Towards an integrated response to the complex interplay of domestic and family violence, alcohol and other drug use and mental health in Western Australia

PROJECT REPORT

wanada
Western Australian Network of Alcohol & other Drug Agencies

Women's Community Health Network WA

STOPPING FAMILY VIOLENCE

WOMEN'S COUNCIL
FOR DOMESTIC & FAMILY VIOLENCE SERVICES (WA)

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Executive Summary

Domestic and family violence is a serious, prevalent and preventable public health, social and human rights issue. Since the age of 15, approximately one in four women has experienced at least one incident of violence by an intimate partner (ANROWS, 2018). Sixty eight per cent of women who have experienced violence by a previous partner have experienced more than one incident of violence by that partner (ANROWS, 2018). Fifty four per cent of women who experience violence from a current partner have experienced more than one incident of violence by that partner (ANROWS 2018). On average one woman a week in Australia is killed by an intimate partner. Intimate partner violence is the greatest health risk factor (greater than smoking, alcohol and obesity) for women aged eighteen to forty four years (ANROWS, 2018). The fact that women experience violence most often at the hands of someone close to them can have complex emotional and economic consequences.

It is broadly recognised that while problematic alcohol and other drug use and mental illness do not cause or drive domestic and family violence the presence of either or both has a bearing on, and implications for, the experience and perpetration of domestic and family violence. Likewise, the mental health and alcohol and other drug use of a victim-survivor of domestic and family violence is usually associated in some way with the domestic and family violence and its impacts[1]. Also, women using alcohol and other drugs are at increased risk of domestic and sexual violence.

This report was prepared for the project: 'Towards an integrated response to the complex interplay of domestic and family violence, alcohol and other drug use and mental health in Western Australia'. The project was initiated by peak bodies working in the domestic and family violence, alcohol and other drugs and mental health sectors in Western Australia. It was borne out of a shared concern for the lack of a systems response in Western Australia to the complex interplay of domestic and family violence, alcohol and other drug use and mental health. There were highly concerning examples emerging of the dreadful and even fatal outcomes for people as a consequence of a poorly integrated system, particularly around the domestic and family violence, alcohol and other drug and mental health intersection.

The complexity of the interrelatedness of domestic and family violence, alcohol and other drug use and mental health and its impact on individuals and families affected was also a recurring theme in various forums and consultations undertaken in 2019 with a focus on domestic and family violence. Similarly, alcohol and other drug and mental health service providers were expressing deep concerns regarding poor systems support to:

- Tailor their service for clients presenting with a complex lived experience of intersecting domestic and family violence, alcohol and other drugs and mental health issues.
- Promote the safety of victims-survivors and their families who are not 'in the room'.
- Work positively with clients presenting with alcohol and other drug and mental health issues who are also perpetrators of domestic and family violence; while also promoting perpetrator accountability and behaviour change to enhance women's and children's safety, but also to improve outcomes for perpetrators.

[1] Importantly, mental illness and alcohol and other drug use in women is strongly associated with the trauma associated with sexual violence. Sexual violence is a prevalent and significant social problem in its own right. However, there is considerable overlap between sexual violence and domestic violence and they share similar antecedents and drivers – such as gender inequality. Also, sexual violence is often a tactic of domestic violence and sexual assault is most often perpetrated by an intimate partner.

Add to this context, a media and a community that was trying to make sense of deeply disturbing and distressing, high profile homicides in Western Australia, by alluding to the mental health or drug use of the perpetrator.

This short-term, preliminary, and exploratory project was possible due to a small grant provided by Lotterywest through the WA Peaks Capacity Building Grants administered by the Western Australian Council of Social Services (WACOSS). The project Working Group was comprised of key peak bodies working in the domestic and family violence, alcohol and other drug and mental health sectors. The purpose of the preliminary project was to:

- Jointly define the complex interplay of domestic and family violence, alcohol and other drugs and mental health.
- Gauge (through consultation and a survey) service provider understanding of this interrelatedness, and their approaches to and capacity and preparedness for working with it.
- Explore via desktop research the evidence on the complex interplay of domestic and family violence, alcohol and other drugs and mental health and its take up in practice.[2]
- Use the evidence gained from consultations and a literature review to inform the planning and development of the second phase of the project and prepare an application for funding for the second and third phase of the project.

Literature review and consultations

The findings of the literature review (to follow) make it clear that the complex interplay of domestic and family violence, alcohol and other drug use and mental health is significant both in terms of lived experience and personal outcomes and in terms of service provision and outcomes. There is general agreement amongst researchers that factors associated with gender inequality are the most consistent predictors of domestic and family violence; and that alcohol and other drug use and mental health issues are reinforcing factors that can interact to increase the probability, frequency or severity of domestic and family violence.

We also learn that for various historical, political and philosophical reasons the domestic and family violence, alcohol and other drug and mental health sectors have emerged as discrete disciplines. We will see that this, along with distinct funding models, political portfolios and policy frameworks make an integrated response to the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health very difficult to achieve without systems support and workforce development. Currently in Western Australia no government resources have been committed to enabling the sectors to work consistently and sustainably in an integrated way to support improved and sustainable outcomes.

The literature review will also briefly explore efforts elsewhere to be fully responsive to the complex interplay of domestic and family violence, alcohol and other drug use and mental health to support improved safety, health and wellbeing outcomes for the individuals and families affected.

In the section discussing consultation findings we will see that service providers are more than aware of the complex interplay between domestic and family violence, alcohol and other drug use and mental health; and how it impacts efforts to work with clients on their presenting issue (whether that be domestic and family violence, alcohol and other drugs or mental health).

[2] This was mostly ‘grey literature’ and open access journal articles due to extremely limited funds.

Furthermore, consultation findings show that service providers are keen to be better supported to work safely and effectively with this complexity. However, it was also clear that the systems infrastructure is not in place to provide practitioners in the alcohol and other drug and mental health sectors with supported opportunities to translate the evidence on domestic and family violence into their day-to-day engagement with their clients.

Similarly, domestic and family violence services see service provider capacity to work in an integrated way with client complexity as essential if we are to improve outcomes for women and their children. Consultation findings also highlight the need for dialogic interaction and learning on the topic of this intersection to inform any workforce development going forward.

Findings of the project report

Briefly, the findings of this preliminary project are as follows:

- While a broad range of violent behaviours intersect with alcohol and others drugs and mental health and impact the safety, health and wellbeing of individuals, families and communities it is justifiable and necessary to have a project with a focus on the complex interplay of domestic and family violence, alcohol and other drug use and mental health. Domestic and family violence is a distinct form of violence with its own particular characteristics and antecedents. Thus it interacts with alcohol and other drug use and mental health in ways that are unique and requires a tailored response.
- The complex interplay of domestic and family violence, alcohol and other drug use and mental health has implications for client engagement and outcomes across these sectors, and requires an integrated or cross-sector collaborative response to improve the safety, health and wellbeing outcomes of people impacted.
- Organisational and service provider capacity and capability to work safely and effectively with the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health is currently inconsistent and not adequately supported systemically.

Moving forward, any workforce development with a focus on the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health in the distinct Western Australian context will require a ‘ground-up’ co-design approach to ensure that it will work in the local and particular contexts of service providers and population groups. This way rigorous use of the evidence can be assured and outcomes are likely to be relevant, useful and practical for a diversity of communities and population groups. Meaningful co-design with the domestic and family violence, alcohol and other drug and mental health sectors will be the focus of the second phase of this project.

A further project phase will be necessary to support the development of contextually suitable, appropriate and interactive workforce development; and its implementation and sustainable uptake in practice.

Literature review findings

Domestic and family violence is a widespread social and public health issues. An analysis by the ABC of statistics from WA Police reveals domestic and family violence offences in Western Australia, including assault and threatening behaviour, have surged more than 100 per cent in the past decade (ABC, 2018). A similar trend can be observed in numbers of breaches of violence restraining orders. Western Australia is second only to the Northern Territory in terms of the recorded rate of domestic and family violence. Domestic and family violence is a highly prevalent, but preventable social problem.

National and local plans to reduce violence against women and their children have put an increased emphasis on whole-of-community, whole-of-government responses to domestic, family and sexual violence. This includes an evidence-based and well-planned response to domestic and family violence by universal services such as mental health and alcohol and other drug services. States such as Victoria are leading the way in this area and have committed significant resources to building a systems and whole-of-community response.

Western Australia – although it aspires to a whole-of-community, whole-of-government response – is yet to commit the resources required to build workforce capacity to ensure that universal services have the core competencies required to play their part in reducing violence against women and their children and hold perpetrators accountable.

Furthermore, a growing body of research recommends the creation of a response to perpetration that links all the parts of the government, justice, health and social services sectors to overcome the existing fragmented and episodic response to perpetrators, and create a mutually reinforcing 'web of accountability' (see, for example, Spencer, 2016, 225–229). Current – albeit limited – evidence shows how a lack of timely intervention misses opportunities for change at best, and vindicates perpetrators at worst. This is not helped by the fact that perpetrator programs and domestic and family violence services often remain dislocated from other services such as those that address mental health concerns and alcohol and other drug use that causes harm to self or others.

It is also recognised in the literature that domestic and family violence has a significant impact on the safety, health and wellbeing of women and their children. Poor mental health outcomes and alcohol and other drug use that causes harm amongst women is very strongly associated with domestic, family and sexual violence. In this section we will focus on the intersection of domestic and family violence, alcohol and other drug use and mental health for both the victim-survivor of domestic and family violence and the perpetrator of it.

The literature review will have a particular focus on domestic and family violence and its interplay with alcohol and other drug use and mental health. This should in no way diminish the impact of other kinds of family violence, such as youth violence, elder abuse or violence used by someone during an experience of psychosis. These kinds of violence are significant; however they fall outside of the scope of this project and report. That said, insisting on tailored responses to distinct kinds of violence should improve the safety, health and wellbeing of all persons and their families.

Initial conversations with the alcohol and other drug and mental health sectors for the purposes of this preliminary project suggests that there is some concern that male victims of domestic and family violence are being overlooked and that they have female clients that appear to be perpetrators of violence themselves. For the purposes of this project and this literature review we are of the position

that a 'fight' involving violence where both people share equal power in the relationship is rare. A pattern of violence that includes control and domination by one of the partners is more common. We know from the data and research that men are overwhelmingly the perpetrators of this kind of violence.

Whilst the use of violence is never condoned it is helpful to understand that the violence used by women against their male partners can take several forms: including self-defence and resistance.

The Royal Commission into Family Violence (RCFV) in Victoria took the position that gender inequality and violence supportive attitudes are the primary causal factors for domestic and family violence, whilst other factors (such as alcohol and drugs, mental health and socioeconomic inequality) are contributing factors that reinforce the gendered drivers of family violence (State of Victoria 2016, vol. III, p. 248).

However, evidence shows that domestic, family and sexual violence are more likely to be excused if the perpetrator was affected by alcohol or other drugs; and the victim of domestic, family and sexual violence is more likely to be blamed for the violence if she is intoxicated (NCAS, 2017). It is likely that such community attitudes are reflected in the mental health and alcohol and other drug workforce and in women's own attitudes to their culpability and the culpability of the perpetrator.

This literature review is divided into the following areas:

- The complex interplay of domestic and family violence and alcohol and other drug use.
- Domestic and family violence and alcohol and other drug use – victims-survivors and perpetrators.
- Domestic and family violence and mental health – victims-survivors and perpetrators.
- Responding to the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health.
- Examples of integration/collaboration.

Splitting up alcohol and other drugs and mental health is somewhat artificial and reflective of the often discrete disciplinary research and practice areas. For example, we know from the evidence that domestic and family violence, the use of alcohol and other drugs among survivors, and trauma-related mental health issues tend to co-exist, and that the relationships among these factors are both complex and interrelated (Connelly *et al*., 2013; Golder *et al*., 2012; Jaquier *et al*., 2015; Paranjape *et al*., 2007; Peters *et al*., 2012).

Domestic and family violence perpetration and alcohol and other drug use

Where there is an association between alcohol use and domestic and family violence, several researchers argue that it is layered. Noonan *et al* (2017:4), for example, found the association to exist in three key ways:

- Alcohol use is linked with the perpetration of violence against women.
- Alcohol use is linked with women's victimisation by violence.
- Alcohol is used as a coping strategy by women who have experienced violence.

Noonan *et al* also conclude that while alcohol use is not a primary cause of violence, 'it has been found to interact with individual characteristics, gendered social scripts, and expectations within specific settings to reinforce the confidence of perpetrators, reduce victim resistance, infer victim culpability, and decrease perpetrator self-perceptions of responsibility' (2017:5).

Braaf (2012) reviewed a range of studies that explored theories of association between alcohol and domestic and family violence, including:

- The disinhibiting effect of alcohol.
- That alcohol causes perpetrators to be less aware of the physical force they are using, increase their risk taking and be less concerned about consequences.
- Heavy and/or frequent drinking can create increased conflict in relationships.
- Cultural and social expectations of the effects of alcohol on aggression can amplify violence.

Like others, Braaf warns that whilst there is an association between alcohol use and the frequency and severity of violence, causal theories for alcohol's contribution to domestic and family violence are contested by evidence that not everyone who drinks alcohol becomes violent towards their partner and that men who are violent to their partners when drinking have been shown to be violent when not using. However, it is estimated that half of the men in perpetrator intervention programs have used alcohol , and approximately half of the men in alcohol and other drug programs have perpetrated intimate partner violence (Mackay *et al* 2015 as cited by Noonan *et al* 2017).

The World Health Organization has noted that harmful use of alcohol and drugs is a commonly cited risk factor for experiencing and perpetrating intimate partner violence and sexual violence (WHO 2006). Numerous studies have found high rates of co-morbidity of mental health problems and alcohol and other drug use that causes harm in populations of domestic and family violence perpetrators (Siegel 2013: 295; Davoren *et al* 2017: 641; Askeland and Heir 2014: 1-2, Easton *et al* 2007).

In the 2-year period 2014–2015, just over 20% of family violence incidents recorded by Victoria Police involved alcohol use by the perpetrator, victim or both (Sutherland *et al*. 2016). Of those, the highest proportion had alcohol use by the perpetrator and no use by the victim with less than two percent involving alcohol use by the victim and not the offender. The use of alcohol by victims only or both parties were associated with a range of victim risk factors including prior victimisation, history of mental illness and having suicidal ideas or having attempted suicide.

The Australian component of the International Violence Against Women Survey found that one in three violent incidents reported by survey participants were alcohol-related and that family violence was more commonly reported by women whose partners got drunk at least twice per month than those whose partners did not (Mouzos and Makkai 2004 as cited by Braaf 2012).

Analysis of the relationship between alcohol and Australian homicides over a six year period found that, in 44 per cent of intimate partner homicides, the offender, the victim, or both, had been drinking (Lee *et al* 2017). From 2002-2003 to 2011-12, 36% of perpetrators of intimate partner homicides had used alcohol (Cussen and Bryant, 2015 cited in Foundation for Alcohol and Research Education 2015). However, in a study by Sutherland et al (2016), four fifths of family violence incidents recorded by Victoria Police did not involve alcohol. FARE found that the majority of men who use alcohol do not engage in violence towards women, and the use of alcohol does not appear to be associated with at least half of all reported domestic assaults in Australia (2015).

