non-hybrids differ significantly only in the portion providing anger management services. Anger management is offered by 41.2% (*N* = 7) hybrids and 6.7% (*N* = 3) non-hybrids (χ^2 (1, *N* = 62) = 10.86, p<.01).[68] There is a trend for hybrids to be less likely to offer victims services, with 58.8% (*N* = 10) hybrids and 81.3% (*N* = 39) offering any services for victims (χ^2 (1, *N* = 65) = 3.4, p=.065). Likely because they are less like to offer victim services than non-hybrids, hybrids are less likely to offer group counseling for victims (52.9%, *N* = hybrids versus 67.4%, *N* = 28 non-hybrids) and legal advocacy (47.1%, *N* = 8 hybrids versus 65.2%, *N* = 20 non-hybrids).

Table VII.vii – Service Profiles of Hybrid and Non-Hybrid Partner Violence Organizations

	Hybrids	Non-hybrids	χ^2
Service populations (*N* = 65)			
Victim services only	35.3% (6)	54.2% (26)	*n.s*
PAIP only	35.3% (6)	16.7% (8)	
Victim services and PAIP	29.4% (5)	29.2% (14)	
Provides any victim services (*N* = 65)	58.8% (10)	81.3% (39)	*n.s*
Index services for PV (*N* = 63)			
Group counseling (VS)	52.9% (9)	67.4% (31)	*n.s*
Individual counseling (VS)	64.7% (11)	60.9% (28)	*n.s*
Legal advocacy (VS)	47.1% (8)	65.2% (30)	*n.s*
Any PAIP	64.7% (11)	45.8% (22)	*n.s*
Children's program	47.1% (8)	43.5% (20)	*n.s*
Emergency shelter	29.4% (5)	34.8% (16)	*n.s*
40-hour training	17.6% (3)	37.0% (17)	*n.s*
Service comprehensiveness (*N* = 65)	58.8% (10)	58.3% (28)	*n.s*
Gender sensitive (*N* = 65)	47.1% (8)	27.1% (13)	*n.s*
Trauma services (*N* = 62)	11.8% (2)	11.1% (5)	*n.s*
Couples counseling (*N* = 62)	29.4% (5)	20.0% (9)	*n.s*
Anger management (*N* = 62)	41.2% (7)	6.7% (3)	10.86**

** p < .01

While findings should be interpreted with caution because of the small number of cases, results for the relationship between position and hybridity in the partner violence field—shown

[68] Fischer's Exact Test was used to calculate significance due to small cell sizes.

below in Table VII.vii—suggest that hybrids are more likely to occupy the outsider position (52.9%, *N* = 9) than are non-hybrids (18.8%, *N* = 9). Compared to non-hybrids, hybrids are less likely to fall into the peripheral position (5.9%, *N* = 1 hybrid versus 20.8%, *N* =10 non-hybrids) and the core position (23.5%, *N* = 4 hybrids compared with 43.8%, *N* = 21 non-hybrids). In the partner violence field, hybrids thus appear to most often occupy positions as either outsiders or at the core of the field.

Table VII.viii – Status and Hybridity in the Partner Violence Field

	Hybrids	Non-Hybrids
Position (*N* = 65)		
Outsider	52.9% (9)	18.8% (9)
Peripheral	5.9% (1)	20.8% (10)
Contender	17.6% (3)	16.7% (8)
Core	23.5% (4)	43.8% (21)

As shown in Table VII.ix, hybrids in the partner violence field are most often segregated in form (64.7%, *N* = 11). The next most common form is assimilated (29.4%, *N* = 5). As in the substance use field, only one organization uses a segregated approach and that organization occupies a core position in the field. There are no blended hybrids in the partner violence field. As in the substance use field, all outsiders use a segmented approach and all core organizations are either segregated (25%, *N* =1) or assimilated (75%, *N* = 3).

Table VII.ix – Status and Strategy in Hybrid Partner Violence Organizations

	Segregated	Segmented	Assimilated	Blended
All hybrids (N = 17)	5.9% (1)	64.7% (11)	29.4% (5)	0% (0)
Position (*N* = 17)				
Outsider	0% (0)	100% (9)	0% (0)	
Peripheral	0% (0)	0% (0)	100% (1)	
Contender	0% (0)	67% (2)	33% (1)	
Core	25% (1)	0% (0)	75% (3)	

Form Versus Substance: Hybridity, Status, and Strategy in Practice

While analysis of relationships between status position and hybridity strategy are complicated by the small number of hybrid organizations, the pattern is similar for both fields. All outsiders, regardless of field, are segmented. While they offer services for both partner violence and substance use—most often, PAIP and either DUI or outpatient treatment—there appear to be little connection between them. PAIP licensure would, in fact, largely prevent cross-issue attention, at least in the PAIP component.[69] What this suggests is most organizations that appear, from the outsider, to work on both partner violence and substance use do little to address the complex set of relationships between them. While they may be hybrid in form, they are not hybrid in substance. These strategies are described in Figures VII.i through VII.iv.

Figure VII.i – Segmentation

Metropolitan Charities is an example of a segmented hybrid. Metropolitan Charities, the local branch of a social service organization with a national network, offers services for a wide

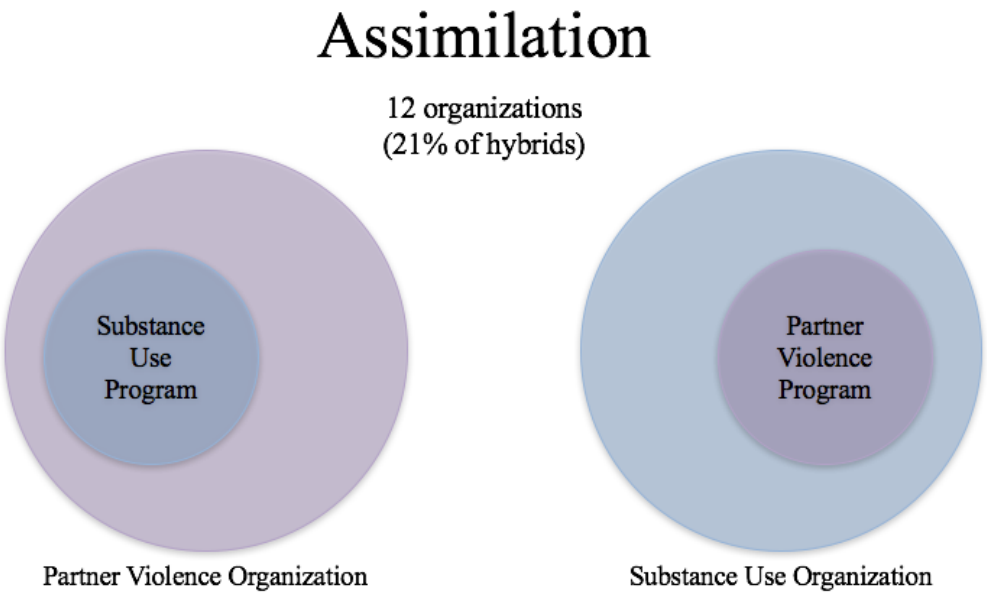
[69] As described in Chapter V, the funding structure for PAIP discourages attention to issues like substance use and mental health and the Administrative Rule on PAIP explicitly prohibit approaches that treat partner violence as the result of mental health or substance use issues or fail to treat substance use and partner violence as discrete issues.

range of social issues and is focused primarily on neither partner nor substance use. However, it has a licensed PAIP and, through its Lighthouse Program, offers a range of substance services, including detox and acute residential care for men with substance use issues. It falls into the outsider category in the partner violence field and the peripheral category in the substance use field. With locations throughout northern Illinois and northwestern Indiana, the existence of both services within the larger organization does not mean they are provided at the same site much less in an integrated way. When asked about handling substance use issues when they arose in PAIP, the facilitator explained that he seldom refers PAIP participants to Metropolitan Charities' own program because it is based at a location on the other side of city (Pete, 2014, interview). While assessments for the PAIP program ask about substance use, the curriculum itself is focuses on partner violence as required by Administrative Rule.

In contrast, organizations occupying higher status positions are most often assimilated. That is, they are focused primarily on substance use or partner violence but include attention to the other issue within the framework of existing programs or services. Orchid Place, a substance use organization that was founded in 1990 was part of the State of Illinois's activities fostering gender-sensitive care, addresses partner violence through work on trauma in its transitional housing program. Donna explained that they keep this work internal, in part, because having clients confront significant trauma may jeopardize their recovery early on: "maybe some of the more intense things happening in an after-care. So for some of the women, they're here 45 days. That is not—that—they don't need to get into the gore and nitty gritty—Of that right away" (2014 interview). Orchid Place has also been approached by Haven for Women, one of the programs involved in establishing a recently-funded partner violence shelter, about establishing a

referral relationship. In this way, the work of assimilation may facilitate use of additional hybridity strategies like segregation.

