

Can I ask...?

An alcohol and drug clinician's guide to addressing family and domestic violence

Michael White, Ann Roche, Roger Nicholas,
Caroline Long, Stefan Gruenert, Samantha Battams





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Michael White

Ann Roche

Caroline Long

Roger Nicholas

Stefan Gruenert

Samantha Battams

National Centre for Education and Training on Addiction
Flinders University



**ODYSSEY HOUSE
VICTORIA**



NCETA

*Australia's National Research Centre
on AOD Workforce Development*

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Any enquiries about or comments on this publication should be directed to:

Professor Ann Roche

National Centre for Education and Training on Addiction (NCETA)
Flinders University
GPO Box 2100 Adelaide 5001
South Australia, Australia

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Disclaimer: While every reasonable effort has been made to ensure that the contents of this document are correct, NCETA and Odyssey House Victoria, do not accept responsibility for the accuracy or completeness of the contents, and are not liable to any person in respect of anything done or omitted to be done in reliance upon the contents of this document. Given the variations between jurisdictions in relation to issues such as information sharing, mandatory reporting to child protection and disclosure to police, readers are advised to check that policies and procedures adopted are consistent with their jurisdiction's requirements.

Foreword

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

This resource explores the relationship between AOD and FDV, with a focus on identifying how the AOD sector can better support clients who have co-occurring AOD and FDV issues, and minimise associated harms experienced by their children.

The companion document to this resource is a literature review.

Nicholas, R., White, M., Roche, AM., Gruenert, S. & Lee, N. (2012). *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia*. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA. www.nceta.flinders.edu.au

The literature review provides the contextual and background information to support AOD staff working with clients experiencing FDV. It is recommended that the two resources are read together.

NCETA

The National Centre for Education and Training on Addiction is an internationally recognised research centre that works as a catalyst for change in the 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.

Odyssey House Victoria

Odyssey House Victoria has been a place of hope and positive change for individuals working towards breaking their pattern of addiction for over 30 years. We are a multi-service agency with a holistic approach to drug treatment.

Odyssey House Victoria's mission is to provide opportunities for change and growth by reducing drug use, improving mental health and reconnecting people to their family and the community.

Our vision is a society free from the problematic use of alcohol and other drugs, in which citizens reach their full potential and are meaningfully engaged in work, family and community life.

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Executive Summary

Purpose

This guide provides alcohol and other drug (AOD) workers and organisations with an introduction to family and domestic violence (FDV). It examines the relationship between AOD use and FDV in the context of AOD treatment settings, from a child and family sensitive practice perspective. It is intended to be used as an initial reference document in training and development, and to assist workers and organisations to consider how to address practice, policy and procedures in relation to FDV.

While the AOD sector has long been aware of the association between FDV and AOD problems, it can be a challenging issue to address. Enhanced responses to FDV reflect growing awareness of the factors that impact on client wellbeing and that may impede their progress with AOD issues.

Addressing FDV is one of a suite of measures being implemented by AOD services to support child and family sensitive practice and to contribute to the wellbeing of clients' children.

Structure

This guide is presented in four parts:

- **Part A** contains a brief introduction to the relationship between AOD and FDV¹
- **Part B** identifies strategies for working with clients with FDV issues, suggests questions to ask and offers “tips and traps” for working with people experiencing or using violence.
- **Part C** reviews policy and organisational responses
- **Part D** provides further information on the relationship between AOD and FDV with specific reference to prevalence, key issues, and specific client groups.

Further resources are provided in **the Appendices** which contains:

- a safety checklist
- a tool to assist clients to self-identify FDV
- a draft referral form and a template for mapping local FDV services
- links to further information and resources.

A companion **CD-ROM**² with a copy of this resource, the associated literature review and related resources is included inside the cover. Further copies are available from www.nceta.flinders.edu.au.

Definition

The term “family and domestic violence” captures a wide range of abusive behaviours that occur in the context of intimate and family relationships. It may involve:

- spouses/de-facto partners
- ex-partners
- children
- siblings
- parents/caregivers.

Whilst FDV predominantly involves males who use violence against their female partners, this is only one manifestation. FDV can also occur in other relationships including:

- non-spousal relationships
- same-sex relationships
- carer relationships.

FDV can also occur:

- in families where there is a culture of violence/abuse (i.e., multiple members use violence)
- where people who have been victims of violence in their past carry that forward into their relationships with other adults and/or children.

¹ This is more extensively covered in the associated literature review (Nicholas, White, Roche, Gruenert, & Lee, 2012).

² Incorporating active hyperlinks.

Other emerging issues are child and adolescent violence directed at adults, predominantly mothers (McKenna & O'Connor, 2012), and violence directed towards aged family members by adult children.

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

- physical violence
 - sexual abuse
 - emotional abuse
 - verbal abuse and intimidation
 - economic and social deprivation
 - damage of personal property
 - harm to pets
 - abuse of power
- (Australian Bureau of Statistics, 2006).

AOD use itself can also be a form of intimidation or threat.

Who Experiences FDV?

Between 41-80% of women in AOD treatment programs have experienced violence, and 4-40% of women in FDV programs report AOD problems, according to USA figures (Gutierrez & Van Puymbroeck, 2006). Hence, FDV is likely to feature in the background of the majority of women in AOD programs.

While the proportion of male AOD clients that have used violence or suffered from FDV is unknown, it is likely to be substantial. As approximately two thirds of people seeking help through AOD services are male, an important opportunity also exists to engage with men who may use violence in their relationships and help them break the cycle.

In addition, Aboriginal and Torres Strait Islander people are substantially over-represented in AOD treatment, FDV and related child abuse and neglect data.

The Impact on Children

For every adult seeking AOD treatment, there is generally one child impacted by problematic parental AOD use (Advisory Council on the Misuse of Drugs, 2003). Witnessing violence can lead to trauma causing significant short and long term problems for children. Responding to FDV issues in the AOD sector may help minimise children's exposure to FDV.

For every adult seeking AOD treatment, there is generally one child impacted by problematic parental AOD use (Advisory Council on the Misuse of Drugs, 2003).

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
- nearly one fifth had a psychiatric disability (Community Care Division, 2002).

Families would benefit from AOD services making the links between AOD use and FDV explicit. This has the potential to increase the client's capacity and motivation to change AOD use, with improved outcomes for their children.

Key Issues

Key FDV issues with important implications for AOD services include the following:

1. The AOD - FDV relationship is complex and multifaceted. The FDV sector has largely rejected problematic AOD use as the essential cause of FDV, and attributes responsibility to the person who uses violence. However, available evidence suggests that it can be a bi-directional relationship.
2. Family and domestic violence is not gender neutral. Evidence shows that:
 - more women, and subsequently their children, are victims of FDV than men (i.e., violence is gender based) (Galvani, 2010)
 - men are more likely than women to use violence in their relationships (Australian Bureau of Statistics, 2006)
 - women are more likely than men to be injured and to express fear as a result of FDV (Gutierrez & Van Puymbroeck, 2006).

3. The high co-occurrence of problematic AOD use and FDV means that it is likely that a significant number of clients of AOD treatment services have experienced violence in their family relationships. For these clients, AOD problems may be inextricably linked to FDV issues. Problematic AOD use increases the likelihood of either carrying out or suffering from FDV, or may be a coping mechanism in response to violence.
4. Families where problematic AOD use and FDV are present are likely to experience a cluster of other problems, which may include poverty, housing challenges, mental health and disability issues.

Addressing FDV can lead to better outcomes for families and children (Bromfield, Lamont, Parker, & Horsfall, 2010) by making clients aware of the interactions between problematic AOD use and the risk of violence. The client's capacity to change AOD use may be increased by reducing violence and the risk of harm. This may also have flow-on benefits for clients' children as a result of reduced parental AOD use, improved parental engagement, and decreased exposure to violence.

Engaging Perpetrators

Working with perpetrators of FDV requires specific skills. This includes avoiding inadvertent collusion with the perpetrator or compromising the safety of victims. Where AOD organisations screen clients in relation to violence, they require clear policies and procedures, appropriately trained staff and on-going supervision in relation to working with perpetrators.

AOD Service Responses

Strategies adopted by AOD treatment organisations to address FDV issues need to be broad-based and may 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. Standardised response frameworks
7. Broad-based rather than single issue focused interventions
8. Access to highly skilled practitioners as required
9. Targeted workforce development
10. Monitoring, accountability and evaluation.

Practitioner Responses

Few AOD staff have received appropriate FDV training or support. Suggested skill sets are:

- **All AOD workers** should have the capacity to provide a basic level response. They require an awareness of FDV issues, knowledge of their organisation's FDV policy and procedures, the ability to respond sensitively and appropriately to FDV issues and immediate concerns.
- **Frontline and counselling staff** should have the capacity to provide enhanced response to FDV issues. They require skills in: raising FDV issues sensitively; screening and assessment; risk assessment; safety planning; referral; and non-collusive engagement.
- **Specialist AOD/FDV staff** should have the capacity to provide an intensive response to FDV issues where they co-occur with AOD issues. They also require skills in working collaboratively with FDV, family, child welfare and child protection services.

Summary

FDV will affect a significant proportion of AOD clients. AOD issues may be inextricably linked to FDV. Addressing FDV may have a beneficial impact on AOD use and has potential to improve outcomes for children of clients. There is substantial capacity for the AOD sector to enhance its ability to detect and respond to FDV problems and to improve inter-sectoral collaboration.

The high co-occurrence of problematic AOD use and FDV means that it is likely that a significant number of clients of AOD treatment services have experienced violence in their family relationships. For these clients, AOD problems may be inextricably linked to FDV issues.



Part A: Background and Definitional Issues

This document provides an introduction to family and domestic violence (FDV) issues and potential responses to clients who experience or use FDV in their relationships in the context of alcohol and other drug (AOD) treatment settings. It focuses on strategies and resources that may be used to enhance the responses of AOD treatment providers.

Defining Family and Domestic Violence

The term “family and domestic violence” includes a wide range of abusive behaviours that may occur in the context of intimate and family relationships. These relationships may involve:

- spouses/de-facto partners
- ex-spouses/partners
- children and siblings
- parents and/or caregivers.

FDV can involve 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
- harm to pets
- abuse of power

(Australian Bureau of Statistics, 2006).

AOD use itself can be a form of intimidation or threat. Where a person (including a child) has experienced violence associated with a perpetrator’s use of alcohol or drugs, any subsequent use or threat to use AOD can be intimidating.

Often underlying these different forms of FDV are controlling and coercive behaviours. FDV is generally an attempt by one partner (usually a male) to exert power and control over the other. It is usually a pattern of behaviour that occurs over time and can involve some or all of the forms of violence outlined in Table 1.

Whilst FDV predominantly involves males who use violence against their female partners, this is only one manifestation. FDV can also occur in other relationships including:

- non-spousal relationships
- same-sex relationships
- carer relationships.

FDV can also occur:

- in families where there is a culture of violence (i.e., multiple members use violence)
- where those who have been victims of violence carry that forward into their relationships with other adults and/or children.

AOD use itself can be a form of intimidation or threat.

