ATODA

Alcohol Tobacco & Other Drug Association ACT

Domestic and Family Violence Capability Assessment Tool:

for Alcohol and Other Drug Settings

Version 1 - December 2017

We acknowledge the Traditional Custodians of the lands and waters of Australia and we pay our respects to the Elders past and present.

The *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings* was developed as part of the *AOD Safer Families Program*, an aspect of the ACT Government's broader Safer Families initiative, with funding provided through ACT Health.

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About the *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings (DFVCAT)*

Harmful alcohol and other drug (AOD) use is acknowledged to be associated with, and a risk factor for, experiencing and/or using domestic and family violence (DFV). Harmful or severe AOD use is a criteria for accessing specialist AOD services. Consequently, it is warranted to implement a universal standardised approach to responding to DFV in these specialist settings. Ultimately, the goal is to improve the health, wellbeing and safety of AOD service consumers, their families and communities, including by reducing the frequency and severity of DFV amongst this population.

Purpose

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.

Intended audience

The DFVCAT has been written specifically for specialist AOD programs/organisations.

Settings

The DFVCAT can be applied to diverse AOD practice settings, ranging from harm reduction to longer term residential and community-based programs.

Methods

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 (see Appendix A for acknowledgements and a description of the co-design process).

This DFVCAT was developed as part of the *AOD Safer Families Program.*

Companion materials

The DFVCAT can be used in conjunction with two other resources to help guide AOD practice when working with AOD service consumers experiencing or using DFV:

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

These documents and further information are available from www.atoda.org.au.

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.

Abbreviations

ACT	Australian Capital Territory
AOD	Alcohol and other drug
ATOD	Alcohol, tobacco and other drug
ATODA	Alcohol Tobacco and Other Drug Association ACT
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DFV	Domestic and Family Violence
DFVCAT	Domestic and Family Violence Capability Assessment Tool
DVSAT	Domestic Violence Safety Assessment Tool
TOR	Terms of Reference
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
MOU	Memorandum of Understanding
NSW	New South Wales

Contents

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/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, safety planning 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/organisation's 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 (DFV) - when using the DFVCAT - 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 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 Dual Diagnosis Capability in Addiction Treatment Index (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

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.

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 records 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 B - E 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 encouraged to develop questions suitable for their service types and service consumers.

Scoring the DFVCAT

Unlike the Dual Diagnosis Capability in Addiction Treatment Index (DDCAT) that was subject to rigorous investigations of its psychometric properties over many years,[3] 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.

3. 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. i.e. focus on capacity building or enhancing existing AOD treatment and support

Capacity for DFV focused responses in AOD care. i.e. above core business of AOD – may reflect innovation

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 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 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 category is ***DFV Ready.***
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 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 category is ***DFV Integrated Care.***

Overall scoring

Until the DFVCAT scores are validated, programs/organisations may find it useful to determine their overall score by summing the number of 1, 2, 3, 4 and 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
4/24X100 = 17% of scores were 1 (DFV Aware)

Score 2 in seven domains
7/24X100= 29% of scores were 2 (DFV Identified)

Score 3 in thirteen domains
13/24X100 = 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.[4]

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

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.