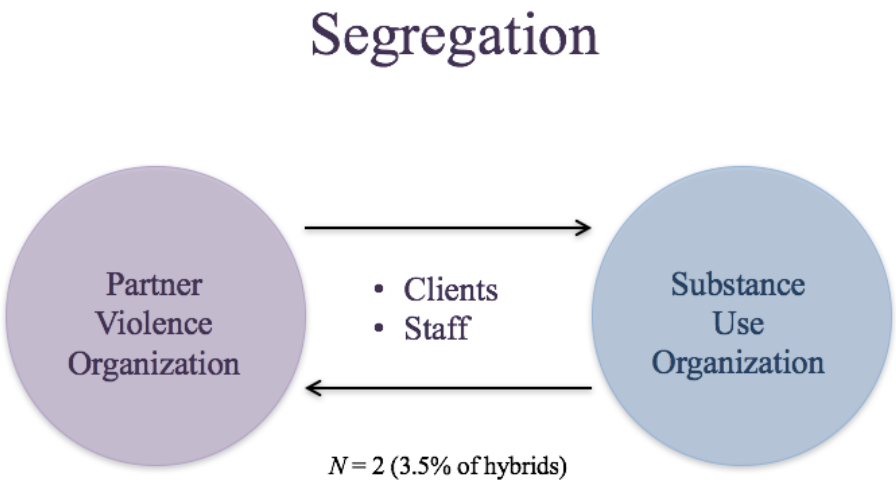
Figure VII.ii – Assimilation



Transitions, an organization that occupies the contender position in both fields, also uses an assimilated approach. Transitions was founded in 1968 and originally focused on mental health and substance use. It added partner violence services in the late 1970s in response to an emerging pattern of needs amongst participants (Lucille, 2014, interview). Until the early 2000s, when Transitions participated in the Domestic Violence/Substance Abuse Interdisciplinary Taskforce's pilot project, there were few internal connections between the partner violence and substance abuse programs and the process of integration through the pilot project was challenging (Ruth, 2011 interview; Susan, 2014 interview). Since the end of the pilot program, Transitions has continued to offer combined victim service and substance use services through support groups and case management and staff in these programs are trained on both issues. The

programs in which partner violence and substance use are both addressed represent a small portion of Transitions' overall focus. Most of its energies are directed towards work on mental health.

Figure VII.iii – Segregation



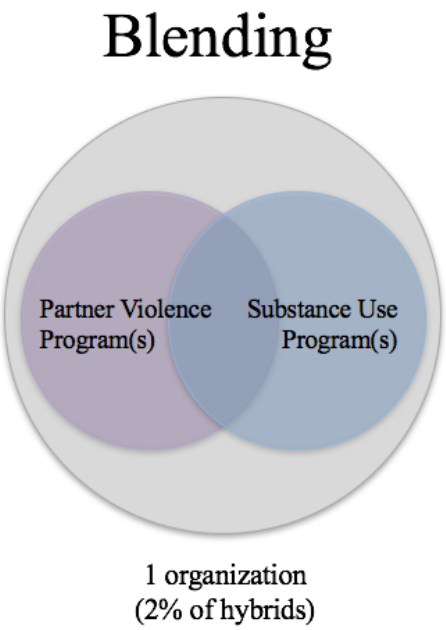
The two organizations employing segregation, Women's Advocacy Center and Recovery House, both core in their primary field, partner with each other to offer combined substance use and victim services. Both organizations employ a staff person who is based primarily at the other organization. This partnership pre-exists the Domestic Violence/Substance Abuse Interdisciplinary Taskforce and has always been supported, in part, through funds form the partner violence field. According to Constance (2011 interview), the collaboration emerged from Women's Advocacy Center's appreciation of the complex ways substance use relates to partner violence victimization. Recovery House had recently adapted its assessment tools to include items on partner violence and was also looking to increase its capacity to respond and so was receptive to Women's Advocacy Center's suggestion that they work together. A staff person from Women's Advocacy Center provides both individual counseling and support groups on-site

in Recovery House's women's program and a staff person from Recovery House offers parallel services at Women's Advocacy Center's shelter. When a participant is assessed as having both needs, they initially enter the program focused on what they identify as their primary issue but may move between organizations later on depending on their needs. Having on-site support for substance use—and a strong relationship with a residential women's program allows Women's Advocacy Center to offer shelter to victims others might turn away. As Constance explained,

> In really extenuating circumstances again, we'll say, "Come on in." If it's the middle of the night and this woman is out there, we're gonna... We know it might be hard for her to get into Recovery House or anyplace else right away, and so again, we look at... The priority is keeping her safe. And we'll get her into the shelter, making sure that she's safe and then the substance abuse counselor... And then next day can really start working with whether it's Recovery House or any other... Orchid Place or something that is available to... Has a bed for her. (2011 interview).

For Women's Advocacy Center and other feminist oriented victim services organizations, hybridity is an outgrowth of a participant-centered approach.

Figure VII.iv -- Blending



The least common strategy, blending, was used by only one organization, Solutions for Health, a substance use organization with a long history of involvement in field-bridging efforts. Solutions for Health's women's program was a replication site for Project SAFE in the 1990s and, later, a pilot site for the Domestic Violence/Substance Abuse Interdisciplinary Taskforce's pilot project. Since that project ended, Solutions for Health has developed its own partner violence program for victims, which included individual and group counseling as well as legal advocacy, and also offers PAIP in-house. Its women's treatment program continues to include attention partner violence issues. Though, like most substance use hybrids Solutions for Health is classed as an outsider in the partner violence field, in 2014, it was awarded funding for its partner violence program through the City of Chicago's Division of Domestic Violence.

Discussion

In metropolitan Chicago, despite historic support for hybrid programs through the Domestic Violence/Substance Abuse Interdisciplinary Taskforce and more recent efforts by the National Center on Domestic Violence, Trauma & Mental Health and the Great Lake Addiction Technology Transfer Center, the overall number of hybrid organizations is low. Of the 379 organizations engaged in work on either issue, only 14.8% offer services for both. Contrary to expectations, there are proportionately more hybrids in the partner violence field than the substance use field. This is likely due to changes in funding structure for substance use. As the field has shifted from comparatively flexible, grant-based models of funding to performance-based contracts and insurance reimbursement, organizations have responded by limiting the provision of various kinds of support services. They also limit participation in the kinds of cross-training and inter-organizational dialogues that have been central to hybrids approaches.

I also find a significant relationship between trauma services and hybridity. Hybridity is much more prevalent amongst organizations that also have services for trauma. While it is not possible to make causal claims about this relationship, it seems equally plausible that hybrids might move towards trauma-informed frameworks to facilitate additional support for work on partner violence and substance use and that organizations committed it trauma-informed frameworks might add services for partner violence or substance use to better address participant needs. Analysis of the characteristics of hybrids within each field, however, shows that the relationship between hybridity and trauma is driven by hybrid substance use organizations. Hybrids and non-hybrids in the partner violence field are equally likely to offer services for trauma. This suggests shifting to a trauma-informed framework may be a particularly valuable strategy for encouraging attention to partner violence in substance use organizations.

For organizations in the substance use field, hybrids are significantly more common amongst large organizations than medium or small organization. This suggests a field-specific relationship between material resources and hybridity. These organizations may have the revenue and staff necessary to support individuals with needs related to partner violence and substance use despite disincentives in terms of field-level funding structure. In terms of services, hybrids differ from non-hybrids only in that the former are more likely to offer DUI services. Hybrid substance use organizations are also more likely to offer at least some PAIP services than they are to work exclusively with partner violence victims. Taken together, the findings underscore the role of the court system in fostering some types of hybrid organizations. As described in previous chapters, PAIPs' reliance on the court system for referrals coupled with the limited availability of funding for their work has resulted in sponsorship of PAIP programs in organizations with strong relationships to local court systems. DUI programs are structured

similarly, receiving referrals from the court system. Neither service is billable to insurance. They thus rely on similar networks and resources.

In the partner violence field, hybrids are dissimilar from non-hybrids along in several meaningful ways. They are significantly less identified with partner violence than non-hybrids: the majority of hybrids neither include partner violence as a focal issue nor mention it in their name or mission statements. There are trends towards hybrids engaging in advocacy activities at a lower rate and being less likely to provide victim services, both central activities within the field. Given how dissimilar hybrids are from the core of the partner violence field, it is relatively unsurprising that they are significantly more likely to offer anger management services, an activity that is controversial in the partner violence field due to court systems in many communities referring partner violence perpetrators to anger management rather than PAIP, whether intentionally or unintentionally.

Literature on the relationship between status and innovation led me to expect that hybridity would be most common amongst organizations in either outsider or core positions, regardless of primary field. My analysis offer only partial support for this hypothesis. In the partner violence field, hybrids are significantly more likely to occupy the outsider position than any of the other three positions. In the substance use field, however, hybridity is significantly more common in peripheral organizations, which represents a lower-middle position.

Findings on relationships between status and hybridity strategy underscore continued barriers to the development of substantively hybrid approaches. Results suggest that most hybrids, regardless of field, use a segmented approach. While they may be hybrid in form in that programs for partner violence and substance abuse exist within the same larger organization, they are not hybrid in substance in that there are few connections between programs. Most

organizations using this approach occupy either the outsider or peripheral position in their primary field, which suggests that their approach to their primary issue may be problematic.

In contrast, more substantive approaches to hybridity appear to require a higher level of resources. Interview data points to the tendency of organizations using a segregated, assimilated, or blended approach to have engaged long-standing work to foster their current hybridity strategy. The current level of hybridity—both in their organizations and in the region, as a whole—is the result of multiple efforts. The limitations of these efforts point to the persistence of tensions between the two fields.

CHAPTER VIII

You Can't Just Get Up in the Morning and Do It: Conclusions and Implications

> I couldn't do that [effectively advocate for combined approaches] until I knew both languages. It took me years to learn them though. You can't just get up in the morning and do it, and it takes a little time. (Judy, 2010, interview).

