



**Practice Guide:**  
for Responding to  
Domestic & Family Violence  
in Alcohol & 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 *Practice Guide: for responding to Domestic and Family Violence in 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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PO Box 7187, Watson, ACT 2602

**Address** 11 Rutherford Crescent, Ainslie, ACT 2602

**Phone** (02) 6249 6358

**Fax** (02) 6230 0919

**Email** info@atoda.org.au

**Web** www.atoda.org.au

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# About the *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings*

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 *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 alcohol and other drug (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 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

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

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

Recommendations were developed through a co-design process involving 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 Appendix B for acknowledgements and a description of the co-design process).

## Companion materials

This Practice Guide can be used with two other resources to help guide AOD practice when working with AOD service consumers experiencing or using DFV:

- *Domestic and Family Violence Capability Assessment Tool: for 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](http://www.atoda.org.au)

## Abbreviations

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

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# Structure of the Practice Guide

The Practice Guide was structured to align with the *Domestic and Family Violence Capability Assessment Tool: for Alcohol and Other Drug Settings* (DFVCAT), which was designed to support specialist alcohol and other drug (AOD) programs/organisations to measure their capacity to respond to domestic and family violence (DFV).<sup>(a)</sup>

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:

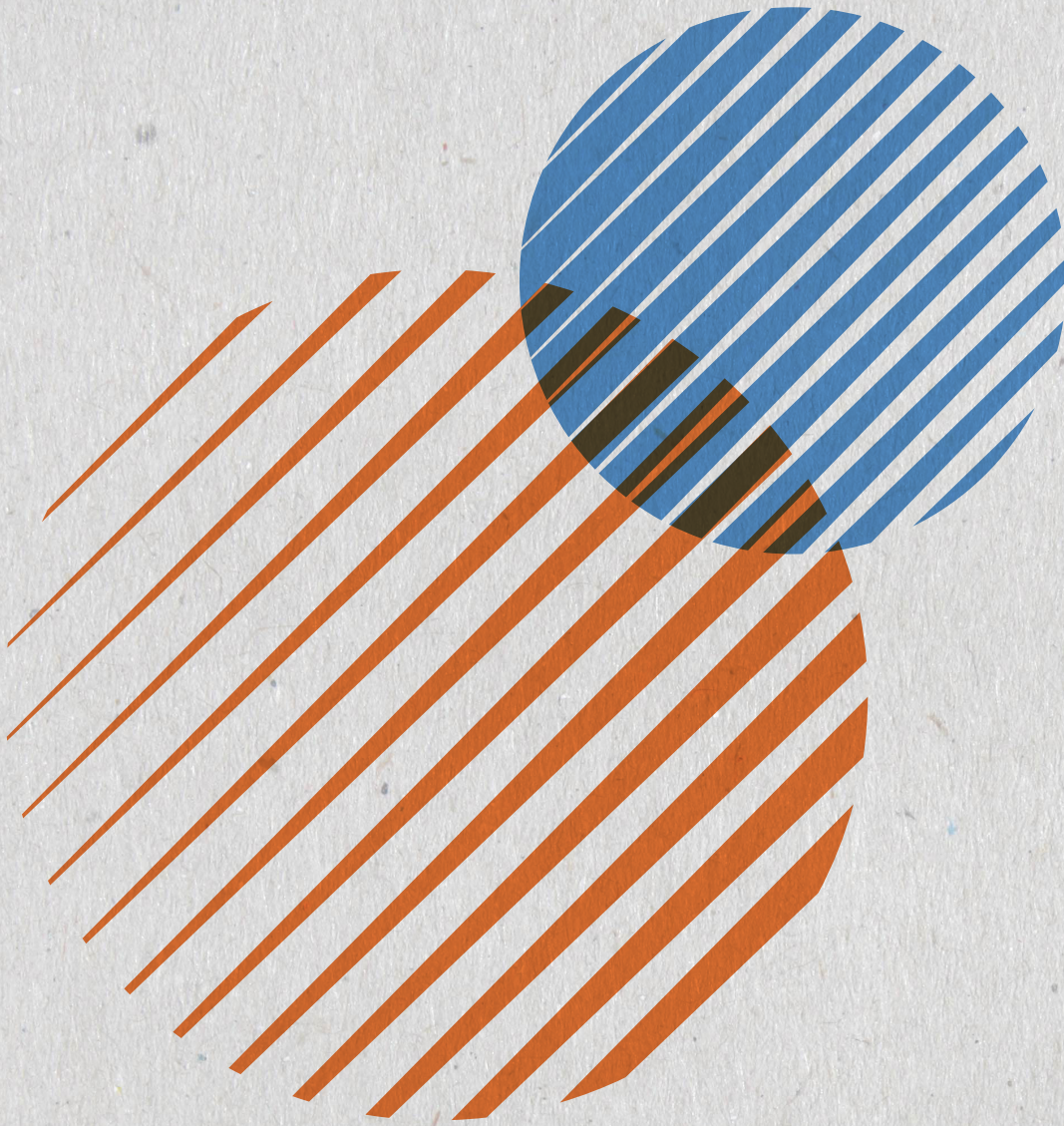
- 1 Program structure**  
Examines four factors that support a program/organisation's capacity to plan and respond to issues of DFV among service consumers.
- 2 Physical environment and organisational culture**  
Examines two factors that establish how issues of DFV are recognised and accommodated by 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.  
  
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.

a. The DFVCAT is a benchmarking tool that can be used as a companion resource to help guide AOD practice when working with AOD service consumers experiencing or using DFV. It can be found at [www.atoda.org.au](http://www.atoda.org.au)

## Terminology

At times, terminology has been used in this Practice Guide that are not the preferred terms of the authors, but reflect terms used in 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

recommendations  
and practice points

# Program Structure

## Recommendations – program structure

- 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, 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.

# Physical environment and organisational culture

## Recommendations – Program environment and organisational culture

- 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](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, safety planning and assessment

## Screening

### Recommendations – screening for DFV

- 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 or programs 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](http://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:<sup>(1)</sup>

- 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.

### Recommendation – Safety planning

- 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 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

### Recommendations – Assessment

- 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](http://www.domesticviolence.nsw.gov.au)).

