Breaking the Silence:

Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia

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ODYSSEY HOUSE VICTORIA

NCETA
Australia's National Research Centre on AOD Workforce Development

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A REVIEW OF THE LITERATURE

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Foreword

There is a growing impetus for a more comprehensive approach to understanding and addressing the causes of family and domestic violence (FDV), and its prevention and treatment across the broader welfare system. This includes an increased focus on the interrelationship between sectors such as alcohol and other drugs (AOD), child and family welfare, child protection and FDV. It is also reflected in a number of national policies related to protection and wellbeing of children and the support provided to their families.

This review explores the relationship between AOD and FDV services, with a focus on identifying how the AOD sector can better support their clients who have co-occurring family and domestic violence issues and minimising the harm experienced by children.

The review extends NCETA's program of work on child protection and child and family practice, and reflects an important collaboration with the treatment and service delivery sector via Odyssey House Victoria.

NCETA

The National Centre for Education and Training on Addiction is an internationally recognised research centre that works as an catalyst for change in the alcohol and other drugs (AOD) field.

Our mission is to advance the capacity of organisations and workers to respond to alcohol- and drug-related problems. Our core business is the promotion of workforce development (WFD) principles, research and evaluation of effective practices; investigating the prevalence and effect of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and organisations.

NCETA is based at Flinders University and is a collaboration between the University, the Australian Government Department of Health and Ageing and the SA Department of Health.

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Executive Summary

This literature review examines the relationships between alcohol and other drug (AOD) use and "family and domestic violence" (FDV) in the context of AOD treatment settings. It focuses on strategies that may be developed to enhance the responses of alcohol and other drug (AOD) treatment providers to FDV issues affecting clients and their children.

While the AOD sector has long been aware of the association between FDV and AOD problems, it can be challenging to address this issue. In a time of contracting resources and growing demands, this task may seem even more daunting. Also few staff have received training or support to address FDV, and hence, may lack the requisite confidence or knowledge and skills.

The impetus to enhance responses to FDV issues reflects a growing awareness of the wide array of factors that impact on client wellbeing and that may impede their progress when dealing with AOD issues. Addressing FDV is also part of a suite of measures increasingly implemented by AOD services in Australia to enable such services to be more family sensitive.

The term "family and domestic violence" includes a wide range of abusive behaviours committed in the context of intimate relationships. These relationships may involve family members such as:

- *Children and siblings*
- *Spouses/de-facto partners*
- *Ex-spouses/partners*
- *Parents and/or caregivers.*

FDV can include many types of behaviour or threats, including:

- *Physical violence*
- *Sexual abuse*
- *Emotional abuse*
- *Verbal abuse and intimidation*
- *Economic and social deprivation*
- *Damage of personal property*
- *Abuse of power*
  (Australian Bureau of Statistics, 2006).

Who Experiences FDV?

AOD clients may have either experienced and/or used violence in their intimate relationships. FDV predominantly involves males who use violence against their female partners. However, this is only one of its manifestations. FDV also occurs in other relationships including non-spousal, same-sex, and carer relationships. Some may also experience violence from their partner, and then subsequently use violence against their children.

Evidence from the USA suggests that many AOD clients have experienced FDV with between 41-80% of women in AOD treatment programs experiencing violence, and 4-40% of women in FDV programs reporting AOD problems (Gutierres & Van Puymbroeck, 2006).

Hence, FDV is likely to feature in the background of the majority of women in AOD programs. In addition, Aboriginal and Torres Strait Islanders are also substantially over-represented in AOD treatment, FDV and related child abuse and neglect data. While it is unknown what proportion of male AOD clients have carried out or suffered from FDV, it is likely to be a substantial proportion on the basis of available indicators. As approximately two thirds of people seeking help through AOD services are male, an important opportunity exists to engage with men who may use violence in their relationships.

The conceivably high prevalence of AOD clients who have experienced FDV highlights the need for services to respond to this problem. Such a response may also minimise AOD clients' children's exposure to FDV. For every adult seeking AOD treatment, there is generally one child impacted by problematic parental AOD use. Addressing FDV within the AOD sector may reduce the risk of harm to clients' children.

To-date, FDV has been a largely neglected issue in AOD services, and an area where staff have received little training. Improvements are most likely to occur when system-wide coordination occurs. Silos in service provision are a major impediment to coordinated services for clients with AOD and FDV problems. Coordination at this level can result in improved access to high quality and effective services for these problems.

Key Issues

Three key issues in the FDV field, with important implications for AOD services, are:

1. *The AOD - FDV relationship*

   When problematic AOD use is involved (particularly alcohol), the incidence of FDV and risk of harm with more severe injuries increases. Nevertheless, the association between problematic AOD use and FDV is complex and multifaceted. The FDV sector has largely rejected problematic AOD use as a cause of FDV, and attributes responsibility to the person who uses violence in their relationships. However, the available evidence suggests that, among women in particular, problematic AOD use and FDV can involve a reciprocal bi-directional relationship. That is, either problem can increase risk of the other.

2. *Family/domestic violence and gender*

   Family and domestic violence is not gender neutral. The evidence clearly shows that:

   - *Women, and subsequently their children, suffer more from FDV than men*
   - *Men are more likely than women to use violence in their relationships*
   - *Women are more likely than men to be injured by FDV and to express fear as a result of the violence.*

3. *Problematic AOD Use and FDV*

   A significant proportion of AOD treatment services' clients have either used, suffered from or been exposed to violence in their intimate relationships. For these clients, AOD problems may be inextricably linked to FDV issues. There are two non-mutually exclusive perspectives in regard to the relationship between AOD use and FDV. These are:

   I. Problematic AOD use by a person who experiences violence increases their likelihood of either carrying out or suffering from FDV

   II. Problematic AOD use may be a response to FDV.

While not all families with AOD problems have experienced FDV, there is considerable evidence that problematic AOD use is associated with increased prevalence of FDV. Families where problematic AOD use and FDV are present are also likely to experience a cluster of other problems. These include:

- *Psychiatric or psychological co-morbidity*
- *Physical health problems*
- *Housing and employment problems*
- *Socio-economic disadvantage*
- *Social isolation.*

Any interventions adopted by AOD treatment organisations to address AOD-related FDV issues should be broad based and address multiple problems.

Impact on Children

There is considerable evidence that problematic parental AOD use is associated with an increased prevalence of child maltreatment. Problematic parental AOD use can affect many aspects of a child's life. It can be difficult to disentangle the effects of problematic parental AOD use from broader social and economic factors that can also affect the wellbeing of children.

Parents with AOD problems can experience additional marginalisation and discrimination due to their parental status, which can be further exacerbated by FDV. It is important for AOD services to counteract this marginalisation and discrimination and develop interventions that support parents' strengths, and build self-esteem and coping skills while addressing AOD issues.

There is an imperative for AOD services to provide treatment that is free from intimidation and safe for all participants. AOD services may be able to enhance parenting skills while simultaneously helping to resolve presenting AOD problems.

The presence of problematic parental AOD use alone is not sufficient to warrant the involvement of child protection authorities in Australia. However, it may be a contributor to neglect or harm which can instigate responses from child protection authorities. All Australian jurisdictions have mandatory child abuse reporting requirements which may involve AOD treatment services.