A Canadian study found alcohol consumption predicted male violence where it coexisted with norms supportive of such violence – when beliefs in male dominance were removed, the effect of alcohol on the occurrence of violence was neutralised (Johnson 2001, cited by Braaf 2012). Community attitudes show that many people believe intoxication is an excuse for violence (Webster *et al* 2018). This belief can be self-perpetuating. The idea that intoxication is a mitigating factor can also result in a level of

victim blaming and reduced perpetrator accountability. The literature suggests that alcohol use by perpetrators of violence may function to excuse responsibility and avoid accountability in some circumstances (Noonan 2017, Parker 2019, Yates 2019).

While it is not a causal factor, alcohol and other drug use is clearly relevant to the issue of domestic and family violence (Noonan *et al* 2017, Braaf 2012, Abramsky et al 2011, Lee et al 2017, Foundation for Alcohol and Research Education 2015, WHO 2006).

Alcohol and other drug use is recognised as an individual risk factor in the Common Risk Assessment and Risk Management Framework as it may influence the incidence and severity of violence (Department for Child Protection 2016). However, there is minimal guidance around how to assess the level of risk the alcohol and other drug use of the perpetrator poses. Studies have shown that the risks are widely varied depending on the nature of use and the substance of choice. There is also very little guidance as how to manage this risk or to integrate it into safety planning.

In their submission to the Royal Commission into Family Violence in Victoria, the National Alliance for Action on Alcohol (NAAA)[3] argue that risk assessment frameworks must address *how* service providers should assess the contribution of alcohol use to family and domestic violence; and that training or support is required to facilitate family and other services in engaging alcohol and other drug treatment services (NAAA 2015). NAAA also states that the continued marginalisation of alcohol and other drug services in domestic and family violence response frameworks will ultimately hinder the prevention of the increased risk and severity of violence due to alcohol and other drug use.

According to Rodney Vlais (2018: 10), there are several ways in which a client's unaddressed use of family violence can significantly interfere with the effectiveness of an alcohol and other drug intervention:

- While substances do not generally cause a perpetrator to choose to use violence, many perpetrators choose to use substances (paradoxically) as a tactic of control. Many victim survivors understandably feel especially frightened when their partner uses substances, due to the correlation between substance use and the severity of violent behaviour. Many perpetrators deliberately use substances as part of creating this climate of fear, and to 'punish' the victim-survivor for asking him to drink or use less.
- Substance use enables perpetrators to 'excuse' their use of violence on the substance.
- Motivational interviewing requires the careful unearthing of dissonance between a client's behaviour and their underlying ethics, goals and strivings for themselves and their life. For many perpetrators, the continued use of violence requires ongoing suppression of these underlying goals and hopes to avoid experiencing this dissonance.
- Perpetrators who want to do something about their behaviour, but are not participating in specialised behaviour change programs to do so, can feel much shame about their behaviour, and low self-efficacy about their ability to change. It can be difficult for them to set and feel confident about meeting substance use reduction goals in this context.

Here we can see that the efficacy of client and service outcomes depends on working effectively with the interplay of domestic and family violence and alcohol and other drug use.

[3] The National Alliance for Action on Alcohol is a national coalition representing more than 75 organisations from across Australia that has formed to strengthen policy to reduce alcohol-related harm. The NAAAs members cover a diverse range of interests, including, public health, law enforcement, local government, Indigenous health, child and adolescent health, and family and community services.

Victims-survivors and alcohol and other drug use

The National Centre for Education and Training on Addiction estimated that at least 40% of women in alcohol and other drug treatment have experienced violence and the number could be as high as 80% (Nicholas *et al* 2012).

For women in particular, alcohol and other drug use that causes harm and domestic and family violence can involve a reciprocal bi-directional relationship. That is, either problem can increase risk of the other – alcohol and other drug use by a person who experiences violence increases their likelihood of being a victim of domestic and family violence and alcohol and other drug use may be a response to domestic and family violence (Nicholas *et al* 2012). Nicholas *et al* (2012) found evidence that alcohol use that causes harm can:

- Impair a victim's judgment and ability to de-escalate situations of conflict.
- Reduce a victim's capacity to implement safety strategies.
- Increase a victim's dependence on a violent partner.
- Decrease a victim's credibility with service providers.

Several studies suggest that survivors may use alcohol and other drugs as a way to cope with ongoing violence and mental health symptoms (Peters *et al.*, 2012; Schumacher and Holt, 2012; Sullivan *et al*., 2009). There is also an interplay with interconnected stressors, such as problems associated with housing or finances, limited social support, effects of childhood and other forms of trauma, and physical health conditions that interfere with daily life (Poole *et al*., 2008).

Studies have also found a reciprocal and reinforcing relationship between the Post Traumatic Stress Disorder (PTSD) effects of sexual victimisation, the use of alcohol to cope with these effects, and further re-victimisation – particularly an increased risk of intimate partner violence and intimate partner sexual violence (Quadara *et al* 2015, as cited by Noonan 2017). Self-medication is common amongst women impacted by intimate partner *and* sexual violence. Victims-survivors may also be coerced into using; and using increases the risk for coercion.

Perpetrators often engage in coercive tactics related to their partner's alcohol and other drug use or mental health as part of a broader pattern of abuse and control. These tactics include a perpetrator's efforts to intentionally undermine their partner's mental health, interfere with their treatment, control their medication, sabotage their recovery, and discredit them with friends, family, helping professionals, and the courts. This is often referred to as substance use coercion. Tactics of control include:

- Introducing partner to drugs
- Forcing or coercing partner to use
- Coercing partner to engage in illegal acts
- Using drug history as threat (e.g., child protection, job, deportation, custody)

This may affect a victim-survivor's ability to access services and supports. Victim-survivors experiencing isolation related to the combination of domestic and family violence, mental health concerns, and alcohol and other drug use may be less likely to seek assistance because of fear of being reported to police or child protection (Bennett and Bland, 2008). Also, due to the stigma that surrounds alcohol and other drug use, mental health concerns, and domestic and family violence, survivors may not be seen as credible when they do try to access sources of support—either informal (for example, friends, families) or formal (for example, alcohol and other drug services, mental health

services and domestic and family violence services). This perception is not unfounded as there is evidence that alcohol use can influence how services respond to victims.

Also, if a victim-survivor does access an alcohol and other drug service they are less likely to complete treatment programs (Noonan *et al*. 2017). Domestic and family violence can affect alcohol and other drug treatment outcomes - the experience of domestic and family violence may trigger relapse to alcohol and other drug use during treatment (Lee *et al* 2017). Nicholas *et al* (2012) found that it is difficult to ascertain on the basis of current Australian and international research if domestic and family violence is a barrier to seeking treatment in alcohol and other drug services and little is known about the impact of alcohol and other drug use on workers' attitudes and beliefs in relation to domestic and family violence. It is worth noting, too, that many women's refuges will not admit women with active alcohol and other drug or mental health problems (Yates 2019, Braaf 2012).

Furthermore, Sutherland *et al* (2016) found that offences were most likely to be recorded by police where only perpetrator alcohol use was recorded. In a regression analysis controlling for multiple variables (for example, frequency and severity), the research found that perpetrator alcohol use is not significantly related to an offence being recorded. However, where only victim alcohol use was recorded, incidents were least likely to have an offence recorded, with under half of these incidents leading to a recorded offence. These results are in line with other studies cited by Sutherland *et al*, which found victim alcohol use was associated with a decreased likelihood of an offence being recorded.

Mental health and perpetrators of domestic and family violence

Whilst it is well understood that mental illness does not make someone more likely to be violent than anyone else, a perpetrator's mental illness is relevant. Most of the available research suggests that there is a variety of psychological health problems among domestic and family violence perpetrators. Specifically, there is evidence of a significant relationship between anger problems, anxiety, depression, suicidal behaviour, personality disorders or problem gambling and perpetration of domestic and family violence (see for example, Sesar, Dodaj and Šimić, 2018). There is also a particularly strong association between recidivist-identified perpetrators and mental illness (Thomas, 2019).

Furthermore, the literature has identified the presence of personality disorders, distorted and antisocial thinking, and psychopathy as presenting significant challenges in engaging corrections and forensic clients and delivering effective interventions (Chambers *et al*, 2008; Day *et al*, 2011; Howells and Day, 2007). Clients exhibiting significant symptomologies associated with these conditions are likely to be excluded from men's behaviour change programs.

In the No to Violence (NTV) submission to the Royal Commission into Victoria's Mental Health System, NTV members referred to the high prevalence of some mental health conditions among the perpetrator clients with whom they work (NTV 2019). They also emphasised that serious mental illness is relatively rare in this client group. Members did however report that sometimes it is necessary to exclude clients from men's behaviour change programs on the basis of mental illness (NTV 2019). Members said they would exclude clients from men's behaviour change programs due to client inability to sit physically or psychologically in the group, concentration deficits (which may or may not be associated with mental illness), client's experiencing frequent triggers in the group environment, or frequent disruptions to group processes due to hypervigilance or other trauma-associated symptoms (NTV 2019).

NTV members expressed a desire to be able to provide alternative options to this client group, including coordinated interventions that build over time to address both mental illness and domestic and family violence perpetration (NTV 2019).

Yu *et al* (2019) examined the risk of intimate partner violence against women perpetrated by men with 9 psychiatric diagnoses in a Swedish population-based study over 1998–2013. The sample sizes of diagnostic groups ranged from 9,529 individuals (with autism) to 88,182 (with depressive disorder). When compared to the general population, the authors found that men with mental disorders[4], apart from those with autism, were more likely to perpetrate intimate partner violence against women. Men with alcohol and drug use problems had the highest risks (7 to 8-fold increased risks) compared with general population controls, and those with ADHD and personality disorders were also consistently at an increased risk across models.

Furthermore, the authors stated that comorbidity of substance use disorders and personality disorders increased the risk of intimate partner violence against women in men with all investigated psychiatric diagnoses. The comorbidity of substance use disorders was associated with a substantially increased risk of intimate partner violence perpetration compared to men with only a mental disorder. Overall, intimate partner violence risk was much lower for men with a mental disorder without comorbidity of substance use disorders.

According to Yu *et al*, these findings underscore that substance use disorders are the primary diagnoses with the highest relative risk among all studied disorders for the risk of intimate partner violence perpetration, and that substance use disorder comorbidity increases the risk of intimate partner violence perpetration for other mental disorders. The authors believe that the findings provide an important preventative target for clinicians working in adult mental health services, who may not be including risk to intimate partners as part of their risk assessments nor focusing on the risk patients may pose in the context of alcohol and other drug use that causes harm (which is more common in individuals with mental disorders than in the general population).

The research of Yu *et al* is consistent with the findings in the interim report of the Royal Commission into Victoria's Mental Health System, which state that: 'most people with mental illnesses are not violent, most violent offenders are not mentally ill, and the strongest risk factors for violence (e.g. past violence) are shared by those with and without mental illnesses' (Skeem *et al* 2011:113, as cited by the State of Victoria 2019:51). Research presented to the Commission suggests that there is 'limited evidence that mental health problems are independent predictors of violence when accounting for other factors, such as substance use or previous violence' (Ahonen *et al* 2019 as cited by the State of Victoria 2019:51).

Victoria's Chief Psychiatrist (2018) reviewed evidence that suggests the relationship between comorbidity and increased risk of violence is stronger with alcohol and other drug use than mental illness per se; and that without substance use, a person with mental illness is only as likely as anybody else in society to be violent (2018). Further, mental illness carries far less weight as a predictor of violence perpetration than variables such as gender, age and history of offending.

Whilst there are cases where the perpetration of domestic and family violence has been linked to mental illness, the perception that mental illness causes domestic and family violence is more strongly linked to community attitudes and stigma around mental illness than the evidence (Victoria's Chief Psychiatrist 2018). Research indicates that people with mental illness are more likely to be a victim of

[4] 'Mental disorder' is the term used by the authors in this particular research paper.

violence than a perpetrator (Maniglio *et al* 2009 as cited by the State of Victoria 2019, Victoria's Chief Psychiatrist 2018).

While mental illness is not generally considered a driver of domestic and family violence, Jonathan Fowler (2018), a UK therapist working at the interface between mental health and the criminal justice system argues that it is vital that there are strong service responses to perpetrators with mental illness that are able to work productively with a perpetrator while also having a clear focus on safeguarding and supporting victims-survivors and their children. Fowler argues that supporting perpetrators to take responsibility becomes more complicated as soon as the possibility of their own mental health problems playing a role in their abusive behaviour arises.

In Fowler's experience the challenges to relating that some mental health problems give are sometimes more extreme versions of some of the issues men already address in the work men's behaviour change programs do with them. An example is having difficulty in taking the perspective of others. Fowler writes:

> Both in 1:1 work and group-work we often ask perpetrators to think about and express the perspective of their partners and children. For many men, doing this is an emotionally challenging experience that encourages them to reflect on their behaviour. These men will typically have some perspective-taking skills that they seem to use, for example, in their work life. They fail to do this at home though, with this failure backed up by entrenched and unhelpful beliefs, for example about how men and women should be in relationships. These entrenched ideas become exposed and can be then questioned during this process. Some men will struggle to do this well, and will need more support. Some will have huge difficulties. These difficulties are typically very apparent, not only in their relationship but also, in the rest of their lives; at work, in their interactions with us, and if they are in a group, their interactions with other group members.

Fowler says that a failure to appreciate the perspective of partners will be found in all the perpetrators they work with. How poor they are at doing this will vary. Sometimes their ability is so consistently poor that it is seen as indicating a mental health problem.

Generally, Fowler argues, while mental health issues may complicate the work that men's behaviour change programs do, or in some cases mean that they cannot work with a particular client, they never remove their focus on how the men they work with can more effectively take responsibility for their behaviour. If there appear to be mental health issues, Fowler is interested in how they impact on a client's ability to take responsibility; what implications this has for support from other services; what this means for what we need to focus on in perpetrator programs, and what the implications are for how we reduce the risk to their families.

Victim-survivors and mental health

Studies have consistently documented higher rates of trauma-related mental health issues among victim-survivors, as compared to those who have not experienced domestic and family violence (Beydoun *et al*., 2012; Dutton *et al*., 2006; see Phillips *et al*., 2014). Depression and Post-traumatic Stress Disorder are among the most common trauma-related mental health effects of experiencing domestic and family violence (Nathanson *et al*., 2012). One review of studies found the odds of experiencing PTSD was about seven times higher for women who had been victims of domestic violence than those who had not (Trevillion *et al*, 2012). The Victorian Royal Commission into Family Violence heard that between 50% and 90% of women accessing mental health services and alcohol and other drug services had been victims of child sexual abuse or domestic violence (State of Victoria Vol III. 2016).

