



**ACT Alcohol and Other Drug Safer Families Program
2017 – 2021: Design, Model, Implementation Plan
and Evaluation Framework**

December 2017

ATODA Monograph Series

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This monograph forms part of the Alcohol Tobacco and Other Drug Association ACT (ATODA) Monograph Series.

ATODA is the peak body for the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT). This includes both government and non-government services.

ATODA's vision is an ACT community and region with the lowest possible levels of alcohol, tobacco and other drug related harm, as a result of the alcohol, tobacco and other drug (and related) sectors' evidence-informed prevention, treatment and harm reduction policies and services.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, education, information and resources. ATODA is an evidence-informed organisation.

The ways ATODA works, and the outcomes it strives to achieve, reflect its commitment to the values of population health, human rights, social justice and reconciliation between Aboriginal and Torres Strait Islander people and other Australians.

ATODA strives to achieve better interaction and integration between alcohol, tobacco and other drug researchers, policy workers, practitioners, consumers and their friends and families in the ACT and region. ATODA hopes this will:

- Improve health and social outcomes for individual clients and their families
- Enhance research utilisation in policy development and its implementation and evaluation
- Mobilise and support knowledge transfer and exchange
- Support demonstration of research and service impact
- Improve the quality of the sector's practice and services
- Improve the health and wellbeing of our community

ATODA has in-house—and a network of external—expertise in alcohol, tobacco and other drug research, policy, advocacy and capacity building, and a proven track record with engaging collaboratively and producing high-quality evidence-informed reports that provide practical expertise to inform policy and decision-making.

Other monographs in the series are:

- No 1. Reducing smoking in the ACT among Aboriginal and Torres Strait Islander women who are pregnant or who have young children.
- No 2. ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014.
- No 3. Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016–2017. An independent expert paper for the ACT Primary Health Network's Baseline Needs Assessment.
- No 4. Service Users' Satisfaction and Outcomes Survey 2015: a census of people accessing specialist alcohol and other drug services in the ACT.

We hope this monograph contributes to the sector, and is a useful resource towards our shared goal of a healthy, strong, safe and supported community.



Carrie Fowlie
Chief Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)

December 2017

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We acknowledge the Traditional Custodians of the lands of the ACT and region and we pay our respects to the Elders, their families and ancestors.

This monograph and its contents were produced through a rigorous and intensive co-design process involving stakeholders from the alcohol, tobacco and other drug, and domestic and family violence sectors; clinicians, consumers and policy workers. A full list of acknowledgements for the Program is available at Section 6: Acknowledgements.

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List of Acronyms

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
ADIVA	Alcohol/Drug-Involved Family Violence in Australia
ADS	Alcohol and Drug Services, ACT Health
AOD	Alcohol and other drug
ATOD	Alcohol, tobacco and other drug
ATODA	Alcohol Tobacco and Other Drug Association ACT
DASP	Drug and Alcohol Service Planning
DFV	Domestic and family violence
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DFVCAT	Domestic and Family Violence Capability Assessment Tool
DVSAT	Domestic Violence Safety Assessment Tool
EOI	Expression of Interest
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
MOU	Memorandum of Understanding
NSW	New South Wales
NGO	Non-Government Organisation
PG	Practice Guide
SoP	Scope of Practice

Executive Summary

Domestic and family violence (DFV) is common in Australia, and occurs among people of all ages, cultures and socioeconomic groups. DFV is a gendered issue that is disproportionately experienced by women. There is an increasing focus on how the community in general, and health services in particular, can help to reduce the incidence of DFV and increase the safety of people, particularly women and children, who experience DFV.

The alcohol, tobacco and other drug sector has been identified as a key partner in reducing the frequency and severity of DFV. This is because alcohol and other drug (AOD) use and DFV frequently co-occur.⁽¹⁾ A high proportion of AOD service consumers are likely to have experienced or used DFV, suggesting that AOD workers have an important role in detecting DFV and intervening sensitively and appropriately.

In acknowledgement of the necessary role played by the ACT specialist AOD service system in responding to DFV, the ACT Government, through the 2016-17 ACT Budget announced multi-year funding focused specifically on “increasing the capacity of specialist AOD services to deliver programs that integrate best practice in addressing family violence”. This investment, funded through a levy introduced on ACT rate payers, was one component of the most comprehensive package to address domestic and family violence in the Territory's history.⁽²⁾

While several Australian resources are available to describe the principles of effective AOD service responses in the area of DFV,⁽³⁾ advice to guide a range of specific practices in AOD work has been lacking. Within the context of emerging evidence, in 2017 ACT Health engaged the Alcohol Tobacco and Other Drug Association ACT (ATODA) to undertake a rigorous and comprehensive co-design process with AOD and DFV stakeholders, clinicians, consumer representatives, and policy workers to design a program of work and companion tools that could inform implementation and resourcing from 2018 onwards.

This led to the development of the ACT *AOD Safer Families Program* which aims to prevent and respond to domestic and family violence by establishing new coordinated/integrated alcohol and other drug and DFV interventions within the specialist alcohol and other drug service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to DFV.

The products of the co-design process, and the first year of the *AOD Safer Families Program (2017)* are the subject of this report, including a model and implementation guidance for the Program delivery from 2018-2021. Underpinning this model, is a series of Australian first tools. When used together, they provide sufficient information to guide AOD practice at an organisational, program and individual worker level when working with AOD service consumers who experience or use DFV:

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	Program/organisational level	<ul style="list-style-type: none">Benchmark and assess capacity to respond to DFV in AOD settingsPlan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated/integrated AOD and DFV responsesAssess and report on progress
Scope of Practice: for Working with	Both program/organisational	<ul style="list-style-type: none">Clarify roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV

Service Consumers in AOD Settings who Experience or Use DFV	level & practice/ clinical level	<ul style="list-style-type: none"> • Guide services and workers on how to work safely and effectively (based on skills, qualifications and training) • Inform workforce planning, training and recruitment
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice/clinical level	<ul style="list-style-type: none"> • Guide practice (e.g. screening, assessment and interventions) • Optimise responses and outcomes for service consumers • Ensure activities funded through the <i>AOD Safer Families Program</i> are evidence based and align with clinical consensus
Monitoring and Evaluation Framework for the ACT <i>Alcohol and Other Drug (AOD) Safer Families Program</i> 2017-2021	Whole of sector/policy level	<ul style="list-style-type: none"> • Monitor and evaluate the entire <i>AOD Safer Families Program</i> • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to DFV in AOD settings

Through the implementation of the *AOD Safer Families Program* model from 2018 – 2021, and the utilisation of the tools developed in 2017, the ACT community can have confidence that:

- People who access specialist alcohol and other drug services (service consumers) receive comprehensive services that more effectively respond to alcohol and other drug issues as well as domestic and family violence and, as a consequence, have enhanced treatment outcomes.
- The ACT has a specialist alcohol and other drug service system that provides alcohol and other drug and domestic and family violence interventions that reflect sound practice and better meets community expectations of safety.
- The frequency and severity of domestic and family violence among people who have used alcohol and other drug services in the ACT is reduced.
- The health, wellbeing and safety of people who have used alcohol and other drug services, their families and friends, are improved.

The next section of this report will provide detailed introduction and background to the *AOD Safer Families Program*.

¹ Miller P, Cox E, Costa B, et al. (2016). *Alcohol/Drug-Involved Family Violence in Australia (ADIVA)*. Canberra: National Drug Law Enforcement Research Fund (NDLERF).

² ACT Government. (2016). *Budget 2016-17 for Canberra*. Accessed on 1 December 2016 at: https://apps.treasury.act.gov.au/_data/assets/pdf_file/0004/870295/Safer-Families.pdf

³ For example, White, M., Roche, AM., Long, C., Nicholas, R., Gruenert, S. & Battams, S. (2013). *Can I Ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. Adelaide: National Centre for Education and Training on Addiction (NCETA). Flinders University.

1 Section 1: Introduction and Background

1.1 About this report

The ACT *Alcohol and Other Drug (AOD) Safer Families Program* aims to prevent and respond to domestic and family violence (DFV) by establishing new coordinated/integrated alcohol and other drug and DFV interventions within the specialist alcohol and other drug service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to DFV.

This report articulates the design, model and implementation plan of the *AOD Safer Families Program*, and the materials and infrastructure that underpin it. It is divided into the following sections and attachments:

Executive Summary		
Section 1	Introduction and Background	Contains information about this report, background and context
Section 2	<i>AOD Safer Families Program</i> Description and Model	Describes the <i>AOD Safer Families Program</i> and the model including the aim, objectives, outcomes, scope, stages, program logic and theory
Section 3	<i>AOD Safer Families Program</i> Implementation Plan January 2018 – June 2021	Contains an implementation plan for the ACT <i>AOD Safer Families Program</i> for the period of 1 January 2018 – 30 June 2021
Section 4	Methodology: Co-design and Collective Impact	Describes the overarching methodology of co-design and collective impact utilised in year 1 (2017) of the <i>AOD Safer Families Program</i> . The methods utilised for the development of each tool/deliverable (the Domestic and Family Violence Capability Assessment Tool; Scope of Practice; Practice Guide and Monitoring and Evaluation Framework) and the broader governance and processes are also described
Section 5	Future Revisions	Describes areas that may require close attention in the future revisions of the Domestic and Family Violence Capability Assessment Tool and Practice Guide
Section 6	Acknowledgements	
Section 7	Conclusion	
Attachment A	<i>Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings</i>	
Attachment B	<i>Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence</i>	
Attachment C	<i>Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings</i>	

As summarised within Section 2 of this report, the sections and attachments of this report, when combined and interacting, constitute the *AOD Safer Families Program*.

1.2 Use of this report

The primary audience of this report is:

- All stakeholders who participated in the *AOD Safer Families Program* co-design and development in 2017, particularly:
 - Specialist alcohol and other drug services in the ACT, NSW and Victoria
 - Domestic and family violence sector stakeholders including the members of the Domestic Violence Prevention Council and the Women's Services Network
- ACT Health policy (as the funding body)
- Office of the Coordinator-General for Family Safety (as the coordinating body for the overarching Safer Families Initiative in the ACT)

The report has been compiled by the Alcohol Tobacco and Other Drug Association ACT (ATODA) and is an outcome of an extensive co-design and co-production effort by a range of stakeholders throughout 2017. Section 4 has details of the methodology used, and Section 6 identifies the key stakeholders and acknowledges those who contributed to the process.

A team undertook the compilation of this report, the development of its components, and the delivery of the first year of the *AOD Safer Families Program* (2017):

- Amanda Bode, ATODA (Program Manager)
- Anke van der Sterren, ATODA (Researcher and Project Manager)
- Linda Jenner and Professor Nicole Lee, 360Edge (Clinical consultants to the Program, lead authors for the Program tools, and facilitators)
- Carrie Fowlie, ATODA (CEO and Program Director)
- David McDonald, Social Research and Evaluation (External advice to the Program)
- Jeanette Bruce and Julie Report (Support to the Program)
- Fiona Christian and Melanie Darvodelsky, ARTD Consultations (Evaluation consultants)

In early 2018, the tools developed through year 1 of the *AOD Safer Families Program*, including the Domestic and Family Violence Capability Assessment Tool (see Attachment A), the Scope of Practice (see Attachment B) and the Practice Guide (see Attachment C), will be published separately, and as stand-alone documents, to support ease of access by specialist AOD services and other key stakeholders in the ACT, and across Australia.

The final report (this document) was provide to ACT Health on 21 December 2017.

This report will be available from www.atoda.org.au

1.3 Background

1.3.1 Defining domestic and family violence

The ACT Government has described domestic and family violence as:

An ongoing pattern of behaviour aimed at controlling a victim through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal.⁽¹⁾

The ACT's new *Family Violence Act 2016* defines domestic and family violence as:

- (a) *any of the following behaviour by a person in relation to a family member of the person:*
 - (i) *physical violence or abuse;*
 - (ii) *sexual violence or abuse;*
 - (iii) *emotional or psychological abuse;*
 - (iv) *economic abuse;*
 - (v) *threatening behaviour;*
 - (vi) *coercion or any other behaviour that—*
 - (A) *controls or dominates the family member; and*
 - (B) *causes the family member to feel fear for the safety or wellbeing of the family member or another person; or*
- (b) *behaviour that causes a child to hear, witness or otherwise be exposed to behaviour mentioned in paragraph (a), or the effects of the behaviour.*⁽²⁾

Amongst Aboriginal and Torres Strait Islander communities family violence is the preferred term because:

... violence against women is conceptualised within extended families and the wider community. Family violence is understood to be the result of, and perpetuated by, a range of community and family factors, rather than one individual's problematic behaviour within an intimate partnership.⁽³⁾

1.3.2 Prevalence of domestic and family violence

Available information about the prevalence of domestic and family violence in Australia is mainly from surveys such as the Australian Bureau of Statistics (ABS) Personal Safety Surveys conducted in 2005, 2012 and 2016; the International Violence against Women Survey conducted in 2002–2003; and from limited sources such as ABS crime data sets compiled from state and territory police records.⁽⁴⁾

Domestic and family violence is common in Australia, and occurs among people of all ages, cultures and socioeconomic groups.⁽⁴⁾ It is not possible to measure the true extent of domestic and family violence in Australia because most incidents are not reported.⁽⁴⁾ It has been estimated that more than one in 10 (approximately 11.2%) of the Australian population aged over 15 years experienced physical or sexual violence perpetrated by a current or former partner.⁽⁵⁾

Women are far more likely to experience domestic and family violence than men.^(4,5) According to the latest data, approximately one in four women experienced violence by an intimate partner, compared to one in thirteen men.⁽⁶⁾ Domestic and family violence remains

a gendered issue where women experience a significantly greater prevalence and impacts than do men. Within that context, it is increasingly recognised that women may also use violence against family members.⁽⁵⁾

Domestic and family violence occurs in lesbian, gay, bisexual, transgender, and intersex (LGBTI) intimate partner relationships^(7,4) at about the same rate as within heterosexual couples.⁽⁸⁾

While there is very little reliable information about rates of family violence among Aboriginal and/or Torres Strait Islander people, the rates appear to be substantially higher than among other Australians.^(4,9) According to data for 2014–2015, the rate of hospitalisation due to family violence was 32 times higher among Aboriginal women than non-Aboriginal women and 23 times higher among Aboriginal men than non-Aboriginal men.⁽⁹⁾ Aboriginal women in some, but not all, states and territories were more likely to experience violence by a current partner than other Australian women.⁽⁹⁹⁾

All Australian state and territory governments have initiated responses to improve safety by preventing and reducing the prevalence of domestic and family violence⁽⁵⁾.

1.3.3 Domestic and family violence and alcohol and other drugs

Relationship between alcohol and other drug use and domestic and family violence

While alcohol is not considered the sole cause of domestic and family violence, there are strong associations between the two.⁽¹⁰⁾ The interaction between alcohol and other drug use and intimate partner violence is complex and can involve the direct pharmacological effects of various substances; loss of inhibition and impulse control; greater sensitivity to and perception of threat; and the emergence of symptoms of withdrawal.^(5, 11)

For alcohol, the pattern of use may be important, as heavy alcohol use (five standard drinks or more on one occasion) has been shown to increase the odds of men using physical or sexual violence with intimate partners.⁽¹²⁾

A study by the World Health Organization found that the odds of intimate partner violence were higher in relationships where one or both partners had a history of 'heavy drinking'^(a) compared with relationships in which neither drank heavily.⁽¹³⁾

While alcohol is considered the largest contributor to domestic and family violence, the use of other drugs is also strongly associated with risk of domestic and family violence. A meta-analysis of international data found that:⁽¹¹⁾

- Having an 'alcohol problem' (i.e. meeting criteria for alcohol abuse/dependence according to the Diagnostic and Statistical Manual of Mental Disorders or other tools used to measure an alcohol problem) correlated more strongly with experiencing intimate partner violence than frequency of alcohol use
- Problems with drug use other than alcohol correlated more strongly with the use of intimate partner violence than substance use alone or frequency of substance use. In contrast, frequency of alcohol use and having an alcohol problem were equally correlated with the use of intimate partner violence

^a Described as 'frequent drunkenness'; the number of drinks on one occasion was unspecified

- Overall, substance use was more strongly correlated with the use of intimate partner violence among men than women

Australian data show similar links between alcohol and other drug use and domestic and family violence. Alcohol is involved in approximately half of domestic and family violence incidents reported to police.⁽⁵⁾ When considering incidents not reported, alcohol involvement is likely to be higher.⁽⁵⁾

The Australian component of the International Violence Against Women Survey found that domestic and family violence was more commonly reported by women whose partners got drunk at least twice per month than those whose partners did not.⁽¹⁴⁾ Women with substance use disorders are also at higher risk of experiencing domestic and family violence.⁽¹⁵⁾

Analysis of the relationship between alcohol and all Australian homicides over a 6-year period found that, in 44 per cent of intimate partner homicides, the offender, the victim, or both, had been drinking.⁽¹⁴⁾ The rate of alcohol consumption before intimate partner homicides may be much higher among Aboriginal and Torres Strait Islander people.⁽¹⁴⁾

Why domestic and family violence is an issue for alcohol and other drug services

It is likely that a high proportion of people who use alcohol and other drug services have domestic and family violence involvement, either experiencing and/or using violence.^(15,16) Most available data concerns men who use family violence and women who experience family violence.

The Victorian Royal Commission into Family Violence heard that between 50 per cent and 90 per cent of women accessing mental health services and alcohol and other drug services had been victims of child abuse or domestic violence.⁽¹⁶⁾ Researchers in other countries have estimated that life-threatening intimate partner violence affect up to three-quarters of women in alcohol and other drug treatment programs.⁽¹⁷⁾

Among men attending alcohol and other drug treatment, up to three-quarters have used emotional, physical or sexual violence towards their partner, and approximately 40 per cent have been physically or sexually violent toward their partner in the previous 12 months, based on international data.⁽¹⁸⁾ Technology-facilitated violence by men receiving alcohol and other drug treatment is increasing.⁽¹⁹⁾

The relationship between women's experience of violence and their alcohol and other drug use is complex and not well understood.⁽²⁰⁾ Domestic and family violence likely affect alcohol and other drug treatment outcomes. Experience of domestic and family violence may trigger relapse to AOD use during treatment (e.g. drinking to cope with violence).^(21, 22, 23)

The high prevalence of domestic and family violence among alcohol and other drug service consumers suggests that alcohol and other drug treatment provides a valuable opportunity to detect and intervene.⁽²⁴⁾ As alcohol use (particularly heavy alcohol consumption and binge drinking) may increase the severity of aggression, reports from Australia and other countries have recommended that clinical services address the role of alcohol in domestic and family violence.^(14, 25) Reports also identify the need for alcohol and other drug services to assess users for domestic and family violence, and for more training of alcohol and other drug workers to respond to users' experiences of domestic and family violence.⁽²¹⁾

The 2016 Alcohol/Drug-Involved Family Violence in Australia (ADIVA) report,⁽⁵⁾ produced for the National Drug Law Enforcement Research Fund, advised that 'because [alcohol and other drug] use can both be a signal of domestic and family violence and also a contributing factor ... a systematic approach is warranted that builds lines of communication between the

agencies dealing with domestic and family violence and those that deal with [alcohol and other drug use].’ The report concluded that ‘framework responses are needed to build and encourage combined resources.’⁽⁵⁾

What we know about alcohol and other drug service consumers who experience or use domestic and family violence

The characteristics of people who access alcohol and other drug services and who experience domestic and family violence are not well defined, other than that the majority are women. Mental health problems such as depression, anxiety and post-traumatic stress disorder also co-occur with alcohol and other drug use problems.⁽²⁶⁾ Many women accessing domestic and family violence services report alcohol and other drug use as a means to cope with mental health problems and other stressors (e.g. poverty, lack of safe and affordable accommodation).⁽²⁷⁾ Limited data suggests that women using alcohol and other drug treatment services who have experienced domestic and family violence encounter particular barriers to accessing treatment (e.g. controlling behaviour by an abusive partner, fear of losing legal custody of children)^(21, 28) and are more likely to experience relapse in alcohol and other drug use.⁽²¹⁾

Similarly, little is known about the characteristics of alcohol and other drug service consumers who use domestic and family violence, compared with other service consumers.

1.3.4 About the ACT’s specialist alcohol, tobacco and other drug sector, service system, workforce and service consumers

About the ACT alcohol, tobacco and other drug sector

The ACT alcohol, tobacco and other drug sector is comprised of diverse services and programs; practitioners; people who use drugs and their families and friends; researchers; law enforcement and legal workers; policy workers and policy makers – with the specialist AOD treatment and support service system being an integral part of the sector.

The ACT *AOD Safer Families Program* is based on the premise that specialist alcohol and other drug services are an appropriate and efficient setting in which to implement improved recognition and responses to domestic and family violence, and for producing valued outcomes for the people who use these services (in terms of reduced frequency and severity of domestic and family violence).

The ACT specialist alcohol and other drug service system is comprised of a diverse range of non-government and government services that work to prevent and reduce alcohol and other drug related harms. The specialist alcohol and other drug services make up an evidence-informed, quality and data driven system that is transparent and accountable to its service consumers, the broader public and its funding bodies.

In the ACT there are 10 publicly-funded (by ACT Health and/or Australian Government Department of Health) specialist alcohol and other drug services that deliver more than 34 programs. These are:

- Alcohol and Drug Services, ACT Health
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Recovery Services, The Salvation Army
- CatholicCare Canberra & Goulburn
- Directions Health Services

- Gugan Gulwan Youth Aboriginal Corporation
- Karralika Programs Inc.
- Ted Noffs Foundation
- Toora Women Inc.
- Winnunga Nimmityjah Aboriginal Health and Community Services

These treatment and harm reduction services are supported by specialist AOD services provided by the peak body, the Alcohol Tobacco and Other Drug Association ACT (ATODA).

These treatment and harm reduction services are also supported by health policy within ACT Health.^b

The ACT alcohol, tobacco and other drug sector, like the harm minimisation policy that guides its practices, is pragmatic and recognises that the views, experiences and goals of service consumers are diverse. For this reason, the specialist AOD service system assists people to address their drug use and the consequences of such use through a diverse and wide range of clinical treatment and support approaches including:

- Needle and syringe programs
- Peer education
- Opioid education and management
- Sobering up shelter
- Medicated withdrawal
- Non-medicated withdrawal
- Brief interventions
- Assessment
- Specialist ATOD therapeutic interventions including Cognitive Behavioural Therapy
- Pharmacotherapies for opioid dependence
- Pharmacotherapies for alcohol use disorder
- Residential rehabilitation
- Day rehabilitation
- Aftercare
- Alcohol and other drug case management
- Specialist alcohol and other drug primary health care
- Consultation and liaison

For a full list of programs available in the ACT visit: www.directory.atoda.org.au

The diversity of intervention types and settings available within the AOD service system provide unique opportunities to enable evidence informed responses to domestic and family violence irrespective of the intensity of the service type (ranging from opportunistic responses to domestic and family violence crisis, all the way to innovative models of integrated, therapeutic domestic and family violence responses).

The ACT specialist alcohol and other drug workforce

The ACT specialist AOD workforce is drawn from diverse occupational fields and contains professional nurses, psychologists, social workers, counsellors, specialist doctors, pharmacists, psychiatrists, allied health workers, education officers and peer workers. The ACT specialist alcohol and other drug workforce is estimated to be 254 workers.⁽²⁹⁾

^b In September 2017, as part of an internal restructure, ACT Health's specialist Alcohol and Other Drug Policy Unit was disbanded, with AOD policy and contract management functions mainstreamed across health policy.

Alcohol and other drug workers collaborate in various responses and care planning activities with service consumers whose support needs are becoming increasingly complex. It is well acknowledged among the workforce that alcohol and other drug workers require not only strongly-developed skills in alcohol and other drug practice, but must also possess skills in responding safely and effectively to a range of related issues, including domestic and family violence.

People who access specialist alcohol and other drug services

It is estimated that 400–500 people access specialist alcohol and other drug services on any single day in the ACT.⁽³⁰⁾ Within a year, 5,774, closed treatment episodes are provided in specialist alcohol and other drug services in the ACT (2015-16 year) to an estimated 3,459 clients.⁽³¹⁾

Based on data from the 2015 Service Users' Satisfaction and Outcomes Survey (SUSOS)⁽³⁰⁾ and the 2015-16 National Minimum Data Set–Alcohol and Other Drug Treatment Services (NMDS–AODTS)⁽³¹⁾ among the ACT service users:

- Two-thirds are male
- Socio-economic status:
 - 74% are unemployed
 - 46% are homeless or at risk of homelessness
 - 25% identified as Aboriginal and/or Torres Strait Islander
- Intensive and ongoing contact with alcohol and other drug services:
 - 70% of service consumers attended non-residential services weekly or more often
 - 56.4% of SUSOS respondents had been coming to the service for more than one year

This means that specialist alcohol and other drug services provide a unique opportunity to respond to domestic and family violence with a known and engaged high-risk population. Specialist alcohol and other drug services have multiple, intensive and ongoing contacts with service users who are often marginalised and excluded from other (non-alcohol and other drug) health and social settings.

As two-thirds of the people accessing alcohol and other drug services are male and there is a strong association between alcohol and other drug use and domestic and family violence, there is an opportunity for specialist alcohol and other drug services to improve targeted prevention and early intervention responses to people who are using, or at risk of using, domestic and family violence.

1.3.5 Policy context

The alcohol and other drug policy context

The ACT AOD *Safer Families Program* is based within, and informed by, a comprehensive and well-established ACT and national alcohol, tobacco and other drug policy environment. The two primary policy documents are the soon-to-be-updated *ACT Alcohol, Tobacco and Other Drug Strategy 2010 - 2014*,⁽³²⁾ and the current *National Drug Strategy 2017 - 2026*,⁽³³⁾ both of which describe and define the broader policy context in which this Program was co-designed and a range of tools co-produced. The Program is consistent with Australia's harm minimisation approach to alcohol and other drug policy, contributing in particular to the harm reduction and demand reduction pillars; and to the underpinning strategic principles of

partnerships coordination and collaboration; national direction, jurisdictional implementation; and evidence-informed responses.

The ACT Government Safer Families Initiatives policy context

The ACT Government, in the 2016-17 ACT Budget, made an unprecedented investment in a Safer Families Initiative to resource whole-of-government, community-backed responses to domestic and family violence. This investment, funded through a levy introduced on ACT rate payers, reflected the most comprehensive package to address family violence in the Territory's history.⁽³⁴⁾ This investment was made within the context of a number of tragic deaths, and subsequent Government reports:

- The *Review into the system level responses to family violence in the ACT* report (April 2016) (the Glanfield Inquiry)⁽³⁵⁾
- The *ACT Domestic Violence Service System Final Gap Analysis Report* (May 2016) (the Gap Analysis)⁽³⁶⁾
- The *Review of Domestic and Family Violence Deaths in the Australian Capital Territory* report (May 2016) (the Death Review)⁽³⁷⁾
- The *ACT Government Response to Family Violence*, addressing the above reports (June 2016) (the Government Response)⁽³⁸⁾

The initiatives funded through the Safer Families Levy are broad in focus and reach, and are supported by the development of a full-time Coordinator-General for Family Safety and a dedicated Safer Families Team to support collaboration, information sharing, awareness raising and working in partnership with the community⁽³⁹⁾.

1.3.6 The AOD Safer Families Program Context

Consistent with the intent of the broader Safer Families initiatives (including reducing and preventing violence, creating whole-of-system change and upskilling diverse workforces), funding announced in the 2016-17 ACT Budget included specific investment to improving support and referrals through specialist AOD service system. This is specifically described as 'increasing the capacity of specialist drug treatment services to deliver programs that integrate best practice in addressing family violence' in the ACT Budget papers. The ACT Budget 2017-18 then confirmed an additional year of resourcing for this purpose. This investment equates to \$500,000 per annum and is recorded in the forward estimates until 2020-21. ACT Health is administering this component of the resourcing as part of the broader Safer Families Initiative, with other components being administered through, for example, the Community Services Directorate.

Between December 2016 – December 2017, ACT Health engaged ATODA to research, scope and design a pilot project to provide more effective responses for people who use alcohol and other drugs in harmful ways and either experience or are at risk of using domestic and family violence. (We now use the term *AOD Safer Families Program* to cover what was originally referred to as the 'pilot project', reflecting the extent of its multiple components and scope.) Included in this, was an expectation that ATODA would:

- Research, scope and design a pilot project (for delivery at a later point) – now referred to as the *AOD Safer Families Program*
- Engage expert clinical expertise
- Develop an evaluation plan
- Identify and consult with key stakeholders

- Consider key partnerships for implementation of the pilot project

Co-design and infrastructure developed in 2017

A co-design approach was implemented throughout 2017 to develop the pilot project—as noted above this is now known as the *AOD Safer Families Program*—and its infrastructure (for delivery from 2018 onwards). This report is the product of that co-design and infrastructure development process. This process acknowledged the emerging evidence base in relation to responding to domestic and family violence in alcohol and other drug settings. This allowed for an approach that not only leverages the existing evidence base of, and investment in, specialist alcohol and other drug services, but also allows for innovation and evaluation. For information on the extensive co-design process see Section 4.

The *AOD Safer Families Program* is conceptualised as a long-term, multi-year initiative that aims to prevent and respond to domestic and family violence by establishing new coordinated/integrated alcohol and other drug and domestic and family violence interventions within the specialist alcohol and other drug service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to domestic and family violence.

See Section 4 & 5 for a full description of the Program model and implementation.

When implemented from 2018 onwards, the Program will utilise the range of tools and infrastructure developed in 2017 (see Table 1).

Table 1 **Infrastructure developed through year 1 of the *AOD Safer Families Program* and described in this report**

Deliverable	Description	Focus
<i>AOD Safer Families Program Design</i>	A model and implementation guide for the <i>AOD Safer Families Program</i> through two 'streams' of activities: service enhancement and capacity building to (core AOD treatment and support); and new coordinated/integrated service delivery pilots (above core business of AOD services)	Whole of sector/policy level
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	A benchmarking tool designed to assist AOD services to assess their current responses to service consumers who experience or use DFV, and plan for future improvements	Program/organisational level
Scope of Practice: for Working with Service Consumers in AOD Settings who Experience or Use DFV	Documentation of the roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV	Both program/organisational level & practice/clinical level
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice/clinical guidelines describing the evidence base and clinical consensus for good practice when responding to DFV in AOD settings	Practice/clinical level

Monitoring and Evaluation Framework: for the ACT AOD Safer Families Program 2017-2021	A blueprint for monitoring and evaluation of the design, implementation and outcomes of the AOD Safer Families Program from 2017 – 2021	Whole of sector/policy level
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The next section of this report will provide detailed information on the AOD Safer Families Program Description and Model.

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2 Section 2: AOD Safer Families Program Description and Model

This section describes the *AOD Safer Families Program* and model including the aim, objectives, outcomes, scope, stages and program logic.

The model outlined was co-designed with: specialist alcohol and other drug (AOD) services; domestic and family violence (DFV) sector stakeholders; clinicians and other experts; the consumer organisation; and policy-workers, including ACT Health. See Section 4 for information on the co-design process.

This Program description and model is complemented by an implementation plan for years 2018 – 2021 that is available in Section 3.

2.1 Aim of the AOD Safer Families Program

The ACT *AOD Safer Families Program* aims to prevent and respond to domestic and family violence (DFV) by establishing new coordinated/integrated alcohol and other drug (AOD) and DFV interventions within the specialist AOD service system, while concurrently enhancing the universal capacity of this service system including services, workforce and service consumers, to respond well to DFV.

2.2 Objectives

The objectives are to effectively resource the development, implementation and evaluation of the ACT *AOD Safer Families Program*:

1. To deliver appropriate responses to domestic and family violence universally in specialist alcohol and other drug services
2. To deliver new coordinated/integrated alcohol and other drug and domestic and family violence interventions capacity within one or more specialist alcohol and other drug services by:
 - a. Ensuring that responses to domestic and family violence in specialist alcohol and other drug services reflect evidence and clinical consensus of sound practice
 - b. Appropriately benchmark and plan for service enhancement/capacity building and new coordinated/integrated interventions through the utilisation of the Domestic and Family Violence Capability Assessment Tool
 - c. Ensuring that new responses reflect an appropriate scope of practice including consideration of alcohol and other drug intervention type and roles, responsibilities, training and capabilities of workers

2.3 Outcomes

The ultimate intended outcomes of the ACT *AOD Safer Families Program* are:

- People who access specialist alcohol and other drug services (service consumers) receive comprehensive services that more effectively respond to alcohol and other

drug issues as well as domestic and family violence and, as a consequence, have enhanced treatment outcomes

- The ACT has a specialist alcohol and other drug service system that provides alcohol and other drug and domestic and family violence interventions that reflect sound practice and better meets community expectations of safety
- The frequency and severity of domestic and family violence among people who have used alcohol and other drugs services in the ACT is reduced
- The health, wellbeing and safety of people who have used alcohol and other drugs services, their families and friends, are improved

Please refer to the Program Logic Model (Figure 2) for all short-, medium-, long-term and ultimate outcomes, with further details provided in the full Monitoring and Evaluation Framework (see Attachment D).

2.4 Scope

All specialist alcohol and other drug services funded by ACT Health and based in the ACT are in scope of the ACT *AOD Safer Families Program*. These services are:

1. Alcohol and Drug Service, ACT Health
2. Alcohol and Drug Services, CatholicCare Canberra & Goulburn
3. Alcohol Tobacco and Other Drug Association ACT^a
4. Canberra Alliance for Harm Minimisation and Advocacy
5. Canberra Recovery Services, The Salvation Army
6. Directions Health Services
7. Gagan Gulwan Youth Aboriginal Corporation
8. Karralika Programs Inc.
9. Ted Noffs Foundation
10. Toora Women Inc.
11. Winnunga Nimmityjah Aboriginal Health and Community Services

The primary recipients of Program activities will include the ACT's specialist AOD service system including these services and workforce. They will subsequently ensure that service consumers receive appropriate responses to domestic and family violence. This means all people who access the ACT's specialist AOD services are in scope including:

- People (particularly women) who experience domestic and family violence currently, in the past, and/or at risk of in the future
- People (particularly men) who use domestic and family violence currently, in the past, and/or at risk in the future

This means that the full range of specialist AOD interventions delivered in the ACT are in scope of the Program, including: harm reduction services (e.g. Needle and Syringe Program, peer support); outpatient psycho-social therapy (e.g. counselling, day program); service enhancement/capacity building (e.g. training); hospital based (e.g. withdrawal); medical (e.g. opioid maintenance therapy); and residential (e.g. rehabilitation).

^a In the context of the *AOD Safer Families Program*, ATODA is included as a specialist AOD service as it is delivering specific programs that support the delivery of AOD treatment and harm reduction services (e.g. training, secretariat support).

The services in scope correspond with the scope of the resources that have been developed through the Program (i.e. Domestic and Family Violence Capability Assessment Tool, Scope of Practice, and Practice Guide), which are only applicable for implementation within, and are fit for purpose for, AOD settings.

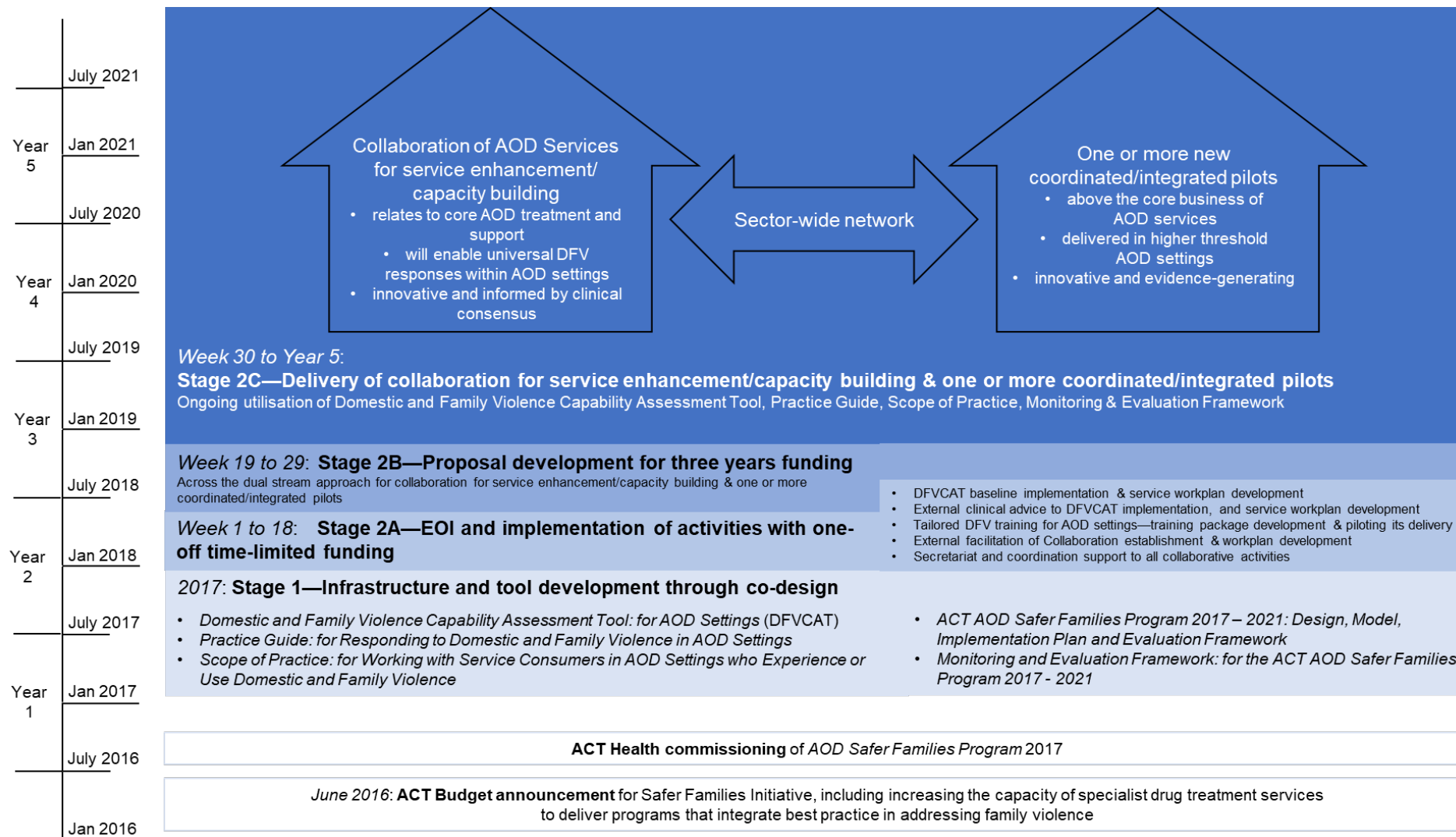
The scope also aligns with the purpose of the funding as allocated through the ACT Budget 2016 – 2017 onwards and the policy objectives of the ACT's overarching Safer Families Initiative (see Section 1).

2.5 Summary of AOD Safer Families Program model (2016 – 2021)

The *AOD Safer Families Program* has been designed in two main stages (Figure 1):

- Stage 1 (2017): Infrastructure and tool development through co-design
 - See Section 2.6 below that describes the components of Stage 1
- Stage 2 (2018-2021): Implementation
 - See Section 2.7 below that describes the components of Stage 2

Figure 1: AOD Safer Families Program model and stages



2.6 Stage 1: Infrastructure and tool development through co-design (completed in 2017)

Year 1 of the *AOD Safer Families Program* focused on the co-design of a number of pieces of infrastructure and tools to inform the delivery of the Program from 2018 onwards. For more information on the co-design process see Section 4.

When used in conjunction with each other, the materials provide sufficient information to guide AOD practice when responding to DFV at an organisational, program and individual worker level for the *AOD Safer Families Program* in Stage 2 (2018 – 2021).

2.6.1 Summary of tools and infrastructure developed in Stage 1

Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings

The *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings* (referred to as DFV CAT) is a benchmarking tool designed to assist AOD services to assess their current responses to service consumers who experience or use DFV, and plan for future improvements. The DFV CAT was modelled on the toolkit *Dual Diagnosis Capability in Addiction Treatment (DDCAT)*,^b which was used by AOD services nationally to enhance care for service consumers with co-occurring mental health problems.

The DFV CAT contains six domains that encompass good practice responses to service consumers who experience or use DFV. It is designed to allow programs/organisations to assess capacity to respond to DFV across each of these domains:

1. Program structure
2. Physical environment and organisational culture
3. Clinical processes – screening and assessment
4. Clinical processes – interventions
5. Continuity of care
6. Staffing considerations

See Attachment A for a copy of the DFV CAT.

Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence

Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence (referred to as Scope of Practice) clarifies the roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV. It can explicitly guide services and workers on how to work safely and effectively when responding to DFV in AOD settings, with consideration to the skills, qualifications and training of workers. For example, the Scope of Practice provides guidance on the appropriate activities that can be undertaken by vocationally trained workers, professionally qualified workers and well-experienced workers.

^b Substance Abuse and Mental Health Services Administration. (2001). *Dual Diagnosis Capability in Addiction Treatment Toolkit Version 4.0*. Rockville: Substance Abuse and Mental Health Services Administration.

See Attachment B for a copy of the Scope of Practice.

Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings (referred to as the Practice Guide), similar to clinical guidelines, has been developed for specialist AOD services to assist programs/services/organisations to work effectively with service consumers who experience or use DFV. It describes, in detail, the evidence base and clinical consensus for good practice when responding to DFV in AOD settings.

See Attachment C for a copy of the Practice Guide.

Monitoring and Evaluation Framework: for the ACT Alcohol and Other Drug Safer Families Program

The *Monitoring and Evaluation Framework: for the ACT Alcohol and Other Drug Safer Families Program* (referred to as the Monitoring and Evaluation Framework) provides a blueprint for monitoring and evaluation of the design, implementation and outcomes of the *AOD Safer Families Program* from 2017 - 2021.

See Attachment D for a copy of the Monitoring and Evaluation Framework.

ACT Alcohol and Other Drug Safer Families Program Model and Implementation Plan

The Program Model and Implementation Plan (Sections 2 & 3 of this report) describes the model for the *AOD Safer Families Program* proposed by stakeholders, particularly the alcohol, tobacco and other drug sector, with essential input from the DFV sector, through the co-design process. The model, as described through this document, provides resourcing to support two 'streams' of activities: service enhancement/capacity building to core AOD service delivery; and new coordinated/integrated service delivery pilots.

2.7 Stage 2: Implementation (2018 – 2021)

2.7.1 Dual streams of service enhancement/capacity building across the specialist AOD service system, and new coordinated/integrated pilots.

From 2018 – 2021 the *AOD Safer Families Program* will more closely focus on the funding of AOD services to implement two main streams of activities:

- Service enhancement/capacity building as it relates to core AOD treatment and support that will enable universal DFV responses within AOD settings
- New coordinated/integrated pilots that are above the core business of AOD services, are delivered in higher threshold AOD settings, and are innovative and evidence-generating

Detailed guidance on stage 2 implementation is provided in Section 3.

Table 2: Summary of activity streams for the *AOD Safer Families Program* (2018 – 2021)

Stream 1: Service enhancement/capacity building	Stream 2: New coordinated/integrated pilots
<p>Scope:</p> <ul style="list-style-type: none"> • All ACT specialist AOD services through a collaboration approach • Programs/organisations with primary AOD focus with increasing capacity to respond to DFV 	<p>Scope:</p> <ul style="list-style-type: none"> • One or more ACT AOD service that is considered ‘higher threshold’ (i.e. therapeutic and treatment planned) • Programs/organisations with capacity for DFV focused responses in AOD care
<p>Description:</p> <ul style="list-style-type: none"> • Focus on capacity building or enhancing existing AOD treatment and support. • Enables an expectation of universally available responses to DFV across the specialist AOD service system. 	<p>Description:</p> <ul style="list-style-type: none"> • Above core business of AOD and therefore reflect innovative service or program delivery • Innovative and will need program level evaluations that generate evidence • Will create new program options that do not currently exist in the ACT AOD sector
<p>Corresponding Domestic and Family Violence Capability Assessment Tool capacity levels</p> <ol style="list-style-type: none"> 1. <i>DFV aware</i>—focused on providing AOD services to consumers, with incidental consideration of experiencing or using DFV in ongoing support or treatment 	<p>Corresponding Domestic and Family Violence Capability Assessment Tool capacity levels</p> <ol style="list-style-type: none"> 4. <i>DFV Coordinated Care</i>— capable of coordinating AOD service consumers with involvement of specialist DFV services and has capacity for some DFV focused

<p>2. <i>DFV identified</i>— focused on providing AOD services to consumers, with ad hoc consideration of DFV experience or use</p> <p>3. <i>DFV Ready</i>— focused on providing AOD services to consumers, can respond to DFV experience or use at a basic level and effectively refer, but has greater capacity to work with AOD issues primarily</p>	<p>case management and/or programming</p> <p>5. <i>DFV Integrated Care</i>— capable of providing interventions with AOD and DFV focused content, and the program can address both issues effectively</p>
<p>Examples of activities from the Practice Guide:</p> <ul style="list-style-type: none"> • DFV crisis responses • DFV screening • DFV safety planning • Collaborations with DFV services • Displays of posters and information materials • DFV training • DFV assessment • Organisational policies and procedures 	<p>Examples of Activities from the Practice Guide:</p> <ul style="list-style-type: none"> • Detailed assessment • Coordinated care with DFV services • Secondary consultations • In-house, specialised, DFV and AOD programs (e.g. respectful relationship programs, new couples therapy, family interventions, or behaviour change groups)
<p>Examples of an appropriate scope of practice:</p> <ul style="list-style-type: none"> • With appropriate training, <u>peer workers and people with vocational qualifications</u> could implement some of the lower intensity activities • With appropriate training, those with <u>professional qualifications</u> could implement some of the higher intensity activities 	<p>Examples of an appropriate scope of practice:</p> <ul style="list-style-type: none"> • Only workers with <u>professional qualifications</u>, adequate experience skills and competencies could deliver coordinated/integrated activities • Workers require specialised training and ongoing supervision

2.7.2 AOD service implementation of the tools developed in 2017 (stage 1) of the AOD Safer Families Program

Irrespective of whether an AOD service is pursuing service enhancement/capacity building approaches, and/or coordinated/integrated pilots (as described in the two streams above), they would be required to utilise and implement the tools and infrastructure developed in year 1 of the Program, as summarised below.

Item	Applicable to	Way that AOD services can implement as part of the AOD Safer Families Program in Stage 2 (2018 – 2021)
<i>Domestic and Family Violence Capability</i>	Program/organisational level	<ul style="list-style-type: none"> • Implement the DFVCAT at baseline to benchmark capacity to respond to DFV

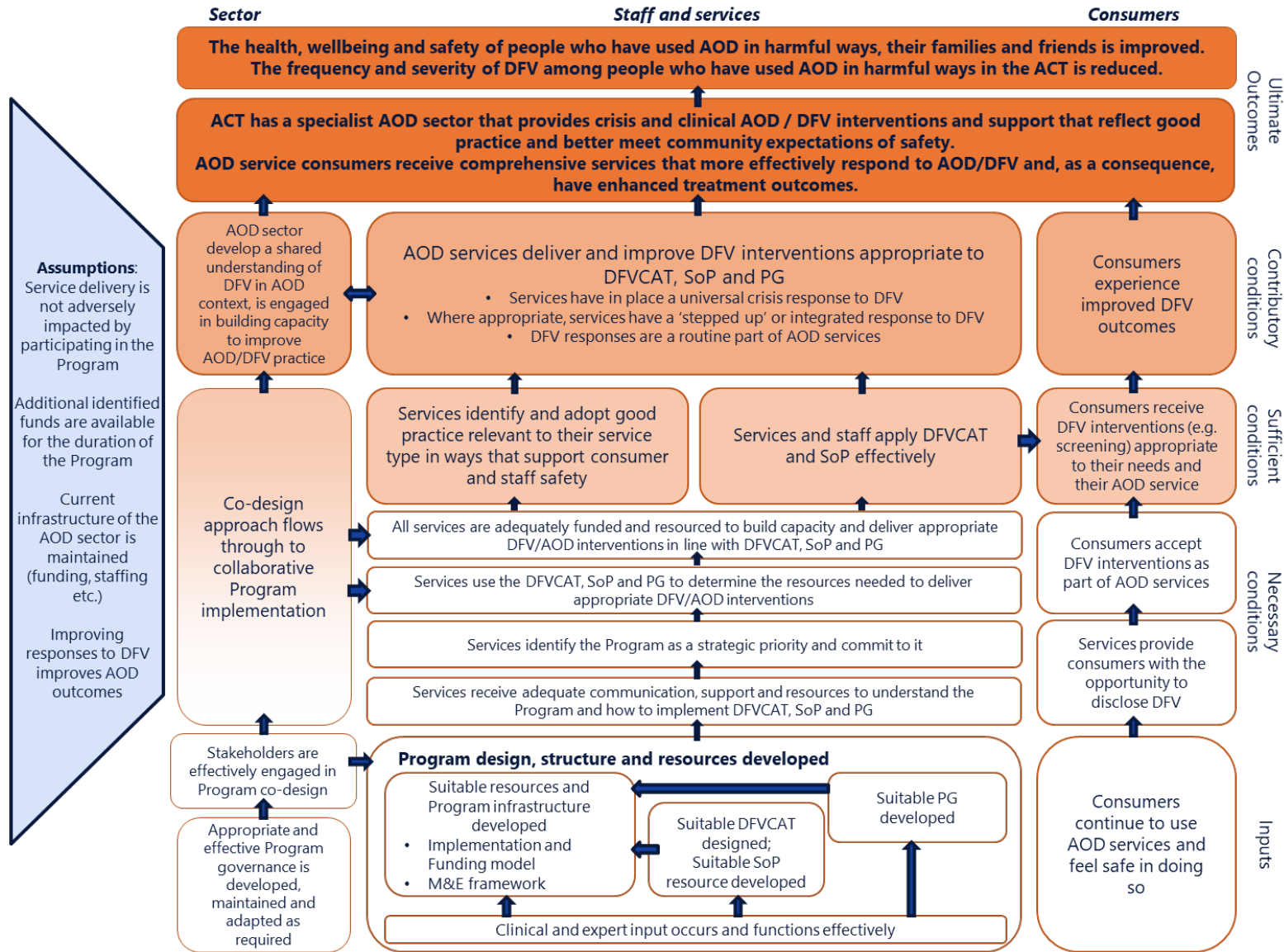
<i>Assessment Tool: for Alcohol and Other Drug Settings</i>		<ul style="list-style-type: none"> • Develop a workplan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated/integrated AOD and DFV responses • Re-implement DFVCAT at regular intervals to assess and report on progress
<i>Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence</i>	Both program/organisational level & practice/clinical level	<ul style="list-style-type: none"> • Review the Scope of Practice and develop a workforce plan to build or attain skills, qualifications and training. This could include guidance for recruitment processes • Demonstrate that all activities are being undertaken by appropriately skilled and qualified workers
<i>Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings</i>	Practice/clinical level	<ul style="list-style-type: none"> • Review clinical and other practices to develop new, and/or augment existing, models of care that are evidence informed and reflect clinical consensus (e.g. screening, assessment and interventions) • Inform on-the-ground clinical and practice delivery
<i>Monitoring and Evaluation Framework: for the ACT Alcohol and Other Drug Safer Families Program 2017-2021</i>	Whole of Sector/Policy Level	<ul style="list-style-type: none"> • Monitor and Evaluate the entire <i>AOD Safer Families Program</i> • Provide a consistent way for stakeholders to contribute data and information to answer evaluation questions, monitor implementation and delivery, and assess outcomes • Note: From 2018 onwards, specific evaluation plans/strategies will need to be developed that operationalise components of the broader Monitoring and Evaluation Framework

2.8 Program logic model

The program logic model (Figure 2) is a visual representation of the important components of the Program and how these components are intended to work together to bring about change for AOD service consumers, workers, organisations and the service system.