AOD Service Responses

Areas where the focus of AOD services could be improved to support clients with FDV issues include:

1. *Evidence based policy and practice responses*
2. *Organisational awareness of family issues*
3. *Prioritising safety*
4. *Coordination of services*
5. *Policies and systems*
6. *Standard response frameworks*
7. *Broad-based interventions*
8. *Access to highly skilled practitioners if required*
9. *Workforce development*
10. *Monitoring, accountability and evaluation*

There is substantial capacity for the AOD sector to enhance its ability to detect and respond to FDV and for the AOD and FDV sectors to work more collaboratively to meet the needs of clients with such complex needs.

Knowledge Gaps

Many knowledge gaps exist in this area. At present, it is difficult to ascertain on the basis of current Australian and international research if FDV is a barrier to seeking treatment in AOD services. Little is also known about the impact of AOD workers' attitudes and beliefs in relation to FDV. Nor is it known what their skill and confidence levels are in identifying and addressing FDV.

Research that has investigated the impact of drugs on FDV is also limited in its generalisability. Much of this research excludes poly-drug use, and suffers from inadequate study designs, sampling biases and measurement difficulties. In addition, as much of the research is international, it may have limited applicability in Australia (Dawe, Atkinson, Frye et al., 2007).

Conclusion

A significant proportion of AOD clients are likely to have currently, or previously, experienced FDV. For these clients, AOD problems may be inextricably linked to FDV issues.

There is substantial capacity for the AOD sector to enhance its ability to detect and respond to FDV problems. There is also significant capacity for the AOD and FDV sectors to work more collaboratively to better support clients with complex needs.

However achieving this will require organisational commitment to the development and implementation of FDV policies and procedures, and the provision of appropriate professional development and supervision.

Significant work has been undertaken in this area internationally, in particular in the United Kingdom (the Stella Project and Alcohol Concern). Australia is therefore well placed to learn from these initiatives, and to develop initiatives tailored to meet the needs of Australian treatment services.

Part A: Introduction

In recent years there has been growing awareness of the wide range of contributory factors that impact on both the development and resolution of alcohol and drug (AOD) problems. For instance, there has been increased awareness of the relationship between mental health and AOD problems, commonly referred to as comorbidity.

Similarly, there is an improved understanding of the nature of the multiple morbidities that many clients of AOD services experience, including a wide array of social problems such as housing, education and employment. It is increasingly recognised that the resolution of AOD problems needs to be broad and comprehensive in terms of the issues addressed.

This examination of family and domestic violence (FDV) is undertaken within this context of a broadened view of the needs of clients and addresses the implications for the roles that services should play. It examines the issue of domestic violence in terms of presentations and needs of AOD clients, and also the needs of the clients' children.

The review outlines the complex array of issues involved in FDV and presents key data on prevalence within AOD treatment settings. Attention is then directed to strategies that may be developed to enhance the responses of AOD treatment services to FDV issues affecting clients and their children.

This review of FDV and AOD focuses predominantly on alcohol. The focus on alcohol is a result of several factors:

1. this is the drug most commonly used in the Australian community
2. substantial research has been undertaken to examine the relationship between alcohol and violence in general
3. there is a detailed understanding of the role played by alcohol
4. the evidence base for other drugs is more limited, and
5. prevalence of illicit drug use is comparatively low.

This is not to imply that other drug use, including poly-drug use, plays an insignificant role in FDV; rather, that research in that area is less advanced. The literature concerning the impact of parental drug use on FDV and child outcomes is less well developed than for alcohol; hence, there is less empirical data to draw upon to identify the relationship between drug use and violence, and FDV in particular.

The work undertaken in relation to the impact of drugs also has limitations that include:

- the narrow range of illicit drugs investigated (generally excluding poly-drug use)
- inadequate study designs
- sampling biases, and
- measurement difficulties.

Much of this work has also been undertaken in other countries and may have limited applicability in Australia (Dawe et al., 2007).

Background and Definitional Issues

For the purposes of this review the term "family and domestic violence" includes a wide range of abusive behaviours committed in the context of intimate relationships. These relationships may involve:

- Children and siblings
- Spouses/de-facto partners
- Ex-spouses/partners
- Parents and/or caregivers.

FDV can include many types of behaviour or threats, including:

- Physical violence
- Sexual abuse
- Emotional abuse
- Verbal abuse and intimidation
- Economic and social deprivation
- Damage of personal property
- Abuse of power
  (Australian Bureau of Statistics, ABS, 2006).

Violence can be located in, and maintained by, the use and threat of power and control whereby those who use violence in their intimate relationships make it difficult, if not impossible, for those subjected or exposed to the violence to see non-abusive life options (Bennett & O'Brien, 2007). As such, a person subjected to a violent relationship may remain in the relationship for a lengthy period.

Reasons for remaining in violent relationships are diverse and complex, and include:

- The fear, emanating from the violent party's threats or behaviour, that the person subjected to violence will suffer further violence, increased danger or loss of life
- Fear of stalking or abduction
- Loss of AOD supply
- Isolation or rejection from community, friends and family
- Loss of home, income, pets and possessions, or having a reduced standard of living
- Negative impacts on children such as loss of school, friends, community, relationship with parent or family
- Grief for the loss of partnership
- Feelings of guilt and self-blame
- Fear of losing children or having children removed (The Stella Project, 2007).

The dynamics of domestic and family violence are complex as illustrated in 'the cycle of violence' model (see Table 1) developed by a US based researcher Dr Lenore Walker (Walker, 1984).

Table 1 The Cycle of Violence (Walker, 1984)

The build-up phase	May begin with normal relations between the people in the relationship, but involves escalating tension marked by increased verbal, emotional or financial abuse. In non-violent relationships these issues would normally be resolved between the people in the relationship.
The stand over phase	Can be extremely frightening for people affected by domestic and family violence. The person subjected to violence may fear that anything they do will cause the situation to deteriorate further and feel that they have to "walk on egg shells". The behaviour of the person who uses violence in relationships escalates to the point that a release of tension is inevitable.
Explosion	This stage marks the peak of violence in the relationship and can involve physical assault, terrorising, threats to bodily integrity, reputation, or financial status, and property damage.
Remorse	In this phase, the person who uses violence in their relationships feels ashamed of their behaviour and/or they may be afraid of the consequences. They may retreat and/or become withdrawn from the relationship. They may try to justify or minimise their actions to themselves and to others.
Pursuit	In this phase, the person who uses FDV promises never to be violent again and may go through a dramatic personality change. The person who uses domestic violence may try to make up for their past behaviour during this period, and blame other factors for their violence (e.g., work stress, drugs, or alcohol). They may try to win back their partner with gifts and promises and attention, or they may act helpless, saying such things as "I can't live without you: or "I'll kill myself". The person affected by the violence will feel hurt, but possibly relieved that the violence is over. If these tactics do not work, the person who uses violence in their intimate relationships may use more threats and violence.
The honeymoon	During this phase both people in the relationship may be in denial about the severity of the abuse and violence. Both people do not want the relationship to end, so ignore the possibility that the violence could occur again.
This cycle may occur many times in abusive relationships. Each phase may last a different amount of time and a full cycle can take anywhere from a few hours to a year or more. Typically over time, the violence escalates whilst the interval between each phase shortens. It is common for the honeymoon phase to become shorter, the longer the relationship continues. In some cases, this phase may become non-existent.	

