Royal Commission into Family Violence

SUPPLEMENTARY WITNESS STATEMENT OF PROFESSOR CATHERINE FRANCES HUMPHREYS

I, Catherine Frances Humphreys, Professor of Social Work, University of Melbourne, Parkville, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2. I have previously made a statement to the Royal Commission into Family Violence (**Royal Commission**), dated 7 July 2015.

Current role

3. I am a Professor of Social Work at the University of Melbourne and have held this position since 2006. I held the Alfred Felton Chair of Child and Family Welfare for five years before the position was funded as a continuing professorship by the University of Melbourne with contributions from Victorian community sector organisations for a further three years.

Background and qualifications

4. I hold a Bachelor of Social Work from the University of Queensland and a Doctor of Philosophy from the University of New South Wales. I practiced as a social worker for 14 years prior to becoming an academic. I have worked in the areas of child protection, mental health and community development. I have been involved either in a voluntary or paid capacity in the area of violence against women and their children all my working life.

5. Prior to joining the University of Melbourne in 2006, I worked as a social work academic at the University of Warwick in the United Kingdom for 12 years. I have experience across both the United Kingdom and Australian systems of interventions in child abuse and domestic violence.

6. Since becoming an academic in 1991, I have had more than 30 research projects in the area of violence against women and their children, as well as projects more recently in the child protection area focussed on out of home care. I have published 68 refereed journal articles, 24 book chapters and 12 monographs or books, mainly though not exclusively in the areas of child abuse and domestic and family violence. Attached to this statement and marked '**CH 1**' is a copy of my curriculum vitae which includes my publication record.

7. A list of the key references which have informed the content of my statement is attached and marked '**CH 2**'.

Connection between family violence and alcohol and other drugs

8. The focus of this statement is on the links between family violence and problematic alcohol use, particularly on the conditions associated with the increase in severity of family violence. My primary focus is on the role of alcohol in domestic and family violence, however discussions with service providers in the Alcohol and Other Drugs area point to the poly-drug use of a very large number of their clients; hence it is appropriate to always silo alcohol from other drugs. This is particularly pertinent with the escalation of the use of ice which is one drug associated with a direct causal link to violence.

9. In this statement, I use the term "domestic and family violence" to refer to all forms of violence, including behaviour which is physically, sexually and emotionally abusive.

10. I developed an interest in the connections between domestic and family violence and alcohol and drug use from working in the United Kingdom on a project called the Stella project, a London based service integrating domestic and family violence and drug and alcohol services.

11. My research team was involved in a two year project researching the links between domestic and family violence and substance use. Attached to this statement and marked '**CH 3**' is an article that I co-authored, entitled: *Domestic Violence and Substance Use: Tackling Complexity.* It provides an overview of the literature on substance use and domestic violence, highlighting the problems with the separation of both practice and policy in these areas.

12. This work was followed by a research overview of services for women experiencing domestic and family violence and substance use problems.

13. The research that I conducted with Dr Menka Tsanfeski last year further highlighted the links, particularly for substance using mothers and their infants. Attached to this statement and marked '**CH 4'** is a copy of our related paper entitled: *Infant risk and safety in the context of maternal substance use*. It explores the factors which contributed to infant risk or safety from the perinatal period to the end of the infant's first year.

14. I continue to be concerned about the profound division between the two sectors, a chasm which belies the evidence base and where there is strong potential to make greater inroads into the reduction of harm from family violence.

Key issue

15. In my view, the critical question is '*why is there a gap between interventions for alcohol and other drug and domestic and family violence?*' when women and their children are so severely impacted and perpetrator programs have the potential to increase their effectiveness if they intervene on drug and alcohol issues.

Challenges

16. There are a number of issues which contribute to siloing the sectors. These include:

    16.1. the concerns about 'causality' (i.e. that perpetrator responsibility will be minimised if alcohol can be 'blamed' for the domestic and family violence);

    16.2. a 'cultural clash' between services (primarily that alcohol and other drug services are often gender neutral and that some explanations for addiction refer to a disease and do not hold the person fully responsible for their actions);

    16.3. the politics of a 'single issue' focus which simplifies the intervention and expertise required;

    16.4. the problems of resourcing projects which address dual or complex needs;

    16.5. a lack of evidence of successful programs which address the dual issues;

    16.6. a lack of knowledge and training across sectors; and

16.7. fragmentation at government level which prevents co-resourcing of intervention programs.

17. The problematic use of alcohol and other drugs is a contributing factor rather than a cause of family violence.

18. Research conducted by Dr Rochelle Braff in 2012, found that when alcohol use co-occurs with attributes and behaviours supportive of violence against women, abuse is more likely to escalate.

19. Severity of family violence is increased by the use of alcohol and some drugs by both the perpetrator and victim. Some victims may have turned to alcohol and drugs as a way of coping with the violence and its repercussions. Hence the reduction of the use of alcohol is a significant harm reduction strategy for domestic and family violence and the wellbeing of children.