Table 1. Forms of family and domestic violence

Form of violence	Tactics of violence
Emotional	Manipulation, humiliation, lying, ridicule, withdrawal, shaming, punishment, blame. All forms of violence are implicitly emotionally violent.
Physical	Any actual or threatened attack on another person's physical safety and bodily integrity; also physical intimidation such as threatening gestures or destroying property, and harming or threatening to harm pets or possessions.
Sexual	Any actual or threatened sexual contact without consent. Note that some forms of sexual violence are criminal acts, for example, sexual assault and rape, many other forms—such as using degrading language—are not.
Social	Any behaviour that limits, controls or interferes with a person's social activities or relationships with others. Includes controlling a person's movements and denying access to family and friends, excessive questioning, monitoring movements and social communications (including phone use, emails, texts or social networking), and being aggressive toward others (e.g., men who are viewed as "competition").
Financial	Any behaviour that limits access to a fair share of the family's resources. Includes incurring debts in the victim's name, spending money without their knowledge or consent, monitoring their spending, and expecting them to manage the household on an impossibly low amount of money and/or criticising and blaming when they are unable to.
Spiritual	Any behaviour that denigrates a person's religious or spiritual beliefs, or prevents them from attending religious gatherings or practising their faith. Includes forcing them to participate in religious activities against their will.

(adapted from NSW Department of Attorney General and Justice, 2012)

Who Experiences or Uses FDV³?

Many AOD clients may have either experienced and/or used violence in their intimate relationships. Evidence from the USA suggests that 41-80% of women in AOD treatment programs experience violence, and 4-40% of women in FDV programs report AOD problems (Gutierrez & Van Puymbroeck, 2006). Caution is warranted in extrapolating overseas studies to the Australian context due to social and cultural differences. Nevertheless, FDV is likely to feature in the background of the majority of women in Australian AOD programs.

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 (Nicholas et al., 2012). While it is unknown what proportion of male AOD clients have experienced FDV (Mulroney & Chan, 2005), available indicators suggest a substantial

proportion of male clients will have used violence, and many may have experienced violence as children (Marsh, Dale, & Willis, 2007).

Where FDV is present, the whole family may be affected either directly (as the perpetrator or victim of the abuse) or indirectly (as a witness) and may be in need of some level of support.

Aboriginal and Torres Strait Islander people are also substantially over-represented in AOD treatment, FDV and child abuse and neglect data. Many Aboriginal and Torres Strait Islander clients are therefore likely to have co-occurring AOD and FDV issues and have children who will need support (Australian Institute of Health and Welfare, 2012b; Grech & Burgess, 2011).

Australian estimates of the prevalence of FDV in culturally and linguistically diverse (CALD) communities have not been established. However, research indicates that FDV is a serious and common issue for women and children in CALD communities (Allimant & Ostapiej-Piatkowski, 2011). For many women, it often remains unreported due to:

³ For further detail on the prevalence of FDV see section D.

- a perception that mainstream services will not understand their situation
- language barriers
- lack of social, financial and family supports
- lack of awareness of services
- cultural beliefs relating to separation, divorce and family privacy
- fear of deportation or other legal ramifications (Department for Child Protection, 2011).

Approximately half of all child abuse and neglect cases investigated by Child Protection in Victoria involved some degree of problematic AOD use by the child's parents (Department of Human Services, 2002).

Children

The overlap between child abuse and neglect, drug and alcohol misuse (Dawe et al., 2007; Scott, 2009), domestic violence and mental disorders is well recognised (O'Donnell, Scott, & Stanley, 2008). Among child wellbeing and protection cases one Victorian report found 52% involved domestic violence, 33% parental drug abuse, 31% alcohol abuse and 19% psychiatric disability (Department of Human Services, 2002). Approximately half of all child abuse and neglect cases investigated by Child Protection in Victoria involved some degree of problematic AOD use by the child's parents (Department of Human Services, 2002). In a USA study, 40% to 60% of married or cohabiting AOD clients reported perpetrating one or more episodes of partner violence 12 months prior to entering treatment (Fals-Stewart, 2003).

Responding to FDV in an AOD treatment environment may minimise exposure to and harms caused by FDV among children of AOD clients.

Numerous issues face AOD services in addressing the needs of clients' children:

- staff may lack the capacity to respond to parents' needs due to a gap in skills, knowledge and confidence in relation to providing parenting or family support (Gruenert & Tsantefski, 2012)
- workers and organisations may not consider addressing parenting and child and family welfare issues as part of their core role
- workers may refrain from asking clients about children in order to avoid any potential need to make child protection notifications which in turn may jeopardise their working relationship with clients (Battams & Roche, 2011)

- services may not have a tradition of working with families and their children (Holmila, Itapuisto, & Ilva, 2011)
- organisations and workers may lack experience in working collaboratively with FDV and child protection services.

Children and FDV

In working with clients who experience or use FDV, it is important to recognise that many will have parenting/ carer roles. Interventions that empower parents with AOD misuse problems to create safe, nurturing and stimulating home environments and that promote the healthy development of children maybe a challenge for service providers (Dawe, Harnett, & Frye, 2008). However, the physical and psychological development of children cannot be put on hold.

Increasingly, children are identified as victims of FDV in their own right (Morris, Toone, Utter, & Christovitchin, 2012). They are particularly vulnerable to early and on-going trauma from FDV. This trauma can have life-long effects, increasing the likelihood of mental health, alcohol and other drug, and social and educational problems (Dawe et al., 2007).

The Relevance of AOD Services Engaging with FDV

Problematic AOD use is typically a chronic, relapsing condition and recovery can be a long term process (Department of Human Services, 2002). Addressing FDV can also be a long term process. It can take time for a person:

- experiencing FDV to recognise that they have an abusive partner or family member
- who uses violence to acknowledge that they are being abusive
- to leave or change their behaviour.

While the AOD sector has long been aware of the association between FDV and AOD problems, to date, FDV has been a largely neglected issue in AOD services because:

- FDV can be a challenging and difficult issue to address
- in a time of diminishing resources and growing demands, dealing with FDV issues in AOD clients may seem outside of the “core role” of workers
- few staff have received training or support to address FDV
- service provision silos are a major impediment to coordinated services for clients with AOD and FDV problems.

The high proportion of AOD clients who may have experienced FDV highlights the need for services to respond to this issue. Improvements, such as access to high quality and effective services, are most likely to occur through system-wide coordination and interagency collaboration.

The motivation for AOD services to enhance responses to FDV reflects a growing awareness of the wide range of factors that impact on a client's wellbeing and that may slow their treatment progress. It also recognises that clients may need to address other issues in their life. Having come to an AOD service, they should not find they have come to the “wrong door”. Contact with any service should open a door to joined-up support (Scott, 2009).

Some people may return to abusive situations a number of times before leaving or effecting positive change (see Reasons for Not Leaving p.18). This may impact on their AOD use and treatment.

Addressing FDV, either directly or through effective referral, is part of a range of measures implemented by AOD services in Australia to enable services to be more child and family sensitive (Nicholas et al., 2012).

The motivation for AOD services to enhance responses to FDV reflects a growing awareness of the wide range of factors that impact on a client's wellbeing and that may slow their treatment progress.



Part B: Strategies to Identify and Respond to FDV

This part of the document addresses a range of strategies that can be used to identify and respond to FDV. It is divided into three sections.

The first section deals with how to address FDV issues presented by clients who experience FDV, including why, who and how to ask, and how to respond to disclosure, including safety planning and referral. It also includes a list of “tips and traps” for working with clients who experience violence, information on why clients may stay with an abusive partner, and the importance of identifying and responding to the needs of clients’ children⁴.

The second section deals with clients who use violence in their relationship.

The third section deals with referral and information sharing.

Specific skills are required to address FDV. This resource does not suggest that all AOD workers should take on a role in comprehensively addressing FDV. However, given the overlap between clients who have AOD problems and those experiencing FDV it is suggested that:

- all AOD workers have at least basic skills in addressing FDV
- all clients are asked about FDV
- all AOD services and workers appropriately support clients who may be experiencing FDV.

To address FDV, organisations and workers may use existing skills, extend their practice skills through policy changes and professional development, or provide support through referral and interagency collaboration.

Responding to Clients’ FDV Issues

Asking Clients Questions

To be able to respond to clients who have FDV issues, it is necessary to identify it as a problem⁵. For many clients, dealing with FDV will be intrinsically linked with their AOD problems. However, FDV may

not be evident without a direct question. The simplest way to identify if a client has FDV issues is to ask. Clients may be reluctant to disclose FDV where they have not been invited or, do not feel welcome to do so, or feel unsafe.

Why Ask?

Inquiring about FDV can be important for a number of reasons. It may:

- identify how AOD use may trigger or exacerbate FDV, or be used as a coping mechanism, as there are strong links between trauma, stress and AOD use
- result in clients who have never or rarely spoken about FDV feeling believed, validated and supported
- enable early intervention before violence escalates or becomes entrenched
- help prevent serious injury or death through support via risk assessment, safety planning, risk management and appropriate information sharing with other agencies
- enable a coordinated response to identify harm and risk to a client’s children as a result of the use of violence towards her and/or her children
- enhance protective factors for children who may be subjected to or witness violence.

⁴ Given that the majority of people who experience FDV are female, this first section refers to clients as female. However, the content presented here may be equally applicable to males in similar circumstances.

⁵ Refer to Appendix 2 for “Signs of Intimate Partner Violence.”

Who to Ask?

Ask all clients - research suggests that given the level at which AOD and FDV co-occurs, it is advisable to ask all clients, and especially female clients, about FDV.

Women represent 33% of clients in Australian AOD treatment services. The main presenting drug of concern is alcohol in 47% of cases and the median age of all clients is 33, with 55% of clients aged 20–39 (Australian Institute of Health and Welfare, 2012a). These are the principal child rearing years, and it is likely that women experiencing violence may have children who are either subjected to and/or exposed to violence.

As some clients may not identify or readily disclose FDV, it may be appropriate to sensitively explore the nature of their family relationships. Indicators of an abusive relationship are provided at Appendix 2.

Where a clinician suspects FDV is present in a client's relationships, but the client does not disclose this, it may be appropriate to share information with other services to confirm or refute this concern. Organisational and State or Territory policies on information sharing should be adhered to in these circumstances.

In some cases the clinician may consider speaking to other family members. Engaging family and friends

in discussions about a client's exposure to FDV or safety planning processes should be considered carefully. They may not be aware of the abuse and/or may not understand the full extent of it. They may overtly or covertly condone the violence and/or there may be risks to their safety (Department for Child Protection, 2012).

How to Ask Questions

Clinicians in AOD services are skilled at questioning clients in relation to their AOD and related issues. However, they may need direction about how to explore issues that traditionally have not been seen as their core business, such as child and family issues (Roche, Pidd, & Freeman, 2009). Many FDV services have developed standardised assessment and screening tools. These may be more extensive than AOD services can adopt.

Organisations must determine the most appropriate questions for use in their service. Careful decisions need to be made about the questions to be asked. In non-FDV specific services, it may be appropriate to ask a limited number of FDV-related questions as part of the initial assessment. This would generally be between two and eight questions.