Prevalence

Not all families with AOD problems experience FDV. Nevertheless, problematic AOD use has strong associations with violence in general, and FDV in particular.

In 2010, 28% of Australians aged 14 years and older were victims of an alcohol-related incident,[1] including almost 8% who were subject to physical abuse. In almost 40% of instances of alcohol-related physical abuse against females, the perpetrator was a current or former spouse/partner, compared with 11.4% of males (Australian Institute of Health and Welfare, 2011a).

The International Violence Against Women Survey (IVAWS) also demonstrated a strong association between alcohol, drugs and FDV. The IVAWS was conducted between December 2002 and June 2003 with 6,677 women from across Australia (Mouzos & Makkai, 2004). Over a third of women, with a current or former intimate partner, reported experiencing at least one form of partner-related violence during their lifetime.

Women in the IVAWS survey reported that on the last occasion of partner violence:

- 35% of partners were drinking alcohol
- 4% of partners were using other drugs
- 6% of partners were using alcohol and other drugs
- 50% of partners were using neither alcohol nor other drugs.

This research found that the strongest risk factors for current intimate partner physical violence were associated with partners' behaviour, including drinking habits, levels of aggression and controlling behaviour (Mouzos & Makkai, 2004).

In 2010, 41% of domestic assault incidents in NSW, were flagged by police as alcohol related (Grech & Burgess, 2011).

Similarly, international research identifies that:

- 44% of domestic violence offenders were under the influence of alcohol and 12% affected by illicit drugs when they committed acts of physical violence (Budd, 2003)
- 51% of respondents from research in UK domestic violence agencies indicated either they or their partners had used AOD in problematic ways in the last 5 years (Humphreys, Thiara & Regan, 2005)
- The likelihood of male to female aggression doubled on days when men misused alcohol and cocaine (but not cannabis or opiates) (Fals-Stewart, 2003).

Correspondingly, clients of AOD services and FDV programs in the US also reported high levels of FDV and AOD (Gutierres & Van Puymbroeck, 2006). The prevalence of FDV among clients in AOD treatment programs (41-80%) was approximately twice the level of AOD problems among clients in FDV programs (4-40%) This indicates that women in AOD programs experienced FDV as the norm, with approximately half to four fifths having experienced FDV (Gutierres & Van Puymbroeck, 2006).

Whilst international research is not necessarily transferrable to Australia, due to differences in the prevalence of AOD use, these figures may be indicative of the prevalence of FDV among AOD sector clients.

The prevalence of AOD problems is less common among women in FDV programs than FDV problems are among AOD clients. Given what is known about potential causal pathways between FDV and the emergence of AOD problems it is of fundamental importance that this issue is addressed in AOD treatment services.

Women represent 31% of the clients in Australian AOD treatment services, the main presenting drug of concern is alcohol in 48% of cases, and 47% of clients are aged between 30 and 49 years (Australian Institute of Health and Welfare, 2011a, 2011b). Therefore, there is a high likelihood of a substantial proportion of clients in most services having an involvement with FDV issues; making this issue particularly salient for all treatment providers. As these are also the principal child rearing years, it is likely that women experiencing violence may also have children who are either subjected to and/or exposed to violence.

[1] Including verbal or physical abuse or being put in fear.

Complex Relationships

There are important FDV relationships which have implications for AOD services in terms of meeting the needs of clients. They are:

- the relationship between problematic AOD use and FDV
- family and domestic violence and gender
- the role of the victim's use of AOD in FDV
- the impact of FDV and AOD use on children.

Alcohol

The association between FDV and problematic alcohol use is well established. There is strong evidence that the level of harm associated with FDV increases, and results in graver injuries, when alcohol is involved.[2]

The most widely accepted explanation of the association between alcohol and violence is that violence results from a range or combination of factors including:

- the pharmacological effects of alcohol
- a person with a propensity to be aggressive when drinking
- a drinking context that allows aggressive acts to be played out
- a culture tolerant of alcohol-related aggression (Graham, Wells & West, 1997).

Alcohol consumption alone is neither a necessary nor sufficient explanation for FDV. This is especially evident when considered in light of the observation that men who are violent to their partners when drinking also tend to be violent when sober (Galvani, 2010).

The domestic violence sector has rejected alcohol use as a cause of FDV (Braaf, 2012) on the basis that if alcohol was viewed as the causal agent, it would imply that it was alcohol, rather than the abuser, that was to blame for the abuse. In other words, the behaviour would be seen as stemming from intoxication-related impairment rather than the characteristics of the person.

Nonetheless, it is evident that excessive consumption can significantly impact on relationships and contribute to a range of negative outcomes including abuse and violence. Alcohol (or other drug use) should not be accepted as an excuse for violence, but it can be understood as increasing the likelihood of and harms from FDV.

[2] See Braff (2012) for a summary of this evidence.

Other Drugs

The association between the use of other drugs and FDV has not been examined to the same extent as alcohol. However, there is evidence of an association between FDV and illicit drug use, particularly among males who use violence in their relationships (for a review of this literature see Stuart (2008)).

In a study of men and women arrested for FDV in the United States, self-reported illicit drug use was a stronger predictor of FDV occurring than either the arrestees' or their partners' problematic alcohol use. Male arrestees' cannabis and stimulant use (i.e., cocaine and amphetamine) was associated with an increased risk of FDV, as were their reports about their female partners' stimulant use (Stuart, 2008).

There is also evidence of an association between the use of some illicit drugs and violence which may include FDV. Use of methamphetamine is related to violence, particularly use which results in psychosis, or transient psychotic episodes (McKetin, McLaren, Riddell & Robins, 2006).

While not implying a causal link between methamphetamine use and violence, McKetin et al. (2006) pointed to experimental evidence that chronic use of the drug increases the risk of violent behaviour, and that some chronic methamphetamine users report problems controlling violent behaviour. However, it was unclear whether violent behaviour was due to methamphetamine use per se, or to co-occurring factors such as alcohol use, psychiatric status, personality, or associated lifestyle factors.

Dawe et al. (2009) suggest that aggressive and violent behaviour among those who use amphetamines may be related to the drug's effect on executive functions which control self-management, decision making and impulsivity coupled with the neurotoxic effect on the dopaminergic and serotinergic systems which has been associated with aggressive behaviour in both human and animal studies.

Cannabis typically causes a sedative effect, potentially making it less likely to be associated with violence than other substances. Nonetheless, it is also associated with aggression and violence. The use of cannabis can lead to fear, anxiety, panic or paranoia or psychosis. Violence occurs more often among people who use cannabis regularly, rather

than those who use it occasionally or not at all. It is plausible that people with violent tendencies also have a range of other psychosocial problems and are therefore more likely to use cannabis (National Cannabis Prevention and Information Centre, 2011).