Domestic and Family Violence Capability Assessment Tool: 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 transgender, and intersex people (LGBTI), Aboriginal and/ or Torres Strait Islander people, culturally diverse people, young people and older people.**	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 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.	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
1C. Coordination and collaboration with 'healthy relationships' focused services (e.g. MOU, consumer pathways, collaborative working relationships, joint case management). 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 people, younger and older people).	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.
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 program/ organisation for, service consumers who experience or use DFV	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. Service consumer input is sought regarding AOD program only.	Program/ organisation expects AOD only; but recognises DFV is relevant to AOD problems and solutions and the program/ organisation emphasises healthy relationships. Refers all service consumers identified as experiencing or using DFV to specialist DFV/healthy relationships sector, while retaining responsibility for AOD care of consumer. Service consumer input is sought regarding AOD program; input regarding DFV is ad hoc.	Focus is on AOD, but DFV and its relationship to AOD use is made explicit in program/ organisation documentation. Service consumer input is sought regarding AOD program; input regarding DFV program and culture is sought from some service consumers.	AOD and DFV are expected. Some steps taken to consider service consumer safety and gender in program design and facilities. Some capacity for service consumer to choose the gender of care coordinator. Service consumer input is sought regarding AOD program; input regarding DFV program and culture is sought from many service consumers.	AOD and DFV are expected. Explicit steps taken to consider service consumer safety and gender in program design and facilities. Private spaces for counselling are routinely available. Gender-responsive; trauma-responsive; providing gendered (including LGBTI) and trauma services; family responsive care. Service consumer input is routinely sought regarding AOD and DFV policies, program and culture.
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 and family information packs; but less distribution of DFV materials than AOD.	Good quality, reliable materials are routinely available for both AOD and DFV (including targeted materials for sub-groups of service consumers such as Aboriginal and Torres Strait Islander, LGBTI, culturally diverse, older and younger persons) with equivalent distribution. Materials available for people who experience or use DFV, including impacts on the family, and benefits of participating in healthy relationship programs.	High quality, reliable materials are routinely and equally available for both AOD and DFV (including targeted materials for sub-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). Materials available for people who experience or use DFV, including impacts on the family and benefits of participating in healthy relationship programs.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
3. Clinical processes: Screening, safety planning and assessment					
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. 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. Screening is repeated at other time points during AOD support/ treatment.	Screening is not routine practice. DFV is identified incidentally (e.g. through physical signs). Identification/ screening, when it does occur, is based on service consumer self-report. Focus is on the individual service consumer only.	Brief screening is conducted with some service consumers only (e.g. those considered to be at higher risk or when DFV is indicated). Screening practices vary across individual workers. Focus is on the individual service consumer only.	Brief screening is conducted with most service consumers, using questions designed to detect experience or use of DFV. Screening questions may consider risk to, and impact on, others (service consumer's partner, children, other family members). Screening usually occurs at one time-point only. Results of screening (including where no experience or use of DFV is found) is recorded in case notes.	Screening is conducted with every service consumer, using a standardised screening tool designed to detect experience or use of DFV. Screening often considers risk to, and impact on, others (service consumer's partner, children, other family members). Screening is sometimes repeated as the therapeutic relationship develops. Results of screening (including where no experience or use of DFV is found) is recorded in case notes.	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. Screening always considers risk to, and impact on, others (service consumer's partner, children, other family members). Screening is always repeated as the therapeutic relationship develops. Results of screening always recorded in case notes.
3B. Routine assessment (including risk, support needs, and safety planning) 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.**	Basic assessment for DFV is not recorded in service consumers' records/case notes. Basic safety planning, if it does occur, may involve referral to specialist DFV sector.	Basic assessment for DFV is conducted for some service consumers, but is not routine. Assessment is occasionally recorded in service consumers' records/case notes. Basic safety planning, if it does occur, may involve referral to specialist DFV sector, or generic checklist. Assessment is not, or rarely, updated.	More involved assessment for experiencing or using DFV is present, formal, standardised, and documented in most service consumers' records/case notes. Basic safety planning is conducted in collaboration with service consumer. Assessment is occasionally updated.	More involved assessment for experiencing or using DFV is present, formal, standardised, and documented in all service consumers' records/case notes. Individualised safety planning is conducted with all service consumers who experience DFV. Assessment is often updated.	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. Individualised and detailed safety planning is conducted with all service consumers who experience or use DFV. Assessment is continually updated as changes occur.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