## Clinical processes - interventions

### Recommendations—implementing interventions aligned with service capacity

The following are recommendations for implementing interventions aligned with AOD service capacity as measured by the Domestic and Family Violence Capability Assessment Tool (DFVCAT): for Alcohol and Other Drug Services. This companion resource can be accessed at: [www.atoda.org.au](http://www.atoda.org.au).

#### 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:

- 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:

- 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:

- 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:

- 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<sup>(1)</sup>

## 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](http://www.salvationarmy.org.au) for the final evaluation report).

### 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)<sup>(2)</sup>

## 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)<sup>(3)</sup>

## Continuity of care

### Recommendations – Post -treatment support

- 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 – Training to improve outcomes for service consumers

- 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

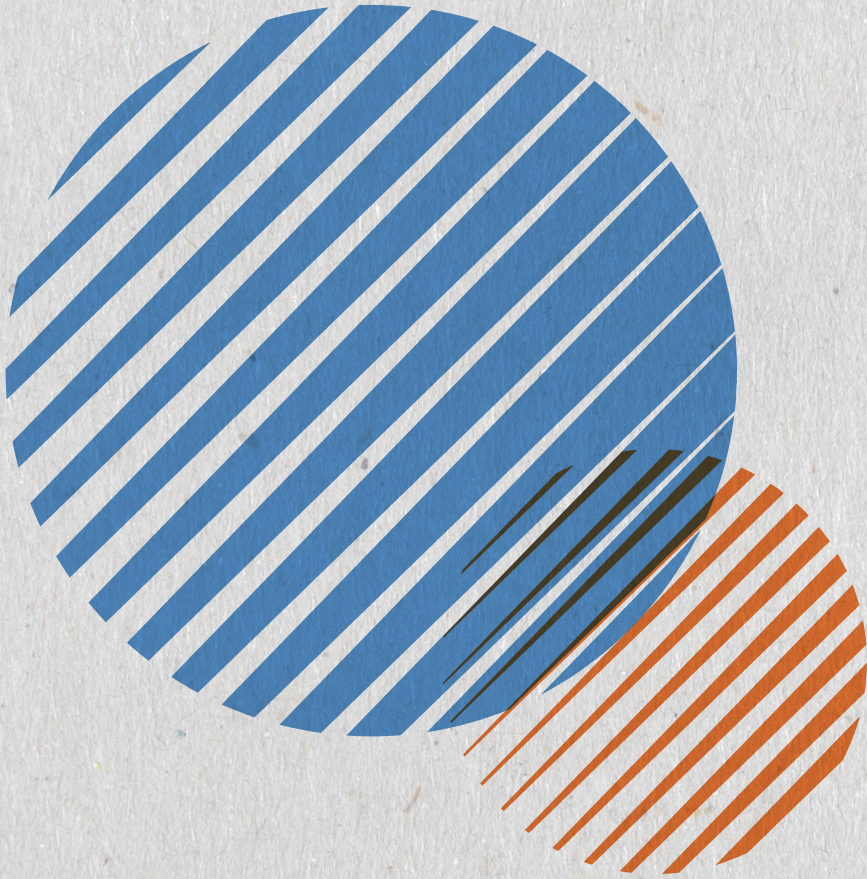
- The specialist DFV sector across Australia often provides foundation training in DFV for other sectors. In the ACT, the Domestic Violence Crisis Service provides training as required ([www.dvcs.org.au](http://www.dvcs.org.au))
- The website DV Alert lists training opportunities in all states and territories, and also offers an e-learning program subsidised by the Australian Government ([www.dvalert.org.au](http://www.dvalert.org.au))
- Online training in DFV is offered by Queensland Health ([www.health.qld.gov.au](http://www.health.qld.gov.au))
- Some universities offer a graduate certificate in domestic violence ([www.qut.edu.au](http://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 a fit for purpose/tailored DFV training packages

## Recommendations — Staff skills and qualifications

- 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).

## Recommendations — Staff safety and self-care

- 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 & 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<sup>(4)</sup> 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. Legislative terminologies and definitions of domestic and family violence differ between Australian jurisdictions, and the use of this Practice Guide and the companion tools (DFVCAT and Scope of Practice) should be in the context of an understanding of the legislation applying in each state or territory (see Appendix C for a list of this legislation and where to access it).

Further, the preferred terminology and conceptualisation of DFV is different 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.<sup>(5)</sup>

In some cases, the state and territory legislation specifically articulates how family violence is legally defined for Aboriginal and Torres Strait Islander people in each jurisdiction (see Appendix C).

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.<sup>(6)</sup>

DFV is common in Australia, and occurs among people of all ages, cultures and socioeconomic groups.<sup>(6)</sup> It is not possible to measure the true extent

of DFV in Australia because most incidents are not reported.<sup>(6)</sup> It has been estimated that more than one in 10 (approximately 11.2%) of the Australian population aged over 15 years has experienced physical or sexual violence perpetrated by a current or former partner.<sup>(7)</sup>

Women are far more likely to experience domestic and family violence than men.<sup>(3,6)</sup> According to the latest data, approximately one in four women experienced violence by an intimate partner, compared to one in thirteen men.<sup>(8)</sup> 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.<sup>(9)</sup>

DFV occurs in LGBTI intimate partner relationships<sup>(2)</sup> at about the same rate as within heterosexual couples.<sup>(10)</sup>

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.<sup>(3,11)</sup> 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.<sup>(11)</sup> Aboriginal women in some, but not all, states and territories were more likely to experience violence by a current partner than other Australian women.<sup>(11)</sup>

All Australian state and territory governments have initiated responses to improve safety by preventing and reducing the prevalence of domestic and family violence.<sup>(7)</sup>

## Relationship between AOD use and DFV

While alcohol is not generally considered a sole cause of DFV, there are strong associations between the two.<sup>(12)</sup> 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.<sup>(9,13)</sup>

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.<sup>(14)</sup>

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'<sup>(b)</sup> compared with relationships in which neither drank heavily.<sup>(15)</sup>

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:<sup>(10)</sup>

- 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;
- 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.<sup>(9)</sup> When considering incidents not reported, alcohol involvement is likely to be higher.<sup>(9)</sup>

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.<sup>(16)</sup> Women with substance use disorders are also at higher risk of experiencing DFV.<sup>(17)</sup>

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.<sup>(16)</sup> The rate of alcohol consumption before intimate partner homicides may be much higher among Aboriginal and Torres Strait Islander people.<sup>(16)</sup>