Causal Attribution

While problematic AOD use does not necessarily *cause* FDV, the extent to which clients, regardless of whether they use and/or are subjected to violence in their intimate relationships, recognise or attribute the cause of the violence to AOD substances is an important issue for clinical practice settings.

Attribution of the role played by alcohol may occur in several ways:

- the person who uses violence in their relationship may blame alcohol for their violent or abusive behaviour rather than take responsibility for it themselves
- the person who experiences violence may blame:
  - alcohol rather than assign responsibility to the abuser for the violent behaviour
  - their own drinking for their partner's violence (Galvani, 2010).

Regardless of the nature of the attribution, it is important for service providers to be aware of both the high prevalence of FDV among clients, and the potential role FDV may play as either a contributor to, or facilitator of AOD problems, or as an impediment to the resolution of such problems. From an intervention perspective, identifying power and control strategies employed by those who use violence, and supporting and preserving the abused person's safety, needs to be considered when understanding and addressing problematic AOD use that is occurring within the relationship (Humphreys et al., 2005).

Gender

FDV is not a gender neutral issue. The evidence clearly shows that women are subjected to FDV more frequently than men (Galvani, 2010), and that men are more likely than women to use violence in their relationships (Australian Bureau of Statistics, 2006). Women are also more likely than men to express fear and suffer injuries as a result of relationship violence (Gutierres & Van Puymbroeck, 2006; Langhinrichsen-Rohling, 2010).

However, not all men who have AOD issues use violence in their relationships, and sometimes men are also subjected to FDV. There is also increasing evidence that FDV, in heterosexual relationships at least, can be bi-directional, with both male and female partners instigating and suffering abuse. [3]

FDV also occurs in non-spousal, same-sex, and carer relationships. While FDV predominantly concerns males who use violence in their relationships and females who experience violence, this is only one of its manifestations. FDV also occurs in other types of relationships, and includes the violence experienced by children.

FDV Exposure and Alcohol and Other Drug Use

A further issue concerns the relationship between the person who experiences violence and problematic AOD use. There are two non-mutually exclusive perspectives related to this issue.

1. *Problematic AOD use increases the likelihood of suffering FDV*

There is a range of mechanisms through which the someone's alcohol use can increase the likelihood of victimisation (Braaf, 2012) or compound associated problems. Problem drinking by the person subjected to violence can:

- impair judgement
- reduce capacity to implement safety strategies
- increase level of dependence on an abusive partner
- reduce ability or desire to seek help from police, possibly due to shame or memory loss
- reduce the likelihood that person who experiences violence will be believed, or taken seriously, by police
- increase the likelihood that they will be blamed for the violence experienced
- exclude women from support services for refuge, advocacy or other assistance
- increase the risk of losing custody of their children.

This does not imply that someone's drinking causes FDV; rather, that a complex set of factors play a role in precipitating and perpetuating violent relationships.

[3] See Langhinrichsen-Rohling (2010) for an examination of the evidence and controversies concerning this issue.

2. *Problematic AOD use may be a response to FDV*

Alcohol and other drugs may also be used in response to FDV and the stressors associated with it. At one level, substances can be used as a short term coping mechanism to help deal with the physical and emotional pain and distress (Braaf, 2012).

Over a lifetime, a complex intra-generational cycle of violence and problematic AOD use among AOD clients (particularly among women) has also been identified. This can begin with the experience of childhood sexual and physical abuse and the later manifestation of AOD problems as an adult, often associated with post-traumatic stress disorder:

> *….victims of childhood sexual and physical abuse exhibit negative psychological outcomes of low self-esteem, depression, and anxiety, and they may turn to substance use as a way to cope with these painful psychological consequences.*
>
> *Once women begin to use substances, their experience in the drug world, coupled with their vulnerable psychological state from childhood trauma puts them at risk for continued victimization from domestic violence, and from sexual assault. The experience of adult victimization reinforces negative feelings of low self-worth, depression and helplessness for these women which in turn leads to continued misuse and dependence on substances* (Gutierres & Van Puymbroeck, 2006, p. 497).

Problematic AOD use can also increase risk of victimisation via other paths, including:

- impairing the judgement of the victim and perpetrator
- exposing victims to potential partners with problematic AOD use problems who are also violent
- encouraging financial dependency on perpetrators (Bennett & O'Brien, 2007).

The available evidence suggests that problematic AOD use and FDV (among women in particular) can each increase the risk of the other (Bennett & O'Brien, 2007).

The complex relationship between problematic AOD use and FDV highlights the need for AOD services to be vigilant in detecting and responding to these issues among their clients. A FDV risk assessment is warranted for all clients. Such assessments should include exposure to, and use of, violence in relationships.

Aboriginal and Torres Strait Islanders

AOD and FDV problems are even more pronounced and complex among Aboriginal and Torres Strait Islanders. Although a much smaller percentage of the Aboriginal and Torres Strait Islander population drink than the general population, this group is substantially over-represented in AOD treatment and FDV data.

In 2009–10, about one in seven (13%) publicly funded AOD treatment episodes in Australia involved clients who identified as being of Aboriginal and Torres Strait Islander origin. Given that 2.5% of the Australian population is Aboriginal and Torres Strait Islander, this group is substantially over-represented in AOD treatment in Australia.

In 2003–04, in Queensland, Western Australia, South Australia and the Northern Territory Aboriginal and Torres Strait Islander women and men were 35 and 22 times, respectively, more likely to be hospitalised due to family violence-related assaults compared with other Australians (Australian Institute of Health and Welfare, 2006).

For Aboriginal and Torres Strait Islander women, about one in two hospitalisations for assault (50%) were related to family violence compared to one in five for Aboriginal and Torres Strait Islander men. Most hospitalisations for family violence-related assault for women were a result of spouse or partner violence (82%) compared to 38% among men (Australian Institute of Health and Welfare, 2006).

NSW Police data from 2010 indicated that the rate of domestic assault for Aboriginal and Torres Strait Islander women was more than six times higher than for non-Aboriginal and Torres Strait Islander women. Aboriginal and Torres Strait Islander men were also almost four times more likely to experience domestic violence than non-Aboriginal and Torres Strait Islander men (Grech & Burgess, 2011).

Child abuse and neglect are serious problems among some Aboriginal and Torres Strait Islanders where rates of substantiated child abuse and neglect notifications exceed those of non-Aboriginal and Torres Strait Islander Australians. In 2010-11, Aboriginal and Torres Strait Islander Australian children were almost 8 times as likely to be the subject of substantiated child abuse and neglect notifications as non-Aboriginal and Torres Strait Islander children.

In 2011, the rate of Aboriginal and Torres Strait Islander children on care and protection orders was over 9 times the rate of non-Indigenous children. Similarly, the rate of Aboriginal and Torres Strait Islander children in out-of-home care was 10 times the rate of non-Aboriginal and Torres Strait Islander children (51.7 and 5.1 per 1,000 children, respectively) (Australian Institute of Family Studies, 2012).

