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Barriers and Facilitators of Implementing Integrated Interventions for Alcohol Misuse and Intimate Partner Violence: A Qualitative Examination with Diverse Experts

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Abstract

Introduction: Alcohol misuse and intimate partner violence (IPV) are major public health burdens with a well-established association. These problems are difficult to remedy individually and can exacerbate one another, compounding treatment complexity. Though scarce, integrated alcohol misuse and IPV treatments exist. Yet implementation remains inadequate. Thus, the current study applied the Consolidated Framework for Implementation Research (CFIR) to examine barriers and facilitators of implementing such integrated treatments.

Methods: Through purposive sampling, we conducted in-depth interviews with diverse IPV and alcohol treatment experts (n = 21) whose ages ranged from 27 to 72 and who averaged 17 years of experience working in alcohol and IPV treatment. The research team conducted analysis using Grounded Theory Methods.

Results: Experts identified barriers and facilitators for integrated treatment of alcohol misuse and IPV in three CFIR domains: intervention, inner setting and provider, and outer setting.

Conclusions: Leveraging the facilitators of implementation and addressing barriers at multiple organizational and intervention levels through an implementation science lens can help to close the research-to-practice gap for integratively treating alcohol misuse and IPV.

Keywords

Alcohol use; Consolidated Framework for Implementation Research; Domestic violence; Implementation science; Treatment

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Author Statement

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1. Introduction

Alcohol misuse poses a major public health burden. It is the seventh leading risk factor for death and disability (Griswold et al., 2018) and results in three million (5.3%) deaths worldwide each year (World Health Organization, 2019). Alcohol misuse has held a consistently strong association with the perpetration of intimate partner violence (IPV), which has impacted almost one-third of women and girls globally (Abramsky et al., 2011; World Health Organization, 2016). This relation holds true among diverse populations globally, as demonstrated in metaanalyses (Duke et al., 2018) and multicountry samples (Graham et al., 2010; Shamu et al., 2011). IPV severity is likewise associated with alcohol consumption across contexts (Graham et al., 2010). Drinking to intoxication, or binge drinking, has presented a stronger association with IPV (Graham et al., 2010). While some dispute has persisted about whether alcohol can be considered a causal contributor to IPV, some studies have established a temporal quality with acute intoxication often preceding IPV (de Bruijn & de Graaf, 2016; Foran & O'Leary, 2008; Katerndahl et al., 2014). Men who have participated in substance use treatment and subsequently relapse are two to three times more likely to perpetrate IPV (Murphy & Ting, 2010). Moreover, almost half of the men who perpetrate IPV following batterer treatment programs have endorsed consuming alcohol within three hours prior to the battering incident (Stuart et al., 2009).

Mechanisms that explain alcohol's relation with IPV highlight pharmacologically induced cognitive impairments in executive functioning. These impairments relate to perceptual biases (Giancola, 2000), such as hostile attribution biases (Clements & Schumacher, 2010); compromised problem solving ability (Sayette et al., 1993); decreased inhibition, potentially mediated by cognitive ability level (Hoaken et al., 1998); heightened risk-taking (Fromme et al., 1997); and escalated discordant relational interactions due to the actual alcohol misuse (Fulu & Heise, 2015). Furthermore, cultural scripts and expectancies that alcohol increases aggression can inform subsequent behavior (Quigley & Kenneth, 2006). Finally, neural mechanisms underlie individual differences in arousal for anger, wherein alcohol decreases restraint (Alia-Klein et al., 2018; Denson et al., 2018).

1.1 Treatment

While psychotherapy could be helpful in reducing alcohol misuse and IPV (Klostermann, 2006), and recommendations exist to address both problems dually (Crane et al., 2014), evidence-based treatments targeting both problems are surprisingly scarce. Some couple-based treatments that focused on alcohol reduction in one partner have also shown reductions in IPV, though pre-post evaluations observed these effects and not randomized controlled trials (Wilson et al., 2014). At the individual level, however, Substance Abuse and Domestic Violence Cognitive-Behavioral Therapy (SADV-CBT) that targets alcohol use and IPV has shown reductions in both, although these differences were not evident at follow-up (Easton et al., 2018). Another study supported the use of CBT to reduce alcohol and IPV and suggested that even including one session focused on IPV in a substance use treatment can be effective (Kraanen et al., 2013).