## 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.<sup>(17,18)</sup> 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.<sup>(18)</sup> Researchers in other countries have estimated that life-threatening intimate partner violence affect up to three-quarters of women in AOD treatment programs.<sup>(19)</sup>

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.<sup>(20)</sup> Technology-facilitated abuse by men receiving AOD treatment is increasing.<sup>(21)</sup>

The relationship between women's experiences of violence and their AOD use is complex and not well understood.<sup>(22)</sup> 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).<sup>(23,24,25)</sup>

The high prevalence of DFV among AOD service consumers suggests that AOD treatment provides a valuable opportunity to detect and intervene.<sup>(26)</sup> 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.<sup>(16,27)</sup> Reports also

<sup>b</sup> Described as 'frequent drunkenness'; the number of drinks on one occasion was unspecified

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.<sup>(23)</sup>

The 2016 Alcohol/Drug-Involved Family Violence in Australia (ADIVA) report,<sup>(9)</sup> 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.'<sup>(9)</sup>

## 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.<sup>(28)</sup> 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).<sup>(29)</sup> 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)<sup>(23,30)</sup> and are more likely to experience relapse in AOD use.<sup>(23)</sup>

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.<sup>(31)</sup> 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.<sup>(31)</sup>

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<sup>(c)</sup> 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.

## 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.

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

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’.<sup>(32)</sup> 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<sup>(33)</sup> and its effect on family court decisions,<sup>(34)</sup> others consider it relevant to understanding AOD-related DFV in Australia.<sup>(9)</sup>

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,<sup>(35)</sup> 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 (Figure 1).<sup>(d)</sup>

It is 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.



**Figure 1.**  
**Conceptual model**  
**of domestic and**  
**family violence**

<sup>d</sup> The relative sizes of the violence categories are conceptual and do not reflect actual prevalence data.

## 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 *Domestic and Family Violence Capability Assessment Tool (DFV CAT): for Alcohol and Other Drug Settings* is intended to guide planning in these areas.<sup>(e)</sup>

## 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 Appendix B.

The Roundtable assessed the evidence identified by the systematic review of literature (see Appendix A 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.<sup>(36)</sup> 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.

<sup>e</sup> Available at [www.atoda.org.au](http://www.atoda.org.au)

## 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;<sup>(37)</sup> and one naturalistic pre–post observational study of integrated care or coordinated care.<sup>(38)</sup>

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).<sup>(39)</sup>

### Summary of findings

A quasi-experimental study<sup>(36)</sup> 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<sup>(38)</sup> 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.

## Collaboration

### 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<sup>(40)</sup> 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<sup>(41)</sup> 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).<sup>(30)</sup>

### **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)<sup>(42-45)</sup> that assessed integrated approaches including cognitive-behavioural therapy (CBT)<sup>(42,43,45)</sup> and one study evaluating a multimodal relapse prevention and relationship safety program.<sup>(44)</sup>

#### Summary of findings

Of the four studies found, two support the benefits of integration,<sup>(26,45)</sup> one showed non-significant trend toward benefit,<sup>(44)</sup> while the other<sup>(43)</sup> 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<sup>(39)</sup> 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.<sup>(42)</sup>

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.<sup>(45)</sup>

Another small, methodologically sound US study<sup>(44)</sup> 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.<sup>(44)</sup>

##### 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.<sup>(43)</sup> Completers in both treatment groups reported significantly fewer episodes of intimate partner violence following treatment.<sup>(43)</sup> 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.<sup>(43)</sup>

##### 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.<sup>(46)</sup> This finding suggests that addressing DFV in AOD settings is likely to be more effective than referral alone.<sup>(47)</sup>

##### 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 – program structure

- ✓ **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

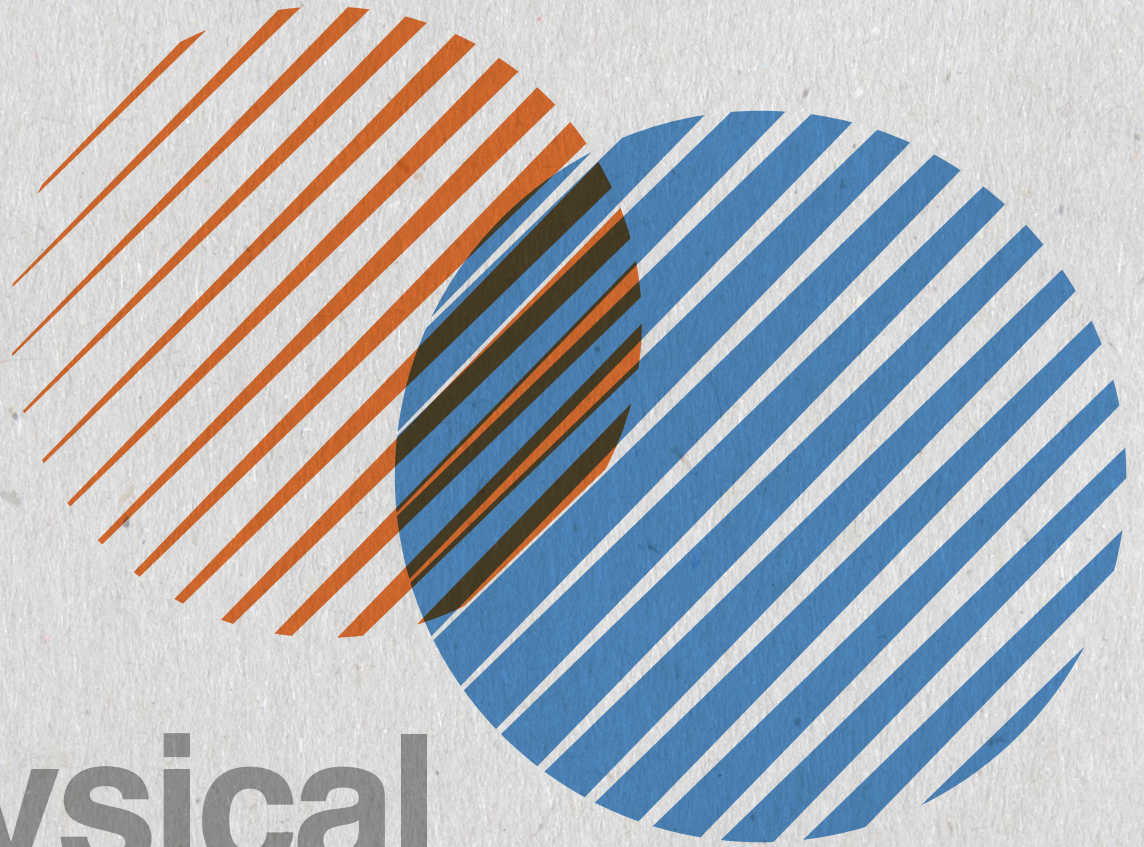
Collaboration with services to assist service consumers experiencing or using DFV can range from simple advice at one end of the spectrum, to coordinated and shared care at the other. These services include specialist DFV and men's behaviour change sectors; family; women's; children and legal services.