Many of the risk and protective factors associated with problematic parental AOD use, FDV and the quality of outcomes for children are similar across cultures (Dawe et al., 2007). Aboriginal and Torres Strait Islander Australians are particularly vulnerable to socio-economic disadvantage. This is, at least in part, a result of a unique historical context, involving colonisation and subsequent loss of cultural identity, and the structural violence that stemmed from past legislative processes and social policies (including the systematic forced removal of children) (Dawe et al., 2007; Gleadle, Freeman, Duraisingam et al., 2010).

The dramatic changes resulted in a group of profoundly hurt people living with multiple layers of traumatic distress, chronic anxiety, physical ill-health, mental distress, fears, depressions, substance abuse and high imprisonment rates. For many, alcohol became the treatment of choice, because there was no other treatment available. Throughout Indigenous society are seen what can only be described as dysfunctional families and communities, where interpersonal relationships are very often marked by anger, depression and despair, dissension and divisiveness. These effects are generational. It is not the drug or alcohol use that is the whole problem. Take the substances away and the pain, the distress, the trauma remain
(Dawe et al., 2007, p. 94).

Given the high prevalence of AOD problems and FDV issues among Aboriginal and Torres Strait Islander Australians, it is particularly important for AOD services to consider the possibility of FDV among Aboriginal and Torres Strait Islander clients.

Part B: Child Abuse and Neglect

The Association Between Problematic AOD Use and Child Abuse or Neglect

In addition to the strong association between AOD problems and FDV, it is also important for services to be mindful of potential associations between problematic AOD use and abuse and neglect of clients' children. There is a substantial body of evidence that problematic parental AOD use is associated with an increased risk of child maltreatment.

The point at which abusive or neglectful behaviours become "abuse" or "neglect" to the extent that the state intervenes to protect a child is dependent on definitions contained in jurisdictionally based legislation (Holzer & Bromfield, 2010).[4]

In recent years there have been increasing calls for adult specialist services to become more focused on the needs of families and children (Scott, 2009). There are also increasing calls for interventions with vulnerable families to be more evidence-informed (Arney, Lewig, Bromfield & Holzer, 2010). There is an emergent literature on enhancing the capacity of AOD programs to more effectively address FDV. A list of resources for AOD programs appears in Appendix 1.

The range of behaviours which are abusive or neglectful of children are shown in Table 2 (Holzer & Bromfield, 2010).

Table 2 Behaviours Abusive or Neglectful of Children

Abusive/neglectful behaviours	Descriptor
Maltreatment	Risky non-accidental, intentional or unintentional injury outside the usual norms of conduct.
Abuse	Acts of commission.
Neglect	Acts of omission.
Physical abuse	Any non-accidental physically aggressive act.
Sexual abuse	Any sexual activity between a child and an adult or an older person (five or more years older) than the child.
Neglectful behaviour	Physical neglect in which caregivers fail to provide for a child's basic needs.
Psychologically abusive or neglectful behaviour	Inappropriate verbal or symbolic acts and a failure to provide adequate non-physical nurturing or emotional availability.
Witnessing family violence	A child is present when a family member is subjected to physical, sexual or psychological abuse or is exposed to the damage caused to people or property by a family member's violent behaviour.

[4] This information along with an outline of mandatory reporting requirements is available at: http://www.aifs.gov.au/cfca/pubs/factsheets/a141787/index.html#table-2

A Victorian study found that among parents involved in substantiated cases of child neglect:

- approximately one third had problems with alcohol
- one third had other drug problems
- more than half had experienced family violence
- 19% had a psychiatric disability
  (Community Care Division Victorian Government Department of Human Services, 2002).

The report also indicated that all of these factors had increased over the preceding five years, with a particularly large increase in the proportion of parents with substance abuse problems and psychiatric disabilities. Further, the report found that as the number of re-notifications increase, so does the proportion of problematic AOD use.

In a study of 38,487 substantiated child protection cases in Victoria between 2001 and 2005 (Laslett, Dietze & Room, 2012), care-giver "alcohol abuse" was identified as involved in:

- one third of all cases
- 36% of protective interventions
- 42% of court orders.

Alcohol use, after adjusting for other drug use and other socio-demographic issues, was a significant predictor of:

- more intensive child protection responses
- protective interventions
- court orders
  (Laslett et al., 2012).

Despite evidence of a close association between problematic AOD use and child abuse and neglect, problematic AOD use by a parent does not necessarily mean that they are abusing or neglecting their children. However, compared to families with no problematic AOD use, families in which parental AOD use occurs are more likely to:

- come to the attention of child protection services
- be re-reported to child protection services
- have children removed from their care
- have the children remain in out of home care for long periods of time
  (Taplin & Mattick, 2011).

It is, therefore, important for AOD services to be aware of potential child maltreatment. It is also equally important not to assume that child maltreatment is occurring with all clients who are parents.

Dawe et al. (2007) suggested that mothers with AOD problems typically experience marginalisation and discrimination related to their parental status. There is an opportunity for AOD services to counteract this and to develop interventions that support these women's parenting strengths, and build their self-esteem and coping skills while addressing AOD issues.

By taking such steps, AOD services may be able to challenge these women's internalised views of being "hopeless parents", enhance their parenting skills and simultaneously help them address their AOD problems.

Mandatory Reporting of Child Abuse and Neglect

The presence of parental AOD problems alone is not sufficient to warrant involvement of child protection authorities in Australia. However, problematic parental AOD use may be a contributor to neglect, harm or other forms of abuse of a child, which can trigger responses from child protection authorities.

Problematic parental AOD use may be a factor in any behaviour that leads to abuse or neglect. It may also be an important indicator of psychological or emotional abuse. Due to the effects of drug use upon a parent's lifestyle, and in particular chronic or regular drug use, behaviours that involve no actual physical harm to a child may nevertheless still warrant a child protection response (Dawe et al., 2007).

All Australian jurisdictions have mandatory child abuse reporting requirements. However, individuals mandated to report, and the types of abuse that are required to be reported, vary significantly between Australian states and territories.

The relevant acts and regulations in the Australian Capital Territory, New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia contain lists of occupations that are mandated to report. Those mandated to notify range from a limited number of specified persons in specified contexts (Queensland) through to every adult (Northern Territory) (Australian Institute of Family Studies, 2012).

There are also differences between Australian jurisdictions with regard to how serious that behaviour, or its results must be before mandatory reporting and child protection action is triggered. Having higher reporting thresholds reduces the number of successful child protection actions (Dawe et al., 2007).

Although requirements vary between jurisdictions, mandated notifiers are generally required to notify authorities of child abuse when they have reasonable grounds to believe that abuse is occurring. In most jurisdictions, this includes providers of alcohol and other drug treatment services, although in some jurisdictions this depends on the professional background of the staff concerned.

Of particular importance to AOD workers is that mandatory reporting may act as an inhibitor to client self-disclosure of parenting problems. It may also have the potential to further marginalise those with substance use problems (Dawe et al., 2007) .

Regardless of the laws applying to their staff, many health and welfare organisations have implemented reporting policies for all staff where children are thought to be at risk of harm.

It is important to note that any person concerned about the safety and welfare of a child is at liberty to make a notification even if they are not mandated to do so.