In this project, I have sought to answer three questions: First, why do so few organizations address both partner violence and substance use? Second, what allows some organizations to address both issues when most do not? Last, when organizations address both partner violence and substance use, what strategies do they use? My response to these questions is shaped by field theory and, specifically, work on mechanisms for field overlap (Evans & Kay, 2008) and hybridity strategies (Skelcher & Smith, 2015). This analysis draws on multiple kinds of data—qualitative and quantitative, interview and archival—collected between 2010 and 2014 and focused geographically on metropolitan Chicago.

Conflicting Logics Limit Hybrid Approaches

Metropolitan Chicago represents, in many ways, a best-case scenario for the development of combined approaches to partner violence and substance use. The region supports a comparatively large population of organizations working on each issue. There have also been state-level efforts that supported combined approaches to partner violence and substance use. Notably, the Domestic Violence/Substance Use Interdisciplinary Taskforce, which was active

between the late 1990s and early 2000s. This effort produced two iterations of the best practices manual *Safety and Sobriety*, a series of conferences, and a pilot project focused on combined services for partner violence victims with substance use issues. Thus, I began the project expecting to find a relative abundance of hybrid organizations—organizations that combine attention to partner violence and substance use—and variation in the strategies through which they accomplish this work.

Instead, I found the overall incidence of hybrid organizations to be remarkably low. Only 15% of partner violence and substance use organizations in Metropolitan Chicago address both issues—a lower rate than has been found in previous studies of substance use organizations. While this difference may be definitional, in part, it underscores the extent to which the logics of these fields remain incompatible and the importance of asking not just whether organizations have both services but also how—and if—they combine them.

I have argued that, despite the well-documented need at the individual level and the existence of frameworks for combined attention, few organizations address both substance use and partner violence because of conflicts between field-level logics. Foundational to the substance use field is the notion that alcohol and other drug use is a disease. While the locus of the disease model has shifted in the last fifty years from a spiritual, family issue to a more individual model based in the brain, the overall trajectory of the field has been towards increased medicalization. The partner violence field, which emerged in the late 1970s from feminist social movements, was largely—albeit not entirely—oriented against traditionally therapeutic approaches that rooted partner violence in family systems. Over time, the partner violence field expanded alongside the criminal justice system. These logics in turn shape the kind of regulations, resources, and networks that exist in both fields. As both fields became more

professionalized and as the result of efforts like the Domestic Violence/Substance Use Interdisciplinary Taskforce, the degree of discordance between their logics has decreased as the networks in each field have increasingly overlapped. Barriers remain, however, in terms of resources and regulations. While its possible, for analytic purposes, to separate out each of these four elements—logics, regulations, resources, and networks—I contend that, in problem-centered fields like the substance use and partner violence fields, the specifics of regulations, resources, and networks are overdetermined by the fields' logics.

This is particularly clear when considering combined services for partner violence perpetrators—partner abuse intervention programs (PAIP)—with substance use needs. Most organizations with services for both partner violence and substance use offer both PAIP and outpatient substance use services. However, these programs remain separate tracks within the same larger organization with few connections between them that might facilitate genuinely combined attention to both issues. This is the result of simultaneous resource concordance and regulatory barriers than can be explained only with recourse to incompatibilities between broader discursive logics.

As the partner violence field emerged, it focused primarily on supporting partner violence victims. Services for perpetrators were, at best, secondary and whether they should be provided at all, by whom, and with what funding were sources of controversy both nationally and in metropolitan Chicago. Because there was little dedicated funding for partner violence services and funds that were available went to victim services organizations, PAIPs were often founded in social services organizations otherwise outside the partner violence field. Reliant on referral mechanisms from the court system, much like outpatient substance use programs, there exists a concordance between networks for PAIP and substance use programs. When the state began

regulating PAIP through licensure in the early 1990s, the content of the resulting State Protocol and subsequent Administrative Rule reflected the field's dominant, feminist logic. They remain constrained in terms of funding and prohibited from using approaches that inadequately separate partner violence form substance use.

Convergences Allow for Some Forms of Hybridity

Despite these incompatibilities, some organizations do address both partner violence and substance use. My results show that hybrids organizations are significantly more common in the partner violence field than in the substance use field. This is largely the result of differences in the logic of resource allocation across the two fields. In the partner violence field, most funding is disbursed through a grant-based model. While grant funds are earmarked for specific purposes and organizations must report on how funds are used and collect and report back data on service utilization patterns, funds are not tightly tied to participant outcomes. In contrast, in the substance use field, funding models have shifted from a grant-based model in the 1980s to a fee-for-service model mirroring Medicaid reimbursement in the 1990s under managed care to, more recently, a system of performance based contracts. In a performance-based system, the receipt of funds is tightly coupled with the production of specific outcomes for participants. This has created disincentives for work with participants with complex needs, like co-occurring substance use and partner violence victimization or perpetration.

Organizations with services for trauma are significantly more likely than those without trauma services to address both partner violence and substance use. As I describe in Chapter IV, trauma-informed care emerged from the mental health field. In Metropolitan Chicago, implementation of trauma-informed frameworks was championed by the National Center on Domestic Violence, Trauma & Mental Health, which is based in Chicago. Trauma informed care

provides a discursive framework that largely resonates with the core logics in both the partner violence and substance use fields. Empowerment is a central value in the partner violence field *and* in trauma informed models of care; trauma informed care is also evidence-based and, emerging from mental health, fits within the broader professionalization projects that have unfolded in the substance use field in recent decades. Significantly, there have also been funds available from SAMHSA—the primary federal-level internal governance unit within the substance use field—to implement these approaches, thus counterbalancing some of the limitations imposed under the current system of performance-based contracts. Trauma-informed care, however promising as a means for addressing both partner violence and substance use, is employed by a minority of organizations in both fields: only 14% of substance use organizations and 11% of partner violence organizations have dedicated services for survivors of trauma.

Consistent with expectations based on studies of field position and innovation, hybrid organizations are also more likely to occupy middle to low status positions in their primary fields. This underscores previous findings (Leblebici et al., 1991; Philips & Zuckerman, 2001; Rao, Monin & Durand, 2005), which suggest that lower status organizations may be more likely to adopt new and potentially controversial practices because they have little to lose in doing so and, potentially, much to gain should the innovation prove adaptive.

Status Shapes the Form Hybridity Takes

In addition to considering relationships between field position and hybridity, I also examine the strategies through which organizations incorporate attention to partner violence and substance use. I find that most organizations with services for partner violence and substance use—nearly 75% of hybrids—adhere to what Skelcher and Smith (2014) describe as segmented form. While both services exist within the same larger organization, there are few internal

connections between them. In some cases, as with Metropolitan Charities, participants in the partner violence program (in this case, a PAIP) are more often referred to a separate organization when substance use needs are identified rather than the Metropolitan Charities' own substance use division.

More substantive approaches to hybridity, such as segregation, assimilation, and blending, are far less common—used by only 4% of organizations in the region—and are more prevalent among organizations occupying higher status positions in their primary field. This illustrates the systematic incompatibility of logics between the two fields. Effective bridging work appears to require a comparatively high level of resources. It also suggests the need for greater attention to not just whether organizations offer services for both partner violence and substance use but *how* they do this work. Further research is needed—using a variety of cases—to explore relationships between organizational status and innovation. My findings suggest that organizational status shapes not just the likelihood that organizations engage in innovative practices but also the form that innovation takes.

Implications and Future Directions

This project contributes to organizational theory in two ways. First, my research demonstrates the need for greater attention to innovation strategies. Considering how organizations within a particularly field innovate and how innovation strategies are patterned by field position may lead to a more nuanced understanding of field dynamics. This research finds that innovation is more common amongst low status organizations and that low and high status organizations approach the same innovation using different strategies. In future projects, I will tease apart relationships between organizational position and hybridity strategies to more fully identify the characteristics of organizations employing each of these approaches.

Second, I show how convergences and divergences between different aspects of fields—following Evans and Kay (2008), rules, resources, networks, and frames—interact to bring otherwise separate fields into a state of overlap. Early in their histories, tensions between frameworks or overall logics precluded the development of combined approaches despite low-level network overlap in service populations (e.g., participants involved in both kinds of services). Internal governance units in both fields fostered the development of network overlap and worked to minimize frame discordance through shared trainings in the early 1980s and, later, coalition-building around women's substance use treatment. The concentration of regulatory authority over both fields in the Department of Human Services in the early 1990s was the catalyst for bridging the fields through the Domestic Violence/Substance Use Interdisciplinary Taskforce. With rulemaking centered within the same larger state department, it became possible to create shared frameworks like the *Safety and Sobriety Manual* and resources like the pilot project. These, in turn, further reduced tensions between frameworks and overall tension in networks. Yet, even as the Taskforce brought these fields together, funding shifts were underway within the substance use field stemming from its deepening medicalization, that effectively blocked subsequent efforts. Thus, embedded in this discussion of field overlap is a larger point about the primacy of logics in shaping field dynamics. While it is analytically possible to isolate each of these four elements, the reasons why particular rules exist, resources have value, or networks matter necessarily reference and are determined by the field's logic.

At this juncture, barriers to combined approaches are the indirect result of field-level logics, appearing primarily in the form of resource and regulatory incompatibilities. Supporting the development of combined approaches to partner violence and substance use requires attention to the complex patterns of tension and potential alliance across fields. My research

indicates that until and unless funding models in the substance use field are broadened to focus on a more holistic set of outcomes, combined approaches will remain quite rare. The current system of performance based contracting is a disincentive for taking on complex issues. Combined attention to partner violence perpetration and substance use—currently blocked by regulations in the partner violence field—will require a careful balancing of the best evidence on combining attention to both issues within a larger proto-feminist framework.