20. The connection between the severity of violence and alcohol use has been known about for more than 30 years; however the domestic and family violence and alcohol and other drug sector services are strongly siloed with few service links between them.

21. Alcohol was consumed by perpetrators in 44 percent of domestic homicides, and 87 percent of Aboriginal domestic homicides. Data on police reported incidents of domestic violence suggest alcohol is present in approximately 50 percent of incidents.

22. The lives of children are at increased risk of harm when both family violence and alcohol issues are present.

23. The argument to support stronger integration of service responses is compelling. The evidence shows that the severity and risk of injury is increased; women's rehabilitation from drug and alcohol problems is directly related to whether they are able to escape domestic violence; and perpetrators use their substance use as a 'tactic of abuse' to increase fear and control.

24. A number of examples of good practice are emerging in the drug and alcohol and domestic and family violence sectors though work is generally under-developed and resources often do not go beyond pilot programs.

Evidence of the connection between alcohol and family violence

25. Alcohol does not cause domestic and family violence. A substantial number of domestic and family violence incidents do not involve alcohol. Many women report that they have been physically attacked both when their partners or ex-partners have used alcohol and when they have not. Many perpetrators of physical and sexual violence do not use alcohol, and the regime of power and control which can involve financial and emotional abuse is frequently ubiquitous and does not involve alcohol.

26. However, there is compelling evidence that alcohol increases the severity of violent incidents. Where injuries are sustained, the domestic and family violence incidents are more serious and more numerous compared to non-alcohol related domestic and family violence.

27. The Australian part of the International Violence Against Women Survey found that for women whose partners got drunk two or more times per month that the risk of physical violence increased by a factor of 3.

28. A comparative study from thirteen countries reported significantly higher numbers of physically violent incidents when one or both partners had been drinking, compared to incidents in which neither partner had been drinking.

29. The analyses of the Personal Safety Survey indicated that approximately 50 percent of all domestic and family violence incidents involved domestic violence and that 73 percent of cases where there was physical assault.

30. The homicide data is particularly compelling with an Australian study over a 6 year period showing 44 percent of domestic homicides involved alcohol, and when Aboriginal domestic violence homicide data was examined, 87 percent involved alcohol.

31. The data is inherently unstable. An interesting study based at an alcohol rehabilitation centre by key domestic and family violence researchers showed that the rate of co-occurring violence and alcohol misuse depended upon who was asked: clinical reports by workers showed 20 percent of men reported domestic and family violence alongside alcohol misuse; men’s self-reports showed 52 percent reported domestic violence; while partner reports showed 82 percent women reported domestic and family violence co-occurring with alcohol consumption.

32. The research evidence on domestic and family violence and alcohol use highlights the gendered nature of both domestic and family violence and alcohol misuse. The research and practice divides into three broad areas:

    32.1. Victims of domestic and family violence (mainly but not only women);

    32.2. Perpetrators of domestic and family violence (mainly but not only men); and

    32.3. Children living with domestic and family violence and substance using mothers and/or fathers.

33. The higher risk of alcohol and drug problems for women living with domestic violence has been noted across all areas of the service system (drug and alcohol services, midwifery, primary care, police domestic and family violence units and child protection services). Substance use agencies show particularly high rates of women experiencing domestic and family violence. Victims are more likely to have alcohol problems, with data suggesting 2 to 9 times the rate of those not living with domestic violence. They are also more likely to suffer injuries; less likely to be believed and supported; and also more likely to be involved in perpetrating abuse, even if it is in self-defence. A well-recognised explanation for the strong association between women living with domestic and family violence and problematic substance use lies in the anaesthetizing effects of alcohol and other drugs in managing the physical and emotional pain of domestic and family violence.

34. The lives of children are significantly and detrimentally impacted when they are exposed to both domestic and family violence and substance misuse. There are heightened rates of children entering out of home care when these issues co-occur.

35. The links between the perpetration of domestic and family violence and alcohol use is not new. A study by Collins in 1981 undertook a meta-analysis of 15 studies and showed alcohol was significant in 60-70 percent of cases. Similarly Hotaling and Sugarman in 1986 examined 52 studies and showed alcohol use as one of four consistent risk factors. The same evidence continues to emerge, and one could argue continues to have a minimal effect on service intervention. A range of explanations are available to explain the link between the two social problems, few suggest a causal relationship. Most explanations argue a link between social context and attitudes. These include:

35.1. a belief (supported by the Australian National Community Attitudes towards Violence Against Women Survey, 2014) that violence is excused when a person is intoxicated;

35.2. that violence supportive attitudes are more dangerous when fuelled by alcohol or other drugs; and

35.3. that drinking is a defining and acceptable aspect of masculinity.