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1.2 The current study

Despite decades of research that has established the association between alcohol misuse and IPV, evidence for efficacious integrated treatments is nascent. We know even less about barriers and facilitators of implementing such treatments. A study conducted in seven alcohol treatment facilities found that 44% of men who sought treatment for alcohol misuse also reported having perpetrated IPV in the past year (Schumacher et al., 2003). Only 17% of these men received referrals for IPV reduction treatment and only 13% of those who received referrals sought additional treatment (Schumacher et al., 2003). Thus, the field neeeds improved understanding of barriers and facilitators at the service level.

We used the Consolidated Framework for Implementation Research (CFIR) to understand barriers and facilitators due to its ability to address widespread public health problems, such as alcohol use and IPV, and capture interactions and underlying sociopolitical vulnerabilities that give rise to these problems (Damschroder et al., 2009; Means et al., 2020). The CFIR can help to determine optimal intervention adaptation and implementation strategies that consider multiple domains and processes. It compiles multi-source cross-disciplinary implementation constructs to examine barriers and facilitators in five domains: intervention (adaptability, fit); provider (training, attitudes); inner setting (organizational culture, structure); outer setting (sociopolitical context); and implementation process (planning, engaging, executing, evaluating). The guiding research question in our study was, What are the barriers and facilitators of integratively treating alcohol misuse and IPV according to the CFIR?

2. Methods

2.1 Procedures

The Institutional Review Board at Columbia University deemed this study exempt from ethical review due to its focus on implementation and not on ascertaining personal experiences. A female research assistant, trained by the first author, interviewed global academic and programmatic IPV experts (n = 21) from the United States (including indigenous researchers in low-resource settings), Canada, Australia, and Uganda. The study employed purposive selection and snowball sampling techniques to identify racially and ethnically diverse experts in alcohol misuse and IPV across professional settings. The research assistant and lead author identified experts online and through word-of-mouth through academic publications, affiliation with organizations that deliver IPV and/or alcohol misuse programming, and previous collaborations (e.g., in Uganda) with the first author who conducts research to reduce the global mental health treatment gap (authors blinded). Contact with key informant professionals was initiated through email. The research assistant gave interested participants a link to an online consent form that explained the goals of the study, procedures, risks, and benefits on the Qualtrics research data collection platform. The link asked participants to provide three times and dates of availability. The research assistant conducted interviews via phone or Skype and audio recorded them. She flexibly followed a semi-structured interview guide that asked about the list of topics. Interviewed professionals were asked to identify other experts. The interviews transpired for approximately 30–45 minutes. The interviewer documented notes of impressions, main themes, and any patterns.

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Interviews continued until no new main themes were evident to interviewer (i.e., saturation occurred). A transcription service then professionally transcribed the audio recordings.

2.2 Data analysis

Two separate research assistants coded transcripts using Grounded Theory methods (Strauss & Corbin, 1990). First, they independently open-coded transcripts line-by-line, assigning an inductive code to encompass meaning, and developing a codebook. They then inductively coded transcripts using Dedoose, an online qualitative coding software. The research assistants resolved coding disparities via conversation with the lead author and discussing the codes until the group reached consensus. The team then organized open codes into conceptual themes and generated overarching axial codes. Next, they deductively organized axial codes according to the domains of the CFIR where possible.

3. Results

Experts (n=21) were ages 27 to 72 ($M = 49.10$, $SD = 13.41$). They averaged 17 years of experience working in alcohol and IPV treatment. The majority (76%) identified as female. Twenty-nine percent identified as Black, 14% as American Indian/Alaska Native, and 10% as Latinx. Less than half (33%) identified as Caucasian/White. Experts mostly held leadership positions (directing, managing, or coordinating a program) (43%). Others held academic positions that involved research and teaching (38%). Remaining roles were training specialist, advocate, and clinician. The professional settings for these roles were academic (38%), nonprofit organizations (24%), and state/government programs (24%).