- 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.





# Physical environment & 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<sup>(48)</sup> and an interview-based study.<sup>(31)</sup>

### Summary of findings

#### 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<sup>(48)</sup> included 25 studies. It reported the following findings from women experiencing intimate partner violence:<sup>(48)</sup>

- 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.<sup>(31)</sup> 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 Health and Care Excellence (NICE)<sup>(49)</sup> 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<sup>(50)</sup> 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.<sup>(50)</sup>

The 2017 UK NICE pathway on domestic violence and abuse<sup>(49)</sup> 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.<sup>(49)</sup> 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).<sup>(49)</sup>

#### Overall finding

There is insufficient evidence from which to formulate evidence-based recommendations for practice.

## Recommendations – Program environment & organisational culture

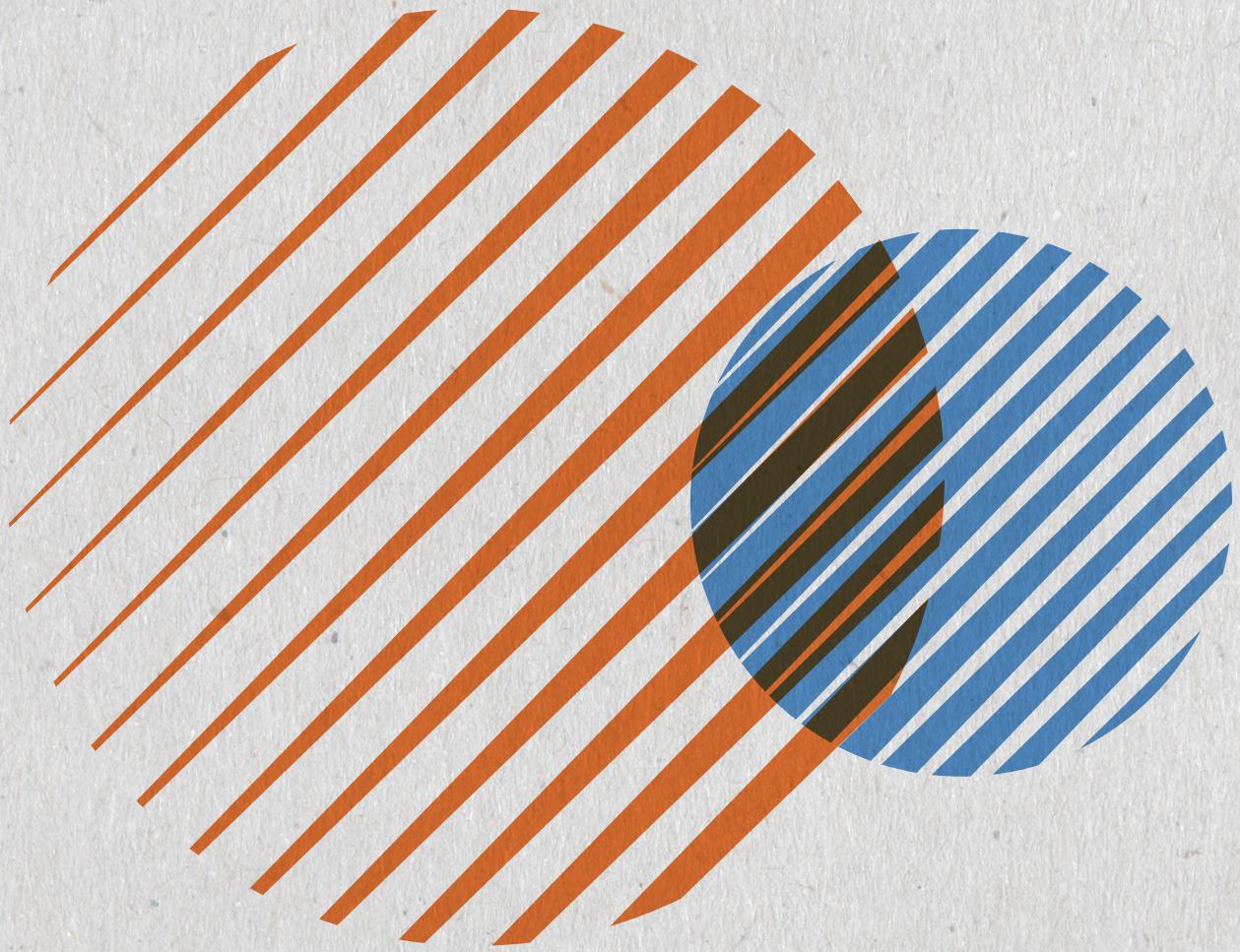
- ✓ **All staff, including clinical, ancillary, contract and administrative staff, should be trained in DFV and trauma awareness.**
- ✓ **All AOD services should provide general DFV information for service consumers (e.g. a poster), which states that the service is open to discussing DFV, and explains 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](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, safety planning  
& assessment

## Screening

### What we know about screening increasing detection of DFV: summary of the evidence

#### Screening for DFV

##### 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<sup>(51,52)</sup> 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<sup>(52)</sup> 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.<sup>(52)</sup> 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.<sup>(52)</sup> 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.<sup>(52)</sup>

#### 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<sup>(50)</sup> 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).<sup>(50)</sup>

#### 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<sup>(51,52)</sup> and two RCTs<sup>(53,54)</sup> 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

##### Evidence from systematic review

The studies from a range of healthcare settings other than AOD services confirm that screening is acceptable to most women.<sup>(51-54)</sup>

- 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.<sup>(51)</sup>

- 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.<sup>(52)</sup>
- 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.<sup>(53)</sup> 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.<sup>(54)</sup>