Guidelines for Asking Questions

- Questions should be direct. Evidence indicates that victims are more likely to accurately answer direct questions (Birmingham Solihull Women's Aid, 2010).
- Ask all female AOD clients about their experience of FDV. They should be seen alone (without their partner or children) for at least part of their assessment to ensure that any disclosures can be made safely.
- State that the questions asked are a standard part of the assessment. This may avoid the client feeling that they are being singled out in any way.
- Explain that the impact of FDV on a person's health and wellbeing can be profound and that many people accessing drug and alcohol services will have experienced FDV (Wall, 2012). Witnessing or experiencing FDV can also have a significant impact on a child's health and wellbeing. Hence, it is organisational policy to ask these questions to ensure that FDV issues can be identified and addressed.
- Clients should also be offered the opportunity to update any information as their relationship with the service or a staff member grows. Some clients may not make any disclose of FDV until trust has been developed.
- Explain to the client how any FDV information they share may affect their engagement and interaction with the service. Advise them that it may lead to a referral to another service rather than an integrated response to both AOD and FDV issues.

What to Ask?

Every organisation has intake and assessment policies and procedures. The purpose of this section is to suggest questions that could be incorporated into existing intake or screening procedures.

Pregnancy is a risk factor for family violence. Women often experience their first assault, or experience an increase in the form or intensity of violence, during pregnancy. The Australian Personal Safety Survey found that 59% of women who experienced violence by a previous partner were pregnant at some time during the relationship; of these, 36% reported that FDV occurred during a pregnancy and 17% experienced FDV for the first time when pregnant (Department of Justice, 2012; Mouzos & Makkai, 2004).

As there are serious health risks to mothers and children when violence is experienced during pregnancy, asking about FDV and sexual violence

should form part of a pregnant patient's assessment (Howard, 2012).

Questions to ask:

- Since you became pregnant, has your partner or anyone close to you:
 - a. forced you into sexual activity against your will?
 - b. hit, slapped, kicked or physically hurt you?

It may also be valuable to ask if the client has attended an antenatal clinic or GP to talk about their health and wellbeing or that of their child. Identify the number of visits, reasons for going to the doctor and if the visits provided useful support. This may assist in identifying the clients' pre-existing supports, referrals, and existing or potential interagency collaboration.

Examples of questions from a range of tools used in the FDV sector are displayed below. It is not suggested that all questions be used, rather that some might be incorporated into initial sessions with clients. For example:

- How is your relationship with your partner?

OR

- How are things at home?

If the client has separated from her partner, you could ask

- What contact do you currently have with your former partner?
- How is that contact going?
- How were things at home when the two of you were together?

Where there are indications that further questioning may identify FDV, the following questions may be used:

- Has your current (or recent partner) ever:
 - a. done things that raised safety concerns for yourself or your children?
 - b. threatened to harm you or your children?
 - c. insulted, screamed or cursed at you?
 - d. physically hurt you, your children or pets?
- Do you feel unsafe in your current relationship?
- Are you afraid of your partner?
- Are you afraid of anyone close to you?
- Have you ever been emotionally or physically abused by your partner or someone close to you? For example, is your partner excessively jealous, possessive and controlling, or hostile towards other men whom he sees as a threat?
- Is there a person from a previous relationship who makes you feel unsafe now?
- Has your partner ever forced you into sexual activity against your will?
- Do you feel unable to interact with friends, family or your community?

(Yes answers indicate likelihood of abuse)

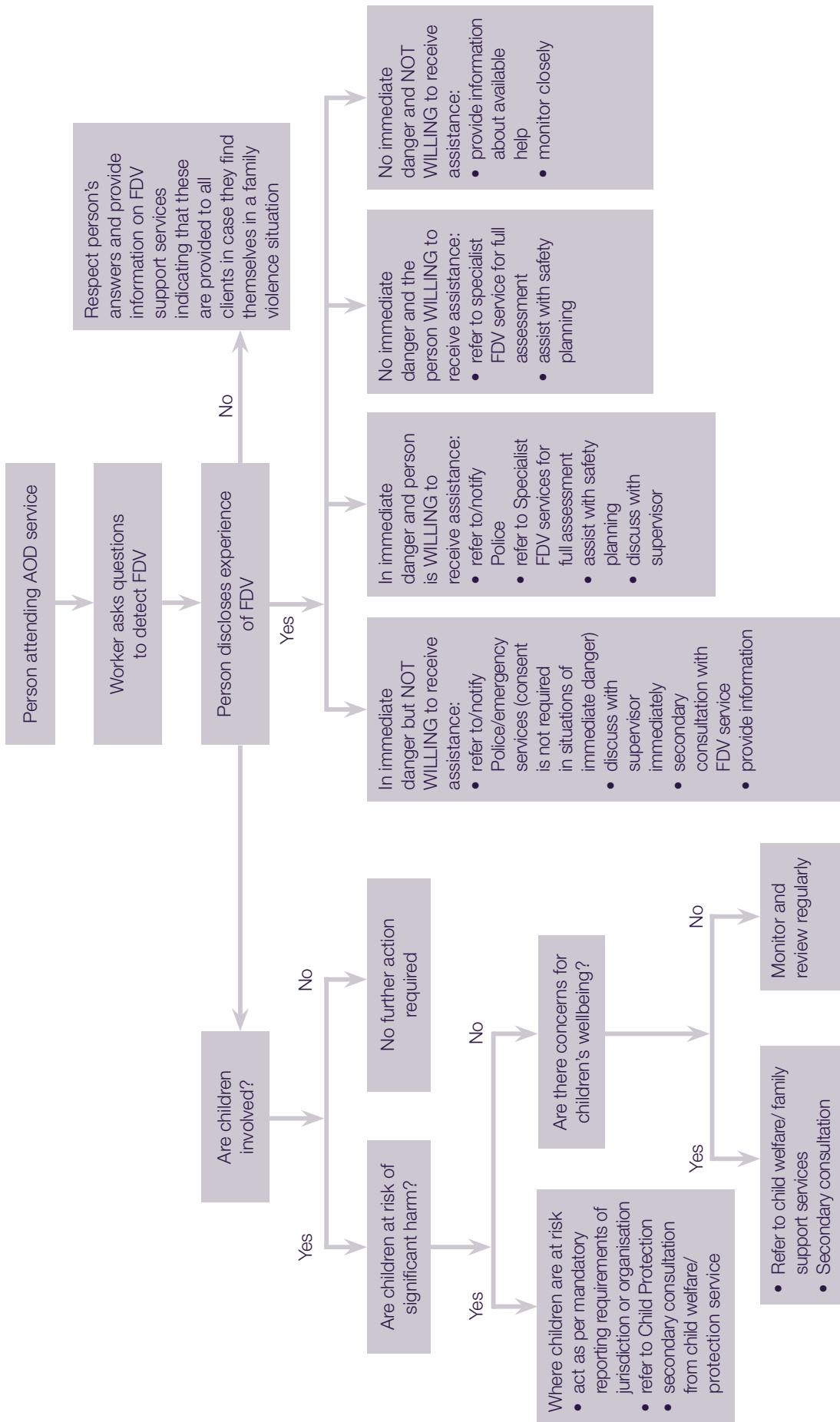


Figure 1. Options for responding to clients experiencing FDV

(Adapted from Department of Human Services, 2012a)

Ask About the Children

There is evidence that supporting parents in their parenting role improves outcomes for both parents and children. Hence, strategies that provide support to clients as parents are recommended (Battams, Roche, Duvnjak, Trifonoff, & Bywood, 2010).

It is important to identify if children are involved in FDV situations and to address their needs. Parents may have concerns about their children but not want to, or know how to, discuss them.

It is also important to go at the client's pace. Be concerned rather than investigative.

Some opening questions may include:

- How are your children?
- Do you have any concerns about them?
- How are they coping at the moment?
- Do the children get support from any services (school, health service, GP etc.)?
- Tell me about the children's relationships with your partner, other family members and friends.

In some instances it may be appropriate to talk to the children, or work in collaboration with a child and family service that can provide appropriate support.

If the client and/or their children are not connected to support, referral to a local child and family support service is appropriate⁶.

Exposure to FDV may put a child at risk of harm. Where a child is at risk of serious or imminent harm, as defined in State or Territory legislation, an AOD worker may be required by law, directed by organisational policy or choose to make a notification to child protection services. If child protection services assess the risk and find that it meets a risk threshold, the child's circumstances will be investigated. This may lead to the family being provided with support, referral to a family welfare service, or the child may be removed in cases of significant risk.

Given the sensitive nature of dealing with children, the Australian Research Alliance for Children and Youth (ARACY) developed a Common Approach to

Assessment, Referral and Support (CAARS). CAARS is designed to help service providers identify children and their families who may need help and to connect them to appropriate support. It uses a tool that helps to identify the strengths of the child, the child's family and the broader community (<http://www.aracy.org.au/projects/caars-common-approach-to-assessment-referral-and-support>).

Responding to Disclosure

What to do in the case of a disclosure of abuse?

1. Focus on safety – for the client, their children and service staff
2. Help them to protect themselves, identify who else can provide support, and how they can safely access information, web-sites and services
3. Listen, hear and believe
4. Take the abuse seriously
5. Emphasise that violence is always the responsibility of person who is violent
6. Be non-judgemental
7. Build the client's self-confidence by acknowledging that disclosure takes a great deal of courage
8. Help the client to think about what they want to do
9. Support their choices and timing
10. Maintain regular contact if possible – negotiate when it is safe to call (Wall, 2012).

Responses may differ according to the client's exposure to violence, their willingness to accept assistance, whether they have children in their care, and the level of risk that they are facing (see Figure 1 and Table 2).

Referral to appropriate services is vital (see Referral section for contact details). All staff should be familiar with local and national FDV services (see Appendix 5 for a FDV service mapping tool). As people experiencing FDV may be fearful of making contact with a FDV service, consider contacting the service yourself (whilst the person is present) rather than just providing the number. It may also be appropriate to offer clients access to a telephone to allow them to make calls in safety and privacy.

⁶ To find local services, use the Infolink Service Seeker database. Searches can be undertaken at State and postcode level and by service type (<http://www.serviceseeker.com.au/>).

Safety Planning

A Personal Safety Plan involves identifying resources and strategies that support the client's, and their children's, safety. The Personal Safety Plan can be developed by the client, or by the client and worker in collaboration. Client empowerment and choice is a critical component of safety planning. The client is the expert in regard to their safety and that of their children. Their choices and timeframes must be respected (Department of Human Services, 2012a; Kirkwood, 2012).

A Safety Plan belongs to the client. Components may be recorded on the client's file as part of an organisational risk assessment or case notes.

Client empowerment and choice is a critical component of safety planning. The client is the expert in regard to their safety and that of their children.

The plan should identify the information and steps required to optimise safety. It can incorporate physical, emotional, social, psychological and financial safety requirements. Typically, it involves planning to avoid serious injury or to escape violence and ensure the safety of the client and their children.

A Personal Safety Plan should:

- Include emergency contact numbers (e.g., for police, FDV organisations, crisis lines, medical services)
- Identify a friend(s), family member or neighbour who can provide support and how to contact them
- Identify safe places for the victim 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 victim 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 client can access them when required
- Identify contents of an emergency bag and where this bag can be stored
- Specifically address any barriers to the client implementing a safety plan (for example mobility or communication problems)
- Establish a distress code with friends/relatives that will trigger a call to the police (Department of Human Services, 2012a).