Respondents echoed that alcohol misuse and IPV are similar in many respects, beyond co-occurrence. Some believed the relationship to be causal with alcohol worsening IPV. Others pointed out that the problems are not always comorbid and cautioned that alcohol misuse should not excuse violence. Experts identified barriers and facilitators to implementation of an integrated treatment that falls into three primary CFIR domains (Table 1). The intervention domain encompassed barriers (e.g., intervention effectiveness and engagement of men) and facilitators of an integrated intervention. Respondents mostly highlighted provider attitudes and approaches as potential barriers and facilitators in the inner setting domain. Outer setting components were issues of related community-based services, policy, and social norms.

3.1 Intervention

Many respondents highlighted the importance of integrated treatment and agreed that integrated treatment offers several advantages over siloed options. However, participants repeatedly bemoaned the lack of effective interventions that target one or both problems. An academic explained some of the challenges in addressing both problems.

> It is difficult to find a program that has any degree of effectiveness because of the combination of the two problems. One, the combination of the fact of the substance abuse problem, which is a very difficult problem to treat and is a chronic condition, plus the inability to control aggressions and so on that results in domestic violence. So you have basically two really difficult behaviors to try to deal with… we only

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> have partial knowledge about why they exist and they are multifactorial, so there is not really one single cause that you can go manipulate and help the individuals in treatment. Um, so it's a very difficult issue to deal with, and so far we have not been successful to develop an intervention that is really effective. (Male Academic)

Another academic explained that the definition of successful treatment varies according to the problem. He said, "There are different rubrics that folks use around success. So one of them is, you know, in substance use, relapse is seen as a part of the process towards sobriety. In domestic violence, relapse is not. It's seen as failure" (Male Clinician). Programs' evaluations of success vary by construct and program. At the same time, treatment must be tailored to individuals since treatment cannot be "one-size-fits-all" (Male Clinician). For example, durable change is slow to achieve, and many studies evaluate progress with relatively brief time durations. Experts concurred that change is slow and incremental with the goal being to change risk and protective factors. Small changes in a person or community constitute successes (Female State Program Professional).

Many participants also considered who the intervention should target. Several participants, for instance, acknowledged the importance of engaging men in integrated interventions for alcohol use and IPV. According to a mental health program director, males are not "showing up" for existing interventions and interventions should focus on male involvement. Another program manager proposed a potential reason for lack of male involvement. She said, "Men in this context naturally have low health-seeking behavior… they do not consider alcohol a health problem… it doesn't come as a priority" (Female Program Manager). The emphasis on men contrasts with most existing IPV interventions that experts described. Placing an emphasis on men could be difficult because, according to one expert, many believe that resources should be directed toward impacted women and families (Male Clinician). To offset the potential barrier of engaging men, experts noted that male perpetrators often expessed motivation to be good husbands and fathers and working with perpetrators is a significant part of developing healthy families. One expert's work focused on increasing the health of children and families by increasing the health of men (Male Clinician). This expert reflected, "I was hearing from the men about their own struggles around wanting to be good fathers, but not being sure how they're going to do that" (Male Clinician). Building on men's desires to be good fathers may catalyze motivation for change.

3.2 Inner setting and provider

Experts considered language, attitudes, and beliefs important contributors to the relationship between the provider and patient and essential for effective care. Participants expressed that adopting a nonjudgmental stance toward patients can facilitate engagement, a central challenge in integrated treatment. A female academic shared a model example of language that emphasizes behavior as opposed to person attributes: "We don't think you're a bad person. This is just some bad habits you've picked up over time, and we're going to fix it." Experts acknowledged the importance of leveraging and discussing the strengths of the person and situation, offering hope, and cultivating a "setting where [the victim and perpetrator] can both feel comfortable to let their guard down and be people" (Female Academic). Overall, "the provider has to be trained on the right language to use as well as the supports that are in the community." Teaching the clinician that "adversity is something

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that can make you stronger… that you can find something good in every situation and person" (Female State Program Professional) is important as well. Experts concurred that providers must understand their own biases toward alcohol misuse and IPV and intervene in a way that is acceptable to patients with consideration of diverse cultural beliefs and perspectives. As a training specialist highlighted, it is critical to be "making sure they have someone there [at the organization] that they can identify with… making sure that language is not a barrier… that atmosphere isn't a barrier" (Female State Program Professional). Many staff are not trained on all facets that intersect with IPV and alcohol (Female State Program Professional).