Constellations of Family Problems

Families with AOD problems, FDV and other potential child maltreatment issues are also likely to experience a constellation of other problems. These may include:

- psychiatric/psychological co-morbidity
- socio-economic disadvantage
- social isolation

> *Many children of substance-abusing parents face a preponderance of negative life circumstances that collectively heighten their risk for negative outcome. Some of these children will go on to replicate their parent's social disadvantage. In a sense, there is an accumulation of disadvantage as negative events compound and become cyclical over time. Other children will move forward and lead healthy and productive lives*
> (Dawe et al., 2007 p. xvi).

In a study examining alcohol-related harms to others, Laslett et al. (2012) found that families reported to child protection services in Victoria were highly likely to be socio-economically disadvantaged and alcohol use was one of several risk factors that predicted more serious child protection outcomes.

An examination of 171 Sydney mothers undergoing treatment for opioid dependence (Taplin and Mattick, 2011), reported that it was factors other than the severity of problematic AOD use which were associated with involvement with the child protection system.

In that study, mothers who were involved with the child protection system had:

- a greater number of children
- current mental health problems (usually depression or anxiety)
- less support from their parents.

As Taplin and Mattick (2011) noted, an exclusive focus on AOD problems may, in practice, obscure a range of other contributory factors that can be ameliorated.

These findings have the following implications for AOD services:

- parents and families in contact with AOD treatment services who are experiencing FDV problems are highly likely to have a range of complex needs and have involvement with a range of organisations which seek to address those needs
- it is important for AOD treatment services to help families to manage the daily stressors in their lives including mental health problems and challenges stemming from socio-economic disadvantage
- tackling problematic AOD use in isolation is unlikely to be effective without addressing these key contextual issues (Dawe, Harnett & Frye, 2008)
- where FDV is occurring, any AOD treatment that focuses on the AOD use alone is unlikely to be very successful.

Part C:
What can Alcohol & Other Drug Services do?

The high prevalence of FDV among AOD clients is an issue that AOD workers are well aware of and deal with every day. However, there has been little specific information to guide AOD service responses to this challenging issue. There have also been a number of important legislative changes that impact on this work.

The National Drug Strategy (2010-15)[5] identified the need for:

- *closer integration of AOD services with child and family services to more effectively recognise and manage the impacts of drug use on families and children*
- *an enhancement in child and family sensitive practice in AOD treatment services and building links and integrated approaches with community, family and child welfare services.*

However, interventions, staff training and organisational workforce development strategies, as well as information to guide policies and procedures of AOD services, have not been readily available for all types of FDV. As a result, service responses to this important issue have been inconsistent both across and within services.

Barriers to Effective Responses to FDV

Improvements in outcomes for families with FDV and problematic AOD use issues are most likely to be achieved through system-wide coordination, which can result in improved access to high quality and effective services for this group (Bennett & O'Brien, 2007).

Barriers between AOD treatment services and FDV services have been well documented both in Australia and internationally (for example see Advisory Council on the Misuse of Drugs, 2003; Bennett & O'Brien, 2007; Dawe et al., 2008; Galvani, 2010; Humphreys et al., 2005; Scott, 2009).

These include:

- a cultural clash between services
- political pressures to continue the provision of single focus services possibly stemming from concerns about substance use being regarded as a cause of FDV
- problems of resourcing services for men, women and children with complex needs in the context of single focus service provision
- lack of knowledge and training in relation to "the other issue"
- problems of fragmentation at government level regarding policy and funding (Humphreys et al., 2005).

These are systemic and cultural barriers that must be addressed over time. However, at the service level, there is a range of ways in which AOD services may address FDV issues to improve outcomes for clients and services.

Child Protection Framework and Action Plan

In 2009, the Council of Australian Governments released a significant policy paper, 'Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children' (Council of Australian Governments, 2009). This framework sets out an intergovernmental approach to tackling the problems of child abuse and neglect in Australia.

A key feature of the Framework is its inclusion of a detailed strategy for Australian governments to work in partnership with non-government organisations (NGOs). The NGO sector includes community and faith-based services that work with children and families and also adult services that work with clients who are parents.

The National Framework calls for organisations to work more effectively across the historical silos that have existed between child and family welfare services and adult specialist organisations providing FDV and AOD services.

[5] The National Drug Strategy (Ministerial Council on Drug Strategy, 2011) is a cooperative venture between Australian, state and territory governments and the non-government AOD sector. It aims to improve health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society.

In August 2012, Australian Community and Disability Services Ministers endorsed a Second Action Plan (2012-15) under the Framework (Department of Families, 2012). The major theme for the Second Action Plan was:

> *Working together to improve the safety and wellbeing of Australia's children through strengthening families, early intervention, prevention and collaboration through joining up service delivery with mental health, domestic and family violence, drug and alcohol, education, health and other services (Department of Families, Housing, Community services and Indigenous Affairs, 2012).*

The problems most commonly associated with the occurrence of child abuse and neglect and identified in families involved with child protection services are:

- Family/domestic violence
- Parental alcohol and drug abuse; and
- Parental mental health problems.

These policies support AOD services adopting organisational measures that would assist clients and their children experiencing FDV problems.

The National Framework for Protecting Australia's Children contains a number outcomes which are relevant to better integration of FDV into AOD services. These are detailed below.

Supporting outcome 1: *Children live in safe and supportive families and communities.*	*Communities are child-friendly. Families care for children, value their wellbeing and participation and are supported in their caring role.* Reducing the vulnerability of families and protecting children from abuse and neglect begins with developing a shared understanding of, and responsibility for, tackling the problem of child abuse and neglect.
Supporting outcome 2: *Children and families access adequate support to promote safety and intervene early.*	*All children and families receive appropriate support and services to create the conditions for safety and care. When required, early intervention and specialist services are available to meet additional needs of vulnerable families, to ensure children's safety and wellbeing.* The basic assumption of this public health approach to protecting children is that by providing the right services at the right time vulnerable families can be supported, child abuse and neglect can be prevented, and the effects of trauma and harm can be reduced.
Supporting outcome 3: *Risk factors for child abuse and neglect are addressed.*	*Major parental risk factors that are associated with child abuse and neglect are addressed in individuals and reduced in communities. A particular focus is sustained on key risk factors of mental health, domestic violence and drug and alcohol abuse.* Key to preventing child abuse and neglect is addressing the known risk factors. Many of the factors associated with abuse and neglect are behaviours or characteristics of parents, which can be targeted by population-based strategies and specific interventions.