Opportunities for policy and practice

36. Despite the strong association between substance misuse (particularly alcohol) and domestic and family violence, and the finding that problematic alcohol use increases the severity of violence, the intervention strategies to address the co-occurring problems are under-developed and not well evaluated.

37. A substantial study by Ingrid Wilson of La Trobe University in 2014, which searched the international literature identified 11 studies that met strict evaluation criteria. These were studies conducted both at community and individual levels. Their conclusion was that the potential for alcohol interventions to reduce intimate partner violence has not been adequately tested.

38. There were nevertheless some promising directions for intervention which could occur at the community (primary prevention) level or at the individual level (tertiary prevention) through individual and group work.

39. The World Health Organisation recognises that there are no simple, quick answers to lowering either the rate of domestic and family violence or the rate of alcohol misuse. Instead, a complex array of interventions is required through a socioecological approach to both domestic and family violence and alcohol misuse; for example:

39.1. The studies on the impact of increased prices and taxes shows weak evidence for the effectiveness of this intervention when strict evaluation criteria are used. However the lowering of the level of binge drinking particularly by students and teenagers in the United Kingdom has had a number of different explanations. The United Kingdom Office of National Statistics which identified the significance of the decrease from 2005 – 2013 suggests that pricing of alcohol combined with unemployment levels rising may have been one of several explanations.

39.2. Studies of community-level policies do show some impact. The longitudinal study by Michael Livingstone (2011) of alcohol outlet density and domestic and family violence in Victoria from 1996 to 2005 showed a stronger association between domestic and family violence and the density of off-license (take-away) liquor outlets in an area than on premise licenses during the same period. The off-license showed that an increase in one off-premise license per 1,000 residents was associated with a 28.6 per cent increase in the mean domestic violence rate. The Foundation for Alcohol Research and Education research organisation also draws attention to the concentration of alcohol outlets in low socio-economic areas in ways which potentially exacerbate the pressures in more vulnerable populations.

39.3. At the level of individual intervention there is some evidence of the effectiveness of short-term brief drug and alcohol interventions in the context of Men's Behaviour Change programs. Unsurprisingly, the effects of the intervention were not sustained. The studies, even though they reached the strict research criteria for research selection would not have met the criteria good practice – no alcohol and other drug sector workers would suggest that a 90 minute intervention would sustain harm reduction or abstinence. In many ways, the research evidence points to the lack of development of complex and integrated interventions.

39.4. There are nevertheless interesting and important practice developments which have occurred as a result of Men's Behaviour Change programs. For example, Communicare in WA was funded for a 3 year pilot program which integrated a Men's Behaviour Change program with a drug and alcohol intervention. Groups to support cessation of drug and alcohol consumption ran parallel to the Men's Behaviour Change groups. Each man had a drug and alcohol worker as well as engagement in the Men's Behaviour Change program. A manual was developed and substantial training of workers occurred. Interestingly, the program found it more effective to train Men's Behaviour Change workers in addiction work than to train the drug and alcohol workers. The latter found much more difficulty in engaging men on the issues of accountability and responsibility.

39.5. In the United Kingdom, the Domestic Violence Intervention Program is developing innovative work with selected substance use organisations to address both substance use and domestic violence perpetration.

39.6. Several Men's Behaviour Change programs in Victoria initially refer men to a substance use program before they are eligible for working in a group with other men on their domestic and family violence issues. However the impact of this approach has not been evaluated. The approach arises from a pragmatic stance that men need to be beyond chaotic substance use before they can actively engage with their other problematic issues.

39.7. Monashlink Community Health Service has an alcohol and other drug practitioner to specifically work with victims and perpetrators at the interface of domestic and family violence. This is a promising example of integration between the service systems.

39.8. The Stella Project in London has developed a range of resources to support greater integration across sectors. Our research (as part of the Stella project) suggested that it was the women's drug workers who were the most attuned to a response for women which addressed both their substance use issues as well as the issues of violence and abuse that they faced. They had a holistic practice in which they were trained and knowledgeable about both domestic and family violence and substance use. From their perspective, they were unable to see the divisions between the service systems and wondered how anyone could work effectively in the area without the skills and knowledge base to support a holistic approach.

39.9. The Foundation for Alcohol Research and Education monograph, Hidden Harm highlights the issues for children living with alcohol affected mothers and fathers. It also raises some issues about the overlap with domestic and family violence for these children. It is clear however that more work is required to develop practices which effectively work across both sectors for children.

Conclusion

40. The Royal Commission provides a very important opportunity and possible circuit breaker to address the problematic siloing between the substance use and domestic and family violence sectors. The use of alcohol and other drugs increases the severity of injury and impact from domestic and family violence. This in itself is a compelling reason to engage in innovative prevention practices to gauge the impact of intervention in this area.

Catherine Frances Humphreys

Dated: 16 July 2015