Streamlined services at the organizational level can help to mitigate common challenges to accessing treatment, such as finding childcare, transportation, and navigating work schedules. These challenges amplified for patients participating in two programs and can impede feasibility of accessing care. According to participants, integrated treatment helped to streamline services so patients were not having to attend two programs at different sites. An academic observed the following benefits to patients resulting from an integrated treatment.

> The benefit of integration is one of simple convenience for the individual… we know from the literature that cross-referrals, treating them separately at different sites, doesn't work. The clients are barely motivated to address these two programs, these two problems at different facilities… they have childcare issues… these behaviors play off of each other. And they can't really be treated alone in a vacuum. (Female Researcher)

3.3 Outer setting

Participants provided multiple ideas for improved prevention that would extend reach beyond the clinic and into the community. Leveraging life transition points, such as fatherhood and marriage, emerged as one such idea. An expert described one program that works:

> With a lot of newlywed couples, and newlywed time period is a critical time period. But we've had a little bit of trouble figuring out how we might want to intervene to reduce heavy drinking, like, right from the beginning of a marriage. (Male Academic)

Marriage classes and counseling are frequently offered through churches, but not everyone takes them. The expert academic proposed providing brief interventions as people apply for marriage licenses but recognized the interventions might not work, and it could be challenging to secure ongoing funding for them (Male Academic).

As a mental health program director asserted, progress gained in treatment might be undone due to community-based influences. A mental health program director explained, "The biggest challenge that there is is that people live within the community and the community has all these things." However, barriers existed for people getting into shelters or other services to escape their toxic environment. In shelters, for example, people are not allowed to use substances, so "people who are alcoholics or can't or haven't decided to stop, they're

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not accessing those services" (State Program Professional). This problem is especially prevalent for victims who use drinking as a coping mechanism. A particularly effective model integrated childcare and head-start for children in the same building as substance treatment to educate children and prevent the cycles of IPV as well as providing help to mothers (Female Non-Profit Director).

Some experts ran community-based programming and cited their benefits. They thought that effectiveness of these interventions stemmed from inciting change in multiple areas, including changing social norms and beliefs. For example, before implementation, women thought "that beating them was okay—their spouses beating them was okay" (Female Religious Organization Professional). Additionally, by creating community change, more accountability exists for perpetrators and actors of the legal system.

> They [the community] do not have adequate services… the police request for some money for going to arrest the perpetrator. Because the police is also not well-facilitated." In this way, "just the preventative interventions are not sufficient. (Female Religious Organization Professional[h])

One program had success by working with church leaders to integrate messages into sermons and visit families struggling with IPV and alcohol, providing "counseling and also guidance… and education on the rights of women and the need to honor women in all decision-making processes" (Female Religious Organization Professional).

These community-based programs included addressing social norms to decrease inequity in relationships and facilitate community conversations about IPV. These efforts include altering roles of respective partners in how decisions are made (unilaterally or jointly) and creating more respect and autonomy (Female Religious Organization Professional). Empowering women economically can be another important consideration (Male Academic). Other programming professionals noted the importance of engaging with cultural institutions to unpack gender dynamics and IPV (Female Non-Profit Director). However, especially in diverse countries like the United States:

> The challenge is, there's never enough of people representative of one culture for us to be able to do a whole lot with an individual culture. We end up having to talk about culture not at a superficial level but at a very abstract level, and to try to help clients relate it to their own experiences… so we don't get to talk about it at the level of specificity that I would like, and that's in part because there's never enough of one group represented in an individual night for us to do anything with. (Female Academic)

Other community-based challenges included ensuring law enforcement sufficiently addressed crimes. In addition to family, participants frequently cited the legal system as a reason for change. However, experts questioned the latter, and perpetrators may not be in treatment voluntarily (Male Academic). In this way, treatment serves as a method "to control the level of their addiction." However, alcohol users quickly escalate use in the absence of having learned improved coping mechanisms (Male Academic). This challenges treatment and emphasizes the need for life-long supports, connections, and "…factors for stability. And that includes housing and employment… what improves their quality of life. What

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gives people passion" (Female State Program Professional). Some have found success in lobbying for IPV policy and districtwide action plans for allocation of resources (Female Religious Organization Professional) since legal regulations may lack sufficient funding to enact and funding for IPV and alcohol is challenging to secure (Female Academic).