### Other relevant information

A meta-analysis of 25 qualitative studies<sup>(48)</sup> 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<sup>(52)</sup> 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<sup>(48)</sup> 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.<sup>(48)</sup>

Qualitative studies with women conducted primarily by one US research group<sup>(55)</sup> 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<sup>(56)</sup> and four papers reporting studies evaluating specific tools.<sup>(54-57)</sup>

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.<sup>(56)</sup> Tools that scored sensitivity greater than 85% include the HITS, STaT, WEB and OVAT.<sup>(56)</sup> Specificity ranged from 83% to 99% for all except STaT, which had a specificity of 37%.<sup>(56)</sup> 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.<sup>(56)</sup> 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.<sup>(56)</sup>

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).<sup>(57)</sup> Both studies demonstrated good psychometric properties to detect victims of any, as well as severe, intimate partner violence<sup>(57)</sup>

A Canadian study comparing WAST with the 30-item CAS<sup>(58)</sup> 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<sup>(1,59)</sup> 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<sup>(60)</sup> 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).<sup>(57)</sup> Both studies demonstrated good psychometric properties to detect perpetrators of any, as well as severe, intimate partner violence<sup>(57)</sup>

## 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 – screening for DFV

- ✓ **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 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](http://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:<sup>(1)</sup>

- 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

## 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<sup>(30)</sup> 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<sup>(1)</sup> 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<sup>(61)</sup> suggest that a telephone intervention could increase the safety-promoting behaviour of women experiencing DFV.

A US study<sup>(62)</sup> 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.<sup>(62)</sup>

Another qualitative study<sup>(63)</sup> 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.<sup>(63)</sup>

## Overall finding

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

## Recommendation – safety planning

- ✓ **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 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

### What we know about assessment of service consumers who experience or use DFV: summary of the evidence

#### Assessment of service consumers who experience 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.

One study was identified that evaluated an assessment tool for use in counselling women with experience of DFV.<sup>(64)</sup>

#### 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.<sup>(64)</sup> 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<sup>(30)</sup> 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<sup>(30)</sup> 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.<sup>(30)</sup> The protocol recommends that healthcare/AOD workers explore the following points with people who use DFV:<sup>(30)</sup>

- 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 – Assessment

- ✓ **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.

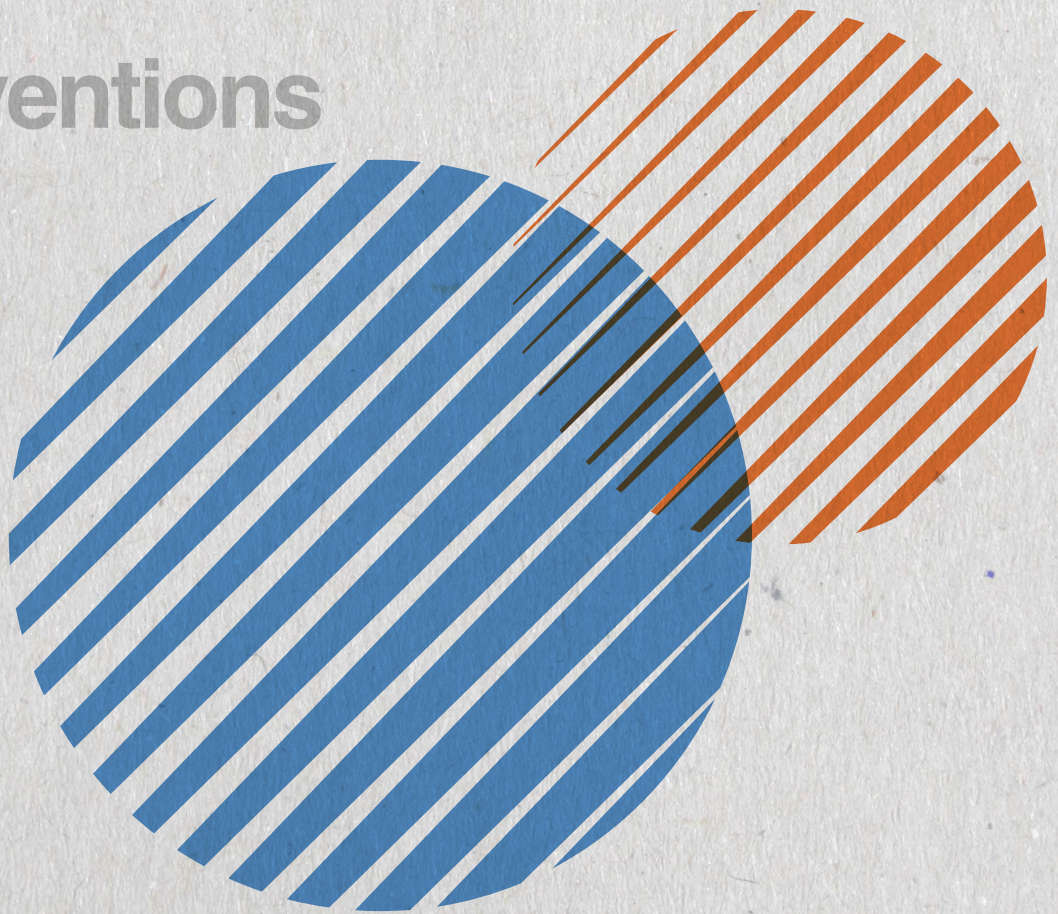
In New South Wales, frontline workers use the Domestic Violence Safety Assessment Tool (DVSAT) to assess risk. The tool explores 25 factors associated with risk in the domains of type of violence used, the relationship between

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 DVSAT and the guide to using the tool can be accessed online ([www.domesticviolence.nsw.gov.au](http://www.domesticviolence.nsw.gov.au)).