The model begins at the bottom with the inputs needed for the Program, and is linked to the ultimate intended outcomes at the top through a series of short-, intermediate- and longer-term outcomes. Each box in the model is a condition that is thought to be necessary to move towards the following outcomes. In combination, the conditions are thought to be sufficient (with certain assumptions and notwithstanding external factors) for ensuring that the outcome occurs. A full description of the program logic model, and its underlying program theory, is available through the Monitoring and Evaluation Framework at Attachment D.

Figure 2. Program logic model



3 Section 3: AOD Safer Families Program Implementation Plan January 2018 – June 2021

This section contains an implementation plan for the ACT *AOD Safer Families Program* for the period of 1 January 2018 – 30 June 2021. As described in the *AOD Safer Families Program Description and Model* (see Section 2) this implementation period is referred to as Stage 2 (with Stage 1 having already been completed in December 2017), and is conceptualised in a number of parts:

- Stage 2A: Expression of Interest (EOI) and implementation of activities with one-off time-limited funding
- Stage 2B: Proposal development for three years funding (across the dual stream approach for collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots)
- Stage 2C: Delivery of collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots

This section outlines the mechanisms for delivering the Program over its various stages.

The implementation plan outlined was co-designed with: specialist alcohol and other drug (AOD) services; domestic and family violence (DFV) sector stakeholders; clinicians and other experts; the consumer organisation; and policy-workers, including ACT Health. See Section 4 for information on the co-design process.

3.1 Background

As described in the introduction to this report (see Section 1), the 2016-2017 ACT Budget has allocated approximately \$500,000 per year focussed on ‘increasing the capacity of specialist drug treatment services to deliver programs that integrate best practice in addressing family violence’.

This funding began in the 2016-17 financial year and is recorded in forward estimates until 2020-21. ACT Health is administering this component of the resourcing as part of the broader Safer Families initiatives, with other components being administered through, for example, the Community Services Directorate, with overall coordination of the initiative by the Coordinator General for Family Safety.

For 2017, ACT Health engaged ATODA to undertake Stage 1 of the *AOD Safer Families Program* and design infrastructure and approaches for delivery of the Program from 2018 onwards.

As shown in Figure 3, the Implementation of the *AOD Safer Families Program* is divided into three parts:

- Stage 2A: EOI and implementation of activities with one-off time-limited funding
- Stage 2B: Proposal development for three years funding (across the dual stream approach for collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots)
- Stage 2C: Delivery of collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots

Each of the three parts of Stage 2 (A, B and C) of the *AOD Safer Families Program* is described in more detail below, with accompanying guidance on the relevant processes and activity development, as determined through the co-design process in 2017 (Stage 1 of the *AOD Safer Families Program*).

3.3 Stage 2A: EOI and implementation of activities with one-off time limited funding

It is proposed that Stage 2A, commencing in early 2018 and occurring over 18 weeks, incorporates an EOI process for one-off, time-limited funding, and implementation of the following 5 activities:

- i. Domestic and Family Violence Capability Assessment Tool (DFV CAT) baseline implementation within ACT AOD services, and service workplan development
- ii. External clinical advice to DFV CAT implementation, and service workplan development
- iii. Tailored DFV training for AOD settings including training package development and piloting its delivery
- iv. External facilitation of Collaboration establishment & workplan development
- v. Secretariat and coordination support to all collaborative activities

3.3.1 Stage 2A: Summary timeline

Table 3 provides a summary timeline and description of key activities proposed for Stage 2A of the implementation of the *AOD Safer Families Program*, with these activities presented graphically in Figure 4.

Table 3: Summary timeline of Stage 2A

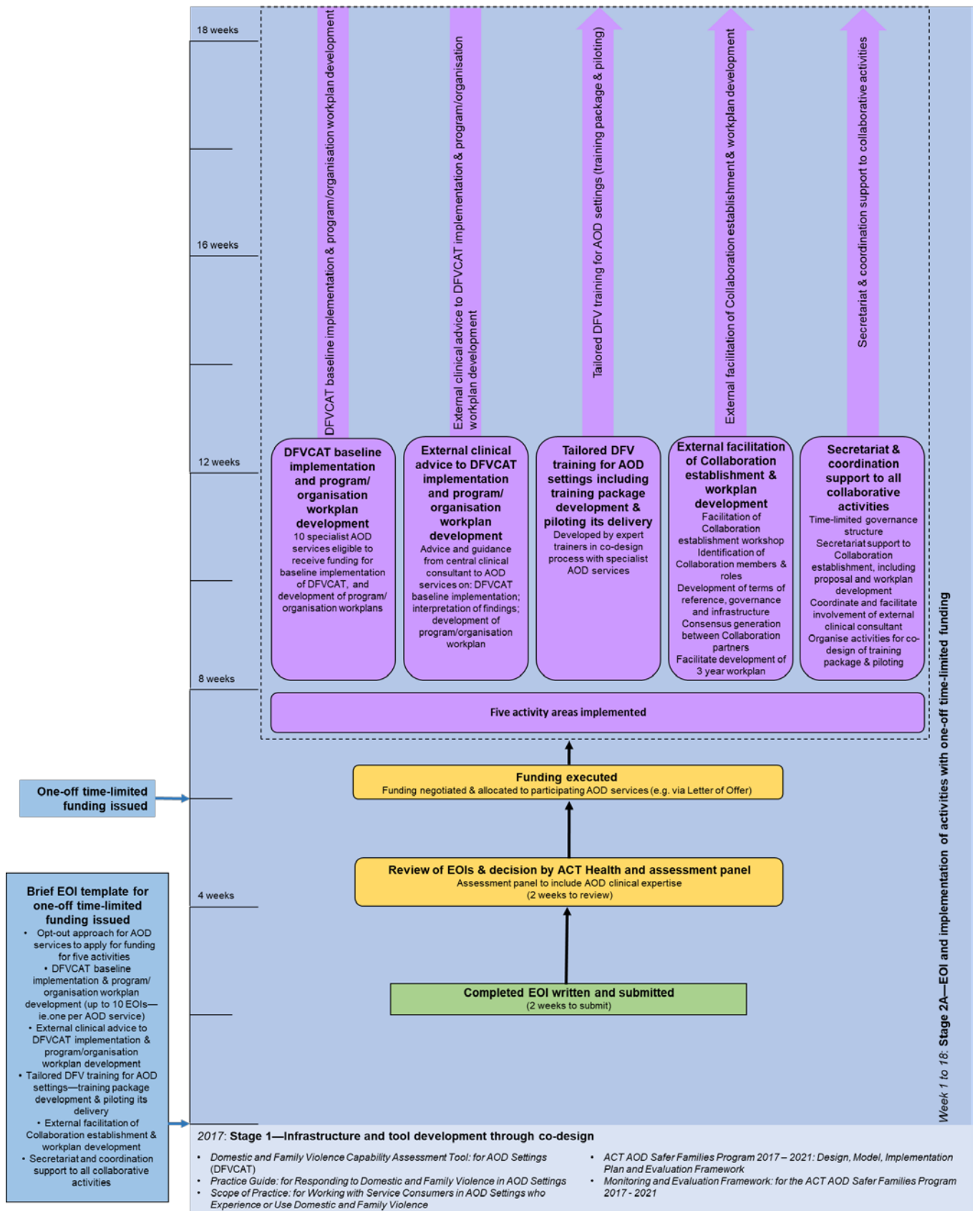
Time (in weeks)	Activity	Further details and cross-referencing
Week 1	Brief Expression of Interest (EOI) template for one-off time-limited funding issued	<ul style="list-style-type: none"> • An opt-out approach is taken, with all specialist AOD services invited to respond to a brief EOI template (see Section 2.4 on scope) • EOIs sought for the following 5 activity areas: <ol style="list-style-type: none"> i. Domestic and Family Violence Capability Assessment Tool (DFV CAT) baseline

		<p>implementation within ACT AOD services and service workplan development</p> <ul style="list-style-type: none"> ii. External clinical advice to DFVCAT implementation and service workplan development iii. Tailored DFV training for AOD settings including training package development and piloting its delivery iv. External facilitation of Collaboration establishment & workplan development v. Secretariat and coordination support to all collaborative activities
Week 2 – 3	Completed EOI submitted	<ul style="list-style-type: none"> • Specialist AOD services submit their completed EOI to ACT Health • Recommend two week process
Week 4 – 5	Review and decision by ACT Health and assessment panel	<ul style="list-style-type: none"> • ACT Health and assessment panel have two weeks to review the EOIs to confirm service eligibility and consistency with Program model • Assessment panel should include AOD clinical expertise (see Section 3.3.2) • Recommend two week process
To be confirmed by ACT Health ^a	Funding executed	<ul style="list-style-type: none"> • Funding negotiated and allocated to participating services (e.g. via Letter of Offer)
Week 7 – 18 ^b	Five activity areas implemented	<ul style="list-style-type: none"> • Activities implemented by individual participating services and collaboratively where relevant

^a Length of time to conduct this activity to be confirmed by ACT Health.

^b Start of this activity is dependent on the timing of the previous activity, see footnote above.

Figure 4: Enlarged view of Stage 2A



3.3.2 Implementation guidance for Stage 2A

Implementation of the activities of the *AOD Safer Families Program* can begin early in 2018 with the release of one-off time-limited funding to specialist AOD services through, for example, an Expression of Interest process. These EOIs would relate to supporting the implementation of five activities as described below:

- i. Domestic and Family Violence Capability Assessment Tool (DFVCAT) baseline implementation within ACT AOD services and service workplan development
- ii. External clinical advice to DFVCAT implementation and service workplan development
- iii. Tailored DFV training for AOD settings including training package development and piloting its delivery
- iv. External facilitation of Collaboration establishment & workplan development
- v. Secretariat and coordination support to all collaborative activities

Further detail of each activity area

This section provides further detail on each of the five activity areas.

i. Domestic and Family Violence Capability Assessment Tool (DFVCAT) baseline implementation within ACT AOD services, and service workplan development

The DFVCAT is a critical tool for the *AOD Safer Families Program* that will enable AOD services to benchmark and assess their current responses to service consumers who experience or use DFV, and plan for future improvements (see overview in Section 2, and full document in Attachment A).

One-off time-limited funding for specialist AOD services will enable the implementation of the DFVCAT within each program/organisation to benchmark and assess capacity to respond to DFV, and will enable the development of a program/organisation workplan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated/integrated AOD and DFV responses. Development of the program/organisation workplan will require reference to how the Scope of Practice and the Practice Guide will be used to support implementation (see overview in Section 2, and full documents in Attachments B and C).

This activity will transition into the development of the proposal and workplan of the Collaboration in Stage 2B; each AOD service will use its program/organisation workplan to input into the Collaboration proposal/workplan (see section 3.4).

Funding estimate: Up to ten (10) x EOIs (i.e. one per specialist AOD service delivery agency) for funding up to a maximum of \$25,000 each (GST inclusive).

ii. External clinical advice to DFVCAT implementation and service workplan development

Implementation of the DFVCAT at baseline will be enhanced by funding an external clinical consultant to work across all specialist AOD services to provide expert advice and guidance on aspects of implementation, to act as a 'critical friend', to support the interpretation of findings and to explore how this informs workplans. Each participating specialist AOD service would have access to a capped number of hours of advice from a central clinical consultant throughout the baseline DFVCAT implementation period.

During the implementation testing of the DFVCAT in Stage 1 (Infrastructure and tool development in 2017), it became clear that this type of external clinical advice is both helpful, good practice and consistent with the practice of engaging external specialist AOD supervision (at a practice level). Specialist AOD services have indicated that this type of support will be useful.

Funding estimate: One (1) EOI for up to a maximum of \$25,000 (GST inclusive)

iii. Tailored DFV training for AOD settings including training package development and piloting its delivery

There is an identified gap among the AOD workforce in relation to both DFV-knowledge and practice/clinical skills specific to AOD settings (see Attachment B).

No suitable DFV training package has been identified that is specifically tailored to the needs of the AOD workforce. The DFV training that is currently available requires adaptation and augmentation to suit the needs of the AOD sector, including training in specific practice/clinical skills in responding to DFV in specialist AOD settings.

Funding for this activity would enable the development of a DFV training package appropriate for the AOD context, and piloting its delivery with AOD workers to refine the package. The training package would be developed by expert trainers in collaboration with specialist AOD services with a view to this training package being available to the ATOD sector in the ACT and nationally.

Implementation of this activity would continue beyond Stage 2A and into Stage 2B (see Section 3.4).

Funding estimate: One (1) EOI for up to a maximum of \$25,000 (GST inclusive)

iv. External facilitation of Collaboration establishment & workplan development

This activity will resource an external consultant (with expertise in the development of collaborations) to undertake a process with stakeholders that will lead to the development of a viable and effective collaboration of specialist AOD services involved in service enhancement/capacity building to enable universal responses to DFV.

The facilitation of the Collaboration establishment and development would enable:

- Convening and facilitation of a collaboration establishment workshop with participation from ACT AOD services and other stakeholders
- Identification of Collaboration members and roles
- Development of the Terms of Reference, governance and other infrastructure
- Consensus generation between Collaboration partners

This activity will continue beyond Stage 2A and into Stage 2B where the external consultant would work with participating services to facilitate the establishment of the Collaboration partners to develop a three-year workplan (see Stage 2B, Section 3.4).

Funding estimate: One (1) EOI for up to a maximum of \$25,000 (GST inclusive)

v. Secretariat and coordination support to all collaborative activities

Each of the activities being funded by the one-off time limited funding require a level of coordination in order to:

- Provide a time-limited governance structure (e.g. meetings and coordination support for specialist AOD services resourced through the one-off time limited funding process to implement the DFVCAT)
- Provide secretariat support to the Collaboration establishment including proposal and workplan development (working closely with the expert collaboration facilitator described in the previous section)
- Coordinate and facilitate the involvement of the external clinical consultant in the DFVCAT implementation
- Organise the activities required for the co-design of the training package and piloting

This activity will continue beyond Stage 2A and into Stage 2B with ongoing secretariat support to the Collaboration (see Stage 2B, Section 3.4).

Funding estimate: One (1) EOI for up to a maximum of \$25,000 (GST inclusive)

Funding and mechanisms

The ACT Budget forward estimates records funding of \$500,000 per annum to 2020-21 for 'increasing the capacity of specialist drug treatment services to deliver programs that integrate best practice in addressing family violence'.

As described throughout this section, the funding mechanism utilised is Stage 2A could be one-off time-limited funding (e.g. Expressions of Interest and Letters of Offer).

Components of the Expressions of Interest

As these are time-limited activities, with relatively small amounts of money, underpinned by fit for purpose tools such as the DFVCAT (that are familiar to specialist AOD services involved in their co-design), the EOI process does not need to be too extensive. The following questions/components are suggested for each EOI template.

Domestic and Family Violence Capability Assessment Tool (DFVCAT) baseline implementation within ACT AOD services and service workplan development

Eligibility: specialist AOD services funded by ACT Health and based in the ACT (see Section 2.4 on Program scope).

Components of the EOI could include:

- Confirmation that the organisation is a specialist alcohol and other drug service that receives funding from ACT Health and is based in the ACT
- Confirmation that the service will implement the DFVCAT and clarification of the program(s) in which it will be implemented
- Details of the key person(s) taking responsibility for the implementation of the DFVCAT in their organisation, and responsibility for the development of the organisation's workplan, including their position(s) within the organisation
 - Note: responsibility for the implementation of the DFVCAT should be taken by one or more people within the service who have senior clinical/management responsibilities
- Confirmation that the organisation is willing to participate in the collaborative activities of the *AOD Safer Families Program Stage 2A*
 - Note: Findings from the implementation of the DFVCAT at baseline can be used by organisations to determine their level of involvement and commitment to the Collaboration in the future. However, to make this assessment, it is important that the organisation undertaking the DFVCAT

baseline implementation participate in collaborative activities in Stage 2A to inform their activities in Stage 2B

- A high-level budget

EOIs for each of the other four activities:

- ii. External clinical advice to DFVCAT implementation and service workplan development*
- iii. Tailored DFV training for AOD settings including training package development and piloting its delivery*
- iv. External facilitation of Collaboration establishment & workplan development*
- v. Secretariat and coordination support to all collaborative activities*

Eligibility: specialist AOD services funded by ACT Health and based in the ACT (see Section 2.4 on Program scope, including the list of services in scope for these EOIs).

Responses to the EOIs could include:

- Confirmation that the organisation is a specialist alcohol and other drug service that receives funding from ACT Health and is based in the ACT
- Confirmation that the organisation is able to deliver the activities described and has established relationships with the AOD services that will be undertaking the DFVCAT baseline implementation
- Details of the key person (or people) involved in activity implementation and their expertise
- Confirmation that the organisation is willing to participate in the collaborative activities of the *AOD Safer Families Program* to June 2018.
- A high-level budget

Review by an assessment panel that includes clinical expertise

An assessment panel should be convened by ACT Health to review the EOIs. This panel should include at least one member with clinical AOD expertise. This assessment panel does not need to be as rigorous in its assessment as the panel suggested for Stage 2B (review of proposals for the Collaboration and coordinated/integrated pilots) (see Section 3.4.2).

3.4 Stage 2B: Proposal development for three years funding (across the dual stream approach for collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots)

Stage 2B will include developing and reviewing proposals for the purpose of the ongoing implementation of two activity streams for the *AOD Safer Families Program* over eleven weeks:

- Service enhancement/capacity building as it relates to core AOD treatment and support that will enable universal responses to DFV within AOD settings
- New coordinated/integrated pilots that are above the core business of AOD services, are delivered in higher threshold AOD settings, and are innovative and evidence-generating

3.4.1 Stage 2B: Summary timeline

Table 4 provides a summary timeline and description of key activities proposed for Stage 2B of the implementation of the *AOD Safer Families Program*, with these activities presented graphically in Figure 5.

Table 4: Summary timeline of Stage 2B

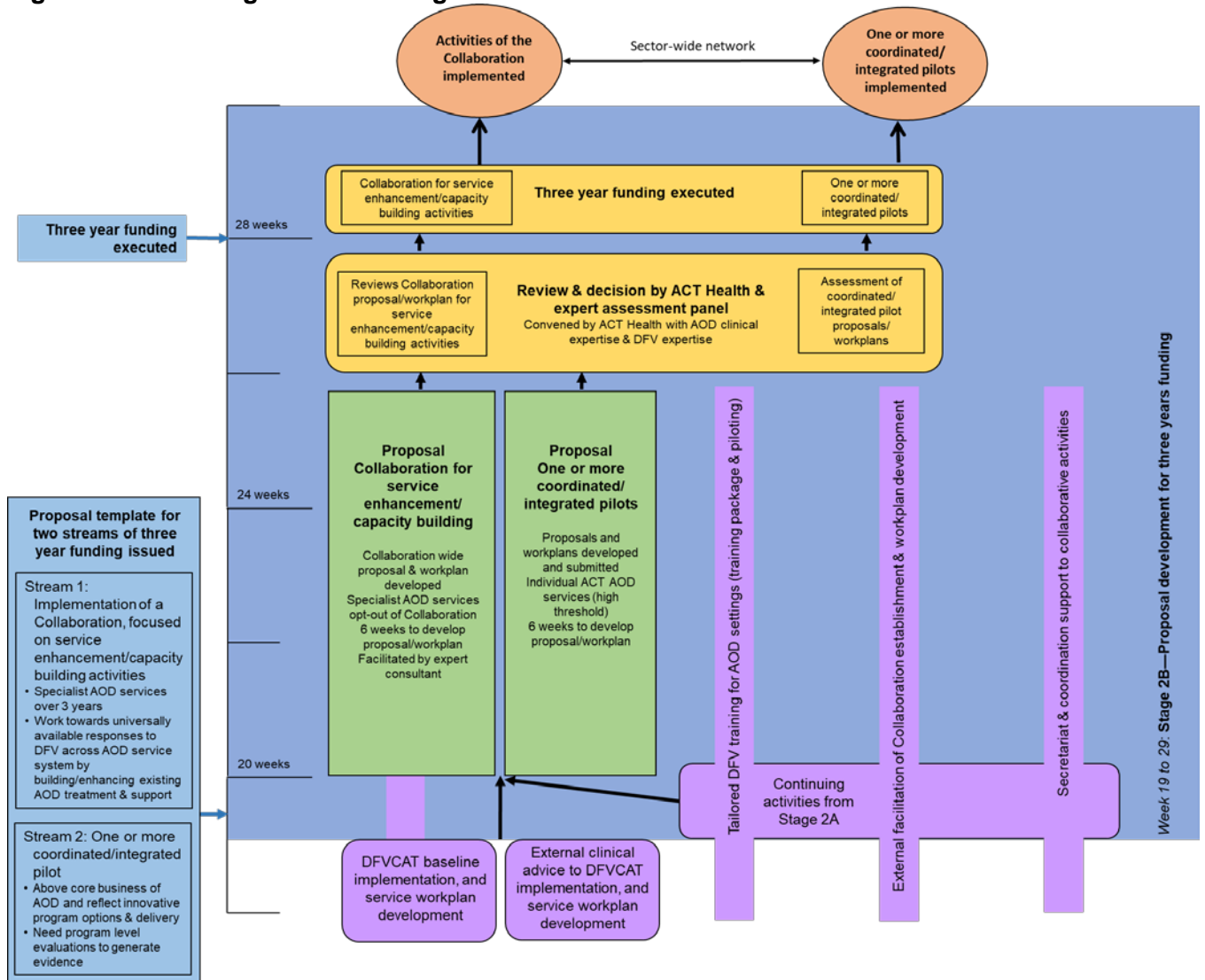
Time (in weeks)	Activity	Further details and cross-referencing
Ongoing from week 7, up to week 25	Continuing activities from Stage 2A	<ul style="list-style-type: none"> • Tailored DFV training for AOD settings including package development and piloting its delivery • External facilitation of Collaboration establishment & workplan development • Secretariat and coordination support to all collaborative activities
Week 19	Proposal template for two streams of three year funding issued	<ul style="list-style-type: none"> • Proposals sought for two streams: <ul style="list-style-type: none"> ○ implementation of a Collaboration focused on service enhancement/capacity building activities ○ one or more coordinated/integrated pilots
Week 20 – 25	Collaboration for service enhancement/capacity building proposal and workplan developed and submitted	<ul style="list-style-type: none"> • Specialist AOD services opt-out approach for Collaboration • Collaboration has six weeks to develop proposal/workplan • Proposal/workplan development facilitated by expert consultant
	One or more coordinated/integrated pilot proposals and workplans developed and submitted	<ul style="list-style-type: none"> • Individual AOD services (high threshold) to develop proposals for one or more coordinated/integrated pilots • AOD services have six weeks to submit proposal
Week 26 – 27	Review and decision by funding body and expert assessment panel	<ul style="list-style-type: none"> • Funding body and panel review the proposals • Assessment panel to include AOD and DFV clinical expertise • Assessment process to take two weeks
To be confirmed by ACT Health ^c	Three year funding executed to Collaboration and one or more coordinated/integrated projects	<ul style="list-style-type: none"> • Funding negotiated and allocated (e.g. via grant)
Week 29 onwards ^d	Two streams of service delivery are implemented	<ul style="list-style-type: none"> • Activities of the Collaboration implemented

^c Length of time to conduct this activity to be confirmed by ACT Health.

^d Start of this activity is dependent on the timing of the previous activity, see footnote c.

		<ul style="list-style-type: none"> Coordinated/integrated pilots implemented
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Figure 5: Enlarged view of Stage 2B



3.4.2 Implementation guidance for Stage 2B

It should be noted that several of the activities funded by the proposal in Stage 2A will continue into Stage 2B. These are:

- Tailored DFV training for AOD settings including training package development and piloting its delivery
- Facilitated workplan development:
 - Following the call for proposal for the service enhancement/capacity building activities (in week 19, see below), the external consultant will facilitate the coming together of the Collaboration partners to develop a three year workplan for the activities of the Collaboration. Each AOD service will bring its own workplan (based on the implementation of the DFVCAT within their service, and with reference to the Scope of Practice and Practice Guide) to this process to enable the identification of shared service enhancement and capacity building activities
- Coordination support to all collaborative activities, specifically:

- Secretariat support to the Collaboration establishment including proposal and workplan development (working closely with the expert collaboration facilitator described in the previous section)
- Coordination and facilitation of the involvement of the external clinical consultant in the DFVCAT implementation
- Organising the activities required for the co-design of the training package and piloting

Further detail on two streams of delivery

Stream 1: Implementation of a Collaboration focused on service enhancement/capacity building activities

Stream 1 would enable a Collaboration and its activities to be resourced to deliver service enhancement/capacity building across all specialist AOD services over a three year period. This would focus on capacity building and enhancing existing AOD treatment and support, and would enable an expectation of universally available responses to DFV across the specialist AOD service system.

All ACT specialist AOD services are eligible to be members of the Collaboration, but are able to opt-out of participation in the Collaboration (see Section 2.4 on Scope).

The process of determining the activities of the Collaboration will already be underway during weeks 7 – 18 of the implementation of the five activities funded by the one-off time limited, funding (see Stage 2A above, Section 3.3). However, following the call for proposals, the Collaboration would meet several times during the six week period to bring together the workplans created by each organisation to inform the Collaboration's workplan (with reference to the findings of the DFVCAT baseline implementation, and the Scope of Practice and Practice Guide).

Members of the Collaboration would meet together to determine the mix of shared activities of the Collaboration, how each of these meet the needs of members of the Collaboration, and the resourcing required to implement each of these activities. These discussions would inform the development of the Collaboration's workplan. Examples of activities that could be in the workplan of the Collaboration include:

- Sector wide governance (of the Collaboration)
- Tailored training in DFV for specialist ACT AOD services
- Communities of Practice (clinical or implementation in focus)
- Clinical supervision specific to DFV in AOD settings
- Practice supervision specific to DFV in AOD settings
- Enhanced Employee Assistance Program or staff support services
- Funding for crisis responses to DFV that are not already funded
- Internal practice improvement management strategies to reflect the types of improvements that need to be made (e.g. reviewing and updating policies and procedure documents)
- Resourcing to maintain service enhancement/capacity building activities over time

If a service chooses to opt-out of the Collaboration, their workers will still have access to the Collaboration's shared activities (e.g. training).

Stream 2: One or more coordinated/integrated pilots

Stream 2 would fund one or more coordinated/integrated pilots that will each be delivered in a specialist AOD service over a three year period. These new pilots are:

- Above core business of AOD and therefore reflect innovative service or program delivery (i.e. level 4 & 5 in the DFVCAT)
- Innovative and will need program level evaluations that generate evidence
- Will create new program options that do not currently exist in the ACT AOD sector

Based on the findings of the DFVCAT baseline implementation, individual specialist AOD services will determine whether they may:

- Only be involved in the Stream 1 service enhancement/capacity building activities of the Collaboration; or
- In addition to their involvement in the service enhancement/capacity building activities of the Collaboration (Stream 1), also apply for resourcing for a coordinated/integrated pilot project (Stream 2).

As detailed above, applying for resourcing for Stream 2 activities (coordinated/integrated pilots) is only appropriate for those services that have some capacity to move to levels 4 and 5 on the DFVCAT (i.e. already have many items of levels 1 to 3 in place), and that provide higher threshold services (i.e. provide therapeutic and treatment planned services).

The specialist AOD services that apply for this resourcing will also be members of the Collaboration, and may build upon the shared service enhancement and capacity building activities of the Collaboration to prepare their three-year proposal and to implement a coordinated/integrated pilot.

Funding, mechanisms and split

Funding

The ACT Budget forward estimates records funding of \$500,000 per annum to 2020-21 for 'increasing the capacity of specialist drug treatment services to deliver programs that integrate best practice in addressing family violence'.

Funding mechanisms

The most appropriate funding mechanism for Stream 1 collaborative service enhancement/capacity building activities could be negotiated between the funding body and individual services through the proposal process (e.g. individual service funding agreements to undertake service specific activities and participate in collaborative activities such as a shared training pool).

The most appropriate funding mechanism for Stream 2 coordinated/integrated pilots could occur, for example, through individual service funding agreements or contract variations to undertake service specific activities and participation in collaborative activities such as a Community of Practice.

Establishment of, for example, a grants program specific to the program model may be warranted.

Split of funding across each stream

Prior to the call for proposals, the funder will need to consider the split of funding required across each stream. Of course, this will depend somewhat on the activities that will be proposed for each stream. One option for informing the split of funding, could include the

Collaboration providing advice to ACT Health, prior to the call for proposals, in relation to the preliminary findings of the DFVCAT implementation. This may help to indicate the most effective split of funding across the two streams (based more closely on the reality of implementation, rather than a pre-determined estimate).

Despite these unknowns, some information exists in relation to the funding of AOD services more generally, that could provide some useful guidance to the funder on the split and quantum of funds of each stream. For example, the Drug and Alcohol Service Planning Model (*DASP Model*)¹ can be utilised as an estimation tool for the resources required to deliver specific components of AOD treatment across a typical population of 100,000 over the course of a year. This tool can guide an estimation of the resourcing required to deliver any full time equivalent positions that may be required for delivering integrated/coordinated pilot projects. The DASP Model has been used to inform AOD funding allocations by both ACT Health and for the Commonwealth.^e

Components of the Proposal

Components of the Proposal for Stream 1: Implementation of a Collaboration focused on service enhancement/capacity building activities

Components of the proposal could include:

- Details of the membership, structure and governance of the Collaboration, and the expected involvement from each member; confirmation that each of the members of the Collaboration are ACT Health-funded specialist AOD services
- Description of the process leading to the development of the workplan
- Objectives of the Collaboration
- Program logic
- Key performance indicators
- Evidence that the proposal aligns with the DFVCAT, Scope of Practice and Practice Guide.
- A 3 year workplan that includes:
 - Description of the proposed activities, including their rationale as it relates to baseline DFVCAT implementations
 - Budget
 - Timeframes

Components of the Proposal for Stream 2: One or more coordinated/integrated pilots

Components of the proposal could include:

- Confirmation that the organisation is a specialist alcohol and other drug service that receives funding from ACT Health and is based in the ACT
- Confirmation that the program/organisation is considered high threshold (i.e. an appropriate setting for providing coordinated/integrated pilots as described in the DFVCAT)
- Objectives of the Pilot
- Program logic
- Key performance indicators

^e The DASP model has been used to inform the roll out of funding from the 2016/17 ACT budget and funding allocated through the Capital Health Network from 2017. For further information on the use of the DASP model, please refer to the ATODA monograph: Alcohol Tobacco and Other Drug Association ACT (ATODA). (2016). *Strengthening Specialist Alcohol and Other Drug Treatment and Support: Needs and Priorities for the ACT 2016 – 2017—An independent expert paper for the ACT Primary Health Network’s Baseline Needs Assessment*. ATODA Monograph Series, No.3. Canberra: ATODA.

- Evaluation plan
- Description of the pilot and associated model of care
- Evidence that the pilot aligns with the DFVCAT, Scope of Practice and Practice Guide
- A workplan that includes:
 - Rationale and evidence of need
 - Budget
 - Timeframes

Review and decision by an assessment panel that includes clinical expertise

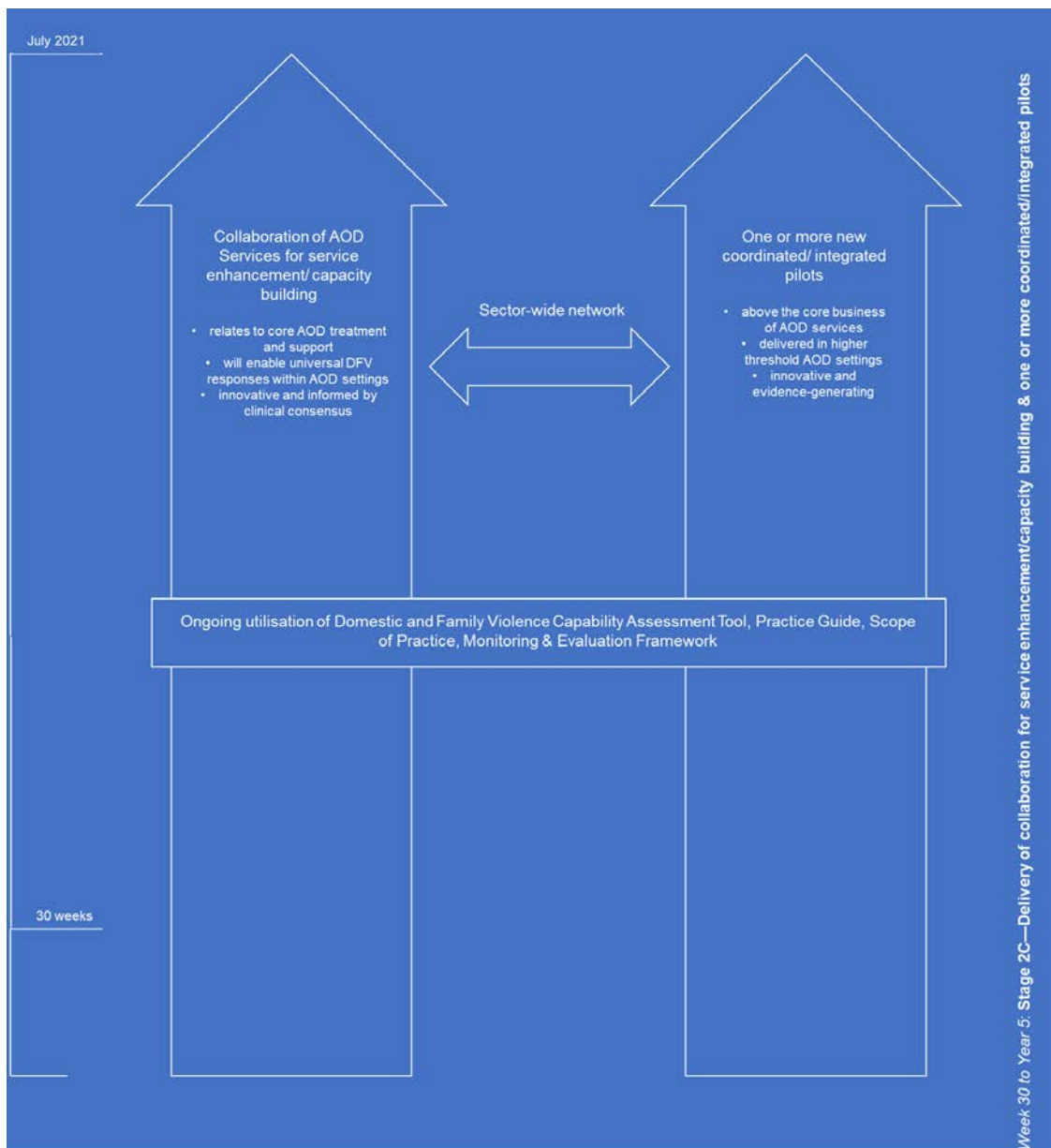
An assessment panel should be convened by the funder to review the proposal of the Collaboration and assess the applications for coordinated/integrated pilots. The panel should include people with clinical AOD expertise, such that they have sufficient technical, clinical and practice expertise to assess the applications against the clinical tools—DFVCAT, Scope of Practice and Practice Guide. It should also include a professional from the domestic and family violence sector.

3.5 Stage 2C: Delivery of collaboration for service enhancement/capacity building & one or more coordinated/integrated pilots

As shown in Figure 6, beginning from week 30 of the process (following Stages 2A and 2B), the three year activities funded in Stage 2B will begin implementation:

- a Collaboration of AOD services delivering service enhancement/capacity building activities
- one or more AOD services delivering new coordinated/integrated pilots that are above the core business of AOD services, are delivered in higher threshold AOD settings, and are innovative and evidence-generating

Figure 6: Enlarged view of Stage 2C



3.5.1 Implementation guidance for Stage 2C

Three-year funding should be subject to standard regular reporting requirements consistent with established reporting mechanisms and practices of ACT Health. Activities should have an evaluation component, particularly the coordinated/integrated pilots that are expected to generate evidence. This will be based upon the *Monitoring and Evaluation Framework for the ACT AOD Safer Families Program* (see Attachment D).

Sections 2 and 3 have described the model and implementation plan for the *AOD Safer Families Program*. Section 4 will describe the overarching methodology of co-design and collective impact used in Stage 1 (year 1—2017) of the Program.

¹ NSW Ministry of Health. (2013). *Drug and Alcohol Service Planning Model, Final Report to the Intergovernmental Committee on Drugs (IGCD) on the development of a population based planning tool for Australia*, North Sydney: NSW Ministry of Health.

4 Section 4: Methodology: Co-design and Collective Impact

This section describes the overarching methodology of co-design and collective impact utilised in year 1 (2017) of the *AOD Safer Families Program*. The methods utilised for the development of each tool/deliverable (the Domestic and Family Violence Capability Assessment Tool; Scope of Practice; Practice Guide and Monitoring and Evaluation Framework) and the broader governance and processes are also described.

4.1 Methodology: Co-design and collective impact

The first year of the *AOD Safer Families Program* has its foundations in two approaches: co-design and collective impact.

The co-design and collective impact processes employed throughout the Program - and the initial investment in infrastructure development in 2017 - acknowledged the emerging evidence base in relation to responding to domestic and family violence (DFV) in alcohol and other drug (AOD) settings. This allowed for an approach that not only leveraged the existing resources (e.g. the Alcohol Tobacco and Other Drug Sector's ACT and Commonwealth funding investment, evidence base, practitioner expertise, collaborative track-record, networks, service infrastructure) but also allowed for collaborative and innovative approaches to be jointly developed.

4.1.1 Co-design

As is the case with all co-design approaches, the *AOD Safer Families Program* designed its deliverables with the key stakeholders of the Program, including those who would enact it, namely people in the specialist AOD service system, the DFV sector stakeholders, policy-makers, AOD workers and consumer organisations. The Program adopted the following co-design principles:⁽¹⁾

- **Inclusive:** Critical stakeholders were involved in all phases of co-design: identifying shared values or common goals; understanding and clearly defining the issue; developing potential solutions; and testing the ideas.
- **Respectful:** All stakeholders irrespective of the nature of their input (e.g. clinical, operational, consumer, policy, research, etc.) were respected as partners sharing expertise in the design of the *AOD Safer Families Program* and year 1 deliverables.
- **Participative:** The process of co-design sought to engage stakeholders openly, across a range of engagement methods—from face-to-face consultations, desk-based document reviews, clinical roundtables, to consumer interviews. High rates of participation and a building of the knowledge base across engagements was a hallmark of the Program's delivery in 2017.
- **Iterative:** All project deliverables (i.e. the Domestic Violence Capability Assessment Tool; Scope of Practice; Practice Guide; and Monitoring and Evaluation Framework) underwent multiple drafts and revisions (including being subject to implementation testing, peer review, etc., as appropriate). This helped to ensure that the deliverables have ownership and are fit for purpose for AOD services.

- **Outcomes focused:** An outcomes hierarchy was generated for the *AOD Safer Families Program* that will enable the co-design process, established in Year 1, to flow through to collaborative implementation from 2018 onwards. This framing will also mean that the Program, throughout its delivery, can be tested, measured and refined.

4.1.2 Collective Impact

Collective Impact is a structured approach to making collaboration work across various types of organisations.⁽²⁾ The ACT alcohol, tobacco and other drug (ATOD) sector is well versed and has a strong track-record in undertaking projects with collective impact. In the case of the *AOD Safer Families Program*, it was acknowledged from the start that responding effectively to these problems is beyond the capacity of any one organisation, and collaboration is required to enact system-level change and innovation. Through the provision of program management and support, ATODA could function as the central ‘backbone organisation’, with dedicated staff that worked to help participating organisations shift from acting alone to acting together.

The following conditions for collective impact were in place throughout the first year of the *AOD Safer Families Program*:

- **A common agenda:** A shared vision for change in relation to preventing and responding to DFV in AOD settings.
- **Shared measurement:** A commitment to producing a monitoring and evaluation framework that will underpin the collection of shared data and measurement.
- **Mutually reinforcing activities:** Ensuring adequate scope and flexibility of the deliverables (Domestic Violence Capability Assessment Tool, Scope of Practice and Practice Guide) to guide delivery within AOD services that acknowledges the specialist expertise, setting and nature of the AOD interventions (so that activities can differ across organisations but be coordinated to a central purpose).
- **Continuous communication:** Maintaining consistent and open communications via email, webpages, eBulletin, Program updates and face-to-face advisory structures, engagements and consultations.
- **Backbone support:** ATODA was resourced to support and coordinate the participating organisations and activities.

4.2 Co-design activities

Activities of the *AOD Safer Families Program* commenced in February 2017 and initiated an intensive and rigorous co-design process.

4.2.1 Preliminary planning

A two-day workshop was hosted by ATODA to commence preliminary Program planning. This included participation from Project Management staff, researchers, evaluation consultants, ACT Health, AOD clinical expertise, and DFV expertise (see Section 6 on acknowledgements). This included consideration of:

- Program background and funding
- Internal Program scope and constraints
- Environmental scanning and policy context
- Program deliverables
- Partners, stakeholders and governance
- Risk assessment

4.2.2 Building relationships with critical friends and engaging expertise

ACT Health

An essential collaborative relationship was developed with the former Alcohol and Other Drug Policy Unit, ACT Health, as the funder of both the *AOD Safer Families Program* and specialist AOD services in the ACT, and also holding specialist AOD policy expertise. The Unit was engaged from commencement all the way through Program development, co-design and review. This included:

- Participation in two full day preliminary Program planning workshops
- Receipt and feedback of all Program development materials (including terms of reference, Program and project plans, and draft versions of the Program and project deliverables)
- Participation in the AOD and DFV Symposium
- Participation in twelve face-to-face meetings with the *AOD Safer Families Program* team to monitor, feedback and further develop the deliverables
- Participation in five x full or half day sector forums to co-design project deliverables
- Participation in two x clinical and expert roundtables to inform project deliverables
- Participation on review panel to select the evaluation consultants
- Participation in two x full day monitoring and evaluation working groups

In mid-September 2017, ACT Health undertook a structural re-alignment and the Program's service funding agreement was subsequently managed by a new area, and associated policy advice was provided by the Health Improvements Branch, ACT Health.

Office of the Coordinator-General for Family Safety

The Coordinator-General for Family Safety and her team provided critical advice throughout the first year's activities including through one-on-one meetings, participation in sector forums and ongoing information and advice to ensure the Program maintained a co-design approach, supported cultural change, strove for reform and was accountable to multiple stakeholders.

ACT specialist alcohol and other drug services

The specialist ACT AOD services were engaged throughout all elements of Program co-design, making significant contributions in both time and expertise. The *AOD Safer Families Program* has (and could continue to) leverage significant in-kind support from these services and utilise the existing collaborative relationships and infrastructure of the sector to progress activities from 2018 (see Section 1 for further information about the sector).

National alcohol, tobacco and other drug sector

Advice was sought, and information was provided to a large range of experts from the ATOD sector in other jurisdictions, particularly New South Wales and Victoria. This included peak organisations, specialist AOD drug services, clinicians and consumers/community representatives (see Section 6 on acknowledgements). There is significant national interest in the deliverables of the *AOD Safer Families Program* (see Section 5 on future revisions).

Domestic Violence Prevention Council

The Domestic Violence Prevention Council is an independent statutory body under the *Domestic Violence Agencies Act 1986*, and is the peak body offering advice to the ACT Attorney-General on issues on domestic violence. The Council provided crucial support and expertise throughout 2017, including the Chair of the Council being a member of the Program's Advisory Group, and speaking at the *Promoting Safety and Prioritising Domestic and Family Violence in the ACT Alcohol Tobacco and Other Drug Sector Symposium*. The Council provided representation in the co-design forums, provided input into Program project materials, and communication structures were established between the Program and the Council, through its Chair. The ATODA Program staff, and one of its clinical consultants, Professor Nicole Lee, also met with all Council members (see Section 6 on acknowledgements).

Women's Services Network

The Women's Services Network is a network of women's services and organisations that support women in the Canberra community. The *AOD Safer Families Program* met with the Women's Services Network and established communication structures with the group through the Chair. This included providing input to project materials and participation in the co-design forums (see Section 6 on acknowledgements).

Domestic and family violence service delivery agencies

Throughout the program, individual DFV service delivery agencies have been engaged in various ways to provide advice to program development and in co-design processes.

Supporting and parallel activities to the *AOD Safer Families Program* have also taken place, including the provision of specialist industry specific AOD training for DFV services. The focus of the training has varied depending on the needs of the individual DFV service and the types of services they provide. The training has included AOD information, harm reduction, brief intervention and use of the World Health Organisation ACT specific electronic adaptation of the validated screening tool the Alcohol, Smoking & Substance Involvement Screening Test (www.act-eASSIST.org.au). Domestic Violence Crisis Services and Toora Women Inc's Domestic Violence Services have been key partners in this capacity building in 2017.

ATODA hopes to continue engaging with DFV sector stakeholders to undertake further AOD-related capacity building activities, including training, as supporting and parallel to the *AOD Safer Families Program* in 2018.

Clinical consultants

The *AOD Safer Families Program* engaged Linda Jenner and Professor Nicole Lee from 360Edge as Clinical Consultants, who advised and led the development of the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide. Both Linda Jenner and Nicole Lee have significant experience in the AOD field through academic research and hands-on clinical experience, and have a good understanding of the local context and close relationships with many specialist ACT AOD services. This includes previous work on developing service models, reviewing and redesigning the ACT withdrawal system using a co-design approach, and providing expert clinical advice to programs.

4.2.3 Environmental scan

An environmental scan was undertaken that incorporated:

- DFV capacity building projects within the AOD Sector (Australia and overseas)
- DFV capacity building projects within other health settings (Australia and overseas)
- DFV service delivery and AOD service delivery in the ACT
- Policy initiatives related to DFV in the ACT and other Australian jurisdictions
- Researchers with expertise in AOD and/or DFV
- Tools related to DFV assessment, screening, referrals, and service policies
- Training related to DFV in general and in an AOD settings in the ACT and Australia

Taking the learnings from the information sourced through the environmental scan, it was identified that a number of the materials to be developed by the *AOD Safer Families Program* would be innovative Australian-first materials (and in some case, the first attempt at such activities internationally). This solidified the necessity to undertake the development of the project materials through a co-design approach.

4.2.4 Alcohol and other drug and domestic and family violence symposium

The *Promoting Safety and Prioritising Domestic and Family Violence in the ACT Alcohol Tobacco and Other Drug Sector Symposium* was held on Wednesday 24 May 2017. This was the first and key step in bringing the various parts of the ACT alcohol, tobacco and other drug sector together (workers, service consumers, researchers, policy makers and service providers) to build a knowledge base and shared dialogue for the important sector-wide changes that lay ahead in relation to strengthening service delivery responses to domestic and family violence. The Symposium was an important opportunity for the ACT ATOD sector to build linkages with DFV service providers and stakeholders. The Symposium was broad in its approach, touching on a range of concepts relevant to specialist AOD treatment and support in the context of DFV, including gender-responsiveness and trauma-informed practice (see Section 6 on acknowledgements for more information). The Symposium included speakers from the ACT and across Australia.

Over 60 people attended the Symposium. Its evaluation showed that it was rated as 'effective' or 'very effective' in relation to:

- Bringing together expertise from the multidisciplinary alcohol and other drug field
- Presenting information about domestic and family violence as it relates to the alcohol and other drug sector
- Promoting an open dialogue, self-reflection and exchange of ideas about alcohol and other drug sector responses to domestic and family violence

- Enhancing understandings of domestic and family violence in the context of alcohol and other drugs

4.2.5 Needs assessment

A survey tool was developed and disseminated to ascertain workforce needs in relation to understanding and responding to DFV in AOD settings. The survey results were analysed – including by the Advisory Group and Clinical Consultants - and at a high level, it indicated that there is a strong foundation to build on—understandings of, attitudes to, and awareness of DFV are good among the AOD workforce. The survey also indicated that capacity building is needed in the AOD sector to build on this strong foundation, and suggestions from the survey were used to inform the development of the deliverables. Needs were also identified throughout the first year’s activities, including through the co-design forums, ongoing engagements, and provision of parallel capacity building activities (e.g. basic and initial training for DFV workers in AOD, and DFV training for AOD workers).

4.2.6 Advisory Group

An Advisory Group was established to provide high level advice, strategic guidance and governance to the *AOD Safer Families Program*. The Advisory Group met monthly (a total of seven meetings) and provided a range of inputs to the *AOD Safer Families Program* including:

- Supporting transparent and inclusive processes for the development and implementation of activities
- Providing advice into the development of materials
- Identifying appropriate stakeholders to participate in consultative mechanisms
- Contributing information on interrelated activities relevant to AOD and DFV including policy, service delivery and governance
- Identifying and communicating barriers, challenges and successes regarding implementation
- Supporting communication about the *AOD Safer Families Program* within networks and interrelated activities, including ensuring that information was available to specialist alcohol and other drug, and domestic and family violence, stakeholders.

Membership included:

- Representatives from specialist AOD services
- Representative from the Women’s Services Network
- Representative from the Domestic Violence Prevention Council
- Consumer organisation
- ATODA
- ACT Health
- Clinical consultant

(See Section 6 on acknowledgements for more information).

4.2.7 Terms of Reference and plan

A high level plan for the first year of the *AOD Safer Families Program* (2017) was developed. It covered the terms of reference for the first year, including an overview of the vision, model and objectives, and a summary table of activities and deliverables. This was followed by a

series of terms of reference related to the individual projects (these are described further in the respective sections below) followed by a combined timetable for key activities.