The production of robust evidence surrounding the benefits of combined approaches—and the specific strategies through which they are produced—is a necessary first step. Available evidence suggests that there are benefits to addressing partner violence and substance use in a combined intervention and increased risks to addressing them separately. It is not clear which strategy for combining attention to both issues produces the highest level of benefits or what level of attention to both issues is ideal. What is clear, from other recent studies (and this dissertation), is that most partner violence and substance use organizations do little to address the other issue.

More research is needed to identify the specific practices conducive to combined partner violence and substance use programs. While I have identified services for trauma as associated with hybridity, particularly for substance use organizations, future studies should explore how substance use organizations are implementing trauma-informed frameworks as well as how trauma-informed care is perceived by practitioners in both fields. Such research must be careful to attend to issues of current safety as well as past trauma.

While organizations may not be able to alter funding and regulatory practices at the field level, they can adopt policies and practices that support combined approaches. Findings here assert the need for victim services organizations to revisit medication policies for shelter

residents and age and gender restrictions for accompanying children. Substance use program—particularly residential programs—might explore ways of expanding supports for parents. While children whose parents are receiving residential substance use treatment are not eligible for school bussing services under laws related to homelessness, there may be other creative solutions at the local level.

For organizations seeking to enhance their capacity to address both issues even in the absence of field-level support for doing so, two potential avenues emerge. First, the kinds of staff exchanges used by organizations employing a segregated strategy appear to partly circumvent the barriers imposed by resource incompatibility. In segregated hybrids, a staff person from a substance use organization carries a caseload drawn from a partner violence organization (and vice versa). Thus, each organization can remain specialized and in compliance with its larger funding and regulatory requirements while participants receive ongoing support for both issues. Organizations might also make use of existing training opportunities in the other field as a way of enhancing capacity at minimal costs. These local and small-scale strategies, however, must not be pursued at the expense of the broader policy changes necessary to ensure all partner violence and substance use organizations can provide a basic level of support to participants affected by both issues.

Addressing partner violence and substance use together seems insurmountably difficult. Despite decades of effort, few organizations do so in any meaningful way. Indeed, one "can't just get up in the morning and do it, and it takes a little time." In highlighting areas of convergence as well as lingering tensions and incompatibilities, this project provides a roadmap for policy makers and practitioners committed to putting in that time.

APPENDIX A

Data Collection Instruments

Semi-Structured Interview Schedule, 2010 interviews

Thank you for agreeing to speak with me.

This study focuses on the relationship between the social service systems for domestic violence and substance abuse. I am interested in learning about the histories of each of these two areas individually and, specifically, how policy developments at the federal, state and local level have shaped practices on the ground and major similarities and differences in approaches and programs between organizations, whether historically, currently, or both. There are no right or wrong answers. Basically, I'm hoping to hear your reflections on the work you and others have done and your perceptions of where the field is today. Do you have any questions before we begin?

History of involvement with [IPV or AOD][70]

- When did you first become involved in work on [IPV or AOD]?
    - At that time, what kinds of services were being offered?
    - What were the major approaches/treatment modalities?
    - What sorts of distinctions were made between programs? (Probe for alcohol versus drugs, different treatment modalities on the AOD side; survivors versus batterers, clinical versus feminist on the IPV side)

[70] In earlier iterations of the project, I used the terms intimate partner violence (IPV) and alcohol and other drug use (AOD) rather than the slightly pithier partner violence and substance use used in the completed dissertation.

- What other types of work related to [IPV or AOD] have you been involved in since then?

- How would you describe the work you do now?

    - (Probe for role of respondent's home organizations vis-à-vis direct service organizations—policy, funding, training, etc.)

Field characteristics

- How does your organization define [IPV or AOD]? In your estimation, how widely shared is this definition amongst organizations like yours (e.g. government, funders, etc.)? Amongst direct service organizations?

- How would you describe the goals of [IPV or AOD] interventions?

    - For your organization?

    - For the organizations with whom your organization works?

- How would you characterize the relationship between [IPV or AOD] policy and the evidence base? Between [IPV or AOD] services and the evidence base?

- To what extent do you see academic research informing policy and/or service for [IPV and AOD]?

- To what extent do you feel research should inform policy and/or services?

Field history

- In the years you've been involved in the [AOD or IPV] field, what would you describe as the major turning points in terms of policy or funding?
    - (For each change, probe for respondent's sense of why this occurred, whether it was positive or negative.)

- What changes have you seen in terms of services and/or approaches?

- What changes have you observed in terms of the types of training and/or credentials organizations value?

Local context

- What, if anything, do you see as unique about the way [AOD or IPV] is addressed in metro Chicago? Is Chicago a microcosm for what is going on at the federal level or are there unique sources of influence here?

    - (If respondent identifies unique features, probe for ideas about why field has developed this way in this context.)

- What do you feel service providers in this community do particularly well? What is more challenging?

Current assessment of the field

- Thinking about all the organizations involved in direct work on [IPV or AOD] in this area, what do you see as the most common services?
    - The most common approaches/treatment modalities?
    - What kinds of services are offered?
- What do you see as major sources of difference between programs? (Probe for alcohol versus drugs, different treatment modalities on the AOD side; survivors versus batterers, clinical versus feminist on the IPV side)
- In you estimation, what are the necessary ingredients for successful [IPV / AOD] service provision?
- How would you describe the cutting-edge of service provision for [IPV or AOD]?
    - What services are provided?

- On what body of research or philosophical position are these based?

- What, if anything, would you like to see done differently? What, if any, changes are necessary in terms of policy, funding, training, to make this possible?

Closing the Interview

- I realize this has been a long interview and I want to thank you for the time that you've taken to share your experiences. I have a few final questions for you – just basic demographic information. But before I get to those, is there anything else you think I should know about either the history or current state of [IPV or AOD] service provision?

- Is there anything you thought I would ask about that I haven't covered?

    - How would you have answered that question?

Demographics

- What is your current age?
- How long have you worked in the [AOD or IPV] field?
- How do you identify in terms of gender?
- How do you identify in terms of race? Ethnicity?
- Current or most recent organizational affiliation (e.g. government office, nongovernmental organization, college or university)

Again, thanks for taking the time to speak with me! Though we're finished with the interview, I'm hoping that you might be willing to help me locate additional participants – individuals with experience in advocacy, policy or services for either IPV or AOD who might be regarded as experts in either area. In order to get a variety of perspectives, I'm hoping you might think of some people who are likely to have a different perspective on these topics than your own.

If you could, would you be willing to either give me the names of three such individuals or pass along some basic information about the study to them so that they may contact me directly?

Semi-Structured Interview Guide, 2011 Organizational Interviews

Interviewee Information

- What is your current title? How long have you worked in this position? How long have you worked in your organization?

Organizational History and Founding Circumstances [Will build from a timeline developed from the organization's website]

- When was your organization officially founded?
- What was your organization's founding mission or focus?
- When your organization was first began its work, how did you determine priorities for programming and activities?
    - Who was involved in these decisions?
    - What steps were involved?
    - Where did you look for inspiration in terms of models and approaches?
- What were your initial sources of revenue?
- Reflecting back on your organization's history, what would you describe as turning points?
    - How has your organization responded to shifts in regulations, funding, and intervention technologies with the [IPV or AOD] field?

- What changes have had the most impact on your organization?

Goals, Activities, and Programs [Request an organizational chart before interview, use to structure discussion]

- What are your organization's major programs or departments?
    - How many FTE staff people work in each of these?
    - With approximately how many participants does each work in a given year?
    - How are your various programs or departments funded?
    - Which positions entail direct work with individuals affected by IPV/AOD and which do not?
- Which programs or activities came first and which were added later?
    - How did you decide to expand to these areas in particular?
    - What, if any, challenges did you face as you expanded?
    - Has your organization ever engaged in work on [IPV or AOD], whether in-house or through a collaborative relationship with another organization?
        - How did you start doing this work? Who was involved in getting it started?
        - What changes did you need to make to facilitate this work?
        - What would you describe as successes? Challenges?
- How are programs and activities distributed across locations?

- For each major program area:
    - What models, approaches, or activities are included? How/have these changed over time?

    - How do you monitor and/or evaluate your organization's activities?

        - What outcomes you are seeking for participants?

        - Which of these activities were initiated

Service Participants and Organizational Pathways

- How do potential participants initially come into contact with your organization?

    - What are some common referral sources?

- Is eligibility for participation in your organizations programs limited in any way (e.g., geographically, by screening/assessment criteria)?

- How do you determine whether a potential participant is a good fit for your organization?

    - What issues or areas are included in screening?

- How would you describe your organization's participants in terms of age, gender, race/ethnicity and income?

- In addition to your organization's primary mission, what other issues do program participants commonly experience?

    - Which of these issues do you address in-house and which do you refer out? What other organizations to you tend to refer to?
- Who is involved in decisions about the specific programs in which a participant will be involved?

    - Are there time limits on participation in your organization's programs? Rules for participants?

Community Context

- What other organizations or types of organizations do you work with in the community?

    - With whom do you have formal agreements or contracts?

    - Whom do you work with, but less formally?

- How do you see your organization's work as different from others in your community also engaged in work on [IPV or AOD]? How is it similar?