Other evidence shows a strong relationship between domestic and family violence and suicidality. An analysis of suicides in Victoria between 2009-2012 found that a substantial number of these suicides had a history of exposure to domestic and family violence – present in almost half of female suicides and one third of male suicides (MacIsaac *et al* as cited by Parker *et al* 2019).

As with alcohol and other drug use, there is a bi-directional relationship between domestic and family violence victimisation and mental illness/health. Not only is domestic and family violence a risk factor for psychological disorders, but women who have pre-existing mental health issues are more at risk of being a target for abuse; and perpetrators may undermine women's efforts to manage their mental health and access health services (Parker *et al* 2019).

The Royal Commission into Victoria's Mental Health System notes that experiences of family violence is one of the key social determinants of mental health, particularly for children and young people (2019). Studies show that children of mothers with a history of domestic and family violence are significantly more likely to access mental health, primary care, specialty care and pharmaceutical services than those who do not live with family violence (Rivara *et al* 2007 as cited by Humphreys *et al* 2015).

In family violence guidelines developed by Victoria's Chief Psychiatrist (2018), the following evidence was cited:

- Australian women who had experienced gender-based violence are more likely to experience mental illness over the course of their lifetime - 'approximately 77 per cent of women who have experienced three or four types of gender-based violence had anxiety disorders, 56 per cent had post-traumatic stress disorder and 35 per cent had made suicide attempts' (citing Rees *et al* 2011).
- The main mental health impacts on people who experience family violence are depression, anxiety, post-traumatic stress and suicidal ideation. Women who experience family violence are almost twice as likely to be depressed, anxious or use alcohol.
- There is also a link between intimate partner violence and postnatal depression.
- Many people with mental illness diagnoses such as bipolar disorder, psychosis, schizophrenia and eating disorders, have experienced high levels of violence.
- Being abused during childhood increases the likelihood of experiencing abuse as an adult and the cumulative effect of abuse increases the likelihood of health and mental health problems and mental illness.

In its submission to Royal Commission into Victoria's Mental Health System 2015, the Bethany Community Support service (2015) reported that practitioners that they had consulted with identified gendered responses to women's and men's experience of mental illness, with women's mental illness identified as a source of blame for the violence perpetrated against them and men's mental illness identified as a potential excuse for their use of violence.

Consequently, many victims-survivors with mental ill-health will experience barriers when considering disclosing domestic and family violence. According to the Safer Lives 'Safe and Well: Mental Health and Domestic Abuse' (2019), these can include:

- **Recognising abuse** – for example, the perpetrator may convince their partner that the problem is 'in their head' or that they are suffering from paranoia or confusion. The perpetrator may also having a caring role, which may create uncertainty for victim-survivors over what is care and what is control.

- **Fear of not being believed** – for example, victim-survivors with mental health needs are often fearful that agencies will judge them, or will assume they are not telling the truth. Perpetrators will often disguise their abuse, and victim-survivors may have a recorded history of mental ill-health with additional concerns regarding substance use, self-harming behaviour, suicide attempts, and/or periods of psychosis or depression, which may make it difficult for the client to feel being believed is likely.
- **Abusive tactics** – for example, perpetrators of domestic and family violence may use their partner's mental health problems as a tool to isolate and further abuse.
- **Alcohol and other drug use** –for example, using substances to self medicate, while understandable, can heighten a victim-survivors risk and increase their barriers to accessing support.
- **Fear of coping alone** – for example, there may be a fear of consequence, particularly regarding perpetrators in a caring role. Victim-survivors may have additional concerns regarding their ability to care for themselves or any dependents. This is increased when the perpetrator has been part of their mental health recovery and is seen as a protective factor by other professionals/agencies. This fear can be intensified by perpetrators telling them that they will not be able to cope alone.
- **Self-blame** – for example, studies suggest that self-blame is exacerbated when the victim-survivor has mental health problems as they may view this as part of their own involvement in provoking the abuse.
- **Shame** – for example, to engage with domestic and family violence services for many clients may mean multiple disclosures; domestic abuse, mental ill health, substance use, etc. The stigma that surrounds these issues, can mean that survivors feel shame and worry that they will be judged or that their disclosure will be minimised. For culturally and linguistically diverse women, expectations linked to 'honour' placed upon them by family or community, can make disclosure very difficult and even a risk to their safety.
- **The impact of mental ill-health -** Many clients are isolated due to their mental ill-health, for example not feeling able to leave the house, struggling to talk on the phone, not being able to remember appointments. Being able to engage with domestic violence services is often very difficult. It is important that services are pro-active and avoid rigid policies, such as three contact attempts before case closure, which can increase the barriers for those with complex needs.

For many victims-survivors, alcohol and other drug use becomes a necessary coping mechanism (Rose *et al* 2011). Yet many mental health services won't treat a woman's depression until the substance use stops (Rose *et al* 2011). And alcohol and other drug services for women that work with an integrated (domestic violence-informed) model of care are rare. Generally, mental health services are not enabled to support victim-survivors of domestic abuse, and women are still turned away from refuges because of their poor mental health.

In their submission to the Royal Commission into the Victorian Mental Health System, Bethany Community Support recommended that:

- Specialist domestic and family violence practitioners receive training in mental disorder – mental illness and personality disorder – and ways to assess and respond to mental health concerns that clients present with to their service.
- Specialist domestic and family violence services develop close working relationships with mental health services to support their ability to manage risk for family violence posed by the mental illness. This needs to be developed in the form of greater service integration with mental health services.

- The gendered experience of mental illness among female victims and male perpetrators be considered in service responses, and in particular, the tendency for women to assume responsibility for managing their partner's symptoms and their partner's expectations of the same. This may pose additional risks to women, in terms of reinforcing issues of gender-based power and control in the dynamic.

The Greater London Domestic Violence Project (GLDVP, 2018) supports the development of more effective and appropriate services for survivors of domestic violence and mental distress. GLDVP objectives include a commitment to:

- Explore access to, or exclusion from, domestic violence and mental health services for women experiencing domestic violence and mental distress.
- Identify models of good practice in service provision for women facing these dual challenges.
- Support networking and information sharing across the dual sectors.
- Develop an action plan to address existing gaps in service provision.
- Develop a set of minimum standards for inclusive service provision.
- Develop a Domestic Violence and Mental Health Handbook.
- Deliver training for front line workers in the domestic violence and mental health sectors.

The evidence thus far clearly suggests that responding to victims-survivors of domestic and family violence is core business for mental health services and should not be something left up to other services. If domestic and family violence is a major cause of a woman's mental health issues (and we know for a large proportion of women accessing mental health services it is), then mental health services will be limited in their efficacy if they do not address this cause. Similarly, domestic and family violence services need to be better supported and trained to engage and work effectively with women experiencing domestic and family violence and significant mental health issues.

Summary

In summary, thus far, it has been established in the literature that:

- Mental health issues or alcohol and other drug use are not the drivers of domestic and family violence.
- Domestic, family and sexual violence are often implicated in a victim-survivor's mental health and alcohol and other drug use.
- A victim-survivor's alcohol and other drug use and/or mental illness is often used by a perpetrator to further coerce and control the victim-survivor. This then impacts on a victim-survivor's capacity to engage/stay engaged with an alcohol and other drug service, mental health service or a domestic and family violence service.
- A victim-survivor's alcohol and other drug use and mental illness may be seen to implicate them in some way in the violence and abuse that they are experiencing (that they are at least partially to blame for it).
- A victim-survivor's alcohol and other drug use and mental illness can impact their access to services and service responses.
- Alcohol and other drug use and mental illness (particularly when it co-occurs with alcohol and other drug use) may interact with the perpetration of domestic and family violence (for example, cause the violence to escalate more quickly, or cause the violence to be more severe in terms of physical injury).

- Alcohol and other drug use and mental illness may be used to explain, excuse or understand the perpetration of domestic and family violence.
- Mental illness has implications for a client's (perpetrator's) ability to take responsibility; which has implications regarding the support required from other services; for the focus in perpetrator programs, and how we reduce the risk to their families.

We will now look at examples in the literature review of workforce development that is responding to the complex interplay of domestic and family violence, alcohol and other drug use and mental health.

Responding to the complex interplay of domestic and family violence, alcohol and other drug use and mental health

The alcohol and other drug and mental health sectors have long acknowledged the complexity of their client groups and the interrelatedness of the two issues. The strong evidence of the co-occurrence of alcohol and other drug use and mental illness has seen the two sectors actively build their capacity to respond more effectively to the comorbidity of their clients and their complex needs.

Comorbidity describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between, in this case, alcohol and other drug use and mental illness, which can worsen the course of both. The identified high rate of comorbidity between alcohol and other drug use and mental illness has seen the emergence of a more comprehensive approach that identifies and evaluates both. Accordingly, anyone seeking help for either alcohol and other drug use or mental illness should be evaluated for both.

The alcohol and other drug and mental health sectors have various frameworks and guidelines for working with comorbidity and co-occurrence – which are considered common-place amongst alcohol and other drug users and people with mental health issues. In the main, trauma informed care and practice also features heavily in these documents; recognising that trauma is often deeply implicated in a person's use of alcohol and other drugs and/or their mental health. For example, in the Mental Health Coordinating Council's 2018 Recovery Oriented Language Guide, 'recovery orientation' has been adopted as an overarching philosophy to guide mental health practice and is embedded into policy and standards nationally (Mental Health Coordinating Council 2018). An understanding of trauma is integral to this recovery oriented approach.

In Western Australia's *Counselling Guidelines: Alcohol and other drug issues* (2019) comorbidity and co-occurrence are strong themes. Practitioners are given techniques for working with clients with comorbidity and co-occurrence, including trauma. For example, due to the inter-relatedness of post-traumatic stress disorder (PTSD) and alcohol and other drug use it is recommended that these conditions be treated in an integrated fashion. It is stated in the Guidelines that:

> Some clinicians maintain the view that the AOD use must be treated first, or that abstinence is necessary before PTSD diagnosis and management can be attempted. In practice however, this approach can lead to clients being passed between services with little coordination of care. Ongoing AOD use may impede therapy, but it is not necessary to achieve abstinence before the commencement of PTSD treatment. Improvements can be obtained even in the presence of continued substance use. The importance of providing trauma-informed care in the context of AOD treatment is now well recognised. Due to the inter-relatedness of PTSD and AOD use, a carefully integrated approach to the treatment of these disorders is recommended.

Interestingly, the strong connection between trauma and domestic and family violence is not often made. Yet, as we have seen, women who have experienced domestic and family violence are at a significantly higher risk of experiencing a range of mental health issues including post-traumatic stress disorder (see above). Nevertheless, the 'carefully integrated approach' recommended for the co-occurrence of alcohol and other drug use and PTSD is a useful one when thinking about how alcohol and other drug and mental health services should respond to the high prevalence of domestic and family violence amongst their client groups.

Studies indicate that outcomes for victims-survivors are improved by integrated service provision and that holistic service provision can maximize the effectiveness of limited resources. For example, the Western Australian Resource *Supporting Women with Complex Needs: The relationship between substance use and domestic and family violence* (Newbegin and Legget 2009) provides some good practice suggestions for a better integrated service response. The authors recommend trauma-informed care, safety planning that includes the additional safety issues associated with substance use; and harm minimisation strategies that incorporate safety issues associated with domestic violence.

Local partnerships between alcohol and other drug services and domestic and family violence services are also highly recommended. The authors write: 'The best way to ensure effective and collaborative service responses for women experiencing domestic and family violence who also have substance use problems is to establish close working relationships between domestic violence and alcohol and other drug services'(p. 15).

The complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health strongly suggests the necessity of an integrated response – as domestic and family violence does not simply 'co-occur' with alcohol and other drug use and mental illness. However, the respective evolution and composition of sectors are unique and have resulted in different approaches, funding models and priorities that are not readily amenable to an integrated, collaborative or multidisciplinary approach.

Within the literature review, the most frequently cited barriers for increased collaboration between domestic and family violence, alcohol and other drug use and mental health services in Australia were differences in philosophical and practice approaches, and a lack of shared understandings (Parker *et al* 2019, Short *et al* 2019, Breckenridge *et al* 2016, Yates 2019, Mason *et al 2014*).

In their submission to the Royal Commission into Victoria's Mental Health System (2019), the Melbourne Research Alliance to End Violence Against Women and their Children (MAEVe) noted that 'while simultaneously targeting substance use that causes harm and domestic and family violence is more effective than addressing either as a single issue, it is surprising that joined-up service provision and responsive care remains elusive and that service models often exist in philosophical tension; siloed approaches are more common than not' (Parker *et al* 2019:28).

In Domestic Violence Victoria's submission to the same Royal Commission, the most persistent challenges for collaboration between the mental health, alcohol and other drug and domestic and family violence sectors was identified as being differing practice frameworks and chronically underfunded services (Mecham 2019). Mason *et al* found that 'despite the clear relationships among IPV, mental health, and substance use problems, programs and practices have evolved along discrete lines governed by different paradigms, professions, languages, training models and funding streams' (2014:2).

Using evidence given to the Royal Commission into Family Violence (Victoria) as a case study, Yates (2019) argues that integration between domestic and family violence, alcohol and other drug and mental health services is challenging due to differences in history, language, analysis and service philosophies, resulting in contested understandings of and responses to the relationship between alcohol and other drugs and domestic and family violence. Yates suggests that concerns about alcohol and other drugs and causation, and differences in service philosophies can be traced partly to deep cultural and historical divisions between the male-dominated alcohol and other drug sector and and the female-dominated domestic and family violence sector.

In the alcohol and other drug sector, 66% of clients are male with a relatively higher proportion of male practitioners (Australian Institute of Health and Welfare 2019), whereas in the domestic and family violence sector the majority of workers and adult clients are female. Roche (2015) notes that alcohol and other drug clinicians have been traditionally reluctant to raise the issue of domestic and family violence in their client relationship and suggests that reasons for this may include that alcohol and other drug services have historically been designed by men for men; the professional principle of providing treatment free from judgement in relation to a client's family circumstances; and challenges in interacting with domestic and family violence services.

Yates (2019) notes the domestic and family violence sector supports women to understand that the violence is not their fault and seek to increase perpetrator accountability – requiring men to take responsibility for their violence. The domestic and family violence sector has largely rejected alcohol and other drug use as a cause of violence, expressing concern that the medical model of addiction can allow men to shift responsibility for violence.

The domestic and family violence sector emphasises societal factors related to gender, power and control, rather than individual level factors such as alcohol and other drug dependence, pathology or illness - 'while most feminist theorists do not deny that some violence is linked to psychopathology or other individual differences, they generally seek to connect psychological analyses to an understanding of the unequal distribution of power and socially structured patterns of male–female relations' (Yates 2019:6). Within the domestic and family violence sector, gender inequality and violence-supportive attitudes are seen as the primary causes of violence against women, with alcohol and other drug use that causes harm framed as a contributing factor (Braaf 2012).