4.2.8 Consultation and co-design engagement strategy

A strategy to engage the AOD service system, DFV stakeholders, clinicians, consumer organisations and other experts in the co-design of the deliverables was developed. Over an intensive six month period, this included (see Table 5 for details):

- Five face-to-face sector forums (combined to three and a half days)
- Two x face-to-face clinical and expert roundtables (combined to two full days)
- Two x face-to-face evaluation working groups (combined to two full days)
- Intensive implementation testing of the DFVCAT in seven AOD services over a three week period
- Desk-based review of the Practice Guide by ACT and interstate clinicians and experts over a ten day period
- Desk-based review of the Monitoring and Evaluation Framework over a one week period

Table 5. Summary of consultation and co-design engagement activities (July – December 2017)

Date	Duration	Audience	Topics	Further details
19 July 2017	½ day	ATOD Sector, invited DFV stakeholders, ACT Health	<ul style="list-style-type: none"> • Domestic and Family Violence Capability Tool • Scope of Practice 	Discussion included: an overview of the <i>AOD Safer Families Program</i> (year 1) from ATODA; a discussion of the Domestic and Family Violence Capability Assessment Tool including potential domains; criteria across the domains; overarching principles of practice; and a discussion of a Scope of Practice
6 September 2017	½ day	ATOD Sector, invited DFV stakeholders, ACT Health	<ul style="list-style-type: none"> • Domestic and Family Violence Capability Tool • Scope of Practice • Program design • Practice Guide • Evaluation Framework 	Discussion included: overview presentation of <i>AOD Safer Families Program</i> (Year 1), a brief on all deliverables components; individual and small group feedback on the Domestic and Family Violence Capability Assessment Tool
7 September 2017	Full day	Clinical and expert roundtable (by invitation), ACT Health	<ul style="list-style-type: none"> • Domestic and Family Violence Capability Tool • Scope of Practice 	Discussion included: overview presentation of <i>AOD Safer Families Program</i> (Year 1), including an update of the components; individual and small group feedback on the

			<ul style="list-style-type: none"> • Practice Guide • Program • Evaluation Framework 	Domestic and Family Violence Capability Assessment Tool; formation of clinical questions to inform the development of the Practice Guide
26 September – 19 October 2017	3 weeks	Specialist AOD services including ACT Health	<ul style="list-style-type: none"> • Implementation testing of the Domestic and Family Violence Capability Tool 	Specialist ACT AOD services were invited to undertake intensive implementation testing of the Domestic and Family Violence Capability Assessment Tool within a single program. When completed in full over the three week period, this included: reviewing domains and potential information sources; file audits; staff interviews; service consumer interviews and the completion of a feedback form
12 October 2017	Full day	ATOD sector, ACT Health, Evaluation consultants	<ul style="list-style-type: none"> • Program Logic from the Monitoring and Evaluation Framework 	Evaluation Working Group discussion included: development of the program logic and program theory of change (for further consultation with broader stakeholders)
19 October 2017	Full day	ATOD sector, ACT Health, Evaluation consultants	<ul style="list-style-type: none"> • Monitoring and Evaluation Framework 	Evaluation Working Group discussion included: development of evaluation questions, an outcomes matrix and data sources (for further consultation with the broader stakeholders)
20 October 2017	Full day	ATOD sector, invited DFV stakeholders, ACT Health	<ul style="list-style-type: none"> • Domestic and Family Violence Capability Tool • Scope of Practice • Program design • Evaluation Framework 	Discussion included: a briefing on the background and status of the <i>AOD Safer Families Program</i> (Year 1); feedback on the implementation testing of the Domestic and Family Violence Capability Assessment Tool and consultation on the draft program logic for the <i>AOD Safer Families Program</i>
24 October 2017	Full day	Clinical and expert	<ul style="list-style-type: none"> • Practice Guide 	Discussion included: review of evidence tables (from a systematic literature review)

		roundtable (by invitation)		related to the Practice Guide. Where evidence was not available or insufficient, clinical consensus was reached in order to provide practice guidance
9 November 2017	Full day	ATOD sector, invited DFV stakeholders, ACT Health	<ul style="list-style-type: none"> • Domestic and Family Violence Capability Tool • Practice Guide • Scope of Practice • Program design • Evaluation Framework 	Discussion included: briefing on the background and status of the <i>AOD Safer Families Program</i> (Year 1); briefing on the finalisation of the Domestic and Family Violence Capability Assessment Tool; briefing on the Practice Guide; consultation on the program design and funding model; consultation on the draft monitoring and evaluation framework
14 November – 24 November 2017	10 days	Clinical and expert roundtable participants, academics, ATOD sector, invited DFV violence stakeholders, ACT Health	<ul style="list-style-type: none"> • Practice Guide 	Final clinical and expert review of the Practice Guide
23 November – 30 November 2017	1 week	ATOD sector, invited DFV stakeholders, ACT Health	<ul style="list-style-type: none"> • Monitoring and Evaluation Framework 	Final review and feedback on the full draft of the Monitoring and Evaluation Framework
4 December 2017	Half day	Specialist alcohol and other drugs Executives, invited DFV violence stakeholders, ACT Health	<ul style="list-style-type: none"> • Program Design including funding model 	Discussion included: further consultation and consensus on the program design

4.2.9 Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings

The co-design process to develop the Domestic and Family Violence Capability Assessment Tool involved extensive consultation with the specialist AOD services; service consumers; policy makers; clinicians; and expert stakeholders in the alcohol, tobacco and other drug,

domestic and family violence, and behaviour change sectors from the ACT, New South Wales and Victoria. It was developed through a five-stage process as described below.

To view a copy of the Domestic and Family Violence Capability Assessment Tool see Attachment A.

Stage 1: Development

The development stage included a range of activities that set the scene for the production of the Domestic and Family Violence Capability Assessment Tool. It included preparation and planning components, as well as a face-to-face sector forum on 19 July 2017.

- Literature scan
- Project plan
- Terms of reference
- Development of an engagement strategy for the alcohol, tobacco and other drug sector
- Half-day workshop with alcohol, tobacco and other drug sector and other experts to gain their insights into the potential scope of the Domestic and Family Violence Capability Assessment Tool. This included obtaining information on their prior experiences with similar tools (e.g. Dual Diagnosis Capability in Addiction Treatment), advice on essential elements of the new tool, and suggestions for scope of practice within the area of DFV.
- Identification of essential elements of a Domestic and Family Violence Capability Assessment Tool, including fidelity measures (gained from the literature scan and suggestions from the alcohol, tobacco and other drug and domestic and family violence sectors).

360Edge synthesised all the information gained through Stage 1 to develop the first draft of the Domestic and Family Violence Capability Assessment Tool.

Stage 2: Consultation with stakeholders on first draft of the Domestic and Family Violence Capability Assessment Tool

The consultation stage included two key workshops to gain feedback on the first draft of the Domestic and Family Violence Capability Assessment Tool from key stakeholders including:

- Half-day sector forum held on 7 September 2017 to gain detailed feedback on the draft. Participants discussed elements of the draft in small groups and within the larger group. They also provided detailed written feedback on a paper version of the first draft, which was collected and used to inform a revision of the draft.
- Half-day clinical and expert roundtable on 8 October 2017, with discussion and opportunity for detailed written feedback on the first draft.

Stage 3: Refinement

This stage involved the refinement of the first draft into a more detailed second draft that reflected the views and opinions of stakeholders.

Revisions to the first draft were substantial and broadly involved:

- Revision of the service capacity/capability categories
- Recognition of the current diversity of services offered by specialist alcohol and other drug services reflected in language and detail
- Additional detail in the response domain descriptions
- A focus on healthy relationships rather than 'behaviour change'

- Merging the domains for consumers who experience violence and those who use violence into one
- Removal of references to percentages of staff with specific skills required for sub-domains
- More detail on the needs of sub-groups of service consumers such as Aboriginal and/or Torres Strait Islander people
- More emphasis on service consumer participation
- Clarification of staff training needs
- More clarity in criteria to distinguish capacity/capability categories across domains

Stage 4: Implementation testing of the Domestic and Family Violence Capability Assessment

The Stage 3 refinement process resulted in a strong second draft that was suitable for the implementation testing in ACT-based AOD programs between 25 September and 19 October 2017.

360Edge and ATODA produced detailed instructions on how to use the Domestic and Family Violence Capability Assessment to assist AOD services to test the tool in their work environments. The instructions were later modified for inclusion in the final Domestic and Family Violence Capability Assessment Tool. ATODA provided substantial in-person support to the services to assist them to conduct the testing.

Seven specialist AOD drug programs conducted implementation testing of the Domestic and Family Violence Capability Assessment Tool, which included one or more of the following activities: reviewing domains and potential information sources; file audits; staff interviews; service consumer interviews; and the completion of a feedback form.

Feedback on the implementation testing

A full-day sector forum to gain feedback from clinicians about applying the Domestic and Family Violence Capability Assessment Tool in practice, including feedback on the feasibility and relevance to AOD services, was undertaken on 20 October 2017.

Participants were asked for feedback on the following points of interest:

- content of the Domestic and Family Violence Capability Assessment Tool and relevance of the domains for AOD services
- feasibility of using the tool
- applicability of the tool to the services/programs that tested it
- resources required to implement the testing

In general, feedback on the second draft was positive. Areas of interest are summarised in this section.

Content and feasibility

Participants reported that the content was relevant. Suggestions for improvement of content related to: slight changes in wording in some criteria; changing the capacity domain 'Domestic and Family Violence Capable' to 'Domestic and Family Violence Ready' (to avoid the implication that if services score 1 or 2, they are not 'capable'); and collapsing domains 6 (staffing) and 7 (staff training) into one domain that dealt with staffing considerations generally.

Most participants reported that the Domestic and Family Violence Capability Assessment Tool was feasible to implement, while acknowledging that it was somewhat time-consuming.

Most felt that ongoing implementation would require less time commitment as services became more familiar with the tool. Participants also suggested it could be implemented within other quality assurance activities.

Applicability

There was broad agreement that the Domestic and Family Violence Capability Assessment Tool was applicable to the alcohol and other drug support and treatment environments, while the diverse settings and program focuses were acknowledged.

Participants reported difficulty in scoring some domains, particularly those that grouped multiple activities within a single capability.

They also suggested that it would be beneficial to have a mechanism for detecting improvement within a domain for services that do not seek to move to a higher capacity level.

Resourcing

Participants varied in their reports of time taken to test the Domestic and Family Violence Capability Assessment Tool in practice. Some participants felt it may take approximately two to five days per program to implement properly. Stakeholders agreed that services would need to nominate a specific staff member to drive the process, organise the consultation sessions with staff and service consumers, and conduct the service consumer chart audits.

There was unanimous agreement that additional resourcing would be required to implement the Domestic and Family Violence Capability Assessment Tool in a thorough way.

Most services thought that testing the Domestic and Family Violence Capability Assessment Tool had brought some practice issues into focus. This included ongoing screening for DFV - some programs considered that it was being done well, when the chart audit showed that this was not necessarily the case. Others reported service consumer perceptions of what they were asked about DFV during assessment did not necessarily match those of workers.

In general, participants reported that the Domestic and Family Violence Capability Assessment Tool will be a highly useful tool, particularly when used in combination with the Practice Guide that was also developed through the *AOD Safer Families Program*.

Stage 5: Finalisation

Revision of the second draft of the Domestic and Family Violence Capability Assessment Tool was conducted according to feedback from participants obtained through the implementation testing.

Revisions to the second draft were relatively minor and broadly involved:

- Changing the wording of 'Domestic and Family Violence Capable' capacity domain to 'Domestic and Family Violence Ready'
- Reducing seven assessment domains to six by merging domains 6 (Staffing) and 7 (Staff training) into one domain 6 (Staffing Considerations)
- Rewording domain 2 from 'Program milieu and organisational culture' to 'Physical environment and organisational culture' and making criteria for the level five category for this domain more closely align with AOD environments
- Clarifying scoring of the Domestic and Family Violence Capability Assessment Tool and allowing for measurement of incremental progress in each domain, in addition to overall capacity

The Domestic and Family Violence Capability Assessment Tool and associated Scope of Practice was finalised on 30 November 2017.

4.2.10 Scope of Practice: for Working with Service Consumers in AOD settings who Experience or Use Domestic and Family Violence

The Scope of Practice document was developed toward the end of the Domestic and Family Violence Capability Assessment Tool development process. This is because a Scope of Practice for AOD workers responding to DFV had never been produced before, and the Domestic and Family Violence Capability Assessment Tool process provided essential insights to inform its drafting.

360Edge drafted a Scope of Practice document that was discussed at the sector forum on 9 November 2017. Attendees acknowledged the challenges in developing such a document and provided feedback in relation to: clearer distinction in capability levels; the application of the scope of practice to program settings; and the need to focus on DFV specific skills (alongside the AOD qualifications and skills of workers).

Participants agreed that the Scope of Practice developed for the *AOD Safer Families Program* was a valuable guide to organisations and individuals on safe and effective practice with AOD service consumers who experience or use DFV.

The major content of the Scope of Practice was endorsed at the 9 November 2017 sector forum, with the minor amendments articulated above incorporated prior to finalisation on 30 November 2017.

To view Scope of Practice see Attachment B.

4.2.11 Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

The process for developing the Practice Guide acknowledged the gaps in the literature regarding responding to DFV in AOD settings. This meant that the development of the Practice Guide needed to be both evidence-informed and consensus-based (through drawing on the experience of clinicians and other experts related to AOD and DFV). As is the case with other clinical guidelines,⁽³⁾ a Clinical and Expert Roundtable was established with inputs from: specialist AOD services; service consumers; and clinicians and other expert stakeholders in the AOD, DFV, and behaviour change sectors from the ACT, New South Wales and Victoria. It was developed through a multi-stage process described below.

To view the Practice Guide see Attachment C.

Stage 1: Generating questions

A half day Clinical and Expert Roundtable was held on 7 September 2017, facilitated by Professor Nicole Lee, 360Edge, to develop the clinical questions that the framework would seek to answer. This included identifying: the types of DFV issues that are present in AOD service settings; the types of service consumers who are experiencing these issues; the way the issues can be identified (e.g. through screening); the most appropriate clinical/practice responses; and the expected outcomes if implemented well.

Stage 2: Systematic literature review

The clinical questions developed in the 7 September workshop were used to guide a systematic literature review, including the development of evidence tables, which contained written information about evidence-informed practice documented against its relevance in real-world settings.

From these evidence tables, 360Edge prepared a preliminary draft of the Practice Guide.

Stage 3: Consensus generation

The Clinical and Expert Roundtable was re-convened on 24 October 2017 to review the draft Practice Guide, draw conclusions about reasonable clinical practice based on evidence, and form a consensus view on strategies and programs to guide practice where evidence is lacking.

360Edge redrafted the Practice Guide to reflect the clinical consensus generated.

Stage 4: Review

The Practice Guide was circulated to a broad range of clinical and expert stakeholders for final review during the period 12 – 24 November 2017. The Framework was accompanied by a briefing paper, and feedback was sought from reviewers on the following questions:

- What is your general impression of the guidelines?
- Is the rationale for and purpose of the guidelines clear?
- Is the scope and focus of the guidelines accurate?
- Is the presentation and wording clear? Are there any issues with the use of language?
- Are the guidelines applicable to all AOD consumers, settings and practitioners?
- Are the conclusions, guidance and practice points accurate and relevant?

In general, feedback on the draft was positive. Areas of interest include:

Document title

Reviewers suggested that the document be re-named to reflect the extent to which the guide is based on clinical consensus.

Content

A number of content amendments were suggested to clarify concepts and evidence, including where evidence had been released since the initial drafting of the Practice Guide.

Additions

It was suggested that a section be added that contains only the consensus recommendations and practice points (for ease of reading). Additional comments were made regarding more thorough referencing to the Domestic and Family Violence Capability Assessment Tool.

In general, reviewers suggested that the Practice Guide will be a highly useful tool to guide practice in responding to DFV in AOD settings (irrespective of the service type and target group).

Stage 5: Finalisation

Revision of the second draft of the Practice Guide was conducted according to feedback from the review process.

The revised Practice Guide was finalised on 4 December 2017.

4.2.12 Monitoring and Evaluation Framework: for the ACT *Alcohol and Other Drug Safer Families Program*

The Monitoring and Evaluation Framework was developed through a four-stage process as described below.

To view the Monitoring and Evaluation Framework see Attachment D.

Stage 1: Identification of external evaluation consultant

A request for monitoring and evaluation proposals and quotations for the *AOD Safer Families Program* was developed by ATODA with expert evaluation advice. Submission closed on Friday 1 September 2017.

An assessment panel involving ATODA, ACT Health, clinical consultants and an evaluation expert was convened to review the applications, and ARTD Consultants were appointed as the external evaluation consultants.

Stage 2: Development of Monitoring and Evaluation Framework

An *AOD Safer Families Program* Evaluation Working Group was convened to progress the substantive development work in relation to a number of areas in the Monitoring and Evaluation Framework. This was progressed through two full day working group meetings facilitated by ARTD Consultants:

- 12 October 2017: Development of a draft program theory, outcomes hierarchy and theory of change
- 19 October 2017: Development of draft evaluation questions, outcomes matrix and identification of data collection sources.

From the information generated through these working groups, ARTD drafted the Monitoring and Evaluation documents, which were provided to the working group for further feedback prior to broader consultation.

Stage 3: Consultation with stakeholders

The consultation stage included two key workshops to gain feedback on the draft components of the Monitoring and Evaluation Framework including:

- Sector Forum on 20 October 2017 to gain detailed feedback on the draft program logic. Participants had an opportunity to review the full draft and suggest amendments or additions.
- Sector Forum on 9 November 2017 to present the revised program logic, outcomes matrix and gain detailed feedback on two key points: 'what do we want to know?' and 'how do we get that information'.

Stage 4: Refinement and review

ARTD Consultants refined the draft materials into more detailed final drafts that reflected the views and opinions of stakeholders. These were disseminated electronically to attendees of the 9 November Sector Forum and the Evaluation Working Group for final feedback from 23 November – 30 November.

Stage 5: Finalisation

The Monitoring and Evaluation Framework was finalised in early December 2017. As its authors from ARTD Consultants wrote:

The evaluation framework is intended to provide a blueprint for monitoring and evaluation of the design, implementation and outcomes of the Program from 2017 to 2021.

...
The framework has program logic and theory of change for the Program, key and guiding evaluation questions, and potential indicators and data sources that could be used for implementation and outcomes evaluations, and for providing monitoring data to a Project governance group or auspice organisation or consortium.

The framework also covers advice on evaluation governance, ethical considerations and planning evaluations, and description of the timing and purpose of possible evaluations for the Program.

The Framework provides a sound basis for developing detailed monitoring and evaluation implementation plans once the details of the next stage of the Program are settled.

4.2.13 Program design

The co-design process to develop the *AOD Safer Families Program* (for delivery from 2018) involved engagement with specialist ACT alcohol and other drug services (particularly Executive Directors), key stakeholders from the domestic and family violence sector, and ACT Health. Support was provided from 360Edge to facilitate input from stakeholders through the various iterations and stages (as described below).

To view the *AOD Safer Families Program* Description and Model and Implementation Plan see Sections 2 & 3.

Stage 1: Defining and re-visiting the scope

The co-design of the *AOD Safer Families Program* reflected an innovative approach to policy and service development in the ACT alcohol, tobacco and other drug sector: funders, policy makers, and service delivery agencies collaborating to define a model and approach to expending the funds available for the *AOD Safer Families Program*. Significant work went into clearly defining and documenting the potential scope for the program design work, including the development of multiple iterations of the terms of reference and meetings with ACT Health (as the funder).

Preliminary engagement of AOD and DFV services occurred at the Sector Forum held on 20 October 2017, and focused on the establishment of threshold principles to underpin the program design and funding approach.

Stage 2: Developing and consulting with stakeholders on potential pilot designs and funding models

This stage involved the development of five draft funding model options, and broader program design components, for consultation at the Sector Forum on 9 November 2017 (facilitated by 360Edge).

The detailed funding models were accompanied by information to enable comparison between each approach, including the identification of strengths and limitations of each. The models ranged from those that closely reflected ‘business as usual’ open market competitive commissioning approaches, to those that reflected consortium/sector driven commissioning process in partnership with funders.

Consultation also occurred in relation to broader program design components or considerations including:

- Government and other funding body commissioning practices
- A core framework to concurrently resource both:
 - collaboration service enhancement and capacity building
 - one or more new coordinated/integrated pilot projects
- Funding Principles
- Eligibility
- Components of program proposals

There was significant discussion on each approach to funding, as well as the broader program design components. This resulted in an agreement to remove funding models that were eventually deemed unfeasible or unworkable, and consensus to further develop two preferred models.

Stage 3: Revisions

Following the 9 November 2017 Sector Forum, major revisions were made to the proposed funding models for program, leading to the development of two potential models:

- Funding to collaboration with collective service enhancement/capacity building, and one or more new coordinated/integrated pilot projects
- Collaboration only

Alongside the detailed funding models, a document reflecting the broader components of the Program design was also produced (reflecting the consensus reached on the program design throughout multiple consultations in 2017). This information was provided to all specialist AOD service Executive Directors, ACT Health and invited DFV stakeholders in advance of a final co-design workshop on 4 December 2017.

Stage 4 Final refinement and consensus

A workshop between Executive Directors of specialist AOD services and Linda Jenner from 360Edge was held on 4 December 2017. This included consultation on the two previously described funding models, and clarification of implementation details. Consensus was reached to proceed with a model that incorporated 1) funding to support collaboration with collective service enhancement/capacity building and 2) one or more coordinated/integrated pilots in individual ACT AOD services.

The program model and implementation plan were revised reflecting the feedback from the final stakeholder consultation. A final draft was distributed to specialist ACT AOD service Executives, invited DFV stakeholders and ACT Health prior to the report being completed.

4.3 Conclusion

The *ACT AOD Safer Families Program* was developed throughout 2017, with funding from ACT Health through the broader ACT Safer Families Initiative, and with support from the Office of the Coordinator General for Family Safety. The funding was enabled through

contributions from every household in the ACT, via the Safer Families Levy applied in Rates Assessment Notices. The co-design and collective impact approach produced the intended outcome: the ACT specialist ATOD sector is confident about moving into implementing DFV interventions, including some discrete pilots, within their services. The methodology used in the Program to date has been highly successful, delivering widespread support (throughout the sector) for moving to the next stages of the Program. The goodwill and collaboration, and the resources that the Program has produced to date, constitute springboards for enhancing DFV responses in the ACT specialist AOD service system.

¹ NSW Council of Social Service (NCOSS). (2017). *Principles of Co-design*. Woolloomooloo: NCOSS. Accessed 1 December 2017 at: <https://www.ncoss.org.au/sites/default/files/public/resources/Codesign%20principles.pdf>

² Kania, J & Kramer, M. (2011). 'Collective impact', *Stanford Social Innovation Review*, Winter 2011, pp. 36-41.

³ Brouwers, MC *et al.* (2010). 'AGREE II: advancing guideline development, reporting and evaluation in health care', *Can Med Assoc J*, vol. 182, no. 18, pp. E839-42.

5 Section 5: Future Revisions

5.1 Future Revisions to the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide

The Domestic Violence Capability Assessment Tool, Scope of Practice and Practice Guide are the first documents of their type in Australia. ATODA encourages the utilisation of these resources across alcohol and other drug (AOD) services throughout Australia. Their applicability across a range of AOD treatment and support settings, models of care and jurisdictions makes them appropriate for adaptation into a range of services and with diverse service consumer groups accessing AOD services.

From their implementation, more will be known about their applicability and usefulness in diverse AOD settings, and this can inform future revisions and refinements to the tools. For example, the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Toolkit, that was used as a model for the current version of the Domestic and Family Violence Capability Assessment Tool, was developed and field tested in 2003. Since that time, it has been subject to rigorous testing of its psychometric properties to ensure that it is a valid and reliable tool.

Some areas that may require close attention in future refinements of the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide include the following.

Quantitative measures

Validation testing of the current version of the Domestic and Family Violence Capability Assessment Tool was not possible within the first year of the *AOD Safer Families Program*. While the tool has been field tested by specialist AOD services in the ACT, it is recommended that resourcing be identified in future years to enable the tool be subject to suitable testing, such as internal consistency, inter-rater reliability and sensitivity to change over time. Studies of this kind will enable the sector to have greater confidence in the Domestic and Family Violence Capability Assessment Tool in the future.

Qualitative measures

It is also anticipated that the Monitoring and Evaluation Framework for the *AOD Safer Families Program* will provide an opportunity to obtain qualitative feedback (in addition to quantitative information) from AOD services on all areas of applying the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide in practice, which could assist in future refinement.

Content review

Much is known about effective approaches to DFV, and the evidence base for AOD interventions is also strong. However, evidence regarding the interface between the two issues is significantly smaller.

As more becomes known about effective responses to AOD service consumers who experience or use DFV, the contents of the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide are likely to require revision. It is recommended that the contents of the documents be reviewed every two years and be revised to align with emerging evidence.

5.2 Future partnerships to revise and improve the instruments

ATODA is interested in working with, and supporting, stakeholders in the ACT and nationally to undertake further refinement of the tools, including by identifying resources to do this work. Please contact ATODA to discuss opportunities for collaboration – www.atoda.org.au

6 Section 6: Acknowledgements

ATODA would like to acknowledge the many individuals, families and communities impacted by domestic and family violence (DFV) and particularly the gendered nature of DFV and its disproportionate impacts on women and children.

ATODA would also like to acknowledge the many individuals, families and communities also impacted by harmful alcohol and other drug (AOD) use.

As demonstrated throughout this section many stakeholders have provided invaluable support, resources and insights from 2017 of the ACT *AOD Safer Families Program*.

These 2017 accomplishments were some of the most rigorous and intensive co-design activities ever led by the ACT Alcohol Tobacco and Other Drug Sector. These achievements speak to the commitment and expertise of our workforce, services, policy workers and consumer organisation in delivering quality AOD care and making Canberra safer for everyone.

The crucial and generous advice and support from our colleagues within the DFV sector throughout 2017 is gratefully acknowledged.

Information is provided below on the many contributors in 2017 to the *AOD Safer Families Program*.

6.1 Funders

The funding for the 2017 *AOD Safer Families Program* was enabled by every household in the ACT through the Safer Families Levy applied in Rates Assessment Notices.

ACT Health through the broader ACT Safer Families Initiative administered the funding.

We estimate that in 2017 the stakeholder contribution to the *AOD Safer Families Program* is approximately \$225,000 in-kind, which again demonstrates the sectors' commitment to the health, wellbeing and safety of our community and particularly to responding well to DFV.

We also extend our thanks to Clayton Utz for pro-bono facilities use.

6.2 Policy makers and workers

- Meegan Fitzharris MLA, Minister for Health and Wellbeing
- Yvette Berry MLA, Minister for Prevention of Domestic and Family Violence
- Jo Wood, Coordinator-General for Family Safety
- Helene Delany, Manager, Alcohol and Other Drug Policy Unit, ACT Health
- Philip Hull, Senior Policy Officer, Alcohol and Other Drug Policy Unit, ACT Health

- Jane Pepper, Health Advisor, Office for the Coordinator General for Family Safety

We would also like to acknowledge Chris Kelly and Kirsty Whybrow from the Health Improvements Projects area of ACT Health for their engagements towards the end of 2017.

6.3 Specialist ACT AOD services

The ACT specialist AOD treatment and support services that were involved in the Program include:

- Alcohol and Drug Services, ACT Health
- Alcohol and Other Drug Services, CatholicCare Canberra & Goulburn
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Recovery Services, The Salvation Army
- Directions Health Services
- Karralika Programs Inc.
- Toora Women Inc.

These services showed their commitment and dedication to this important issue through regular and intensive (un-resourced) involvement through multiple consultations, the implementation testing of the Domestic and Family Violence Capability Assessment Tool (DFVCAT), and through providing regular feedback on the many iterations of the Project's outputs.

6.4 Domestic and family violence sector stakeholders

The Program sought advice from, and engaged with, the existing governance and advisory structures related to domestic and family violence in the ACT, particularly the Domestic Violence Prevention Council and the Women's Services Network. Within this groups, particular thanks is owed to the following DFV sector stakeholders who attended events, participated in Program governance, or offered advice including:

- Marcia Williams, Domestic Violence Prevention Council (Chair), Women's Services Network & Women's Centre for Health Matters
- Mirjana Wilson, Domestic Violence Crisis Service
- Jo Wood, Coordinator-General for Family Safety
- Jane Pepper, Health Advisor, Office of the Coordinator-General for Family Safety
- Nikki Goddard, Women's Services Network & Women's Health Services, ACT Health
- Greg Aldridge, Domestic Violence Prevention Council & EveryMan
- Jess O'Dea, Women's Services Network & Domestic Violence Crisis Service
- Niesa Petley, Women's Services Network & Domestic Violence Crisis Service

6.5 Consultants

The Program received expert leadership and advice from a number of consultants, including:

- Linda Jenner, 360Edge (Clinical Consultant)
- Professor Nicole Lee, 360Edge (Clinical Consultant)
- David McDonald, Social Research and Evaluation (Evaluation and Project Consultant)
- Fiona Christian, ARTD Consultants (Evaluation Consultant)
- Melanie Darvodelsky, ARTD Consultants (Evaluation Consultant)

6.6 ATODA staff

Project management and support was provided by the following ATODA staff:

- Amanda Bode, Program Manager
- Anke van der Sterren, Researcher and Project Manager
- Carrie Fowlie, Chief Executive Officer

Additional project activities were undertaken by:

- Jeanette Bruce, Organisational Development Officer
- Julie Robert, Communications Officer
- Dave Corby, Office Manager
- Melinda Petrie, Project Manager

6.7 Project Advisory Group

The Project Advisory Group provided high level advice, strategic guidance and governance to the Program. Membership included:

- Chris Gough, Canberra Alliance for Harm Minimisation and Advocacy
- Jill Hughes, Alcohol and Drug Services, ACT Health
- Linda Jenner, 360Edge (Clinical Consultant)
- Marcia Williams, Domestic Violence Prevention Council & Women's Services Network
- Professor Nicole Lee, 360Edge (Clinical Consultant)
- Sharon Tuffin and Anna McKendry, Karralika Programs Inc.
- Susan Clarke-Lindfield, Toora Women Inc & Women's Services Network
- Amanda Bode, ATODA
- Anke van der Sterren, ATODA
- Carrie Fowlie, ATODA (Chair)

6.8 Clinical and expert roundtable and reviewers

The Domestic Violence Capability Assessment Tool, Scope of Practice and Practice Guide were developed through input, review and clinical consensus of the following people:

- Anna McKenry, Karralika Programs Inc.
- David McDonald, Social Research and Evaluation
- Donna Ribton-Turner, Uniting Care ReGen
- Dr Stefan Gruenert, Odyssey House Victoria
- Dr Suzie Hudson, Network of Alcohol and Drug Agencies

- Eleanor Morrison, Consumer Representative
- Kate Gardner, Alcohol and Drug Services, ACT Health
- Linda Jenner, 360Edge
- Philip Hull, Health Improvements Projects, ACT Health
- Professor Nicole Lee, 360Edge
- Rebecca Wood, Toora Women Inc.
- Shannon Wright, YWCA NSW
- Sione Crawford, Consumer Representative

- Amanda Bode, ATODA
- Anke van der Sterren, ATODA
- Carrie Fowlie, ATODA

Contributions to the Practice Guide were also made by Jacquie Cameron and Jenni Harman from 360Edge.

The Practice Guide underwent further external review, with contributions received from a range of stakeholders (elsewhere listed in the acknowledgements). Specific thanks is owed to:

- Professor Peter Miller, Violence Prevention and Addiction Studies; Deakin University Centre for Drug, Alcohol and Addiction Research
- Assistant Professor Petra Staiger, Violence Prevention and Addiction Studies; Deakin University Centre for Drug, Alcohol and Addiction Research
- Dr Ashlee Curtis, Violence Prevention and Addiction Studies; Deakin University Centre for Drug, Alcohol and Addiction Research

Feedback was also received from ACT Health and the Office of the Coordinator-General for Family Safety.

6.9 Sector forum participants

The following individuals participated in the six sector wide forums (for AOD and invited DFV stakeholders):

- Aimee Capper, Canberra Alliance for Harm Minimisation and Advocacy
- Amanda Bode, ATODA
- Angie Keir, Canberra Recovery Services, The Salvation Army
- Anke van der Sterren, ATODA
- Anna McKenry, Karralika Programs Inc.
- Bronwyn Hendry, Directions Health Services
- Carrie Fowlie, ATODA
- Cassie Taylor, CatholicCare Canberra & Goulburn
- Chris Gough, Canberra Alliance for Harm Minimisation and Advocacy
- Chris Kelly, Health Improvements Projects, ACT Health
- David McDonald, Social Research and Evaluation
- Diana Rodrigues, Canberra Recovery Services, The Salvation Army
- Fiona Christian, ARTD Consultants
- Greg Aldridge, Domestic Violence Prevention Council & EveryMan
- Helene Delany, Manager, Alcohol and Other Drug Policy Unit, ACT Health
- Jacqui Warrington, Canberra Recovery Services, The Salvation Army

- Jane Pepper, Health Advisor, Office of the Coordinator General for Family Safety
- Jeanette Bruce, ATODA
- Jess O’Dea, Women’s Services Network & Domestic Violence Crisis Service
- Jill Hughes, Alcohol and Drug Services, ACT Health
- Josh Vaughan, CatholicCare Canberra & Goulburn
- Julie Robert, ATODA
- Kate Gardner, Alcohol and Drug Services, ACT Health
- Kate Kidston, Canberra Recovery Services, The Salvation Army
- Kirsty Whybrow, Health Improvements Projects, ACT Health
- Kristy Morris, Toora Women Inc.
- Krysia Keefe, Directions Health Services
- Linda Jenner, 360Edge
- Marcia Williams, Domestic Violence Prevention Council; Women’s Services Network & Women’s Centre for Health Matters
- Meg Diggle, Directions Health Services
- Melanie Darvodelsky, ARTD Consultants
- Melinda Petrie, ATODA
- Niesa Petley, Women’s Services Network & Domestic Violence Crisis Services
- Nikki Goddard, Women’s Services Network & Women’s Health Services, ACT Health
- Philip Hull, Senior Policy Officer, Alcohol and Other Drug Policy Unit, ACT Health
- Professor Nicole Lee, 360Edge
- Rebecca Wood, Toora Women Inc.
- Riddhi Blackley, Canberra Recovery Services, The Salvation Army
- Sharon Tuffin, Karralika Programs Inc.
- Stephanie Stephens, Directions Health Services
- Susan Babic, Toora Women Inc.
- Susan Clarke-Lindfield, Toora Women Inc.
- Tilly Gardner, Toora Women Inc.
- Zac Hampson, Ted Noffs Foundation

6.10 DFVCAT implementation testers

The following services and staff were involved in the implementation testing of the DFVCAT:

- Directions Health Services including Kim Fleming and the Arcadia Team
- Toora Women Inc. including Rebecca Wood and the AOD Day Program Team
- Canberra Recovery Services, The Salvation Army including Jacqui Warrington and Diana Rodrigues
- Karralika Programs Inc. including Anna McKenry, Dawn Bainbridge and Andrea Andrew
- Canberra Alliance for Harm Minimisation and Advocacy including Chris Gough, Aimee Capper, Juda Weerheim, Peter Parkes and Geoff Ward
- CatholicCare Canberra & Goulburn including Riddhi Blackley and the Sobering Up Shelter team
- Alcohol and Drug Services, ACT Health including Jill Hughes and the ADS team

6.11 Evaluation Working Group

The program logic, program theory and monitoring and evaluation framework were developed with the support of an Evaluation Working Group comprised of:

- David McDonald, Social Research and Evaluation
- Fiona Christian, ARTD Consultants
- Melanie Darvodelsky, ARTD Consultants
- Philip Hull, Health Improvements Projects, ACT Health

- Amanda Bode, ATODA
- Anke van der Sterren, ATODA
- Carrie Fowlie, ATODA

6.12 Promoting Safety and Prioritising DFV in the ACT AOD Sector Symposium

A range of speakers contributed to the Symposium including:

- Mrs Agnes Shea OAM, Ngunnawal Elder
- Amanda Bode, ATODA
- Carrie Fowlie, ATODA (Chair)
- Sione Crawford, Consumer Representative and Symposium Discussant
- Eleanor Morrison, Consumer Representative and Symposium Discussant
- Marcia Williams, Domestic Violence Prevention Council
- Dr Anna Olsen, Research School of Population Health, Australian National University
- Anke van der Sterren, ATODA
- Professor Nicole Lee, 360Edge and National Drug Research Institute
- Dr Stefan Gruenert, Odyssey House Victoria
- Trevor King, Uniting Care ReGen

Over 60 people attended the symposium from the following invited organisations:

- 360Edge
- Aboriginal and Torres Strait Islander Elected Body
- ACT Community Corrections, Justice and Community Safety Directorate
- Australian Institute of Health and Welfare
- ACT Greens
- ACT Health – Policy
- ACT Health Representative - CGFSIDC
- ACT Labor
- ACT Policing
- ACT Council of Social Service Inc.
- Alcohol and Drug Services, ACT Health
- AOD Policy Unit, ACT Health
- Alcohol Tobacco and Other Drug Association ACT
- Beryl Women Inc.
- Canberra Alliance for Harm Minimisation and Advocacy
- Canberra Liberals
- Canberra Rape Crisis Centre

- Canberra Recovery Services, The Salvation Army
- CatholicCare Canberra & Goulburn, Sobering Up Shelter
- Chief Minister Treasury and Economic Development
- Child and Youth Protection Services, Community Services Directorate
- Consumer representatives
- Council of Australian Government Advisory Panel on Reducing Violence against Women and their Children
- Criminal Law Group, Department of Justice and Community Safety
- DFV Advisory Group of ACT Health Staff
- Directions Health Services
- Domestic Violence Crisis Service
- Domestic Violence Prevention Council
- Doris Women's Refuge
- Family Violence Intervention Program Committee
- Families and Friends for Drug Law Reform
- Gugan Gulwan Youth Aboriginal Corporation AOD Program
- Hepatitis ACT
- Institute of Child Protection Studies, Australian Catholic University
- Karralika Programs Inc.
- Legislation, Policy & Programs, Justice and Community Safety Directorate
- Minister for Health's Office
- Minister for Women
- Ministerial Advisory Council on Women representative on the ACT ATOD Strategy Evaluation Group
- National Centre for Epidemiology and Population Health, Australian National University
- Northside Community Services
- Odyssey House Victoria
- Office for Women, Community Services Directorate
- Office of the Coordinator-General for Family Safety
- Research School of Population Health, Australian National University
- Social Research and Evaluation
- Ted Noffs Foundation
- Toora Women Inc. AOD Programs
- Toora Women Inc.
- UnitingCare ReGen
- Victims Liaison Office (ACT Policing)
- Victims of Crime Commission
- Winnunga Nimmityjah Aboriginal Health and Community Services
- Women's Centre for Health Matters
- Women's Health Service
- Women's Services Network
- YWCA

6.13 Additional critical friends

Additional advice was provided by a range of stakeholders, not elsewhere recorded in this acknowledgements section including:

- Dr Justin Barker, Institute of Child Protection Studies, Australian Catholic University

- National Centre for Epidemiology and Population Health, Australian National University
- National Drug and Alcohol Research Centre, University of New South Wales
- Australian AOD Peaks Network:
 - Association of Alcohol and other Drug Agencies NT
 - Alcohol, Tobacco and other Drugs Council of Tasmania
 - Network of Alcohol and other Drugs Agencies (NSW)
 - Queensland Network of Alcohol and other Drug Agencies
 - South Australian Network of Drug and Alcohol Services
 - Victorian Alcohol and Drug Association
 - Western Australian Network of Alcohol and other Drug Agencies

7 Section 7: Conclusion

The activities of the *AOD Safer Families Program* in 2017, and its focus on co-design, has led to the development of infrastructure and a Program design that is evidence-based, fit-for-purpose, feasible and well supported by the specialist AOD and DFV stakeholders in the ACT.

If implemented as proposed from 2018, specialist AOD services will be well-placed to recognise and respond to DFV resulting in earlier identification and improved interventions; leading ultimately to better outcomes for people who access specialist AOD services in the ACT, namely:

- People - particularly women - who experience domestic and family violence currently, in the past, and/or at risk of in the future
- People - particularly men - who use domestic and family violence currently, in the past, and/or at risk in the future

New coordinated/integrated interventions for AOD/DFV that have not previously been available will form part of the broader AOD service system intervention landscape. Concurrently, enhancements made across all specialist AOD services will universally contribute to improved safety, health and wellbeing for AOD service consumers, their families and friends.

Within the context of an emerging evidence base, the *AOD Safer Families Program* has potential to continue to show leadership in the ACT and Australia more broadly when developing and piloting new approaches that respond to people who use alcohol and other drugs and experience or use domestic and family violence.

Attachment A: Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings

This attachment contains the Domestic and Family Violence Capability Assessment Tool (DFVCAT): for Alcohol and Other Drug (AOD) Settings.

About this document:

The DFVCAT is a benchmarking tool designed to assist AOD services to assess their current responses to service consumers who experience or use domestic and family violence (DFV), and plan for future improvements. The DFVCAT was modelled on the toolkit *Dual Diagnosis Capability in Addiction Treatment (DDCAT)*,⁽¹⁾ which was used by AOD services nationally to enhance care for service consumers with co-occurring mental health problems.

Although applicable nationally, it was more specifically developed to guide benchmarking and planning within the context of the *ACT AOD Safer Families Program*.

The DFVCAT was developed through an intensive co-design process with AOD and DFV services, clinicians and other experts, consumer organisations and policy makers (see Section 4).

Relationship to the *AOD Safer Families Program*:

The DFVCAT should be used by specialist AOD services funded through the *AOD Safer Families Program* to benchmark and assess capacity to respond to DFV; plan for service enhancement/capacity building and new coordinated/integrated pilots to respond to AOD and DFV; and assess and report on progress. In particular, those services that are funded through the *AOD Safer Families Program* should be required to implement the DFVCAT as a baseline, make a subsequent plan of action and then re-implement the DFVCAT at regular intervals to monitor progress.

As described in the *AOD Safer Families Program* model (see Section 2); the DFVCAT is designed as a companion tool to both the Practice Guide (see Attachment C) and Scope of Practice (see Attachment B).

When used in conjunction with each other, the materials provide sufficient information to guide AOD practice when responding to DFV at an organisational, program and individual worker level. Additionally, these documents are all subjects of the *AOD Safer Families Program* Monitoring and Evaluation Framework which will help to provide evaluation guidance at a whole of sector / policy level:

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	Program / organisational level	<ul style="list-style-type: none"> • Benchmark and assess capacity to respond to DFV in AOD settings • Plan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated / integrated AOD and DFV responses. • Assess and report on progress
Scope of Practice: for Working with Service	Both program / organisational level & practice /clinical level	<ul style="list-style-type: none"> • Clarify roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV

Consumers in AOD Settings who Experience or Use DFV		<ul style="list-style-type: none"> • Guide services and workers on how to work safely and effectively (based on skills, qualifications and training) • Inform workforce planning, training and recruitment
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice / clinical level	<ul style="list-style-type: none"> • Guide practice (e.g. screening, assessment and interventions) • Optimise responses and outcomes for service consumers • Ensure activities funded through the <i>AOD Safer Families Program</i> are evidence based and align with clinical consensus
Monitoring and Evaluation Framework: for the ACT <i>Alcohol and Other Drug (AOD) Safer Families Program</i> 2017-2021	Whole of sector / policy level	<ul style="list-style-type: none"> • Monitor and evaluate the entire <i>AOD Safer Families Program</i> • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to DFV in AOD settings

Suggested Citation:

The suggested citation for a copy of the document provided as attachment is:

Jenner, L., Lee, N. & Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings*. Canberra: ATODA.

Available At:

The Domestic and Family Violence Capability Assessment Tool: for AOD Settings will also be made available as a stand-alone document available from www.atoda.org.au.

Attachment A

Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings

Version 1

December 2017

The Domestic and Family Violence Capability Assessment Tool: for AOD Settings (DFVCAT)

What is the DFVCAT?

The DFVCAT is a benchmarking tool designed to assist alcohol and other drug (AOD) services to assess their current responses to AOD service consumers who experience or use domestic and family violence (DFV), and plan for future improvements. The DFVCAT was modelled on the toolkit *Dual Diagnosis Capability in Addiction Treatment (DDCAT)*,⁽¹⁾ which was used by AOD services nationally to enhance care for service consumers with co-occurring mental health problems.

How was the DFVCAT developed?

The DFVCAT was developed through a co-design process involving extensive consultation with the specialist AOD services; service consumers; and expert stakeholders in the ATOD, DFV, and behaviour change sectors from the ACT, New South Wales and Victoria. The DFVCAT was finalised through a five-stage process described below.

Stage 1 Development

The development stage included preparation and planning, identifying other benchmarking tools, and early engagement with specialist AOD services to provide advice on essential elements that would comprise the first draft.

Stage 2 Consultation with stakeholders

The consultation stage included workshops with the specialist AOD services and other experts to gain feedback on the first iteration of the DFVCAT.

Stage 3 Refinement

The refinement stage involved revision of the first draft to produce a refined second draft suitable for implementation testing in various AOD practice settings.

Stage 4 Implementation testing

The second draft of the DFVCAT was subject to testing at the organisational/program level by AOD services during September and October 2017. Feedback on applying the DFVCAT in practice, including feedback on the feasibility and relevance to AOD services generally, was gained through a full-day workshop.

Stage 5 Finalisation

Feedback from the implementation testing was used to produce the final version of the DFVCAT in December 2017.

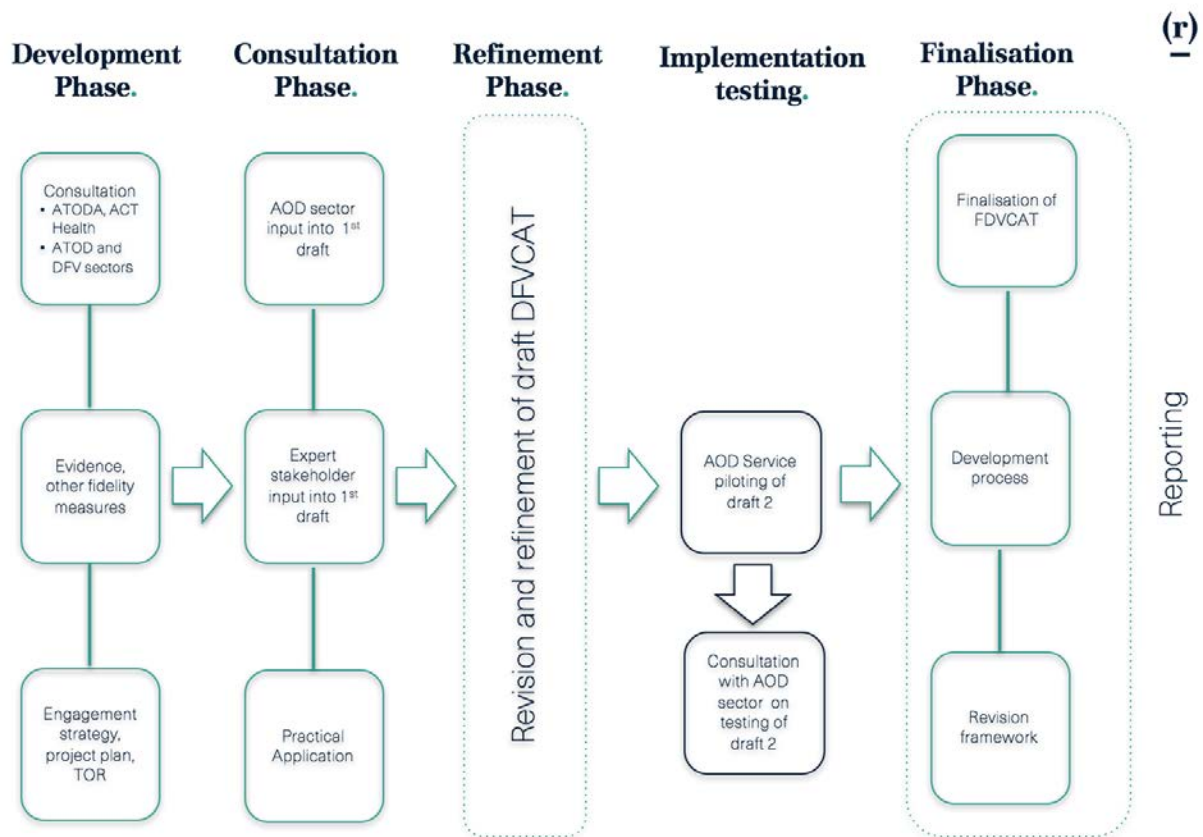


Figure 1: DFVCAT development overview

For more information on the co-design process and development of the DFVCAT see Section 4.

DFVCAT domains

The DFVCAT contains six domains that encompass good practice responses to service consumers who experience or use DFV. It is designed to allow programs/organisations to assess capacity to respond to DFV. That is, it is not intended to provide a measure for AOD work, which is assumed.

1. Program structure

Examines four factors that support a program/organisations capacity to plan and respond to issues of DFV among service consumers.

2. Physical environment and organisational culture

Examines two factors that establish how issues of DFV are recognised and accommodated by the particular program/organisation.

3. Clinical processes – screening and assessment

Examines the extent to which screening for DFV and associated assessment inform program/organisation decision making.

4. Clinical processes – interventions

Examines how AOD and DFV issues are addressed in the context of specialist AOD care.

5. Continuity of care

Examines how service consumers with both AOD and DFV issues are supported over time.

6. Staffing considerations

Determines staffing mix, staff support activities, availability of AOD staff members with expertise in DFV issues, and staff training required to work safely and effectively.

DFVCAT service capacity levels

The DFVCAT describes five levels of service capacity that can be used to benchmark responses by a particular organisation, or specific program within an organisation that delivers multiple service types. The levels were identified by expert stakeholders who contributed to the development of the DFVCAT.

It is important to note that not all AOD programs/organisations will or should strive for the advanced levels of capacity in the area of DFV (DFV Coordinated Care and DFV Integrated Care).

Programs/organisations need to consider their service type, purpose, and service structure when considering how to benchmark against these categories.

1. DFV Aware

While the program/organisation is aware of issues related to DFV as they relate to AOD use and they may be addressed incidentally, the program/organisation aims to deliver high quality care that focuses on AOD issues and other core service responses such as addressing blood-borne viruses, mental health issues and tobacco smoking.

2. DFV Identified

The program/organisation is not only aware of DFV issues, but may also identify service consumers' issues related to DFV within the context of quality AOD care, although identification is not routine. The focus is primarily on AOD and other core service responses relevant to the program/organisations purpose and setting.

3. DFV Ready

The program/organisation has capacity to identify issues related to DFV with most service consumers, and is capable of delivering some basic DFV specific programming to service consumers within the context of quality AOD care. Responses primarily involve referral to specialist DFV and healthy relationships/behaviour change services, with monitoring of service consumer's progress.

4. DFV Coordinated Care

The program/organisation has capacity to identify issues related to DFV with all service consumers, and is capable of delivering some advanced DFV specific programming to service consumers in collaboration with specialist DFV and healthy relationships/behaviour change services staff. The primary focus is AOD, but DFV is routinely addressed in all areas of treatment planning.

5. DFV Integrated Care

The program/organisation has capacity to identify issues related to DFV with all service consumers, and treatment planning addresses both AOD and DFV equally when they co-occur. Advanced DFV specific programming is delivered within the program/organisation. Staff trained in both AOD and DFV are employed within the program/organisation.

Principles of practice for the DFVCAT in AOD settings

The principles that underpin the responses to domestic and family violence - when using the DFVCAT - in AOD settings are:

- Domestic and family violence is a violation of human rights and is unacceptable in any form, in any community, and in any culture.
- The safety of service consumers and children who have experienced, or are experiencing, DFV is the priority.
- AOD use, while not a cause of DFV, is significantly associated with DFV.
- AOD services work collaboratively with other services to address DFV, including specialist DFV, men's behaviour change, and mental health sectors.
- AOD services are delivered within a trauma-informed care paradigm; and above all do no harm to service consumers or their children.
- AOD services provide non-judgmental care to service consumers who use DFV, while communicating DFV in all forms is unacceptable and the service consumer is entirely and always responsible for their actions.
- DFV can impede AOD treatment outcomes, and must be considered in the context of AOD service delivery.
- The issue of DFV is raised with AOD service consumers, and followed-up by conducting or facilitating risk assessment and treatment planning (including safety planning) when experience of DFV is detected. Harm reduction and stepped-care approaches are also used.
- AOD services consult with service consumers to ensure that the information they receive about DFV is relevant, accurate and accessible.
- AOD services consult with service consumers to identify and overcome barriers to disclosure of DFV in the context of AOD support and treatment.