# Clinical processes

interventions



## DFV interventions in AOD settings

### 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<sup>(40, 65, 66)</sup> 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<sup>(40)</sup>
- a 2016 narrative review of interventions to reduce intimate partner violence perpetration among people with substance use disorder<sup>(65)</sup>
- a 2009 narrative review of the association between treatment for substance misuse and reductions in intimate partner violence.<sup>(66)</sup>

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.<sup>(40,65,66)</sup>

The most comprehensive review<sup>(40)</sup> 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.<sup>(40)</sup> 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.<sup>(40)</sup> 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.<sup>(40)</sup>

##### 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<sup>(44,45)</sup> and one qualitative research study<sup>(67)</sup> 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.<sup>(44)</sup>

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.<sup>(45)</sup> 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<sup>(67)</sup> 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.<sup>(67)</sup> 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<sup>(68-71)</sup> and two non-randomised comparative studies<sup>(72,73)</sup> 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<sup>(68)</sup> 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%,  $p = 0.10$ )<sup>(68)</sup>. 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.<sup>(68)</sup>

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.<sup>(69)</sup> 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.<sup>(69)</sup> Another US RCT evaluated a telephone-delivered motivational enhancement therapy intervention for men with AOD problems who perpetrated intimate partner violence.<sup>(70)</sup> At 30-day follow-up, men in the intervention group reported engaging in intimate partner violence less frequently than those in the control group.<sup>(70)</sup>

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).<sup>(71)</sup> 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<sup>(74)</sup> 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<sup>(75)</sup> 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 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

## 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,<sup>(44,76,77)</sup> one nonrandomised comparative study,<sup>(78)</sup> one qualitative study,<sup>(67)</sup> one case study,<sup>(79)</sup> and one non-systematic review<sup>(80)</sup> that addressed this question.

### Summary of findings

#### Evidence from systematic review

A small US RCT<sup>(44)</sup> 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.<sup>(44)</sup> 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.<sup>(44)</sup>

A Spanish pilot RCT<sup>(77)</sup> 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).<sup>(77)</sup> The intervention group attended a mean of five sessions (range 0–9).<sup>(77)</sup> 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).<sup>(77)</sup> 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 ( $p=0.035$ ).<sup>(77)</sup> Both groups also showed increases in assertiveness scores and reductions in depression scores.<sup>(77)</sup>

A US pilot RCT<sup>(76)</sup> 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.<sup>(76)</sup>

A US nonrandomised survey-based pre–post comparative study<sup>(78)</sup> 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<sup>(80)</sup> 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).<sup>(80)</sup>

#### Other relevant information

An Australian online intervention currently being evaluated for women experiencing DFV (I- DECIDE, available at [www.idecide.org.au](http://www.idecide.org.au)),<sup>(81)</sup> is very similar to the US emergency department intervention evaluated by Choo et al.<sup>(76)</sup> 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<sup>(74)</sup> for an extensive examination of programs). Other programs involve adding AOD interventions to

primary DFV work.<sup>(19,82)</sup> 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),<sup>(83)</sup> 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<sup>(1)</sup>

## 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,<sup>(19)</sup> three RCTs,<sup>(77,84,85)</sup> and two nonrandomised pre–post comparative studies<sup>(86,87)</sup> 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<sup>(19)</sup> 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](http://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 a small US study evaluating a multimodal relapse prevention and relationship safety program<sup>(44)</sup> and a US naturalistic pre–post observational study of integrated care or coordinated care<sup>(38)</sup> (included in the evidence summaries for questions in the sections: ‘What we know about coordinated care’; ‘What we know about integrated care’; ‘What we know about addressing DFV in an AOD setting’ and ‘What we know about interventions for AOD service consumers who experience DFV’).

A Spanish pilot RCT<sup>(77)</sup> 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).<sup>(77)</sup> The intervention group attended a mean of five sessions (range 0–9).<sup>(77)</sup> Both groups reduced symptoms of depression (Beck Depression Inventory II) at 12-month follow-up. Effects on AOD outcomes are

described in the previous section on ‘What we know about interventions for AOD service consumers who experience DFV’.

A US RCT<sup>(84)</sup> 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.<sup>(84)</sup> Effects on DFV and AOD outcomes were not reported.

A US double-blind placebo-controlled RCT<sup>(85)</sup> 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 the 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.<sup>(85)</sup> 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.<sup>(85)</sup> The treatment group showed an improvement in irritability subscale scores (completer analysis, last-observation-carried-forward analysis, and intention-to-treat analysis).<sup>(85)</sup>

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,<sup>(86)</sup> 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.<sup>(86)</sup>

A US nonrandomised pre–post comparative study<sup>(87)</sup> 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.<sup>(87)</sup>

### 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.

# Interventions for children of AOD service consumers

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).<sup>(68)</sup>

A 2014 review<sup>(89)</sup> 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:<sup>(89)</sup>

- 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:<sup>(49)</sup>

- 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](http://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.

# Interventions for specific population groups

## 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<sup>(88)</sup> 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<sup>(1)</sup> targeting the medical community recommended a range of strategies for implementation in various settings (Table 1).

#### People from culturally and linguistically diverse communities:

a 2016 ANROWS qualitative study of women's experiences with DFV<sup>(3)</sup> 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).

### **Overall finding**

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

**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)<sup>(2)</sup>

## 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)<sup>(3)</sup>

# Interventions to promote healthy relationships

## 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<sup>(90)</sup> 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,<sup>(67)</sup> 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](http://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.<sup>(91,92)</sup>

Caring Dads ([www.caringdads.org](http://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 – implementing interventions aligned with service capacity

The following are recommendations for implementing interventions aligned with AOD service capacity as measured by the *Domestic and Family Violence Capability Assessment Tool (DFV CAT): for Alcohol and Other Drug Services*. This companion resource can be accessed at: [www.atoda.org.au](http://www.atoda.org.au).

### ✓ 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 their DFV CAT category.

### ✓ DFV-identified services

- 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

- 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

- 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

- 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<sup>(30)</sup> 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 – post-treatment support

- ✓ **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/workforce development activities for (professional and peer) staff are required for good service consumer outcomes?**

### Evidence identified

The current systematic review identified one systematic review<sup>(93)</sup> and two RCTs<sup>(94,95)</sup> that addressed this question.

### Summary of findings

#### Evidence from systematic review

A 2014 systematic review<sup>(93)</sup> 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<sup>(94)</sup> 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).<sup>(94)</sup>

A Canadian RCT<sup>(95)</sup> 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<sup>(96)</sup> 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 to 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 responses 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 – training to improve outcomes for service consumers

- ✓ 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 services, 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<sup>(93)</sup> and one RCT<sup>(95)</sup> that addressed this question. Another RCT<sup>(94)</sup> did not involve AOD staff but provides indirect evidence.

## Summary of findings

### Evidence from systematic review

A 2014 systematic review<sup>(93)</sup> 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 to improve capacity building for the AOD sector.