    - What is your relationship with these other organizations like?

        - To what extent do you compete for participants? Funding? Staff?

        - To what extent do you cooperate on systems advocacy? Raising public awareness?

    - In the time that you've been involved in this work, what changes have you observed amongst other [IPV or AOD] organizations?

Organizational Structure and Characteristics

- How are decisions about which programs to provide made? Which approaches are used within specific programs? Sources of funding? Program expansion?
    - To what extent do staff working directly with participants have input into these? Participants themselves?

- How do you foster relationship building within the organization? Do you, for example, have agency-wide meetings? Trainings or in-service? Social events?

- When hiring new staff, what do you look for in terms of credentials? Experience? Personal capacities?

    - Probe for differences between departments, changes over time.

- Does your organization use volunteers?

    - What in what capacities do they work?

- Does your organization use student interns?

    - From what programs are interns drawn?

    - What in what capacities do they work?

- To what extent do you encourage former participants to stay involved the organization, whether as staff or as volunteers?

Funding and Revenue

- What are your organization's major sources of revenue?

    - How are the various programs/departments funded?

- How has this changed over time?

- Are some programs or activities easier to support than others? Which areas of work a particularly tough (or easy) sell?

    - Are there particular approaches, populations or activities for which you wish more funding was available?

Community Involvement

- To what extent does your organization engage in educational work in the community?

    - In what sorts of venues does this occur? Do you seek these opportunities out or do they find you?

    - What topics or issues do you address?

- Do you provide training or consultation to others? On what issues?

- Does your organization engage in any public fundraising activities? If so, what are these like? Who do you target?

- To what extent has your organization taken part in coalitions or community-level collaborative work? Around what issues?

Interview Topics, 2014 Interviews

Study Title: The Cultural Logics of Intimate Partner Violence and Substance Abuse Service Provision
IRB Number: HUM00038408
Principal Investigator: Elizabeth Marie Armstrong, MSW; Joint Doctoral Program in Social Work and Sociology; University of Michigan; 1080 S. University Ave., 3680 SSWB; Ann Arbor, MI 48109-1106; Phone 734-223-0593; email elimarie@umich.edu

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Study Purpose
This study focuses on the relationship between the social service systems for intimate partner violence (IPV) and alcohol and other drug use (AOD). You have been asked to participate because of your expertise related to IPV and/or AOD. I am interested in learning about the histories of each of these two areas individually and, specifically, how policy developments at the federal, state and local level have shaped practices on the ground and major similarities and differences in approaches and programs between organizations, whether historically, currently, or both. I am also interested in understanding how the work of specific organizations or agencies fits within this broader context.

Basic Information
- Length of time in IPV or AOD field
- Current position
- Your organization's work on IPV, AOD, and other related issues
    - Relationship to direct service organizations (e.g., IPV shelters, PAIPs, AOD treatment organizations)
    - Relationship to other policy and/or training organizations focused on IPV and/or AOD
- How your organizations defines IPV or AOD (depending on primary focus)
- Your organization's goals related to IPV or AOD

Field History
- Turning points in terms of policy and funding
    - Impacts on organizational activities in metro Chicago
- Turning points with regards to services and broad approaches
- Changes in types and/or levels of training or credentialing within the field
- Current debates and/or points of tension within the field
- Major areas of consensus

Reflections on Current Services Landscape
- Most common activities, services and approaches
- Categories of organizations within your primary field (IPV or AOD) and differences between them

- Perceptions of the relationship between research on IPV or AOD and policy and practice
- Hallmarks of high quality work on IPV/AOD
- Special considerations about IPV or AOD work in metro Chicago
- Factors facilitating work on both IPV and AOD
    - Macro level (policy, funding)
    - Organizational level

Semi-Structured Interview Schedule, 2014 Interviews

Thank you for agreeing to speak with me.

This study focuses on the relationship between the social service systems for domestic violence and substance abuse. I am interested in learning about the histories of each of these two areas individually and, specifically, how policy developments at the federal, state and local level have shaped practices on the ground and major similarities and differences in approaches and programs between organizations, whether historically, currently, or both. There are no right or wrong answers. Basically, I'm hoping to hear your reflections on the work you and others have done and your perceptions of where the field is today. Do you have any questions before we begin?

History of involvement with [IPV or AOD]

- When did you first become involved in work on [IPV or AOD]?
    - At that time, what kinds of services were being offered?
    - What were the major approaches/treatment modalities?
    - What sorts of distinctions were made between programs? (Probe for alcohol versus drugs, different treatment modalities on the AOD side; survivors versus batterers, clinical versus feminist on the IPV side)
- What other types of work related to [IPV or AOD] have you been involved in since then?
- How would you describe the work you do now?
    - (Probe for role of respondent's home organizations vis-à-vis direct service organizations—policy, funding, training, etc.)

Field characteristics

- How does your organization define [IPV or AOD]? In your estimation, how widely shared is this definition amongst organizations like yours (e.g. government, funders, etc.)? Amongst direct service organizations?

- How would you describe the goals of [IPV or AOD] interventions?

    - For your organization?

    - For the organizations with whom your organization works?

- How would you characterize the relationship between [IPV or AOD] policy and the evidence base? Between [IPV or AOD] services and the evidence base?

    - To what extent do you see academic research informing policy and/or service for [IPV and AOD]?

    - To what extent do you feel research should inform policy and/or services?

Field history

- In the years you've been involved in the [AOD or IPV] field, what would you describe as the major turning points in terms of policy or funding?

- (For each change, probe for respondent's sense of why this occurred, whether it was positive or negative.)

- What changes have you seen in terms of services and/or approaches?

- What changes have you observed in terms of the types of training and/or credentials organizations value?

Local context

- What, if anything, do you see as unique about the way [AOD or IPV] is addressed in metro Chicago? Is Chicago a microcosm for what is going on at the federal level or are there unique sources of influence here?

    - (If respondent identifies unique features, probe for ideas about why field has developed this way in this context.)

- What do you feel service providers in this community do particularly well? What is more challenging?

Current assessment of the field

- Thinking about all the organizations involved in direct work on [IPV or AOD] in this area, what do you see as the most common services?

- The most common approaches/treatment modalities?

- What kinds of services are offered?

- What do you see as major sources of difference between programs? (Probe for alcohol versus drugs, different treatment modalities on the AOD side; survivors versus batterers, clinical versus feminist on the IPV side)

- In you estimation, what are the necessary ingredients for successful [IPV / AOD] service provision?

- How would you describe the cutting-edge of service provision for [IPV or AOD]?

    - What services are provided?

    - On what body of research or philosophical position are these based?

- What, if anything, would you like to see done differently? What, if any, changes are necessary in terms of policy, funding, training, to make this possible?

Closing the Interview

- I realize this has been a long interview and I want to thank you for the time that you've taken to share your experiences. I have a few final questions for you – just basic

demographic information. But before I get to those, is there anything else you think I should know about either the history or current state of [IPV or AOD] service provision?

- Is there anything you thought I would ask about that I haven't covered?
    - How would you have answered that question?

Demographics

- What is your current age?
- How long have you worked in the [AOD or IPV] field?
- How do you identify in terms of gender?
- How do you identify in terms of race? Ethnicity?
- Current or most recent organizational affiliation (e.g. government office, nongovernmental organization, college or university)

Again, thanks for taking the time to speak with me! Though we're finished with the interview, I'm hoping that you might be willing to help me locate additional participants – individuals with experience in advocacy, policy or services for either IPV or AOD who might be regarded as experts in either area. In order to get a variety of perspectives, I'm hoping you might think of some people who are likely to have a different perspective on these topics than your own.

If you could, would you be willing to either give me the names of three such individuals or pass along some basic information about the study to them so that they may contact me directly?

APPENDIX B

Constructing the Dataset

This appendix details the construction of the Metropolitan Chicago Substance Use and Partner Violence Services Fields Database. Section II describes the process of identifying relevant organizations. Section III describes the implications of identifying organizations in this manner. Section IV describes additional sources of data used to construct the database.

Creating an Organizational Census

Organizations are understood to be members of either the substance use or partner violence field insofar as they are formally tasked with or identified as providers of interventions for either of these issues. For both fields, existing organizational directories—whether maintained by the state or federal government or by an issue-specific membership organization—were used to develop an organizational census for both field. To be included, organizations had to have one more site located within the 9-county Chicago MSA. Because much of the information used the build the database is at the site level (e.g., separate listings for each location of a single organization), the database includes data at both the site and organizational levels.

For organizations in the substance use field, state licensure was used as a primary indicator of field membership. To become a licensed substance use provider, organizations must apply and gain state approval to provide a predetermined set of services (e.g., detox, intensive outpatient) based on the American Society of Addiction Medicine's Patient Placement Criteria. The Department of Human Services' (DHS) Division of Alcohol and Substance Abuse's (DASA)

Directory of Substance Abuse Facilities by Illinois County and City (2012) provided an initial list of all licensed substance use organizations (255 organizations or 83.3% of substance use organizations in the final dataset). It includes entries for all substance abuse facilities licensed by DASA for fiscal year 2012, with individual locations often (though not always) listed separately. All listings for all sites of all organizations in the Chicago MSA were included. Additional organizations were identified using the Substance Abuse and Mental Health Services Administration's (SAMHSA) online *Treatment Locator,* which contains results from the 2011 National Survey of Substance Abuse Treatment Services (219, 71.6%).[71] The list is updated regularly, with new facilities added monthly and information on existing listings updated weekly if programs inform SAMHSA of changes. Individual sites were often also listed separately in this second data source. Lists for the nine counties of interest were downloaded in January 2013. Organizations—and sites—were added to the directory if they appeared on either list. 63.4% (194) substance use organizations had one or more sites listed in both directories; thus, each provided a number of unique organizations.[72] A small number of organizations (n=4) listed by DASA were excluded because they appeared either to be private practitioners or to not provide direct services. Shared fields—organization name, address, phone number—between the DASA directory and Treatment Locator were used to consolidate entries and cull duplicate sites from the census.