3C. AOD use and DFV history documented in service consumers' records/case notes, and updated.	Collection of AOD use history only.	Standard form collects AOD use history only. DFV history collected incidentally and inconsistently, or following self-disclosure. Records are not, or rarely, updated.	Routine documentation of both AOD use history and DFV history recorded in narrative section of case notes. Records are occasionally updated.	Specific section in service consumer's record dedicated to history and chronology of both AOD use and DFV. Records are often updated.	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). Records are updated regularly.
3D. Accurate data on the results of screening for DFV and other activities is recorded and retrieved. 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.	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.	A system for recording DFV-related data is in place and is used routinely. Reliable, accurate and comprehensive data are available for reporting, service planning and quality improvement purposes.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
4. Clinical processes: Interventions					
4A. Treatment plans reflect the needs and goals of service consumers in relation to AOD and DFV in accordance with findings from assessments. Treatment plans describe responses to service consumers who experience DFV (and their children) and those who use DFV. 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.	Treatment planning is conducted for AOD only (DFV not referred to).	Treatment plans address AOD and DFV, but do so only incidentally and inconsistently; and variable by worker. When DFV is included, treatment plans primarily address service consumer safety or referral to specialist DFV and/or healthy relationships programs. AOD use is primary and DFV is peripheral.	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. Referral of service consumers who use DFV to behaviour change/healthy relationships programs. Relationship between AOD use and DFV is addressed in relapse prevention/ treatment plan. Referrals for children and other family impacted by DFV. AOD use is primary and DFV is secondary.	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, or behaviour change/ healthy relationships programs for those who use DFV. Relationship between AOD use and DFV is detailed in relapse prevention/ treatment plan. Case collaboration is available with DFV specialist services. Referrals for children and other family impacted by DFV. Primary focus is AOD, but DFV is routinely addressed in treatment planning, with the plan monitored and updated regularly.	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. Behaviour change/healthy relationships programs may be offered on site for service consumers who use DFV. Relationship between AOD use and DFV is detailed in relapse prevention treatment plan. Focus is on AOD use and DFV equally when they co-occur. Children have their own treatment plans that address the impact of parental AOD and DFV, and addresses trauma.
4B. Assess and monitor the relationship between AOD and DFV and the impact on progress for both issues. 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.	No documentation of DFV as AOD support or treatment progresses.	Variable reports by individual workers of DFV as AOD support or treatment progresses.	Routine clinical focus in treatment plan review or progress notes DFV issues; description tends to be generic.	Treatment monitoring and documentation shows equivalent in-depth focus on both AOD and DFV but is variably used.	Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both AOD use and DFV equivalently.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
4C. Procedures for DFV emergencies and crisis management. Procedures are supported by formal policy and procedures, resources, training and worker supervision.	No DFV crisis procedures conveyed in any manner. Crisis management varies by individual worker.	DFV crisis management through verbally conveyed in-house procedures. Information about emergency services is available for service consumers.	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). For service consumers who use DFV, early intervention and crisis/escalation prevention strategies.	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; and procedures for service consumers who use DFV.	Formal, routinely implemented process to ascertain risk and manage emergencies related to DFV. For users of DFV, structured plans for early intervention to prevent or minimise crisis and escalation of DFV.
4D. Interventions tailored for service consumers' readiness to address DFV (including as it relates to AOD). **Recognition** that readiness to address each issue may change rapidly. Motivational interviewing strategies used to enhance service consumers' readiness are applied.	Readiness not assessed or explicit in treatment plan. No interventions offered to those incidentally identified as ready to address DFV.	Readiness incidentally and variably assessed and documented in treatment plans; variable by individual worker. Readiness occasionally re-assessed. Referrals to DFV or healthy relationships services sometimes made; variable by individual worker.	Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan. Readiness is sometimes re-assessed, particularly among service consumers at highest risk. 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.	Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan. Readiness is re-assessed regularly. Interventions are delivered in accordance with service consumers' readiness. Generic behaviour change interventions that focus on healthy relationships are provided to most service consumers.	Readiness to address DFV (including as it relates to AOD) is routinely incorporated into individualised plan. Readiness is re-assessed regularly. 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. Motivational interviewing strategies used to enhance service consumers' readiness.