Personal Safety Plans should be tailored to the needs of the individual client and their particular circumstances. Some circumstances may require Safety Plans for each member of the family, with separate plans for each child (Department for Child Protection, 2011).

A client Safety Plan should be treated with care, never disclosed to a potential perpetrator, or left where a perpetrator may obtain access to it. A comprehensive Safety Plan checklist is attached at Appendix 1.

An **Organisational Safety Plan** can be developed and used to ensure that all workers are aware of the risk of violence from perpetrators and how to deal with it. An example is provided by LawLink NSW

(see <http://www.lawlink.nsw.gov.au/lawlink/vaw/dvguidelines.nsf/pages/worker>).

An **Interagency Safety Plan** may be developed by a service to support a client, when working in collaboration with other agencies. An Interagency Safety Plan should be developed in consultation with other services and overseen by an identified case manager, whose role is to monitor and review the Safety Plan on a regular basis.

It should identify:

- protective factors in place to support the victim (and their children where appropriate)
- what else the victim can do (with support) to reduce risk of further harm (Women's Health Policy and Projects Unit, 2007).

Table 2. Potential responses to clients' disclosure of experiencing violence

Timeframe	Reasons To Ask About FDV	Possible Responses
Past violence	<p>Past violence may leave clients with trauma issues. Provision of appropriate trauma counselling may be necessary.</p> <p>Such counselling may also enable them to deal with AOD problems that may be associated with trauma and post-traumatic stress.</p>	<p>Referral to, or provision of, appropriate trauma counselling for clients and their children.</p> <p>Referral to FDV services for on-going support including legal support.</p>
Current violence	<p>In the case of clients experiencing current violence the key concern is their immediate safety. Where these clients have children, provision for the safety of the children must also be made. The development of a Safety Plan that includes strategies for mitigating immediate risk and appropriate referral is essential.</p>	<p>Every Safety Plan should encourage clients to call 000 in a crisis as the 000 service can trace a call and send the closest police car.</p> <p>Support clients to develop and implement a Safety Plan.</p> <p>Provision of referrals to:</p> <ul style="list-style-type: none"> • domestic violence services including counselling services • medical services • legal services • crisis accommodation • immediate financial support. <p>Consider interagency case conferencing and information sharing with FDV, child and family welfare, child protection and other relevant services.</p>
Future risk of violence (clients in fear or at risk of violence)	<p>Exploring a client's sense of safety may lead to disclosures that identify potential risk of harm to clients or their children. In such cases the development of a Safety Plan and or immediate referral is an important first step in supporting the client and potentially preventing harm.</p>	<p>Provide information, resources (e.g., information cards, contact lists).</p> <p>Display resources in public spaces and have accessible in treatment spaces.</p> <p>Develop and implement Safety Plan.</p> <p>Provision of referrals to:</p> <ul style="list-style-type: none"> • FDV services including counselling services • medical services • legal services • crisis accommodation • immediate financial support. <p>Consider interagency case conferencing and information sharing with FDV, child and family welfare, child protection and other relevant services.</p>

Tips

Useful tips for working with clients who have experienced FDV include:

1. start by finding out what the client wants to do about FDV
2. ask them what they need
3. ensure that the person experiencing violence retains control over as much of the response as possible, e.g., whether they accept referral to other services
4. be compassionate and respectful. In particular, respect the client's timeframes
5. be vigilant about privacy – it can be a safety issue (e.g., negotiate times to call or who calls)
6. be explicit about confidentiality and its limitations (e.g., where there is a mandatory requirement to report risk of harm to children, commission of serious crimes)
7. consider what will and will not be included in file notes (addresses, contact numbers, children's educational details, appointment times etc.) and how to document disclosures and referrals, with particular reference to who may access the files (e.g., records subject to court subpoena). This may require a review of organisational policy and procedures
8. be sensitive to the effects of trauma – victims/survivors (including children) often suffer complex trauma and require support to deal with it
9. where possible ask about/discuss FDV more than once, it may take several sessions for a client to develop enough trust to address FDV
10. manage your own emotional response and focus on the client's story and experiences
11. be aware of your body language; keep it open, relaxed and confident, maintain eye contact (where culturally appropriate)
12. develop interagency linkages with local FDV, child welfare and child protection services to facilitate secondary consultation, complex case management and information sharing to provide support for clients and their children with FDV issues
13. if a decision is made by the client to leave a partner, provide the necessary referral and supports, and acknowledge the grief associated with loss of the relationship.

Traps

Some of the most common traps in working with clients who have experienced FDV include:

1. asking a client about FDV in the company of others, this includes partners, other family members and children. This can put victims at risk
2. recommending couples or family therapy based interventions when FDV is indicated, as this can increase the danger to victims and reinforce a perpetrator's tendency to blame violent behaviour on "their relationship" (Men's Referral Service, 2012)
3. operating outside your area of expertise; FDV can be a complex and high risk area of work. Seek help from supervisors and professionals in the FDV area
4. telling a client to leave a situation, blaming them for staying or assuming a client will leave a relationship. The client needs to move at their own pace
5. leaving an abusive or violent situation is often the time of highest risk. Do not assume that leaving will make a client safer
6. providing referral phone numbers alone. Support clients to contact referral agencies. Explore the client's issues and how they may be assisted by other services as this may be the client's only opportunity to disclose and explore options safely
7. forgetting that the client may not be able to take information home or keep phone numbers of support services for fear of the abuser discovering them. Be mindful of what you give them
8. contacting the client outside the guidelines agreed for contact as this could increase the risk if the abuser finds out they are seeking support
9. clients with children not disclosing their parenting responsibilities as they have concerns about engagement with other services due to fear of being mandatorily reported
10. not identifying clients with parenting/carer responsibility resulting in children being "invisible" to the service system.

Reasons for Not Leaving FDV Situations

Reasons for remaining with abusive partners, or in abusive situations, are diverse and complex. Leaving the relationship is a process, and it can take a long time and may involve many attempts. Reasons include:

- fear, arising from perpetrator's threats or behaviour, that the person experiencing the violence may suffer further violence, increased danger or loss of life
- fear of losing children or having children removed
- fear of stalking or abduction
- a deep emotional attachment to the perpetrator
- the person experiencing the violence wishes and hopes that the violence will stop
- grief for the loss of partnership
- profound loss of self-esteem and feelings of low personal efficacy from years of abuse
- feelings of guilt and self-blame
- fear of being alone (particularly if physically or mentally unwell)
- loss of alcohol or drug 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
- having grown up with violence, for some people violence in a relationship seems normal or is to be expected.

FDV is a choice that is made by perpetrators about how they behave towards their partners and other family members.

Responding to Clients Who May Use Violence⁷

Clients Who Use Violence

As the majority of AOD clients are male, and there is a strong correlation between AOD use and FDV, it is likely that many male AOD clients may use violence in their relationships (Laslett et al., 2010). In some circumstances, asking clients who may be perpetrators of violence about FDV can provide an opportunity to positively engage with them and provide early support and referral.

Self-reports of violence can be unreliable. Most people who use violence will deny or minimise its use. They may blame others (e.g., their partner for “provoking” them) or attempt to justify their violence in other ways. Further, many people who use violence can be quite convincing in their minimisations or excuses. They may invite others to collude in avoiding responsibility for their behaviour.

One of the most common minimisations used is the assertion that “I only hit her once – I’ve never done it again, ” when in reality multiple forms of violence (emotional, social, controlling behaviours) are current and on-going. Clients who have disclosed previous use of violence will generally continue to use violence. Partner’s corroboration is usually the only way of knowing if violence has stopped.

It is important that workers are clear that FDV is a choice that is made about how perpetrators behave towards their partners and other family members. See www.mrs.org.au for a further explanation. Table 3 displays some commonly held misconceptions of FDV.

Responses to Perpetrators

Intervention with perpetrators is considered a specialist area of expert practice. It requires a range of skills to ensure appropriate interventions. Risks associated with inappropriate interventions include inadvertent collusion with the perpetrator and compromising the safety of victims. The No To Violence site (<http://www.ntv.org.au>) cautions against attempting to address a client’s use of violence unless the practitioner is sufficiently skilled and has the time to do this competently (NSW Department of Attorney General and Justice, 2012).

Referral of an AOD client who uses violence to a specialist organisation may never be acted on by the client. There may also be limited resources for perpetrators in many locations. Consequently, individual organisations need to decide if it is in the best interest of their client (and their family) to directly address FDV. They should determine whether they have appropriate policies, staff training and supervision in place to opportunistically or routinely address violence by perpetrators. See Figure 2 and Table 4 for initial guidance in this regard.

Where violence is discussed with the perpetrator, the following should be considered:

- if the perpetrator displays anger, resists or rejects a discussion about violence, bring the subject to a close and move back to the presenting issue. State that you are willing to return to FDV issues when the client is ready.
- for many reasons, intervening with those who use violence may present its own risks. Violence can escalate once the use of violence becomes known to others (Department of Human Services, 2012b). Violence can be directed to previous victims or new targets, which may include other family members and staff of the AOD service.
- effective responses to FDV should anticipate the possibility of an escalation of violence once it is disclosed and strategies put in place to mitigate this (e.g., safety plans, information sharing, liaison with FDV services and police).
- workers need to be aware of the risk of unwittingly colluding with clients who use violence. Examples of collusion include:
 - saying nothing when violence is disclosed
 - minimising the use of violence (“*At least you didn’t...*”)
 - focusing on a narrow view of violence, and not picking up how the client might use emotional, social, financial and other forms of non-physical violence
 - body language – responding with a half-smile or a brief nod of the head may indicate acceptance when a joke, derogatory comment or generalisation is made
 - being drawn into a “matey” conversation with the client
 - not challenging a client’s stories and language used to minimise their behaviour and responsibility.

⁷ Information relating to perpetrators of FDV has been sourced in part from No To Violence, a project of the Male Family Violence Prevention Association: www.ntv.org.au.

Table 3: Factors incorrectly attributed as causes of FDV

Factor	False Attribution
The perpetrator's psychological profile	While various attempts have been made to identify a particular set of personality traits and develop psychological profiles of perpetrators, these have been unsuccessful. Perpetrators of FDV are identifiable only by their use of power and controlling behaviours.
The victim's psychological profile	That some people allow themselves to be abused, or have psychological problems that lead them to choose partners who perpetrate violence. However, there is no evidence that it is a particular "type" of person who is likely to experience FDV.
Alcohol and drugs	Perpetrators of FDV can be more dangerous when they are under the influence of alcohol or other drugs. However, not all people who abuse alcohol are violent, and many people are violent whether they are drunk or sober. While alcohol and other substances might exacerbate violence in some men, their underlying attitudes and values are the starting point for violence.
Family history	Often people seek to explain FDV by suggesting that men who perpetrate violence had traumatic childhoods, or that they repeat the violence they witnessed in their own family backgrounds. While this may be true for some, this belief cannot account for the very large number of men and women who have been exposed to family violence as a child and are not violent in adulthood. Nor does it explain how a significant number of people who report happy and non-violent childhoods perpetrate violence in an adult relationship.
Failure to manage emotions (such as anger or frustration)	<p>Perpetrators and the broader community commonly attribute violence to a failure to manage anger or frustration. However, perpetrators of violence often experience a number of other emotions—such as anxiety, distress, impatience, agitation, possessive jealousy and frustration—before and during violent acts, instead of or in addition to anger.</p> <p>Most people can manage anger and other feelings without resorting to violence. Indeed, most perpetrators of FDV successfully manage a range of feelings (including anger and distress) outside of their domestic environment. People who are violent towards family members usually do not perpetrate violence against their work colleagues, bosses or friends. This suggests that failure to manage emotions is not at the core of FDV – but rather, a deliberate choice about how to behave in particular situations.</p>
Mental illness	There is no evidence that those who are violent have higher rates of psychiatric disorders than others. Given that FDV affects a significant proportion of the population, it cannot be explained in terms of "abnormal" personality characteristics. Those who perpetrate family and domestic violence look and act like "ordinary" members of society.
Cultural or religious customs used to excuse control over women	All communities - including Anglo Australian ones - have violence-condoning and violence-supporting values, systems and practices. In all communities, there are women and children resisting family and domestic violence while still upholding their cultural or religious texts, beliefs and customs.