A Canadian RCT<sup>(95)</sup> 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.<sup>(95)</sup> The findings support interdisciplinary/cross-disciplinary training.<sup>(95)</sup>

### Other relevant information

An Australian RCT<sup>(94)</sup> 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](http://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](http://www.dvalert.org.au))
- Online training in DFV is offered by Queensland Health ([www.health.qld.gov.au](http://www.health.qld.gov.au))
- Some universities offer a graduate certificate in domestic violence ([www.qut.edu.au](http://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 a 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 the National Centre for Education and Training on Addiction (NCETA)<sup>(97)</sup> 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 – staff skills & qualifications

- ✓ **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<sup>(98,99)</sup> and one qualitative focus group study<sup>(98)</sup> that partly addressed this question.

### Summary of findings

An Australian survey-based study<sup>(99)</sup> 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.<sup>(99)</sup>

A US survey-based study<sup>(98)</sup> 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<sup>(100)</sup> 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.<sup>(100)</sup>

### 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 - staff safety & self-care

- ✓ **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](http://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](http://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](http://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](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](http://www.nada.org.au/media/92629/responding_to_dv_what_you_need_to_know.pdf)

### USA

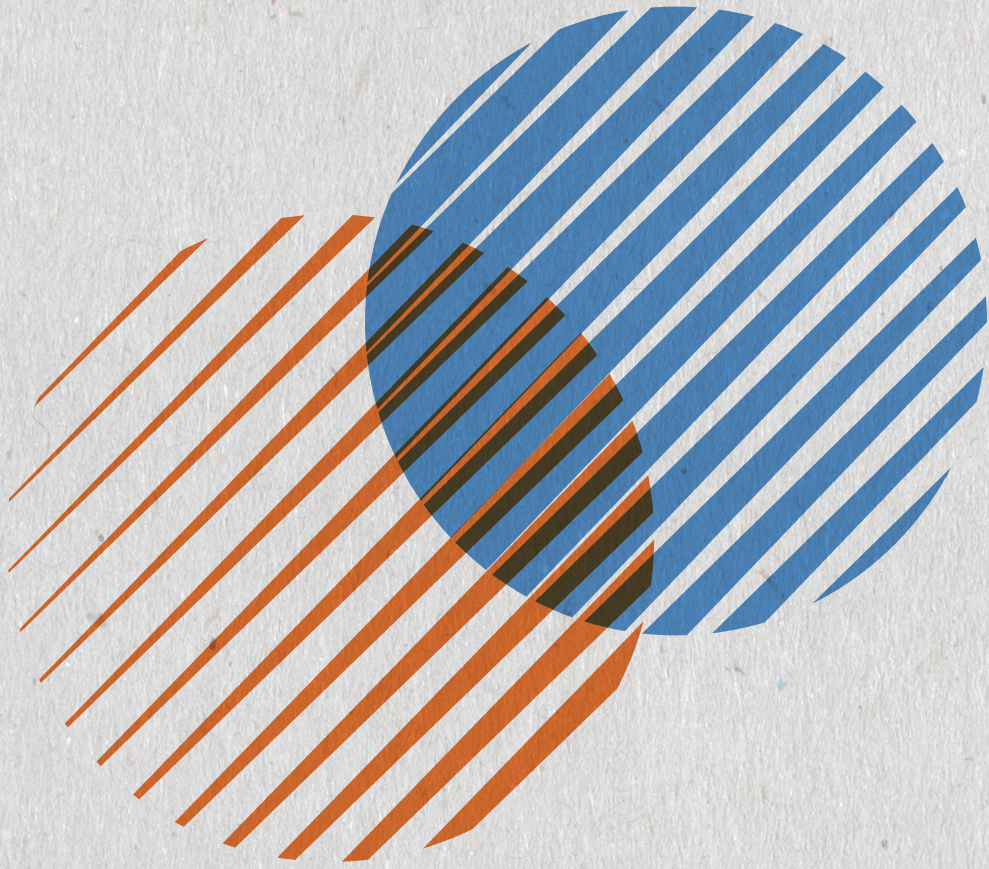
Substance Abuse and Mental Health Services Administration (US). (1997). *Substance abuse treatment and domestic violence. Treatment Improvement Protocol (TIP) Series No. 25*. Rockville: Department of Health and Human Services USASAMHSA.

Available from: [www.samhsa.gov](http://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/resources/complicated-matters/>



# Appendices

# Appendix A:

## 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

#### 1<sup>st</sup> 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).

#### 2<sup>nd</sup> screen

All of 1<sup>st</sup> screen INCLUDED studies merged into one EndNote, duplicates removed and 2<sup>nd</sup> screen INCLUDED/EXCLUDED completed of all studies (N=323).

#### 3<sup>rd</sup> screen

All of 2<sup>nd</sup> 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.

#### 4<sup>th</sup> 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.

## Appendix B:

### Co-design Process and Acknowledgements

#### Co-design Process

The *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings* was 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.

The process for developing the Practice Guide acknowledged the gaps in the literature regarding responding to DFV in AOD settings. As is the case with other clinical guidelines,<sup>(101)</sup> 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.

#### Stage 1 Generating questions

A half day Clinical and Expert Roundtable developed the clinical questions that the framework would seek to answer, including in relation to: 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 generated in Stage 1 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.

#### Stage 3 Consensus generation

The Clinical and Expert Roundtable reviewed and considered the draft Practice Guide, drew conclusions about reasonable clinical practice

based on evidence, and formed a consensus view on strategies and programs to guide practice where evidence is lacking.

#### Stage 4 Review

The Practice Guide was circulated to a broad range of clinical and expert stakeholders for final review and feedback.

#### Stage 5 Finalisation

Stage 4 review and feedback guided revision of the second draft of the Practice Guide, which was finalised in December 2017.

#### 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 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;*
- *Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings* (this document)

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.

### **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)
- 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**

- 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 McKenry, Karralika Programs Inc.