	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. Assist service consumers to understand the different types of DFV, and how DFV may increase AOD use, and how AOD use can worsen DFV. Assist service consumers to become familiar with services and programs available to assist with DFV, and benefits of engaging in support/ intervention for DFV.	Not offered.	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, offered variably to some service consumers according to the judgement of individual workers/ clinicians.	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, delivered routinely in individual, couple or group formats.	Generic content (not specific to service consumer's particular circumstances) about interactions and impacts, delivered routinely in individual, couple or group formats. 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	Specific content about interactions and impacts, tailored for individual service consumers, routinely delivered in individual sessions (and or couples, families sessions if appropriate). Opportunities to explore specific issues further on other occasions.
4G. Case review processes emphasise and consider DFV in AOD treatment.	Focus is on AOD; case review does not consider DFV.	Focus is on AOD, consideration of DFV is variable and or undocumented.	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.	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.	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.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
5. Continuity of care					
5A. AOD and DFV issues both addressed in discharge planning process. For example: • 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. Discharge planning for DFV primarily referral.	AOD issues and DFV issues are both addressed routinely in discharge planning for all service consumers who experience or use DFV. Action plans to manage AOD and/ or DFV relapse are detailed, and coordinated with specialist DFV, healthy relationships/ behaviour change services workers. Assertive follow-up planned, documented and conducted for service consumers considered to be at high risk for relapse.	Assertive follow-up planned, documented and conducted for all service consumers who experience or use DFV. Action plans to manage AOD and/ or DFV relapse are detailed and reviewed with service consumer at follow-up. Ongoing links with specialist DFV sector established for service consumers who require extended support.
5B. Focus on ongoing improvement in both AOD and DFV issues. Changes in both AOD and DFV issues are monitored and explored with service consumers throughout AOD treatment/support.	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. AOD and DFV seen as mutual triggers for relapse.	Routine focus on improvement in both AOD use and DFV issues equally and consistently. AOD and DFV relapse expected and planned for, together with the interactions between the two.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
6. Staffing considerations					
6A. All staff members receive training in DFV. Training could include: • 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.	Although aware of DFV, few staff have had systematic, basic training in DFV as it relates to AOD care/ outcomes.	Variably trained in the basics of DFV. Ad hoc, external training not integrated into routine professional development plan.	All staff have basic training in DFV, including screening, basic assessment and safety planning, monitoring of progress and referral. In-service education about DFV is integrated into routine professional development plan for some staff.	All staff have basic training in DFV. 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. In-service education about DFV is integrated into routine professional development plan for many staff.	All staff have basic training in DFV. Training needs periodically re-assessed through review of systematic staff training plan. Key workers have advanced or specialised training in integrated interventions for service consumers who experience or use DFV. In-service education on DFV integrated into routine professional development plan for most staff.
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.