(adapted from NSW Department of Attorney General and Justice, 2012)

Collusion may reinforce patterns of blaming a partner and/or others for their behaviour, placing partners and their children at further risk.

However, engaging a client in a conversation about use of family violence – if the circumstances are appropriate and done carefully and skilfully – may provide an opportunity for the client to identify and take responsibility for their behaviour. A skilfully managed conversation including the use of Motivational Interviewing techniques might be helpful (see Tips for Talking to Perpetrators below). It may also present one of the few opportunities for a perpetrator to reflect on their use of violence, assess its impact and implications and hear that violence is not acceptable.

It is never appropriate to disclose information to a perpetrator obtained from those affected by the use of violence, such as a (ex)partner or children. In particular, if the client is unaware that you know about their use of violence, it is generally not safe to confront them. Doing so could place those affected by it at risk of retaliation.

The priority in these situations is to attempt to find a way to offer support and referral to those affected by violence (usually the partner and children). A discussion with your supervisor or secondary consultation with an FDV service can help determine appropriate options.

Written information (e.g., file notes, contact details, safety plans etc.) that may include details about a (ex) partner and/or children should be stored safely where it cannot be accessed by a client who uses violence (Department of Human Services, 2012a; Office of the Guardian, 2008).

Tips for Talking to Perpetrators

In relation to working with clients who perpetrate violence:

1. the victim and/or children should not be present when discussing FDV with the perpetrator. Interviewing them together can result in the risk of retaliation if victims disclose the violence, or to under-reporting due to fear of retaliation
2. use a calm and respectful manner
3. use reflective statements in ways that direct the conversation to his behaviour:
Client: "She just yells and screams and tells me to f... off when I talk about xxxxxx, I'm sick of it."
Counsellor: "I can hear that you have a lot of worries about xxx. Can you tell me more about what happens in these situations? What do you do next?"
4. provide an opportunity for the client to talk about what they want to be different in their life and relationships, and focus on how their behaviour may sabotage the possibility of things improving (keep in mind that they may have caused some irreparable damage to their relationships and that it is important not to provide hope that the relationship/s will recover)
5. do not "lock horns" when the conversation appears to be going nowhere – try a different angle. In Motivational Interviewing terms "roll with resistance"
6. talk with the client about the difference between anger and violence – that anger is a feeling, whilst violence is a behavioural response and that they have choices about how to behave when they feel anger, jealousy, etc
7. focus on how participation in a behaviour change program might be of benefit.
Counsellor: "I hear you saying that you don't like things the way they are. I hear that you love your kids, but my guess is that your behaviour is frightening your family, maybe even affecting your kids. Would you like to talk about where you can get some assistance to change your behaviour?"

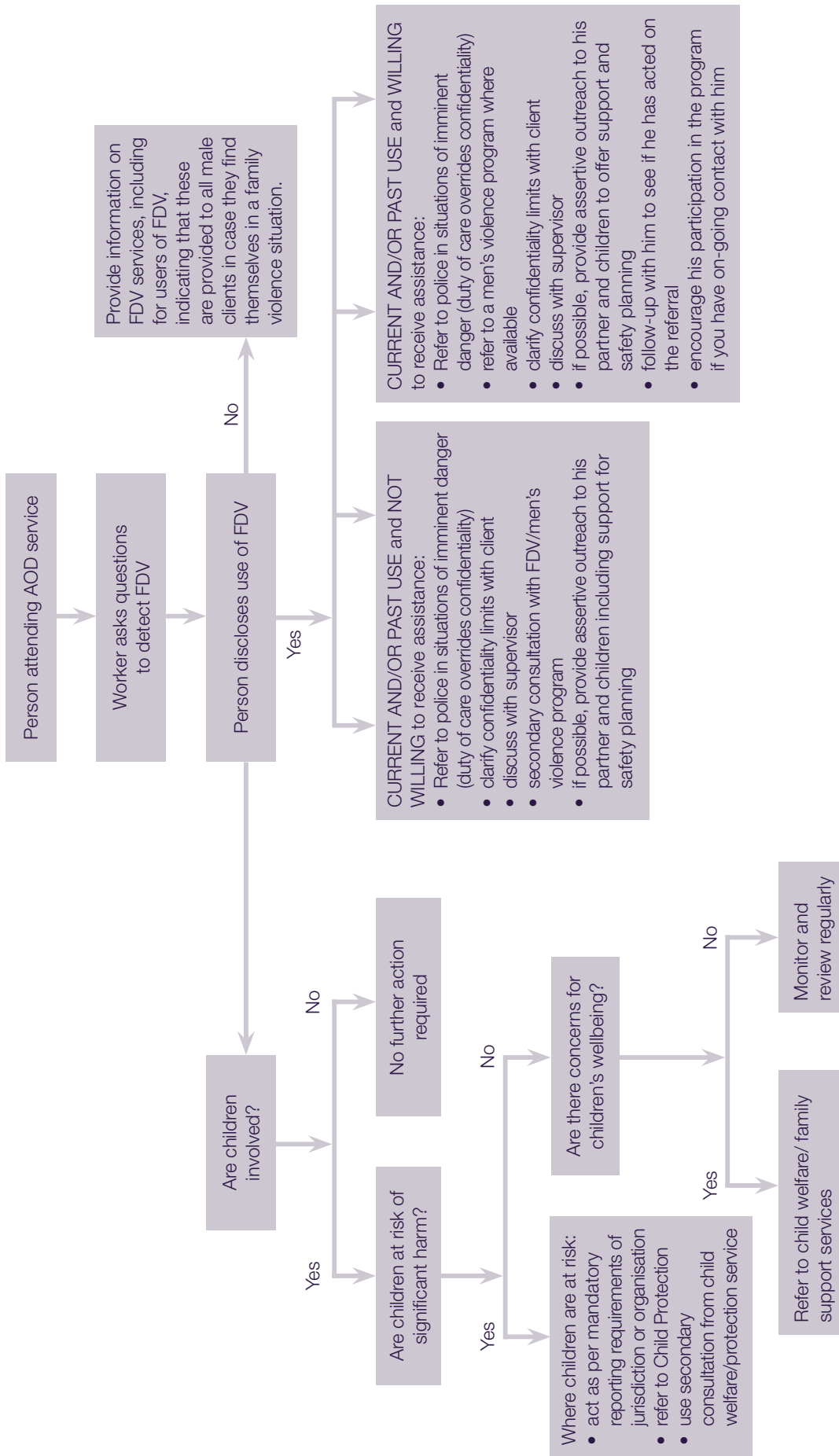


Figure 2. Options for responding to clients who may use FDV

(based on Department of Human Services, 2012a)

Table 4. Potential responses to client disclosure of using violence

Timeframe	Reasons to ask about FDV	Possible Responses
Clients who may use violence	<p>Clients disclosing an intention to or fear that they may perpetrate violence should be provided with support to eliminate or minimise the risk of the violence occurring. This may include referral to an appropriate violence intervention service, rehousing away from the potential victims, notification to police in cases of imminent danger and/or child protection if children are at risk.</p>	<p>Whilst there are limited resources for perpetrators, Men's Behaviour Change Programs are run in many Community Health services, and also by agencies such as Relationships Australia, Baptist Community Services Lifecare and Anglicare. These support men in a peer setting to acknowledge and take responsibility for using violence.</p> <p>Anger management programs are not an appropriate referral option for FDV perpetrators (see www.mrs.org.au for an explanation).</p> <p>See referral information below.</p>
Clients who use violence - past or current	<p>Asking provides the clinician with the opportunity to provide information and referral in a non-judgemental and supportive way.</p> <p>It is important to note that most perpetrators of FDV are not likely to disclose their use of violence.</p>	<p>Where a client discloses that they have used violence refer them to a specialist men's behaviour change or men's violence program.</p> <p>Assistance and referral information:</p> <ul style="list-style-type: none"> • for referral information in all Australian States and Territories, contact National 1800RESPECT Line - 1800 737 732 • Men's Referral Service (Victoria; www.mrs.org.au) • Qld DV Connect Mensline www.dvconnect.org/mensline/default.asp. • WA Men's Domestic Violence Helpline www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx • for specific information about same-sex domestic violence. www.acon.org.au/anti-violence/Same-Sex-Domestic-Violence <p>Anger management, couple counselling and general family therapy may be unsafe referrals as they can strengthen the perpetrators' excuses for their use of violence (e.g., that their anger is "out of control", or that relationship issues are the source of the violence) – see www.mrs.org.au for a further explanation.</p>

Referral and Finding Local Domestic Violence Services

In asking about violence, it is important to respond appropriately to disclosures and refer clients to appropriate specialist FDV and sexual assault services. These services will assist clients to access specific information, resources and emotional support. They may also be able to assist with secondary consultations and participate in complex case management meetings. It can be helpful to use a formal referral form for interagency referral. An example is attached at Appendix 3.

The National Sexual Assault, Domestic Family Violence Counselling Service, 1800RESPECT, is a national 24-hour service providing assistance in regard to domestic and family violence and sexual assault for victims and workers. It is the most appropriate first point of contact searching for information on local or regional support services.

1800RESPECT also provides secondary consultations and advice for workers and professionals who are unsure how to help a client who is experiencing or using FDV or has experienced sexual assault.

1800RESPECT National Sexual Assault, Domestic Family Violence Counselling Service

Call 1800 737 732 (24-hours), or visit 1800RESPECT Online www.1800respect.org.au/index.html

Information Sharing

Each State/region has specific legislation and guidance on privacy information sharing. It is important to understand the rules about information sharing in your jurisdiction and organisation. Your organisation will have information sharing policies and procedures. In general, these should be used in relation to clients with FDV issues (see <http://www.gcyp.sa.gov.au/information-sharing-guidelines/> for examples of how to develop appropriate policies).

Individuals including victims and perpetrators own all information you gather about them including any that has been provided to, or shared with you, or your organisation. It is a client's right to be consulted before their information is shared with

other organisations. It is also important to consider what information is documented in each client's file, especially if it has been obtained from another source without the client's consent.

There may be circumstances where information can be shared without consent e.g.:

- serious imminent threat to an individual's life, health, safety or welfare
- a serious threat to public health, safety or welfare
- a suspicion of serious unlawful activity.