Short *et al*. (2019) examined twenty eight New Zealand death reviews to highlight how responses to domestic and family violence within health care settings has generally been poor, particularly in mental health and addiction services. Short *et al*. suggests that poor service responses has resulted in a 'pattern of system failure'. At the heart of this failure is a framework that focuses on individualistic self management (in seeking help) and leaves women and children at risk of further harm by individualising a complex social problem that requires collective responses to safety.

It is also argued that service responses that do not utilise a trauma/domestic violence informed lens can inadvertently problematise a victim-survivor's responses to abuse and fail to recognise ways in which a victim-survivor's response are acts of resistance. For example, MAEVe argues that mental health issues for victim-survivors are mostly not treated as a 'normal' response to living with violence or as a symptom of abuse; and that perpetrators can discredit the mental health of their victims in order to hide abuse (Parker *et al* 2019).

MAEVe discussed unpublished data from a research project currently underway in the Safer Families Centre of Research Excellence that explores how psychologists respond to intimate partner violence. Women interviewed in the study talked about experiences with psychologists which mirrored the

behaviours of intimate partner violence, such as blaming the women for the abuse by pathologising why they got involved with the abuser and why they didn't leave (Parker *et al* 2019).

Furthermore, where services are not alert to domestic and family violence or do not understand the nature of coercion, they may inadvertently collude with the perpetrator and cause 'secondary abuse' of the victim. As argued by Short *et al*, agency 'responses focussed on autonomy and empowerment ignore any responsibility of services, including MH&A services, to take safety-enabling actions that actually help victims' (2019:1212).

Domestic Violence Victoria argues that the medical model traditionally used in mental health services results in a static diagnosis with little analysis of family violence risk or how changing levels of risk might affect the patient's mental health or needed treatment (Mecham, 2019).[5]

The Royal Commission into Family Violence in Victoria found that the medical model utilised by most mental health services focused on symptoms, diagnosis and treatment – without attention to factors, such as abuse, that might interrelate with the mental illness (State of Victoria, 2014 Vol IV p 30, as cited by Mecham 2019). The RCFV found a failure by health professionals to inquire about domestic and family violence and/or respond to disclosures represents missed opportunities to intervene and offer support to victim-survivors (2016:29). Reasons given for this failure included a lack of domestic and family violence training and awareness, inadequate referral options and time pressures.

Similar barriers were noted by Parker *et al* (2019) in addition to issues such as concerns about role boundaries, competency, confidence, lack of effective interventions and fear of offending the individual. Research cited by MAEVe found that only 15% of mental health practitioners routinely ask about domestic and family violence, 60% report a lack of knowledge about domestic and family violence and 27% believed that they did not have adequate referral resources (Parker et al 2019).

Domestic Violence Victoria (Mecham 2019) identifies a chronic shortfall in access to therapeutic services as being a critical issue for providing integrated responses, noting that the decision by the Victorian Government to move funding for community mental health into NDIS has exacerbated this shortfall. Domestic Violence Victoria argues that, whilst often pathologised as mentally ill, many victim-survivors are not mentally ill but are recovering from violence and trauma. Where access to therapeutic support rests upon a formal diagnosis and permanent disability, many victim-survivors will never qualify for the NDIS and therefore will not receive the mental health services they need.

In relation to working with men who use violence, Short *et al* (2019) found that there was a lack of formalised approaches in mental health and alcohol and other drug services, resulting in failures to support men to address their violence and strengthen the safety of victims. Yates (2019) also argues that men's behaviour change programs have not historically integrated alcohol and other drug treatment.

The Victorian Royal Commission into Family Violence recognised mental health and alcohol and other drug use as being in a unique position to identify domestic and family violence in service users and intervene early, recommending improved capacity and service integration between the alcohol and other drugs, mental health and domestic and family violence sectors. The Commission noted that mental health and alcohol and other drug services must play a more direct role in identifying and responding to family violence and domestic and family violence services need to increase their

[5] Please note that the recovery, trauma-informed model currently being promoted in the mental health sector is a distinct shift away from the medical model approach.

understanding of and skill in managing alcohol and other drugs and mental health issues with their clients.

In a Canadian scoping study of the literature on co-occurring intimate partner violence, mental health and substance use problems, Mason and O'Rinn (2014) found that education, collaboration, coordination and integration across services were the most frequently occurring recommendations. Mason and O'Rinn also cite a paper by Laing *et al* (2012) which found that factors that contributed to successful collaborations were commitment to building trust and a shared sense of purpose, personal relationships, the development of institutional empathy, and involved leaders who work to create a sense of inclusion.

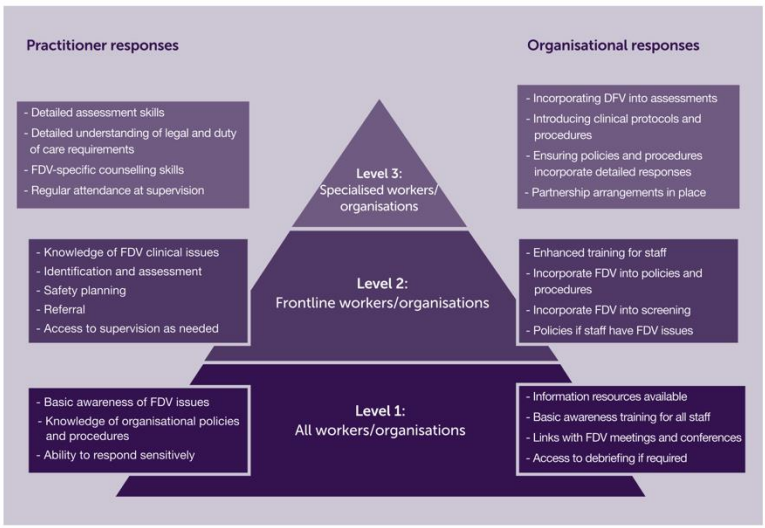
Several Canadian researchers working in the areas of women's substance use, mental health, violence against women and trauma, argue that there is a tendency for mental health, domestic violence and alcohol and other drug use to be viewed separately as though they have unique causes and outcomes (see, for example, SAMHSA 2014, Poole and Grieves 2012, Hien *et al* 2009). The reality, however, is that domestic and family violence, alcohol and other drug use and mental health overlap so significantly that it is often impossible to tease them apart into individual and separate problems. In fact, researchers argue that as we become aware of the intersecting relationships between these issues, it becomes evident that it makes more sense to consider them together than apart. Taking an integrated perspective promises to improve our understanding of each issue but also invites us to work together across disciplines rather than in silos.

Accordingly, recognition of the complex interplay of domestic and family violence, alcohol and other drug use and mental health requires a transdisciplinary approach, whereby different disciplines can work together to create more nuanced and effective approaches to research, policy, education and service response. An integrated approach to understanding the relationships among domestic and family violence, alcohol and other drug use and mental health will potentially lead to a furthering of our knowledge in all these areas and allow us to improve how we respond to clients.

Nicholas *et al* argue that it is of fundamental importance that domestic and family violence issues are addressed in alcohol and other drug treatment services and identified ten principles of best practice across three levels (2012):

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

Figure 1: Levels of AOD service responses to DFV, Nicholas et al 2012



Informed by the work by Nicolas *et al*, in 2013 the National Centre for Education and Training on Addiction (NCETA) and Odyssey House Victoria produced the guide *Can I Ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence* (White *et al* 2013). This resource explores the relationship between alcohol and other drugs and domestic and family violence with a focus on identifying how the alcohol and other drug sector can better support clients who have co-occurring alcohol and other drug and domestic and family violence issues, and minimise associated harms experienced by their children.

Whilst much of the literature emphasises the need for trauma informed practices, Short et al (2019) advocates for *trauma and violence informed practice* (TVI), bringing into focus structural inequities, colonization, intergenerational violence and the responsibility of organisations to change the systems that perpetuate harm. Adopting a trauma and violence informed approach was also supported by MAEVe (Parker *et al* 2019) and Hegarty *et al* (2017, as cited by Mecham 2019).

Whilst acknowledging the need for self-determination, Short et al suggests that reframing domestic and family violence as a form of social entrapment could allow for a more integrated practice response. Such framing applies a domestic and family violence and gender lens to make visible patterns of control that limit a woman's ability to be self-determining. Yates argues that domestic and family violence affects alcohol and drug use in gendered ways. Thus one way forward is to understand how alcohol and other drugs and gender combine to influence the perpetration and experience of domestic and family violence, as well as barriers to help-seeking (Yates 2019:12).

Short *et al* advocate for mental health and alcohol and other drug practitioners to act as 'safety allies' with victims, so as to maximise safety and build relationships of dignity and respect (2019). Short et al also argue for a more response based practice, moving beyond 'tick-box' screening to an understanding of the complexity of what women are presenting with - 'health service responses to victims usually involve running through a rote safety checklist ...without consideration of what victims have already tried, what helped (or did not), how their partner reacted and what actual access to social, economic, and cultural supports they may have' (2019:1212).

Nicolas *et al* (2013) argue that because two-thirds of clients that attend alcohol and other drug treatment services are men, the sector is well placed to play a role in engaging men and breaking the cycle of violence. Translating evidence in practice requires alcohol and other drug sector workforce development, intersectoral collaboration and macro-level leadership and support.

MAEVe recommends all primary and specialist health care services ask routinely about domestic and family violence and deliver a first line response. To enable this, health services need to develop a holistic health system model; reform policy and practice guidelines; ensure staff training and support; and go beyond diagnosis and treatment to trauma and violence informed practice (Parker *et al* 2019).

Blagg *et al* (2018) argue that, while not sacrificing women's safety, interventions should be underpinned by a greater focus on social and emotional wellbeing, including a range of issues facing Aboriginal people, such as grief and loss, trauma, removal from family, substance use, family breakdown, cultural dislocation, racism, discrimination and social disadvantage.

In the same way that the Victorian Capacity Framework is designed to increase family violence literacy across all services, Domestic Violence Victoria recommends that a Mental Health Capacity Framework and universal screening tool is needed to assist specialist family violence services respond to unmanaged mental health issues, noting that mental health presentations often become a barrier to accessing domestic and family violence services, 'clearly there is opportunity to skill up non-mental health services' capacity to identify and respond appropriately to mental health issues ' (Mecham 2019:15). WAAMH and Mental Health Matters 2 also highlight that it is critical that people working in the domestic and family violence service system receive training in the areas of mental health and alcohol and other drug use (2019).

In 2015, ANROWS undertook a meta-evaluation of Australian integrated responses to violence against women (Breckenridge *et al* 2016). The literature review identified the following challenges to integrated responses:

- lack of common ground between perspectives and disciplines
- power imbalances between agencies
- client perceptions of cross-agency control
- communication between and across services
- resource limitations
- loss of specialisation and tailored responses.

Because there is a significant correlation between victimisation and alcohol and other drug use, all domestic violence service providers need to address the issue of substance use. A formal screening for alcohol and other drug use should be included in the intake process. If victims are to remain free of violence, they should understand the impact substance use has on their safety. It is an empowering process for both client and staff to address safety and alcohol and other drug use at the same time. By assisting a woman to become safer a practitioner may also be helping to eliminate the very reason that the victim-survivor feels the need to use alcohol and other drugs or improve her ability to access treatment.

A reduction in a victim-survivors alcohol and other drug use greatly impacts her ability to get and stay safe. It is not a question of either safety or treatment for alcohol and other drug use and/or mental health first, but rather safety and treatment, since one is less likely without the other. The presence or threat of abuse often interferes with, a victim-survivor's ability to achieve their goals in regards to alcohol and other drug use and mental health recovery; and continuing (untreated/managed) alcohol and other drug use and mental health interferes with safety. The complex interplay between domestic and family violence , alcohol and other drug use and mental health clearly creates unique challenges to treatment/recovery/safety and encourages 'relapse' in all areas.

Similarly, Australian studies have found that men with pre-existing alcohol dependence are more likely to drop out of perpetrator programs, and that other forms of intervention, such as alcohol and other drug treatment, are crucial if the group-based component of Men's Behaviour Change Programs are to be effective (Braaf, 2012; Salter, 2012). At the same time, treatment for alcohol and other drug use that does not also address co-occurring domestic and family violence is less likely to be successful and may be unsafe, exposing victims-survivors to further abuse (Nicholas *et al* 2012). Service integration can improve retention rates in programs and ensure that there is prioritisation of safety issues for victims when working with either victims or perpetrators (Braaf 2012).

Despite the barriers, integration is widely regarded as a means to overcome the limitations of traditional, arguably "siloed", service delivery. Equally, the negative consequences of fragmentation and disconnection are clear. However, there are significant challenges associated with integration. Therefore, while the model of attempted integration is important, *how* that model is implemented is equally important. Partly because of these implementation challenges, the evidence base on the effectiveness of integration is limited.

While both academic and grey literature show consistent themes about the significance of responding to high rates of domestic and family violence amongst alcohol and other drug users and people with mental illness, and highlight the principles of trauma and domestic violence informed care, there is little evaluative evidence to inform organisational and systemic change. For example, there is very little practical advice regarding quality and sustainable integration of domestic and family violence, alcohol and other drug and mental health service paradigms and the successful implementation of this at an organisational level. Nonetheless, there do exist some programs that show the potential benefits of integration.

Before moving on to the next section, it is important to note that Aboriginal voices have long critiqued theories of domestic and family violence that do not take into account the intersection of multiple forms of domination and conflict. Whilst acknowledging the place of gender in understanding domestic and family violence, many Aboriginal women have called for a greater analysis of the effects of racism and colonisation. Research conducted for ANROWs on innovative models of addressing violence against Aboriginal women argues that the current focus on coercive control and male power does not fully explain or describe violence in Aboriginal communities and calls for a paradigm shift towards collective processes of community healing grounded in Aboriginal knowledge (Blagg et al, 2018).

Aboriginal led approaches to domestic and family violence focus on both individual and societal risk factors and connect the use of violence, mental health issues and alcohol and other drug use with experiences of racism, intergenerational trauma and resistance (Blagg *et al* 2018b:3).

Understanding the inappropriateness and inadequacy of current 'western' approaches to addressing domestic and family violence requires recognising the incongruity between Aboriginal and western ontological understandings of the self. Aboriginal peoples understand the self as being centrally defined by relationships to kinship groups and the natural world. Western understandings by contrast generally see the nature of self in an individualised and autonomous context (Cunneen and Rowe 2015). Thus usually Aboriginal people define domestic violence in the broader and relational concept of *family violence*, a term reflective of the centrality of the relationality to Aboriginal worldviews.

The Eurocentric domestic violence paradigm imposed in Aboriginal contexts is often predicated on an incongruent ontological and epistemological reality; a reality based on the potential for autonomous and individualised decision-making. From a western perspective self-determination is usually viewed as an individual concern; from an Aboriginal perspective, self determination is usually viewed as a collective concern (Green and Baldry 2008, pp. 398-399).

From this perspective, current (and perhaps even currently proposed) approaches to the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health are limited by their failure to conceptualise and interrogate the practical manifestations and impacts of ongoing colonisation; and are restricted also by their inability to conceptualise and interrogate the complex forms of victimisation to which Aboriginal peoples are affected (Cunneen and Rowe 2015). This renders invisible the impact of ongoing colonisation on the causation and perpetuation of violence (Cunneen and Rowe 2015).