Organizations within the partner violence field were identified from three sources. DHS maintains a list of licensed Partner Abuse Intervention Programs (PAIPs). The 2012 directory

[71] In the second half of 2012, data in the Treatment Locator would have been drawn from the N-SSATS wave completed in March 2011 and made publically available in April 2012. The list is updated regularly, with new facilities added monthly and information on existing listings updated weekly if programs inform SAMHSA of changes. Records for each of the 9 counties in the target region were downloaded in January 2013.

[72] 19.9% (61) were listed in the DASA Directory but not the Treatment Locator; 8.2% (25) were listed in the Treatment Locator but not the DASA Directory.

was used to generate a list of partner violence programs focused on batterers (38.3% of the total population of partner violence organizations or 23 organization). Partner violence programs for survivors are not licensed or, as a class, regulated by the state. A census of these organizations was compiled from membership lists for two organizations: The Illinois Coalition Against Domestic Violence (38.3%, 23) and the Chicago Metro Battered Women's Network (46.7%, 28). The latter includes a number of organizations that provide non-residential partner violence services for survivors (e.g., legal services, counseling) and/or related services (e.g. supervised visitation and exchange programs). 18 organizations (30% of PV population) were listed in multiple directories; thus, each provided a number of unique organizations.[73]

A final strategy for identifying field members involved searching for organizations in the target region with any of several field-relevant designations on the National Taxonomy for Exempt Entities (NTEE)[74]. These searches were conducted after the initial database had been assembled such that the search strategy was guided by patterns in the existing dataset. For the 119 nonprofit organizations in the substance use field, I pooled primary, secondary and tertiary designations. This produced a set of 192 designations. The three most common F20 (Alcohol, Drug and Substance Abuse, Dependency Prevention and Treatment), F21 (Alcohol, Drug Abuse

[73] 8.3% (5) were listed by ILCADV only; 23.3% (14) were listed by CMBWN only; 26.7% (16) were listed by ILDHS only. 25% (15) partner violence organizations were listed in two directories; 5.0% (3) were listed in all three. 11.7% (7) were identified by a search in GuideStar.

[74] NTEE stands for National Taxonomy of Exempt Entities. This is a formal system for classifying nonprofit organizations on the basis of their substantive focus. Prior to 2007, designations are assigned IRS "determination specialists" at the time of an organization's filing for nonprofit status. Beginning in 2007, the assignment of codes was automated using a system developed by the National Center for Charitable Statistics. Organizations are assigned up to three designations (primary, secondary and tertiary), though many have only one. For the purposes of identifying field-relevant designations, I looked for patterns across all three designations (e.g., when considering the proportion of organizations with a given designation, I did not distinguish between primary, secondary, and tertiary designations.

(Prevention Only)), F22 (Alcohol, Drug Abuse (Treatment Only)).[75] These designations accounted for 33.8% (68) of the total 192, while the next largest designation category—E22 (Hospital (General))—accounted for only 9.8%.

Searching for the four substance use specific NTEE designation in the Chicago MSA (using GuideStar) yielded profiles for 217 organizations, 39 of which were already included in the database. For each of these organizations, I examined its GuideStar profile and searched for its website, which was used to fill in information on its services and characteristics. Using this strategy, an additional 26 substance use organizations were added to the database (8.5% of total substance use organizations). Of the remaining organizations, 90 appear to be defunct (e.g., they had not filed a 990 for 3 or more consecutive years), 38 did not appear to provide direct services,[76] 15 were not included due to a lack of information about their activities,[77] and 6 were not relevant (miscoded).[78]

For the 48 nonprofit partner violence organizations, combining primary, secondary and tertiary designations yielded a total of 95 designations. Of these, the most common were P43 (Family Violence Shelters and Services) (26.3%, 24), P62 (Victims' Services) (6.3%, 6), and

[75] When searching by NTEE designation, I also searched for organizations with the designation F50 (Addictive Disorders, N.E.C.). Although only one organization in the initial census had this designation, I included it because of its obvious relevance to the field. However, no additional organizations with this designation were added to the dataset.

[76] These included prevention programs focused on public education, 12-step meeting houses and/or area service offices, and fundraising organizations.

[77] For these 15 organizations, minimal information was available in GuideStar (often only basic information about location, NTEE designation, and income) and they did not have websites. Two had founding dates in 2013 and thus were not included in the other substance use data sources. Essentially, there was nothing to code about their characteristics and practices.

[78] Some organizations appeared to have been genuinely miscoded. For example, one organization, though designated as an F20, was clearly an assisted living facility for older adults. The NTEE designations used to locate partner violence organizations are not specific to this type of work. Thus, organizations designated as P43 that focused on sheltering abused and neglected adolescents and where there was no evidence of services related to intimate partner violence were not included.

P99 (Human Services - Multipurpose and Other N.E.C.) (5.3%, 5). Although the P99 category was the third most frequent amongst organizations in the partner violence field, it was not used to identify additional organizations because of its vagueness.[79] Instead, I used the fourth most common designation—171 (Spouse Abuse, Prevention of) (3.2%, 3)—which was clearly relevant to the partner violence field. Cumulatively, these three designations accounted for 34.7% (33) of NTEE designations in the partner violence field. Searching for the partner violence - specific NTEE designations yielded profiles for 71 organizations, 19 of which were already in the database. Seven additional organizations were added to the database. Of the remaining organizations, 27 appeared to be defunct, 10 were not included due to a lack of information on their activities, and 8 were not relevant to the project (miscoded or no evidence of direct services for partner violence).

Additional Datasources

Entries in the directories used to identify relevant organizations provided limited information about their characteristics and activities. Thus, it became necessary to seek out additional sources of data for information on founding dates, ownership status, size, mission, and, in some cases, services.

Organizational websites

When organizations were added to the database, I searched for their website using the organization's name and approximate location in Google (e.g., "Healthcare Alternative Systems Chicago IL"). I quickly read through the website to make sure it was the correct organization. I then looked for information on founding date and mission and added these to the database. When

[79] A preliminary search in GuideStar indicated the existence of 387 organizations with this designation in the Chicago MSA. Reading through each GuideStar profile and website for these organizations to determine their relevance would have been prohibitively time consuming and likely would have produced few new, relevant organizations.

a URL was available but the page was disabled, I searched for the URL in the Wayback Machine (an internet archive).[80] Websites—whether active, current pages or archived versions—were located for 72.0% (278) organizations.

While the state- or federally-maintained directories include some information on organizational practices, the directories of partner violence organizations focused on survivors did not. Thus, reading organizational websites allowed me to code for categories of partner violence service provision (based on knowledge of modal practices in the partner violence field).

As the limitations of data in the organizational directories became clear, I began archiving organizational websites for in-depth, qualitative analysis using a web capture program (FireShot Pro).[81] For each organizational website, I visited and captured the main page and all relevant subpages, including but not limited to pages on the organization's history, mission, services, events, locations and sponsors. For organizations whose webpages were only accessible via Wayback Machine, the banner indicating the date the page was archived is maintained. For extremely large organizations—such as community hospitals and health systems—where many services were not relevant to the goals of the project, I read and archived only pages related to the organization's focus and history (e.g., pages under the "About Us" heading), locations, and relevant services (e.g., all pages under the "Behavioral Health" heading).

GuideStar profiles

This database contains information from nonprofit organization's IRS filings (from form 990 filings). Information for several fiscal years is available, but only 2012 data was used. I searched for each organization by name and approximate location (Illinois) to determine ownership status. For nonprofits, GuideStar was used to ascertain founding date, total revenue, number of

[80] Wayback Machine. http://archive.org/web/
[81] Fireshot. http://getfireshot.com/

employees, and mission (when this could not be collected from organizational websites). GuideStar profiles were available—albeit with some missing information—for 51.9% (200) organizations.

When searches revealed multiple listings for organizations, I attempted to match these to individual sites by address and entered information accordingly. When this was not possible, I read through profiles to identify the primary site for the organization (the largest in terms of revenue and/or number of employees or as designated on the organization's website) and entered this information into the database.

ReferenceUSA profiles

ReferenceUSA is a database housing information on over 14 billion businesses in the United States. According to the ReferenceUSA website, information is compiled from a variety of sources and verified through a phone call to each business. ReferenceUSA profiles were used to ascertain organizations' SIC and NAICS codes, total revenue, number of employees, and founding date.

Information from ReferenceUSA was integrated after the initial census was conducted. To locate records for organizations, I (or a research assistant) searched for each location of each organization by name and approximate location (Illinois), then by phone number, then by street address. This generated a list of all of the organization's sites, which were cross-referenced with the existing dataset. Information on individual sites in ReferenceUSA not yet in the dataset was included by aggregating site-level data into a composite organizational-level entry below. Records were located for one or more sites of 83.4% (322) of the dataset.