In these circumstances the information can be shared without consent if it is disclosed as a necessary part of investigating or reporting the matter to the relevant authorities (Wall, 2012).

Initially such information should be shared with the police or appropriate emergency services.

It is recommended that all organisations develop a general statement about their information sharing policies and procedures. This should be included in privacy and confidentiality information provided to clients. For example:

This agency/organisation will work closely with other agencies to coordinate the best support for you and your family. Under normal circumstances your informed consent for the sharing of information will be sought and respected in all situations unless:

- *it is unsafe or impossible to gain consent or*
- *consent has been refused and without information being shared it is anticipated that a person or persons will be at risk of serious harm, abuse or neglect, or pose a risk to their own or public safety*

(Based on Office of the Guardian, 2008).



Part C: AOD Systems and Organisational Responses

Policy Frameworks

A number of policy and procedural documents on AOD and FDV have been produced at a national level and State and Territory level.

The **National Drug Strategy** highlights that:

- Short episodes of heavy alcohol consumption are a major cause of ... domestic and public violence, and crime. Long-term heavy drinking... contributes to family breakdown and broader social dysfunction
- Brief interventions, treatment for alcohol dependence and family support services can help reduce the incidence and impact of family conflict and violence (Ministerial Council on Drug Strategy, 2011 p.17-18).

A major focus of the Strategy is Objective 2: **Reduce harms to families:**

- The families of people using drugs—their parents, partners and children—often suffer significant impacts from their drug use. Support needs to be available to families, particularly with children, to help them manage the stresses they may be experiencing from a family member's drug use and help engage them in managing the individual's drug-related problem. Families also aid in recovery
Services for people with drug-related problems need to recognise the impact of drug use on families and help ensure they are provided or connected with the right support. This applies both to specialist alcohol and other drug treatment services and to policing, social welfare and other services that may be interacting with people with drug-related problems
- Review existing national frameworks which address some of the causes of drug use, for example domestic violence strategies, and consider related actions that could be taken under the National Drug Strategy (Ministerial Council on Drug Strategy, 2011 p. 15).

*The overarching policy framework for working with children and families in Australia is the **National Framework for Protecting Australia's Children 2009-2020***

The National Strategy also highlights the importance of **partnerships:**

- Closer integration with child and family services is needed to more effectively recognise and manage the impacts of drug use on families and children
- On-going partnerships with Aboriginal and Torres Strait Islander communities are also needed to help reduce the causes, prevalence and harms of alcohol misuse and tobacco and other drug use among Aboriginal and Torres Strait Islander peoples (Ministerial Council on Drug Strategy, 2011 p. 7).

The overarching policy framework for working with children and families in Australia is the **National Framework for Protecting Australia's Children 2009-2020** (the National Framework), which was endorsed by the Council of Australian Governments in April 2009. It is an ambitious, long-term approach to ensuring the safety and wellbeing of Australia's children. It aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time (Council of Australian Governments, 2009).

The National Framework represents the highest level of collaboration between Commonwealth, State and Territory governments and non-government organisations, through the Coalition of Organisations Committed to the Safety and Wellbeing of Australia's Children. It provides guidance to encourage all levels of government and the NGO sector to work together to ensure Australia's children and young people are safe and well. It sets outcomes and actions throughout a series of three-year action plans.

Table 5. National framework outcomes

<p>Supporting outcome 1: Children live in safe and supportive families and communities</p>	<p><i>Communities are child-friendly. Families care for children, value their wellbeing and participation and are supported in their caring role.</i></p> <p>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.</p>
<p>Supporting outcome 2: Children and families access adequate support to promote safety and intervene early</p>	<p><i>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.</i></p> <p>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.</p>
<p>Supporting outcome 3: Risk factors for child abuse and neglect are addressed</p>	<p><i>Major parental risk factors that are associated with child abuse and neglect are addressed in individuals and reduced in communities.</i></p> <p><i>A particular focus is sustained on key risk factors of mental health, domestic violence and drug and alcohol abuse.</i></p> <p>The 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.</p>

(Council of Australian Governments, 2009)

Specifically, the National Framework contains a number of outcomes of relevance to addressing FDV in AOD services. These are detailed in Table 5.

Other policy frameworks that can inform organisational policy and procedure development are:

- Investing in the Early Years—A National Early Childhood Development Strategy
- National Mental Health Strategy
- National Suicide Prevention Strategy.

United Nations Convention on the Rights of the Child

In addition, Australia, as a signatory to the United Nations Convention on the Rights of the Child (CROC; United Nations, 1991), has an obligation to protect children's rights and to support parents in child rearing responsibilities. Through its ratification of the UN CROC, Australia acknowledges that children have a special need for protection by the State and

recognises their rights to protection (Roche, Bywood, Pidd, Freeman, & Steenson, 2009).

State/Territory Resources

Every State in Australia has legislation that establishes AOD service provision, FDV service provision and child and family welfare services. Many States and Territories have developed and distributed information and resources on working with clients who may experience FDV. It is recommended that those who have high levels of engagement with clients with FDV issues seek out relevant resources in their jurisdiction. Links to State/Territory resources are included in Appendix 6.

AOD Service Responses

Areas where the focus of AOD services could be improved to support clients with FDV issues are detailed in Table 6.

Table 6. Principles of best practice

<p>1. <i>Evidence based policy and practice responses</i></p>	<p>Interventions should:</p> <ul style="list-style-type: none"> • be based upon well-tested models of therapeutic practice and sound theories regarding FDV and child development • include methods for improving the parent-child relationship (Roche et al., 2009) • use a partnership and empowerment approach involving clients and their families (Asmussen & Weizel, 2009).
<p>2. <i>Organisational awareness of family issues</i></p>	<p>Like other common problems that co-occur with problematic AOD use, FDV and other family issues are an essential but ancillary part of AOD work; that is, not all clients have FDV or other family concerns. 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 problematic AOD, FDV or parenting difficulties (Alcohol Concern, 2009).</p> <p>Developing organisational awareness of FDV includes:</p> <ul style="list-style-type: none"> • understanding the prevalence of FDV • knowing the indicators of FDV • understanding the impact of FDV on partners & children • understanding the importance of addressing FDV to reduce AOD use and minimise harm.
<p>3. <i>Prioritising safety</i></p>	<p>Given the high prevalence of FDV within the AOD treatment population, it is essential to adopt organisational practices that prioritise the safety of those who experience violence (both partners and children) as well as the safety of staff (Alcohol Concern, 2009; Asmussen & Weizel, 2009; Battams & Roche, 2011b).</p> <p>A number of legislative changes have prioritised the safety of children when dealing with FDV situations. Organisations and workers should be aware of their legal and duty of care responsibilities.</p>
<p>4. <i>Coordination of services</i></p>	<p>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.</p> <p>Effective responses 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 welfare and protection organisations (Alcohol Concern, 2009)</p>
<p>5. <i>Policies and systems</i></p>	<p>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, information sharing, and referral pathways (Asmussen & Weizel, 2009; Battams & Roche, 2011b).</p>

6. <i>Standard response frameworks</i>	It is important to develop standard assessment and response protocols across an organisation. Assessments should identify the individual strengths and challenges of parents who have problematic AOD use problems. 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).
7. <i>Broad-based interventions</i>	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 (Battams & Roche, 2011b).
8. <i>Access to highly skilled practitioners if required</i>	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 sensitively and intensively to FDV issues. It is important for AOD services to ensure that clients can access the requisite level of expertise necessary. Links with external practitioners should be identified for secondary consultation, complex case management support and referral where necessary.
9. <i>Workforce development</i>	<p>Increasing the emphasis on FDV may require a range of additional workforce development activities.</p> <p>All staff require basic awareness, training and information on organisational policies and procedures.</p> <p>Some staff will require specialist training on assisting clients who experience and use violence in their relationships (State/Territory level resources are available and should be incorporated into organisational policies and procedures).</p> <p>Other relevant workforce development activities include</p> <ul style="list-style-type: none"> • incorporating FDV intervention practices into job descriptions • mentoring and clinical supervision and • support programs for staff (Alcohol Concern, 2009). <p>Commitment to addressing FDV 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. It is important to have designated individuals at both service delivery and strategic development levels to drive organisational change (Alcohol Concern, 2009).</p>
10. <i>Monitoring, accountability and evaluation</i>	Addressing FDV requires not only strong commitment but also robust lines of reporting within an organisation. In addition, 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 reliable recording and monitoring systems which document their work and its outcomes (Nicholas et al., 2012).

Responses to FDV in AOD organisations can operate at various levels. Galvani (2010) has suggested two related levels of response to FDV issues for AOD services:

Basic and **Enhanced**. However, for many services there is scope for a more differentiated range of responses as illustrated in Figure 3 (based on Nicholas et al., 2012).

Identifying differing levels and types of responses appropriate for an organisation, or worker, allows for the consideration of the limitations or constraints that may have to be addressed whilst working towards best practice models.

The hierarchical model suggested here identifies three levels of response that are not mutually exclusive (see Figure 3):

- Level 1 is a **basic response level**, which might be expected of, or aimed for by all AOD organisations and staff.
- Level 2 identifies the range of initiatives and skills that could reasonably be expected of all **frontline and counselling staff**, 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 **specialist AOD/FDV staff**, 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. They include the four elements of the basic response (above) but do more to ensure that FDV issues are integrated into the infrastructure of an organisation.

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

As most AOD services will generally operate in relation to FDV at Level 2, it would benefit AOD services to have access to or support on FDV issues from an identified FDV organisation. This may require the development of inter-organisational collaboration between an AOD and local FDV service. This may include shared training, secondary consultation, joint debriefing and shared complex client case management processes.