Principles of Best Practice

There is a number of principles and strategies that AOD organisations should employ in implementing initiatives to address FDV issues among their clients:

1. Evidence based policy and practice responses	Interventions should be based upon well-tested models of therapeutic practice and sound theories of child development. Where appropriate, interventions should include methods for improving the parent-child relationship (Asmussen & Weizel, 2009). The interventions should also use a partnership and empowerment approach involving clients and their families (Battams & Roche, 2011).
2. Organisational awareness of family issues	Like other common issues that co-occur with AOD problems, FDV and family issues are an essential but ancillary part of alcohol and other drug work; that is not all clients have FDV or family issues. As a result AOD workers may need structures in place to ensure that they attend to these issues on a routine basis. Although the involvement of families can be valuable, the ways that this occurs needs to be carefully considered. This is because other family members may have similar problematic AOD use issues, FDV or parenting difficulties (Asmussen & Weizel, 2009). Awareness of FDV issues includes. • the prevalence of FDV • the indicators of FDV • the impact on partners & children • the importance of addressing FDV to reduce AOD use and minimise harm.
3. Prioritising safety	Given the high prevalence of FDV within the AOD treatment population, it is essential to adopt practices throughout organisations that prioritise the safety of those who experience violence (both partners and children) as well as the safety of staff (Alcohol Concern, 2009). A number of legislative changes have prioritised particularly the safety of children when dealing with FDV situations and organisations and workers should be cognisant of their legal and duty of care responsibilities.
4. Coordination of services	Interventions that address complex family problems are likely to involve input from multiple organisations. Service planning should therefore consider methods for sharing information and referring families. Partnerships are crucial to coordinated service provision. This will involve multi-organisation and cross-sectoral work engaging with services such as FDV organisations, child care providers, supported accommodation services, maternal and child health and disability services, mental health services and child protection organisations (Alcohol Concern, 2009; Asmussen & Weizel, 2009; Battams & Roche, 2011).
5. Policies and systems	AOD organisations need to develop systems and tools to support safe and effective practice. These should include policies, procedures and protocols concerning screening and assessment tools, information sharing, and referral pathways (Alcohol Concern, 2009).

6. Standard response frameworks	It is important to develop assessment and response frameworks that are standard across an organisation. Assessments should identify the individual strengths and challenges of parents who have problematic AOD use. Assessment procedures should address risk and protective factors, the presence of FDV, child care responsibilities and arrangements, measures of family functioning, cultural influences and involvement with statutory child protection services (Asmussen & Weizel, 2009; Battams & Roche, 2011).
7. Broad-based interventions	Interventions should address a variety of risk and protective factors because people who experience FDV, and who use alcohol or other drugs, are likely to be coping with numerous problems. Practitioners need to be able to accurately assess each family's needs and identify resources so that they can provide the appropriate type and level of support (Asmussen & Weizel, 2009).
8. Access to highly skilled practitioners if required	Clients with FDV and AOD problems can require a high degree of intervention, by qualified practitioners, particularly if child protection is an issue. AOD services may not always have practitioners within their services with the required level of skill to respond intensively to FDV issues. It is important for AOD services to ensure that clients can access the requisite level of expertise if necessary and links with external practitioners for this purpose should be identified for both secondary consultation and referral.
9. Workforce development	Increasing the emphasis on FDV may require a range of additional workforce development activities. All staff require basic awareness training and information on organisational policies and procedures. Some staff will require specialist training on assisting clients who experiences violence and clients who use violence in their relationships. Staff also need to be informed of their duty of care concerning child safety and welfare. Other relevant workforce development activities include incorporating FDV intervention practices into job descriptions, mentoring and clinical supervision and in support programs for staff (Battams & Roche, 2011). Commitment is needed at all levels of the organisation from reception and other frontline staff to senior management. In some organisations, the introduction of routine assessments or responses to FDV may require a large cultural shift and requires both strong commitment and robust lines of reporting within the organisation. It is important to have designated individuals at both service delivery and strategic development levels to drive organisational change (Alcohol Concern, 2009).
10. Monitoring, accountability and evaluation	The evidence base in this field is limited and much of the clinical work that is taking place is not recorded. It is, therefore, important for organisations to develop simple and robust recording and monitoring systems which record their work and its outcomes (Alcohol Concern, 2009).

Specific Responses to FDV

Responses to FDV can operate at various levels. Galvani (2010) has suggested two related levels of response to FDV issues for AOD: basic and enhanced. However, for many services there is scope for a more differentiated range of responses as illustrated in Figure 1 below.

Identifying the various levels and types of interventions and responses appropriate to a given organisation or a particular worker allows for consideration of the limitations and constraints that need to be addressed while attempting to work towards a best practice model and an optimal level of care.

The hierarchical model suggested here identifies three levels of response that are not mutually exclusive. First, a basic response level, which might be expected of, or aimed for by all AOD organisations and staff (Level 1). Beyond that, Level 2 identifies the range of initiatives and skills that could reasonably be expected of all frontline workers, many of whom may come across this group of clients in their day to day work but do not work intensively with them. Level 3 identifies the responsibilities entailed for counsellors and case managers, and those that work on a more intensive level with this client group.

The enhanced level responses (Level 2 and 3) entail a more holistic response. It includes the four elements of the basic response above but does more to ensure that FDV issues are integrated into the infrastructure of the organisation.

In parallel with this is the need for organisations to also implement support mechanisms for workers involved in addressing FDV issues. This includes appropriate supervision and debriefing for staff, and ongoing professional development in this area.