How to use the DFVCAT

Implementing the DFVCAT in practice

The DFVCAT is a baseline measure that assists programs/organisations to plan for improved services according to their service type and main focus of care. While many programs/organisations will aim to increase capacity in this area, not all AOD programs/organisations will strive for the higher levels of capacity. For example, a program/organisation may choose to improve *within* a particular category if higher categories are inappropriate for the program/organisation offered. Therefore, programs/organisations need to consider their service type, purpose and service structure when considering how to benchmark against these categories and plan for the future.

Where an organisation delivers a range of service types, the DFVCAT will provide a better assessment of response if it is implemented at the individual program level. For example, responses to DFV by workers in a needle syringe program are likely to be opportunistic (e.g. DFV Aware or DFV Identified), while responses by workers in a residential rehabilitation setting are more likely to be routine and embedded into structured programming and case management activities (e.g. DFV Ready, DFV Coordinated Care or DFV Integrated Care).

Assessment using the DFVCAT

Assessment of program/organisation capacity can be conducted through self-assessment and/or through assessment by an independent external assessor. Lessons learnt from implementing the DDCAT in AOD settings over more than a decade show that self-assessing services tend to over-estimate capacity when compared to external assessment.⁽²⁾ While self-assessment is feasible, workers should aim to conduct the process objectively and seek to verify their assessment with as much supporting evidence as possible.

Sources of information that can be used to inform the DFVCAT assessment (both self-assessment and external) are suggested in this section. In the case of service consumer record audits (case notes), it's recommended that **at least 10 records are reviewed in programs with lower throughput** (e.g. residential programs) and **at least 20 records are reviewed if service consumer throughput is higher** (e.g. community programs). Records would ideally be chosen at random, but should be representative of all workers' contributions to service consumers' records within the specific program. Greater numbers of records audited would increase confidence in the overall findings.

Potential sources for assessing program/organisation capacity aligned with DFVCAT domains include:

1. Program structure

- Policies and procedures manual or documents
- Memoranda of Understanding (MOU) or other documented collaboration arrangements with specialist DFV, healthy relationships and men's behaviour change services
- Staff interviews
- Contracts/service agreements with funding bodies

2. Program environment and organisational culture

- Observation of physical environment, including posters and materials available to service consumers

- Walkthrough of the program/organisation facilities and audit of available private spaces for disclosure or discussion of sensitive topics related to DFV
 - Interviews with staff and service consumers
- 3. Clinical processes – screening and assessment**
- Policies and procedures manual or documents
 - Screening and assessment forms
 - Interviews with staff and service consumers
 - Consumer records audit
- 4. Clinical processes – interventions**
- Treatment/care planning forms
 - Interviews with staff and service consumers
 - Interviews with partner specialist agencies (e.g. specialist DFV sector)
 - Review of program/organisation content materials
 - Observation of group program
 - Service consumer records audit
- 5. Continuity of care**
- Discharge plan documents
 - Interviews with staff and service consumers
 - Service consumer chart audit
- 6. Staffing considerations**
- Review of current staffing profile documentation
 - Review of staff recruitment documents, policies and procedures
 - Interviews with staff
 - Review of strategic training plan and staff training records

Appendices 1- 4 provide a range of checklists and materials to assist programs/organisations to implement the DFVCAT. Questions for staff and service consumer consultations are a guide only and programs/organisations are free to develop questions suitable for their service types and service consumers.

Scoring the DFVCAT

Unlike the DDCAT that was subject to rigorous investigations of its psychometric properties over many years,^a scoring of the DFVCAT has not yet been rigorously tested. At present, DFVCAT scores should only be used as an indication of current capacity to respond to service consumers who use or experience DFV, and to provide a benchmark for each program/organisation to assess progress along a planned improved response continuum.

Future refinement of the DFVCAT will ideally involve testing of the psychometric properties of the DFVCAT including reliability (including inter-rater reliability) and validity. For more information on priorities for future revisions of the DFVCAT see Section 5).

^a In the case of the DDCAT, a program is deemed to meet criteria for a particular capacity category if 80 per cent or more of the scores from the sum of all domains reflect that category.

Primary AOD focus with increasing capacity to respond to DFV

A score of 1 describes a program/organisation that is focused on providing AOD services to consumers, with incidental consideration of experiencing or using DFV in ongoing support or treatment. The DFVCAT for this category is *DFV Aware*.

A score of 2 describes a program/organisation that is focused on providing AOD services to consumers, with ad hoc consideration of DFV experience or use. The DFVCAT for this category is *DFV Identified*.

A score of 3 describes a program/organisation that is focused on providing AOD services to consumers, can respond to experiences or use of DFV at a basic level and effectively refer, but has greater capacity to work with AOD issues primarily. The DFVCAT for this category is *DFV Ready*.

Capacity for DFV focused responses in AOD care

A score of 4 describes a program/organisation that is capable of coordinating services for AOD service consumers with involvement of specialist DFV services and has capacity for some DFV focused case management and/or programming. The DFVCAT for this category is *DFV Coordinated Care*.

A score of 5 describes a program/organisation that is capable of providing interventions with AOD and DFV focused content, and the program can address both issues effectively. The DFVCAT for this category is *DFV Integrated Care*.

Overall scoring

Until the DFVCAT scores are validated in future, programs/organisations may find it useful to determine their overall score by summing the number of 1, 2, 3, 4, 5, scores gained and determining the percentage of each score across the 24 domains measured.

For example, if a program/organisation scored 1 in four domains, 2 in seven domains and 3 in thirteen domains, the calculation would be as follows:

Score 1 in four domains
 $4/24 \times 100 = 17\%$ of scores were 1 (*DFV Aware*)

Score 2 in seven domains
 $7/24 \times 100 = 29\%$ of scores were 2 (*DFV Identified*)

Score 3 in thirteen domains
 $13/24 \times 100 = 54\%$ of scores were 3 (*DFV Ready*)

For AOD programs/organisations that aim to be *DFV Ready*, an overall score of 54 per cent in that category is promising, while it indicates that work is needed to enhance the service or

program to meet requirements for that overall level of capacity if 80 per cent were the target.^b

Domain specific scoring

An increase in focus on DFV may not be achievable by, or even appropriate for, some AOD programs/organisations (e.g. low threshold services) so those programs/organisations may aim to improve their responses and increase their scores *within* a specific domain. In that case, programs/organisations are encouraged to determine sub-scores for each domain and plan for increasing capacity in the relevant domains to enable measurement of incremental and planned progress over time.

Measurement using domain specific activities

Beyond relying on scoring to benchmark activity, programs/organisations may also choose to assess progress against current activities and planned future activities.

Programs/organisations may opt to list the specific activities they currently engage in for each domain and the activities they plan to achieve in future to enhance capacity in the area of DFV. Using this approach, programs/organisations could determine progress in each domain over time. This strategy is routinely used in generic quality improvement activities.

^b Scoring of the DDCAT (on which the DFVCAT was modelled) sets 80 per cent as the benchmark for each capacity level.

DFVCAT: AOD service response assessment

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
1. Program structure					
1A. Primary focus of the program/organisation as stated in policies, procedures and guidelines.	AOD is the primary focus. Awareness of DFV but not explicitly mentioned in supporting documents.	AOD is the primary focus. DFV is identified and is acknowledged in a minor way in supporting documents.	AOD is the primary focus. Recognition of the impact of DFV, which is usually addressed through formalised referrals to DFV specialist services, with processes documented for all staff.	DFV addressed collaboratively with DFV specialist services. Some capacity to address DFV within the program/organisation, which is formally documented.	Primary focus is on AOD and DFV equally; for service consumers who experience DFV in all of its forms (including children/families) and those that use DFV. Dual focus is comprehensively and formally documented.
1B. Coordination and collaboration with DFV services for AOD service consumers, including diverse consumer groups, experiencing DFV in all of its forms. Examples include MOU, service consumer pathways, collaborative working relationships, joint case management, care planning. Diverse service consumer groups include lesbian, gay, bisexual,	No formal documentation or mechanisms for collaboration in place, although collaboration may occur ad hoc.	Vague, or informal relationship with DFV services, or consulting with a staff member from that agency when required after DFV is identified.	Formalised and documented coordination or collaboration with DFV service; identified consumer pathways between AOD and DFV services.	Formalised coordination and collaboration, and the availability of case management staff with AOD/DFV focus. Has some components consistent with integration, but they are informal and undocumented. May include joint case management with specialist DFV/healthy relationships/behaviour change service. (Note: a shared understanding of the service	Formal documentation of integrated care (one service consumer, one care plan), or routine use of case management staff with integrated AOD/DFV focus. Mechanism for identifying lead case manager.

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
transgender, and intersex people (LGBTI), Aboriginal and/or Torres Strait Islander people, culturally diverse people, young people and older people.				consumer's needs, shared commitment to care of the consumer - and family in some cases -, agreement on the role of each worker, and regular communication is needed for effective joint case management). Mechanism for identifying lead case manager.	
<p>1C. Coordination and collaboration with 'healthy relationships' focused services (e.g. MOU, consumer pathways, collaborative working relationships, joint case management).</p> <p>These services work with individuals (including those who use DFV), couples and families (and may include Lesbian, gay, bisexual, transgender and intersex people, Aboriginal and/or Torres Strait Islander people, culturally diverse</p>	No formal documentation or mechanisms for collaboration in place, although collaboration may occur ad hoc.	Vague, or informal relationships with healthy relationships services, or consultation with a staff member from that agency when required after DFV is identified.	Formalised and documented coordination or collaboration with healthy relationships services; identified service consumer pathways between AOD and healthy relationships services.	Formalised coordination and collaboration, and the availability of case management staff. Has some components consistent with integration, but they are informal and undocumented. Mechanism for identifying lead case manager.	Formal documentation of integrated care (one service consumer, one care plan), or routine use of case management staff with integrated AOD/DFV focus. Mechanism for identifying lead case manager.

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
people, younger and older people).					
1D. Funding structure Programs/organisations that receive funding to provide AOD treatment and DFV responses have greater capacity to provide integrated services for service consumers and their families affected by DFV.	Funded for AOD services and AOD activities only.	Funded for AOD services and AOD activities only, but may be some flexibility for DFV-related activities.	AOD funding is primary, however the service may receive some funding for DFV-related activities or services.	Funded to provide both AOD and DFV services; recognised as having funding for coordinated care services.	Funded to provide both AOD and DFV services; recognised as having funding for integrated services. Partnership between AOD and DFV service may be funded.

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
2. Physical environment and organisational culture					
2A. Routine expectation of, and welcome to the organisation, for service consumers who experience or use DFV	<p>Program/organisation expects, and responds to AOD only; refers all service consumers found to be experiencing or using DFV to specialist DFV sector, while retaining responsibility for AOD care of consumer.</p> <p>Service consumer input is sought regarding AOD program only.</p>	<p>Program/organisation expects AOD only; but recognises DFV is relevant to AOD problems and solutions and the program/organisation emphasises healthy relationships.</p> <p>Refers all service consumers identified as experiencing or using DFV to specialist DFV/healthy relationships sector, while retaining responsibility for AOD care of consumer.</p> <p>Service consumer input is sought regarding AOD program; input regarding DFV is ad hoc.</p>	<p>Focus is on AOD, but DFV and its relationship to AOD use is made explicit in program/organisation documentation.</p> <p>Service consumer input is sought regarding AOD program; input regarding DFV program and culture is sought from some service consumers.</p>	<p>AOD and DFV are expected.</p> <p>Some steps taken to consider service consumer safety and gender in program design and facilities.</p> <p>Some capacity for service consumer to choose the gender of care coordinator.</p> <p>Service consumer input is sought regarding AOD program; input regarding DFV program and culture is sought from many service consumers.</p>	<p>AOD and DFV are expected.</p> <p>Explicit steps taken to consider service consumer safety and gender in program design and facilities. Private spaces for counselling are routinely available.</p> <p>Gender-responsive; trauma-responsive; providing gendered (including LGBTI) and trauma services; family responsive care.</p> <p>Service consumer input is routinely sought regarding AOD and DFV policies, program and culture.</p>
2B. Display and distribution of accessible, reliable and relevant literature and service consumer educational materials.	Good quality, reliable AOD materials available only.	Good quality, reliable materials available for both AOD and DFV, but DFV materials not routinely offered or formally available.	Good quality, reliable materials are routinely available for both AOD and DFV in waiting and treatment areas, orientation materials	Good quality, reliable materials are routinely available for both AOD and DFV (including targeted materials for sub-groups of service	High quality, reliable materials are routinely and equally available for both AOD and DFV (including targeted materials for sub-

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
			and family information packs; but less distribution of DFV materials than AOD.	<p>consumers such as Aboriginal and Torres Strait Islander, LGBTI, culturally diverse, older and younger persons) with equivalent distribution.</p> <p>Materials available for people who experience or use DFV, including impacts on the family, and benefits of participating in healthy relationship programs.</p>	<p>groups of service consumers such as Aboriginal and Torres Strait Islander, LGBTI, culturally diverse, older and younger persons), and for the relationship between both issues (e.g. each is a risk factor for other).</p> <p>Materials available for people who experience or use DFV, including impacts on the family and benefits of participating in healthy relationship programs.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
3. Clinical process: Screening, safety planning and assessment					
<p>3A. Routine screening for DFV (i.e. experiencing and using DFV in mixed gender settings) is conducted with service consumers after entry to the AOD program/organisation.</p> <p>Screening may occur at any time after the service consumer enters the AOD service, while results of screening are never used to determine suitability for AOD care.</p> <p>Screening is repeated at other time points during AOD support/treatment.</p>	<p>Screening is not routine practice.</p> <p>DFV is identified incidentally (e.g. through physical signs).</p> <p>Identification/screening, when it does occur, is based on service consumer self-report.</p> <p>Focus is on the individual service consumer only.</p>	<p>Brief screening is conducted with some service consumers only (e.g. those considered to be at higher risk or when DFV is indicated).</p> <p>Screening practices vary across individual workers.</p> <p>Focus is on the individual service consumer only.</p>	<p>Brief screening is conducted with most service consumers, using questions designed to detect experience or use of DFV.</p> <p>Screening questions may consider risk to, and impact on, others (service consumer's partner, children, other family members).</p> <p>Screening usually occurs at one time-point only.</p> <p>Results of screening (including where no experience or use of DFV is found) is recorded in case notes.</p>	<p>Screening is conducted with every service consumer, using a standardised screening tool designed to detect experience or use of DFV.</p> <p>Screening often considers risk to, and impact on, others (service consumer's partner, children, other family members).</p> <p>Screening is sometimes repeated as the therapeutic relationship develops.</p> <p>Results of screening (including where no experience or use of DFV is found) is recorded in case notes.</p>	<p>Screening for a range of DFV types (including financial abuse) is conducted with every consumer, using a standardised screening tool designed to detect experience or use of DFV.</p> <p>Screening always considers risk to, and impact on, others (service consumer's partner, children, other family members).</p> <p>Screening is always repeated as the therapeutic relationship develops.</p> <p>Results of screening always recorded in case notes.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
<p>3B. Routine assessment (including risk, support needs, and safety planning) conducted if the screen is positive for experiencing or using DFV.</p> <p>Assessments are monitored, updated and service consumers re-assessed at other time points during AOD support/treatment.</p>	<p>Basic assessment for DFV is not recorded in service consumers' records/case notes.</p> <p>Basic safety planning, if it does occur, may involve referral to specialist DFV sector.</p>	<p>Basic assessment for DFV is conducted for some service consumers, but is not routine.</p> <p>Assessment is occasionally recorded in service consumers' records/case notes.</p> <p>Basic safety planning, if it does occur, may involve referral to specialist DFV sector, or generic checklist.</p> <p>Assessment is not, or rarely, updated.</p>	<p>More involved assessment for experiencing or using DFV is present, formal, standardised, and documented in most service consumers' records/case notes.</p> <p>Basic safety planning is conducted in collaboration with service consumer.</p> <p>Assessment is occasionally updated.</p>	<p>More involved assessment for experiencing or using DFV is present, formal, standardised, and documented in all service consumers' records/case notes.</p> <p>Individualised safety planning is conducted with all service consumers who experience DFV.</p> <p>Assessment is often updated.</p>	<p>In depth assessment for experiencing or using DFV is formal, standardised, and integrated with assessment for substance use, and documented in all service consumers' records/case notes.</p> <p>Individualised and detailed safety planning is conducted with all service consumers who experience or use DFV.</p> <p>Assessment is continually updated as changes occur.</p>
<p>3C. AOD use and DFV history documented in service consumers' records/case notes, and updated.</p>	<p>Collection of AOD use history only.</p>	<p>Standard form collects AOD use history only. DFV history collected incidentally and inconsistently, or following self-disclosure.</p> <p>Records are not, or rarely, updated.</p>	<p>Routine documentation of both AOD use history and DFV history recorded in narrative section of case notes.</p> <p>Records are occasionally updated.</p>	<p>Specific section in service consumer's record dedicated to history and chronology of both AOD use and DFV.</p> <p>Records are often updated.</p>	<p>Specific section in service consumer's record devoted to history and chronology of both AOD use and DFV and the relationship between them is documented in detail (e.g. trigger for relapse in both).</p> <p>Records are updated regularly.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
<p>3D. Accurate data on the results of screening for DFV and other activities is recorded and retrieved.</p> <p>Data for reporting, service planning and quality improvement purposes may include number of service consumers experiencing or using DFV, referrals made, shared care arrangements etc.</p>	No systems for recording DFV-related data are in place.	A system for recording DFV-related data is in place, but is rarely used.	A system for recording DFV-related data is in place, is sometimes used and some reliable data are available for reporting and service planning.	A system for recording DFV-related data is in place, is usually used, and a moderate amount of reliable and accurate data are available for reporting, service planning and quality improvement purposes.	<p>A system for recording DFV-related data is in place and is used routinely.</p> <p>Reliable, accurate and comprehensive data are available for reporting, service planning and quality improvement purposes.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
4. Clinical process: Interventions					
<p>4A. Treatment plans reflect the needs and goals of service consumers in relation to AOD and DFV in accordance with findings from assessments.</p> <p>Treatment plans describe responses to service consumers who experience DFV (and their children) <u>and</u> those who use DFV.</p> <p>Treatment plans are responsive to service consumer diversity. Diverse consumer groups include lesbian, gay, bisexual, transgender, and intersex (LGBTI) people, Aboriginal and/or Torres Strait Islander people, culturally diverse people, young people and older people.</p>	<p>Treatment planning is conducted for AOD only (DFV not referred to).</p>	<p>Treatment plans address AOD and DFV, but do so only incidentally and inconsistently; and variable by worker.</p> <p>When DFV is included, treatment plans primarily address service consumer safety or referral to specialist DFV and or healthy relationships programs.</p> <p>AOD use is primary and DFV is peripheral.</p>	<p>Treatment plans routinely address both AOD use and DFV; establish safety plans for service consumers and their children, with 24/7 support from DFV services.</p> <p>Referral of service consumers who use DFV to behaviour change/healthy relationships programs.</p> <p>Relationship between AOD use and DFV is addressed in relapse prevention/treatment plan.</p> <p>Referrals for children and other family impacted by DFV.</p> <p>AOD use is primary and DFV is secondary.</p>	<p>Treatment plans routinely address AOD and DFV, with safety planning for those who experience DFV and their children with 24/7 support from DFV services, <u>or</u> behaviour change/ healthy relationships programs for those who use DFV.</p> <p>Relationship between AOD use and DFV is detailed in relapse prevention/treatment plan.</p> <p>Case collaboration is available with DFV specialist services.</p> <p>Referrals for children and other family impacted by DFV.</p> <p>Primary focus is AOD, but DFV is routinely addressed in treatment planning, with the plan monitored and updated regularly.</p>	<p>Treatment plans routinely address both AOD and DFV equivalently and in detail when they co-occur; safety plans for those who experience DFV and their children are established and enacted, with 24/7 support from DFV services.</p> <p>Behaviour change/healthy relationships programs may be offered on site for service consumers who use DFV.</p> <p>Relationship between AOD use and DFV is detailed in relapse prevention treatment plan.</p> <p>Focus is on AOD use and DFV equally when they co-occur.</p> <p>Children have their own treatment plans that addresses the impact</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
					of parental AOD and DFV, and addresses trauma.
<p>4B. Assess and monitor the relationship between AOD and DFV and the impact on progress for both issues.</p> <p>AOD and DFV may act as triggers for relapse in the other issue; AOD use may increase if DFV escalates; AOD may be used to 'recover' from an episode of DFV; readiness to address each issue may be directly influenced by the other issue.</p>	<p>No documentation of DFV as AOD support or treatment progresses.</p>	<p>Variable reports by individual workers of DFV as AOD support or treatment progresses.</p>	<p>Routine clinical focus in treatment plan review or progress notes DFV issues; description tends to be generic.</p>	<p>Treatment monitoring and documentation shows equivalent in-depth focus on both AOD and DFV but is variably used.</p>	<p>Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both AOD use and DFV equivalently.</p>
<p>4C. Procedures for DFV emergencies and crisis management.</p> <p>Procedures are supported by formal policy and procedures, resources, training and worker supervision.</p>	<p>No DFV crisis procedures conveyed in any manner.</p> <p>Crisis management varies by individual worker.</p>	<p>DFV crisis management verbally conveyed in-house procedures.</p> <p>Information about emergency services is available for service consumers.</p>	<p>Documented DFV crisis procedures: Referral to or collaboration with DFV services or place of safety for service consumers at risk and their children; others at risk (e.g. carers of consumer's children, new partners of consumers at risk).</p>	<p>Documented DFV crisis procedures with variable use: formal risk assessment tools (e.g. NSW DVSAT Safety Planning tool) for DFV crises, including procedures for service consumers at risk and their children and others;</p>	<p>Formal, routinely implemented process to ascertain risk and manage emergencies related to DFV.</p> <p>For users of DFV, structured plans for early intervention to prevent or minimise</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
			For service consumers who use DFV, early intervention and crisis/escalation prevention strategies.	and procedures for service consumers who use DFV.	crisis and escalation of DFV.
<p>4D. Interventions tailored for service consumers' readiness to address DFV (including as it relates to AOD).</p> <p>Recognition that readiness to address each issue may change rapidly.</p> <p>Motivational interviewing strategies used to enhance service consumers' readiness are applied.</p>	<p>Readiness not assessed or explicit in treatment plan.</p> <p>No interventions offered to those incidentally identified as ready to address DFV.</p>	<p>Readiness incidentally and variably assessed and documented in treatment plan, variable by individual worker.</p> <p>Readiness occasionally re-assessed.</p> <p>Referrals to DFV or healthy relationships services sometimes made; variable by individual worker.</p>	<p>Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan.</p> <p>Readiness is sometimes re-assessed, particularly among service consumers at highest risk.</p> <p>If not ready to address DFV and accept referral to specialist service, harm reduction advice and safety planning strategies are provided to some service consumers.</p>	<p>Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan.</p> <p>Readiness is re-assessed regularly.</p> <p>Interventions are delivered in accordance with service consumers' readiness.</p> <p>Generic behaviour change interventions that focus on healthy relationships are provided to most service consumers.</p>	<p>Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan.</p> <p>Readiness is re-assessed regularly.</p> <p>Interventions that match readiness for both AOD and DFV are delivered on site, or facilitated through established partnerships with specialist DFV sector or behaviour change /healthy relationships program specialists.</p> <p>Motivational interviewing strategies used to enhance service consumers' readiness.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
4E. Specialised interventions with DFV content.	No DFV content in AOD program/organisation provided.	DFV content within AOD program/organisation not formalised; delivered variably by individual workers based on their own judgment, confidence, and awareness of DFV and specialised interventions.	DFV content in AOD program/organisation format as generalised intervention approach. Interventions are trauma-informed; gender-specific groups may be available. Level of care is stepped-up/down according to AOD treatment progress and risk for experience or use of DFV. Active referrals to DFV service or behaviour change/healthy relationships programs are made in accordance with stepped-care needs.	Some specialised DFV interventions provided by specially trained clinicians in addition to routine generalised interventions; delivered to individuals, groups and/or families. Co-delivery of specialised interventions in partnership with specialist DFV, behaviour change/healthy relationships worker. Joint case management with DFV service or behaviour change/healthy relationships worker available within the service.	Trauma-specific interventions for service consumers experiencing DFV delivered by specially trained clinicians, integrated with AOD interventions. Evidence-based/informed, structured program for service consumers who use DFV delivered by specially trained clinicians, integrated with AOD interventions. Other evidence-based/informed programs available and delivered by the service's specially trained clinicians to individuals, couples and families (e.g. family program, couples program, healthy relationships program).
4F. Service consumer education about DFV and relationship to AOD use.	Not offered.	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, offered	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, delivered	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, delivered	Specific content about interactions and impacts, tailored for individual service consumers, routinely delivered in individual

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
<p>Assist service consumers to understand the different types of DFV, and how DFV may increase AOD use, and how AOD use can worsen DFV.</p> <p>Assist service consumers to become familiar with services and programs available to assist with DFV, and benefits of engaging in support /intervention for DFV.</p>		<p>variably to some service consumers according to the judgement of individual workers/clinicians.</p>	<p>routinely in individual, couple or group formats.</p>	<p>routinely in individual, couple or group formats.</p> <p>Individual follow-up of generic information with service consumers, with opportunity to explore issues specific to their circumstances; and/or tailored educational content for some service consumers only.</p>	<p>sessions (and or couples, families sessions if appropriate).</p> <p>Opportunities to explore specific issues further on other occasions.</p>
<p>4G. Case review processes emphasise and consider DFV in AOD treatment.</p>	<p>Focus is on AOD; case review does not consider DFV.</p>	<p>Focus is on AOD, consideration of DFV is variable and or undocumented.</p>	<p>Experience or use of DFV documented in case review; conducted on-site or off-site as needed (e.g. case conferences, case review, peer review) for many service consumers.</p>	<p>Experience or use of DFV documented in case review, conducted on-site or off-site (e.g. case conferences, case review, peer review) for all service consumers whose care is coordinated by the program/organisation.</p>	<p>Documented, routine, and systematic review of AOD treatment and experience or use of DFV with a range of providers and specialists for all service consumers receiving integrated care from the program/organisation.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
5. Continuity of care					
<p>5A. AOD and DFV issues both addressed in discharge planning process.</p> <p>For example:</p> <ul style="list-style-type: none"> • Appropriate referrals are provided to service consumers including to specialist DFV services if required • Safe housing is considered and planned for • Ongoing opportunities for counselling (e.g. for trauma) are organised 	AOD issues addressed; DFV issues not addressed in discharge planning.	AOD issues addressed; DFV issues addressed in discharge planning for some service consumers only; variable by individual workers/clinicians.	AOD issues and DFV issues are both addressed routinely in discharge planning for all service consumers who experience or use DFV.	AOD issues and DFV issues are both addressed routinely in discharge planning for all service consumers who experience or use DFV.	Assertive follow-up planned, documented and conducted for all service consumers who experience of use DFV.
			Discharge planning for DFV primarily referral.	Action plans to manage AOD and/or DFV relapse are detailed, and coordinated with specialist DFV, healthy relationships/behaviour change services workers.	Action plans to manage AOD and/or DFV relapse are detailed and reviewed with service consumer at follow-up.
				Assertive follow-up planned, documented and conducted for service consumers considered to be at high risk for relapse.	Ongoing links with specialist DFV sector established for service consumers who require extended support.
<p>5B. Focus on ongoing improvement in both AOD and DFV issues.</p> <p>Changes in both AOD and DFV issues are monitored and explored with service consumers throughout AOD treatment/support.</p>	Changes in AOD observed; changes in DFV not observed.	Changes in AOD observed; changes in DFV observed ad hoc at discretion of individual workers/clinicians, or when raised by service consumer.	Routine focus is on improvement in AOD use; DFV seen as a potential trigger for AOD relapse.	Focus on improvement in both AOD and DFV for most service consumers.	Routine focus on improvement in both AOD use and DFV issues equally and consistently.
				AOD and DFV seen as mutual triggers for relapse.	AOD and DFV relapse expected and planned for, together with the

					interactions between the two.
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	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
6. Staffing considerations					
<p>6A. All staff members receive training in DFV.</p> <p>Training could include:</p> <ul style="list-style-type: none"> • Attitudes and values • Prevalence of DFV, and impact on AOD outcomes • Identification and screening • Safety planning • Risk assessment • Referral • Child protection/ mandatory reporting related to DFV • Evidence informed/based responses to those who experience or use DFV, and their families. 	<p>Although aware of DFV, few staff have had systematic, basic training in DFV as it relates to AOD care/outcomes.</p>	<p>Variably trained in the basics of DFV.</p> <p>Ad hoc, external training not integrated into routine professional development plan.</p>	<p>All staff have basic training in DFV, including screening, basic assessment and safety planning, monitoring of progress and referral.</p> <p>In-service education about DFV is integrated into routine professional development plan for some staff.</p>	<p>All staff have basic training in DFV.</p> <p>Key workers have more advanced training, including collaboration with DFV/healthy relationships sector and treatment planning, to enable effective coordinated care is delivered to a range of service consumers.</p> <p>In-service education about DFV is integrated into routine professional development plan for many staff.</p>	<p>All staff have basic training in DFV.</p> <p>Training needs periodically re-assessed through review of systematic staff training plan.</p> <p>Key workers have advanced or specialised training in integrated interventions for service consumers who experience or use DFV.</p> <p>In-service education on DFV integrated into routine professional development plan for most staff.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
6B. Staffing profile emphasises and supports consideration of DFV in AOD treatment.	Staffing profile focuses on AOD and other core responses such as blood-borne viruses, mental health issues and tobacco smoking; DFV skills considered peripheral.	Staffing profile focuses on AOD and other core responses such as blood-borne viruses, mental health issues and tobacco smoking; DFV skills considered useful but not emphasised.	Staffing profile focuses on AOD other core responses such as blood-borne viruses, mental health issues and tobacco smoking; DFV emphasised in staff skills mix.	Staffing profile focuses on AOD with additional DFV skills. Staff experienced in coordinating care for service consumers who experience or use DFV (and their families) actively recruited. Basic information on DFV, including needs of family and children, included in staff orientation/induction. Basic resources (e.g. referral options, practice guides) available to assist staff to coordinate care.	Staffing profile focuses on AOD with additional, high level DFV skills given equal weight. Staff experienced in delivering integrated care for service consumers who experience or use DFV (and their family) actively recruited. In-depth information on DFV, including needs of family and children, included in staff orientation/induction. A wide range of resources (e.g. referral options, practice guides, treatment manuals) available to assist staff to deliver integrated care.
6C. Onsite workers /clinical staff members with training or substantive experience working with service consumers who experience or use	Specialist AOD staff onsite; many staff aware of DFV, but none have training or experience in DFV.	Specialist AOD staff onsite; many aware of DFV and some can identify DFV, but none are trained or experienced in responding to DFV.	Specialist AOD staff onsite; most aware of DFV, many can identify DFV, many have skills in screening for DFV, some have skills in basic assessment of DFV including risk.	Specialist AOD staff onsite; all aware of DFV, most can identify DFV, most have skills in screening for DFV, many have skills in assessment of DFV including risk.	Specialist AOD staff onsite; all aware of DFV, all can identify DFV, all have skills in screening for DFV, most have skills in assessment of DFV including risk.

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
<p>DFV (and their families) including</p> <ul style="list-style-type: none"> • Awareness of DFV • Ability to identify DFV • Screening for DFV • Assessment of DFV <p>Able to respond appropriately and safely</p>			<p>Most staff skilled in active referral processes.</p> <p>Ad hoc access to experienced staff with DFV skills outside of the service.</p>	<p>Key worker(s) with training and or experience in AOD and DFV (including children and families) available onsite to coordinate appropriate care when required.</p>	<p>Key workers demonstrate leadership in DFV, which is seen as a priority and care business of the service.</p> <p>Key worker(s) with training and or experience in AOD and DFV (including children and families) available onsite to deliver integrated care when required.</p>
<p>6D. Onsite workers /clinical staff members with training or experience working with individuals (and families) with diverse needs who experience or use DFV.</p> <p>Groups may include:</p> <ul style="list-style-type: none"> • LGBTI people • Aboriginal and/or Torres Strait Islander people • Culturally diverse people • Young people • Older people 	<p>No workers have specific training or experience in responding to DFV with diverse groups of service consumers.</p>	<p>Few workers are able to identify needs of diverse groups who experience or use DFV and are able to refer appropriately.</p>	<p>Some workers are able to identify needs of diverse groups who experience or use DFV and are able to refer appropriately and actively.</p> <p>Evidence of culturally specific/diverse populations interventions available. Formal or informal working relationships with organisations that can support service consumers with diverse needs.</p>	<p>Most needs of diverse populations can be met by the service.</p> <p>Evidence of policies, procedures and practices designed to meet the needs of diverse populations available.</p> <p>Care can be coordinated with organisations that support service consumers with diverse needs and who experience or use DFV.</p>	<p>Most needs of diverse populations can be met within the service.</p> <p>Evidence of policies, procedures and practices detailing culturally specific interventions are available.</p> <p>Integrated care that supports service consumers with diverse needs who experience or use DFV can be provided by the service.</p>

	1 - DFV Aware	2 - DFV Identified	3 - DFV Ready	4 - DFV Coordinated Care	5 - DFV Integrated Care
<ul style="list-style-type: none"> • People who are homeless • People with mental health issues 					
<p>6E. Access to supervision and consultation that considers DFV in AOD.</p> <ul style="list-style-type: none"> • Regular, formal supervision (peer, specialist supervisor) • Informal supervision (irregular, as needed) • Staff personal experiences of DFV accounted for in supervision 	<p>Access to AOD specific clinical/practice supervision only; no access to supervision that considers DFV.</p>	<p>Access to AOD specific clinical/practice supervision only; access to supervision that considers DFV for some workers occasionally or informally.</p>	<p>Access to supervision from an experienced supervisor that considers DFV, provided by the service on-site or off-site to some staff at arranged times.</p> <p>Ad hoc access to consultation.</p>	<p>Access to both informal and formal supervision from an experienced supervisor that considers DFV, provided by the service on-site at specific times and as needed for most staff.</p> <p>Access to consultation with key workers onsite as needed.</p>	<p>Supervision from an experienced supervisor routinely provided by the service on-site and focuses on in-depth learning and skills development. Informal access to supervision is provided when needed.</p> <p>Regular access to consultation with key workers onsite.</p>

Appendix 1. DFVCAT domains and potential information sources

Domain	Data source	Available?	Used?
Program structure	Policies and procedures manual	Y N	Y N
	MOU with specialist DFV services and other documented collaborative arrangements	Y N	Y N
	Staff interviews	Y N	Y N
	Contracts with funding bodies	Y N	Y N
Program milieu and organisational culture	Observation of physical environment, including posters and materials available to consumers	Y N	Y N
	Interviews with staff	Y N	Y N
	Interviews with service consumers	Y N	Y N
Clinical processes – screening and assessment	Policies and procedures manual	Y N	Y N
	Screening forms	Y N	Y N
	Assessment forms	Y N	Y N
	Interviews with staff	Y N	Y N
	Interviews with service consumers	Y N	Y N
	Service consumer file audit	Y N	Y N
	Data collection and retrieval systems review	Y N	Y N
Clinical processes – interventions	Treatment/care planning forms	Y N	Y N

Domain	Data source	Available?	Used?
	Review of program content materials	Y N	Y N
	Observation of group program	Y N	Y N
	Interviews with staff	Y N	Y N
	Interviews with service consumers	Y N	Y N
	Interviews with partner specialist agencies (e.g. specialist DFV sector)	Y N	Y N
	Service consumer file audit	Y N	Y N
Continuity of care	Discharge plan documents	Y N	Y N
	Interviews with staff	Y N	Y N
	Interviews with service consumers	Y N	Y N
	Service consumer file audit	Y N	Y N
Staffing	Review of staffing profile	Y N	Y N
	Interviews with staff	Y N	Y N
Staff training	Review of strategic training plan	Y N	Y N
	Review of staff training records	Y N	Y N
	Interviews with staff	Y N	Y N

Appendix 2. File audit guide

		Yes	No	N/A	Comments
Clinical processes Screening	Screen for DFV completed once Screen for DFV is repeated				
Clinical processes Assessment	Assessment of DFV completed Assessment for DFV is updated Readiness to address DFV assessed Assessment for interactive courses of each issue Assessments are updated AOD and DFV history documented Data on DFV is collected and able to be retrieved				

		Yes	No	N/A	Comments
<p>Clinical processes</p> <p>Interventions (treatment planning)</p>	<p>Treatment plans address both AOD and DFV issues</p> <ul style="list-style-type: none"> • Treatment plans account for the dynamic relationship between both AOD and DFV (e.g. each act as mutual triggers for relapse; AOD use may increase to cope with DFV; readiness to address each issue may be influenced by the status of the other etc.) <p>Plans for crisis/emergencies are documented</p> <p>Readiness for addressing each issue integrated into treatment/support plan</p> <p>Records are updated</p> <p>AOD interventions contain DFV content</p> <p>Education about course and interaction of DFV with AOD provided</p> <p>Coordination and collaboration with specialist DFV sector described</p> <p>Coordination and collaboration with healthy relationships/behaviour change sector described</p> <p>Needs of children of service consumers</p>				

		Yes	No	N/A	Comments
	addressed Needs of service consumers' significant others addressed				
Continuity of care	DFV addressed in discharge/ ongoing support plan Improvements in both DFV and AOD are observed and noted Ongoing links with specialist DFV/behaviour change services made for service consumers				

Appendix 3. Staff interview questions example^c

Assessment domain	Potential questions for staff
1B. Coordination and collaboration with DFV services for people experiencing DFV in all of its forms.	Do we have in place collaborative arrangements with specialist services to strengthen our responses to service consumers who experience or use DFV? What do those arrangements entail? (e.g. MOU, informal arrangements, consumer pathways?) Is the relationship formalised/documentated?
2A. Routine expectation of, and welcome to the organisation, for services consumers who experience or use DFV.	What service consumers are expected and welcomed to the program/organisation? Do we expect to respond to service consumers who experience or use DFV? Does our program/organisation foster confidence among service consumers to disclose DFV (experiencing or using DFV)? Does our program/organisation communicate an awareness of DFV and capacity to help service consumers?
3A. Routine screening for DFV (i.e. experiencing and using DFV in mixed gender settings) is conducted with service consumers after entry to the program/organisation.	Does screening for DFV occur? What type of screening for DFV occurs? Who does it, when and how? What tool is used if any? Is screening repeated at any time? Is screening documented? When and how many times?
3B. Routine assessment (including risk, safety and support needs) is conducted if the screen is positive for experiencing or using DFV. Assessments are monitored, updated and service consumers re-assessed at other time points during AOD support/treatment.	What's the process for following up on a screen that is positive for experience or use of DFV? Are follow-up assessments routine for positive screens? What is involved in the subsequent assessment? Are assessments revisited at any other time during AOD treatment/support?
4A. Treatment plans reflect the needs and goals of service consumers in relation to AOD and DFV in accordance with findings from assessments.	Are the findings from the assessment for experience or use of DFV reflected in service consumers' treatment plans? How?
4C. Procedures for DFV emergencies and crisis management.	What's the process for managing emergencies and crises related to DFV? Are there policies, procedures, guidelines for managing risk? Are there pathways for consumers at risk? What are they? Are all staff

^c These are examples only. Programs/organisations are encouraged to adapt them to suit their context.

Assessment domain	Potential questions for staff
	responding consistently or is the approach ad hoc?
4D. Interventions tailored for service consumers' readiness to address AOD use and/or DFV.	Do we assess for readiness to address DFV issues as well as AOD? How? Is readiness addressed in treatment planning? Is readiness reassessed at any time?
4E. Specialised interventions with DFV content.	What types of interventions that are specific to DFV do we offer? Are families or children considered? Are significant others considered?
4F. Service consumer education about DFV and interaction with AOD use.	Do we provide information about how AOD and DFV affect each other? (e.g. trigger relapse). Is the information reliable? Tailored to service consumer needs? Does it reflect the needs of families/children?
5A. AOD and DFV issues addressed in discharge planning process.	Is DFV considered when making plans for service consumer discharge (or when the service consumer ceases active involvement with the program/organisation)? How and to what extent? Is follow-up arranged? For which service consumers, how and when?
5B. Focus on ongoing improvement in both AOD and DFV issues.	Is improvement in AOD and DFV measured as treatment/support progresses? How?
6B. Onsite workers/clinical staff members with training or substantive experience working with individuals (and families) who experience or use DFV.	What proportion of workers have training or experience in working with service consumers who experience DFV? Are any experienced with working with service consumers who use DFV? Do any staff members have experience and can demonstrate competencies to work with families or children?
6C. Onsite workers/clinical staff members with training or experience working with individuals who experience or use DFV (and their families).	What proportion of workers have training or experience in working with service consumers with diverse needs who experience DFV? Are any experienced with working with consumers with diverse needs who use DFV? Do any staff members have experience and can demonstrate competencies to work with consumers with diverse needs?
6D. Case review processes emphasise and support DFV responses in AOD treatment.	Do we conduct case reviews to monitor progress in AOD and DFV? For which service consumers? How are reviews conducted (e.g. onsite, at partner service, regularly or as needed)? Do we have sufficient resourcing (time, financial, human) to enable case reviews that acknowledge DFV?
6E. Access to supervision and consultation that considers DFV in AOD.	Do staff have access to supervision that considers DFV in AOD? Which staff have access? How often? In what form (regular, ad hoc, onsite, off-site)? Who is the supervision provided by? What are the credentials of the supervisor/s?

Assessment domain	Potential questions for staff
<p>7A. All staff members have received training in DFV.</p>	<p>What type of training have staff members received in the area of responding to service consumers with diverse needs who have experienced or used DFV? What proportion of the total staff complement have received training? Have some staff received more advanced training than others? Has the training prepared them sufficiently for their role? Is training for DFV integrated into professional development for staff? If so, what proportion and what are their roles?</p>

Appendix 4. Service consumer interview questions examples^d

Assessment domain	Potential questions for service consumers
2A. Routine expectation of, and welcome to the program/organisation, for consumers who experience or use DFV.	<p>Did you feel you could talk about relationship problems or experience (or use) of domestic and family violence to staff in the program/organisation? Did you think that the program/organisation could help you with relationship or family problems?</p> <p>Did you feel safe to talk about these things?</p>
2B. Display and distribution of accessible, reliable and relevant literature and service consumer educational materials.	Were brochures or written information about domestic and family violence available or given to you? Did you get anything in writing or another form that let you how and where to get help for you or your children/family if you needed it?
3B. Routine assessment (including risk, safety and support needs) is conducted if the screen is positive for experiencing or using DFV.	Were you ever asked about your relationships or family situation? Can you tell me more about that?
4A. Treatment plans reflect the needs and goals of service consumers in relation to AOD and DFV in accordance with findings from assessments.	Was your relationship or family taken into account in how alcohol and other drug treatment/support was planned for you by the program/organisation? How?
4B. Assess and monitor the interaction of both AOD and DFV and the impact on progress for both issues.	Were you asked about your relationship and or family issues as time went on in the program/organisation? How and when?
4E. Specialised interventions with DFV content.	Is any information about domestic and family violence or healthy relationships given as a part of treatment/support in this program/organisation? Can you tell me more about that?
5A. AOD and DFV issues addressed in discharge planning process.	When you were getting ready to finish the program, were your relationships or family issues part of the plan for aftercare? How?

^d These are examples only. Programs/organisations are encouraged to adapt them to suit their particular consumer group.

Assessment domain	Potential questions for service consumers
	Has your case manager/key worker/other staff member planned with you how the service will follow-up (check on how you are going) after you leave the service? How and when will that happen?
Is there anything else you'd like to tell us?	

¹ Substance Abuse and Mental Health Services Administration. (2001). Dual Diagnosis Capability in Addiction Treatment Toolkit Version 4.0. Rockville: Substance Abuse and Mental Health Services Administration.

² Lee, N., & Cameron, J. (2009). 'Difference in self and independent ratings on an organizational dual diagnosis capacity measure'. *Drug and Alcohol Review*, v.28, pp.682-684.

Attachment B: Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence

This attachment contains a copy of the Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug (AOD) Settings who Experience or Use Domestic and Family Violence (Scope of Practice).

About this document:

The Scope of Practice clarifies the roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to domestic and family violence (DFV).

Although applicable nationally, it was more specifically developed to inform workforce planning, training and recruitment within the context of the ACT *AOD Safer Families Program*.

The Scope of Practice was developed through an intensive co-design process with AOD and DFV services, clinicians and other experts, consumer organisations and policy makers (see Section 4).

Relationship to the AOD Safer Families Program:

The Scope of Practice will be used by AOD services funded through the *AOD Safer Families Program* to ensure that responses to DFV delivered by AOD services and workforces are safe and effective; reflecting the appropriate skills, qualifications and training of the workforce.

As described in the *AOD Safer Families Program* model (see Section 2); the Scope of Practice is designed as a companion to both the Practice Guide (see Attachment C) and DFVCAT (see Attachment A).

When used in conjunction with each other, the materials provide sufficient information to guide AOD practice when responding to DFV at an organisational, program and individual worker level. Additionally, these documents are all subjects of the *AOD Safer Families Program* Monitoring and Evaluation Framework which will help to provide evaluation guidance at a whole of sector / policy level:

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	Program / organisational level	<ul style="list-style-type: none"> Benchmark and assess capacity to respond to DFV in AOD settings Plan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated / integrated AOD and DFV responses Assess and report on progress
Scope of Practice: for Working with Service Consumers in AOD Settings	Both program / organisational level & practice / clinical level	<ul style="list-style-type: none"> Clarify roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV Guide services and workers on how to work safely and effectively (based on skills, qualifications and training)

who Experience or Use DFV		• Inform workforce planning, training and recruitment
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice / clinical level	<ul style="list-style-type: none"> • Guide practice (e.g. screening, assessment and interventions) • Optimise responses and outcomes for service consumers • Ensure activities funded through the <i>AOD Safer Families Program</i> are evidence based and align with clinical consensus
Monitoring and Evaluation Framework: for the ACT <i>Alcohol and Other Drug (AOD) Safer Families Program</i> 2017-2021	Whole of sector/ policy level	<ul style="list-style-type: none"> • Monitor and evaluate the entire <i>AOD Safer Families Program</i> • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to DFV in AOD settings

Suggested Citation:

The suggested citation for the attachment is:

Jenner, L., Lee, N. & Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence*. Canberra: ATODA.

Available At:

The Scope of Practice: for Working with Service Consumers in AOD Settings who Experience or Use DFV will also be made available as a stand-alone document available from www.atoda.org.au.

Attachment B

Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use Domestic and Family Violence

Version 1

December 2017

The alcohol and other drug workforce

Alcohol and other drug (AOD) workforce profile

Specialist AOD workers' central role involves preventing and responding to a broad spectrum of AOD-related harms. The AOD workforce is drawn from diverse occupational fields such as nursing, psychology, social work, counselling, specialist doctors, General Practitioners, pharmacists, psychiatrists, allied health workers, education officers and peer workers.

Nationally, the largest occupational groups in the sector are 'generalist AOD workers' (40% of the non-government organisation [NGO] sector workforce) and nurses (31% of specialist workers in government services).⁽¹⁾ In the ACT, the main occupational groups (across both NGO and government services) are AOD workers (clinical) at 40.7%, nurses at 13.6% and AOD workers (non-clinical) at 10.7%.⁽²⁾

The ACT and Victoria have a minimum qualification strategy for AOD workers; they must hold either an AOD-specific qualification such as a Certificate IV in Alcohol and Other Drug Work or a tertiary qualification in health, social or behavioural science with a set minimum level of AOD specific training.^a

Roles and responsibilities

AOD workers collaborate in various responses and care planning activities with service consumers whose support needs are becoming increasingly complex. AOD workers require not only strongly developed skills in AOD practice, but must also possess skills in responding safely and effectively to a range of related issues including mental health, trauma, cognitive impairment, child protection, domestic and family violence (DFV), and those resulting from the social determinants of health such as homelessness, family and financial stress.

AOD workers provide support and treatment that is trauma and gender informed, family sensitive, and responsive to service consumer diversity including Aboriginal and/or Torres Strait Islander people, lesbian, gay, bisexual, transgender and intersex (LGBTI) people, culturally and linguistically diverse people, younger and older people.

^a Qualification requirements of ACT and Victorian qualification strategies:

1. A qualification in ATOD or addiction studies which is equivalent to, or above, the Australian Qualifications Framework Certificate IV in Alcohol and Other Drugs (CHC43215).

OR

2. A health, social, or behavioural science related tertiary (university) qualification plus the 'Alcohol and Other Drug Skill Set':

CHCAOD001	Work in an alcohol and other drugs context
CHCAOD004	Assess needs of clients with AOD issues
CHCAOD006	Provide interventions for people with AOD issues
CHCAOD009	Develop and review individual AOD treatment plans

AND

3. A First Aid qualification equivalent to the following units:

HLTAID001	Provide cardiopulmonary resuscitation
HLTAID002	Provide basic emergency life support
HLTAID003	Provide first aid

Challenges to developing a scope of practice related to DFV in AOD settings

To date, a scope of practice for AOD workers in the area of DFV has not been developed. Key challenges in developing such a document include the following:

- The AOD field involves a diverse range of roles, requiring differing levels of knowledge and skills. On a national basis, these roles have not been uniformly described and mapped to sets of capabilities required to undertake them.⁽³⁾ Despite this there is practice wisdom on which to develop a scope of practice for this relatively new practice area of DFV as it becomes a focus for the ATOD sector.
- AOD workers with professional qualifications, including those registered with the Australian Health Practitioner Regulation Agency (AHPRA), are required to work within the scope of practice for their particular discipline; whereas AOD workers without professional qualifications lack this discipline-specific guidance.
- In contrast to other countries such as the USA, there is no requirement in Australia for credentialing AOD workers according to educational attainment, training and experience that allows for clear delineation of activities aligned to each practice license.
- Evidence for effective DFV responses in AOD settings is emerging, and as more is known, the scope of practice will require regular revision to align with advances in the knowledge base.

Despite these issues, this Scope of Practice can provide guidance to organisations and individuals on safe and effective practice with AOD service consumers who use or experience DFV.

About the Scope of Practice

What is a scope of practice?

A scope of practice is a document that refers to the roles, responsibilities, activities and decision-making capacities that workers are trained, capable and authorised to perform in a given context.

Purpose of the DFV Scope of Practice for AOD settings

The DFV Scope of Practice has been developed to assist AOD services to plan safe and effective responses to DFV among AOD service consumers.

A scope of practice framework is usually developed by a regulating board to proscribe practice in a particular profession, for example nursing, medicine, psychology, and social work. This Scope of Practice document holds no such authority; however, it will instead provide guidance for AOD services and individual AOD workers on how to work safely and effectively in the area of DFV within the context of their particular AOD setting and focus of the service provided.

This Scope of Practice is to be read as a companion document to:

- Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings
- Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

Who does the DFV Scope of Practice apply to?

The Scope of Practice applies to specialist AOD services only. It applies to entire programs/organisations and individual workers within those programs/organisations.