Cunneen and Rowe (2015) argue that when we fail to foreground the voices, worldviews, subjectivities and perspectives of Aboriginal peoples we see outcomes such as Aboriginal victims-survivors not reporting the violence to state authorities because of a direct fear, if police are called, that their children will be removed by child protection agencies (Cunneen 2009, p. 326). The effects of colonial policies structure contemporary Aboriginal decision-making.

How we 'know' violence in our society impacts on the understanding of the causes and remedies for violence. Aboriginal perspectives are largely based on different understandings and explanations for the violence. Thus they may require differing interventions than mainstream approaches to domestic violence (Cunneen and Rowe 2015).

Practical policy interventions flow from ontological and epistemological positions. An essential element of Aboriginal healing is recognising the interconnectedness between, and the effects of, violence, social and economic disadvantage, racism and dispossession from land and culture on Aboriginal peoples, families and communities (Cunneen and Rowe 2015). Healing is not simply an individualised response. It is fundamentally about addressing trauma in a range of areas from the personal, social and inter-generational to the historical. Healing is quintessentially and simultaneously an individual and collective experience (Cunneen and Rowe 2015).

In the light of this, the integrated approach to responding to the complex interplay between domestic and family violence, alcohol and other drug use and mental health suggested in this project report may seem entirely unsuitable or insufficient from an Aboriginal point of view. It will be necessary to explore this in greater depth in the second phase of the project through meaningful dialogue and co-design.

Examples of integration/collaboration

The literature on intersectionality, barriers to collaboration, enablers of collaboration and good practice is extensive. Less extensive is publicly available examples of inter-sector collaboration models. Most of the examples found in this review come from Victoria and the ACT.

Identifying and Responding to Family Violence Project

The Inner North West Primary Care Partnership brings together 46 partner organisations operating in the Inner North West region of metropolitan Melbourne. One of the partnership's key initiatives was

the *Identifying and Responding to Family ViolenceProject*[6]. A four year project commencing in 2014 over three phases, the project aimed to provide a more streamlined and coordinated service system response to family violence by:

- Building the capacity of health and mainstream organisations to identify and respond to family violence.
- Supporting organisations to develop a whole of organisation approach to family violence.
- Strengthening and consolidating the pathways between mainstream health organisations and the integrated family violence service.

The project had a focus on responses to staff disclosures of family violence, as well as client disclosures. Resources and activities included:

- Step by Step Guide: Organisational Family Violence Implementation Checklist
- Managers' Training Guide
- Family Violence Policy Templates
- Practice Guidelines.

The project's evaluation report (Trezona 2018) found that the project had a positive influence on the knowledge and understanding of participants, and assisted leadership, collaboration and workforce development. Challenges included having a clear authorising environment, the lack of a clear directive for services to align with the project, and resource constraints to drive system wide change. A limitation reported by participants was that project membership became too broad, making it difficult to target and tailor activities to specific needs. Identified barriers to implementation were:

- Inability to keep pace with the reforms and a rapidly changing family violence system
- Inability to prioritise family violence due to competing reform demands
- Lacking the readiness or confidence to address family violence (and in some cases resistance to addressing it)
- Not having the organisational structures and systems in place to support policy and procedure implementation and culture change
- A shortage of people with the skills and expertise to support the work.

ACT Alcohol and Other Drug Safer Families Program

The *Alcohol and Other Drug Safer Families Program* was part of a broad investment by the ACT Government in initiatives to address domestic and family violence and was funded by a levy on ACT rate payers. In 2017, the Alcohol Tobacco and Other Drug Association ACT (ATODA) was engaged by ACT Health to 'to scope and design a multi-year multi-component pilot project that provides more effective responses for people whose use of alcohol and other drugs causes harm and either experience domestic and family violence or are at risk of using violence'.[7] The work undertaken by ATODA was based on a co-design process with alcohol and other drugs and domestic and family violence stakeholders, clinicians, policy workers and consumer representatives.

[6] Inner North West Primary Care Partnership, *Identifying and Responding to Family ViolenceProject* https://inwpcp.org.au/resources/identifying-and-responding-to-family-violence/

[7] Full details of the project, including Terms of Reference, are available at http://www.atoda.org.au/research-scope-and-design-a-pilot-project-safer-families/.

Stage 1 of the Program (2017) involved a focus on infrastructure and tool development through co-design, whilst Stage 2 (2018-2021) focuses on implementation. Stage 1 produced three tools to enable specialist alcohol and other drug services to provide more effective responses to clients experiencing or at risk of domestic and family violence and an overarching monitoring and evaluation framework for the sector as a whole (ATODA 2017: vii).

Table 1: Alcohol and Other Drug Safer Families Program outputs

Item	Applicable to	Purpose
Domestic and Family Violence Capability Assessment Tool (DFVCAT)	Program/ organisational level	• Benchmark and assess capacity to respond to domestic and family violence in alcohol and other drug settings • Plan for service enhancement/capacity building (to existing alcohol and other drug treatment and support) or new coordinated/integrated alcohol and other drug and domestic and family violence responses • Assess and report on progress
Scope of Practice: for Working with Service Consumers in Alcohol and Other Drug Settings who Experience or Use DFV	Both program/ organisational level & practice/ clinical level	• Clarify roles, responsibilities, activities and decision making capacities of the alcohol and other drug workforce as it relates to responding to domestic and family violence • Guide services and workers on how to work safely and effectively (based on skills, qualifications and training) • Inform workforce planning, training and recruitment
Practice Guide: for Responding to Domestic and Family Violence in Alcohol and Other Drug Settings	Practice/clinical level	• Guide practice (e.g. screening, assessment and interventions) • Optimise responses and outcomes for service consumers • Ensure activities are evidence based and align with clinical consensus
Monitoring and Evaluation Framework for the ACT Alcohol and Other Drug Safer Families Program 2017-2021	Whole of sector/policy level	• Monitor and evaluate the entire alcohol and other drug Safer Families Program • Provide in depth understanding of key issues and measure outcomes • Inform future roll out of initiatives to respond to domestic and family violence in alcohol and other drug settings

DFVCAT was modelled on the toolkit Dual Diagnosis Capability in Addiction Treatment, used in relation to co-occurring mental health problems. The tool addresses six domains of good practice with five service capacity levels - DFV Aware, DFV Identified, DFV Ready, DFV Coordinated Care, DFV Integrated Care (Jenner & Lee, 2017). Across the domains, indicators are provided to assess and score capacity. Scoring in DFVCAT has not been rigorously tested for reliability and validity at this stage and scores are designed to show indicative capacity within a program, not comparative scores across programs. DFVCAT acknowledges that not all alcohol and other drug programs will have the same capacity goals and that benchmarking is based on consideration of a service type and main focus of care.

The *Alcohol and Other Drug Safer Families Program* includes the Scope of Practice tool (Jenner, Lee & ATODA, 2017). It is the first of its kind in Australia and focuses on alcohol and other drug worker roles and responsibilities. Scope of practice is identified program wide (for example, screening, safety planning, assessment and interventions) and within individual practice (for example, working with service users who experience or use domestic and family violence). At a minimum, the resource says that all workers should receive foundation training in domestic and family violence , including the relationship between domestic and family violence and alcohol and other drug use, and how best to support service consumers who experience domestic and family violence (universal approach).

The Practice Guide (Lee, Jenner and ATODA, 2017) applies to workers in all alcohol and other drug settings, including peer workers. The Guide provides recommendations and practice points around program structure; physical environment and organisational culture; and clinical screening, assessment and intervention. The Guide also includes a systematic review of the evidence base and provides a summary of key findings.

From 2018 – 2021, Stage 2 of the *Alcohol and Other Drug Safer Families Program* will focus on the funding of alcohol and other drug services to implement two main streams of activities:

1. Service enhancement/capacity building as it relates to core alcohol and other drug treatment and support that will enable universal domestic and family violence responses within alcohol and other drug settings.
2. New coordinated/integrated pilots that are above the core business of alcohol and other drug services, are delivered in higher threshold alcohol and other drug settings, and are innovative and evidence- generating.

In Stage 2 the expectation is that all alcohol and other drug services (whether seeking funding under one of the above streams or not), will utilise and implement the tools developed in Stage 1.

Victorian Specialist Family Violence Advisor Capacity Building Program

The *Specialist Family Violence Advisor Capacity Building Program* is based on recommendations 98 and 99 from the Victorian Royal Commission into Family Violence:

- Recommendation 98 - The Victorian Government fund the establishment of specialist family violence advisor positions to be located in major mental health and drug and alcohol services. The advisors' expertise should be available to practitioners in these sectors across Victoria [within 12 months].
- Recommendation 99 - The Victorian Government encourage and facilitate mental health, drug and alcohol and family violence services to collaborate [within 12 months] by:
    - Resourcing and promoting shared casework models; and
    - Ensuring that mental health and drug and alcohol services are represented on Risk Assessment and Management Panels and other multi-agency risk management models at the local level.

The Program seeks to strengthen the mental health and alcohol and other drug sectors' understanding of family violence and build capacity across these sectors and specialist domestic and family violence services to better coordinate service delivery. Domestic Violence Victoria is the auspice organisation for state-wide coordination. The objectives of the Program are to:

- Strengthen networks and collaboration between agencies and across the three sectors.
- Enhance referral pathways to provide a more coordinated and collaborative health and human service system response to family violence.

- Increase capacity within the MH and AOD sectors through access to specialist family violence expertise and advice in identifying, recognising and responding to family violence.
- Facilitate earlier recognition of, and response to, family violence situations for patients/clients of mental health and alcohol and other drug services.
- Enhance quality and consistency of the service response to victims, survivors and perpetrators of family violence at whatever point they access the health and human services systems.

The program will be implemented in two stages:

Stage 1 - place Specialist Family Violence Advisors in regions across Victoria to work with key mental health services and alcohol and drug agencies, supported by Local Area Based Implementation Committees. A Community of Practice has been established to add action research learnings to the program.

Stage 2 - a four year initiative that will see Specialist Family Violence Advisors located within mental health services and alcohol and drug agencies. The Advisors will be working with senior management to increase capacity of services to respond to family violence. Advisors will also assist with systemic and organisational responses, and the development of secondary consultation.

Program Guidelines were developed for Stage 1 (Family Safety Victoria, no date), including a program logic for Stage 1 and Specialist Family Violence Advisor key activities. The Program is currently moving into Stage 2. Whilst a presentation by Domestic Violence Victoria suggests that Guidelines have been released for Stage 2[8], they have not been able to be sourced in this review. Active program support requires agencies demonstrate:

- Executive/senior management leadership and accountability for organisational change.
- Communication with workers relating to program objectives and implementation.
- Identification of opportunities to improve operating or service models to ensure effective service responses to family violence victims and perpetrators.
- Active participation in Area-based Implementation Committees.
- Facilitate co-location arrangements where possible.
- Engage in endorsed evaluation activities.

Domestic Violence Victoria states that collaboration between the mental health, alcohol and other drug and specialist family violence services has increased substantially as a result of the *Specialist Family Violence Advisor Capacity Building Program* (Mecham 2019), whilst noting that several challenges still remain.

The Ovens Murray area Family Violence/Mental Health/Alcohol and Other Drug Capacity Building Project is an example of a locally coordinated initiative under the *Specialist Family Violence Advisor Capacity Building Program*. A report on the project was provided in a submission to the Royal Commission into Victoria's Mental Health System (2019). The project planned activities across a range of elements (Table 2).

[8] https://static1.squarespace.com/static/5b6a7f7e71069901ea5ef1eb/t/5c735e08e79c704c50cb9b29/1551064593953/FV+Presentation.pdf

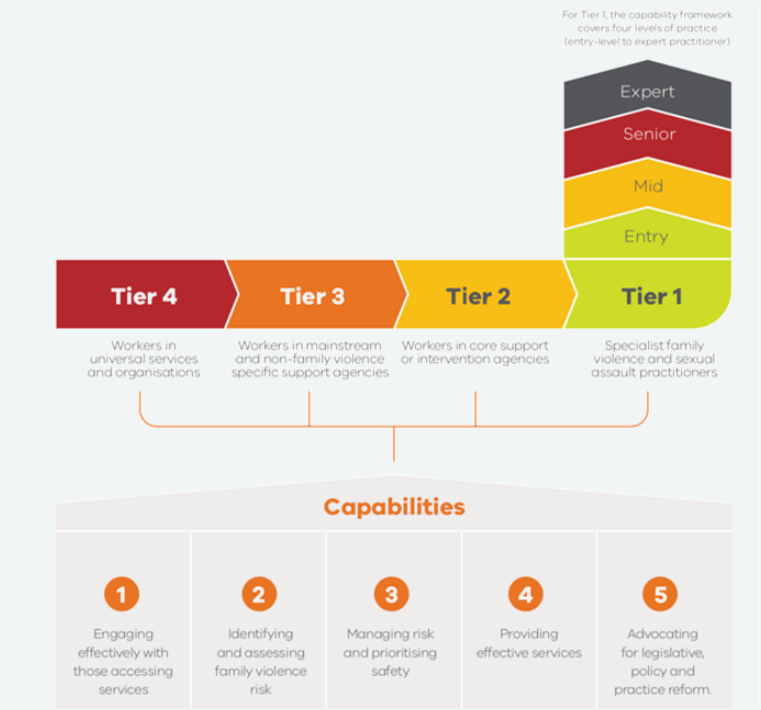
Table 2: Specialist Family Violence Advisor Capacity Building Program - Ovens Murray 18/19 workplan Activity Plan

Agency sector collaboration	Identify existing networks & collaborations Contribute to maintenance of existing networks and/or the establishment of new cross-sector networks Promote a Shared Understanding across agencies in relation to family violence reforms
Service coordination	Identify and map local referral pathways (including eligibility criteria) through desktop research and/or access to existing catchment planning Identify opportunities to strengthen existing pathways or where appropriate, establish new pathways between agencies
Professional capacity and capability	Create opportunities to share family violence expertise with workers in AOD and MH agencies
Organisational practice	Provide Family Violence expertise relating to service systems, screening tools, referral processes, information sharing and/or other legislative changes to AOD and MH workers. Assist AOD and MH workers to understand and navigate the Family Violence system. Audit workforce capacity and identify the need for AOD and MH worker training and professional development activities. Work with AOD and MH workers and agencies to understand capacity gaps relating to family violence identification and response. Identify gaps and opportunities to refresh policies, processes and practices to demonstrate responsiveness to reforms Promote the use of family violence risk assessment frameworks Provide advice to MH and AOD agencies regarding endorsed screening tools, referral processes, information sharing and other legislative changes Assess local MH and AOD agency organisational readiness through assessment of current policy contact, practice approach and protocols for family violence matters
System development	Maintain awareness of family violence reforms through participation of the Programs Community of Practice and professional development activities Maintain continual feedback with state-wide coordinator and auspice agency Support continuous improvement through feedback to local implementation committee Collate relevant data to satisfy reporting and evaluation requirement

Key outcomes of the project to date have included a Shared Care Model Framework, cross sector workshops, a Family Violence Organisational Readiness Assessment Tool and individual organisational readiness assessments. The Ovens Murray submission indicates that their localised project has delivered enhanced pathways, improved referrals, a better understanding of reform and commitment to ongoing capacity building.