- Susan Clarke-Lindfield, Toora Women Inc & Women's Services Network
- Amanda Bode, Anke van der Sterren and Carrie Fowlie, ATODA

### **External Reviewers**

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

### **ATODA Staff**

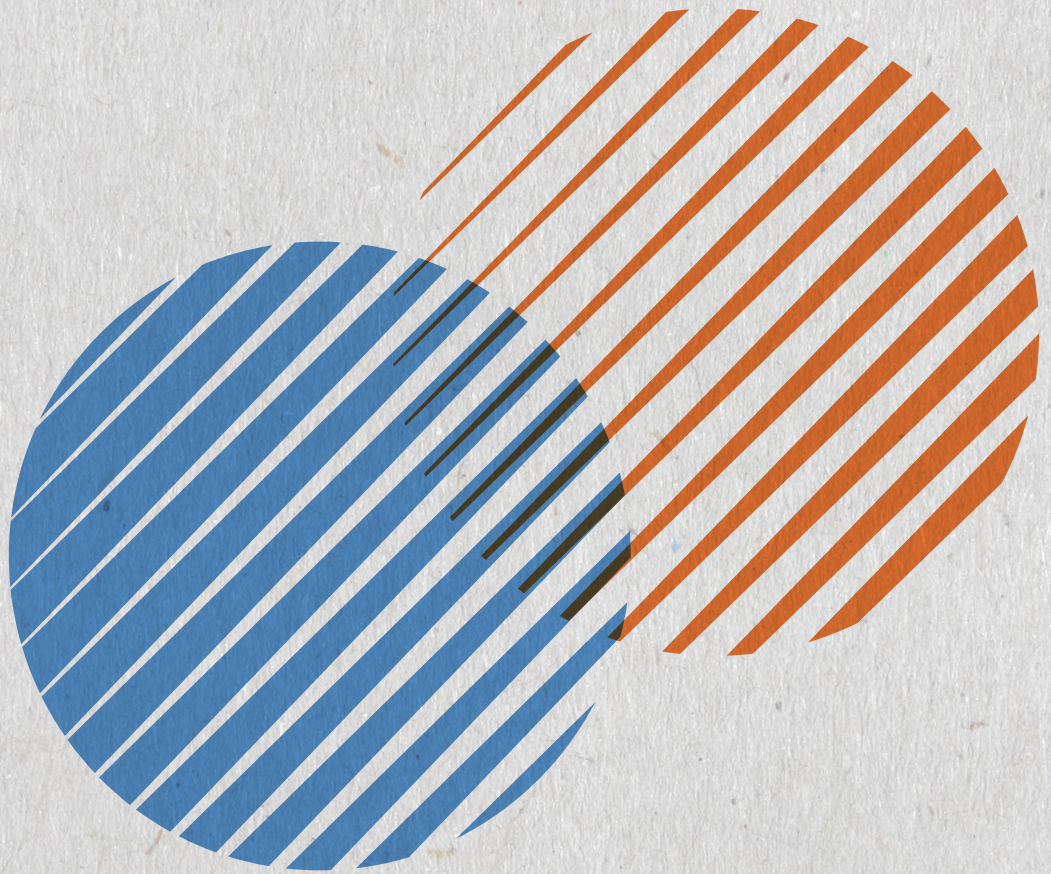
- Amanda Bode, Program Manager
- Anke van der Sterren, Researcher and Project Manager
- Carrie Fowlie, Chief Executive Officer
- Jeanette Bruce, Organisational Development Officer
- Julie Robert, Communications Officer
- Dave Corby, Office Manager
- Melinda Petrie, Project Manager

## Appendix C:

### Definitions of domestic and family violence in jurisdictions of Australia

The use of this Practice Guide should be with consideration of the various legislative terminologies and definitions of domestic and family violence in each of the Australian jurisdictions. The legislation for each state and territory can be found at the following locations:

Jurisdiction	Title of Legislation	Location
Australia	Family Law Act 1975	<a href="http://www.legislation.gov.au">www.legislation.gov.au</a>
ACT	Family Violence Act 2016	<a href="http://www.legislation.act.gov.au">www.legislation.act.gov.au</a>
NSW	Crimes (Domestic and Personal Violence) Act 2007	<a href="http://www.legislation.nsw.gov.au/#/">www.legislation.nsw.gov.au/#/</a>
NT	Domestic and Family Violence Act	<a href="http://www.legislation.nt.gov.au">www.legislation.nt.gov.au</a>
QLD	Domestic and Family Violence Protection Act 2012	<a href="http://www.legislation.qld.gov.au">www.legislation.qld.gov.au</a>
SA	Intervention Orders (Prevention of Abuse) Act 2009	<a href="http://www.legislation.sa.gov.au">www.legislation.sa.gov.au</a>
TAS	Family Violence Act 2004	<a href="http://www.legislation.tas.gov.au">www.legislation.tas.gov.au</a>
VIC	Family Violence Protection Act 2008	<a href="http://www.legislation.vic.gov.au">www.legislation.vic.gov.au</a>
WA	Restraining Orders Act 1997	<a href="http://www.slp.wa.gov.au/legislation/statutes.nsf">www.slp.wa.gov.au/legislation/statutes.nsf</a>



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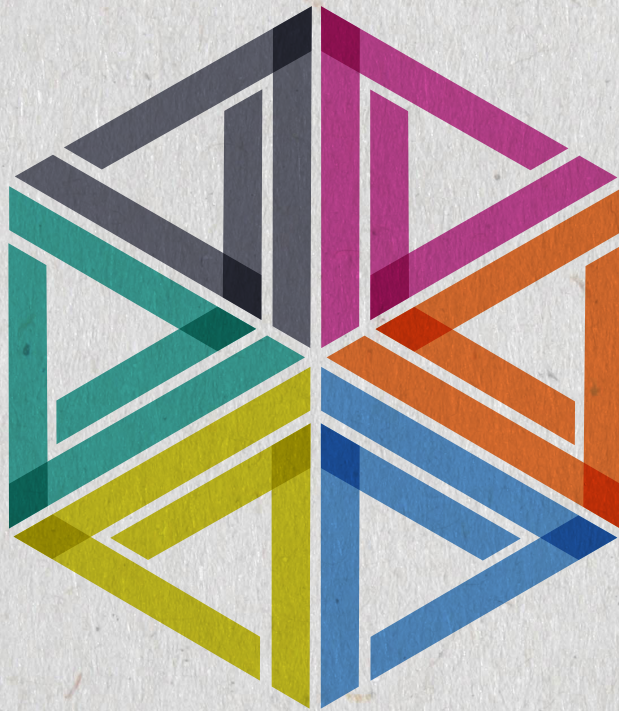
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