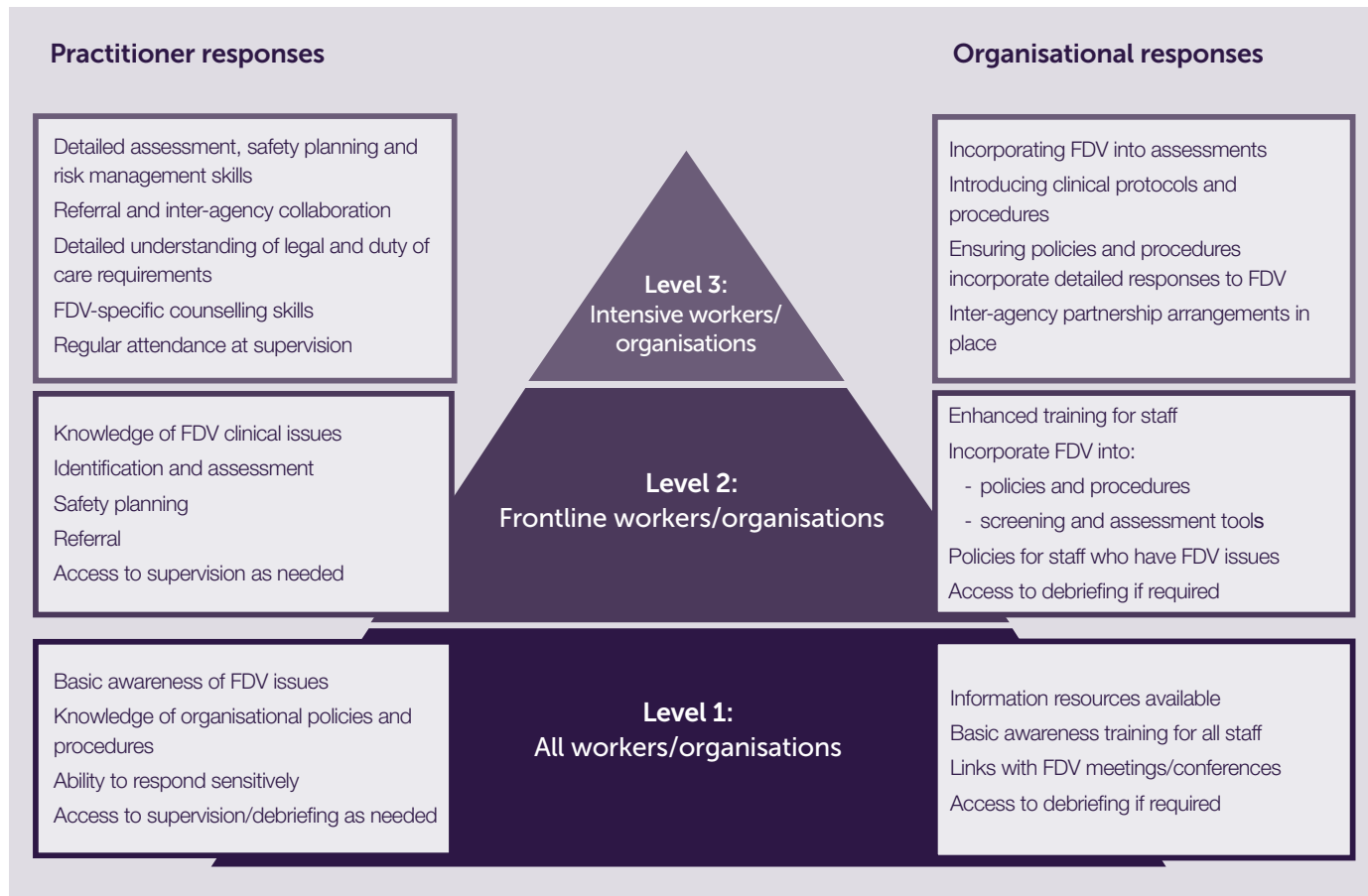


Figure 3. Responses to FDV

(based on Nicholas, 2012)



Part D: Further Information

Dynamics of Domestic Violence

The dynamics of domestic and family violence are complex. There are numerous models that seek to explain how and why violence is adopted by some people in relationships.

One such model is “the cycle of violence” (Walker, 1984) (see Table 7). Whilst the “cycle of violence” is not the only explanatory model of domestic violence, it is a useful starting point for exploring patterns of

violence. For many victims and perpetrators, abuse is part of a consistent pattern of behaviour – rather than an isolated incident, or the cyclical build-up of tensions leading to repeated explosions.

An alternative model is the “Power and Control Wheel” developed by the Duluth Domestic Abuse Intervention Project in Minnesota – which emphasises controlling behaviours by perpetrators (<http://www.theduluthmodel.org/pdf/PowerandControl.pdf>).

Table 7. The cycle of violence

<i>The build-up phase</i>	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.
<i>The stand over phase</i>	Can be extremely frightening for people affected by FDV. 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.
<i>Explosion</i>	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.
<i>Remorse</i>	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.
<i>Pursuit</i>	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.
<i>The honeymoon</i>	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.

(Walker, 1984)

The “cycle of violence” may occur many times in relationships where one partner is abusive. Each phase may last for varying amounts of time and a full cycle can take anywhere from a few hours to a year or more. Typically, violence escalates over time, 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 clients with AOD problems experience FDV. Nevertheless, problematic AOD use has strong associations with violence in general, and FDV in particular.

An estimated 19,443 substantiated child protection cases in Australia in one year (2006/7) involve a carer's drinking and 24,581 assaults on family members reported to the police involve drinking (Laslett et al., 2010).

In 2010, 28% of Australians aged 14 years and older were victims of an alcohol-related incident, 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, 2011).

The International Violence Against Women Survey (IVAWS) also demonstrated a strong association between alcohol, drugs and FDV. The IVAWS surveyed 6,677 women from across Australia. 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 (Mouzos & Makkai, 2004).

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 a partner's drinking habits, levels of aggression and controlling behaviour (Mouzos & Makkai, 2004).

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

Similarly, international research identified that:

- 44% of domestic violence offenders were under the influence of alcohol and 12% were affected by illicit drugs when they committed acts of physical violence (Budd, 2003).
- 51% of respondents who were clients of UK domestic violence agencies indicated that 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, US clients of AOD services reported high levels of FDV and clients of FDV programs reported high levels of AOD. 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%) (Gutierrez & 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. Given what is known about potential causal pathways between FDV and the emergence of AOD problems, it is important that this issue is addressed in AOD treatment services.

Key Issues

Key issues in the FDV field with important implications for AOD services include the following:

1. The AOD – FDV relationship
Problematic AOD (particularly alcohol) use increases the incidence of FDV, the risk of harm and the severity of injuries caused by FDV. Nevertheless, the association between problematic AOD use and FDV is not necessarily causal. The relationship 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 and gender based violence.

2. Family/domestic violence and gender
Family and domestic violence is not gender neutral. The evidence clearly shows that:
 - ▶ more women, and subsequently their children, are victims of FDV than men (i.e., violence is gender based) (Galvani, 2010)
 - ▶ men are more likely than women to use violence in their relationships (Australian Bureau of Statistics, 2006)
 - ▶ women are more likely than men to be injured and to express fear as a result of FDV (Gutierrez & Van Puymbroeck, 2006).
3. Problematic AOD use and FDV
A significant proportion of AOD treatment services' clients have used, been victims of or witnessed violence in their intimate relationships. For these clients, AOD problems may be inextricably linked to FDV issues. The available evidence suggests that, among women in particular, problematic AOD use and FDV can be a bi-directional relationship. That is, either problem can increase risk of the other. That is:
 - ▶ problematic AOD use increases the likelihood of experiencing FDV
 - ▶ alcohol and other drugs may be used in response to FDV and the stressors associated with it. From this perspective, substances can be used as a short term coping mechanism to help deal with physical and emotional pain and distress.
4. Complex needs
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 broadly based and address multiple problems.

Specific Client Groups

This document is too short to do justice to specific client groups in detail. However, it would be remiss not to mention two significant groups, Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) clients. Both of these groups have complex relationships with AOD and FDV issues.

Aboriginal and Torres Strait Islander Clients

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 people 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) (Gleadle et al., 2010).

The dramatic changes [post colonisation] 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 people, it is particularly important for AOD services to consider the possibility of FDV among this client group. It is also critical that services provide culturally safe and appropriate interventions for these clients.

Refer to 1800RESPECT for Indigenous FDV support services by State and Territory (<http://www.1800respect.org.au/>).

Culturally and Linguistically Diverse Clients

Clients from CALD communities may require specialised support. This may include access to bicultural health and legal professionals, culturally sensitive risk assessment, information, support and advocacy (Allimant & Ostapiej-Piatkowski, 2011). Most States and Territories have specialised services that can provide advice and information, resources and referral to translation services (see Appendix 6).

Where a client expresses cultural reservations about identifying FDV, it may assist them if it is explained as a human rights issue. Violence against women and children is recognised as a contravention of the International Convention of Human Rights, which states that all people have the right to be free from fear and violence and that domestic violence is prevalent, preventable and an abuse of human rights (Morris et al., 2012).

Women from CALD backgrounds may consider their experiences of violence (especially sexual violence) as shaming them and therefore may not consider disclosing it and seeking support. This makes it very important that if they do disclose FDV that they get appropriate support (Allimant & Ostapiej-Piatkowski, 2011).

It is also essential that CALD clients can access information in their own language. However, some clients may not be literate in either their first language or English and so information may need to be provided verbally. Where interpreters are required it is strongly advised that only professional interpreters are used. Engaging non-professionals, or family members, as interpreters may compromise confidentiality and create misunderstandings (Department of Human Services, 2012a; Odyssey House, 2009; Wall, 2012).

Refer to 1800RESPECT for CALD FDV support services by State and Territory (<http://www.1800respect.org.au/>).

Violence against women and children is recognised as a contravention of the International Convention of Human Rights, which states that all people have the right to be free from fear and violence and that domestic violence is prevalent, preventable and an abuse of human rights (Morris et al., 2012).

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Appendices

Appendix 1: Safety Checklist for Clients Experiencing Violence

This checklist is designed to assist clients to plan leaving an abusive partner. It is not intended that it would be given to clients as it may prove dangerous if a perpetrator found it in their possession. It could however be used to facilitate a discussion in a one-on-one session with a client (Based on Department for Child Protection, 2011; Department of Human Services, 2012a).

For some clients leaving will be a response to immediate danger and in such they may not have the chance to take anything. It is important to assure them that in such circumstances there is support for them. Clients should not put themselves at risk trying to get “essentials” that can be replaced. Police can also assist by being present when women return to pick up their belongings. Personal safety is always the first priority.

If you are planning to leave, or have left your partner make a safety plan, and involve your children.

Before you leave:	After you leave:
<ul style="list-style-type: none"> • What do you need to take with you? <ul style="list-style-type: none"> ▸ cards – ATM card/bank book, driving licence, Medicare & Centrelink cards ▸ other documents – birth, marriage & divorce certificates, passport, family court orders, rental agreement or mortgage documentation, utility bills, car registration ▸ medication and toiletries ▸ keys to house/car/work ▸ money ▸ mobile phone & charger (consider changing your number, redirecting bills) ▸ telephone numbers for family & friends ▸ change of clothes and basic food. • Have a safe place to put pre-packed essential items in case you need to leave in a hurry. • Consider who you can safely tell about the violence at home and about your plan to leave. • Consider where you will go and plan how to get there. • Do not leave lists or other indications you are planning to leave where your partner can find them. 	<p>Consider whether you should:</p> <ul style="list-style-type: none"> • apply for a restraining order • improve home security e.g., silent number, security/duress alarms, changing locks • tell your trusted friends and relatives about the violence. see what help they can provide • inform trusted neighbours and ask for help in a crisis • let others e.g., work colleagues, doctors, lawyers know the importance of maintaining your security, including when it is safe to discuss your situation with you • withdraw your share of money from bank accounts and opening new accounts (bank, credit card, loans) • change email address, Internet and social media profiles (for self and children), and privacy and security settings • tell schools and others who take care of your children the names of people who are allowed to contact them • avoid places where your partner might expect to see you (e.g., shops, bus stops) • be careful to whom you give your new address and phone number • find someone whom you can speak to if you feel down • clear phone and computer logs regularly (recently dialled numbers and web page history).
<p>What about my children?</p> <ul style="list-style-type: none"> • Take children with you away from the violence. • Take baby formula, changes of clothes, favourite toys and books, school uniforms and books, and medical records (as appropriate). 	
<p>What about my pets?</p> <ul style="list-style-type: none"> • Ask friends if they can look after pets. • Call your local animal welfare service. 	