The Victorian Capability Framework, MARAM and Information Sharing Scheme

Supporting initiatives such as the *Specialist Family Violence Advisor Capacity Building Program*, is the Victorian *Responding to Family Violence Capability Framework* (the Capability Framework), the *Multi Agency Risk Assessment and Management* (MARAM) framework and the *Family Violence Information Sharing Scheme*.



The Capability Framework (Family Safety Victoria, 2017:7) organises the service sector into four tiers according to roles and responsibilities to provides a map of how workers in mainstream and specialist services can respond to family violence (Figure 2). The framework outlines knowledge and skill indicators across all the tiers.

Figure 2: Structure of Victorian Capability Framework

The *Multi Agency Risk Assessment and Management* (MARAM) framework consists of 10 responsibilities for workers depending on how they are required to respond to family violence. Complimenting implementation of the MARAM is a range of guidelines and tools across all 10 areas of responsibility.[9] Domestic Violence Victoria (Mecham 2019) argues that a gap in the MARAM Framework is the absence of a universal screening tool for Domestic and family violence. The current MARAM recommends screening where indicators of family violence are present, which can result in an under-identification of domestic and family violence. Domestic Violence Victoria recommends a set of four to five questions as a universal tool that provides a victim survivor with the opportunity to disclose domestic and family violence.

The Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS) sets out the responsibilities of authorised organisations to share information in relation to family violence and the safety and wellbeing of children.

Practice guidelines from Victoria's Chief Psychiatrist

Arising out of recommendations from the RCFV, practice guidelines from Victoria's Chief Psychiatrist (2018) highlight that mental health services have an active responsibility to address

[9]MARAM practice guides and resources, https://www.vic.gov.au/maram-practice-guides-and-resources

family violence and that 'mental health clinicians are expected to become skilled in recognising, understanding, enquiring about and responding to family violence'. The guidelines expect mental health services to identify and respond to family violence by supporting those experiencing family violence, facilitating safety and protection, especially of children, and holding those who perpetrate violence accountable.

Effective responses to those experiencing or perpetrating family violence should be integrated into usual mental health care. The guidelines have a strong focus on the responsibility of mental health service leadership groups to:

- Ensure family violence training and supervision is accessible to all clinicians
- Create an authorising environment and provide leadership
- Develop effective organisational policies and procedures
- Proactively support collaboration and partnerships with other service providers
- Ensure services follow the new Information Sharing Schemes and MARAM
- Ensure the organisation supports staff who are experiencing family violence.

Under the guidelines, mental health clinicians have a responsibility to:

- Undertake family violence training and development appropriate to their level and role
- Identify and respond to people who experience and those who perpetrate violence
- Actively consult senior clinicians, supervisors or specialist family violence services to optimise their response.

Key strategies for mental health services include:

- Identifying a family violence executive sponsor within the leadership group
- The formation of a family violence committee to oversee implementation of the guidelines and clinical family violence champions
- Family violence policies
- Increased collaboration with specialist family violence services.
- Active participation in regional Risk Assessment and Management Panels
- Workforce development strategies include training, clinical supervision and support for staff affected by DFV.

An eight step clinical checklist has been developed to outline the expectations of clinicians, with the main message being to 'enquire, support, assess risk, plan for safety, follow-up, consult, refer and collaborate'. Prompts, example questions and practice tips are also provided.

Safe &Together Addressing ComplexitY

STACY (Safe &Together: Addressing ComplexitY) is an action research project that aims to 'investigate and develop practitioner and organisational capacity to work collaboratively across services providing interventions to children and families living with domestic and family violence (DFV) and where there are parental issues of mental health (MH) and alcohol and other drug use (AOD) co-occurring.'[10] The project utilises Communities of Practice, with training and coaching from the US Safe & Together Institute. With 36 project partners across three states (NSW, Queensland and Victoria), researchers work alongside the Communities of Practice to investigate and support practice,

[10] Violence Against Women and Children website: https://violenceagainstwomenandchildren.com/?p=327

collaboration and organisational change. The focus is on meaningful, systemic and systematic change around domestic violence policy and practice.

The Stella Project

The Stella Project[11] is a joint initiative between the Greater London Domestic Violence Project (GLDVP) and the Greater London Alcohol and Drug Alliance (GLADA). The Stella Project works to promote, at practice and policy level, the development of inclusive, integrated service provision for survivors and perpetrators of domestic violence who experience significant alcohol and other drug issues.

The Stella Project supports drug, alcohol and domestic violence agencies to effect sustained change in service delivery and outcomes. At a strategic level, the project works to influence and support policy development with the view of catalysing change on the ground. Underlying the project's approach is the belief that where domestic violence and substance use overlap, interventions undertaken in partnership across the sectors will improve the safety of clients and prevent ineffective repeat interventions. Importantly, the Stella Project recongises the importance of systemic supports and enablers of an integrated approach on the ground.

Practice guides and training

The Tasmania and Queensland governments and Domestic Violence NSW have all developed guides for service providers in relation to domestic and family violence. These guides include a discussion on co-morbidity and highlight the need for training and cross referrals between domestic and family violence, alcohol and other drug, and mental health services, but do not include specific strategies for how to improve collaboration. The South Australia Network of Drug and Alcohol Services have been funded to provide a Workforce Development Project, which will include workshops on responding to domestic and family violence for clinical alcohol and other drug services.

Improved Services Initiative

Whilst not including domestic and family violence, the Improved Services Initiative (ISI, 2008-2010) was a national project funded by the Department of Health (Commonwealth) aiming to build the capacity of alcohol and other drug organisations to effectively identify and treat comorbid alcohol and other drug use and mental illness. The initiative was part of the *National action plan on mental health (2006-2011)*. ISI included capacity building grants and funding to alcohol and other drug peaks to provide support to ISI grant recipients.

In Western Australia, the WA Network of Alcohol and other Drug Agencies (WANADA) facilitated the development of a consortium approach to ISI in order to ensure that capacity building was spread as far across the sector as possible. The project included attention to training, policy, referral pathways, data collection and increased inter-sector collaboration. A *Dual Diagnosis Capability in Addiction Treatment Toolkit* provided a measure of each service's capacity to assist clients with comorbidity - covering dimensions of program structure, program milieu, clinical process assessment and treatment, continuity of care, staffing and training.

An evaluation of the WA ISI found that the project had proven to be very effective in raising the capability of alcohol and other drug services with regard to consumers with co-occurring substance

[11] See http://www.gldvp.org.uk/the-stella-project/

use and mental health disorders (WANADA, 2011). Outcomes from a national forum show that additional benefits included stronger links between peak bodies, increased professionalism, partnerships with a broad array of services (not just mental health providers) and increased awareness of working with diverse populations (Australian State and Territory Peak Alcohol and Other Drugs Non-Government Organisations 2010).

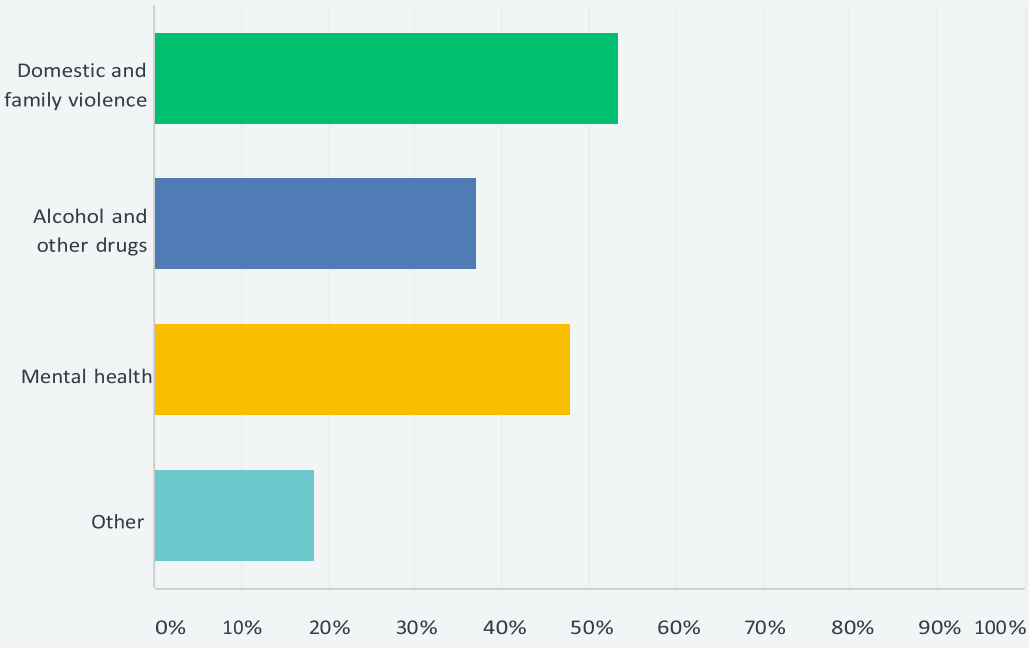
Survey findings

The project's capacity to consult with the domestic and family violence, alcohol and other drugs and mental health sectors was limited due to resourcing and the short duration of the project. An online survey was developed to gauge service provider perceptions, training and activity pertaining to the intersection of domestic and family violence, alcohol and other drugs and mental health of practitioners across the three sectors. The peak bodies collaborating on this project disseminated the survey amongst their members. The following peak bodies participated:

Western Australian Alcohol and other Drug Agencies
Women's Community Health Network
Western Australian Association of Mental Health
Women's Council for Domestic and Family Violence Services
Stopping Family Violence
Mental Health Matters2
Aboriginal Health Council of Western Australia

The survey was sent to member services just as COVID-19 struck. Knowing how extraordinarily busy our members were at this time, we were quite surprised to receive 92 responses in the three weeks that the survey remained open. Judging by the many emails received by members stating their interest in the project, it may indicate the level of concern regarding the complex interplay of domestic and family violence, alcohol and other drug use and mental health and its impact on service delivery and client outcomes.

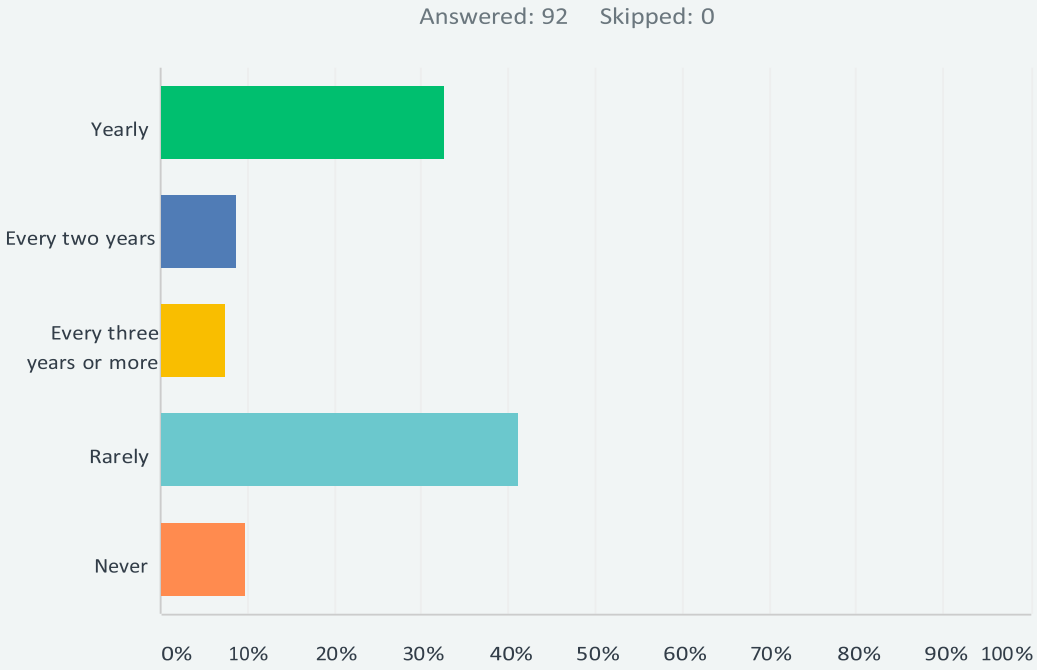
Service providers that participated in the survey indicated that they worked in one or more of the following sectors:



The majority of survey respondents indicated that a high percentage of their clients (75% or more) experienced a combination of domestic and family violence, alcohol and other drug and mental health issues.

A large proportion of survey respondents (over 80%) indicated that they felt confident working with victim-survivors of domestic and family violence experiencing mental health and/or alcohol and other drug issues. In contrast, respondents expressed significantly less confidence working with perpetrators; with only 44% feeling confident working with perpetrators of family and domestic violence experiencing mental health and alcohol and other drug issues.