Information from ReferenceUSA was downloaded by two trained research assistants and housed in Excel spreadsheets. I reviewed this information (including spot checking entries in

ReferenceUSA) and created organization-level consolidated variables for SIC and NAICS codes, total revenue, number of employees, and founding date, as detailed in Appendix B.

Consolidating Cases

The DASA directory, Treatment Locator, DHS PAIP list and ILCADV directory all contained basic identifying information for organizations such as their addresses, phone numbers, and website URLs. This information was included in the database and was used to cull duplicate entries.

As noted above, for many organizations, directory listings and database records are at the site level. During the first pass of data entry (from the DASA directory, Treatment Locator, DHS PAIP directory, ILCADV and CMBWN member lists), all listed sites were added to the database. This allowed for preservation of unique service profiles when information at this level of detail was available.[82] When organizational websites, GuideStar profiles, or ReferenceUSA records contained site-specific information, this is reflected in coding.

A number of variables—such as mission, founding date and, in many cases, number of employees and revenue[83]—are most meaningful at the organizational level. Moreover, site-specific information on services was available in a minority of organizations. To compensate for these issues, for each organization with multiple sites, I created a "consolidated case" summarizing information across sites. Each consolidated case includes several variables on number of locations (described below) and homogenizing services across sites (e.g., an organization offering a PAIP at one site is, as a consolidated case, treated as always having a

[82] This was often the case for substance use organizations but rarely for partner violence organizations.

[83] When number of employees and revenue were coded from GuideStar or websites, they were at the organizational level (except in the rare cases where organizations had multiple GuideStar records). To generate organizational level measures from site-level records in ReferenceUSA, one of two approaches was employed. When it was clear that one record represented the organization as a whole (based on cross-referencing with the organization's webpage and/or GuideStar profile), that information was privileged. Otherwise, values for each site were summed to create organizational-level values.

PAIP). Thus, for consolidated cases, services variables indicate an organization's capacity to engage in a particular type of work, regardless of where, within the organization, such work occurs.

Variable Creation

This section provides information on the processes by which variables within the database were coded from primary source materials, including directory listings, entries in existing databases (GuideStar and ReferenceUSA), and organizational websites.

Founding Date

When an organization listed its founding date on its website, this was added to the database. In the event that multiple dates were mentioned in the narrative about its founding, the earliest date was prioritized. This means that in some cases there is a discrepancy between the founding date listed for the organization and the year in which the organization officially began operations. When information on founding dates was not available on organizational websites, this information was taken from either GuideStar or ReferenceUSA to the extent that it was available. For a small number of nonprofit organizations, GuideStar listed a ruling year (the year in which the organization received its tax-exempt status) but not a founding date. In these instances, ruling year was treated as founding date.

To minimize missing data, approximate founding dates were estimated for organizations whose website provided some indication of the year in which they were established (e.g., "Our organization has been providing substance abuse treatment for over 20 years"). If the webpage indicated a date it had last been updated, the duration of service provide was subtracted from that date to generate an approximate founding date. Absent information on webpage updates, the

current year (2013) was used. Using these strategies, founding dates were coded from 64.8% (250) of the dataset.

Indicators of Size

The database includes several variables meant as proxies for size, which were coded from GuideStar, ReferenceUSA and/or organizational websites.

Number of sites. I included information on both the number of sites within the Chicago MSA and the number of sites in Illinois. Both reflect the tally of discrete locations (separate addresses) listed in each data source. For very large organizations (e.g., health systems), numbers should be regarded as approximate as it was not possible to count, by hand, each separate location. Organizations were taken at their word when their websites claimed "over 400 locations in Chicagoland."

Locations nationally. This is a dichotomous variable indicating whether or not an organization has sites outside of Illinois, as indicated on the organization's website.

Number of employees. For nonprofit organizations, this was coded from GuideStar profiles, to the extent that it was available. For for profit organizations or those missing this field in GuideStar, number of employees was estimated by tallying the number of employees associated with each site in Reference USA.[84] Organizational websites served as an additional source of data (and validity check) for the subset of organizations that included information on the number of employees (e.g., "our interdisciplinary team of 15") or a list of employees. Employee lists were treated as complete—and tallied to code for number of employees—when they included staff in administrative or clerical as well as para- or professional roles.

[84] This may be problematic in that at least for some organizations in that there are discrepancies between the measure of number of employees constructed from ReferenceUSA and the measure coded from GuideStar. When this occurred, I generally favored the information in GuideStar.

Total revenue. For nonprofit organizations, this was coded from GuideStar profiles, when it was listed. For for profit organizations or those missing this field in GuideStar, total revenue was coded from ReferenceUSA. This was a straightforward process for organizations with a single site or in cases where the primary site was clearly identified. For organizations with multiple sites, I downloaded and compared revenue information for all available records. If one site appeared to be primary based on its total revenue and number of employees, this was used for the consolidated case. Otherwise, site level information was added to reach the organizational level.

Ownership Status. Organizations without GuideStar profiles were listed as for profit entities unless their websites or names indicated otherwise.[85]

Services. For the substance use organizations, the DASA directory provided identifying information for each organization as well as basic information on categories of service provision. In addition to each organization/site's address, phone number, program contact, the directory specifies the types of licensure held by each, which offers some insights into the types of services available. Additional information on organizational foci, services, and characteristics was coded from entries in the SAMHSA Treatment Locator. These categories of variables include provider focus, services provided, type of care, special programs/groups offered, forms of payment accepted, payment assistance, and special language services. Each category was treated as a dichotomous variable (provided/not provided). Organizations not listed by DASA were coded as missing (not listed by DASA).

An initial set of codes for partner violence services was developed from knowledge of modal practices in the partner violence field. These include categories for PAIP services and

[85] For example, an organization whose names or website indicated that they were part of a country health department, probation department or the Veterans' Services Administration were listed as public.

services for partner violence victims. Because neither ILCADV or CMBWN directories contain information about the services offered by each organization, I read the websites of partner violence organizations carefully to code for the partner violence services variables. In the process, I kept notes on each organization.

Coding organizational services was an iterative process. As I read organizational webpages for the initial coding pass, I began to notice other areas in which a substantial number of organizations identified with either or both fields provided services as well as patterns of services for issues other than partner violence or substance use common within each field. This includes services like anger management, couples counseling, and trauma work. I constructed an initial list and began coding for these services as well, ultimately circling back and returning to the websites of all organizations in the dataset during the archiving/case consolidation process.

A separate challenge arose in coding for the provision of partner violence services with substance use organizations and vice versa. Often, the level of detail available in descriptions of these services on organizational website precluded coding using the original set of services variables for either issue. I created a more general set of codes for both substance use and partner violence services to address this issue and recoded accordingly.

Focal Issues. NTEE designations were entered verbatim from GuideStar profiles. I then generated frequencies for the three NTEE designation variables (primary, secondary and tertiary designations) and clustered them into eleven thematic categories, partially coterminous with the clusters reflected in the taxonomy itself. Resultant categories are based on similarities in focus across the included designations and, in some cases, knowledge of common patterns of service provision. For example, three designations specific to rape, sexual assault, or abuse/neglect are included in the "partner violence specific" category—itself more accurately a "family violence"

category—because services for these issues are often (though not always) provided alongside services for partner violence. However, the designation P62 Victims' Services is not, despite a large portion of partner violence organizations employing this designation. That designation was included, instead, in a "criminal justice" category that includes formal legal services as well as services for currently or formerly incarcerated individuals and their families. See Table C.i for coding scheme.

SIC and NAICS codes were taken from site-level data in Reference USA. In many cases, there were differences in codes across sites. To create organizational-level measures, I downloaded primary, secondary, and tertiary codes for all sites of each organizations for which records were available. If one site was designated as the organizations headquarters, the codes for this location were used in the consolidated case. In cases were a primary site could not be identified, I pool all available designations for the organization, taking into account whether they were primary, secondary or tertiary. I coded the most common designation as primary, the second most as secondary, and the third most common as tertiary. When codes were "tied" for any of these positions, all contenders were entered.

Coding across the three taxonomies helped limit the amount of missing data. It also partially compensated for weaknesses associated with any individual taxonomy. For example, the NAICS and SIC have very few codes related to domestic violence while the NTEE has several. To develop a set of general codes to use across the three taxonomies, I first read through all designations for all organizations. I then considered thematic clusters within them and developed an initial set of 11 codes (10 substantive categories and 1 "other" category) and definitions for them. (See Table 1 for categories, definitions, and the designations coded within them.) I then returned to the list of designations and attempted to fit each designation within one

of these 11 categories, refining definitions as I went. Finally, I revised the "other" category and, noticing several codes related to religious identity, created a twelfth, "faith-based category."

Mission Statements. Organizational mission statements were taken verbatim from organizational websites. To the extent that they were not available—or not easily identifiable—they were taken from GuideStar records (when available). When both sources contained a mission statement, the version on the webpage was prioritized if there were discrepancies between the two. This was based on the assumption that websites—unlike 990 filings—represent public position-takings and are likely more carefully curated by organizational representatives.

Primary Field. Organizations were assigned a primary field based on the directory through which they were identified. Organizations identified through the DASA or SAMHSA directories or by searching for substance use -specific NTEE designations were coded as substance use organizations, those identified through the DHS listing of PAIPs, ILCADV or CMBW member lists, or searching for partner violence -specific NTEE designations were listed as partner violence organizations. The small number of organizations listed in both one of the substance use sources and one of the partner violence sources were coded as "SU&PV" from the outset—an early, if imperfect, measure of integration. This measure, "Primary Field," is at the site level. Only locations in which both partner violence and substance use services are provided are coded as SU&PV. An organization with both substance use and partner violence services, but in separate locations, would not be coded as SU&PV.