	1 - DFV Aware	2. DFV Identified	3. DFV Ready	4. DFV Coordinated Care	5. DFV Integrated care
6C. Onsite workers/clinical staff members with training or substantive experience working with service consumers who experience or use DFV (and their families) including: • Awareness of DFV • Ability to identify DFV • Screening for DFV • Assessment of DFV Able to respond appropriately and safely	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. Most staff skilled in active referral processes. Ad hoc access to experienced staff with DFV skills outside of the service.	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. Key worker(s) with training and or experience in AOD and DFV (including children and families) available onsite to coordinate appropriate care when required.	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. Key workers demonstrate leadership in DFV, which is seen as a priority and core business of the service. Key worker(s) with training and/or experience in AOD and DFV (including children and families) available onsite to deliver integrated care when required.
6D. Onsite workers/clinical staff members with training or experience working with individuals (and families) with diverse needs who experience or use DFV. Groups may include: • LGBTI people • Aboriginal and/ or Torres Strait Islander people • Culturally diverse people • Young people • Older people • People who are homeless • People with mental health issues	No workers have specific training or experience in responding to DFV with diverse groups of service consumers.	Few workers are able to identify needs of diverse groups who experience or use DFV and are able to refer appropriately.	Some workers are able to identify needs of diverse groups who experience or use DFV and are able to refer appropriately and actively. Evidence of culturally specific/ diverse populations interventions available. Formal or informal working relationships with organisations that can support service consumers with diverse needs.	Most needs of diverse populations can be met by the service. Evidence of policies, procedures and practices designed to meet the needs of diverse populations available. Care can be coordinated with organisations that support service consumers with diverse needs and who experience or use DFV.	Most needs of diverse populations can be met within the service. Evidence of policies, procedures and practices detailing culturally specific interventions are available. Integrated care that supports service consumers with diverse needs who experience or use DFV can be provided by the service.
6E. Access to supervision and consultation that considers DFV in AOD. • Regular, formal supervision (peer, specialist supervisor) • Informal supervision (irregular, as needed) • Staff personal experiences of DFV accounted for in supervision.	Access to AOD specific clinical/practice supervision only; no access to supervision that considers DFV.	Access to AOD specific clinical/practice supervision only; access to supervision that considers DFV for some workers occasionally or informally.	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. Ad hoc access to consultation.	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. Access to consultation with key workers onsite as needed.	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. Regular access to consultation with key workers onsite.