The frequency of training to work with the intersecting issues of domestic and family violence, alcohol and other drugs and mental health varied significantly amongst survey respondents:



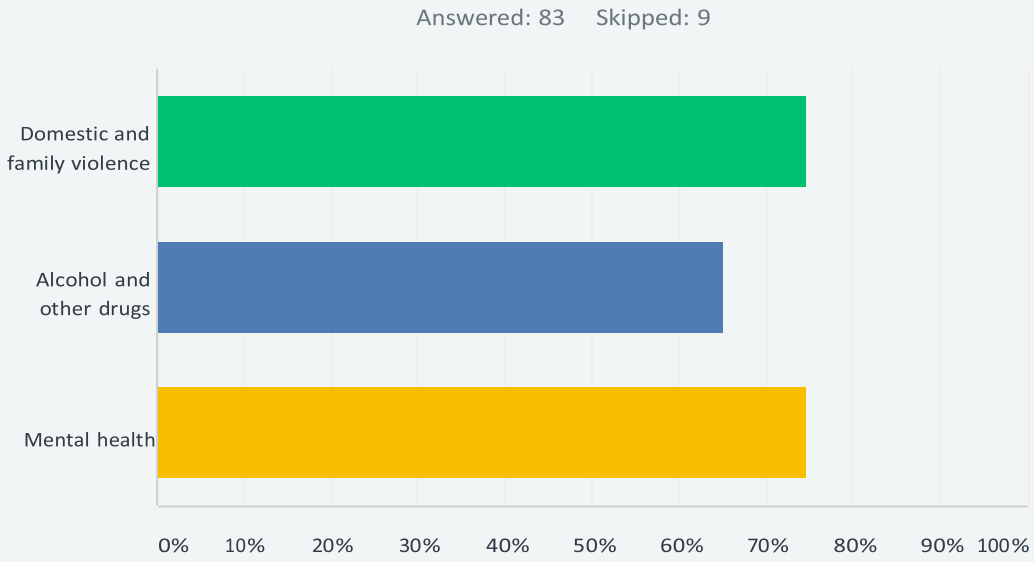
When survey participants were asked how they respond when a client presents with a combination of domestic and family violence, alcohol and other drugs and mental health issues, they indicated the following:

ANSWER CHOICES	RESPONSES
Work with the intersection in house	45.05%
Refer to another organisation	34.07%
Work with the client in collaboration with services with relevant expertise	80.22%
Total Respondents: 91	

Interestingly – given the responses above – when service providers were asked what training they would find useful to enhance their knowledge and skills in working with clients affected by the intersecting issues of domestic and family violence, alcohol and other drugs and mental health their was considerable appetite for training and support across the following areas:

ANSWER CHOICES	RESPONSE
More information on the intersecting issues of domestic and family violence, alcohol and other drugs and mental health	57.61%
More information on referral pathways	48.91%
More practical tips, tools and assistance for working with the interdependencies of domestic and family violence, alcohol and other drugs and mental health	76.09%
Opportunities to collaborate and develop partnerships with organisations with expertise in domestic and family violence, alcohol and other drugs and mental health	68.48%
Training to screen more effectively (for domestic and family violence, or if you are a domestic and family violence practitioner to screen for mental health and alcohol and other drug use)	55.43%
Total Respondents: 92	

Survey responses suggest that basic screening for domestic and family violence, alcohol and other drugs and mental health is mostly already occurring across the three sectors:



Concluding remarks

Service providers working across domestic and family violence, alcohol and other drugs and mental health sectors are clearly aware of the significance and impact of the intersection of these three issues on the lives of their clients and service access and engagement. While most service providers felt confident working with victims-survivors impacted by this intersection this was less the case when working with perpetrators. Importantly, working with clients impacted by the intersecting issues of domestic and family violence, alcohol and other drug use and mental health is not very well supported – although there seems to be screening occurring and a level of competency working with intersecting issues. Finally, there was very strong interest in receiving training and support to build workforce capacity to collaborate with other sectors and work in an integrated way across intersecting issues of

domestic and family violence, alcohol and other drug use and mental health to ensure better outcomes for clients.

Conclusion

Domestic and family violence is a widespread social and public health problem. The evidence and current government policy supports an approach that prioritises the safety, health and wellbeing of victims-survivors and their children and holds perpetrators accountable and keeps them in view. Keeping perpetrators 'in view' refers to the process of identifying, assessing, monitoring and managing their risk over time. This notion of increased perpetrator visibility relies on coordination and information sharing between a range of men's services, criminal justice agencies, domestic and family violence specialists and other support services, such as those dealing with mental health and alcohol and other drugs.

There is also an understanding that domestic and family violence is preventable given that it is enabled by modifiable social, cultural and economic conditions. Literature and policy agree that reducing violence against women and their children will require a whole-of-government and whole-of-community response. In Western Australia this is more aspirational than it is actual. Nonetheless, it is critical if we are to see an end to the achingly large number of women and children harmed and killed. Rodney Vlais writes: sectors and services that have contact with family violence perpetrators 'have an ethical responsibility to victim-survivors who are not in the room. Family violence requires all of us to think beyond the person in front of us. People's lives—both the fact of their lives and their ability to live free dignified lives without fear—depend on this wider vision' (Vlais 2018: 11).

The purpose of the preliminary project 'Toward an Integrated Response to the Complex Interplay of Domestic and Family Violence, Alcohol and Other Drug Use and Mental Health in Western Australia' was to unpack this complexity, its impact, and possible ways forward based on the evidence gathered.

The literature review and consultation with service providers and other stakeholders revealed a high level of domestic and family violence among people receiving treatment for drug and alcohol use and mental health issues. We saw that reported rates of domestic violence perpetration among men receiving treatment for alcohol and other drug use are higher than among men in the general population, and that complexity and difficulty is increased when there is a dual diagnosis of mental illness. We also saw that women receiving treatment for alcohol and other drug use and mental health issues experience domestic and sexual victimisation at rates far exceeding general population estimates.

For victims-survivors alcohol and other drugs are often used to help them cope with PTSD associated with domestic and sexual violence; and the evidence suggests that poor mental health is a reasonable response to domestic and sexual violence. We also saw that perpetrators often use alcohol and other drugs as a coping mechanism due to, for example, trauma, mental health issues, and personal and environmental stressors; but that this is not a reason to understand, or explain the domestic and family violence that is perpetrated.

The literature also revealed that alcohol and other drug use can be a factor in the severity and frequency of domestic and family violence perpetration. Mental health can also be a relevant factor in domestic and family violence perpetration, particularly in the case of a dual diagnosis of mental illness and alcohol and other drug use. The literature review showed that significant alcohol and other drug use, mental illness and behavioural issues usually exclude a perpetrator from men's behaviour change programs. Victims-survivors, too, are often excluded from refuges and other family, domestic

and sexual violence services if they have significant mental health issues and/or are using alcohol and other drugs.

Two broad explanations for domestic and family violence perpetration among men who use alcohol and other drugs and have a mental illness could be distinguished in the literature review. Firstly, domestic and family violence was explained by the 'power and control' model in which violence perpetrated upon an intimate partner is considered as coercive, strategic and tactical. In this view, alcohol and other drug use and mental health issues are considered as a post hoc excuse used by perpetrators for their domestic and family violence perpetration.

Secondly, domestic and family violence was explained in some of the literature as an aspect of multiple complexities and adversities. This is consistent with the view in some literature that men using alcohol and other drugs and/or with mental health issues are vulnerable, socially disadvantaged and are themselves frequently victims of violence (see also Radcliffe and Gilchrist 2016, Bellis *et al* 2013, Stevens, 2011). The latter narrative challenges both the criminalisation of offending drug users and the responsibilising discourse of domestic violence sector theory.

It was evident in the literature, too, that alcohol and other drug use and mental health issues amongst perpetrators and victims-survivors interact with the effects of broader culture, subculture, family and individual characteristics in domestic and family violence.

Importantly, the literature review reveals that the complex interplay between domestic and family violence, alcohol and other drug use and mental health affects the efficacy of interventions in either of these areas. For example, the experience of domestic and family violence can significantly constrain the ability of therapeutic interventions to achieve desired goals. Domestic and family violence perpetration, for instance, can have a significant impact on a client's motivation and efforts towards meeting alcohol and other drug and mental health service intervention goals. In this case, 'training and practice guidance is required to enable practitioners to engage perpetrators about their use of domestic and family violence in ways that will help rather than harm victim-survivors, and that simultaneously allow a positive and therapeutic interaction with the (perpetrator) client' (Vlais 2018).

Workforce development with a focus on the complex interplay of domestic and family violence, alcohol and other drug use and mental health is necessary to reduce domestic and family violence, alcohol and other drug and mental health issues in our community.

There is very little evidence in Western Australia of policies and strategies attending to the complex interplay between domestic and family violence, alcohol and other drug use and mental health. There is certainly no dedicated resourcing for this critical intersection. Thus there is little guidance provided as to how service providers might respond to men who disclose or are identified as perpetrating domestic and family violence in the context of alcohol and other drug use or mental health treatment in a way that does not obfuscate the perpetrator's individual responsibility.

The Family and Domestic Violence Therapeutic Women's Refuge (Peel Refuge) model expected to come into fruition in 2020 is a response to the mental health and/or alcohol and other drug impacts on women experiencing domestic and family violence. However, there is no policy, strategic and resourced commitment to building the capacity of the workforce across the domestic and family violence, alcohol and other drugs and mental health sectors to work in an integrated way to improve victim-survivors safety, health and wellbeing outcomes.

Organisational and service provider capacity and capability to work safely and effectively with the complex interrelatedness of domestic and family violence, alcohol and other drug use and mental health is currently inconsistent and not adequately supported systemically or financially. The findings of the 2016 Victorian Royal Commission into Family Violence identified the need for improved integration between the family violence, alcohol and other drug and mental health sectors. Financial investment and a systems framework is being implemented to support integrated practice and the cross sector engagement, competencies and capabilities required to enable and sustain it. This seems to be the most promising approach to ensuring efficacy across sectors and improved safety, health and wellbeing outcomes for victims-survivors.

Moving forward, any workforce development (the second phase of this project) with a focus on the complex interplay between domestic and family violence, alcohol and other drug use and mental health in the distinct Western Australian context will require a 'ground-up' co- design approach to ensure that it will work in the local and particular contexts of sectors, service providers and population groups. Through a dialogic and co-design process a rigorous use of the evidence can be assured and outcomes are likely to be relevant, useful and practical for all three sectors and a diversity of communities.

A third project phase will be necessary to support the development of contextually suitable, appropriate and interactive workforce development; and its implementation and sustainable uptake in practice.

Bibliography

ABC (2018) 'WA crime data reveals domestic violence surge'. https://www.abc.net.au/news/2018-02-21/wa-crime-data-reveals-domestic-violence-surge/9462172)

Abramsky, T. *et al.* (2011) 'What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence', *BMC Public Health*, 11(1), p. 109.

Alcohol Tobacco & Other Drugs Association ACT (ATODA) (2017) *ACT Alcohol and Other Drug Safer Families Program 2017 – 2021: Design, Model, Implementation Plan and Evaluation Framework December 2017*. Canberra: ATODA. Available at: http://www.atoda.org.au/research-scope-and-design-a-pilot-project-safer-families/

Australia's National Research Organisation for Women's Safety. (2018). *Violence against women: Accurate use of key statistics* (ANROWS Insights 05/2018). Sydney, NSW: ANROWS.

Armenti, N. A., Snead, A. L., and Babcock, J. C. (2018). Exploring the Moderating Role of Problematic Substance Use in the Relations Between Borderline and Antisocial Personality Features and Intimate Partner Violence. *Violence Against Women*, *24*(2), 223–240.

Askeland, I. R., & Heir, T. (2014). Psychiatric disorders among men voluntarily in treatment for violent behavior: A cross-sectional study. *BMJ Open, 4*, pp. e004485.

Australian Institute of Family Studies (2016) *Establishing the connections: Guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors*. Melbourne, Victoria.

Australian Institute of Health and Welfare (2019) *Alcohol and other drug treatment services in Australia 2017-18*. Canberra: AIHW.

Australian Institute of Health and Welfare (2018) *Mental health services in brief 2018*. Canberra: AIHW.

Australian State and Territory Peak Alcohol and Other Drugs (AOD) Non-Government Organisations (2010) *Outcomes From The National Improved Services Initiative Forum : A Tale of Two Systems*. Available at: http://www.atoda.org.au/wp-content/uploads/National-ISI-Forum-Report-2010.pdf

Baulch, M. and McCormack, F. (2015) 'Exploring the connections between family violence and alcohol and other drugs', *Advocate*, (3), pp. 3–4.

Bellis, M, H. Lowey, N. Leckenby, K. Hughes, D. Harrison, (2013) Adverse childhood experiences: Retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. Journal of Public Health, April, pp. 1-11.

Bennett, L., & O'Brien, P. (2010). The effects of violence acuity and door to service. *Journal of Social Work Practice in the Addictions, 10,* 139-157.

Bethany Community Support (2015). Submission to the Victorian Royal Commission into Family Violence. Victoria.

Beydoun, H.A., May A.Beydoun, Jay S.Kaufman, Bruce Lo, Alan B.Zonderman (2012). Intimate partner violence against adult women and its association with major depressive disorder, depressive symptoms and postpartum depression: A systematic review and meta-analysis. Social Science & Medicine. Volume 75, Issue 6, September 2012, Pages 959-975

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Blagg, H., Bluett-Boyd, N. and Williams, E. (2015) *Innovative models in addressing violence against Indigenous women: State of Knowledge paper*, *ANROWS Horizons*. Available at: https://www.anrows.org.au/publication/innovative-models-in-addressing-violence-against-indigenous-women-state-of-knowledge-paper/ (Accessed: 27 December 2019).

Blagg, H.,Williams, E., Cummings, E., Hovane, V., Torres, M. and Woodley, K.N. (2018) *Innovative models in addressing violence against Indigenous women: Final Report*, ANROWS Horizons.

Blagg, H.,Williams, E., Cummings, E., Hovane, V., Torres, M. and Woodley, K.N. (2018b) *Innovative models in addressing violence against Indigenous women : Key findings and future directions*, *Compass*, (01), ANROWS. Available at: https://www.anrows.org.au/publication/innovative-models-in-addressing-violence-against-indigenous-women-state-of-knowledge-paper/

Braaf, R. (2012) 'Elephant in the Room: Responding to Alcohol Misuse and Domestic Violence', *Australian Domestic and Family Clearinghouse Issues Paper*, (24), pp. 1–23. Available at: papers2://publication/uuid/7300A480-6415-4782-8DE4-B3197EB51447.

Breckenridge, J., Rees, S., Kylie, Valentine, K. & Murray, S. (2016) 'Meta-evaluation of existing interagency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: Final Report', ANROWS Horizons. Sydney, 1(11), pp. 1–84. Available at: https://www.anrows.org.au/publication/meta-evaluation-of-existing-interagency-partnerships-collaboration-coordination-and-or-integrated-interventions-and-service-responses-to-violence-against-women-final-report/

Chang, J.C., Cluss, P.A., Burke, J.G., Hawker, L., Dado, D., Goldstrohm, S. & Scholle, S.H. (2011). Partner violence screening in mental health. General Hospital Psychiatry, 33, 58–65. 9.

Connelly, C. D., Hazen, A. L., Baker-Ericzén, M. J., Landsverk, J., & Horwitz, S. M. (2013). Is screening for depression in the perinatal period enough? The co-occurrence of depression, substance abuse, and intimate partner violence in culturally diverse pregnant women. *Journal of Women'sHealth*, *22*(10), 844–52. doi:10.1089/jwh.2012.4121.

Cunneen, C. 2009. Criminology, Criminal Justice and Indigenous People: A Dysfunctional Relationship? *Current Issues in Criminal Justice* 20(3), pp. 323-336.

Cunneen C., Rowe S. (2015) Decolonising Indigenous Victimisation. In: Wilson D., Ross S. (eds) Crime, Victims and Policy. Palgrave Studies in Victims and Victimology. Palgrave Macmillan, London.

Davoren, M., Kallis, C., Gonzalez, R., Freestone, M., &Coid, J. W. (2017). Anxiety disorders and intimate partner violence: Can the association be explained by coexisting conditions or borderline personality traits? *Journal of Forensic Psychiatry & Psychology, 28*(5), 639-658.

Department for Child Protection and Family Support (2015). Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (2nd ed.), Perth, Western Australia: Western Australian Government.

Department of Premier and Cabinet (2018) 'Responding To Family Violence - A guide for service providers and practitioners in Tasmania'. State of Tasmania. Available at: www.dpac.tas.gov.au.