Program-wide Scope of Practice

The Scope of Practice for a whole program/organisation will be influenced by the setting of the AOD program/organisation, the main focus of intervention (e.g. peer based harm reduction, residential rehabilitation program), staff qualifications and skills mix, organisational policy, and the needs of service consumers.

The Scope of Practice for a particular program/organisation will be informed by the findings from conducting the DFVCAT assessment through self-assessment or an external assessment process. The DFVCAT provides detail about relevant activities for each level of DFV responsiveness, which is summarised in Figure 1.

In considering a program/organisation wide Scope of Practice in DFV, programs/organisations need to ensure that the physical environment is suitable for the planned response and that staff members with appropriate training and competencies are available to provide the planned response. Opportunities should be provided for new and existing staff members to acquire skills in DFV during their employment. It is recommended that AOD services develop a whole-of-workforce training needs analysis in relation to DFV and a detailed training plan.

The main activities carried out by workers in specialist AOD settings, and workers who may conduct those activities are described in this section. **All staff require training in DFV and**

ongoing support and supervision that is appropriate for their service setting, role and experience.

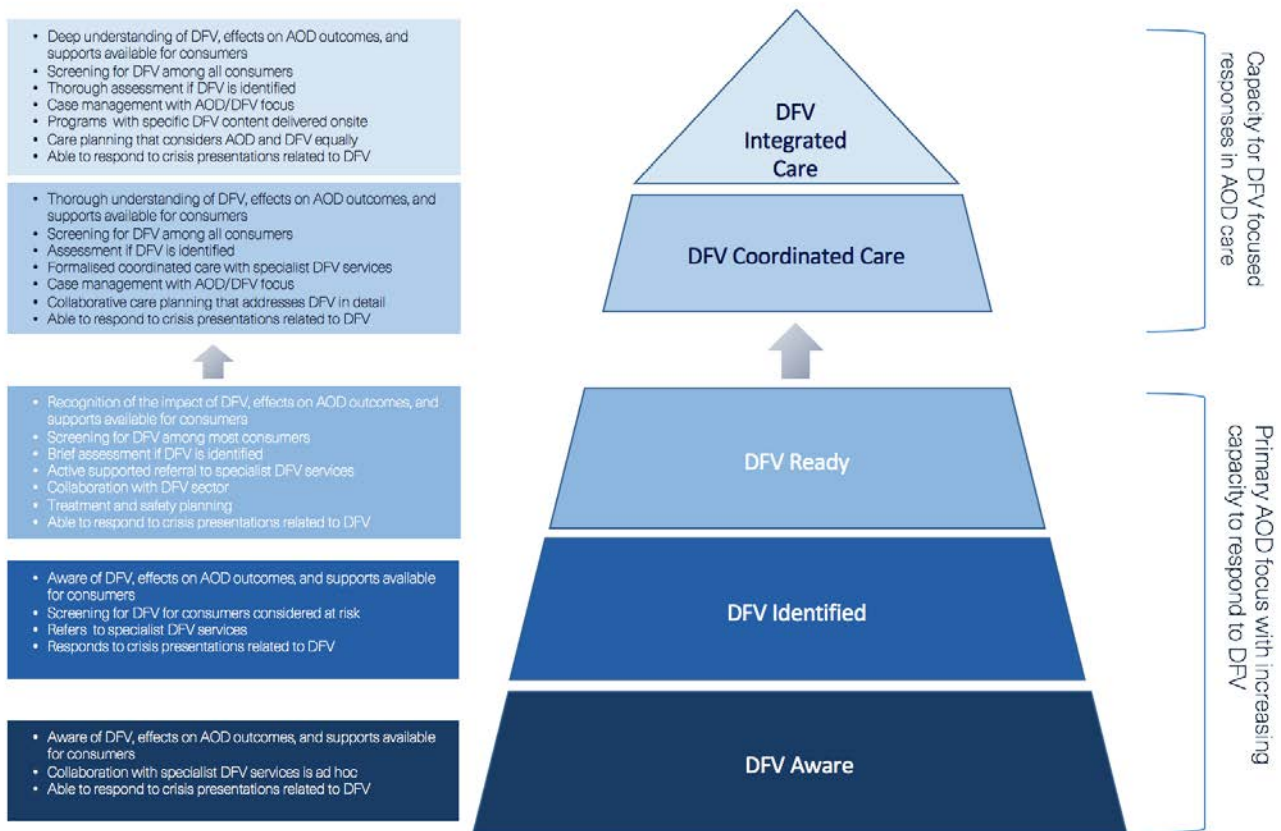


Figure 1. Program-wide Scope of Practice

Universal approach to DFV

All staff members should receive foundation training in DFV, including the relationship between DFV and AOD, and how best to support service consumers who experience DFV including crisis management and safety planning.

With appropriate training, it is likely that workers without relevant qualifications^b, workers who possess vocational qualifications in AOD, and workers with professional qualifications could provide education to service consumers on different forms of DFV, the relationship between AOD and DFV, provide appropriate support to increase safety, and refer service consumers to relevant support services (e.g. DFV specialist sector).

Screening for DFV

In programs/organisations where screening for DFV is conducted, staff require training to enable them to ask service consumers sensitively about DFV, and how to take the next steps if DFV is identified.

^b This could include, for example, people employed in administrative or other roles who may have contact with people experiencing DFV crises. These people may have qualifications related to their position (e.g. finance, business etc) but do not have, and are not required to have, qualifications as described in the ACT and Victorian AOD Qualification Strategies.

With appropriate training, it is likely that workers without relevant qualifications and workers with vocational qualifications in AOD could screen for DFV using careful questioning (e.g. “Do you feel safe at home”?).

With appropriate training, it is likely that vocationally trained AOD workers with demonstrated experience and competence in DFV responses and workers with professional qualifications could conduct screening with validated screening tools.

Safety planning

When DFV is detected, staff require training to enable them to conduct a safety plan with service consumers that also addresses the safety of children.

With appropriate training, it is likely that workers without relevant qualifications and workers with vocational qualifications in AOD could collaborate with service consumers to develop a basic safety plan.

With appropriate training, it is likely that vocationally trained AOD workers with demonstrated experience and competence in DFV responses and those with professional qualifications could develop a more sophisticated, detailed and individualised safety plan in collaboration with service consumers.

Assessment of DFV

Assessment of DFV beyond screening, including care planning that considers DFV and AOD risk as mutual factors for triggering relapse, should only be conducted by adequately trained staff. In particular, assessment of service consumers who use DFV can be complex and AOD staff who are used to advocating for their clients are at risk of inadvertently colluding with the service consumer to shift blame for their behaviour from the service consumer to the partner who is the victim of DFV. This conflicts with recommended practices intended to rest total responsibility with the person who uses DFV.

With appropriate and sufficient training and ongoing supervision in DFV, it is likely that vocationally trained AOD workers with demonstrated experience and competence in DFV responses, and those with professional qualifications who also have substantial experience in AOD, could conduct an assessment for DFV. This would contain sufficient information to allow the development of an AOD treatment plan that addresses the service consumer’s needs in relation to DFV and the impact of both AOD and DFV on treatment outcomes.

DFV specific support and interventions

In programs/organisations where case management with an AOD/DFV focus is offered, or programs/organisations with DFV specific content, the program/organisation is responsible for ensuring staff members have sufficient education, training and the required capabilities to perform this specialised work. Research evidence (mainly originating in the US) reporting outcomes from integrated interventions for AOD service consumers that included a DFV focus (experiencing or using DFV) were delivered by highly skilled and trained therapists (usually at post-graduate master’s level), so it is essential that only trained staff deliver co-ordinated, collaborative and integrated AOD and DFV care.

Competencies in the DFV area, including evidence based interventions with people who experience DFV and people who use DFV, couples, families, and children who have

witnessed DFV may be achieved through tertiary study, in-service training and ongoing supervision, completion of a professional development program, or by gaining direct experience from working in the DFV field.

With appropriate and specialised training and ongoing supervision, it is likely that AOD workers with a professional qualification and adequate experience, skills and competencies could deliver specialist care with a coordinated or integrated AOD/DFV focus.

Individual Scope of Practice

The Scope of Practice for the whole program/organisation is important; however, equally important is the scope of practice of each individual AOD worker *within* the program/organisation. An individual's scope of practice will align with their education and training, qualifications, skills, and competence in addressing DFV among AOD service consumers.

Individual AOD workers should self-assess their knowledge, skills, confidence and competence in each area of practice required by the program/organisation in regard to DFV. Staff members may develop an individualised training plan, which could be reviewed during supervision sessions. Individuals may need to increase their knowledge, skills or competence in the area of DFV to practice safely and skilfully in the area.

Working with AOD service consumers who experience DFV

The following practice points have been recommended for working with service consumers who have experienced DFV:⁽⁴⁾

1. Maintain confidentiality, except in cases where mandatory reporting is required (e.g. imminent risk of danger to the consumer or children)
2. Believe the service consumer
3. Offer choices and work together to increase safety
4. Maintain a non-judgemental attitude
5. Align with the service consumer's readiness to address DFV and do not push the person to take steps they are not ready to take
6. Develop skills in questioning about DFV with every service consumer
7. Keep accurate, concise and up-to-date service consumer records in relation to incidents of DFV as the record may be used for legal purposes
8. Develop skills in assessing for risk of harm from DFV
9. Develop skills in safety planning
10. Develop skills in effective referral strategies

Working with AOD service consumers who use DFV

A list of capabilities for working with male AOD service consumers who use DFV were developed in the United Kingdom.⁽⁵⁾ The Capabilities could potentially apply to working with consumers of both genders who use DFV and include:

1. Knowledge of the prevalence of DFV among AOD services consumers, the link between AOD and DFV, types of DFV, and how people who use violence may minimise or justify using violence
2. Interpersonal skills including ensuring responsibility rests with the person who uses DFV, therapeutic optimism that change is possible, expressing empathy without collusion, maintaining a non-judgemental attitude
3. Role legitimacy that asking about DFV is an acceptable pursuit for an AOD worker
4. Awareness of signs of use of violence, including being alert for DFV in day to day practice and knowing the 'red flags' for DFV
5. Facilitating disclosure, by fostering a therapeutic relationship, normalising questioning about use of violence, reflecting on own feelings about DFV, using probing questioning to elicit crucial information
6. Gathering information on specific risks, with the safety of the partner and children as first priority, conducting a risk assessment, and risk management planning

7. Knowing what to do with disclosure, including AOD team work and working with external agencies, knowing when to involve police and child protective services, knowing pathways for people who use violence and making effective referral for people who use violence and their partners and children
8. Continuing to work with the service consumer after disclosure, including maintaining optimism and re-establishing 'common ground' such as therapeutic alliance and continuing goal focussed AOD treatment
9. Committing to ongoing professional development in the area of DFV, including training and supervision

An example of a self-assessment in the main domains of DFV work within an AOD environment is shown in Table 1.

Table 1. Example self-assessment questions

Activity	Appraisal 0= not required 1=not at all developed 2= slightly developed 3= somewhat developed 4= developed 5= highly developed
Knowledge of the relationship between AOD and DFV	
Training plan:	
Knowledge of educating service consumers in types of DFV and the relationship between AOD and DFV	
Training plan:	
Knowledge of how to raise the issue of DFV sensitively	
Training plan:	
Knowledge of informal DFV screening questions	
Training plan:	
Knowledge of DFV validated screening tools and procedures	
Training plan:	
Knowledge of referral options and resources for service consumers	
Training plan:	
Knowledge of safety planning	
Training plan:	
Knowledge of conducting assessment for DFV in the context of AOD	
Training plan:	
Knowledge of treatment planning for AOD and DFV	

Training plan:	
Knowledge of developing collaborative working relationships with the DFV sector	
Training plan:	
Knowledge of case management for service consumers with DFV involvement	
Training plan:	
Knowledge of integrated interventions (AOD and DFV) for service consumers who experience DFV	
Training plan:	
Knowledge of interventions for the children of service consumers who witness DFV	
Training plan:	
Knowledge of issues regarding Aboriginal and/or Torres Strait Islander service consumers who experience or use DFV	
Training plan:	
Knowledge of issues regarding lesbian, gay, bisexual, transgender and intersex (LGBTI) service consumers who experience or use violence	
Training plan:	
Knowledge of issues regarding culturally and linguistically diverse service consumers who experience or use DFV	
Training plan:	

¹ Roche, A. M., Pidd, K. (2010). *Alcohol & Other Drugs Workforce Development Issues and Imperatives: Setting the Scene*. Adelaide: National Centre for Education and Training on Addiction (NCETA), Flinders University. Accessed on 1 December 2017 at:

<http://nceta.flinders.edu.au/files/4912/7200/2031/EN422%20Roche%20%20Pidd%202010.pdf>

² Alcohol Tobacco and Other Drug Association ACT (ATODA). (2015). *ACT Alcohol, Tobacco and Other Drug Workforce Qualification and Remuneration Profile 2014. Monograph Series, No.2*. Canberra: ATODA. Accessed on 1 December 2017 at: www.atoda.org.au

³ Intergovernmental Committee on Drugs. (2014). *National Alcohol and other Drug Workforce Development Strategy 2015–2018*. Canberra: Intergovernmental Committee on Drugs. Accessed on 1 December 2017 at: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/\\$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf)

⁴ The Stella Project. (2007). *Domestic Violence, Drugs and Alcohol: Good practice guidelines toolkit Second Edition*. London: The Stella Project.

⁵ Hughes et al. (2015). *A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings*. London: Kings College.

Attachment C: Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

This Attachment contains the *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug (AOD) Settings*.

About this document:

This Practice Guide has been developed for specialist AOD services to assist programs/organisations to work effectively with service consumers who experience or use domestic and family violence (DFV). Although applicable nationally, it was more specifically developed to guide practice within the context of the ACT *AOD Safer Families Program*.

The Practice Guide was developed through an intensive co-design process with AOD and DFV services, clinicians, consumer organisations and policy workers (see Section 4).

Relationship to the *AOD Safer Families Program*:

The Practice Guide is to be used by AOD services funded through the *AOD Safer Families Program* to develop responses to DFV that reflect the evidence and consensus of sound practice (including in clinical work). This includes practice guidance that ranges from screening and disclosure of DFV, all the way to clinical interventions for people who experience or use DFV. In particular, those services that are funded to deliver coordinated / integrated pilots will need to demonstrate that the pilot delivery aligns with the Practice Guide.

As described in the *AOD Safer Families Program* model (see Section 2), the Practice Guide is designed as a companion tool to both the Domestic Violence Capability Assessment Tool (DFVCAT) (see Attachment A) and Scope of Practice (see Attachment B).

When used in conjunction with each other, the materials provide sufficient information to guide AOD practice when responding to DFV at an organisational, program and individual worker level. Additionally, these documents are all subjects of the *AOD Safer Families Program* Monitoring and Evaluation Framework which will help to provide evaluation guidance at a whole of sector/policy level:

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	Program/organisational level	<ul style="list-style-type: none"> • Benchmark and assess capacity to respond to DFV in AOD settings • Plan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated/integrated AOD and DFV responses • Assess and report on progress
Scope of Practice: for Working with Service Consumers in AOD Settings who Experience or Use DFV	Both program/organisational level & practice/clinical level	<ul style="list-style-type: none"> • Clarify roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV • Guide services and workers on how to work safely and effectively (based on skills, qualifications and training) • Inform workforce planning, training and recruitment

Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice / clinical level	<ul style="list-style-type: none"> • Guide practice (e.g. screening, assessment and interventions) • Optimise responses and outcomes for service consumers • Ensure activities funded through the <i>AOD Safer Families Program</i> are evidence based and align with clinical consensus
Monitoring and Evaluation Framework for the ACT <i>Alcohol and Other Drug (AOD) Safer Families Program</i> 2017-2021	Whole of sector/policy level	<ul style="list-style-type: none"> • Monitor and Evaluate the entire <i>AOD Safer Families Program</i> • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to DFV in AOD settings

Suggested Citation:

The suggested citation for the Attachment is:

Lee, N., Jenner, L. & Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings*. Canberra: ATODA.

Available At:

The Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings will also be made available as a stand-alone document available from www.atoda.org.au.

Attachment C

Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings

Version 1

December 2017

Abbreviations

AAS	Abuse Assessment Screen
ACON	formerly AIDS Council of New South Wales
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	alcohol and other drug
ATOD	alcohol, tobacco and other drug
ATODA	Alcohol Tobacco and Other Drug Association ACT
BRFSS	Behavioural Risk Factor Surveillance Survey
CAS	Composite Abuse Scale
CBT	cognitive behaviour therapy
CTS	Conflict Tactics Scale
DFV	domestic and family violence
DVSAT	Domestic Violence Safety Assessment Tool
HITS	Hurts, Insults, Threatens and Scream scale
J-IPV	Jellinek intimate partner violence screen
LGBTI	lesbian, gay, bisexual, transgender, and intersex people
NICE	National Institute for National Health and Care Excellence (UK)
OVAT	Ongoing Violence Assessment Tool
PVS	Partner Violence Screen
RCT	randomised controlled trial
SAMHSA	Substance Abuse and Mental Health Services Administration (USA)
STaT	Slapped, Threatened or Thrown Scale
WAST	Woman Abuse Screening Tool
WEB	Women's Experience with Battering scale

Background

Purpose

The *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings* (Practice Guide) has been developed for the alcohol, tobacco and other drug (ATOD) sector to assist programs and organisations to work effectively with service consumers who experience or use domestic and family violence (DFV).

The Practice Guide assumes that good quality and evidence informed core AOD practice is already in place, and seeks to build on that when responding to DFV.

Intended audience

The Practice Guide has been written specifically for the specialist alcohol and other drug (AOD) workforce. It applies to workers in all AOD settings, including peer workers, those with a professional qualification, those with a Certificate IV in AOD Work and those with other vocational qualifications.

Target service consumer group

The Practice Guide is intended to guide practice with all AOD service consumers, including people of all genders who experience or use DFV, couples and families. Consideration of the needs of Aboriginal and/or Torres Strait Islander people; people from culturally and linguistically diverse communities; and lesbian, gay, bisexual, transgender, and intersex (LGBTI) service consumers are included where evidence exists.

Settings

The Practice Guide can be used by specialist AOD workers from all AOD practice settings including residential and community-based programs.

Methods used to develop the Practice Guide

The Practice Guide was informed by a systematic review of literature on the management of DFV in AOD settings. See the Appendix for the search strategy.

Recommendations were developed by a multidisciplinary clinical and expert roundtable, which included clinicians from the ACT, NSW and Victoria with expertise in AOD treatment and/or domestic and family violence; members with expertise in AOD policy, research and evaluation; and consumer representatives (see Section 6 for Acknowledgements).

For information on how the recommendations were developed, see *About the recommendations* sub-heading.

For more information on the co-design process see Section 4.

Structure of the Practice Guide

The Practice Guide was structured to align with the *Domestic and Family Violence Capability Assessment Tool: for AOD settings* (DFVCAT),^a which was designed to support specialist AOD programs/organisations to measure their capacity to respond to DFV. The DFVCAT describes five categories across a continuum of increasing responsiveness to service consumers experiencing or using DFV that also involves collaborative working arrangements with the specialist DFV and healthy relationships sectors.

The DFVCAT contains six domains that should be considered when measuring capacity to respond to AOD service consumers who experience or use DFV. The DFVCAT domains used in the headings of this Practice Guide were:

1. Program structure

Examines four factors that support a program's/organisation's capacity to plan and respond to issues of DFV among service consumers.

2. Physical environment and organisational culture

Examines two factors that establish how issues of DFV are recognised and accommodated by the particular program/organisation.

3. Clinical processes – screening and assessment

Examines the extent to which screening for DFV and associated assessment inform program/organisation decision making.

4. Clinical processes – interventions

Examines how AOD and DFV issues are addressed in the context of specialist AOD care.

5. Continuity of care

Examines how service consumers with both AOD and DFV issues are supported over time.

6. Staffing considerations

Determines staffing mix, staff support activities, availability of AOD staff members with expertise in DFV issues, and staff training required to work safely and effectively.

Consensus recommendations and practice points can be found in the 'At a glance' heading at the beginning of the Practice Guide for quick reference. Other helpful resources are listed at the end of the Practice Guide.

Terminology

At times, terminology has been used in this Practice Guide that are not the preferred terms of ATODA and/or the terms used throughout the rest of this report, but reflect terms used in

^a The DFVCAT was modelled on the toolkit *Dual Diagnosis Capability in Addiction Treatment (DDCAT)*, which was used by AOD services nationally to enhance care for service consumers with co-occurring mental health problems. <https://www.centerforebp.case.edu/client-files/pdf/ddcattoolkit.pdf>

the literature reviewed for the Practice Guide. Where necessary, these terms have been intentionally retained to maintain the integrity of the evidence presented. Examples of these terms include 'patient', 'perpetrator', 'victim', 'intimate partner violence', 'abuse', 'LGBT', 'problem' (e.g. 'AOD problem' or 'mental health problem').

At a glance

Program structure

Recommendations

- AOD services should ensure that routine screening and assessment for DFV is conducted as part of good AOD treatment.
- All AOD services should aim to build relevant relationships with DFV services in their local area.
- AOD services that are able to provide integrated care (treatment for both AOD and DFV provided in-house) for people who experience DFV and for people who use DFV, should ensure that staff are suitably skilled, that good organisational policy and supports are in place, and that integrated programs are regularly evaluated.

Practice Point: Collaboration

Collaboration with services to assist service consumers experiencing or using DFV can range from simple advice at one end of the spectrum, to coordinated and shared care at the other. These services include specialist DFV and men's behaviour change sectors; family; women's; children and legal services.

- Identify relevant local agencies and become familiar with the services they offer.
- Meet with staff of the target service and determine if collaboration could occur.
- Decide on the nature of the collaboration including roles, function and desired outcomes. These might include fast-tracked responses, reciprocal advice, coordinated training, sharing of relevant information when permitted, collaborative care planning and joint case conferencing etc.
- Consider formalising the arrangement through Memoranda of Understanding, formal referral pathways, procedures for collaboration, and scheduling regular meetings to maintain and review the progress of the collaboration.

Program environment and organisational culture

Recommendations

- All staff, including clinical, ancillary, contract and administrative staff, should be trained in DFV and trauma awareness.
- All AOD services should provide general DFV information for service users (e.g. a poster), which states that the service is open to discussing DFV, and explains how to get help.
- All services should provide a physical environment that is welcoming and is safe to discuss DFV issues, such as private confidential spaces, sound-proof rooms, and women-only spaces.
- All services should establish policies and procedures to ensure service consumers' information is safe and confidential, including written information (e.g. service consumer case notes) and conversations with and about service consumers.

Practice Point: Resources

Service consumers should be consulted to ensure available resources are easily understood, relevant and targeted correctly.

A few examples are:

- Charmed and Dangerous (<http://womenscentre.org.au/wp-content/uploads/Charmed-and-Dangerous.pdf>)
- Gathering Support (<http://www.dvrcv.org.au/sites/default/files/DVRCV-Gathering-Support.pdf>)
- Walking a tightrope; a guide for families (http://www.fds.org.au/images/FDS/NCETA_Walking_a_Tightrope.pdf)
- ACON's *Say it out loud* campaign (<http://sayitoutloud.org.au>)
- Gay and Lesbian Health Victoria's poster for health service waiting rooms: 'You don't have to tell us if you're gay or lesbian. But you can. Gay, lesbian, bisexual, transgender and intersex people and their families are welcome at this service.'

Clinical processes

Recommendations

- AOD services should routinely screen service consumers for risk of DFV (both experience and use of DFV) with a single question or series of trigger questions.
- AOD services should undertake formal screening if effective follow-up responses are available (either in-house management or referral).
- Formal screening should use a validated screening tool.
- AOD services without the capacity to conduct formal screening should use careful questioning about safety instead, and ask about risk.
- Risk screening should occur at the beginning of treatment and again at various points through the treatment process.
- Formal screening for DFV and risk screening should be conducted by appropriately trained staff when good rapport between worker and service consumer has been established.
- Low-threshold AOD services (including peer based services, needle syringe programs, drop-in programs, sobering up programs), should undertake risk screening opportunistically when appropriate to do so.
- Staff members who conduct screening should be trained to do so.

Practice Point: Screening

Some services will use validated screening tools, while it may be more appropriate for other services, such as peer-based organisations and low threshold services, to use careful questioning when appropriate to do so.

One simple question for service consumers who may have experienced DFV may be “Do you feel safe at home”?

The Australian Institute of Family Studies (www.aifs.gov.au) lists the following three potential questions:

1. Do you have any reason to be concerned about your own safety or the safety of your children?
2. Do you have any other concerns about your children’s wellbeing at the moment?
3. Do you have any reason to be concerned about the safety of anyone else?

This approach provides an opportunity for further exploration of important areas of concern.

The following questions for service consumers who may have used DFV were recommended by the UK’s Stella Project:⁽¹⁾

- Has your drug or alcohol use affected your relationships with your partner and family?
- Has anyone in your family been frightened or harmed by you when you’ve been substance affected?

Followed by one or two further questions:

- Do you ever make decisions or rules about who your partner can or can't see?
- Have you ever felt that your behaviour got out of hand when you've lost your temper or been violent? If yes, what happened?"

Practice Point: Responding to disclosure of experiencing DFV

Some AOD workers may be reluctant to screen for DFV because they may not feel confident to take the next steps if a service consumer discloses that they have experienced DFV. It is critical that AOD workers understand that leaving the violent relationship will not necessarily make the service consumer safer—in fact, leaving the situation is often when the service consumer is at highest risk of experiencing DFV.

The following steps for responding to disclosure were recommended by the National Centre for Education and Training on Addiction (NCETA):

1. Focus on safety of the service consumer, their children and AOD service staff
2. Help the service consumer to protect themselves, identify who else can provide support, and how they can safely access information, websites and services
3. Listen, hear, and believe
4. Take the DFV seriously
5. Emphasise that DFV is always the responsibility of the person who is using violence
6. Maintain a non-judgemental stance (do not criticise the violent partner, nor judge the service consumer for staying with their partner)
7. Acknowledge the courage it takes to disclose DFV
8. Assist the service consumer to explore their options for next steps to take
9. Support their choices and the timing of their choices
10. Maintain regular contact if possible and negotiate how to maintain contact safely (i.e. when and how to call them)

Adapted from White, M. et al (2013) *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. NCETA, Flinders University.

Safety planning

Recommendations

- Safety plans should be developed for AOD service consumers who are experiencing DFV and their children who are witnessing DFV.

Practice Point: Safety planning

Safety planning is a crucial component of assisting service consumers who experience DFV. Unlike an AOD relapse prevention plan that is often given to the service consumer in hard copy, having a copy of a DFV safety plan can be extremely risky for people who experience DFV if the person using DFV finds it in their possession. A copy of the safety plan could be kept in the service consumer's case notes and reviewed at regular intervals.

A Personalised Safety Plan should:

- Include emergency contact numbers (e.g., for police, DFV organisations, crisis lines, medical services)
- Identify a friend(s), family member or neighbour who can provide support and the means to contact them
- Identify safe places for the service consumer to go to and how to get there, (e.g., friends, relatives, motel, refuge)
- Identify strategies to ensure children's safety (consider travel to and from school/childcare, mobile phone use, social media risks, safe person/place for the child to go to in emergency)
- Identify ways for the service consumer to get access to money in an emergency
- Identify and plan for access to any medications for personal or children's use
- Identify a place to store valuables and important documents (or copies) so that the service consumer can access them when required (e.g. birth, marriage and divorce certificates, passport, family court orders, rental agreement or mortgage documentation, utility bills, car registration, debit and credit cards, driver's license etc.)
- Identify contents of an emergency bag and where this bag can be stored safely (e.g. medication and toiletries, spare keys to house/car/work, money, mobile phone and charger change of clothes and basic food)
- Specifically address any barriers to the service consumer following through on actions identified in the safety plan (for example mobility or communication problems)
- Establish a distress code with friends/relatives that will trigger them to call to the police in an emergency

Source: White, M. et al (2013) *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. NCETA, Flinders University

Assessment for DFV

Recommendations

- Services should undertake detailed assessment for DFV only if the service consumer, staff and service have the capacity and intention to respond to issues identified.
- Only staff members who are well trained should undertake detailed assessment for DFV.
- When assessment is conducted for people who experience DFV, it should include assessment of:
 - their safety and that of their children (including developing a personalised safety plan)
 - the degree to which their harmful AOD use is tied to the partner who uses DFV
 - physical, emotional and mental health issues
 - use of medications
 - decision-making skills
 - social functioning, legal issues, parenting issues
 - relapse-prevention planning
 - what supports, networks and services they are using or have access to
 - what actions the person is prepared to take in respect of DFV.
- When assessment is conducted for people who use DFV, it should include assessment of:
 - the precise timing of DFV in relation to an instance of AOD use
 - the proportion of violent behaviour that occurs while the person is using AOD
 - which substances are used before the violent act
 - what feelings precede and accompany the use of AOD
 - whether AOD are used to ‘recover’ from the violent incident.

Practice Point: Assessing risk

A risk assessment involves determining the level of threat posed to a service consumer who has experienced, or may experience, DFV from the person who is using DFV. Risk can change over time and workers should review risk with service consumers at periods relevant to the service consumer’s circumstances.

In New South Wales, frontline workers use the Domestic Violence Safety Assessment Tool (DVSAT) to assess risk. The tool explores 25 factors associated with risk in the domains of type of violence used, the relationship between the person experiencing violence and their partner, relevant characteristics of the person using violence (e.g. employment status, mental health, access to firearms, forensic history), issues concerning children, and issues concerning sexual assault. Scores between one and 11 indicate a person is *at threat*, while a score of 12 or greater indicates a person is *at serious threat*. The DFVSAT and the guide to using the tool can be accessed online (www.domesticviolence.nsw.gov.au).

Interventions

Recommendations for implementing interventions aligned with service capacity measured by the *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Services*

Universal responses

- All services should follow the principles of good AOD practice and offer holistic AOD responses appropriate to their service type.
- All services should model respectful relationships in all interactions, including those between staff and those between service consumers and staff.
- The charter of rights should be displayed and meaningful service consumer involvement in the development and delivery of AOD programs, including those that involve DFV, be encouraged.
- All staff should be trained in DFV awareness and DFV supports available for service consumers.
- Staff should be able to respond to crisis presentations related to DFV.
- In addition to the universal recommendations, services should establish policy, capacity, and protocols according to DFVCAT category.

DFV-identified services should:

- Ensure information about DFV (e.g. a poster) is displayed where service consumers can see it.
- Offer holistic AOD treatment that includes mental health assessment and responses, including psychoeducation.
- Actively screen service consumers for risk of experiencing or using DFV.
- Establish referral linkages for DFV care (active supported referral).

DFV-ready services should:

- Routinely undertake formal DFV screening.
- Respond effectively to disclosure of DFV issues.
- Offer insight-based interventions (e.g. psychoeducation, motivational enhancement) that acknowledge links between AOD and DFV.
- Work with service consumers to develop safety plans and to review the effectiveness of the plans regularly.
- Offer harm reduction interventions for those who experience or use DFV.
- Offer groups in-house that are facilitated by specialist DFV workers (in-reach groups)
- Focus on promoting and supporting healthy relationships.

DFV-coordinated care services should:

- Undertake detailed assessment when formal screening identifies DFV risk or current DFV.
- Respond to assessed DFV issues by working with external specialised services.
- Maintain contact with DFV treatment/programs delivered by other services and provide coordinated care designed to enhance safety.

- Offer appropriate interventions (e.g. in-house couples therapy, other family interventions).
- Focus on building respectful relationships.

Integrated AOD/DFV services should:

- Respond to DFV issues by arranging secondary consultation, providing internal referral to a specialised DFV service onsite, or providing care through specialised care provided by appropriately trained AOD staff.
- Incorporate DFV care into staff training and into all the service's policies and protocols.
- Provide in-house, or arrange referral to, appropriate interventions such as in-house couples therapy, other family interventions, or men's behaviour groups. Selected interventions should be appropriate to the population and either evidence-based or conducted within a research protocol.

Practice Point: Recommended capabilities for working with AOD service consumers who use DFV

- Knowledge of the prevalence of DFV among AOD service consumers, the link between AOD and DFV, types of DFV, and how people who use DFV may minimise or justify using DFV
- Interpersonal skills including ensuring responsibility rests with the service consumer who uses DFV, therapeutic optimism that change is possible, expressing empathy without collusion, maintaining a non-judgemental attitude
- Role legitimacy, in that asking about DFV is acceptable for an AOD worker
- Awareness of signs of use of DFV, including being alert for DFV in day to day practice and knowing the 'red flags' for DFV
- Facilitating disclosure by fostering a therapeutic relationship, normalising questioning about use of DFV with all service consumers, reflecting on own feelings about DFV, using probing questioning to elicit crucial information
- Gathering information on specific risks, with the safety of the partner and children as first priority, conducting a risk assessment, and risk management planning
- Knowing what to do with disclosure, including AOD team work and working with external agencies, knowing when to involve police and child protective services, knowing pathways for people who use DFV and making effective referrals for people who use DFV and their partners and children
- Continuing to work with the service consumer after disclosure, including maintaining optimism and re-establishing 'common ground' including therapeutic alliance and continuing goal focussed AOD support and treatment
- Committing to ongoing professional development in the area of DFV, including training and supervision

Adapted from Hughes, L. et al (2015) *A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings*, Kings College London

Practice Point: Working with AOD service consumers who experience DFV

The following practice points have been recommended for working with service consumers who have experienced DFV:

- Maintain confidentiality, except in cases where mandatory reporting is required (e.g. imminent risk of danger to the service consumer or children)
- Believe the service consumer
- Offer choices and work together to increase safety
- Maintain a non-judgemental attitude
- Align with the service consumer's readiness to address DFV and do not push the person to take steps they are not ready to take
- Develop skills in questioning about DFV with every service consumer
- Keep accurate, concise and up-to-date service consumer records in relation to incidents of DFV as the record may be used for legal purposes
- Develop skills in assessing for risk of harm from DFV
- Develop skills in safety planning
- Develop skills in effective referral strategies
- Participate in training and supervision relevant to DFV

Source: AVA toolkit, Stella project, UK⁽¹⁾

Practice Point: Considerations for children exposed to DFV

- Exposure to DFV can affect a child's psychological wellbeing and is thought to contribute to a range of emotional and behavioural issues, including low self-esteem, depression, PTSD, impaired cognitive functioning, and poorer educational outcomes.
- DFV is one of a constellation of risk factors for healthy child development that also includes parental AOD use.
- Mandatory reporting of children exposed to DFV may act as a barrier for parental help-seeking out of fear that children will be removed. This is particularly relevant for Aboriginal and/or Torres Strait Islander Australians.
- Child-aware approaches that emphasise family-sensitive, strengths based, collaborative and culturally appropriate service delivery are recommended.
- A good example of a child-aware program delivered in an adult homelessness service is the Salvation Army's *Safe from the Start* program that uses play-based therapy with specifically sourced books and toys that help children aged 0-6 to make sense of their experiences related to DFV (Go to www.salvationarmy.org.au for the final evaluation report).

Adapted from Campo, M. (2015) *Children's exposure to domestic and family violence: key issues and responses*. Melbourne: Australian Institute of Family Studies.

Table 1. Proposed strategies for working with LGBTI people in various settings

Clinical settings

Inquire about sexual behaviour and desire in a non-judgmental manner during the clinical history-taking of all patients; do not assume heterosexuality.

Avoid labelling a patient as gay, lesbian, bisexual, or transgender, unless prompted by the patient.

Screen for intimate partner violence in LGBT patients. Consider initiating the conversation with a question such as ‘Does your partner ever hit, kick, hurt, or threaten you?’ or ‘Do you feel safe at home?’ rather than asking if a patient has concerns about domestic violence or abuse.

Interview patients about intimate partner violence alone, regardless of the gender of those accompanying them to the clinic, and assure confidentiality.

Educate LGBT patients about intimate partner violence.

Evaluate and treat health complications associated with intimate partner violence in LGBT patients, including substance abuse, HIV, and other sexually transmitted infections in men who have sex with men.

Make informed referrals to institutional and community services for LGBT patients experiencing intimate partner violence.

Verify with the patient the level of disclosure of sexual orientation or gender identity that is appropriate in any referrals to other professionals.

Providers who are not comfortable treating LGBT patients should refer them to clinicians who are.

Institutional or community settings

Adapt institutional pamphlets, posters, and other materials on intimate partner violence to incorporate LGBT persons.

Advocate for the full inclusion of LGBT individuals in institutional and community intimate partner violence services, such as hospital abuse programs and community shelters.

Educational

Revise clinical resources and guidelines on intimate partner violence to reflect the burden of violence in the LGBT community.

Include information on LGBT intimate partner violence in medical trainee and continuing medical education curricula; consider incorporating testimony by a trained survivor of LGBT intimate partner violence.

Research settings

Collect data on sexual behaviour, sexual orientation, and gender identity in population-based studies of intimate partner violence.

Increase intimate partner violence research on particularly vulnerable and under-studied groups, such as transgender individuals, bisexual individuals, and sexual minority adolescents.

Source: Ard et al (2011)⁽²⁾

Table 2. Proposed strategies for working with women from culturally and linguistically diverse backgrounds

Increase linkages between DFV responses and agencies relevant for immigrant and refugee populations (such as migration and settlement services, multicultural and ethno-specific services, consular services and English language programs).

Ensure DFV definitions and risk assessment tools across Australia are relevant for immigrant and refugee populations, recognising that family violence includes multi-perpetrator violence, immigration-related abuse, ostracism from family and community, and exploitation of joint and extended family arrangements and financial obligations.

Train and resource services that come into contact with immigrant and refugee women (e.g. settlement services, cultural associations, English language programs, healthcare services) to understand and respond to the dynamics of DFV and facilitate referral pathways to specialist support.

Recognise interpreters as an integral part of the DFV system, and support reform of the interpreting industry through development of interpreter capacity and mechanisms for interpreter support, monitoring and feedback in relation to family violence interpreting.

Create multi-language written and audio resources for broad dissemination in places that are central to daily life (e.g. schools, workplaces, shopping centres, health services) to provide information about family violence, where to access support, and what to expect from police, courts, family violence and other relevant services.

Provide options for women to access 'mainstream' as well as specialist multicultural family violence services, and ensure availability of refuges that are funded to provide intensive and long-term support for immigrant and refugee women and children.

Develop a robust bilingual, bicultural DFV services workforce that is reflective of local populations and adequately trained and clinically supported to respond to the needs of immigrant and refugee families.

Provide ongoing training to all parts of the DFV system about the additional risk factors, immigration issues and support needs of immigrant and refugee women and their children.

Ensure DFV prevention programs engage with multicultural women's services and women leaders from immigrant and refugee communities, and are based on evidence about the contexts in which immigrant and refugee women experience family violence.

Source: Vaughan et al (2016)⁽³⁾

Continuity of care

Recommendations

- Planning of post-treatment support in AOD services should include consideration of the links between AOD and DFV, and include relapse planning for both issues.
- After treatment, AOD services should link service consumers to relevant services based on their individual needs.
- After-care planning should encourage opportunities to promote healthy relationships.
- Safety plans should be reviewed, updated and reinforced.

Staffing considerations

Recommendations

- All staff should have ongoing training in AOD interventions relevant to their work.
- All staff should have training in DFV, tailored for the AOD sector.
- Staff should have access to ongoing training related to the elements that they are required to undertake.
- All staff need training in service consumer engagement related to DFV, basic DFV awareness, trauma-informed care, mandatory reporting, and cultural competence specifically related to DFV.
- Staff required to undertake screening, safety planning, and interventions should have specific training in these areas, including training in working with children and in family interventions.
- AOD services should develop a plan for implementation of training, ensuring that training is continuous.
- AOD services should give consideration to other forms of training such as placements with DFV, collaborative experiences with DFV services, case review and conferencing, access to consultation-liaison and supervision as required.

Practice Point: Options for training in DFV

- The specialist DFV sector across Australia often provides foundation training in DFV for other sectors. In the ACT, the Domestic Violence Crisis Service provides training as required (www.dvcs.org.au)
- The website DV Alert lists training opportunities in all states and territories, and also offers an e-learning program subsidised by the Australian Government (www.dvalert.org.au)
- Online training in DFV is offered by Queensland Health (www.health.qld.gov.au)
- Some universities offer a graduate certificate in domestic violence (www.qut.edu.au)
- Elective units in responding to DFV are available through the Certificate IV in AOD and the Diploma of AOD courses
- In partnership with DFV stakeholders, the AOD sector should consider developing fit for purpose/tailored DFV training packages

Staff skills and qualifications

Recommendations

- For staff delivering DFV interventions in AOD settings, the minimum qualification corresponds to that required in other settings (e.g. advanced training in family therapy or men's behaviour change interventions, as applicable).

Staff safety and self-care

Recommendations

- AOD services should ensure that all staff members have access to practice supervision and/or support appropriate to their role, level of experience and reflective of the service consumers they work with.
- In addition to practice supervision, AOD services should provide formal and informal consultation on DFV issues for AOD workers, provided by nominated staff members and according to clearly documented processes.
- All AOD staff should have access to an employee assistance program or similar.
- All AOD services should have safety policies and procedures for managing violence, including policies on outreach, equipment (duress alarms), and appropriate staff training.
- All services should have policies and procedures to support staff after a critical incident.

Context

About domestic and family violence

Definition and overall prevalence

Violence against intimate partners and within families is variously termed ‘domestic violence’, ‘intimate partner violence’ and ‘domestic and family violence’. The Australian Government⁽⁴⁾ defines domestic and family violence (DFV) as physical, verbal, emotional, sexual or psychological abuse, neglect, financial abuse, stalking, harm to an animal or property, restricting spiritual or cultural participation, or exposing children to the effects of these behaviours.

The ACT Government has described domestic and family violence as:

An ongoing pattern of behaviour aimed at controlling a victim through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal.⁽⁵⁾

The ACT’s new *Family Violence Act 2016* defines domestic and family violence as:

- (a) any of the following behaviour by a person in relation to a family member of the person:
- (i) physical violence or abuse;
 - (ii) sexual violence or abuse;
 - (iii) emotional or psychological abuse;
 - (iv) economic abuse;
 - (v) threatening behaviour;
 - (vi) coercion or any other behaviour that—
 - (A) controls or dominates the family member; and
 - (B) causes the family member to feel fear for the safety or wellbeing of the family member or another person; or
- (b) behaviour that causes a child to hear, witness or otherwise be exposed to behaviour mentioned in paragraph (a), or the effects of the behaviour.⁽⁶⁾

Amongst Aboriginal and Torres Strait Islander communities family violence is the preferred term because:

... violence against women is conceptualised within extended families and the wider community. Family violence is understood to be the result of, and perpetuated by, a range of community and family factors, rather than one individual’s problematic behaviour within an intimate partnership⁽⁷⁾

Available information about the prevalence of DFV in Australia is mainly from surveys such as the Australian Bureau of Statistics (ABS) Personal Safety Surveys conducted in 2005, 2012 and 2016; the International Violence against Women Survey conducted in 2002–2003; and from limited sources such as ABS crime data sets compiled from state and territory police records.⁽⁸⁾

DFV is common in Australia, and occurs among people of all ages, cultures and socioeconomic groups.⁽⁸⁾ It is not possible to measure the true extent of DFV in Australia because most incidents are not reported.⁽⁸⁾ It has been estimated that more than one in 10

(approximately 11.2%) of the Australian population aged over 15 years experienced physical or sexual violence perpetrated by a current or former partner.⁽⁹⁾

Women are far more likely to experience domestic and family violence than men.^(8,3) According to the latest data, approximately one in four women experienced violence by an intimate partner, compared to one in thirteen men.⁽¹⁰⁾ Domestic and family violence remains a gendered issue where women experience significantly greater prevalence and impacts than do men. Within that context, it is increasingly recognised that women may also use violence against family members.⁽¹¹⁾

DFV occurs in LGBTI intimate partner relationships^(2,3) at about the same rate as within heterosexual couples.⁽¹²⁾

While there is very little reliable information about rates of family violence among Aboriginal and Torres Strait Islander peoples, rates appear to be substantially higher than among other Australians.^(3,13) According to data for 2014–2015, the rate of hospitalisation due to family violence was 32 times higher among Aboriginal women than non-Aboriginal women and 23 times higher among Aboriginal men than non-Aboriginal men.⁽¹³⁾ Aboriginal women in some, but not all, states and territories were more likely to experience violence by a current partner than other Australian women.⁽¹³⁾

All Australian state and territory governments have initiated responses to improve safety by preventing and reducing the prevalence of domestic and family violence.⁽⁹⁾

Relationship between AOD use and DFV

While alcohol is not generally considered a sole cause of DFV, there are strong associations between the two.⁽¹⁴⁾ The interaction between alcohol and other drug use and intimate partner violence is complex and can involve the direct pharmacological effects of various substances; loss of inhibition and impulse control; greater sensitivity to and perception of threat; and the emergence of symptoms of withdrawal^(11, 15).

For alcohol, the pattern of use may be important, as heavy alcohol use (five standard drinks or more on one occasion) has been shown to increase the odds of men using physical or sexual violence with intimate partners.⁽¹⁶⁾

A study by the World Health Organization found that the odds of intimate partner violence were higher in relationships where one or both partners had a history of ‘heavy drinking’^b compared with relationships in which neither drank heavily.⁽¹⁷⁾

While alcohol is considered the largest contributor to DFV, the use of other drugs is also strongly associated with risk of DFV. A meta-analysis of international data found that:⁽¹⁰⁾

- having an ‘alcohol problem’ (i.e. meeting criteria for alcohol abuse/dependence according to the *Diagnostic and Statistical Manual of Mental Disorders* or other tools used to measure an alcohol problem) correlated more strongly with experiencing intimate partner violence than frequency of alcohol use;
- problems with drug use other than alcohol correlated more strongly with the use of intimate partner violence than substance use alone or frequency of substance use. In contrast, frequency of alcohol use and having an alcohol problem were equally correlated with the use of intimate partner violence;

^b Described as ‘frequent drunkenness’; the number of drinks on one occasion was unspecified

- overall, substance use was more strongly correlated with the use of intimate partner violence among men than women.

Australian data show similar links between AOD use and DFV. Alcohol is involved in approximately half of DFV incidents reported to police⁽¹¹⁾. When considering incidents not reported, alcohol involvement is likely to be higher.⁽¹¹⁾

The Australian component of the International Violence Against Women Survey found that DFV was more commonly reported by women whose partners got drunk at least twice per month than those whose partners did not.⁽¹⁸⁾ Women with substance use disorders are also at higher risk of experiencing DFV.⁽¹⁹⁾

Analysis of the relationship between alcohol and all Australian homicides over a 6-year period found that, in 44 per cent of intimate partner homicides, the offender, the victim, or both had been drinking.⁽¹⁸⁾ The rate of alcohol consumption before intimate partner homicides may be much higher among Aboriginal and Torres Strait Islander people.⁽¹⁸⁾

Why DFV is an issue for AOD services

It is likely that a high proportion of people who use AOD services have DFV involvement, either experiencing or using violence.^(19, 20) Most available data concern men who use domestic and family violence and women who experience domestic and family violence.

The Victorian Royal Commission into Family Violence heard that between 50 per cent and 90 per cent of women accessing mental health or AOD services had been victims of child or domestic abuse.⁽²⁰⁾ Researchers in other countries have estimated that life-threatening intimate partner violence affect up to three-quarters of women in AOD treatment programs.⁽²¹⁾

Among men attending AOD treatment, up to three-quarters have used emotional, physical or sexual violence towards their partner, and approximately 40 per cent have been physically or sexually violent toward their partner in the previous 12 months, based on international data.⁽²²⁾ Technology-facilitated abuse by men receiving AOD treatment is increasing.⁽²³⁾

The relationship between women's experiences of violence and their AOD use is complex and not well understood.⁽²⁴⁾ DFV may affect outcomes of AOD treatment. Experience of DFV may trigger relapse to AOD use during treatment (e.g. drinking to cope with violence).^(25,26,27)

The high prevalence of DFV among AOD service consumers suggests that AOD treatment provides a valuable opportunity to detect and intervene.⁽²⁸⁾ As alcohol use (particularly heavy alcohol consumption and binge drinking) may increase the severity of aggression, reports from Australia and other countries have recommended that clinical services address the role of alcohol in DFV.^(18, 29) Reports also identify the need for AOD services to assess clients for DFV, and for more training of AOD workers to respond to clients' experience of DFV.⁽²⁵⁾

The 2016 Alcohol/Drug-Involved Family Violence in Australia (ADIVA) report,⁽¹¹⁾ produced for the National Drug Law Enforcement Research Fund, advised that that 'because [alcohol and other drug] use can both be a signal of DFV and also a contributing factor ... a systematic approach is warranted that builds lines of communication between the agencies dealing with DFV and those that deal with [alcohol and other drug use].' The report concluded that 'framework responses are needed to build and encourage combined resources.'⁽¹¹⁾

What we know about AOD service users who use or experience DFV

The characteristics of people who access alcohol and other drug services and who experience DFV are not well defined, other than that the majority are women. Mental health problems such as depression, anxiety and post-traumatic stress disorder also co-occur with AOD use problems.⁽³⁰⁾ Many women accessing DFV services report AOD use as a means to cope with mental health problems and other stressors (e.g. poverty, lack of safe and affordable accommodation).⁽³¹⁾ Limited data suggest that women using AOD treatment services who have experienced DFV encounter particular barriers to accessing treatment (e.g. controlling behaviour by an abusive partner, fear of losing legal custody of children)^(25,32) and are more likely to experience relapse in AOD use.⁽²⁵⁾

Similarly, little is known about the characteristics of AOD service consumers who use DFV, compared with other service consumers.

Involving service consumers in DFV initiatives

The specialist DFV sector has a long-standing history of involving women in all areas of service development, program delivery and reviews.

In an interview-based research project, Australian women who had experienced sexual violence emphasised the need for holistic services that acknowledge service consumers' multiple problems, and for connections between different services.⁽³³⁾ The report highlighted the need for relationships between teams at various services, improved integration of care and referral processes, and more training and support for staff.⁽³³⁾

AOD services also involve service consumers in the development and evaluation of services and programs, and initiatives for addressing DFV should also be informed by sensitively conducted service consumer involvement.

In their booklet on service consumer participation in AOD settings, UnitingCare REGEN^c suggests the following opportunities represent meaningful consultation with and participation by service consumers:

- **Contributions to organisational decision making** – contributing to program planning meetings and policy development, participating on staff recruitment panels and in working groups, participating in quality accreditation.
- **Preparing and giving presentations** – presenting at staff meetings, external forums, and to other service consumers during treatment or support programs.
- **Participating in education and training** – receiving training by the organisation or from other relevant sources, contributing to training content, evaluating training services.
- **Other activities** – administering consumer satisfaction surveys, providing materials for the organisation's website or newsletters, reviewing information materials provided by the service.

^c *The Reason Why We're Here: ReGen's Model for Consumer Participation*, UnitingCare REGEN (2016)

Towards a practical model of responses to DFV in AOD settings

The AOD sector and the specialist DFV sectors have different, though overlapping, service consumer groups. Considering the large number of men who use AOD services, the AOD sector requires a broad conceptual model of DFV to be effective in this important area.