Appendix 2: Signs of Intimate Partner Violence

This list of indicators can be used by or with clients to help them self-identify if they are experiencing intimate partner violence. It should not be used when the potential abuser is present.

Inner Thoughts and Feelings – Do you:

- feel afraid of your partner much of the time?
- avoid certain topics out of fear of angering your partner?
- feel that you can't do anything right for your partner?
- believe that you deserve to be hurt or mistreated?
- sometimes wonder if you're the one who is crazy?
- feel emotionally numb or helpless?

Verbal Abuse – Does your partner:

- humiliate or yell at you?
- criticise you and put you down?
- treat you so badly that you're embarrassed for your friends or family to see?
- ignore or put down your opinions or accomplishments?
- blame you for their abusive behaviour?
- see you as property or a sex object, rather than as a person?

Violent Behaviour or Threats – Does your partner:

- have a bad and unpredictable temper?
- hurt you, or threaten to hurt or kill you?
- threaten to take your children away or harm them?
- threaten to commit suicide if you leave?
- force you to have sex?
- destroy your belongings?

Controlling Behaviour – Does your partner:

- act excessively jealous and possessive?
- control where you go or what you do?
- limit your access to money, the phone, or the car?
- constantly check up on you?

(From: http://www.helpguide.org/mental/domestic_violence_abuse_types_signs_causes_effects.htm)

Appendix 3: Agency to Agency Referral Form

Confidential

Date:

RE: Referral in relation to family and domestic violence issues

FROM	TO
Agency name:	Agency name:
Address:	Address:
Referrer's name:	Agency contact:
Direct phone number:	Contact phone:
Email:	Email:

Client's name Date of birth:

Address:

Client contact numbers: Phone: Mobile:

It is safe / NOT safe to contact the client on these numbers (circle as appropriate).

My client presented for assistance with drug and alcohol issues. In the course of our conversation, issues of family and/or domestic violence were disclosed.

..... (name) feels safe / unsafe (circle as appropriate) to return home today.

There are children in their care.

She has / does not have (circle as appropriate) immediate concerns for their safety.

Child's Name	Age	Gender	Resides with Client (Y/N)

With client consent and involvement this agency has put into place the following interim arrangements to keep her safe until a comprehensive assessment of risks and support needs has been undertaken.

With client consent I am making this referral to your service for the purpose of assessing the client's level of risk and advising her of options that are available to keep her and her children safe.

I have previously advised in your organisation that I am making this referral today.

A copy of relevant documentation (screening/risk assessment tool, excerpts from case notes) completed by our agency is attached.

..... (client's name) speaks (language name) and an interpreter was/was not used in our interview.

Thank you for assisting in this matter. Please do not hesitate to contact me if I can be of any further assistance.

Referrer's name:

Signature:

Appendix 4: FDV Service Mapping Tool

Emergency Contact Numbers:

- Police 000
 - Local station Phone:
 - FDV Liaison Officer Name: Phone:
Mobile: Email:

- Child Protection Services
 - Key Contact Name:
 - Phone: Mobile:
 - Email: After Hours Number:

Local Family Violence Services:

Organisation Name:

Key contacts:	Name:	Job title/role	
	Phone:	Mobile:	Email
	Name:	Job title/role:	
	Phone:	Mobile:	Email

Local Child Welfare Services:

Organisation Name:

Key contacts:	Name:	Job title/role	
	Phone:	Mobile:	Email
	Name:	Job title/role:	
	Phone:	Mobile:	Email

Local Men's Services

Organisation Name:

Key contacts:	Name:	Job title/role	
	Phone:	Mobile:	Email
	Name:	Job title/role:	
	Phone:	Mobile:	Email

Appendix 5: Child Protection Contacts

State/Territory	Responsible authority
ACT	Office for Children, Youth and Family Support – Department of Disability, Housing and Community Services
NSW	Community Services – Department of Family and Community Services
NT	Children, Youth and Families – Department of Health and Families
QLD	Department of Communities (Child Safety Services)
SA	Families SA – Department of Families and Communities
TAS	Child Protection – Department of Health and Human Services
VIC	Child Protection and Family Services – Department of Human Services
WA	Department for Child Protection

(From <http://www.aifs.gov.au/cfca/pubs/factsheets/a141787/index.html>)

Appendix 6: Links to information, training materials and other resources

Some Key Australian Resources

Organisation	Resource name	Weblink/email	Comments
1800RESPECT National Sexual Assault, Domestic Family Violence Counselling Service	Call 1800 737 732 (24-hours), or visit 1800RESPECT Online	www.1800respect.org. au/index.html	FDV resources for workers and clients.
Australian Domestic and Family Violence Clearinghouse	The Elephant In The Room: Responding to alcohol misuse and domestic violence	http://www.adfvc.unsw. edu.au/PDF%20files/ IssuesPaper_24.pdf	An analysis of the links between alcohol abuse and domestic and family violence.
Family Law Branch Attorney-General's Department, Canberra	AVERT: Family violence training package	http://www.avert familyviolence.com.au/	A national resource for providing training to those working in the legal sector on FDV. Includes comprehensive training materials and DVD and web based resources.
National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA	Family sensitive practice in the alcohol and other drug field	http://nceta.flinders.edu. au/index.php?cID=291	A comprehensive package of research and resources focusing on drug and alcohol service provision and child and family focused practice.
	Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia	http://nceta.flinders.edu. au/files/6513/5285/7437/ EN469_Nicholas_2012.pdf	A brief literature review that explores the relationships between AOD and FDV services with a focus on how the AOD sector can better support clients with FDV issues.
Australian Centre for the Study of Sexual Assault (ACSSA) Australian Institute of Family Studies	Resource Sheet: Asking women about intimate partner sexual violence	http://www.aifs.gov.au/ acssa/pubs/sheets/rs4/ index.html	This Resource Sheet aims to provide current information to those working in health care settings about how to approach the discussion of intimate partner sexual violence with their female clients and patients.

No To Violence and the Men's Referral Service	No to Violence website	www.ntv.org.au www.mrs.org.au	No To Violence is the only Australian peak body focusing on working with men to stop their use of FDV. The Men's Referral Service has a comprehensive website and telephone referral service regarding men's use of FDV.
Men's Violence Services	Qld DV Connect Mensline WA Men's Domestic Violence Helpline	www.dvconnect.org/mensline/default.asp www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/FamilyandDomesticViolence.aspx	State based men's support services.
ACON (AIDS Council of NSW)	GLBTIQ Domestic Violence Toolkit	www.acon.org.au/anti-violence/Same-Sex-Domestic-Violence	Specific information about same-sex domestic violence.
Lawlink NSW	Domestic violence interagency guidelines	http://www.lawlink.nsw.gov.au/lawlink/vaw/dvguidelines.nsf/pages/worker	Guidelines for workers in the field working in or dealing with the legal system and/or working with women dealing with the legal system.
The Australian Drug Foundation	Responding to the needs of children and parents in families experiencing alcohol and other drug problems	http://www.druginfo.adf.org.au/attachments/587_PRQ_May2012.pdf	Provides a summary of current research and professional opinion relevant to working with families, especially when a parent presents for treatment or support. A useful resource for both service providers and practitioners, providing tips and advice on family sensitive and family inclusive practice, with a specific focus on supporting children.
Women's Council for Domestic and Family Violence Services (WA)	Supporting women with complex needs	http://www.womenscouncil.com.au/uploads/6/1/1/9/6119703/supporting_women_2nd_edition.pdf	A WA resource that provides information on supporting women with complex needs.
New South Wales Legal Assistance Forum (NLAF)	Domestic violence resources	http://www.nlaf.org.au/cb_pages/domestic_resources.php	Links to NSW and national resources on FDV and the law.

Department of Human Services, Victoria	Family violence risk assessment and risk management framework and practice guides 1-3	http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/718858/1_family_violence_risk-assessment_risk_management_framework_manual_010612.PDF	A comprehensive resource for workers in a range of services (including AOD) on addressing family violence appropriately.
The Victorian Alcohol and Drug Association (VAADA)	Connections: Family violence and AOD - VAADA position paper	See attached CD-Rom	<p>The VAADA Position paper discusses the relationship between AOD misuse and family violence. It argues that a stronger focus by AOD services on the relationship between AOD misuse and family violence would:</p> <ul style="list-style-type: none"> • improve the safety of women and children (and conversely family violence services reflecting on said relationship), • better address the impact of family violence • improve treatment outcomes of AOD clients. <p>Concludes with policy and practice recommendations for consideration.</p>
Department of Child Protection, WA	The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework	http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/CRARMF.pdf	A resource for FDV services in WA supporting the implementation of common approach to screening, risk assessment and response for all services in WA.
Domestic Violence Services SA	Understandings of the Criminal Justice System & Domestic Violence	http://www.dvsa.asn.au/documents/20_Resources/h_CJS%20Manual.pdf	A resource for workers seeking to understand the links between domestic violence and the justice system.
Relationships Australia, SA; Flinders University; Southern Junction Community Services	Walking on Eggshells: Child and adolescent violence in the family	http://www.flinders.edu.au/ehl/fms/law_files/Law%20Resources/Walking%20on%20Eggshells%20Family%20Booklet.pdf	This booklet offers suggestions and resources for parents and carers who are dealing with violent and abusive behaviour from their children and adolescents.

Guardian for Children and Young People, SA	Information Sharing Guidelines	http://www.gcyp.sa.gov.au/information-sharing-guidelines/	The ISG are overarching principles and practice which bring together all relevant SA government agencies and non-government organisations in the interests of early intervention, better coordination of services, and consistent information sharing across the State.
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Some Key International Resources

Organisation	Resource name	Weblink/email	Comments
Alcohol Concern UK	Alcohol Concern Knowledge Set One: Domestic Abuse	http://www.alcoholconcern.org.uk/assets/files/Embrace/Knowledge%20set%201.pdf	A comprehensive UK resource on Domestic Violence.
The Stella Project UK	Domestic violence, drugs and alcohol: good practice guidelines (2007, 2nd edition)	http://www.avaproject.org.uk/our-resources/good-practice-guidance-toolkits/stella-project-toolkit-%282007%29.aspx	A comprehensive resource site on AOD, child and family welfare and FDV.
Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Agency for Substance Misuse (NTA) UK	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	A UK resource providing examples of collaborative practice between AOD and child and family welfare services.
Birmingham and Solihull Women's Aid (2010) UK	Women with Complex Needs: Good Practice Guidelines and Pathways for Working with Women Affected by Domestic Violence, Substance Misuse and Mental Health Issues	http://www.bsward.org/wp-content/uploads/2011/02/Complex-Needs-Full-Guidelines.pdf	This guide seeks to support staff to manage the impact and risks associated with domestic violence, and navigate the specialist provision needed to meet the range and complexity of needs that abuse creates.
Helpguide.org USA	Domestic Violence and Abuse Signs of Abuse and Abusive Relationships	http://www.helpguide.org/mental/domestic_violence_abuse_types_signs_causes_effects.htm	An international online resource that includes information for the general public on FDV.



NCETA

*Australia's National Research Centre
on AOD Workforce Development*

Level 3B, Mark Oliphant Building
Laffer Drive, Science Park
Bedford Park SA 5042

Phone: +61 8 8201 7535

Fax: +61 8 8201 7550

Email: nceta@flinders.edu.au



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