Hybridity. Through reading and coding organizational websites, it quickly began clear that many organizations that are not cross-licensed provide services for both partner violence and substance use. As noted above, I created a general set of codes for both partner violence and substance use services to capture these types of work, given the vagueness of many

organizational descriptions (e.g., mention of a domestic violence prevention program would be coded within the "PV other" category; mention of counseling for substance use with no indication of it being on an individual or group basis would be coded within the "SU other" category). Organizations were coded as providing services when there was any evidence of service specialization around this issue. For example, a website describing individual counseling services that lists domestic violence (the dominant terminology in the field) or substance abuse alongside depression, anxiety, relationship difficulties, and stress as possible topics for individual counseling was not coded as providing services for partner violence or substance use. However, an organization that lists domestic violence or substance abuse counseling as its own service category would be coded as providing these services.

Table B.i – Focal Issue Categories, Inclusion Rules, and Designations

Focal issue	Inclusion rule	NTEE Designations	SIC Codes	NAICS Codes
Substance use	Designation reflects substantive focus on alcohol and other drug use or addiction treatment, including testing.	• F20 (Alcohol, Drug and Substance Abuse, Dependency Prevention and Treatment) • F21 (Alcohol, Drug Abuse (Prevention Only)) • F22 (Alcohol, Drug Abuse (Treatment Only) • F50 (Addictive Disorders N.E.C.)	• Alcoholism information & Treatment Ctrs • Drug Abuse & Addiction Info & Treatment • Counselors-Drug Alcohol & Nicotine • Drug Detection Service & Equipment	• Psychiatric & Substance Abuse Hospitals
Partner Violence	Designation reflects substantive focus on family violence, spouse abuse or a closely related issue (sexual assault, rape, abuse/neglect/exploitation).	• F42 (Rape Victim Services) • I70 (Protection Against and Prevention of Neglect, Abuse, Exploitation) • I71 (Spouse Abuse, Prevention of) • I73 (Sexual Abuse, Prevention of) • P43 (Family Violence Shelters and Services)	• Domestic Abuse Information & Treatment • Sexual Assault & Abuse Crisis Services	--
Education/vocational training	Designation emphasizes educational or job training activities for adults.	• B60 (Adult, Continuing Education) • B80 (Student Services and Organizations)	• Employment Agencies & Opportunities • Schools	• Employment Placement Agencies • Vocational

		• B90 (Educational Services and Schools - Other) • B99 (Education N.E.C.) • J20 (Employment Procurement Assistance and Job Training) • J30 (Vocational Rehabilitation (includes Job Training and Employment for Disabled and Elderly)) • J99 (Employment, Job Related N.E.C.)	• Educational Cooperative Organizations	Rehabilitation Services • Educational Support Services
Health	Designations reflect provision of primary health care (including laboratories and equipment), but not mental/behavioral health or substance abuse.	• E20 (Hospitals and Primary Medical Care Facilities) • E21 (Community Health Systems) • E22 (Hospital (General)) • E30 (Health Treatment Facilities (Primarily Outpatient)) • E99 (Health - General and Rehabilitative N.E.C.)	• Physicians & Surgeons • Hospitals • Laboratories-Medical • Physical Therapy Equipment (Whls) • Handicapped Equipment-Sales & Svc (Whls) • Rehabilitation Services • Clinics • Medical & Surgical Svc Organizations	• Offices Of Physicians (Exc Mental Health Specs) • General Medical & Surgical Hospitals • Medical Laboratories • All Other Misc Ambulatory Health Care Services • Offices Of All Other Misc Health Practitioners • Freestanding

			• Health Services • Handicapped Equipment-Sales & Svc (Whls) • Physical Therapy Equipment (Whls) • Aids & Hiv Counseling Svc • Health Care Instruction • County Government-Public Health Programs • Nurses & Nurses' Registries	Ambulatory Surgical & Emergency Ctrs • Medical, Dental/Hospital Equip/Supls Mrchnt Whlsrs • Administration Of Public Health Programs
Mental health	Designations emphasis mental health (as distinct from substance abuse or primary health care) or the provision of counseling services, whether on a long-term or emergency basis.	• F30 (Mental Health Treatment) • F31 (Psychiatric, Mental Health Hospital) • F32 (Community Mental Health Center) • F33 (Group Home, Residential Treatment Facility - Mental Health Related) • F40 (Hot Line, Crisis Intervention) • F60 (Counseling Support Groups)	• Counseling services • Crisis Intervention Service • Marriage & Family Counselors • Employee Assistance Programs • Mental Health Services • Psychiatric	• Offices-Mental Health Practitioners (Exc Physcns)

		• F70 (Mental Health Disorders) • P46 (Family Counseling, Marriage Counseling) • P40 (Family Services) • P50 (Personal Social Services)	Social Workers • Stress Management Services • Psychologists • Social Workers • Gambling Abuse/Addiction Info/Treatment	
Criminal justice	Designations focus on individuals in, transitioning from custody or their families and/or the provision of formal legal services.	• I20 (Crime Prevention N.E.C.) • I21 (Delinquency Prevention) • I31 (Transitional Care, Half-Way House for Offenders/Ex-Offenders) • I40 (Rehabilitation Services for Offenders) • I43 (Services to Prisoners/Families) • I80 (Legal Services) • I83 (Public Interest Law/Litigation) • P62 (Victim Services)	• Attorneys • County Government-Courts • Probation Services • Legal Clinics	• Offices Of Lawyers • Courts • Parole Offices & Probation Offices
Housing/homelessness	Designations emphasize services for homeless individuals, including shelter and affordable (permanent) housing.	• L20 (Housing Development, Construction, Management) • L40 (Low-Cost Temporary Housing	• Homeless Shelters	• Temporary Shelters

		(includes Youth Hostels)) • L41 (Temporary Shelter For the Homeless) • L80 (Other Housing Support Services) • L99 (Other Housing, Shelter N.E.C.) • P70 (Residential, Custodial Care (Group Home)) • P85 (Homeless Services/Centers)		
Human service/multi-service organizations	Designations reflect involvement in a range of services focused on individuals, families, or communities.	• P20 (Human Service Organizations) • P24 (Salvation Army) • P28 (Neighborhood Center, Settlement House) • P99 (Human Services - Multipurpose and Other N.E.C.) • S80 (Community Service Clubs (Kiwanis, Lions, Jaycees, etc.))	• Social Service & Welfare Organizations • Human Services Organizations • City Government-Social & Human Resources • Government-Individual/Family Social Svcs	• Other Social Advocacy Organizations • Other Individual & Family Services
Children's services	Designations emphasize children and/or youth as the target population, whether services relate to direct care, education, or other activities.	• B21 (Kindergarten, Nursery Schools, Preschool, Early Admissions) • O50 (Youth Development Programs)	• Family & Children Services • Child Care Service	• Child & Youth Services • Child Day Care Services • Elementary &

		• O54 (Citizenship Programs, Youth Development) • O99 (Other Youth Development N.E.C.) • P30 (Children's and Youth Services) • P33 (Child Day Care)	• Youth Organizations & Centers	Secondary Schools
Identity-based services	Emphasis on services/rights for specific groups and/or communities	• P01 (Alliance/Advocacy Organizations) • P80 (Services to Promote the Independence of Specific Populations) • P84 (Ethnic/Immigrant Services) • R20 (Civil Rights, Advocacy for Specific Groups) • R22 (Minority Rights) • R24 (Women's Rights) • R26 (Lesbian/Gay Rights) • R30 (Intergroup/Race Relations) • S21 (Community Coalitions) • S31 (Urban, Community)	--	• Human Rights Organizations • Services For The Elderly/Persons With Disabilities
Faith-based		• X20 (Christian) • X22 (Roman Catholic)	• Religious Organizations	• Religious Organizations

			Churches	• Missions •
Other		• K30 (Food Service, Free Food Distribution Programs) • N67 (Swimming, Water Recreation) • P29 (Thrift Shops) • P81 (Senior Centers/Services) • T20 (Private Grantmaking Foundations) • T70 (Fund Raising Organizations That Cross Categories includes Community Funds/Trusts and Federated Giving Programs) e.g. United Way) • T31 (Community Foundations) • Z99 (Unknown)	• E-Commerce • Hypnotists • Organizations • Thrift Shops • Associations • Charitable Institutions • Business Management Consultants • Nonclassified Establishments • Federal Government Contractors • Social Security Counselors & Reps • Packaging Service • Property Maintenance • Social Security Counselors & Reps • Home Centers • Charitable Institutions • Hypnotists • Insurance	• Electronic Shopping • Marketing Consulting Services • Unclassified Establishments • All Other Specialty Trade Contractors • Home Centers • Insurance Agencies & Brokerages • Business Associations • Process, Physical Distr/Logistics Consulting Svcs • Legislative Bodies • Used Merchandise Stores • Ambulance Services • All Other Support Services

			• Associations • Business Management Consultants • Government Offices-County • Rescue Squad • Non-Profit Organizations • Business Services NEC • Fire Damage Restoration • Taxicabs & Transportation Service • Trucking • Driving Instruction	• Residential Remodelers • Taxi Service • Specialized Freight (Exc Used Gds) Trcking Lng-Dist • Automobile Driving Schools

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