A US group of researchers developed an expanded model of violence that included a category of 'situational partner violence', which 'arises in the context of specific conflicts that turn into arguments that escalate to verbal aggression and, ultimately, to physical violence'.⁽³⁴⁾ This category could be important for AOD service consumers, particularly in cases where violence is used between partners. While some authors have questioned the applicability of the Johnson *et al* model to the general population⁽³⁵⁾ and its effect on family court decisions,⁽³⁶⁾ others consider it relevant to understanding AOD-related DFV in Australia.⁽¹¹⁾

A model of DFV that also includes AOD-involved family violence (encompassing situational partner violence) may have practical and clinical utility for the AOD sector whose service consumers are universally affected by AOD use. Furthermore, evidence-based AOD interventions have been reported to reduce the frequency and severity of DFV among AOD service consumers,⁽³⁷⁾ suggesting that the AOD sector may exert the greatest effect on situational violence in which alcohol and other drug use plays a part.

Throughout the development of this Practice Guide, an expanded conceptual model of DFV was adopted that takes into consideration the association between AOD use and experiencing or using DFV^d (Figure 1). Philosophically, the model is consistent with Objective 4 of the *ACT Prevention of Violence Against Women and Children Strategy 2011-2017*^e; that states "men who use violence are held accountable and supported to change their behaviour."

It's important to note that some permutations of DFV cannot be captured by a simple visual representation. These include inter-generational violence, the risk that those who have been subjected to violence as children may mature into adult users of violence, and multi-directional violence within a complex family dynamic. Formalised approaches by the ATOD sector to service consumers who experience or use DFV are also emerging. The model will be subject to review in future iterations of this Practice Guide as the body of practice-based evidence and evidence-based practice grows.

^d The relative sizes of the violence categories are conceptual and do not reflect actual prevalence data.

^ehttp://www.communityservices.act.gov.au/__data/assets/pdf_file/0014/231341/ACT_Prevention_of_Violence_Against_Women_and_Children_Strategy_2011.pdf



Figure 1. Conceptual model of DFV

Implications for AOD service delivery

AOD use is a dynamic risk factor for experiencing or using DFV, and is amenable to change through evidence-based AOD interventions that have demonstrated effectiveness in reducing the quantity and/or frequency of substance use.

The Practice Guide clarifies that AOD services should undertake screening for DFV, followed by an assessment of service consumers found to be experiencing or using DFV. In cases where AOD use (e.g. intoxication, withdrawal, procuring substances) is found to be associated with DFV, services with the capacity and capability to do so should conduct treatment planning that may include a coordinated or integrated approach where episodes of using or experiencing DFV is measured and re-assessed during AOD treatment, in much the same way that mental health symptoms are measured as part of routine AOD care. Emotional regulation skills, prevention and early intervention for DFV would be integrated with AOD treatment. Safety of consumers, their children and staff members will always be paramount.

Where DFV is found to be predominantly gendered violence (e.g. relating to power, control and coercion; a belief in gender stereotypes and negative attitudes towards women), the Practice Guide provides for the AOD sector to work closely with the DFV sector to maximise safety of women and their children. Where other forms of DFV are evident (e.g. sexual, psychological, emotional, economic, cultural abuse), AOD organisations should refer to, or work collaboratively with, the most appropriate agency that can meet the particular needs of service consumers experiencing DFV.

Male clients who use controlling and coercive DFV would be referred to specialist men's behaviour change services, while the AOD sector would continue to deliver AOD treatment in collaboration with the men's behaviour change service according to their capacity. Specialist AOD services with capacity to deliver integrated men's behaviour change and AOD treatment programs may choose to do so (in the context of expanded services and resourcing to do so).

Similarly, specialist AOD services with capacity to deliver integrated DFV and AOD treatment to women service consumers (and potentially children and families) may also expand their services. Use of the DFVCAT is intended to guide planning in these areas.

About the recommendations

This Practice Guide provides consensus-based recommendations developed with input from an *AOD Safer Families Program Clinical/Expert Roundtable*. For more information on the Roundtable and development process see Section 4.

The Roundtable assessed the evidence identified by the systematic review of literature (see the Appendix for methods). For each clinical question, identified studies were summarised and rated according to the National Health and Medical Research Council (NHMRC) Levels of evidence.⁽³⁸⁾ The Roundtable used the following process to formulate recommendations:

- Evidence-based recommendations could be developed on questions for which the body of evidence was considered sufficiently reliable and relevant.
- Where evidence for a question was lacking or insufficient, the Roundtable developed consensus-based recommendations based on available evidence, existing good practice guidelines, and their own expertise and experience.

The Roundtable considered that the body of evidence for each of the 25 questions was insufficient to support an evidence-based recommendation. Accordingly, all recommendations in this Practice Guide are consensus-based and informed by the available evidence.

Principles of practice for the Practice Guide in AOD settings

The principles that underpin the responses to domestic and family violence - when using the Practice Guide - in AOD settings are:

- DFV is a violation of human rights and is unacceptable in any form, in any community and in any culture.
- The safety of service consumers, and children who have experienced or are experiencing DFV, is the priority.
- AOD use, while not a cause of DFV, is significantly associated with DFV.
- AOD services work collaboratively with other services to address DFV, including specialist DFV, men's behaviour change, and mental health sectors.
- AOD services are delivered within a trauma informed care paradigm; and above all do no harm to service consumers or their children.
- AOD services provide non-judgmental care to service consumers who use DFV, while communicating DFV in all forms is totally unacceptable and the service consumer is entirely responsible for their actions.
- DFV can impede AOD treatment outcomes, and must be considered in the context of AOD service delivery.
- The issue of DFV is raised with all consumers of AOD services, and risk assessment and treatment planning (including safety planning) is conducted when indicated. Harm reduction and stepped-care approaches are also used.
- AOD services consult with service consumers of their organisation to ensure that the information they receive is relevant, accurate and accessible.
- AOD services consult with service consumers to identify and overcome barriers to disclosure of DFV in the context of AOD support and treatment.

Program structure

Coordinated care

What we know about coordinated care: summary of the evidence

Is coordinated care (case coordination with DFV/men's behaviour change services) or integrated care (case management of DFV issues within AOD) more effective for addressing DFV in AOD services?

Evidence identified

The systematic review identified only two relevant published studies: one quasi-experimental comparison of integrated care and coordinated care;⁽³⁹⁾ and one naturalistic pre–post observational study of integrated care or coordinated care.⁽⁴⁰⁾

We also found several high-quality conceptual papers that examine the essential elements of collaboration/coordination between agencies, but do not answer this clinical question because they do not provide direct comparative data. These included a literature review by Australia's National Research Organisation for Women's Safety (ANROWS).⁽⁴¹⁾

Summary of findings

A quasi-experimental study⁽³⁸⁾ compared integrated care for AOD, trauma and mental health with treatment as usual in a community sample (n=2006) of women with AOD problems and mental health problems and a history of physical or sexual abuse. At 6-month follow-up, integrated care was associated with significantly greater benefits in mental health, posttraumatic symptom severity and substance use, than treatment as usual. However, no conclusions can be drawn about the relative benefits of coordinated versus integrated care, due to heterogeneity between programs, multimodal program design, and the fact that the programs were not designed to specifically evaluate effects on DFV.

A US naturalistic pre–post observational comparative study⁽⁴⁰⁾ evaluated counselling provided by agencies offering integrated AOD/DFV care (two settings) or coordinated care between AOD and DFV agencies (four settings), in a community sample (n=255) of women with AOD problems experiencing DFV. Improvements in DFV (Women's Experience of Battering Scale; Domestic violence self-efficacy scale) and AOD use (substance use days in past month) were reported at 4–6 months follow-up with both approaches, but comparative data were not reported.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

What we know about collaboration between services: summary of the evidence

Does collaborating with DFV services help to reduce the frequency/severity of DFV more than AOD treatment alone?

Evidence identified

The systematic review identified no studies that directly compared outcomes of AOD treatment alone with those of AOD treatment in collaboration with DFV services.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

Previous studies⁽⁴²⁾ have reported a reduction in DFV associated with AOD treatment alone. A US study that examined the characteristics of AOD workers who screened for DFV and had linkages with the DFV sector⁽⁴³⁾ found that there was increased likelihood of both routine screening and referring service consumers to the specialist DFV sector through established linkages when all of the following conditions applied:

- the worker was in an administrative (senior) position
- the worker estimated the prevalence of DFV among service consumers to be high
- the agency had in place policies concerning screening for DFV and linkages were established at an AOD agency level.

Collaboration between AOD and DFV agencies is recommended by consensus guidelines, including a treatment improvement protocol on AOD use and DFV by the US Government Substance Abuse and Mental Health Services Administration (SAMHSA).⁽³²⁾

Overall finding

No evidence is available to answer the question, or from which to formulate evidence-based recommendations for practice.

Integrated care

What we know about integrated care: summary of the evidence

Does integrating DFV work with AOD work help reduce frequency/severity of DFV more than AOD alone?

Evidence identified

The systematic review identified four randomised controlled trials (RCTs)^(44, 45, 46, 47) that assessed integrated approaches including cognitive–behavioural therapy (CBT)^(44, 45, 47) and one study evaluating a multimodal relapse prevention and relationship safety program.⁽⁴⁶⁾

Summary of findings

Of the four studies found, two support the benefits of integration,^(28, 47) one showed non-significant trend toward benefit,⁽⁴⁶⁾ while the other⁽⁴⁵⁾ concluded that a good-quality CBT intervention for AOD use alone was equally effective as integrated AOD/DFV care in reducing intimate partner violence among people with harmful AOD use.

Evidence from systematic review

Studies supporting integrated AOD/DFV treatment

A well-designed RCT in India⁽³⁹⁾ compared CBT with treatment as usual (psychoeducation and pharmacotherapy) in men with alcohol dependence admitted for AOD treatment and who screened positive for violence towards their intimate partner. It reported significantly lower scores on severity of violence among men in the treatment group at 1-month follow-up, compared with the control group.⁽⁴⁴⁾

A US study compared manualised CBT (focusing on AOD use, interpersonal violence, and the relationship between both) with a twelve-step facilitation group (solely focused on AOD) in adult men with alcohol dependence who had been arrested for domestic violence in the previous year. The proportion of men reporting any violence in the past 30 days decreased from 42% at baseline to 10% at post-treatment in the CBT group and from 22% to 6.9% in the twelve-step facilitation group. Conclusions about the relative benefits of integrated and AOD-only approaches cannot be drawn from these findings, due to the difference between treatment models and the study design.⁽⁴⁷⁾

Another small, methodologically sound US study⁽⁴⁶⁾ evaluated an integrated relapse prevention and relationship safety intervention based on social and cognitive empowerment theories and incorporating a range of approaches (targeted coping strategies, skills building, boundary setting, negotiation and communication skills, and reinforcing self-efficacy) in women in a methadone program with experience of intimate partner violence. Compared with a control group who attended an information session (didactic presentation), the treatment group (integrated intervention) reported fewer experiences of ‘minor’ physical intimate partner violence, ‘minor’ psychological intimate partner violence, and severe psychological intimate partner violence at 3-month follow-up, but these differences were not statistically significant.⁽⁴⁶⁾

Studies not supporting integrated AOD/DFV treatment

A well-designed RCT in the Netherlands compared an integrated CBT intervention for AOD and intimate partner violence with cognitive–behavioural therapy for AOD problems alone, in men and women who reported using intimate partner violence at least seven times in the past year.⁽⁴⁵⁾ Completers in both treatment groups reported significantly fewer episodes of intimate partner violence following treatment.⁽⁴⁵⁾ There were no significant differences in outcomes between groups on a range of outcome measures (Conflict Tactics Scale revised;

Timeline Follow Back for AOD, Brief Symptom Inventory, Marital Satisfaction Scale, Treatment Satisfaction), and noted that the integrated intervention was more complex to deliver in an AOD setting.⁽⁴⁵⁾

Other relevant information

A US study found that few alcohol treatment providers initiated referrals for men who used violence and that, when they did, rates of referral uptake were very low.⁽⁴⁸⁾ This finding suggests that addressing DFV in AOD settings is likely to be more effective than referral alone.⁽⁴⁹⁾

Overall finding

Limited evidence from RCTs supports the integration of DFV treatment services with AOD treatment services. However, evidence is inconsistent and few well-designed studies have addressed this question.

Recommendations

AOD services should ensure that routine screening and assessment for DFV is conducted as part of good AOD treatment.

All AOD services should aim to build relevant relationships with DFV services in their local area.

AOD services that are able to provide integrated care (treatment for both AOD and DFV provided in-house) for people who use or experience DFV, should ensure that staff are suitably skilled, good organisational policy and supports are in place, and that integrated programs are regularly evaluated.

Practice Point: Collaboration

Collaboration with services to assist service consumers experiencing or using DFV can range from simple advice at one end of the spectrum, to coordinated and shared care at the other. These services include specialist DFV and men's behaviour change sectors; family; women's; children and legal services.

- Identify relevant local agencies and become familiar with the services they offer.
- Meet with staff of the target service and determine if collaboration could occur.
- Decide on the nature of the collaboration including roles, function and desired outcomes. These might include fast-tracked responses, reciprocal advice, coordinated training, sharing of relevant information when permitted, collaborative care planning and joint case conferencing etc.
- Consider formalising the arrangement through Memoranda of understanding, formal referral pathways, procedures for collaboration, and scheduling regular meetings to maintain and review the progress of the collaboration.

Program environment and organisational culture

Promoting a safe environment

What we know about safety-promoting environments: summary of the evidence

What type of environments promote safety/accessibility/engagement in different populations involved in DFV in AOD services?

Evidence identified

The systematic review identified no studies that compared the effects of different environments on outcomes, or contributed data relevant to identifying the optimal environment, for AOD service consumers with DFV involvement.

We identified a small body of relevant findings from qualitative research: a systematic review⁽⁵⁰⁾ and an interview-based study.⁽³³⁾

Summary of findings reported

Evidence from systematic review

A systematic review of studies designed to identify the expectations and experiences of encounters with health professionals (any setting) among women aged 15 years and over with experience of intimate partner violence⁽⁵⁰⁾ included 25 studies. It reported the following findings from women experiencing intimate partner violence:⁽⁵⁰⁾

- Women wanted healthcare workers to be non-judgemental, compassionate and sensitive, and to maintain confidentiality.
- Women wanted the worker to increase their confidence to address domestic and family violence, but also to recognise that they may not be ready. Repeated enquiry was viewed as desirable to allow a woman to disclose when she chose.
- Women wanted to proceed at their own pace and not be pressured to disclose, leave the relationship, or press charges.
- Women varied in their attitudes towards having children present when the issue of domestic and family violence was raised. Women who were still in the abusive relationship were less likely to want children present.

A study by ANROWS was based on interviews with staff and women attending one clinical mental health service and three sexual assault services.⁽³³⁾ Women stressed the need for the whole organisation to be trauma-informed, from the environment to reception staff, and the importance of broadening the concept of trauma to include current experience of violence. The researchers made a recommendation for regular environmental and workplace scans to ensure adequate spaces to have private and confidential discussions, and to review workflow to ensure sufficient time is available to engage with women on sensitive topics.

Other relevant information

A 2017 guideline developed by the UK National Institute for National Health and Care Excellence (NICE)⁽⁵¹⁾ recommended the following actions to create an environment that promotes disclosure of DFV by users of healthcare services, including AOD services:

- Clearly display information about DFV, including service contact details.
- Ensure people have maximum privacy (e.g. providing a place where people cannot be overheard).
- Provide opportunities to see people on their own.
- Establish referral pathways, embed in policy and procedures.
- Identify barriers for service consumers in consultation with consumers and local groups, and develop a strategy to overcome them.
- Use professional interpreters and ensure the services are confidential.

Overall finding

There is insufficient evidence from which to formulate evidence-based recommendations for practice. Limited qualitative data suggest that safety, accessibility and engagement for AOD service consumers experiencing DFV could be maximised by designing services to ensure that staff are non-judgemental, compassionate and sensitive, and that the whole organisation is 'trauma and violence informed'.

Australian and UK guidance recommend that disclosure of DFV by service consumers is facilitated by providing adequate spaces to have private and confidential discussions, ensuring workers have sufficient time to engage with consumers on sensitive topics, displaying information about services and how to contact them, and providing interpreters as necessary, and that referral pathways and protocols are well established.

Resources for service consumers

What we know about visible resources: summary of the evidence

Do visible resources (e.g. posters, brochures) improve service consumers' understanding, enhance safety and encourage disclosure about DFV in AOD settings?

Evidence identified

The systematic review identified no studies that compared the effects of resources on service consumers' understanding, safety or disclosure of DFV in AOD services.

Summary of findings

Evidence from systematic review

No directly relevant evidence was identified.

Other relevant information

Guidance is available for other healthcare settings.

The 2013 World Health Organization clinical and policy guideline for responding to intimate partner violence and sexual violence against women in healthcare settings⁽⁵²⁾ recommends that information resources (e.g. posters and pamphlets) on violence against women be displayed and also made available in private areas such as women's toilets, with appropriate warnings about taking them home if the partner who uses violence is there.⁽⁵²⁾

The 2017 UK NICE pathway on domestic violence and abuse⁽⁵¹⁾ recommends that health care settings (including AOD services) clearly display (e.g. in waiting areas) information about available support for people affected by DFV, including contact details of relevant local and national helplines.⁽⁵¹⁾ It could also include information for groups who may find it more difficult to disclose that they are experiencing DFV. NICE also recommends that the information is available in a range of local community languages and formats (e.g. large fonts, braille, audio, key rings with helpline number or pens).⁽⁵¹⁾

Overall finding

There is insufficient evidence from which to formulate evidence-based recommendations for practice.

Recommendations

All staff, including clinical, ancillary, contract and administrative staff, should be trained in DFV and trauma awareness.

All AOD services should provide general DFV information for service consumers (e.g. a poster), which states that the service is open to discussing DFV, and explains how to get help.

All services should provide a physical environment that is welcoming and is safe to discuss DFV issues, such as private confidential spaces, sound-proof rooms, and women-only spaces.

All services should establish policies and procedures to ensure service consumers' information is safe and confidential, including written information (e.g. service consumer case notes) and conversations with and about service consumers.

Practice Point: Resources

Service consumers should be consulted to ensure available resources are easily understood, relevant and targeted correctly.

A few examples are:

- Charmed and Dangerous (<http://womenscentre.org.au/wp-content/uploads/Charmed-and-Dangerous.pdf>)
- Gathering Support (<http://www.dvrcv.org.au/sites/default/files/DVRCV-Gathering-Support.pdf>)
- Walking a tightrope; a guide for families (http://www.fds.org.au/images/FDS/NCETA_Walking_a_Tightrope.pdf)
- ACON's *Say it out loud* campaign (<http://sayitoutloud.org.au>)
- Gay and Lesbian Health Victoria's poster for health service waiting rooms: 'You don't have to tell us if you're gay or lesbian. But you can. Gay, lesbian, bisexual, transgender and intersex people and their families are welcome at this service.'

Clinical processes

Screening for DFV

What we know about screening increasing detection of DFV: summary of the evidence

Does screening for DFV increase detection?

Evidence identified

The systematic review identified no studies that measured the effects of screening for DFV on detection rates within AOD services.

Two systematic reviews^(53, 54) were identified that evaluated screening for DFV in other healthcare settings.

Summary of findings

Evidence from systematic review

A 2012 review by the US Preventive Services Task Force⁽⁵⁴⁾ evaluating the effects of screening women in health care settings for intimate partner violence, including diagnostic accuracy of screening instruments and adverse effects of screening, concluded that screening instruments accurately identify women experiencing intimate partner violence.

A 2015 Cochrane Collaboration systematic review evaluated the effects of screening for intimate partner violence conducted within healthcare settings on identification, referral, re-exposure to violence, and health outcomes for women, and to determine if screening causes any harm.⁽⁵⁴⁾ This review was designed to identify studies conducted in AOD services, but none were included in the analysis. It concluded that screening increases the identification of women experiencing intimate partner violence in healthcare settings, but that expected prevalence rates are likely to significantly exceed rates of detected cases.⁽⁵⁴⁾ There was no evidence of harm arising from screening. The reviewers concluded that, although screening increases identification of intimate partner violence, there is insufficient evidence to justify screening in healthcare settings.⁽⁵⁴⁾

Other relevant information

The 2013 World Health Organization clinical and policy guideline for responding to intimate partner violence and sexual violence against women in healthcare settings⁽⁵²⁾ does not recommend routine screening in generalist health care settings, primarily because studies have shown that positive screening often fails to trigger health care providers to take the next step (e.g. assessment or referral).⁽⁵²⁾

Overall finding

No evidence is available to answer the question, or from which to formulate evidence-based recommendations for practice specific to AOD services. Systematic reviews of studies conducted in a range of health care settings confirm that screening increases detection of DFV.

Screening for DFV and the therapeutic alliance

Does routine screening for DFV (experiencing or using DFV) disrupt the therapeutic alliance?

Evidence identified

The systematic review identified no studies that assessed this question in an AOD setting.

Two systematic reviews^(53, 54) and two RCTs^(55, 56) assessed screening for DFV in a range of other healthcare settings.

No studies were found that evaluated routine screening for the use of DFV, or assessed effects of screening for DFV on healthcare users who use DFV.

Summary of findings reported

Evidence from systematic review

The studies from a range of healthcare settings other than AOD services confirm that screening is acceptable to most women:^(53, 54, 55, 56)

- A 2012 systematic review of 15 studies by the US Preventive Services Task Force evaluated screening for intimate partner violence among women in health care settings, including potential adverse effects. Fourteen studies reported few adverse effects, and when they were reported (e.g. concerns about privacy and feeling judged by the health care provider) they had minimal effects on the women screened.⁽⁵³⁾
- A 2015 Cochrane Collaboration review evaluated 13 studies involving screening of women for intimate partner violence, including potential adverse effects. No study reported adverse effects from screening.⁽⁵⁴⁾
- A 2015 US RCT conducted among 191 substance-using women in forensic settings (probation and community court) assessed the feasibility, safety and efficacy of a single-session computerised brief intervention and referral to treatment services, compared with the same service delivered by a case manager.⁽⁵⁵⁾ The study measured effects on rates of identification of intimate partner violence victimisation and access to intimate partner violence services. No adverse effects were reported among the sample.
- A high-quality Canadian RCT conducted in 2009 among women attending emergency departments, general practice and obstetrics/gynaecology clinics evaluated screening for intimate partner violence, including potential adverse effects including distress associated with screening (Consequences of Screening Tool). No adverse effects of screening were detected among the women involved.⁽⁵⁶⁾

Other relevant information

A meta-analysis of 25 qualitative studies⁽⁵⁰⁾ found that screening for DFV, including repeated enquiry to encourage disclosure, was acceptable to women in generalist healthcare settings.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Timing of screening

Does the timing of screening affect service consumer disclosure or discussion about DFV?

Evidence identified

The systematic review identified no studies that assessed the optimal timing of screening for DFV.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

The 2015 Cochrane review⁽⁵⁴⁾ reported effect sizes for detection of DFV among studies that screened immediately or within one month, but explicitly examined the timing of screening and its effects on disclosure.

A meta-analysis of 25 qualitative studies⁽⁵⁰⁾ found that, in some studies, women reported that a trusting relationship with their health care provider encouraged disclosure of DFV when the woman was ready. In some studies, women favoured repeated inquiry, while in others they found repeated enquiry to be offensive. The authors hypothesised that the apparently conflicting data could be explained by women's circumstances over time; women were in favour of repeated inquiry if they were at a later stage of the abusive relationship (ready to make changes), while women who did not recognise their partner's behaviour as abusive may be more likely to be offended by the repeated initiation of the discussion about DFV.⁽⁵⁰⁾

Qualitative studies with women conducted primarily by one US research group⁽⁵⁷⁾ demonstrate that women may not be ready to disclose intimate partner violence until a range of turning points have been reached (e.g. desire to protect others, increased severity, increased awareness of support options).

Overall finding

There is insufficient evidence from which to formulate evidence-based recommendations for practice. Available evidence suggests that the timing of screening and readiness to disclose are both important factors, and that repeated enquiry appears to be generally acceptable.

Screening tools

Which screening tools increase detection of DFV?

Evidence identified

The systematic review identified one systematic review of studies evaluating screening tools for detecting experience of DFV⁽⁵⁸⁾ and four papers reporting studies evaluating specific tools.⁽⁵⁴⁻⁵⁷⁾

The following tools were evaluated (as intervention or comparator) in these studies:

- Abuse Assessment Screen (AAS)
- Behavioural Risk Factor Surveillance Survey (BRFSS)
- Conflict Tactics Scale (CTS)
- Composite Abuse Scale (CAS)
- Hurts, Insults, Threatens and Scream scale (HITS)
- Jellinek intimate partner violence Screen (J-IPV)
- Ongoing Violence Assessment Tool (OVAT)
- Partner Violence Screen (PVS)
- Single question: Do you feel safe at home?
- Slapped, threatened or Thrown scale (STaT)
- Woman Abuse Screening Tool (WAST)
- Women's Experience with Battering scale (WEB).

Summary of findings

Evidence from systematic review (A): screening for service consumers who experience violence

A systematic review of studies evaluating screening tools for detecting experience of DFV found that several short screening tools were valid and reliable for use in healthcare settings to detect experience of DFV.⁽⁵⁸⁾ Tools that scored sensitivity greater than 85% include the HITS, STaT, WEB and OVAT.⁽⁵⁸⁾ Specificity ranged from 83% to 99% for all except STaT, which had a specificity of 37%.⁽⁵⁸⁾ Index tools with a specificity greater than 85% included the AAS, HITS, single question 'Are you safe at home?', WAST, PVS, WEB and the BRFSS.⁽⁵⁸⁾ HITS had the best predictive power (sensitivity ranged from 86% to 100%; specificity ranged from 86% to 99%), concurrent and construct validity (ranged from 0.75–0.85; $p < 0.001$) and reliability (Cronbach's alpha ranged from 0.61 to 0.80), with a suitable cut-off score.⁽⁵⁸⁾

A Dutch study reported two studies evaluating the effectiveness of the J-IPV to identify people who experience violence (as well as to detect people who use violence).⁽⁵⁹⁾ Both studies demonstrated that good psychometric properties to detect victims of any, as well as severe, intimate partner violence⁽⁵⁹⁾

A Canadian study comparing WAST with the 30-item CAS⁽⁶⁰⁾ found that WAST identified 22.1% of women as experiencing past year abuse and the CAS identified 14.4% ($k=0.63$; standard error 0.01). Characteristics associated with being identified by both tools included mental health problems (odds ratio [OR] 2.3; 95% CI, 1.3–4.0; $p = 0.002$), substance use problems (OR, 1.7; 95% CI, 1.1–2.9; $p=0.036$), or having a partner with a substance problem (OR, 2.0; 95% CI, 1.2–3.2; $p=0.006$).

A US study^(1, 61) evaluated a four-item HITS domestic violence screening tool for detecting male victims. Correlation of HITS and CTS (the index tool) was 0.86 ($P < 0.0005$), whether men had a female or male partner. A cut-off score of 11 on the HITS showed good sensitivity (88% for clinic patients and 97% for self-identified victims of violence) and specificity (97% for clinic patients and 88% for self-identified victims).

In contrast, another US study⁽⁶²⁾ evaluating validity of HITS and PVS to identify men who experience DFV accessing the emergency department reported that the sensitivity of both tools was 30–45%, and specificity was 83–88%, with CTS as the index screening tool. The rate of false negatives ranged from 14% to 33%.

Evidence from systematic review (B): screening for service consumers who use violence

A Dutch study reported two studies evaluating the effectiveness of the J-IPV to identify people who use violence (as well as who experience violence).⁽⁵⁹⁾ Both studies demonstrated that good psychometric properties to detect perpetrators of any, as well as severe, intimate partner violence⁽⁵⁹⁾

Other relevant information

The Domestic Violence Safety Assessment Tool (DVSAT) is used in NSW for universal screening for clients of healthcare settings, including mental health services and AOD services.

The Common Screening Tool is used in Western Australia services.

Overall finding

Several short screening tools are valid and reliable for use in healthcare settings to detect experiences of DFV. There is insufficient evidence to make recommendations on particular tools for screening for use of DFV.

Recommendations

AOD services should routinely screen service users for risk of DFV (both use and experience of DFV) with a single question or series of trigger questions.

AOD services should undertake formal screening if effective follow-up responses are available (either in-house management or referral).

Formal screening should use a validated screening tool.

AOD services without the capacity to conduct formal screening should use careful questioning about safety instead, and ask about risk.

Risk screening should occur at the beginning of treatment and again at various points through the treatment process.

Formal screening for DFV and risk screening should be conducted by appropriately trained staff when good rapport between worker and service consumers has been established.

Low-threshold AOD services (including peer based services, needle syringe programs, drop-in programs, sobering up programs), should undertake risk screening opportunistically when appropriate to do so.

Staff members who conduct screening should be trained to do so.

Practice Point: Screening

Some services or programs will use validated screening tools, while it may be more appropriate for other services, such as peer-based organisations and other low threshold services, to use careful questioning when appropriate to do so.

One simple question for consumers who may have experienced DFV may be “Do you feel safe at home”?

The Australian Institute of Family Studies (www.aifs.gov.au) lists the following three potential questions:

- Do you have any reason to be concerned about your own safety or the safety of your children?
- Do you have any other concerns about your children’s wellbeing at the moment?
- Do you have any reason to be concerned about the safety of anyone else?

This approach provides an opportunity for further exploration of important areas of concern.

The following questions for service consumers who may have used DFV were recommended by the UK’s Stella Project⁽¹⁾:

- Has your drug or alcohol use affected your relationships with your partner and family?
- Has anyone in your family been frightened or harmed by you when you’ve been substance affected?

Followed by one or two further questions:

- Do you ever make decisions or rules about who your partner can or can’t see?

- Have you ever felt that your behaviour got out of hand when you've lost your temper or been violent? If yes, what happened?"

Practice Point: Responding to disclosure of experiencing DFV

Some AOD workers may be reluctant to screen for DFV because they may not feel confident to take the next steps if a service consumer discloses that have experienced DFV. It is critical that AOD workers understand that leaving the violent relationship will not necessarily make the service consumer safer—in fact, leaving the situation is often when the service consumer is at highest risk of experiencing DFV.

The following steps for responding to disclosure were recommended by the National Centre for Education and Training on Addiction (NCETA):

1. Focus on safety of the service consumer, their children and AOD service staff
2. Help the service consumer to protect themselves, identify who else can provide support, and how they can safely access information, websites and services
3. Listen, hear, and believe
4. Take the DFV seriously
5. Emphasise that DFV is always the responsibility of the person who is using violence
6. Maintain a non-judgemental stance (do not criticise the violent partner, nor judge the service consumer for staying with their partner)
7. Acknowledge the courage it takes to disclose DFV
8. Assist the service consumer to explore their options for next steps to take
9. Support their choices and the timing of their choices
10. Maintain regular contact if possible and negotiate how to maintain contact safely (i.e. when and how to call them)

Adapted from White, M. et al (2013) *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. NCETA, Flinders University.

Safety planning

What we know about effective safety planning: summary of the evidence

What does an effective safety plan contain?

Evidence identified

The systematic review identified no studies that addressed this question in the AOD setting.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

A safety plan is a document that records the circumstances of people who experience violence and details the specific strategies to be used to increase safety in a range of situations. Few studies have investigated the content of such planning.

The SAMHSA treatment improvement protocol on AOD use and DFV⁽³²⁾ includes a comprehensive, six-page personalised safety plan template. Examples of important areas covered include:

1. Strategies for maintaining safety during a violent incident—leaving a high risk space (e.g. the kitchen), escaping the house safely, having ready access to purse and car keys, where to go to seek safety, using a code word with children to leave the house, planning with neighbours to call the police if suspicious noises are heard.
2. Safety when preparing to leave—storing money, spare car keys, copies of important documents, spare clothes, and numbers of DFV crisis services with a trusted person.
3. Safety in own residence—change the locks; install security doors, smoke detectors and outside sensor lights; instruct school and other carers in who is authorised to pick up children.
4. Safety with a protection order—safe storage; keeping a copy; informing important people (work, school, friend, neighbour etc)
5. Safety on the job and in public—inform relevant colleagues; organise to screen telephone calls; security when leaving work and driving home; banking arrangements.
6. Safety and drug or alcohol use—if drinking or using other drugs, do so in a safe place with people committed to the service consumer's safety; what to do if partner is drinking or using other drugs; how to protect children when drinking or using other drugs.
7. Safety and emotional health—what to do if feeling tempted to return to violent situations due to negative emotional states; assertive communication with partner; self-help materials; telephoning support persons; attending support groups.

A toolkit⁽¹⁾ developed by the UK Stella Project Mental Health Initiative recommends that a safety plan for children considers the following components:

- helping children to identify a safe place to go in the event of violence
- including information on how to contact emergency services, safe contacts
- ensuring that children know their address and telephone number
- making sure children know it is not their place to intervene in DFV
- role-playing calling the police, including teaching children the basic information to give (name, address, and the fact that someone is hurting their mother), and to leave the phone off the hook

- familiarise the older children with the local services and community resources for dealing with DFV.

Traditionally, safety planning has occurred in face-to-face planning sessions. However, recent work has investigated the feasibility and acceptability of telephone and web-based options. The findings of one pre–post study⁽⁶³⁾ suggest that a telephone intervention could increase the safety-promoting behaviour of women experiencing DFV.

A US study⁽⁶⁴⁾ assessing the effects of counselling and referrals within the emergency department for patients experiencing intimate partner violence reported that almost all participating patients increased their level of perceived safety and about half completed part of a safety plan. Although follow-up was limited in this study, it suggested that emergency department programs might help patients make safety plans.⁽⁶⁴⁾

Another qualitative study⁽⁶⁵⁾ reported on staff perceptions of the process of completing safety planning with service consumers, but not their content. Among other themes, participants emphasised that safety plans must include detailed information about how to access community resources, that safety planning must be ongoing, and involves coordination across services and between various agencies.⁽⁶⁵⁾

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendation

Safety plans should be developed for AOD service consumers who are experiencing DFV and their children who are witnessing DFV.

Practice Point: Safety planning

Safety planning is a crucial component of assisting service consumers who experience DFV. Unlike an AOD relapse prevention plan that is often given to the service consumer in hard copy, having a copy of a DFV safety plan can be extremely risky for people who experience DFV if the person using DFV finds it in their possession. A copy of the safety plan could be kept in the service consumer’s case notes and reviewed at regular intervals.

A Personalised Safety Plan should:

- Include emergency contact numbers (e.g., for police, DFV organisations, crisis lines, medical services)
- Identify a friend(s), family member or neighbour who can provide support and the means to contact them
- Identify safe places for the service consumer to go to and how to get there, (e.g., friends, relatives, motel, refuge)
- Identify strategies to ensure children’s safety (consider travel to and from school/childcare, mobile phone use, social media risks, safe person/place for the child to go to in emergency)
- Identify ways for the service consumer to get access to money in an emergency
- Identify and plan for access to any medications for personal or children’s use
- Identify a place to store valuables and important documents (or copies) so that the service consumer can access them when required (e.g. birth, marriage and divorce certificates, passport, family court orders, rental agreement or mortgage)

documentation, utility bills, car registration, debit and credit cards, driver's license etc.)

- Identify contents of an emergency bag and where this bag can be stored safely (e.g. medication and toiletries, spare keys to house/car/work, money, mobile phone and charger change of clothes and basic food)
- Specifically address any barriers to the service consumer following through on actions identified in the safety plan (for example mobility or communication problems)
- Establish a distress code with friends/relatives that will trigger them to call to the police in an emergency

Source: White, M. et al (2013) *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. NCETA, Flinders University

Assessment for DFV

What we know about assessment of service consumers who experience DFV: summary of the evidence

What are the essential elements of DFV assessment that should inform an AOD treatment plan?

Evidence identified

The systematic review identified no studies that evaluated elements of DFV assessment in AOD settings.

One study was identified that evaluated an assessment tool for use in counselling women with experience of DFV.⁽⁶⁶⁾

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

The only identified study that evaluated an assessment tool for healthcare users experiencing DFV is of very limited relevance to AOD services, as it was conducted in the context of individual psychotherapeutic counselling within a specialised program for victims of abuse.⁽⁶⁶⁾ Although the domains are highly relevant, the tool was administered by trained DFV counsellors, and is likely to be suitable for use in AOD settings only by specially trained staff.

Other relevant information

The SAMHSA treatment improvement protocol on AOD use and DFV⁽³²⁾ recommends that the following issues are considered and that strategies for managing them are integrated into the AOD treatment plan of the service consumer experiencing DFV:

- safety of the service consumer and children (including developing a personalised safety plan)
- the degree to which the service consumer's AOD problem is tied to the partner who uses violence
- physical, emotional and mental health, medications
- decision making skills
- social functioning, legal issues, parenting issues
- relapse prevention planning.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Assessment of service consumers who use DFV

What are the essential elements of DFV assessment that should inform an AOD treatment plan?

Evidence identified

The systematic review identified no studies that evaluated elements of DFV assessment in AOD settings.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

The SAMHSA treatment improvement protocol on AOD use and DFV⁽³²⁾ acknowledges that assessment with people who use DFV can be complex, and AOD service staff who are used to advocate for their clients are at risk of colluding with the service consumer to shift blame for their behaviour from the service consumer to the partner who is experiencing DFV. It recommends AOD workers receive training and supervision to conduct an assessment of the relationship between AOD and DFV to inform the treatment plan.⁽³²⁾ The protocol recommends that healthcare/AOD workers explore the following points with people who use DFV:⁽³²⁾

- the precise timing of DFV in relation to an instance of substance use
- the proportion of violent behaviour that occurs while the person is drinking or using other drugs
- which substances are used before the violent act
- what feelings precede and accompany the use of alcohol or other drugs
- whether alcohol or other drugs are used to 'recover' from the violent incident.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendations

Services should undertake detailed assessment for DFV only if the service consumer, staff and service have the capacity and intention to respond to issues identified.

Only staff members who are well trained should undertake detailed assessment for DFV.

When assessment is conducted for people who experience DFV, it should include assessment of:

- their safety and that of their children (including developing a personalised safety plan)
- the degree to which their harmful AOD use is tied to the person who uses DFV
- physical, emotional and mental health issues
- use of medications
- decision-making skills
- social functioning, legal issues, parenting issues
- relapse-prevention planning
- what supports, networks and services they are using or have access to
- what actions the person is prepared to take in respect of DFV.

When assessment is conducted for people who use DFV, it should include assessment of:

- the precise timing of DFV in relation to an instance of substance use
- the proportion of violent behaviour that occurs while the person is using AOD
- which substances are used before the violent act
- what feelings precede and accompany the use of alcohol or other drugs
- whether AOD are used to 'recover' from the violent incident.

Practice Point: Assessing risk

A risk assessment involves determining the level of threat posed to a service consumer who has experienced, or may experience, DFV from the person who is using DFV. Risk can change over time and workers should review risk with service consumers at periods relevant to the service consumer's circumstances.

In New South Wales, frontline workers use the Domestic Violence Safety Assessment Tool (DVSAT) to assess risk. The tool explores 25 factors associated with risk in the domains of type of violence used, the relationship between the person experiencing violence and their partner, relevant characteristics of the person using violence (e.g. employment status, mental health, access to firearms, forensic history), issues concerning children, and issues concerning sexual assault. Scores between one and 11 indicate a person is *at threat*, while a score of 12 or greater indicates a person is *at serious threat*.

The DFVSAT and the guide to using the tool can be accessed online

www.domesticviolence.nsw.gov.au

Interventions

What we know about the impact on DFV from AOD interventions alone: summary of the evidence

Does effective AOD treatment alone help reduce frequency/severity of DFV?

Evidence identified

The systematic review identified three reviews^(42, 67, 68) that addressed this clinical question.

Summary of findings

Evidence from systematic review

The reviews included:

- a 2010 non-systematic review of effects of treatment for substance use problems on intimate partner violence⁽⁴²⁾
- a 2016 narrative review of interventions to reduce intimate partner violence perpetration among people with substance use disorder⁽⁶⁷⁾
- a 2009 narrative review of the association between treatment for substance misuse and reductions in intimate partner violence.⁽⁶⁸⁾

All three reviews included the same studies and reached the same conclusion that AOD treatment alone may reduce the prevalence and severity of intimate partner violence.^(42, 67, 68)

The most comprehensive review⁽⁴²⁾ found that in all included studies, the prevalence of intimate partner violence decreased after AOD treatment. The authors estimated pre- and post-intervention prevalences at 63 per cent and 22 per cent respectively, overall and at 25 per cent and 9 per cent, respectively, for severe intimate partner violence.⁽⁴²⁾ The relative risk of intimate partner violence after AOD treatment among participants who had relapsed was 2–3 times greater than among those who had not relapsed.⁽⁴²⁾ The review reported effect sizes ranging from 0.23 for severe male-to-female intimate partner violence, to 0.52 for male-to-female intimate partner violence and 0.94 for male-to-female psychological intimate partner violence.⁽⁴²⁾

Other relevant information

Although AOD use is not a causal factor in DFV, it is a widely acknowledged risk factor.

Overall finding

AOD treatment alone may reduce DFV.

What we know about addressing DFV in an AOD setting: summary of the evidence

Does addressing DFV in AOD services improve AOD outcomes?

Evidence identified

The systematic review identified two RCTs^(46, 47) and one qualitative research study⁽⁶⁹⁾ that addressed this question.

Summary of findings

Evidence from systematic review

A US RCT compared an integrated relapse prevention and relationship safety intervention (RPRS) with an information session (a 1-hour didactic presentation on community services that women could access for DFV) in women with experience of intimate partner violence attending a community methadone clinic. The investigators reported a non-statistically significant greater reduction in drug use among the RPRS group than the control group at 90-day follow-up (OR=3.3, p=0.8). Women in the RPRS group were also less likely to binge drink, but this was not statistically significant. No differences were found on heroin or cannabis use between groups.⁽⁴⁶⁾

Another US RCT compared manualised CBT (focusing on AOD use, interpersonal violence, and the relationship between both) with a twelve-step facilitation group (solely focused on AOD) in adult men with alcohol dependence who had been arrested for domestic violence in the previous year.⁽⁴⁷⁾ During the 12-weeks treatment period, the CBT group had significantly more days abstinent from alcohol than the twelve-step (90.2% versus 79.8%; p<0.02).

A US qualitative research study conducted among women in supported accommodation for women recovering from AOD problems⁽⁶⁹⁾ found that women reported greater understanding of the role of AOD in DFV and DFV in AOD use, increased agency and resilience in regard to DFV, and increased awareness and understanding of what healthy relationships entail.⁽⁶⁹⁾ While this small study reinforces the benefit of addressing DFV in a traditional AOD setting, it did not report AOD use outcomes or compare the intervention with standard AOD support.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice. Limited available data provide weak evidence for benefits on AOD outcomes.

What we know about interventions for AOD service consumers who use DFV: summary of the evidence

Which interventions for people who use DFV improve outcomes in AOD treatment settings (AOD use and harms, DFV behaviours, engagement, readiness to change, safety, improved relationships, longer stay in treatment)?

Evidence identified

The systematic review identified four RCTs^(70, 71, 72, 73) and two non-randomised comparative studies^(74, 75) that addressed this question.

Interventions include parenting skills training, motivational enhancement, and behavioural couples' therapy. Most studies were conducted in the context of criminal justice and high levels of supervision.

Summary of findings

Evidence from systematic review

A US pilot study (RCT design) evaluating an intervention for substance use and intimate partner violence (Fathers for Change) in comparison with individual drug counselling⁽⁷⁰⁾ reported that both groups reduced substance use (no significant difference). A non-significantly higher proportion of men in the Fathers for Change group completed treatment compared with the control group (67% versus 33%, p=0.10).⁽⁷⁰⁾ There was a trend towards reduced violence in the Fathers for Change group. The Fathers for Change group also expressed higher satisfaction with treatment than the control group.⁽⁷⁰⁾

Another US pilot study (RCT design) evaluated a brief motivational enhancement intervention for intimate partner violence among men receiving AOD treatment in a residential setting, compared with assessment and a list of community resources only.⁽⁷¹⁾ At 2-week follow-up, the treatment group reported seeking significantly more types of help than did the control group, showed marginally more help-seeking behaviour, a greater increase in readiness to change and a greater increase in action, compared with the control group.⁽⁷¹⁾ Another US RCT evaluated a telephone-delivered motivational enhancement therapy intervention for men with AOD problems who perpetrated intimate partner violence.⁽⁷²⁾ At 30-day follow-up, men in the intervention group reported engaging in intimate partner violence less frequently than those in the control group.⁽⁷²⁾

Another US RCT evaluating intensive interventions for fathers' problem alcohol use randomised participants to parent skills with behavioural couples' therapy (PSBCT), behavioural couples' therapy only, or individual-based treatment (control).⁽⁷³⁾ All groups increased days of abstinence from alcohol. At 12 months' follow-up, higher percentage of days abstinent was recorded in the PSBCT group (78.6%) and the behavioural couples therapy group (77.8%) than the control group (70.2%). Men in the PSBCT group and behavioural couples therapy group, but not the control group, reported significantly reduced episodes of intimate partner violence at 6-month and 12-month follow-up (effect size $r > 0.20$).

Other relevant information

A 2013 review⁽⁷⁶⁾ concluded that the effectiveness of intervention programs for people who use violence was mixed at best regarding their ability to reduce DFV, and noted that many studies had methodological flaws. A 2017 review conducted by researchers from ANROWS⁽⁷⁷⁾ largely agreed with this view.

A body of work has examined programs for people (mainly men) who use violence, but most were conducted in the context of criminal justice and high levels of supervision, which is not applicable to community AOD settings. Examination of interventions for DFV in an AOD context are now beginning to emerge.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice. Limited available data suggest some interventions may benefit men with harmful AOD use who use DFV.

Practice Point: Recommended capabilities for working with people in AOD settings who use DFV

1. Knowledge of the prevalence of DFV among AOD service consumers, the link between AOD and DFV, types of DFV, and how people who use DFV may minimise or justify using DFV
2. Interpersonal skills including ensuring responsibility rests with the service consumer who uses DFV, therapeutic optimism that change is possible, expressing empathy without collusion, maintaining a non-judgemental attitude
3. Role legitimacy, in that asking about DFV is acceptable for an AOD worker
4. Awareness of signs of use of DFV, including being alert for DFV in day to day practice and knowing the 'red flags' for DFV
5. Facilitating disclosure by fostering a therapeutic relationship, normalising questioning about use of DFV with all service consumers, reflecting on own feelings about DFV, using probing questioning to elicit crucial information

6. Gathering information on specific risks, with the safety of the partner and children as first priority, conducting a risk assessment, and risk management planning
7. Knowing what to do with disclosure, including AOD team work and working with external agencies, knowing when to involve police and child protective services, knowing pathways for people who use DFV and making effective referral for people who use DFV and their partners and children
8. Continuing to work with the service consumer after disclosure, including maintaining optimism and re-establishing 'common ground' including therapeutic alliance and continuing goal focussed AOD support and treatment
9. Committing to ongoing professional development in the area of DFV, including training and supervision

Adapted from Hughes, L. et al (2015) *A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings*, Kings College London

What we know about interventions for AOD service consumers who experience DFV: summary of the evidence.

Which interventions for people who experience DFV improve outcomes in AOD treatment settings (AOD use and harms, DFV behaviours, engagement, readiness to change, safety, improved relationships, longer stay in treatment)?

Evidence identified

The systematic review identified three RCTs,^(46, 78, 79) one nonrandomised comparative study,⁽⁸⁰⁾ one qualitative study,⁽⁶⁹⁾ one case study,⁽⁸¹⁾ and one non-systematic review⁽⁸²⁾ that addressed this question.

Summary of findings

Evidence from systematic review

A small US RCT⁽⁴⁶⁾ evaluating an integrated relapse prevention and relationship safety intervention for women on methadone measured short-term effects on intimate partner violence and substance use. The control group received an information session on community services for women experiencing DFV. Compared with the control group, the intervention group showed a non-significant ($p=0.8$) reduction in drug use, a nonsignificant reduction in binge drinking, and significantly lower levels of depression at 3-month follow-up.⁽⁴⁶⁾ Women in the intervention group were also more than six times more likely to report a decrease in having sex while intoxicated than those in the control group.⁽⁴⁶⁾

A Spanish pilot RCT⁽⁷⁹⁾ evaluated a 5-week (ten 2-hour sessions) group CBT program to reduce intimate partner violence among women using drugs in a community AOD centre. The control group received treatment as usual (fortnightly monitoring of AOD use, motivational interviewing, relapse prevention and counselling).⁽⁷⁹⁾ The intervention group attended a mean of five sessions (range 0–9).⁽⁷⁹⁾ Both the intervention and control groups reported large reductions in intimate partner violence at 12-month follow-up (80% and 60%, respectively, no significant difference).⁽⁷⁹⁾ The intervention group, but not the control group, showed a reduction in mean days of alcohol consumption at 1-month follow-up, compared with baseline ($p=0.035$).⁽⁷⁹⁾ Both groups also showed increases in assertiveness scores and reductions in depression scores.⁽⁷⁹⁾

A US pilot RCT⁽⁷⁸⁾ evaluated a web-based intervention for drug use and intimate partner violence for women delivered in the emergency department and followed up 2 weeks later by a phone to review goals, assess current AOD use, and provide motivational interviewing (discrepancy, barriers to change, problem solving, reinforcement). The control group participated in a web-based program on home fire safety in the emergency department. Preliminary findings suggest that this model is feasible and acceptable to women. At 2-week follow-up, the investigators estimated a small reduction in intimate partner violence among the intervention group, compared with the control group.⁽⁷⁸⁾

A US nonrandomised survey-based pre–post comparative study⁽⁸⁰⁾ evaluated comprehensive AOD treatment services for women with a history of intimate partner violence. At 12-month follow-up, service utilisation and experience of intimate partner violence were not correlated with AOD use. The focus of this survey was mainly on correlations between client characteristics and service usage patterns.

A non-systematic review⁽⁸²⁾ of psychotherapies for women with AOD problems and experience of trauma (not limited to intimate partner violence) found that, of the treatment models assessed, evidence of benefit on posttraumatic stress disorder symptoms and AOD use was strongest for the Seeking Safety model (a present-focused coping skills model

designed to address trauma and substance abuse at the same time, targeting cognitive, behavioural, and interpersonal domains and providing case management).⁽⁸²⁾

Other relevant information

An Australian online intervention currently being evaluated for women experiencing DFV (I-DECIDE, available at www.idecide.org.au),⁽⁸³⁾ is very similar to the US emergency department intervention evaluated by Choo et al.⁽⁷⁸⁾ The developers of I-DECIDE describe it as a 'healthy relationship tool and safety decision aid'. It emphasises healthy relationships, not just safety planning. AOD providers may be in a position to assist service consumers to access online support if appropriate and safe to do so.