Domestic Violence NSW (2017) 'Good Practice Guidelines for the Domestic and Family Violence Sector NSW'. Available at: http://dvnsw.org.au/wp-content/uploads/2017/08/DFV-Practice-Guidelines.pdf

Dutton, M. A., Green, B. L., Kaltman, S. I., Roesch, D. M., Zeffiro, T. A., & Krause, E. D. (2006). Intimate Partner Violence, PTSD, and Adverse Health Outcomes. *Journal of Interpersonal Violence*, *21*(7), 955–968. https://doi.org/10.1177/0886260506289178

Easton CJ, Mandel DL, Hunkele KA, Nich C, Rounsaville BJ, Carroll KM: A cognitive behavioral therapy for alcohol-dependent domestic violence offenders: An integrated substance abuse-domestic violence treatment approach (SADV). Am J Addict. 2007, 16 (1): 24-31.

Family Safety Victoria (no date) 'Specialist Family Violence Advisor Capacity Building Program Stage 1 Program Guidelines'. Available at: https://southsafe.com.au/wp-content/uploads/2018/03/Program-Guidelines_SFV-Advisor-Capacity-Building-Program_Feb2018.pdf.

Family Safety Victoria (2017) 'Responding to Family Violence Capability Framework', (December). Available at: https://www.vic.gov.au/sites/default/files/2019-05/Responding-to-family-violence-capability-framework_0.pdf.

Foundation for Alcohol and Research Education (2015) 'National framework for action to prevent alcohol-related family violence', (June), pp. 5–55.

Fowler, Jonathon (2018). 'The impact of mental health on the response to perpetrators of domestic abuse'. https://safelives.org.uk/practice_blog/mental_health_of_perpetrators

George, S. (2019) 'Building cross-sector collaboration to prevent family violence', *DVRCV Advocate*, (April), p. 2019.

Gilchrist, Gay, Fay Dennis, Polly Radcliffe, Juliet Henderson, Louise M. Howard, David Gadd. The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. International Journal of Drug Policy Volume 65, March 2019, Pages 8-23.

Golder, S., Connell, C. M., & Sullivan, T. P. (2012). Psychological distress and substance use among community-recruited women currently victimized by intimate partners: A latent class analysis and examination of between-class differences. *Violence Against Women, 18*(8), 934–957. doi:10.1177/1077801212456991.

Graham K, Bernards S, Wilsnack SC, Gmel G: Alcohol may not cause partner violence but it seems to make it worse: a cross national comparison of the relationship between alcohol and severity of partner violence. J Interpers Violence. 2011, 26 (8): 1503-1523.

Green, S. and Baldry, E. 2008. Building Indigenous Australian social work. *Australian Social Work* 61(4), 389-402.

Gruenert, S. (2015) 'Addressing family violence in the AOD sector', *Advocate*, (3), p. 5.

Hien, D., Litt, L. C., Cohen, L. R., Miele, G. M., & Campbell, A. (2009). *Trauma services for women in substance abuse treatment: An integrated approach*. Washington, DC US: American Psychological Association.

Humphreys, Cathy and research team Submission to the Royal Commission into Family Violence Victoria 2015. University of Melbourne.
Humphreys, C., Healey, L. and Diemer, K. (2015) 'Melbourne Research Alliance to End Violence Against Women and their Children ~ Submission to the Australian Children's Commissioner', pp. 1–26. Available at: https://www.humanrights.gov.au/sites/default/files/18. Melbourne Alliance to End Violence Against Women and their Children.pdf.

Inner North West Primary Care Partnership (no date) *Step by Step Guide: Organisational Family Violence Implementation Checklist*. Melbourne, Victoria, pp. 1–2. Available at: http://inwpcp.org.au/resources/identifying-and-responding-to-family-violence/.

Jaquier, V., Flanagan, J. C., & Sullivan, T. P. (2015). Anxiety and posttraumatic stress symptom pathways to substance use problems among community women experiencing intimate partner violence. *Anxiety, Stress & Coping: An International Journal, 28*(4), 445-455.

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

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

La Flair, L. N., Bradshaw, C. P., Storr, C. L., Green, K. M., Alvanzo, A. A. H., & Crum, R. M. (2012). Intimate partner violence and patterns of alcohol abuse and dependence criteria among women. *Journal of Studies on Alcohol and Drugs, 73*(3), 351–360.

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

Mason, R. and O'Rinn, S. E. (2014) 'Co-occurring intimate partner violence, mental health, and substance use problems: A scoping review', *Global Health Action*. Co-Action Publishing, 7(1).

Mecham, K. (2019) DV Vic Submission to Mental Health Royal Commission. Domestic Violence Victoria, pp. 1–27. Available at: http://dvvic.org.au/publications/submission-to-the-royal-commission-into-victorias-mental-health-system/.

Mental Health Coordinating Council (2018). Recovery Oriented Language Guide - Second Edition Revised.

Nathanson, A. M., Shorey, R. C., Tirone, V., & Rhatigan, D. L. (2012). The Prevalence of Mental Health Disorders in a Community Sample of Female Victims of Intimate Partner Violence. *Partner abuse*, *3*(1), 59–75. https://doi.org/10.1891/1946-6560.3.1.59

National Alliance for Action on Alcohol (2015). Submission to the Royal Commission into Family Violence. Victoria.

Newbigin, J. and Leggett, N. (2009) *Supporting Women with Complex Needs, The relationship between substance use and domestic and family violence*. Perth, WA. Available at: -publications/capacity-building-complex-needs.html

Nicholas, R., White, M., Roche, A., Gruenert, S., & Lee, N., (2012). *Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia*. Adelaide: National Centre for Education and Training on Addiction, Flinders University. Available at: http://nceta.flinders.edu.au/files/6513/5285/7437/EN469_Nicholas_2012.pdf.

Noonan, P., Taylor, A. and Burke, J. (2017) *Links between alcohol consumption and domestic and sexual violence against women: Key findings and future directions,* ANROWS Compass, (8). Sydney, NSW: ANROWS. Available at: https://www.anrows.org.au/node/1466.

No to Violence (2019). Submission to the Royal Commission into Victoria's Mental Health System. Victoria.

Office of the Chief Psychiatrist, D. of H. and H. S. (2018) *Chief Psychiatrist guideline and practice resource: family violence*. Melbourne, Victoria: State of Victoria, Department of Health and Human Services. Available at: https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist%3E

Our Curious Minds Pty Ltd (2019) 'Information Sharing in the AOD sector using the FVISS and CISS Information sharing by an ISE : The Must / May Model ™'. Melbourne, Victoria: VAADA, p. 2019. Available at: https://www.vaada.org.au/wp-content/uploads/2019/10/16019.VAADA_Posters_A3-FA.pdf

Ovens Murray Area Family Violence/Mental Health/Alcohol and Other Drug Capacity Building Project (2019) 'Submission to the Royal Commission into Victoria's Mental Health System'. Available at: https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/3815/6858/2634/Ovens_Murray_Family_Violence_Mental_Health_Alcohol_and_other_Drug_Capacity_Building_Integration_and_Sector_Reform_Project.pdf.

Paranjape, A., Heron, S., Thompson, M., Bethea, K., Wallace, T., & Kaslow, N. (2007). Are alcohol problems linked with an increase in depressive symptoms in abused, inner-city African American women? *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health*, *17*(1), 37–43. doi:10.1016/j.whi.2006.08.004

Parker, R. Hegarty, K., Humphreys, C., Marsden, S., Healey, L. and the Weavers Group (2019) 'Melbourne Research Alliance to End Violence Against Women and their Children - Submission to The Royal Commission into Victoria's Mental Health System'. Available at: https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/8015/6651/8107/Melbourne_Research_Alliance_to_End_Violence_Against_Women_and_their_Children_MAEVe.pdf

Phillips H. (2014). Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness. National Center on Domestic Violence, Trauma & Mental Health. Chicago, IL. http://www.nationalcenterdvtraumamh.org/wpcontent/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf

Poole, N., & Greaves, L. (Eds.). (2012). *Becoming Trauma Informed*. Toronto, ON: Centre for Addiction and Mental Health.

Price Waterhouse Coopers, *A High Price to Pay: The economic case for preventing violence against women* accessed athttps://www.pwc.com.au/publications/economic-case-preventing-violence-against-women.html.

Radcliff, P and Gail Gilchrist (2015) You can never work with addictions in isolation": Addressing intimate partner violence perpetration by men in substance misuse treatment. International Journal of Drug Policy, Volume 36, October 2016, Pages 130-140.

Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., Kaewken, O. (2015). An applied research paper on the relationship between intimate partner violence and substance use. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.
Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G., & Howard, L. (2011). Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. *British Journal of Psychiatry, 198*(3), 189-194. doi:10.1192/bjp.bp.109.072389

Safer Lives (2019). Safer Lives 'Safe and Well: Mental Health and Domestic Abuse'. Safer Lives, UK.

Salter, M., (2012). *Managing Recidivism Amongst High Risk Violent Men*. Australian Domestic & Family Violence Clearinghouse, Issues Paper No. 23, January 2012. http://www.adfvc.unsw.edu.au/PDF%20files/IssuesPaper_23.pdf.

SAMHSA. (2014). *Trauma-informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57*. Retrieved from Rockville, MD
http://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf
Sesar, K., Dodaj, A. and Šimić, N. (2018), "Mental health of perpetrators of intimate partner violence", *Mental Health Review Journal*, Vol. 23 No. 4, pp. 221-239. https://doi.org/10.1108/MHRJ-08-2017-0028

Short, J., Cram, F., Roguski, M., Smith, R. and Koziol-McLain, J. (2019) 'Thinking differently: Re-framing family violence responsiveness in the mental health and addictions health care context', *International Journal of Mental Health Nursing*, 28(5), pp. 1206–1216..

Spangaro, J. and Ruane, J. (2014) 'Health Interventions for Family and Domestic Violence: A Literature Review for NSW Kids and Families', (October).State of Victoria (2019) *Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87*, *College Composition and Communication*.
State of Victoria (2019) Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87. Available at https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.fi

Stevens, A (2011). Drugs, crime and public health: The political economy of drug policy. Routledge-Cavendish, London.

Stone, J., Marsh, A., Dale, A., Willis, L., O'Toole, S., Helfgott, S., Bennetts, A., Cleary, L., Ditchburn, S., Jacobson, H., Rea, R., Aitken, D., Lowery, M., Oh, G., Stark, R., & Stevens, C. (2019). *Counselling Guidelines: Alcohol and other drug issues* (4th ed.).Perth, Western Australia: Mental Health Commission

Sutherland, P., Mcdonald, C. and Millsteed, M. (2016) 'Family violence , alcohol consumption and the likelihood of criminal offences', *In Brief*, (7).

Shorey, Ryan C., JeniimarieFebres, Hope Brasfield, and Gregory L. Stuart 2012 Journal of Family Violence. 2012 Nov 1; 27(8): 741–748.

Schumacher, J. A. & Holt, D. J. (2012). Domestic violence shelter residents' substance abuse treatment needs and options. *Aggression and Violent Behavior, 17,* 188-197.

Siegel, J. P. 2013. An expanded approach to batterer intervention programs incorporating neuroscience research. *Trauma, Violence and Abuse, 14*(4), 295-304.

Spencer, P. (2016). Strengthening the Web of Accountability: Criminal Courts and Family Violence Offenders. *Alternative Law Journal*, *41*(4), 225–229.

State of Victoria, Royal Commission into Family Violence: Report and recommendations, 2014 -16. Victoria.

Sullivan, T., & Cavanaugh, C. (2009). Testing posttraumatic stress as a mediator of physical, sexual, and psychological intimate partner violence and substance problems among women. *Journal of Traumatic Stress*, *22*(6), 575–584. doi:10.1002/jts.20474.

Sullivan, T. P., & Holt, L. J. (2008). PTSD symptom clusters are differentially related to substance use among community women exposed to intimate partner violence. *Journal of Traumatic Stress*, *21*(2), 173–80. doi:10.1002/jts.20318.

The Victorian Government (2018) *Family Violence Multi-Agency Risk Assessment and Management Framework*. Available at: https://www.vic.gov.au/familyviolence/family-safety-victoria.htm.

Trevillion, Kylee, Elizabeth Corker, Lauren E. Capron & Siân Oram (2016) Improving mental health service responses to domestic violence and abuse, International Review of Psychiatry, 28:5, 423-432, DOI: 10.1080/09540261.2016.1201053

Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLOS ONE 7(12): e51740. https://doi.org/10.1371/journal.pone.0051740

Trezona, A. (2018) *Identifying and Responding to Family Violence Project Evaluation Report*. Melbourne, Victoria.

Vlais, R. (no date) 'Guidelines for Identifying and Responding to People Who Cause Family Violence Harm'. Melbourne Inner North West Primary Care Partnership.

Vlais, R (2018). Family Violence Perpetration and AOD Services. The Advocate. June, Issue 2. NADA. NSW.

Warshaw, Carol, Eleanor Lyon, Patricia J. Bland, Heather Phillips, Mikisha Hooper Mental Health and Substance Use Coercion Surveys Report from the National Center on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline.

Webster, K., Diemer, K., Honey, N., Mannix, S., Mickle, J., Morgan, J., Parkes, A., Politoff, V., Powell, A., Stubbs, J., & Ward, A. (2018). *Australians' attitudes to violence against women and gender equality. Findings from the 2017 National Community Attitudes towards Violence against Women Survey* (NCAS) (Research report, 03/2018). Sydney, NSW: ANROWS.

Western Australian Association for Mental Health & Mental Health Matters 2 (2019) 'Submission to the Ten Year Strategy to Reduce Family and Domestic Violence in Western Australia'.

Western Australian Network of Alcohol and other Drug (2011) 'Review of the Impact of the AOD Improved Services Initiative in Western Australia'. Available at: https://healthinfonet.ecu.edu.au/key-resources/publications/22850/?title=Review of the impact of the AOD improved services initiative in Western Australia&contentid=22850_1

White, M., Roche, A.M., Long, C., Nicholas, R, Gruenert, S. and Battams, S. (2013) *Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence*. Adelaide, SA.

Wolford-Clevenger C, Grigorian H, Brem MJ, et al. Associations of Emotional Abuse Types with Suicide Ideation among Dating Couples. Journal of Aggression, Maltreatment & Trauma. 2017; 26(9):1042-1054.

World Health Organisation (2006) Intimate partner violence and alcohol, WHO.
World Health Organisation (2013) 'Responding to intimate partner violence and sexual violence against women'. Available at: https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=E2A03ACEEDD8FA713EAF551D285B816C?sequence=1

Yates, S. (2019) '"An exercise in careful diplomacy": talking about alcohol, drugs and family violence', *Policy Design and Practice*. Routledge, 2(3), pp. 258–274.

Yu R, Nevado-Holgado AJ, Molero Y, D'Onofrio BM, Larsson H, Howard LM, et al. (2019) Mental disorders and intimate partner violence perpetrated by men towards women: A Swedish population-based longitudinal study. PLoS Med 16(12): e1002995. https://doi.org/10.1371/journal.pmed.1002995

Zaleski M, Pinsky I, Laranjeira R, Ramisetty-Mikler S, Caetano R. Intimate partner violence and alcohol consumption. *Rev SaudePublica* (2010) 44:53–9.