4. Discussion

To our knowledge, this is the first study to apply an implementation framework to examine experts' perceptions of barriers and facilitators of integrated treatment for alcohol misuse and IPV. Experts identified several challenges and possibilities within the intervention, inner setting and provider, and outer setting domains of the CFIR. At the intervention level, experts noted the potential intergenerational impact as an opportunity, although engagement of men and intervention effectiveness were challenges. To offset challenges to treatment engagement, provider attitudes and practices were central. In the outer setting, community norms and socialization could impact alcohol use and IPV. Thus, providers recommended integration programming into community services and policy.

One of the perceived main benefits of integrated treatment was the importance of preventing cycles of violence and alcohol misuse in future generations. A meta analysis of 127 studies found that witnessing IPV as children was associated with perpetration (stronger effect for men) and victimization (stronger effect for women) as adults (Smith-Marek et al., 2015). The effects for perpetration later in life were significantly stronger than effects for victimization. However, witnessing severe IPV was more likely to be associated with alcohol misuse as an adult for women than for men (Smith et al., 2010). Another meta analysis of 391 studies that examined risk markers for physical IPV victimization showed that while alcohol use was a stronger risk factor for IPV victimization among women, witnessing IPV as a child was associated with IPV victimization for men and women equivalently (Spencer et al., 2019).

While experts agreed that integrated treatment has benefits such as prevention of violence, they frequently mentioned a lack of effective integrated treatments. This lack could be due to operationalization of success and timing of measurement, as experts said. Providers may view relapses in alcohol recovery as indicative of a normal component of progress. Contrastingly, interventionists and researchers may perceive relapses in violence as failure. Some studies have investigated whether treatment approaches for alcohol misuse, such as Motivational Interviewing and Relapse Prevention methods, could be applied to treatment of IPV (Mbilinyi et al., 2011). Implementation protocols should also consider screening for both problems incorporated across settings. One study found that while most family planning clinics screened for IPV (92%), fewer (17%) screened for alcohol and substance use, and only 1% discussed IPV and alcohol as intersecting problems (Hill et al., 2021).

Another central question raised by participants was who should be the main recipient of the intervention. Respondents agreed that a significant challenge was the engagement of men due to stigmatization and lack of health care seeking among this population. Men have shown lower proclivity to engage in health- and mental health–seeking behaviors than women, a disparity that is associated with gender role socialization. Traditional masculine

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norms correspond with expectations for men to be self-sufficient, invulnerable, and stoic (Center for Substance Abuse Treatment, 2013). Health care–seeking behaviors are closely connected to men's understanding of masculinities, internalized masculine norms (Staiger et al., 2020), and perceptions of gender roles (Novak et al., 2019). As such, the help-seeking and treatment process can seem threatening to men and they are likely to seek treatment due to external pressures from work, family, or the criminal justice system (especially in the case for IPV). Practitioners should be aware of these masculine norms, assess how they are internalized, and note that men with adherence to more traditional gender roles may be hesitant to enter treatment (Center for Substance Abuse Treatment, 2013). An intersectional analysis, for example, elucidated that variations existed among men, with White, gay, single, and older men more likely to seek mental health care than other men (MC et al., 2018).

A potential method for overcoming engagement issues at the inner setting and provider level is to use a strength-based approach and train providers to recognize their own biases and stigma about these problems to adopt a nonjudgmental attitude. Other literature has emphasized provider bias by demonstrating the incongruence between IPV survivors' preferred method of intervention and that of providers. Survivors often opted for short-term methods they could implement individually to reduce harm (e.g., avoidance of the abuser while inebriated), while providers often favored more extreme solutions such as leaving permanently (Wood et al., 2019). Moreover, 36% of at-risk drinkers in the United States perceived stigma from care providers (Fortney et al., 2004) and alcohol dependence has repeatedly been found to be stigmatized around the world (Hammarlund et al., 2018; Ronzani et al., 2009). However, the degree to which stigma has impacted care-seeking decisions has varied widely across studies (Hammarlund et al., 2018). Concealable stigmatized identities, such as alcohol misuse and IPV victimization, are correlated with worse mental, physical, and behavioral outcomes, especially if providers react negatively to disclosure (Quinn & Earnshaw, 2013). Studies have recommended education programs for providers to decrease bias and stigma (Maghsoudi, 2018; Ronzani et al., 2009). Other suggestions have included targeting misperceptions and strengthening social support networks (Fortney et al., 2004). Finally, to better support individuals experiencing IPV and alcohol misuse, integration of survivors' preferences with experts' suggestions is crucial (Wood et al., 2019).