A body of work has examined programs for women who experience violence (with or without PTSD), but most have been conducted and assessed in the context of specialist DFV settings and refuges, and few have addressed AOD use. These programs tend to be lengthy and intensive and most have limited applicability to an AOD setting (see Eckhardt et al 2013⁽⁷⁶⁾ for an extensive examination of programs). Other programs involve adding AOD interventions to primary DFV work.^(21, 84) Some studies have examined the effect of brief intervention and referral in primary care (e.g. the WEAVE study assessing screening and counselling in for women who have experienced intimate partner violence, conducted in primary care services in Victoria),⁽⁸⁵⁾ but these studies did not assess for AOD use/involvement.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Practice Point: Working with AOD service consumers who experience DFV

The following practice points have been recommended for working with service consumers who have experienced DFV:

- Maintain confidentiality, except in cases where mandatory reporting is required (e.g. imminent risk of danger to the service consumer or children)
- Believe the service consumer
- Offer choices and work together to increase safety
- Maintain a non-judgemental attitude
- Align with the service consumer's readiness to address DFV and do not push the person to take steps they are not ready to take
- Develop skills in questioning about DFV with every service consumer
- Keep accurate, concise and up-to-date service consumer records in relation to incidents of DFV as the record may be used for legal purposes
- Develop skills in assessing for risk of harm from DFV
- Develop skills in safety planning
- Develop skills in effective referral strategies
- Participate in training and supervision relevant to DFV

Source: AVA toolkit, Stella project, UK⁽¹⁾

What we know about interventions that address mental health, AOD and DFV: summary of the evidence

Do programs that address mental health, in addition to AOD use and DFV improve outcomes?

Evidence identified

The systematic review identified one meta-analysis,⁽²¹⁾ three RCTs,^(79, 86, 87) and two nonrandomised pre–post comparative studies^(88, 89) that addressed this question. Most of these studies evaluated interventions for women with both trauma histories (including childhood trauma) and a co-occurring mental health disorder such as PTSD.

Summary of findings

A meta-analysis⁽²¹⁾ of data from three studies, including a subgroup of women with intimate partner violence who participated in the Women, Co-occurring Disorders and Violence Study (www.wcdvs.com), reported small-to-moderate effect sizes for reduction in AOD use among women with intimate partner violence and AOD problems. Overall, women with recent intimate partner violence had greater improvement in AOD outcomes when participating in trauma-focused intervention programs than women who had not experienced recent intimate partner violence. The other two included were small US study evaluating a multimodal relapse prevention and relationship safety program⁽⁴⁶⁾ (included in the evidence summaries for questions 3, 12 and 14) and a US naturalistic pre–post observational study of integrated care or coordinated⁽⁴⁰⁾ (included in the evidence summary for question 1).

A Spanish pilot RCT⁽⁷⁹⁾ evaluated a 5-week (ten 2-hour sessions) group CBT program to reduce intimate partner violence among women using drugs in a community AOD centre. The control group received treatment as usual (fortnightly monitoring of AOD use, motivational interviewing, relapse prevention and counselling).⁽⁷⁹⁾ The intervention group attended a mean of five sessions (range 0–9).⁽⁷⁹⁾ Both groups reduced symptoms of depression (Beck Depression Inventory II) at 12-month follow-up. Effects on AOD outcomes are described at question 14.

A US RCT⁽⁸⁶⁾ evaluated an intensive 6-week meditation program in the management of mental health outcomes among women with a history of interpersonal violence co-occurring disorders including AOD problems. The control group received individual and group interventions for AOD. The intervention group showed significant reductions in mental illness symptoms and trauma symptoms, while the control group showed no significant improvements.⁽⁸⁶⁾ Effects on DFV and AOD outcomes were not reported.

A US double-blind placebo-controlled RCT⁽⁸⁷⁾ evaluated fluoxetine treatment for men and women with a diagnosis of DSM-IV alcohol disorder and a history of using intimate partner violence at least twice in past year. Both the treatment and placebo group received cognitive and motivational therapies in addition to self-help groups (e.g. AA) for alcohol and individualised CBT for DFV.⁽⁸⁷⁾ There was a high drop-out rate. Both groups showed significant reductions in abuse compared with baseline (Spouses'/ significant others' physical and nonphysical Partner Abuse Scale ratings), with no significant difference between groups.⁽⁸⁷⁾ The treatment group showed an improvement in irritability subscale scores (completer analysis, last-observation-carried-forward analysis, and intention-to-treat analysis).⁽⁸⁷⁾

In a US pre–post nonrandomised comparative study designed to assess whether integrated care was better than non-coordinated care for women with a history of interpersonal trauma, mental health and an AOD disorder of any type,⁽⁸⁸⁾ women with the most severe post-traumatic stress disorder symptoms and AOD (severe comorbid group) showed the greatest improvement in post-traumatic stress disorder symptoms.⁽⁸⁸⁾

A US nonrandomised pre–post comparative study⁽⁸⁹⁾ evaluating a trauma-informed and gender-responsive intervention based on two programs (Helping Women Recover, and Beyond Trauma) for women in residential AOD treatment reported statistically significant reductions in both trauma symptoms and depression scores. Clients were highly satisfied with the program.⁽⁸⁹⁾

Overall finding

There is some good-quality evidence that addressing mental health (particularly PTSD symptoms and depression) in an integrated AOD/DFV intervention assists women who have experienced violence. There is insufficient evidence for the effectiveness of fluoxetine in reducing DFV in people who use violence.

What we know about interventions for specific groups: Aboriginal and Torres Strait Islander people, LGBTI people, men and women: summary of the evidence

Are there different interventions for specific populations of DFV clients (e.g. Aboriginal and/or Torres Strait Islander people, LGBTI people, men, women) in AOD settings? . What are the best interventions in same-gender couples and when is it safe to conduct them?

Evidence identified

Interventions designed specifically for men who use DFV are described in the evidence summary for 'What we know about interventions for AOD service consumers who use DFV' subheading.

Interventions designed specifically for women experiencing DVF are described in the evidence summary for 'What we know about interventions for AOD service consumers who experience DFV' subheading.

The systematic review identified no studies that described interventions for any other specific populations in AOD settings.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

Aboriginal and/or Torres Strait Islander people: the authors of a 2017 ANROWS qualitative study⁽⁹⁰⁾ conducted among representatives of the specialist DFV sector (including the ACT Domestic Violence Crisis Centre) identified some practice principles for working with Aboriginal women:

- Safety planning must be an ongoing process, conducted collaboratively and with regard for culture and complex family relationships, in a range of ways (including pictorially), and in the context of relationship and trust building.
- Advocating for women without positioning the worker in a position of power that may re-traumatise Aboriginal women and only speaking to other services with her permission, and help her speak for herself.
- Face to face work, listen carefully, use interpreters, offer an Aboriginal worker, think more broadly about family and safer accommodation, think and talk carefully about children's safety (bearing in mind child removal worries/histories).

LGBTI: To date, most experimental studies of interventions for people who use family violence have excluded LGBTI people from participating. A body of evidence is available from studies examining DFV among the LGBTI community, but these are mostly prevalence studies and conceptual/discussion papers that are not specific to AOD settings. One discussion paper⁽¹⁾ targeting the medical community recommended a range of strategies for implementation in various settings (Table 1).

Table 1. Proposed strategies for working with LGBTI people in various settings

Clinical settings

Inquire about sexual behaviour and desire in a non-judgmental manner during the clinical history-taking of all patients; do not assume heterosexuality.

Avoid labelling a patient as gay, lesbian, bisexual, or transgender, unless prompted by the patient.

Screen for intimate partner violence in LGBT patients. Consider initiating the conversation with a question such as ‘Does your partner ever hit, kick, hurt, or threaten you?’ or ‘Do you feel safe at home?’ rather than asking if a patient has concerns about domestic violence or abuse.

Interview patients about intimate partner violence alone, regardless of the gender of those accompanying them to the clinic, and assure confidentiality.

Educate LGBT patients about intimate partner violence.

Evaluate and treat health complications associated with intimate partner violence in LGBT patients, including substance abuse, HIV, and other sexually transmitted infections in men who have sex with men.

Make informed referrals to institutional and community services for LGBT patients experiencing intimate partner violence.

Verify with the patient the level of disclosure of sexual orientation or gender identity that is appropriate in any referrals to other professionals.

Providers who are not comfortable treating LGBT patients should refer them to clinicians who are.

Institutional or community settings

Adapt institutional pamphlets, posters, and other materials on intimate partner violence to incorporate LGBT persons.

Advocate for the full inclusion of LGBT individuals in institutional and community intimate partner violence services, such as hospital abuse programs and community shelters.

Educational

Revise clinical resources and guidelines on intimate partner violence to reflect the burden of violence in the LGBT community.

Include information on LGBT intimate partner violence in medical trainee and continuing medical education curricula; consider incorporating testimony by a trained survivor of LGBT intimate partner violence.

Research settings

Collect data on sexual behaviour, sexual orientation, and gender identity in population-based studies of intimate partner violence.

Increase intimate partner violence research on particularly vulnerable and under-studied groups, such as transgender individuals, bisexual individuals, and sexual minority adolescents.

Source: Ard et al (2011)⁽²⁾

People from culturally and linguistically diverse communities: a 2016 ANROWS qualitative study of women's experiences with DFV⁽³⁾ reported experiences of DFV among women from culturally and linguistically diverse communities, some of which differ from those experienced by women in the general community. The study made the following observations:

- A woman's father was sometimes the primary perpetrator.
- Family violence was sometimes perpetrated by extended family, including family members overseas using threatening and abusive behaviour towards the woman or towards her family living overseas.
- Women experienced physical, sexual, emotional, psychological and financial violence (including abuse related to dowry and other inter-familial financial relations), as well as verbal and religious abuse, intimidation, shaming, reproductive control and imposed social isolation.
- Immigration-related violence was reported in most circumstances. It included threats of deportation (often without their children), visa cancellation and withholding immigration documents.
- Communicating with services and the legal system could be a struggle. The report stated that 'several women and many service providers reported problems communicating through interpreters and instances of unprofessional and dangerous interpreter behaviour'. Interpreters also highlighted challenges for themselves, such as vicarious trauma.

The report made recommendations for working with women from culturally and linguistically diverse communities (Table 2).

Table 2. Proposed strategies for working with women from culturally and linguistically diverse backgrounds

Increase linkages between DFV responses and agencies relevant for immigrant and refugee populations (such as migration and settlement services, multicultural and ethno-specific services, consular services and English language programs).

Ensure DFV definitions and risk assessment tools across Australia are relevant for immigrant and refugee populations, recognising that family violence includes multi-perpetrator violence, immigration-related abuse, ostracism from family and community, and exploitation of joint and extended family arrangements and financial obligations.

Train and resource services that come into contact with immigrant and refugee women (e.g. settlement services, cultural associations, English language programs, healthcare services) to understand and respond to the dynamics of DFV and facilitate referral pathways to specialist support.

Recognise interpreters as an integral part of the DFV system, and support reform of the interpreting industry through development of interpreter capacity and mechanisms for interpreter support, monitoring and feedback in relation to family violence interpreting.

Create multi-language written and audio resources for broad dissemination in places that are central to daily life (e.g. schools, workplaces, shopping centres, health services) to provide information about family violence, where to access support, and what to expect from police, courts, family violence and other relevant services.

Provide options for women to access 'mainstream' as well as specialist multicultural family violence services, and ensure availability of refuges that are funded to provide intensive and long-term support for immigrant and refugee women and children.

Develop a robust bilingual, bicultural family violence services workforce that is reflective of local populations and adequately trained and clinically supported to respond to the needs of immigrant and refugee families.

Provide ongoing training to all parts of the DFV system about the additional risk factors, immigration issues and support needs of immigrant and refugee women and their children.

Ensure DFV prevention programs engage with multicultural women's services and women leaders from immigrant and refugee communities, and are based on evidence about the contexts in which immigrant and refugee women experience family violence.

Source: Vaughan et al (2016)⁽³⁾

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

What we know about interventions for children of AOD service consumers who use or experience DFV: summary of the evidence

Which interventions are effective for children of AOD service consumers in DFV situations?

Evidence identified

The systematic review identified no studies that addressed this question.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

Some studies of evaluating parenting interventions for service consumers who use violence have reported benefits for children (e.g. the Fathers for Change intervention for substance use and intimate partner violence, described under 'What we know about interventions for AOD service consumers who use DFV' subheading).⁽⁷⁰⁾

A 2014 review⁽⁹¹⁾ prepared for the US Futures Without Violence organisation evaluated interventions for children exposed to DFV (without specific AOD involvement). The review found 12 programs with evidence for effectiveness that were available for children exposed to DFV. They ranged from four sessions to a duration of six months. Most were intended to be delivered by a mental health clinician. The programs were:⁽⁹¹⁾

- Child-Parent Psychotherapy (CPP)
- Child Witness To Violence Project
- Kids Club and Mom's Empowerment
- Trauma-focused CBT (TF-CBT)
- Project Support
- Shelter-based Group Intervention with CEDV
- CBT intervention for Trauma in Schools
- Parent-Child Interaction Therapy (PCIT)
- Child and Family Traumatic Stress Intervention
- Seeking Safety (SS, *Adolescents*)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Trauma Affect Regulation: TARGET-A.

A 2017 UK NICE Pathway on domestic violence and abuse overview included the following guidance:⁽⁵¹⁾

- Address emotional, psychological and physical harms arising from a child or young person exposed to DFV as well as their safety.
- Provide a coordinated package of care and support that takes individual needs and preferences into account.
- Ensure support meets the child's developmental stage.
- Interventions should be timely and should continue over a long enough period to achieve long-lasting effects.
- Provide interventions that aim to strengthen the child or young person and the parent who does not use violence, in parallel or together – may involve group, or individual sessions, and advocacy.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Practice Point: Considerations for children exposed to DFV

- Exposure to DFV can affect a child's psychological wellbeing and is thought to contribute to a range of emotional and behavioural issues, including low self-esteem, depression, PTSD, impaired cognitive functioning, and poorer educational outcomes.
- DFV is one of a constellation of risk factors for healthy child development that also includes parental AOD use.
- Mandatory reporting of children exposed to DFV may act as a barrier for parental help-seeking out of fear that children will be removed. This is particularly relevant for Aboriginal and/or Torres Strait Islander Australians.
- Child-aware approaches that emphasise family-sensitive, strengths based, collaborative and culturally appropriate service delivery are recommended.
- A good example of a child-aware program delivered in an adult homelessness service is the Salvation Army's *Safe from the Start* program that uses play-based therapy with specifically sourced books and toys that help children aged 0-6 to make sense of their experiences related to DFV (Go to www.salvationarmy.org.au for the final evaluation report).

Adapted from Campo, M. (2015) *Children's exposure to domestic and family violence: key issues and responses*. Australian Institute of Family Studies.

What we know about interventions to promote healthy relationships in an AOD setting: summary of the evidence

Which prevention interventions are effective in enhancing healthy relationships among AOD service consumers? What are some universal (including prevention) interventions?

Evidence identified

The systematic review identified no studies that addressed this question.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

An issues paper⁽⁹²⁾ considering the conceptual application of universal, selective and indicated prevention approaches from the public health field and their potential application to preventing DFV among AOD service consumers found no studies that explicitly explored this important issue. They highlight research that shows reductions in DFV following AOD interventions (see evidence summary for 'AOD interventions alone' subheading), and suggest that future research efforts examine a range of prevention strategies.

A US qualitative research study conducted among women in supported accommodation (Sober Living Homes) for women recovering from AOD problems included women with children,⁽⁶⁹⁾ but did not report outcomes for children.

Australian researchers have developed the Parents Under Pressure (PUP) program to promote healthy relationships among parents and children (www.pupprogram.net.au). PUP

is a home-based 3-month program that combines methods for improving parental mood and parenting skills to enhance family functioning. The program has been trialled successfully among parents on methadone maintenance.^(93, 94)

Caring Dads (www.caringdads.org) is an early intervention pilot program aimed at fathers experiencing AOD issues who have committed, or are at risk of committing family violence. It is currently being evaluated in a pilot program in Victoria.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendations for implementing interventions aligned with service capacity measured by the Domestic and Family Violence Capability Assessment Tool (DFVCAT): for alcohol and other drug services

Universal responses

- All services should follow the principles of good AOD practice and offer holistic AOD responses appropriate to their service type.
- All services should model respectful relationships in all interactions, including those between staff and those between service consumers and staff.
- The charter of rights should be displayed and meaningful service consumer involvement in the development and delivery of AOD programs, including those that involve DFV, be encouraged.
- All staff should be trained in DFV awareness and DFV supports available for service consumers.
- Staff should be able to respond to crisis presentations related to DFV.
- In addition to the universal recommendations, services should establish policy, capacity, and protocols according to DFVCAT category.

DFV-identified services should:

- Ensure information about DFV (e.g. a poster) is displayed where service consumers can see it.
- Offer holistic AOD treatment that includes mental health assessment and responses, including psychoeducation.
- Actively screen service consumers for risk of experiencing or using DFV.
- Establish referral linkages for DFV care (active supported referral).

DFV-ready services should:

- Routinely undertake formal DFV screening.
- Respond effectively to disclosure of DFV issues.
- Offer insight-based interventions (e.g. psychoeducation, motivational enhancement) that acknowledge links between AOD and DFV.
- Work with service consumers to develop safety plans and to review the effectiveness of the plans regularly.
- Offer harm reduction interventions for those who experience or use DFV.
- Offer groups in-house that are facilitated by specialist DFV workers (in-reach groups).
- Focus on promoting and supporting healthy relationships.

DFV-coordinated care services should:

- Undertake detailed assessment when formal screening identifies DFV risk or current DFV.
- Respond to assessed DFV issues by working with external specialised services.
- Maintain contact with DFV treatment delivered by other services and provide coordinated care designed to enhance safety.
- Offer appropriate interventions (e.g. in-house couples therapy, other family interventions).

- **Focus on building respectful relationships.**

Integrated AOD/DFV services should:

- **Respond to DFV issues by arranging secondary consultation, providing internal referral to a specialised DFV service onsite, or providing care through specialised care provided by appropriately trained AOD staff.**
- **Incorporate DFV care into staff training and into all the service's policies and protocols.**
- **Provide in-house, or arrange referral to, appropriate interventions such as in-house couples therapy, other family interventions, or men's behaviour groups. Selected interventions should be appropriate to the population and either evidence-based or conducted within a research protocol.**

Continuity of care

Post-treatment support

What we know about post-AOD treatment supports and linkages: summary of the evidence

What post treatment supports and linkages improve DFV outcomes among people in AOD treatment?

Evidence identified

The systematic review identified no studies that addressed this question.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

The SAMHSA treatment improvement protocol on AOD use and DFV⁽³²⁾ suggests that the following linkages are important to ensure women and children receive the wrap-around support that they need:

- health care providers
- education/schools
- adult education
- justice system
- social welfare
- specialist DFV sector
- mental health
- other AOD programs
- other community resources (finance, transport, child care, housing etc).

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendations

Planning of post-treatment support in AOD services should include consideration of the links between AOD and DFV, and include relapse planning for both issues.

After treatment, AOD services should link service consumers to relevant services based on their individual needs.

After-care planning should encourage opportunities to promote healthy relationships.

Safety plans should be reviewed, updated and reinforced.

Staffing considerations

Training to improve outcomes for service consumers

What we know about training staff for good service consumer outcomes: Summary of the evidence

What training/WFD activity for (professional and peer) staff are required for good service consumer outcomes?

Evidence identified

The current systematic review identified one systematic review⁽⁹⁵⁾ and two RCTs^(96, 97) that addressed this question.

Summary of findings

Evidence from systematic review

A 2014 systematic review⁽⁹⁵⁾ of papers on working with service consumers with co-occurring intimate partner violence and AOD problems found that most relevant papers referred to the knowledge areas thought to support good client outcomes (e.g. trauma-informed care, the dynamics of sexual assault in childhood, motivational interviewing, CBT, and relapse prevention), but that there was limited concrete information on the specific core knowledge or skills required to work with this population group.

An Australian RCT⁽⁹⁶⁾ evaluated a 6-month educational intervention to promote an approach to psychosocial risk assessment during pregnancy among midwives and doctors.

Participation increased antenatal health workers' confidence in asking women directly about DFV, past sexual abuse and concerns caring for the baby, and in addressing psychosocial issues. It also improved their ability to pick up cues, and to identify and support women experiencing psychosocial issues, and their use of consultation skills (e.g. setting women at ease, eye contact, using open-ended questions, identifying underlying concerns, using attentive silence asking directly about sensitive issues and supporting women who are upset).⁽⁹⁶⁾

A Canadian RCT⁽⁹⁷⁾ evaluated a workshop training program for AOD, mental health and DFV workers and reported that the training increased participants' confidence in working with service consumers experiencing co-morbidities, increased their understanding of the effects of co-occurring problems, the system of services, and how to make referrals, and reduced stigmatising beliefs. The findings support interdisciplinary/cross-disciplinary training.

Other relevant information

A 2014 UK NICE guideline⁽⁹⁸⁾ on effective responses of services to DFV and abuse recommended the following:

- ensuring that all front-line staff are trained to recognise the indicators of DFV and abuse and can ask relevant questions to people disclose their past or current experiences
- routinely asking service consumers whether they have experienced DFV or abuse
- ensuring that all staff are aware of relevant policies and procedures and are able to make appropriate referrals
- providing training on response according to levels of interventions (responding to disclosure, asking, understanding of the epidemiology of DFV and abuse, risk identification and assessment, providing advice, raising awareness of DFV and addressing misconceptions).

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendations

All staff should have ongoing training in AOD interventions relevant to their work.

All staff should have training in DFV, tailored for the AOD sector.

Staff should have access to ongoing training related to the elements that they are required to undertake.

All staff need training in service consumer engagement related to DFV, basic DFV awareness, trauma-informed care, mandatory reporting, and cultural competence specifically related to DFV.

Staff required to undertake screening, safety planning, and interventions should have specific training in these areas, including training in working with children and in family interventions.

AOD service should develop a plan for implementation of training, ensuring that training is continuous.

AOD services should give consideration to other forms of training such as placements with DFV, collaborative experiences with DFV services, case review and conferencing, access to consultation-liaison and supervision as required.

Training to enhance the skills and confidence of staff.

What we know about building skills and confidence: Summary of the evidence

What training/workforce development activity for staff builds confidence, improves engagement and competence in AOD (professional and peer) staff in working with DFV?

Evidence identified

The systematic review identified one systematic review⁽⁹⁵⁾ and one RCT⁽⁹⁷⁾ that addressed this question.

Another RCT⁽⁹⁶⁾ did not involve AOD staff but provides indirect evidence.

Summary of findings

Evidence from systematic review

A 2014 systematic review⁽⁹⁵⁾ of papers on working with service consumers with co-occurring intimate partner violence and AOD use concluded that collaboration, cross-sectoral, and multidisciplinary cooperation and systematic evaluation of new education and training initiatives was required for to improve capacity building for the AOD sector.

A Canadian RCT⁽⁹⁷⁾ evaluated a workshop training program for AOD, mental health and DFV workers that gave them the opportunity to work together with health professionals in other sectors. The investigators reported that the training increased participants' confidence in working with clients experiencing co-morbidities, increased their understanding of the effects

of co-occurring problems, the system of services, and how to make referrals, and reduced stigmatising beliefs.⁽⁹⁷⁾ The findings support interdisciplinary/cross-disciplinary training.⁽⁹⁷⁾

Other relevant information

An Australian RCT⁽⁹⁶⁾ evaluated a 6-month educational intervention to promote an approach to psychosocial risk assessment during pregnancy among midwives and doctors. It did not discuss problematic AOD use or interventions.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice. Consensus recommendations can be informed by existing guidance, and taking into consideration the skills that would be required by workers to safely and effectively respond to service consumers with DFV involvement.

Practice Point: Options for training in DFV

- The specialist DFV sector across Australia often provides foundation training in DFV for other sectors. In Canberra, the Domestic Violence Crisis Service provides training as required (www.dvcs.org.au)
- The website DV Alert lists training opportunities in all states and territories, and also offers an e-learning program subsidised by the Australian Government (www.dvalert.org.au)
- Online training in DFV is offered by Queensland Health (www.health.qld.gov.au)
- Some universities offer a graduate certificate in domestic violence (www.qut.edu.au)
- Elective units in responding to DFV are available through the Certificate IV in AOD and the Diploma of AOD courses
- In partnership with DFV stakeholders, the AOD sector should consider developing fit for purpose/tailored DFV training package.

Staff skills and qualifications

What we know about minimum qualifications of AOD workers responding to DFV: Summary of the evidence

What are the minimum qualifications of staff working with DFV in AOD services?

Evidence identified

The systematic review identified no studies that addressed this question.

Summary of findings

Evidence from systematic review

No directly relevant evidence identified.

Other relevant information

Most of the studies of complex interventions were delivered by trained therapists with at least Master's level qualifications.

A guide developed by National Centre for Education and Training on Addiction (NCETA)⁽⁹⁹⁾ suggests that specialised AOD workers need detailed assessment skills, detailed understanding of legal and duty of care requirements and DFV-specific counselling skills, while frontline AOD workers require skills in identification and assessment, safety planning and referral. The guide makes no recommendations concerning minimum qualifications.

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice.

Recommendations

For staff delivering DFV interventions in AOD settings, the minimum qualification corresponds to that required in other settings (e.g. advanced training in family therapy or men's behaviour change interventions, as applicable).

Staff safety and self-care

What we know about preventing staff burnout: Summary of the evidence

Which strategies improve safety and reduce burnout for AOD workers working with service consumers who experience or use DFV?

Evidence identified

The systematic review identified two cross-sectional surveys^(100, 101) and one qualitative focus group study⁽⁹⁸⁾ that partly addressed this question.

Summary of findings

An Australian survey-based study⁽¹⁰¹⁾ among AOD workers found that 19% met criteria for secondary traumatic stress. The proportion of workers who had received training in AOD, mental health or trauma did not differ significantly between groups with and without secondary traumatic stress. The level of clinical supervision was inversely correlated with secondary traumatic stress. The findings suggested that risk might be reduced by workplace strategies that help workers reduce stress and anxiety, spread caseloads of clients with trauma across workers, and provide regular high-quality supervision.⁽¹⁰¹⁾

A US survey-based study⁽¹⁰⁰⁾ reported that 56% of AOD counsellors met the criteria for at least one of the core symptom clusters of secondary traumatic stress, but did not report on the effectiveness of specific strategies to address this problem.

Investigators in a focus group study⁽¹⁰²⁾ concluded that AOD staff who work with women experiencing DFV need sufficient in-depth training in DFV to increase their skills and confidence and reduce stress. They also suggested that organisations need policies and procedures to guide staff and improve consistency of care, and that successful organisational change may require on-site expertise, cross-system collaboration and expansion of resources for women who use AOD services.⁽¹⁰²⁾

Overall finding

There is insufficient evidence to answer the question, or from which to formulate evidence-based recommendations for practice. Limited evidence suggests workplace strategies to reduce stress and anxiety, manage caseloads of workers with high numbers of consumers who experience or use DFV, provide regular good quality supervision and opportunities for addressing workers' own experiences of DFV may be of benefit, as is ongoing training.

Recommendations

AOD services should ensure that all staff members have access to practice supervision and/or support appropriate to their role, level of experience and reflective of the service consumers they work with.

In addition to practice supervision, AOD services should provide formal and informal consultation on DFV issues for AOD workers, provided by nominated staff members and according to clearly documented processes.

All AOD staff should have access to an employee assistance program or similar.

All AOD services should have safety policies and procedures for managing violence, including policies on outreach, equipment (duress alarms), and appropriate staff training.

All services should have policies and procedures to support staff after a critical incident.

Helpful resources

Other practice guides and resources

Australia

White, M. et al. (2013). *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. Adelaide: Flinders University.
Available: www.nceta.flinders.edu.au

Nicholas, R., White, M., Roche, A. M., Gruenert, S., & Lee, N. (2012). *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia*. Adelaide: Flinders University.
Available from: www.nceta.flinders.edu.au

Women's Council for Domestic and Family Violence Services Western Australia. (2009). *Supporting women with complex needs; the relationship between substance use and domestic violence*. Western Australia: Women's Council for Domestic and Family Violence Services Western Australia.
Available from: www.womenscouncil.com.au

Department of Child Protection and Family Support. (2015). Practice Tool 2. Common risk assessment tool. *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (2nd ed.)*. Perth: Western Australian Government.
Available from:
<https://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/2015/PracticeTool2Commonriskassessmenttool.pdf>

Department of Child Protection and Family Support. (2015). Practice Tool 4. Personal Safety Plan Template. *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (2nd ed.)*. Perth: Western Australian Government.
Available from:
<https://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/2015/PracticeTool4Personalsafetyplantemplate.pdf>

Network of Alcohol and Drug Agencies (NADA). (2017). Domestic and Family Violence Screener. *NADA Policy Toolkit*. Sydney: NADA.
Available from: http://www.nada.org.au/media/92623/dfv_screener_paper.pdf

Network of Alcohol and Drug Agencies (NADA). (2017). Responding to domestic violence in AOD settings: What you need to know. *NADA Policy Toolkit*. Sydney: NADA.
Available from:
http://www.nada.org.au/media/92629/responding_to_dv_what_you_need_to_know.pdf

USA

Substance Abuse and Mental Health Services Administration (US). (1997). *Substance abuse treatment and domestic violence. Treatment Improvement Protocol (TIP) Series No. 25*. Rockville: Department of Health and Human Services USA SAMHSA.
Available from: www.samhsa.gov

UK

Against Violence and Abuse (AVA). (2007). *Complicated Matters: a toolkit addressing domestic and sexual violence, substance use and mental ill-health*. London: AVA.
Available from: <https://avaproject.org.uk/wp-content/uploads/2016/03/Complicated-Matters-A-toolkit-addressing-domestic-and-sexual-violence-substance-use-and-mental-ill-health.pdf>

Appendices

Systematic review search strategy

The following databases were searched:

- Medline
- PsychINFO
- Scopus
- SocINDEX
- CINAHL
- Google Scholar

Example of search terms

Medline

- 1 (Battered women* or "violence against women" or ((Domestic or spous* or partner* or elder* or family or gender-based) adj3 (violen* or abus* or mistreatment or aggression or victimi?ation))).tw,kw.
- 2 Domestic violence/ or intimate partner violence/ or spouse abuse/ or battered women/
- 3 ((men or male*) adj2 behavio*r change).tw,kw.
- 4 1 or 2 or 3
- 5 (((Substance use* or substance abuse* or substance misuse* or drug use* or drug using or drug abuse* or illicit drug* or alcohol use* or alcohol abuse* or alcohol dependen* or alcohol misuse* or alcohol problem* or alcoholism or alcoholic* or problem drinker* or addict* or methadone or opioid dependen* or cannabis use* or cannabis dependence or prescription opioid* or cocaine or ecstasy or methamphetamine* or amphetamine* or crack or crystal meth or stimulant* or opiate addiction or heroin or injecting drug* or inject drug* or Alcohol) and other drug*) or marijuana or morphine dependen*).ti,ab.
- 6 drug abuse/ or drug usage/ or exp alcohol abuse/ or exp inhalant abuse/ or exp polydrug abuse/ or exp addiction/ or drug addiction/ or exp drug dependency/ or drug seeking/ or intravenous drug usage/
- 7 5 or 6
- 8 4 and 7
- 9 limit 8 to (english language and humans and yr="2000 - 2017")
- 10 (Treatment* or intervention* or program* or service* or therap* or rehabilitat* or recover* or non-residential or non-residential or outpatient or aftercare or Community based or community-based or assessment or screen*).ti,ab.
- 11 (train* or staff* or workforce development or workforce train*).ti,ab
- 12 10 or 11
- 13 8 and 12
- 14 limit 13 to (english language and humans and yr="2000 - 2017")
- 15 9 or 14

1st screen

Original searches by database screened for INCLUDED/ EXCLUDED in separate EndNote's including Medline (n=1408), PsycINFO (n=1577), Scopus (n=623), SocINDEX (n=246), CINAHL (n=375), Google & Google Scholar (n=43).

2nd screen

All of 1st screen INCLUDED studies merged into one EndNote, duplicates removed and

2nd screen INCLUDED/EXCLUDED completed of all studies (N=323).

3rd screen

All of 2nd screen INCLUDED studies sorted by topic (n=162).

Hand searching of reference lists and other publications relevant to the clinical questions was also conducted, which provided an additional 23 papers to the search.

4th screen

Of 185 papers, 130 were excluded because they were conceptual papers, reviewed the same papers already included, were conducted in non-AOD settings, focused on a topic outside of the clinical question, or could not be used to answer the clinical question

The final number of papers reviewed and extracted into evidence tables for the Domestic and Family Violence in Alcohol and Other Drugs Practice Guide Development Group was 55.

Additional papers and guidelines were summarised to provide context for the Practice Guide Development Group's consensus statements meeting, particularly where evidence was lacking.

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- ² Ard KL, & Makadon, HJ. (2001). 'Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients.' *J Gen Intern Med*. Vol.26 no.08. pp.930-3.
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Attachment D: Monitoring and Evaluation Framework: for the ACT *Alcohol and Other Drug Safer Families Program 2017-2021*

This attachment contains the Monitoring and Evaluation Framework for the ACT *Alcohol and Other Drug (AOD) Safer Families Program*.

About this document:

This Monitoring and Evaluation Framework provides a blueprint for monitoring and evaluation of the design, implementation and outcomes of the *AOD Safer Families Program* from 2017 - 2021.

The Monitoring and Evaluation Framework was developed through an intensive co-design process with AOD and DFV services, clinicians and other experts, consumer organisations and policy makers (see Section 4).

Relationship to the *AOD Safer Families Program*:

The Monitoring and Evaluation Framework will outline a consistent way for stakeholders (namely the AOD services funded through the *AOD Safer Families Program*) to contribute data and information to answer evaluation questions, monitor delivery and assess outcomes. From 2018 onwards, specific evaluation plans/strategies will need to be developed that operationalise components of the broader Monitoring and Evaluation Framework.

As described in the *AOD Safer Families Program* model (see Section 2); the Monitoring and Evaluation Framework is designed to provide a blueprint for monitoring and evaluating the *AOD Safer Families Program* as a whole. Its purpose and alignments with other components of the *AOD Safer Families Program* is described below:

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool: for AOD Settings	Program/ organisational level	<ul style="list-style-type: none"> Benchmark and assess capacity to respond to DFV in AOD settings Plan for service enhancement/capacity building (to existing AOD treatment and support) or new coordinated / integrated AOD and DFV responses. Assess and report on progress
Scope of Practice: for Working with Service Consumers in AOD Settings who Experience or Use DFV	Both program/ organisational level & practice/ clinical level	<ul style="list-style-type: none"> Clarify roles, responsibilities, activities and decision making capacities of the AOD workforce as it relates to responding to DFV Guide services and workers on how to work safely and effectively (based on skills, qualifications and training) Inform workforce planning, training and recruitment
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice/clinical level	<ul style="list-style-type: none"> Guide practice (e.g. screening, assessment and interventions) Optimise responses and outcomes for service consumers Ensure activities funded through the <i>AOD Safer Families Program</i> are evidence based and align with clinical consensus

Monitoring and Evaluation Framework for the ACT Alcohol and Other Drug (AOD) Safer Families Program 2017-2021	Whole of sector/policy level	<ul style="list-style-type: none"> • Monitor and evaluate the entire <i>AOD Safer Families Program</i> • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to DFV in AOD settings
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Suggested Citation:

The suggested citation for the attachment is:

ARTD Consultants & Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *Monitoring and Evaluation Framework: for the ACT Alcohol and Other Drug Safer Families Program 2017-2021*. Canberra: ATODA.

Available At:

The Monitoring and Evaluation Framework for the ACT AOD Safer Families Program will also be made available from www.atoda.org.au.

Attachment D

Monitoring and Evaluation Framework: for the ACT *Alcohol and Other Drug Safer Families Program* 2017-2021

December 2017

MONITORING AND EVALUATION FRAMEWORK: FOR THE ACT AOD SAFER *FAMILIES PROGRAM* 2017 - 2021



DECEMBER 2017

ARTD CONSULTANTS
strategy & evaluation

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ARTD consultancy team

Fiona Christian and Melanie Darvodelsky

Suggested citation:

ARTD Consultants & Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *Monitoring and Evaluation Framework: for the ACT Alcohol and Other Drug Safer Families Program 2017-2021*. Canberra: ATODA.

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Key evaluation terms and definitions

Contributory conditions	A state that your program can expect to contribute to. Generally, relate to the strategic objectives of a program.
Evaluation	A rigorous, systematic and objective process to make an evidence-based assessment of the effectiveness, efficiency, appropriateness and sustainability of an initiative.
Evaluation design	How a particular evaluation is set up to provide the evidence to achieve its purpose (e.g. experimental design). The design takes account of the appropriateness of methods for the programs scope and status, as well as ethical safeguards.
Evaluation framework	A structure to guide evaluation and monitoring activities, based on systematic and conceptual thinking about what a 'program' is setting out to achieve and how the anticipated outcomes can be assessed.
Evaluation plan	The mechanics of how a particular evaluation will be carried out. It sets out the tasks and responsibilities to implement an evaluation program/ study and the budget.
Evaluation strategy	An overall approach to evaluation that reflects the strategic priorities and state of the program at the time. It starts with the purpose (why), focus (what), and stakeholder information needs (what evidence, by when). It references the program outcomes framework and links with other policy frameworks/ strategies. It includes the main evaluation activities/ studies, with an outline of designs and methods. It also sets out the timing, responsibilities and resources.
Inputs	The resources (human and other) you use to do the work.
Necessary conditions	A condition (in this case, in the form of an outcome) that must be present for an event to occur. In program logic, necessary conditions are similar to a short term outcomes.
Outcome	A result that can be measured or observed and a changed condition of people/ organisations/ systems.
Outputs	The tangible products or services the activity will deliver.
Outcomes matrix	A matrix of program outcomes at different levels, causally linked by a results logic diagram. For each outcome, it shows attributes of success and is usually used to frame an evaluation strategy and/or a monitoring system.
Performance monitoring	Provides information about whether or not an initiative is on track. That is, information about how much has been done to what quality and sometimes about the immediate outcomes achieved. Performance monitoring is one source of evidence for an evaluation study but monitoring by itself is not evaluation and is less in-depth

	than evaluation. Monitoring is ongoing while evaluation is typically periodic; mainly uses data captured as part of delivering services; informs quality assurance activities and is used to manage programs/ businesses on an ongoing basis.
Program theory	An explicit statement of how an intervention/ program is understood to contribute to observed or intended outcomes.
Program logic model	A diagram that shows how an intervention/ program is assumed to work by causally linking program activities with intended outcomes.
Purposive sampling	A sample of subjects selected deliberately (on purpose) because these subjects have particular characteristics of interest.
Reach	Used in program logic to show which group/s are being targeted by particular activities
Sufficient conditions	Outcomes that your program is expected to be sufficient to create.
Theory of change	These are the big research-based theories about how change occurs for individuals, groups, organisations and communities. Theories of change can provide a conceptual framework for developing or critiquing a program theory.
Ultimate outcomes	The best case scenario or intended state of a program or target group. The next link in the causal chain after the contributory conditions.

Executive summary

This is the evaluation framework for the ACT *AOD Safer Families Program* (the Program). The evaluation framework is intended to provide a blueprint for monitoring and evaluation of the design, implementation and outcomes of the Program from 2017 to 2021.

The development of the evaluation framework has been a collaborative process. The main components of the framework were developed with a working group comprised of ATODA staff, their evaluation advisor, and ACT Health representatives in two workshops. Draft components were presented to a broader stakeholder group in two sector forums for further refinement.

The framework has the program logic and theory of change for the Program, key and guiding evaluation questions, and potential indicators and data sources that could be used for implementation and outcomes evaluations, and for providing monitoring data to a Program governance group or auspice organisation or collaboration.

The framework also covers advice on evaluation governance, ethical considerations and planning evaluations, and description of the timing and purpose of possible evaluations for the Program.

It is not known at the time of writing how the Program will be implemented, and what structures or resources will be available for monitoring implementation and evaluating outcomes. As a result, the framework is designed to support a future Program governance group or auspice organisation or consortium to design approaches to monitoring and evaluation for the Program that fit their context, remit and resources.

1. Introduction

1.1 The policy context

The ACT Government, in the 2016-17 ACT Budget, made an unprecedented investment in a Safer Families Initiative to resource whole-of-government, community-backed responses to domestic and family violence. This investment was made within the context of a number of tragic deaths, and subsequent Government reports:

- The *Review into the system level responses to family violence in the ACT* report (April 2016) (the Glanfield Inquiry)¹
- The *ACT Domestic Violence Service System Final Gap Analysis Report* (May 2016) (the Gap Analysis)²
- The *Review of Domestic and Family Violence Deaths in the Australian Capital Territory* report (May 2016) (the Death Review)³
- The *ACT Government Response to Family Violence*, addressing the above reports (June 2016) (the Government Response)⁴

As part of their response to the report, ACT Health has engaged the Alcohol Tobacco and Other Drug Association ACT Inc. (ATODA) to research, scope and design a multi-year pilot project to provide more effective responses to people who have used alcohol and other drugs (AOD) in harmful ways and experience, or are at risk of using, domestic and family violence (DFV). This is now known as the *AOD Safer Families Program*.

1.2 The Program

The ACT *AOD Safer Families Program* aims to prevent and respond to domestic and family violence (DFV) by establishing new coordinated/integrated alcohol and other drug and DFV interventions within the specialist alcohol and other drug service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to DFV.

In the first year, ATODA has been funded to lead a co-design process to develop:

- A design for the *AOD Safer Families Program*.

¹ ACT Health (2016) *Report of the Inquiry: Review into the system level responses to family violence in the ACT*. Canberra: ACT Health http://www.cmd.act.gov.au/_data/assets/pdf_file/0010/864712/Glanfield-Inquiry-report.pdf

² ACT Government (2016) *ACT Domestic Violence Service System: Final Gap Analysis Report*. Canberra: ACT Government http://www.cmd.act.gov.au/_data/assets/word_doc/0009/864711/ACT-Domestic-Violence-Service-System-Final-Gap-Analysis-Report.DOCX

³ Domestic Violence Prevention Council (2016) *Findings and Recommendations from the Review of Domestic and Family Violence Deaths in the Australian Capital Territory. Public Report*. Canberra: ACT Government http://www.cmd.act.gov.au/_data/assets/pdf_file/0003/864714/DVPC-Review-of-Domestic-and-Family-Violence-Deaths.pdf

⁴ ACT Government (2016) *ACT Government Response to Family Violence, addressing the above reports*. Canberra: ACT Government http://www.cmd.act.gov.au/_data/assets/pdf_file/0008/883484/ACT-Government-Response-family-violence.pdf

- Domestic and Family Violence Capability Assessment Tool: for AOD Settings
- Scope of Practice: for Working with Service Consumers in AOD settings who Experience or Use DFV
- Practice Guide: for Responding to DFV in AOD settings
- A monitoring and evaluation framework (this document)

These will be used to guide programs/organisations who are involved in the implementation of the *AOD Safer Families Program*.

Following the development and implementation of the Program from 2018, participating services will undertake service enhancement/capacity building activities to better respond to DFV. A smaller number of services will provide integrated/coordinated pilots. As part of this work, participating services will be required to undertake a capability assessment for responding to DFV using the DFVCAT. Services will then determine what the appropriate capability is for the future, and will use the Scope of Practice and the Practice Guide to determine appropriate approaches to practice and the required resources.

The Program has been developed using a co-design approach involving the ACT AOD sector, DFV stakeholders, consumer organisations and representatives, policy workers and clinical experts. The Program will be implemented in a staged approach over multiple years. 2017 has been led by ATODA, focusing on designing and developing the infrastructure and model for the Program to be implemented in subsequent years. The target group for the Program when implemented are the 10 organisations funded by ACT Health to deliver specialist AOD services in the ACT.

1.3 Evaluation of the *AOD Safer Families Program*

As part of the development of the *AOD Safer Families Program*, ATODA was also funded to commission the development of a monitoring and evaluation framework, to support the development and implementation of monitoring and evaluation activities over the life of the Program. ATODA engaged ARTD Consultants to develop the Monitoring and Evaluation Framework: for the ACT *Alcohol and Other Drug Safer Families Program 2017-2021*, this document.

It is not known at the time of writing how the Program will be implemented, and what structures or resources will be available for monitoring implementation and evaluating outcomes. As a result, the framework is designed to support a future Program governance group or auspice organisation or consortium to design approaches to monitoring and evaluation for the Program that fit their context, remit and resources.

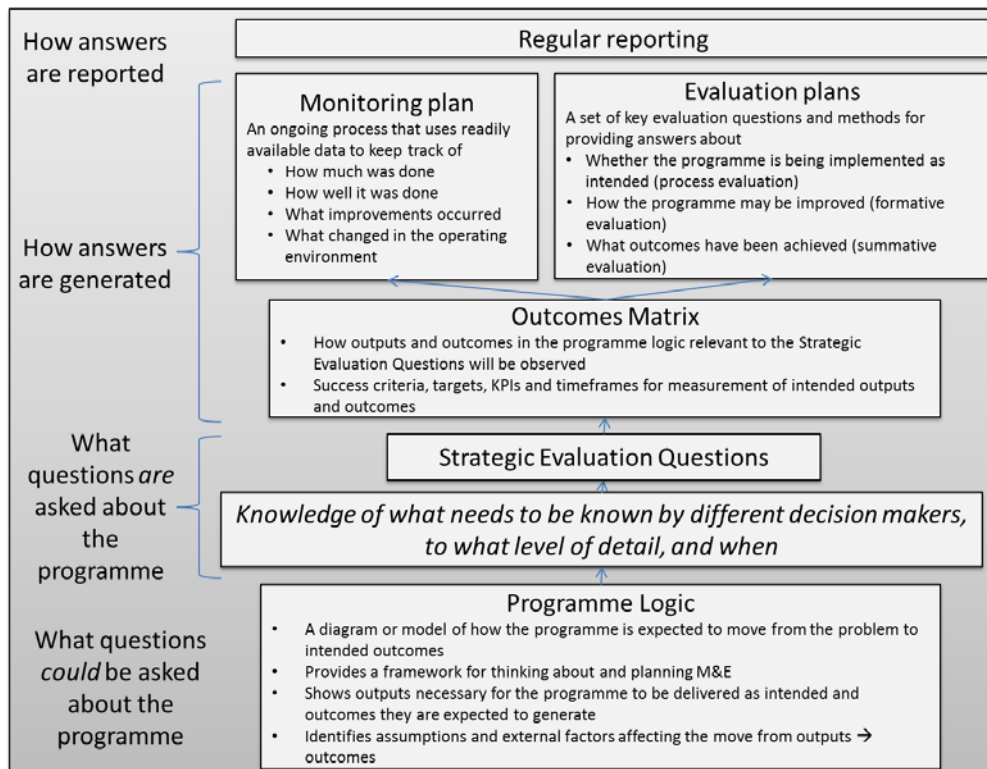
2. Framing monitoring and evaluation activity

This section describes the logic and theory that underpins the Program. The program logic describes the sequence of conditions to be achieved from inputs to outcomes. The program theory describes how the movement from inputs to outcomes is expected to occur.

2.1 Overview of the Monitoring and Evaluation Framework

The components of this Monitoring and Evaluation Framework are described in Figure 1. The first component is the **Program Logic**. This describes the rationale for the program and helps identify what *could* usefully be asked about the program. Next are the **Strategic Evaluation Questions**. These describe what *needs* to be known about the program, both to inform improvements and provide accountability. The data for addressing these questions is identified in the **Outcomes Matrix**. This includes outputs and outcomes, success criteria and KPIs. Following this, a **Monitoring plan** would be developed focused on keeping track of readily available data, and a series of **Evaluation plans** to provide for in-depth understanding of key issues and measurement of outcomes. **Regular reporting** is required to keep policy and operations decisions up-to-date with findings for continuous improvement, and to meet reporting requirements.

Figure 1. Overview of an M&E Strategy, from the program logic to the development of M&E plans and reporting



2.2 A program logic approach to evaluation

A program logic (and program theory) approach to evaluation provides a means of identifying and measuring outcomes, but also determining how they were achieved, under what circumstances they were achieved, how they could be maximised, or at what stage problems occurred that limited outcomes from occurring, and can generate data for continuous improvement.

Typically, a program logic driven evaluation will not rely on one or even a few KPIs to draw conclusions about a program. Instead, it will use mixed methods (administrative data sets, surveys, interviews, etc.) to develop evidence-based arguments about the value of each part of the program and to identify areas of the program that need to be addressed to support the ultimate intended outcomes. This is particularly useful in this case, because the innovative nature of the Program means that success is not only determined by long-term outcomes for service consumers, but the strength and capacity of the AOD service system to take on and implement a new approach to service provision, which will be indicated through the strength of the immediate and intermediate outcomes.

2.3 The program logic

The program logic (Figure 2) is a visual representation of the important components of the Program and how these components are intended to work together to bring about change for AOD service consumers, workers, organisations and the service system. The model begins at the bottom with the inputs needed for the Program, and is linked to the ultimate intended outcomes at the top through a series of short, intermediate and longer term outcomes. Each box in the model is a condition that is thought to be necessary to move towards the following outcomes. In combination, the conditions are thought to be sufficient (with certain assumptions and notwithstanding external factors) for ensuring the outcome occurs.

2.3.1 Reading the diagram from inputs to ultimate intended outcomes

The diagram shows outcomes in three streams – outcomes for the AOD service system on the left, services and staff in the centre, and service consumers on the right.

The inputs

The inputs required for program implementation are shown at the bottom of the diagram: that appropriate and effective Program governance is developed, and that stakeholders from the AOD and DFV sectors are engaged in Program co-design (bottom left boxes). As the Program continues, it is necessary for governance to be maintained and adapted to suit the stage of implementation and needs of the Program.

From this, appropriate program design, structure and resources are required (centre bottom box) with input and collaboration from stakeholders. These start with getting appropriate clinical and expert support, which feeds into developing a suitable and appropriate DFV CAT tool, Scope of Practice (SoP) and Practice Guide (PG). Following this, suitable resources and program infrastructure are developed including the implementation and funding model, and the Monitoring and Evaluation Framework (this document). At the same time, it is necessary that service consumers continue to use AOD services and feel safe in doing so (box to the right).

The necessary conditions

Following this, heading up the diagram, the logic is that if all these inputs are correctly developed and available, the Program has everything necessary for implementation. This is seen through a series of outcomes: sector co-design transitions to a collaborative approach (box to the left), as services receive adequate communication, support and resources to understand the Program and how to implement the tools, identify the Program as a strategic priority and commit to implementation, use the tools to determine the resources needed and receive adequate funds to build the capacity of their organisation and deliver appropriate DFV/AOD interventions in line with the tools (middle stream). Arrows from the left box show how collaboration from the sector influences the decisions around and implementation of the funding model.

It is also necessary at this point for service consumers to receive opportunities to disclose DFV to AOD services, and for service consumers to accept that AOD services or staff have the skills or appropriate role to be discussing service consumer experiences of DFV, in order for higher up outcomes to occur.

The sufficient conditions

At the next level up of the diagram, in the pale orange boxes, the logic is that if these conditions are all achieved, and any program assumptions met, with continued collaboration from the AOD sector, then the Program will be sufficient for services to:

- Identify and adopt PG (Practice Guide) relevant to their service type in a way that supports consumer and staff safety
- Apply the DFV CAT (Domestic and Family Violence Capability Assessment Tool) and SoP (Scope of Practice) effectively.

Because of this, and service consumer's acceptance of AOD services delivering DFV interventions, these outcomes should also be sufficient for service consumers to receive DFV interventions (such as screening) appropriate to their needs and the AOD service they are using (to the right of the diagram).