Appendix A:

Co-design Process and Acknowledgements

Co-design Process

The DFVCAT was produced as part of the *AOD Safer Families Program* which aims to prevent and respond to DFV by establishing new coordinated/integrated AOD and DFV interventions within the specialist AOD service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to DFV.[5]

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.

Note: the literature underpinning the DFVCAT is current to September 2017.

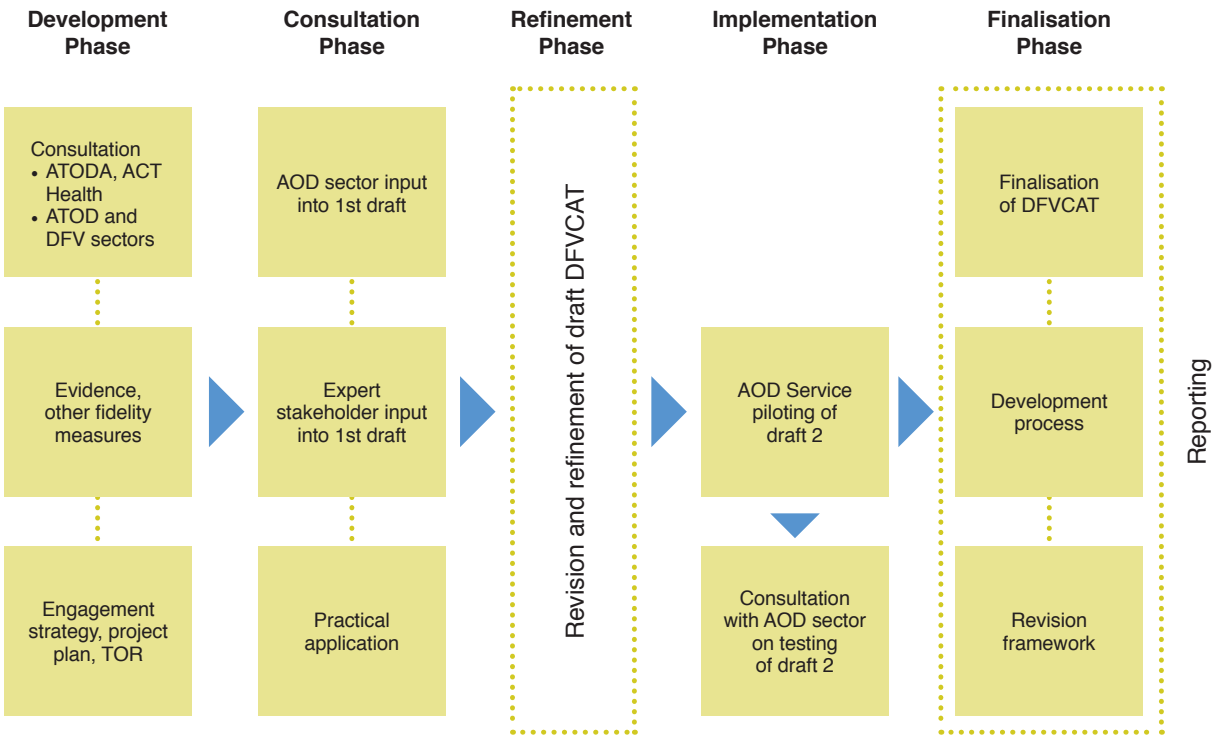

Figure 1: DFVCAT development overview

Acknowledgements

We 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.

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

The following Australian-first resources were produced as part of the ACT *AOD Safer Families Program* which aims to prevent and respond to DFV by establishing new coordinated/integrated AOD and DFV interventions within the specialist AOD service system, while concurrently enhancing the universal capacity of the service system including services, workforce and service consumers, to respond well to DFV:

- *Domestic and Family Violence Capability Assessment Tool: for AOD Settings* (this document);
- *Scope of Practice: for Working with Service Consumers in AOD Settings who Experience or Use DFV;*
- *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings*

Funded by ACT Health, and coordinated by the Alcohol Tobacco and Other Drug Association ACT with clinical consultancy from 360Edge; the co-design process to develop these materials was rigorous and comprehensive involving AOD and DFV stakeholders, clinicians, consumer representatives, funders and policy workers. Information is provided below on the many contributors in 2017 to the AOD Safer Families Program.[5]

Specialist ACT AOD Services

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

ACT Domestic and Family Violence Sector Stakeholders

- Jo Wood, Coordinator-General for Family Safety
- Members of the Domestic Violence Prevention Council and the Women's Services Network including:
  - Domestic Violence Crisis Service
  - Everyman
  - Office of the Coordinator-General for Family Safety
  - Women's Centre for Health Matters
  - Women's Health Service, ACT Health.

Ministers

- Ms Meegan Fitzharris MLA, Minister for Health and Wellbeing
- Yvette Berry MLA, Minister for Prevention of Domestic and Family Violence

Funders

- ACT rate payers through the Safer Families Levy, administered through ACT Health

Consultants

- Linda Jenner, 360Edge (Clinical Consultant)
- Professor Nicole Lee, 360Edge (Clinical Consultant)
- David McDonald, Social Research and Evaluation (Evaluation and Project Consultant)

5. For a full description of the co-design process and acknowledgements see Alcohol Tobacco and Other Drug Association ACT (ATODA). (2017). *ACT Alcohol and Other Drug Safer Families Program 2017 – 2021: Design, Model, Implementation Plan and Evaluation Framework.* Canberra: ATODA. Available online at www.atoda.org.au.

- Fiona Christian, ARTD Consultants (Evaluation Consultant)
- Melanie Darvodelsky, ARTD Consultants (Evaluation Consultant)

Clinical and Expert Roundtable

- 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, ACT Health
- Professor Nicole Lee, 360Edge
- Rebecca Wood, Toora Women Inc.
- Shannon Wright, YWCA NSW
- Sione Crawford, Consumer Representative
- Amanda Bode, Anke van der Sterren and Carrie Fowlie, ATODA

Project Advisory Group

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- Professor Nicole Lee, 360Edge (Clinical Consultant)
- Sharon Tuffin and Anna McKenry, Karralika Programs Inc.
- Susan Clarke-Lindfield, Toora Women Inc & Women's Services Network
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External Reviewers

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ATODA Staff

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- Anke van der Sterren, Researcher and Project Manager
- Carrie Fowlie, Chief Executive Officer
- Jeanette Bruce, Organisational Development Officer
- Julie Robert, Communications Officer
- Dave Corby, Office Manager
- Melinda Petrie, Project Manager

Appendix B:

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
Physical environment 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, safety planning 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
	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 considerations	Review of staffing profile	Y	N	Y	N
	Interviews with staff	Y	N	Y	N
	Review of strategic training plan	Y	N	Y	N
	Review of staff training records	Y	N	Y	N