Another unique component of both alcohol misuse and IPV from other mental disorders is their strong grounding in social and community norms. Experts frequently spoke about the importance of going outside of a traditional clinic setting to work with communities, especially when referencing reducing IPV. However, they cited challenges associated with a lack of integrated programming, such as shelters excluding those who use substances. Yet changing beliefs and norms, holding perpetrators accountable, and utilizing existing community supports can facilitate improvement. Taking advantage of existing infrastructure like marriage certification, to screen and intervene early in relationships, could be a cost-effective, wide-reaching, and lasting way to create change. Additionally, experts concurred that policy-level implementation was an integral component of change at the community level. However, a review of studies found that taxation on alcohol and community-level regulation (e.g., alcohol outlet density) had little association with reduction of IPV (Wilson et al., 2014), suggesting that laws and policy regarding IPV should be more targeted.

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Our findings should be interpreted within the limitations of the study. First, we focused our sample to include experts (researchers/academics, programming directors) to understand barriers and facilitators from a provider perspective. Thus, this study does not represent patient perspectives, which could have added insight about acceptability of an integrated treatment for alcohol and IPV. Next, while we purposively strived to interview a diverse group of experts who were working with diverse populations, as one participant noted, many intersections of diversity exist. We were likely unable to capture perspectives from those representing all possibilities of diverse intersections. Our findings, therefore, may not be transferable to all populations and settings. Finally, we did not develop our semi-structured interview guide to specifically inquire about all domains of the CFIR. This method was intentional to allow experts to talk about implementation in ways that were most meaningful to them.

5. Conclusion

Guided by the Consolidated Framework of Implementation Research, we found barriers and facilitators at the intervention, inner setting and provider, and outer setting domains for integrated treatment of alcohol misuse and IPV. At the intervention level, main facilitators were positive impacts on families and children and prevention of future violence. Barriers were lack of effective integrated interventions, engagement of men, and lack of understanding about causal mechanisms. Provider biases and ineffective communication were challenges in the inner setting that could be offset by adopting a strengths-based approach that was not stigmatizing. Outer setting services were not always effective or accessible to those who experienced both problems. However, increasing community awareness, advocating for policy changes and resources, and integrating interventions into community programs facilitated implementation. Integrated treatment of correlated problems can benefit health systems and patients. Leveraging the facilitators of implementation and addressing barriers at multiple organizational and intervention levels can help to close the research-to-practice gap for conditions that co-occur with alcohol misuse.

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Highlights

- Twenty-one experts were interviewed to understand barriers and facilitators to implementing.
- Integrated treatment was examined with application of an implementation framework.
- Barriers and facilitators were identified at the intervention, inner, and outer setting domains.

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Table 1

Barriers and Facilitators of Integrated Alcohol and Intimate Partner Violence Treatment

CFIR Domain	Barriers	Facilitators/Benefits
Intervention	male engagement; identifying effective interventions; both target problems difficult to change; lack of understanding about causal mechanisms	prevention of future violence; may prevent relapse in one problem in case of relapse of related problem; positive impact on families and children
Inner Setting/ Provider	provider communication; lack of training; provider attitudes and biases	creating a setting where both perpetrator and victim are comfortable; streamlined services; provider adopting a nonjudgmental stance; offering hope; emphasizing strengths; being mindful of communication
Outer Setting	static environment undoing progress; services closed to those using alcohol; lack of services/ funding; ineffectiveness of law enforcement	shelters; holding perpetrators accountable; integrating treatment with community services (e.g., church, community shelters); banning illicit alcohol; banning drinking during work hours; lobbying for policy and resources; increasing community awareness; changing gender norms/ beliefs