The contributory conditions

The logic then follows (in the darker orange boxes further up the diagram) that if these conditions are met, the Program will likely contribute to significant change in AOD services, where:

- services deliver and improve DFV interventions appropriate to the DFVCAT (Domestic Violence Capability Assessment Tool), SoP (Scope of Practice) and PG (Practice Guide)
- services have a universal crisis response to DFV in place
- services have a 'stepped up' or integrated response to DFV where appropriate
- DFV responses are a routine part of AOD services.

To the left of the diagram, the collaboration and capacity building of the sector will then be likely to contribute to a shared understanding across the sector, of DFV in an AOD context, and established engagement for future capacity building in AOD/DFV practice.

To the right of the diagram, the interventions that service consumers receive from AOD services are likely to contribute to improved DFV outcomes for themselves and their families.

The ultimate outcomes

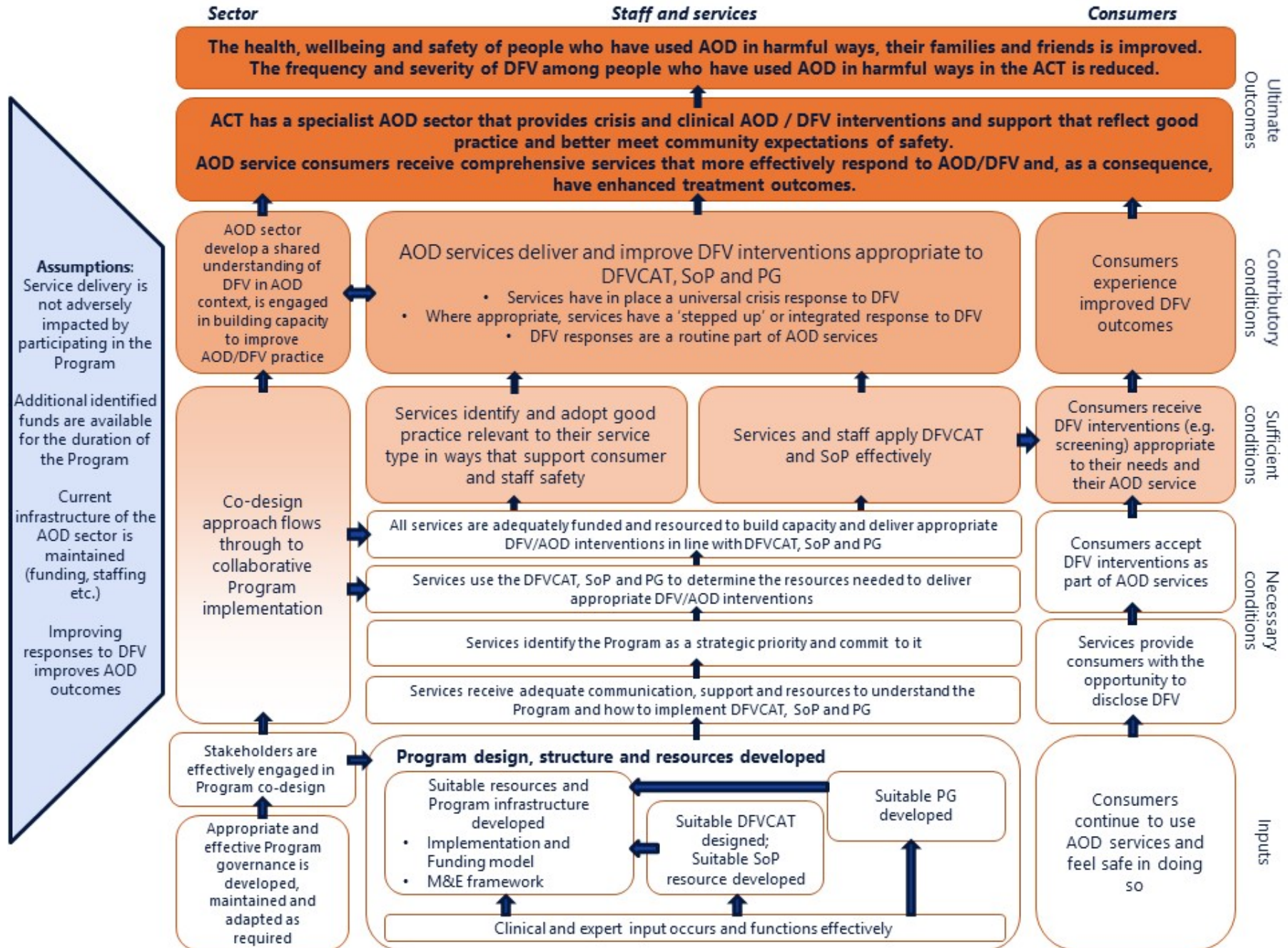
At the top of the diagram, if all these outcomes occur, barring extenuating circumstances, the logic is that:

- AOD consumers receive comprehensive services that more effectively respond to AOD issues/DFV and, as a consequence, have enhanced treatment outcomes
- ACT has a specialist AOD sector that provides crisis and clinical AOD/DFV interventions and support that reflect good practice and better meet community expectations of safety
- The frequency and severity of DFV among people who have used AOD in harmful ways in the ACT is reduced
- The health, wellbeing and safety of people who have used AOD in harmful ways, their families and friends is improved.

It is highly likely that while the Program will be sufficient for intermediate outcomes (such as services applying the DFVCAT and SoP effectively etc.) it will contribute to, rather than be sufficient to cause the ultimate intended outcomes to occur. This is because ultimate outcomes present a 'best case' scenario and do not account for external factors affecting service consumers, organisations and the sector.

These external outcomes may include such things as home factors that outweigh the interventions received by service consumers at AOD services, funding shortages or events occurring in local communities that increase mistrust between service consumers and AOD services. Given the many other factors in addition to the Program, it will be difficult to clearly and consistently show how the Program has an impact on long-term trajectories such as greater health and wellbeing for people in the ACT.

Figure 2. Program logic



2.4 Program theory (Theory of Change)

The theory underlying the Program relates to the need for the intervention and the reason why it is expected to be effective.

In relation to the need for the Program, the core idea is that harmful AOD use is a major risk factor for DFV and that harmful AOD use and DFV often co-occur, and so enabling AOD services to recognise and respond to DFV will produce earlier identification, higher disclosure rates and enhanced interventions. At the same time, the established relationship⁵ between the two issues means that preventing or reducing one will also reduce the severity and frequency of the other. The Program therefore operates under the theory that more holistic, rather than siloed, treatment will produce more effective and longer-lasting outcomes for the individual across a number of sectors.

The theory behind the Program's effectiveness in creating sector change is to co-design the tools, implementation and funding models with the AOD sector, and collaborate further throughout the life of the Program. There are a number of theories or rationales as to why co-design and collaboration will be effective in this Program. The first is that there is a gap in the literature concerning DFV interventions in AOD services. Using co-design will bring in expertise from across the sector to support a somewhat uncharted territory, to support best practice for service consumers and staff and make up for the lack of existing evidence. Documenting and sharing the process through co-design will also allow the Program to contribute to the literature in this area, generating evidence through the process. Finally, as it stands, the AOD sector has an overall narrative that they are willing and able to work together on new approaches to treatment for the good of their service consumers. By leveraging this good will and engaging with the sector throughout development and implementation, it is likely that services and government will have buy-in and ownership for the Program, despite it being in a new policy area for most organisations. Collaboration with the DFV sector should also contribute more effectively towards sector wide change by strengthening the partnerships between the two sectors. In this way, service consumers will be most supported through a communicative and united sector so as to have consistent DFV responses and referral pathways across their AOD treatment.

2.5 What questions will the evaluation answer?

Evaluation questions support reality-testing, which is finding out what is actually going on in a program and its effects. This can then be compared to what was intended and hoped for as stated in the program objectives and related policies. Evaluation questions should describe what you need to find out about how a program is being implemented, its value and impacts. Guiding questions point towards additional information needed to answer the evaluation questions and are useful to identify performance information. Performance tables prescribe

⁵ World Health Organisation. (2006). Interpersonal Violence and Alcohol. WHO Policy Briefing.

the full set of information that **can potentially be collected** to answer the evaluation questions and likely sources of performance information. What is collected then depends somewhat on strategic decisions about allocation of resources based on identified priorities and on the feasibility of collecting these data.

2.5.1 Evaluation questions

ARTD, in collaboration with the ACT *AOD Safer Families Program* Monitoring and Evaluation Working Group and the broader sector, has developed nine key questions which span the logic model (Figure 2) from bottom to top and cover the Program as a whole, the effectiveness of the processes and delivery, and the achievement of immediate, intermediate and ultimate outcomes.

1. How has the *AOD Safer Families Program* contributed to the ACT strategy of reducing the frequency, intensity and severity of DFV in the ACT?
2. Overall, how well are AOD services in the ACT delivering appropriate DFV interventions and how can delivery be improved?
3. Has the *AOD Safer Families Program* achieved its immediate and longer term outcomes?
4. Was the AOD sector effectively involved in co-design and collaboration throughout the Program commencement and implementation?
5. Has the Program changed the way the AOD sector and services perceive and respond to DFV?
6. How well did the implementation and funding models enable organisations to participate effectively in the *AOD Safer Families Program*?
7. Do the Domestic and Family Violence Capability Assessment Tool, Scope of Practice and Practice Guide enable AOD organisations to make the appropriate changes needed to contribute to the Programs overall outcomes?
8. Did AOD service consumers have improved AOD and DFV outcomes as a result of the Program?
9. Have there been any positive or negative indirect consequences as a result of implementing the Program for service consumers, their families and friends, staff, programs, organisations, or the AOD sector?

2.6 Outcomes matrix

The Program's Outcome Matrix details how the outcomes in the program logic will be observed through monitoring and evaluation activities over time. It describes how each output and outcome of strategic importance will be observed through indicators (or proxy measures), and where the data will come from or how it will be collected. It explains how each evaluation question is mapped to different streams including the sector, staff and services and consumers.

Table 1. Outcomes matrix

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Ultimate outcomes			
The health, wellbeing and safety of people who have used AOD in harmful ways, their families and friends is improved.	To what extent has the health, wellbeing and safety of people who have used AOD in harmful ways, their families and friends improved?	<ul style="list-style-type: none"> ▪ Overall health and wellbeing indicators have improved for this subgroup (e.g. mental health, child safety) ▪ Quality of life has improved ▪ Overall safety indicators have improved for this subgroup ▪ Reduction in deaths from DFV for this subgroup 	<ul style="list-style-type: none"> ▪ Surveys, service consumer assessment data (e.g. quality of life measures), custom extractions from existing population data ▪ Surveys, service consumer assessment data, custom extractions from existing population data ▪ Surveys, service consumer assessment data, custom extractions from existing population data ▪ Coroners reports
The frequency and severity of DFV among people who have used AOD in harmful ways, in the ACT is reduced.	To what extent has the frequency and severity of DFV among people who have used AOD in harmful ways, in the ACT reduced?	<ul style="list-style-type: none"> ▪ Reduced incidence of DFV in this sub-population ▪ Reduced police responses for this sub-population ▪ Reduced DFV-related deaths in this sub-population 	<ul style="list-style-type: none"> ▪ Surveys, service consumer assessment data, custom extractions from existing population data ▪ Surveys, service consumer assessment data, custom extractions from existing population data ▪ Surveys, service consumer assessment data, custom extractions from existing population data

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
<p>ACT has a specialist AOD sector that provides crisis and clinical AOD/DFV interventions and support that reflect good practice and better meet community expectations of safety.</p>	<p>To what extent have the program/ tools/ responses/ intervention become sustainable? I.e. part of routine care.</p>	<ul style="list-style-type: none"> ▪ Tools are still consistently used by the end of the Program period ▪ Tools are considered part of common practice ▪ New AOD service employees are trained in use of the tools ▪ Tools and approach reflect current evidence at the end of the Program period 	<ul style="list-style-type: none"> ▪ Surveys, document review, interviews, focus groups ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups, document review ▪ DFVCAT review, document review, interviews
<p>AOD service consumers receive comprehensive services that more effectively respond to AOD/DFV and, as a consequence, have enhanced treatment outcomes.</p>	<p>To what extent are AOD outcomes (e.g. severity of dependence) improved for service consumers who receive a concurrent DFV intervention?</p>	<ul style="list-style-type: none"> ▪ Reduced level of substance use ▪ Reduced exposure to AOD-related harms ▪ Improved health and wellbeing 	<ul style="list-style-type: none"> ▪ Service consumer assessment data, Surveys, interviews ▪ Service consumer assessment data, Surveys, interviews ▪ Service consumer assessment data, Surveys, interviews
	<p>To what degree has a pro-safety environment/ culture been developed?</p>	<ul style="list-style-type: none"> ▪ Service provider attitudes to responding to DFV in an AOD setting 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups, document review of casefiles (to show service provider responses)
	<p>To what extent does the sector as a whole show improvement in its response to DFV?</p>	<ul style="list-style-type: none"> ▪ Increased policy responses to DFV in AOD settings ▪ Service provider attitudes to responding to DFV in an AOD setting ▪ Public perception of AOD/DFV crossover is positive 	<ul style="list-style-type: none"> ▪ Document review ▪ Surveys, interviews, focus groups, document review of casefiles (to show service provider responses) ▪ Document review of media descriptions, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Sector stream			
AOD sector develop a shared understanding of DFV in AOD context, is engaged in building capacity to improve AOD/DFV practice.	To what extent has the AOD sector developed a shared understanding of DFV in AOD context, and engaged in building capacity to improve AOD/DFV practice?	<ul style="list-style-type: none"> ▪ Common DFV terms used across sector ▪ Common views on AOD service responsibility to respond to DFV ▪ Increased sector wide activities related to DFV ▪ Attendance at AOD/DFV sector activities including networking events, training, seminars ▪ Increased role of sector peak in raising the profile of DFV ▪ Sector is responsive to initiatives in the AOD/DFV area 	<ul style="list-style-type: none"> ▪ Document review, administrative data ▪ Interviews, focus groups, survey ▪ Document/ online review ▪ Admin data ▪ Document review of events ▪ Surveys, admin data (attendance)
	Which parts of the sector became and stayed engaged?	<ul style="list-style-type: none"> ▪ Type of services involved in training/seminars/other sector wide activity ▪ Type of services giving feedback and communication to peak, funders, governance body etc. 	<ul style="list-style-type: none"> ▪ Admin data, document review, interviews, focus groups ▪ Document review, interviews
	To what extent has collaboration over time led to collective capacity building (Collective impact)?	<ul style="list-style-type: none"> ▪ AOD services report shared vision for the Program and sector ▪ AOD services are engaging in mutually reinforcing activities ▪ AOD services are involved in collective decision making ▪ Services within sector working together to build DFV capacity 	<ul style="list-style-type: none"> ▪ Focus groups, interviews, surveys ▪ Document review, interviews, focus groups ▪ Document review, interviews, focus groups ▪ Document review, interviews, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	<p>To what extent has the sectors capacity changed to respond to DFV? And to violence more generally?</p>	<ul style="list-style-type: none"> ▪ Common views on AOD service responsibility to respond to DFV ▪ Sector wide knowledge of referral pathways ▪ Sector wide knowledge of current best practice in DFV responses ▪ Sector wide knowledge of current best practice in violence responses 	<ul style="list-style-type: none"> ▪ Focus groups, interviews, surveys ▪ Surveys ▪ Surveys ▪ Surveys
<p>Co-design approach flows through to collaborative Program implementation.</p>	<p>To what extent was the Program collaboratively implemented?</p> <ul style="list-style-type: none"> ▪ With who? ▪ To do what? ▪ Were they the right people? 	<ul style="list-style-type: none"> ▪ High number of services and organisations involved ▪ Interests of whole sector represented during collaboration activities ▪ Effective and regular communication between peak, funders, governance body and services ▪ Communication strategy established ▪ Networks established ▪ Sector’s view on their involvement in collaboration ▪ Shared vision for sector in future ▪ Mutual/peer/colleague support across services ▪ Shared evaluation and data plan ▪ Pooled activities ▪ Operated as a collective with a backbone/ coordinating organisation 	<ul style="list-style-type: none"> ▪ Admin data, document review ▪ Admin data, document review, surveys ▪ Document review, surveys ▪ Document review ▪ Document review, interviews ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys ▪ Document review ▪ Document review, interviews ▪ Document review, interviews, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Stakeholders are effectively engaged in Program co-design.	Did the funding model facilitate or impede this?	<ul style="list-style-type: none"> ▪ Services' attitude towards funding model and outcomes ▪ Peak and policy makers perspective on effectiveness of funding model 	<ul style="list-style-type: none"> ▪ Interviews, focus group, surveys ▪ Interviews, focus groups
	How was this reflected in Program governance?	<ul style="list-style-type: none"> ▪ Program governance explicitly requires collaborative approach to Program implementation ▪ Governance structures reflect collaborative approach 	<ul style="list-style-type: none"> ▪ Document review, Interviews, focus groups ▪ Document review, Interviews, focus groups
	To what extent were stakeholders effectively engaged in Program co-design?	<ul style="list-style-type: none"> ▪ Services and stakeholders in attendance at peak events and meetings ▪ Stakeholder feedback received from events and meetings ▪ Stakeholder feedback incorporated as relevant on tools 	<ul style="list-style-type: none"> ▪ Document review, Interviews, focus groups ▪ Document review ▪ Document review, Interviews, focus groups
	How important was taking an inclusive, collaborative and collective approach to the design, implementation and evaluation of the Program?	<ul style="list-style-type: none"> ▪ Stakeholder feedback received on approach to the design, implementation and evaluation components 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups
	To what extent were the right people involved in the Program co-design?	<ul style="list-style-type: none"> ▪ Type of services involved in co-design ▪ Type of services most affected by the Program 	<ul style="list-style-type: none"> ▪ Document review, Interviews, focus groups ▪ Surveys, admin data, interviews

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
<p>Appropriate and effective Program governance is developed, maintained and adapted as required.</p>	<p>To what extent was appropriate and effective governance developed, maintained and adapted?</p>	<ul style="list-style-type: none"> ▪ Governance structure established ▪ Regular meetings of governance structure ▪ Governance structure satisfaction with governance processes ▪ Governance structure membership reflects Program stakeholder groups ▪ Clear internal and external communication about governance ▪ Governance change over the course of the Program to reflect Program changes ▪ Governance requirements facilitate smooth oversight of the Program 	<ul style="list-style-type: none"> ▪ Document review ▪ Document review ▪ Interviews, focus groups ▪ Document review ▪ Document review, Interviews, focus groups ▪ Document review, Interviews, focus groups ▪ Interviews, focus groups, surveys
	<p>What aspects of the Program governance worked well, what improvements can be made?</p>	<ul style="list-style-type: none"> ▪ Committee feedback ▪ Services feedback ▪ Other stakeholder feedback 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Staff and services stream			
<p>AOD services deliver and improve DFV interventions appropriate to the Domestic and Family Violence Capability Assessment Tool (DFVCAT), Scope of Practice (SoP) and Practice Guide (PG).</p> <ul style="list-style-type: none"> ▪ Services have in place a universal crisis response to DFV ▪ Where appropriate, services have a 'stepped up' or integrated response to DFV ▪ DFV responses are a routine part of AOD services 	<p>To what extent do AOD services deliver and improve DFV interventions appropriate to DFVCAT, Scope of Practice (SoP) and Practice Guide (PG)?</p>	<ul style="list-style-type: none"> ▪ AOD services offer DFV interventions to service consumers ▪ Services offer DFV interventions consistent to their service type ▪ Clinical tools for DFV included in treatment plans 	<ul style="list-style-type: none"> ▪ Document review, DFVCAT ▪ DFVCAT and SOP mapping ▪ Document review, DFVCAT
	<p>To what extent have staff and services knowledge, skills, confidence across multiple areas improved to respond to DFV as part of AOD treatment?</p>	<ul style="list-style-type: none"> ▪ Staff and service skill level ▪ Staff and service knowledge level ▪ Staff and service assessment of confidence to respond ▪ High likelihood of staff to respond appropriately to instances of DFV 	<ul style="list-style-type: none"> ▪ Surveys, document review ▪ Surveys, document review ▪ Surveys, document review ▪ Surveys, interviews, focus groups
	<p>To what extent has Scope of Practice (SoP) been applied/ matched to interventions/ service types/ settings?</p>	<ul style="list-style-type: none"> ▪ Interventions are appropriate to service types and settings 	<ul style="list-style-type: none"> ▪ Document review
	<p>To what extent has the AOD sector attained a minimum standard/ universal approach, systematic and documented and routine across the sector?</p>	<ul style="list-style-type: none"> ▪ All services have identify and respond crisis approaches ▪ Services have common responses, data collection terminology, policies and referral pathways 	<ul style="list-style-type: none"> ▪ Document review, DFVCAT ▪ Document review
	<p>To what extent can all services within the Program demonstrate adherence to a minimum universal response?</p>	<ul style="list-style-type: none"> ▪ All services have identify and respond crisis approaches 	<ul style="list-style-type: none"> ▪ Document review, DFVCAT

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	To what extent can all services within the Program demonstrate improvements from benchmark within DFVCAT based on their assessment of what they want?	<ul style="list-style-type: none"> Comparison of original benchmark level and service level at the end of the Program 	<ul style="list-style-type: none"> Document review, DFVCAT
	To what extent do staff deliver practice consistent with Practice Guide DFVCAT?	<ul style="list-style-type: none"> Staff practice is consistent with Practice Guide and Domestic and Family Violence Capability Assessment Tool (DFVCAT) 	<ul style="list-style-type: none"> Document review, interviews, focus groups
	How many and which types of organisations have changed their level?	<ul style="list-style-type: none"> Number and type of organisation that have changed their level 	<ul style="list-style-type: none"> DFVCAT, document review, interviews, focus groups
	Which organisations have stayed at the same level, but improved their DFV service delivery within that level?	<ul style="list-style-type: none"> Quality improvement by services within level. 	<ul style="list-style-type: none"> DFVCAT, document review, interviews, focus groups
	Services identify and adopt evidence based practice relevant to the service type.	To what extent do Services identify and adopt evidence based practice relevant to their service type?	<ul style="list-style-type: none"> Service characteristics match chosen evidence based practice (from the Practice Guide)
Services and staff apply the Domestic and Family Violence Capability Assessment Tool (DFVCAT) and Scope of Practice (SoP) effectively	To what extent have the tools (Practice Guide, DFVCAT, Scope of Practice) been taken up by services?	<ul style="list-style-type: none"> Number of services using the tools at different time points of the Program Appropriateness of tools to services' needs and capacity Services plan to incorporate tools into standard procedures 	<ul style="list-style-type: none"> Admin data, document review Interviews, focus groups, surveys Interviews, focus groups, surveys
	Are they seen as credible and feasible by the services?	<ul style="list-style-type: none"> Service view of tools 	<ul style="list-style-type: none"> Interviews, focus groups, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
All services are adequately funded and resourced to build capacity and deliver appropriate DFV/AOD interventions in line with DFVCAT, Scope of Practice (SoP) and Practice Guide (PG).	Have they been used by services to do systematic planning?	<ul style="list-style-type: none"> ▪ Role of tools in service planning 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys, document review
	Have they been applied effectively?	<ul style="list-style-type: none"> ▪ All components of DFVCAT and SoP completed ▪ Consistency of responses in DFVCAT and SoP ▪ Components of DFVCAT and SoP understood 	<ul style="list-style-type: none"> ▪ Audit and review of DFVCAT/SoP implementation paperwork ▪ Audit and review of DFVCAT/SoP implementation paperwork ▪ Document review (DFVCAT and SoP), interviews, focus groups with staff
	What did staff feel were the enabling factors (most important elements) of the program?	<ul style="list-style-type: none"> ▪ Staff view of enabling factors 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys
	Were there sufficient resources for the sector and agencies to implement the Program?	<ul style="list-style-type: none"> ▪ Services report adequate resources to implement their project plan ▪ Resources are not cited as a barrier to Program participation ▪ Funding available for duration of the Program 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups ▪ Document review
	To what extent do aspects of the Program need ongoing resources to enable sustainability? I.e. routine care, training?	<ul style="list-style-type: none"> ▪ Implementation plan cites needs for ongoing resources 	<ul style="list-style-type: none"> ▪ Document review

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	To what extent were resources allocated effectively?	<ul style="list-style-type: none"> ▪ Resources are allocated to AOD services with capacity and motivation to implement the Program ▪ Resources are allocated to an extent that allows participation by the maximum number of services in the AOD sector ▪ Resources are allocated to both capacity building (service enhancement) and innovation (integrated pilot programs) 	<ul style="list-style-type: none"> ▪ Document review, interviews ▪ Document review, interviews ▪ Document review
	What additional resourcing would be needed to implement the Program in the next phase?		<ul style="list-style-type: none"> ▪ Evaluation recommendations ▪ Services demonstrating their capacity to use more funding
	What trade-offs had to be made in allocating resources? What were the impacts of these trade-offs, and on who?	<ul style="list-style-type: none"> ▪ Decisions made around funding allocation ▪ Services reported impacts on service delivery and Program implementation ▪ Areas of the sector and their service consumers who waited longer to receive funding for implementation 	<ul style="list-style-type: none"> ▪ Document review, interviews ▪ Interviews, surveys, focus groups ▪ Document review
	What is the funding model chosen by ACT health?	<ul style="list-style-type: none"> ▪ Funding model chosen 	<ul style="list-style-type: none"> ▪ Document review

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Services use the Domestic and Family Violence Capability Assessment Tool (DFV CAT), Scope of Practice (SoP) and Practice Guide (PG) to determine the resources needed to deliver appropriate DFV/AOD interventions.	To what extent services use the DFV CAT, Scope or Practice and Practice Guide to determine resources needed to deliver appropriate DFV/AOD interventions?	<ul style="list-style-type: none"> ▪ Role of tools in decision making around resources 	<ul style="list-style-type: none"> ▪ Document review, interviews
Services identify the Program as a strategic priority and commit to it.	To what extent did services identify the Program as a strategic priority and commit to it?	<ul style="list-style-type: none"> ▪ Service leadership express interest in being involved in Program implementation ▪ Services allocate own resources to being involved in the Program ▪ Service leadership communicate the priority of the Program to all staff ▪ Services develop plans around their participation in the Program 	<ul style="list-style-type: none"> ▪ Document review, interviews ▪ Document review, interviews ▪ Document review, interviews ▪ Document review
Services receive adequate communication and support to understand the Program and how to implement Domestic and Family Violence Capability Assessment Tool (DFV CAT), Scope of Practice (SoP) and Practice Guide (PG).	To what extent was the communication received by services adequate to understand the Program?	<ul style="list-style-type: none"> ▪ Comprehensive stakeholder communication and engagement strategy developed and implemented ▪ Stakeholder satisfaction with level, type and content of communication ▪ Stakeholder understanding of the Program 	<ul style="list-style-type: none"> ▪ Document review ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups
	To what extent was the communication received by services timely to understand and engage with the Program and tools?	<ul style="list-style-type: none"> ▪ Services receive communication with enough time to engage 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	To what extent was the support provided sufficient for services to understand implementing the tools?	<ul style="list-style-type: none"> ▪ Services have sufficient understanding of how to implement the tools ▪ Services are satisfied with the type of support provided 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups
Service consumer stream			
Service consumers experience improved DFV outcomes.	To what extent do service consumers experience improved DFV outcomes? <ul style="list-style-type: none"> ▪ What outcomes? ▪ For whom? ▪ In what contexts and settings? 	<ul style="list-style-type: none"> ▪ Reduced frequency and severity of DFV ▪ Reduced AOD use and harms ▪ Reduced DFV behaviours ▪ Better engagement with services ▪ Improved readiness to change ▪ Improved relationships ▪ Service consumers stay longer in treatment 	<ul style="list-style-type: none"> ▪ Population data, admin data ▪ Population data, admin data ▪ Population data, admin data ▪ Admin data, interviews, focus groups ▪ Admin data, interviews, focus groups ▪ Case file review, interviews, focus groups ▪ Admin data
	To what extent have there been any adverse impacts of the Program on service consumers? How were they resolved?	<ul style="list-style-type: none"> ▪ Service consumer feedback ▪ Staff feedback ▪ Service feedback 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups ▪ Surveys, interviews, focus groups

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
<p>Service consumers receive DFV interventions (e.g. screening) appropriate to their needs and their AOD service.</p>	<p>To what extent do Service consumers receive DFV interventions appropriate to their needs and their AOD service?</p>	<ul style="list-style-type: none"> ▪ Service consumers receive DFV informed crisis responses, including safety planning where appropriate ▪ Service consumers are screened and assessed where appropriate ▪ Service consumers are treatment matched where appropriate ▪ Service consumer treatment plans have DFV responses where appropriate 	<ul style="list-style-type: none"> ▪ Document review, DFVCAT, assessment and admin data ▪ Document review, DFVCAT, assessment and admin data ▪ Document review, DFVCAT ▪ Document review
	<p>How many service consumers were exposed to a DFV response and of what intensity and purpose?</p>	<ul style="list-style-type: none"> ▪ Number of service consumers exposed to DFV response ▪ Service/staff reasoning behind DFV response 	<ul style="list-style-type: none"> ▪ Document review, admin data ▪ Document review, interviews, focus groups
<p>Service consumers accept DFV interventions as part of AOD services.</p>	<p>To what extent do Service consumers accept DFV interventions as part of AOD services?</p>	<ul style="list-style-type: none"> ▪ Service consumers have positive or neutral responses to DFV interventions ▪ Service consumer retention stays the same or improves after Program implementation 	<ul style="list-style-type: none"> ▪ Document review, interviews (staff and service consumers) ▪ Admin data
	<p>To what extent are service consumers satisfied with services implementing DV responses?</p>	<ul style="list-style-type: none"> ▪ Positive or neutral service consumer feedback 	<ul style="list-style-type: none"> ▪ Interviews (staff and service consumers), surveys
<p>Services provide service consumers with the opportunity to disclose DFV</p>	<p>To what extent do services provide service consumers with the opportunity to disclose DFV?</p>	<ul style="list-style-type: none"> ▪ Staff often provide service consumers with opportunity to disclose where appropriate 	<ul style="list-style-type: none"> ▪ Document review, interviews, focus groups, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Service consumers continue to use AOD services and feel safe doing so.	To what extent do service consumers continue to use AOD service and feel safe in doing so?	<ul style="list-style-type: none"> ▪ Service consumer numbers remain stable after Program implementation ▪ Service consumers report feeling safe in services and with staff 	<ul style="list-style-type: none"> ▪ Admin data (ACT MDS) ▪ Surveys, interviews, focus groups
	To what extent and how did the Program facilitate or impede the engagement of service users in treatment? E.g. safe environment	<ul style="list-style-type: none"> ▪ Service consumer feedback on level of safety in services 	<ul style="list-style-type: none"> ▪ Surveys, interviews, focus groups, SUSOS, DFVCAT

Program design and resources			
Suitable resources and Program infrastructure developed. <ul style="list-style-type: none"> ▪ Implementation and Funding model ▪ M&E framework 	To what extent were the required tools developed in the required timeframes?	<ul style="list-style-type: none"> ▪ All 5 elements developed and documented, disseminated ▪ Document development met the planned timing/ schedule 	<ul style="list-style-type: none"> ▪ Document review ▪ Document review
	To what extent were the tools fit for purpose?	<ul style="list-style-type: none"> ▪ Services give positive feedback during and after co-design process 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, document review

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
Suitable Domestic and Family Violence Capability Assessment Tool (DFVCAT) designed; Suitable Scope of Practice (SoP) resource developed.	To what extent was the DFVCAT designed and suitable?	<ul style="list-style-type: none"> ▪ Diverse expert and clinical stakeholders involved in design ▪ Diverse expertise consulted with in design process ▪ Participating services share satisfied feedback ▪ Participating services view DFVCAT as fit for purpose 	<ul style="list-style-type: none"> ▪ Document review ▪ Document review, interviews ▪ Document review, interviews, focus groups ▪ Document review, interviews, surveys
	To what extent was the Scope of Practice resource developed and suitable?	<ul style="list-style-type: none"> ▪ Diverse expert and clinical stakeholders involved in design ▪ Diverse expertise consulted with in design process ▪ Participating services share satisfied feedback ▪ Participating services view SOP as fit for purpose 	<ul style="list-style-type: none"> ▪ Document review ▪ Document review, interviews ▪ Document review, interviews, focus groups ▪ Document review, interviews, surveys
Suitable Practice Guide developed.	To what extent was the Practice Guide developed and suitable?	<ul style="list-style-type: none"> ▪ Diverse expert and clinical stakeholders involved in design ▪ Diverse expertise consulted with in design process ▪ Participating services share satisfied feedback ▪ Participating services view EBPF as fit for purpose 	<ul style="list-style-type: none"> ▪ Document review ▪ Document review, interviews ▪ Document review, interviews, focus groups ▪ Document review, interviews, surveys
Clinical and expert input occurs and functions effectively.	To what extent was mobilizing clinical and other experts into the design and tool development effective?	<ul style="list-style-type: none"> ▪ Engagement of clinical and other experts lead to fit for purpose tool ▪ Engagement of clinical and other experts allowed greater trust and engagement from stakeholders 	<ul style="list-style-type: none"> ▪ Document review, interviews ▪ Interviews, focus groups, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	Were appropriate experts and clinicians identified? Were they cross-sectoral (AOD and DFV)	<ul style="list-style-type: none"> ▪ Fields and experience of experts and clinicians 	<ul style="list-style-type: none"> ▪ Document review
	What was the role of clinical and expert input? Did the clinical and expert input enhance the Program?	<ul style="list-style-type: none"> ▪ Clinical input into tools ▪ Stakeholder feedback on receiving clinical input 	<ul style="list-style-type: none"> ▪ Document review, interviews ▪ Interviews, focus groups, surveys

Overall evaluation questions			
	What have we learnt from undertaking an innovative Program in a space of unknowns? <ul style="list-style-type: none"> ▪ Process ▪ Deliverables ▪ Enabling factors ▪ Barriers ▪ What would staff change in the program? 	<ul style="list-style-type: none"> ▪ Steering committee reflections ▪ Stakeholder reflections ▪ Staff reflections 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
	<p>To what extent has the Program fit within the established AOD practice? And complemented services in related sectors (particularly DFV)?</p> <ul style="list-style-type: none"> ▪ How well did the resourcing enable/ impede this? ▪ To what extent does the sector engage effectively with other systems re DFV? 	<ul style="list-style-type: none"> ▪ Staff and service feedback ▪ Feedback from DFV sector ▪ Feedback from other relevant sectors (e.g. homelessness, mental health) 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys ▪ Interviews, focus groups, surveys
	<p>To what extent can we clarify and communicate our responses to violence?</p>	<ul style="list-style-type: none"> ▪ Improvement in communication from AOD services about DFV 	<ul style="list-style-type: none"> ▪ Document review, interviews, focus groups
	<p>What unexpected or unintended consequences were encountered and how were they handled?</p> <ul style="list-style-type: none"> ▪ Were there any collective impacts above and beyond service developments? 	<ul style="list-style-type: none"> ▪ Feedback from peak, sector and services 	<ul style="list-style-type: none"> ▪ Interviews, focus groups, surveys
	<p>What opportunities are there to extend this work?</p>	<ul style="list-style-type: none"> ▪ Evaluation ▪ Steering committee and stakeholder views 	<ul style="list-style-type: none"> ▪ Document review (evaluation) ▪ Interviews, focus groups, surveys
	<p>How worthwhile is the Program overall?</p>	<ul style="list-style-type: none"> ▪ Evaluation 	
Assumptions			

Outcome	Evaluation question	Performance information	Proposed data collection methods/sources
<ul style="list-style-type: none"> ▪ Service delivery is not adversely impacted by participating in the Program. ▪ Identified funds are available for the duration of the Program. ▪ Current infrastructure of the AOD sector is maintained (funding, staffing, etc.) ▪ Improving responses to DFV improves AOD outcomes. 	<p>To what extent were assumptions about the Program correct?</p>	<ul style="list-style-type: none"> ▪ Core AOD interventions continue as they did prior to the Program at the same quality ▪ Funding continues throughout duration of the Program ▪ AOD sector in ACT remains similar and stable ▪ Research literature continues to show that responding to DFV improves AOD outcomes 	<ul style="list-style-type: none"> ▪ Document review, admin data, surveys ▪ Document review ▪ Document review, interviews ▪ Document review

3. Guiding the evaluation

This chapter provides more detailed guidance on how to design and implement an evaluation.

3.1 Key considerations in planning an evaluation

As a systematic inquiry, evaluation needs careful planning. Each evaluation is designed by taking into account the evaluation purpose, questions and broader context including the significance of the program, the size of investment, and the risks and sensitivities. An evaluation design also takes account of the need for decisions—when and by whom—the stage and maturity of program implementation; the readiness of the program for evaluation including the extent and quality of monitoring data.

3.1.1 Decide on the purpose of the evaluation

Being explicit about the reasons for evaluating the program helps decide what resources are needed and what data to collect and when. What is the evaluation trying to achieve?

- Examine how much is being done and how well (quality).
- Improve the Program.
- Find out whether the Program is benefiting individuals and/or organisations and what the benefits are (outcomes).

3.1.2 Decide on the focus of the evaluation

The next step is program logic analysis using the logic in the framework, to identify the right level and detail for the evaluation. In this way, the program logic helps to frame the evaluation, and provide the basis of the data collection and the focus of evaluative argument around the outcomes achieved.

Be realistic. If the program is being implemented for the first time it may be good idea to focus on the lower level outcomes in the framework, using process evaluation to answer questions about access, participant engagement and satisfaction. In general, a reliable outcomes evaluation requires a reasonable investment and is best taken at a more mature stage of program implementation, once it is clear that a program is reaching its intended participants and appears to be meeting their needs.

3.1.3 Decide on the evaluation questions

The evaluation questions in the framework are aligned to the framework outcomes. In designing the evaluation it is best to draw on these as key questions. The guiding questions

also point towards what else might need to be understood about how the program is working and to answer an evaluation question. Often guiding questions help tease out in more detail what a successful outcome looks like.

A small set of clear, well targeted questions is highly preferable over a lengthy list of questions that cannot all be adequately addressed. The 'shopping list approach' is often tempting as there is often so much we want to know about our programs, but this approach will often mean a lack of clear focus and direction in the evaluation.

3.1.4 Evaluation design

There are different levels of evidence involved in evaluation design, and some will bring greater confidence to external stakeholders than others. There are three main types of outcomes design: experimental, quasi-experimental and non-experimental.

Experimental and quasi-experimental design

Experimental and quasi-experimental designs provide the strongest form of evidence but require some form of 'control group' i.e. a group of non-participants whose outcomes are also measured. In experimental designs, people are randomly assigned to either an 'intervention' or 'control' group and in quasi-experimental designs—often more feasible in a human services context—a comparison group is identified through non-random processes, for example identifying people with similar characteristics who are not participants.

These designs require careful planning and a sound statistical basis to enable stakeholders to draw conclusions about whether any observed changes are results of the program. They may also require ethical approval and technical support.

Non-experimental design

Outcomes evaluation based on non-experimental design is often more feasible for small scale programs and where evaluation resources are limited. These descriptive studies can still collect evidence about outcomes, but without the use of control it is not possible to make strong statements about attribution or causality.

3.1.5 Contribution analysis

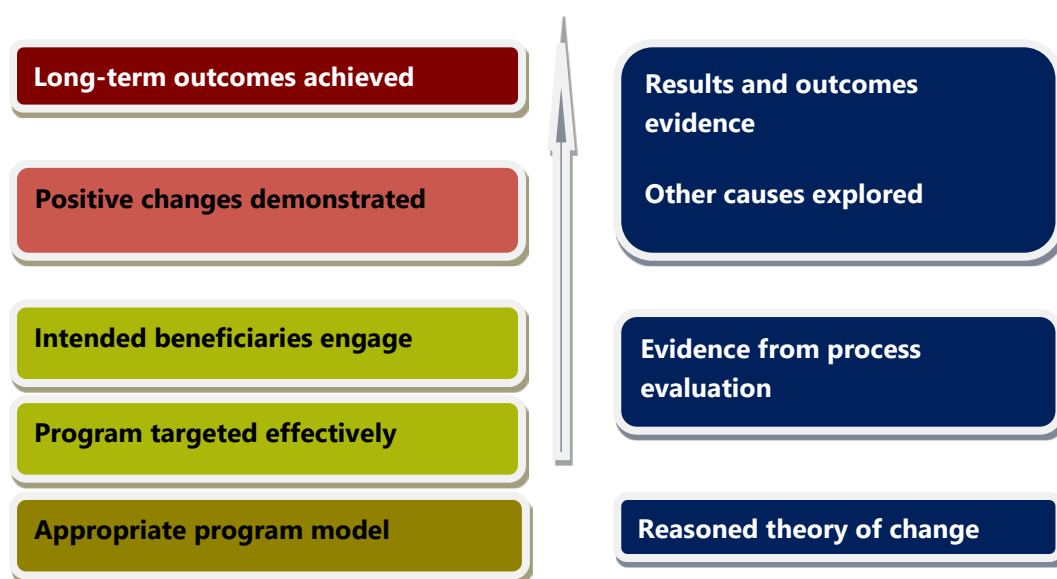
Contribution analysis offers a practical approach to help determine whether a given intervention has contributed to an observed result. Causality is inferred from a four-step logic and evidence.⁶

⁶ Mayne, J. 2012, *Contribution analysis: Coming of Age?* <http://evi.sagepub.com/content/18/3/270>

1. The intervention is based on a reasoned theory of change: the chain of results and the assumptions behind why the intervention is expected to work are plausible, sound, informed by existing research and supported by key stakeholders.
2. Activities of the intervention are implemented as outlined in the theory of change.
3. The theory of change is verified by evidence: the chain of expected results occurred and the assumptions held.
4. External factors and rival explanations are assessed and their contribution recognised.

Figure 3 maps how program logic maps against the contribution analysis approach.

Figure 3. Program logic mapped to contribution analysis logic



3.2 Data collection methods

Each evaluation is designed using a mix of data collection methods selected according to the scale, type and purpose of the evaluation. The methods used to collect data vary much depend on the overall design, most importantly whether it is a process or outcomes evaluation, but also considering practical issues including timeframe and budget.

Generally using a combination of methods and approaches is best—called a mixed method design—but using the whole suite of methods is not necessary. Rather the evaluation should be designed to use the method that will best answer the evaluation questions within the resources available.

Surveys are one of the most common methods used in evaluation—satisfaction and outcomes surveys provide a good starting-point. Interviews and focus groups are two of the other most commonly used methods within evaluation as they are often the most practical and efficient options. As computerised records and minimum datasets have become more common, service data in the form of service consumer registrations, assessments and casefiles have become an increasingly important part of mixed method approaches.

An overview of methods and when they are best used is described below (see Table 2).

Table 2. Commonly used methods in evaluation⁷

Method	Strengths	Weaknesses	Considerations
Survey	Can generate a large amount of quantitative and qualitative data.	Does not allow for interaction or probing of responses. Surveys are becoming ubiquitous and may not be sufficiently salient to obtain sufficient response rates to be useful. Self-reported changes.	Must be developed and tested to ensure questions are comprehensive and unambiguous and sample is representative of the population of interest.
Focus groups	Allow for exploration of key issues that are relatively complex or not top-of-mind for respondents.	Difficult to analyse individual responses and not suited to quantitative analysis.	Requires a skilled facilitator and the ability to bring participants together.
Interviews	Good for gathering in-depth information from respondents who understand an issue. Can include both quantitative and qualitative data.	May not draw out new ideas or be feasible to conduct enough for a representative sample.	Can be conducted face-to-face or on the phone.
Case studies	Can effectively illustrate an issue, promote a practice, or explain a complex phenomenon in a specific context.	Cases may not be representative even if the findings may be useful in a range of contexts.	Often used as part of a broader evaluation.
Media analysis	Provides insight into media coverage of politically sensitive issues.	May reflect media rather than key stakeholder views on an issue.	News media is relatively easy and cheap to obtain.

⁷ Sources: ARTD Report for Work Health and Safety Division, WorkCover NSW. *Contemporary approaches and methods for cost effective evaluation*. 13 February 2015. Scriven, Michael (1991). *Evaluation Thesaurus*. 4th Edition. Sage Publications.

Method	Strengths	Weaknesses	Considerations
Administrative data	Describing the demographic profile of participants, and the intensity and duration of the service they received	Data quality can be very variable. Data may not be kept up to date.	Different organisations may use different systems, methods or items.
Service consumer assessments	Describing service consumer situations and capabilities at baseline and change at regular intervals, or on exit	Assessments may not be conducted for all service consumers at all times, creating discontinuous data for some people.	Different organisations may use different tools or timing, making the data hard to aggregate. See the SCORE method in chapter 4.
Longitudinal studies	Individuals are followed over time to see whether changes are due to a specific intervention.	Can but generally do not consider the counter-factual, i.e. do not follow a control group.	Require baseline data to be collected before Program is implemented.
Experimental/ Quasi-experimental designs	Involve a comparison group. Measure impact comparing treatment and control groups.	Subjects self-select into groups, which can introduce bias.	Requires checking intervention and control groups are equivalent, prior to an intervention.

3.3 Economic evaluation

Economic evaluation is used primarily for the purpose of making decisions about the allocation of funds for a program. It is often conducted to justify new or continued expenditure on a program, but may be most reliable when used to make decisions about the relative merits of different programs, and where the same assumptions and proxy measures are used in different analyses. Economic analysis methods answer questions about the value of a program—in particular ‘was it worth it?’ or ‘should we fund this again?’

Economic evaluation may require specialist input to be done successfully. In practice, economic evaluations are rarely as accurate or precise as they may appear as they are based on numerous assumptions that are difficult to test. A rigorous economic analysis relies on a rigorous outcomes design.

Cost benefit analysis is the most comprehensive approach to economic analysis. It places a monetary value on all the benefits of a program and compares these to the total program costs.

Cost effectiveness analysis is more useful when the benefits of a program cannot be easily quantified in monetary terms. It compares the relative cost of programs and their intended or actual outcomes.

In applying cost effectiveness analysis it is most important to understand both the similarities and differences in the programs being compared, so an overall assessment of program value can be made. This includes factors cost per participant, the duration and intensity of each program, its delivery setting and target group. Cost effectiveness analysis also summarises the outcomes of each program, as well as the quality of the evidence regarding these outcomes. These are all important dimensions to consider in reaching conclusions about the relative value of any particular program.

3.4 Evaluation and ethics

It is important that the Program evaluation governance group, including those commissioning evaluation studies and any evaluation contractors, consider the ethics of collecting and storing evaluation data and be guided about ways to solve ethical dilemmas that may arise during the evaluation. Evaluation planning should also consider how consent will be obtained.

The implementation and commissioning of all evaluation activities should be guided by the Australasian Evaluation Society (AES) Guidelines for the Ethical Conduct of Evaluations, the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research and the NHMRC Ethical Considerations in Quality Assurance and Evaluation Activities (2014). Where participants may be vulnerable, an external ethical review may be required and should be considered.

Triggers for ethical review

The NHMRC Ethical Considerations in Quality Assurance and Evaluation Activities (2014) provides advice about triggers for ethical review. These are:

- where the activity potentially infringes the privacy or professional reputation of participants, providers or organisations
- secondary use of data – using data or analysis from QA or evaluation activities for another purpose
- gathering information about the participant beyond that which is collected routinely. Information may include bio specimens or additional investigations
- testing of non-standard (innovative) protocols or equipment
- comparison of cohorts
- randomisation or the use of control groups or placebos
- targeted analysis of data involving minority or vulnerable groups, whose data is to be separated out of that data collected or analysed, as part of the main quality assurance or evaluation activity.

3.5 Evaluation plan

A work plan to implement a program evaluation is a key step for putting the evaluation design into practice. Like any project plan, a work plan sets out the tasks, responsibilities, reporting requirements, team, governance, resources, risk management and timing for the evaluation. The details and scope will differ from evaluation to evaluation, but the following sections provide a good general guide for a plan:

- Context: description of policy context and program (target group, service model, intended outcomes)
- The evaluation: purpose, scope, timeframe
- Methods: purpose, scope
- Work plan: stages, resources, delivery schedule
- Project management: project governance, roles and responsibilities, communications, ethical considerations, risk management, quality measures

3.6 Evaluation governance

Strong and effective governance and management structures for evaluation initiatives are important to ensure that appropriate evaluation studies are conducted and that stakeholders are effectively engaged in the evaluation as needed. Governance structures also provide a mechanism to inform program improvement and policy decisions. It is important to have governance structures in place that facilitate decision-making and allow advice to be sourced when partners are involved in the initiative, and when an external team is conducting the evaluation.

Role and functions of evaluation steering committees

A steering committee is appropriate when a new program of work is planned and where this work involves multiple sectors and stakeholders; and where decisions about program improvement and policy are expected to be influenced directly by the findings of the evaluation. Their role in regards to evaluation governance could encompass:

- Supporting the implementation across organisations
- Making decisions about which parts of initiatives should be evaluated
- Making decisions about funding amounts and mix for evaluation studies
- Making decisions about the procurement of external evaluation services
- Approving detailed evaluation plans
- Accepting evaluation reports
- Identifying key policy and program implications
- Supporting the dissemination of findings to key decision makers, operational officers.

Role and functions of evaluation advisory or working groups

Evaluation advisory groups are time limited and formed to provide specific advice for an evaluation study. Having an evaluation advisory or working group is important where there are multiple agencies and stakeholders involved and when sector specific advice will be needed to refine data collection methods and engage stakeholders in the evaluation. Advisory groups are also useful in these circumstances because they are able to provide in-depth knowledge about the program or policy being implemented. The usual roles and functions of evaluation advisory groups encompass providing advice about:

- Planning and implementing specific evaluation activities

- How, and by whom, issues impacting on the implementation of the evaluation should be raised, escalated and resolved
- Where or from whom to get sector specific advice where the expertise is not available from within the advisory group
- How to communicate with stakeholders about the evaluation and protocols for doing so
- the accuracy of findings, evaluation reports and other products
- How to interpret and contextualise findings
- How to disseminate the evaluation findings for program or policy improvement and accountability.

3.7 Possible timing and purpose of evaluations for the Program

While structures and resources for evaluating the implementation and outcomes of the Program are not clear at this time, some consideration was given to the timing and purpose of evaluations that could prove useful to Program funders and stakeholders.

3.7.1 Process and design evaluation

The Program has been innovative in the use of collaborative design principles in the development of evidence based tools and approaches to bring about systemic change at the intersection of AOD and DFV. An evaluation of the actions and outputs of year 1 of the Program, 2017, would provide evidence to funders, peaks and participating services of the merits and challenges of this approach to systemic change.

Timing: 2018

3.7.2 Implementation and early outcomes evaluation

Implementation and early outcomes evaluations provide funders, Program governance groups and other stakeholders with timely information about where a Program is going well, where adaptations are being made, and where assumptions may have proved incorrect. These evaluations also provide opportunities to test and review data sources and program theories, in advance of a later outcomes evaluation.

Timing: 2018-9

3.7.3 Summative or outcomes evaluation

A summative or outcomes evaluation will provide funders, governance groups and stakeholders with evidence of the intermediate and longer term outcomes and impacts of the Program, for service consumers, services and the sector. Ideally, the evaluation would commence while the Program is still running, to enable the evaluators to engage with people

who have experience of the implementation of the Program, and extend beyond it somewhat to allow complete data collection of the final stages.

Timing: 2021-22



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