Appendix C:

File audit guide

Clinical processes - Screening	Yes	No	N/A
Screen for DFV completed once Screen for DFV is repeated	Comments:		

Clinical processes - Assessment	Yes	No	N/A
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 Treatment plans address both AOD and DFV issues • 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.)	Comments:		

Clinical processes - Interventions (treatment planning)	Yes	No	N/A
Plans for crisis/emergencies are documented Readiness for addressing each issue integrated into treatment/support plan Records are updated AOD interventions contain DFV content Education about course and interaction of DFV with AOD provided Coordination and collaboration with specialist DFV sector described Coordination and collaboration with healthy relationships/behaviour change sector described Needs of children of service consumers addressed Needs of service consumers' significant others addressed	Comments:		

Continuity of care	Yes	No	N/A
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	Comments:		

Appendix D:

Staff interview questions examples[6]

Assessment domain	Potential question 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/documented?
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, support needs and safety planning) 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 responding consistently or is the approach ad hoc?
4D. Interventions tailored for service consumers' readiness to address DFV (including as it relates to AOD).	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 relationship to 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?

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

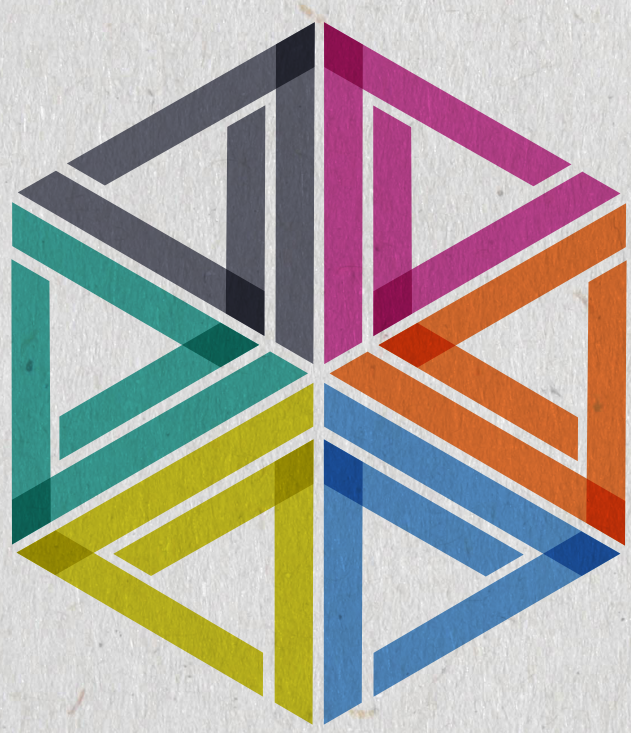
Assessment domain	Potential question for staff
4G. Case review processes emphasise and support DFV responses in AOD treatment.	Do we conduct case reviews to monitor progress in AOD and DFV? For which service consumers? How are reviews conducted (e.g. onsite, at partner service, regularly or as needed)? Do we have sufficient resourcing (time, financial, human) to enable case reviews that acknowledge DFV?
5A. AOD and DFV issues both 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?
6A. All staff members have received training in DFV.	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?
6C. Onsite workers/clinical staff members with training or substantive experience working with service consumers who experience or use DFV (and their families).	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?
6D. Onsite workers/clinical staff members with training or experience working with individuals (and families) with diverse needs who experience or use DFV.	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?
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?

Appendix E:

Service consumer interview questions examples[7]

Assessment domain	Potential question for staff
2A. Routine expectation of, and welcome to the program/ organisation, for service consumers who experience or use DFV.	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? Did you feel safe to talk about these things?
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, support needs and safety planning) 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.	Were you ever asked about your relationships or family situation? Can you tell me more about that?
4B. Assess and monitor the relationship between 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? 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?	

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



ATODA

Alcohol Tobacco & Other Drug
Association ACT