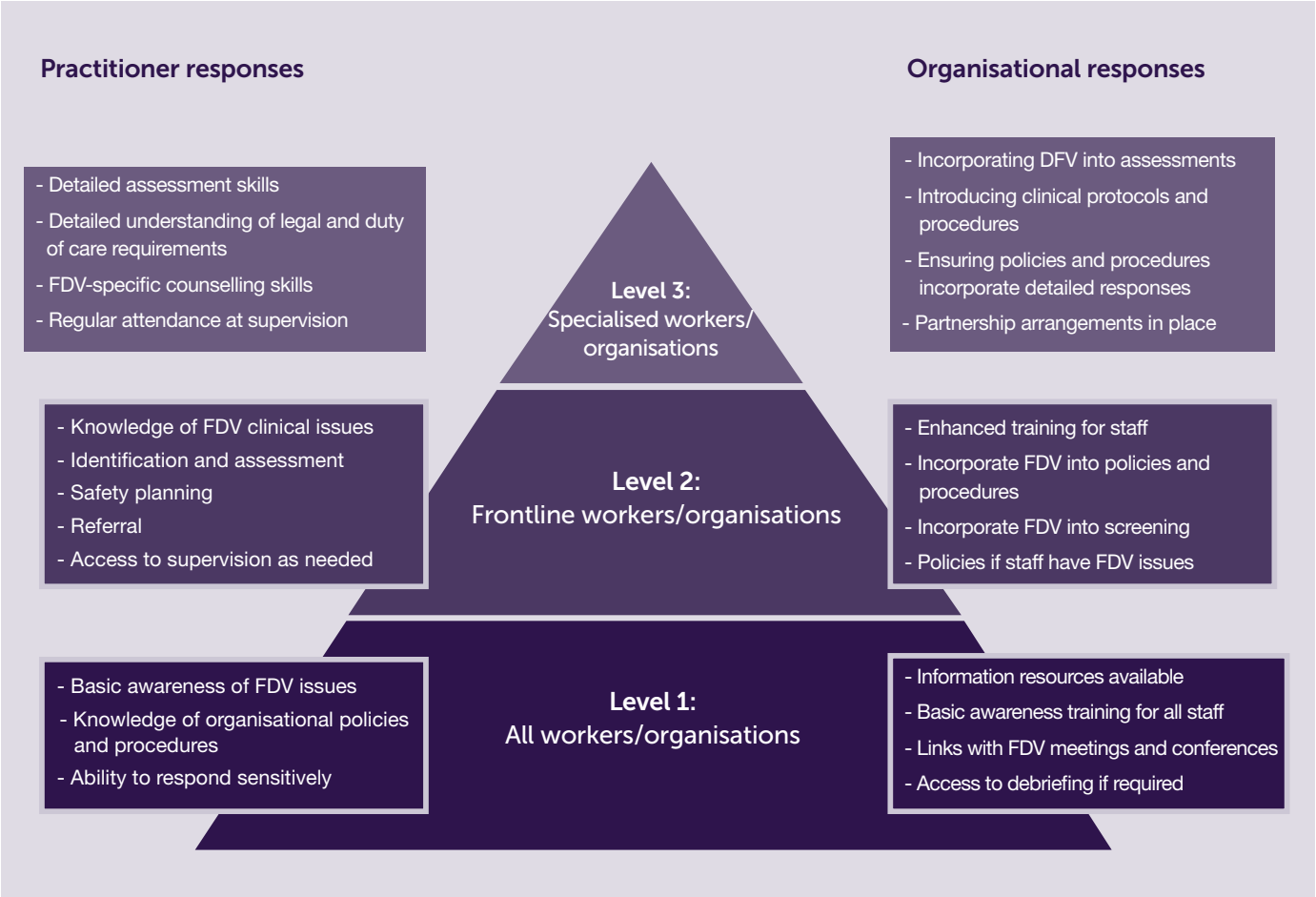

Figure 1 Responses to FDV

Level 1 Response: Basic Responses

Workers

All workers including reception, frontline and counselling staff should have the following:

- Basic awareness of FDV issues
- Knowledge of organisational policies and procedures relating to FDV
- Ability to respond sensitively if the issue is raised by clients, e.g. receptionist might respond empathetically and refer the issue to a counsellor
- Ability to respond if FDV issues arise within the service environment, e.g. a child is being harmed in the clinic.

Organisations

The basic level of response that all organisations can provide with minimal resource implications includes:

- Displaying domestic violence posters, leaflets, business cards and the organisation's position statement on FDV in waiting areas, toilets and meeting or interview rooms
- Providing all staff and managers with basic awareness training
- Having AOD service representation on any FDV meetings and multi-organisation risk assessment conferences
- Having a resource folder/box file of specialist domestic violence information (including a directory of local FDV service providers available to all staff and service users)
- Access to debriefing or supervision for staff after any FDV incidents if required.

Level 2 Response: Enhanced Level (Frontline Workers/Organisations)

Frontline workers, such as NSP workers, triage or intake workers, crisis team members may encounter this group in their day to day work but their contact is briefer or less intensive than for level 3 responders.

The Level 2 response includes the Level 1 response.

Workers

Workers (including frontline and counselling staff) require:

- Skills in how recognise signs of FDV and to raise the issue sensitively
- Skills in screening or basic assessment
- Skills in safety planning
- Knowledge of appropriate referral and clinical pathways
- Access to supervision as needed.

Organisations

- Reviewing organisational policies to incorporate basic responses to FDV (e.g. identification and referral, access to additional supports, duty of care)
- Enhanced training for staff (e.g. recognising signs of FDV, asking about FDV during assessments and undertaking safety planning)
- Incorporating questions on FDV risk into screening and assessment (e.g. screening, risk assessments)
- Having policies in place to deal with situations in which staff themselves are experiencing FDV.

Level 3 Response: Specialised Level (Counsellors and Case Managers/ Organisations)

Level 3 workers and organisational responses take into account a more intensive level of working with clients with FDV issues. A higher level of skill is required of individual workers at this level and a higher level of organisational preparedness and support is necessary.

Workers

- Detailed knowledge of FDV issues and the various sequelae
- Knowledge of how to conduct detailed assessment of FDV issues
- Detailed understanding of duty of care, child protection and referral issues
- Skills in intensive or longer term counselling and case management for people with FDV issues
- Attendance at regular clinical supervision.

Organisations

- Incorporating questions on FDV risk into all forms of assessment
- Discussing and writing clinical protocols concerning working with partners and children of people suffering or perpetrating violence and abuse, (e.g. couples' counselling is not suitable where domestic violence has been disclosed)
- Reviewing organisational policies to incorporate more detailed responses to FDV (e.g. child protection, confidentiality, fast-tracking through admissions procedures, ensuring safe data storage and safe information sharing)
- Putting partnership arrangements in place with local domestic violence organisations (e.g. including a rolling programme of cross-training or priority access to each other's services). This may be formalised by service level agreements
- Regular workforce development and training for staff on responding to FDV issues is counselling and case management (e.g. supporting parents through notification court procedures, motivational interviewing to assist clients to think through potential changes).

Conclusion

A significant proportion of AOD treatment service clients are likely to have currently, or previously, experienced FDV. For these clients, AOD problems may be inextricably linked to FDV issues. There is substantial capacity for the AOD sector to enhance its ability to detect and respond to FDV problems. There is also significant capacity for the AOD and FDV sectors to work more collaboratively to meet the needs of clients with such complex needs.

Achieving this will require organisational commitment to the development and implementation of FDV policies and procedures, and the provision of support to staff through professional development and supervision.

Significant work has been undertaken on these issues in other countries, in particular in the United Kingdom (the Stella Project and Alcohol Concern). Australia is therefore well placed to learn from initiatives such as these, and to develop approaches and initiatives tailored to the specific features of Australian treatment services and their characteristics.

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Appendix 1:

Resources available for alcohol and other drug services to enhance their capacity to respond to family and domestic violence issues among their clients.

DHS. (2012). Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3.	A comprehensive resource developed by the Victorian Government to support a wide range of services (including AOD services). It includes a range of resources and tools to support FDV strategies to be implemented in mainstream services.
Department for Child Protection (2011). The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework, Perth Western Australia: Western Australian Government.	http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/CRARMF.pdf
Alcohol Concern Knowledge Set One: Domestic Abuse	http://www.alcoholconcern.org.uk/assets/files/Embrace/Knowledge%20set%201.pdf
Asmussen, K., & Weizel, K. (2009). *Evaluating the evidence: What works in supporting parents who misuse drugs and alcohol*. **London: National Academy for Parenting Practitioners:**	http://www.pupprogram.net.au/media/8998/napp_briefing_substance_misuse.pdf
The Stella Project	Perhaps the most well-known international project focussing on enhancing the quality of service provision for those experiencing problems with problematic AOD use and FDV is the Stella Project (2007). This project was formed in 2002 as a partnership between the Greater London Domestic Violence Project and the Greater London Alcohol and Drugs Alliance. It was developed as a result of a dearth of services for FDV victims and their children experiencing problematic AOD use. The Stella Project Toolkit contains a chapter written for workers in AOD treatment services concerning best practice in working with FDV victims and perpetrators. http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/stella-project-toolkit-%282007%29.aspx
Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Organisation for Substance Misuse (NTA), *Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*	http://www.nta.nhs.uk/uploads/yp_drug_alcohol_treatment_protocol_1109.pdf

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