VICTORIAN ALCOHOL & DRUG ASSOCIATION

Royal Commission into Family Violence

VAADA Submission

May 2015

VAADA Vision

A Victorian community in which the harms associated with alcohol and other drug use are reduced and wellbeing is promoted

VAADA Purpose

To represent the membership by providing leadership, advocacy and information within the AOD sector and across the broader community in relation to alcohol and other drugs

About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

Acknowledgements

VAADA would like to thank those AOD services who contributed to the development of this submission by sharing their experiences of responding to family violence within AOD treatment settings and highlighting opportunities to enhance and improve responses to family violence across the AOD sector. VAADA extends thanks also to those outside of the AOD sector who contributed to the development of this submission.

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Executive Summary

The devastating and tragic impacts of family violence cannot be overstated. The impacts on the individual are enormous with family violence identified as the leading cause of illness, disability and premature death of Victorian women under the age of 45 years (VicHealth 2004). Beyond the effects on the individual experiencing violence, the consequences extend to the whole family and the broader community and into our legal and health systems and social and community services.

VAADA welcomes the Royal Commission into Family Violence as a significant step in addressing the enormity of the problem. We also welcome the Victorian Government's commitment to implementing the recommendations of the Royal Commission.

As the peak body representing alcohol and other drug (AOD) services in Victoria, the focus of this submission is the relationship between AOD misuse and family violence and opportunities to enhance responses to family violence within AOD services in Victoria.

The relationship between AOD misuse and family violence is complex, multidimensional and contested. Alcohol and other drug use does not cause family violence but is one of a number of contributing factors, and as such, efforts focussing on AOD issues are a necessarily part of a holistic response to family violence.

Families experiencing violence are also likely to be dealing with multiple, complex and inter-related issues which can include AOD issues and mental health problems. This points to the need for coordinated and integrated responses for both victims and perpetrators of family violence.

Some communities may be disproportionality affected by family violence and experience a number of additional barriers to accessing appropriate support. It is paramount that the specific needs of Aboriginal communities, Culturally and Linguistically Diverse (CALD) and Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) communities as well as young people are examined by the Royal Commission and that the relationship between AOD and family violence for these communities receives attention.

In many ways, community services including AOD services deal with the consequences of family violence on a daily basis. It is likely to feature the lives of a significant proportion of people seeking treatment for substance use issues. AOD misuse may be a consequence of family violence as well as a contributing factor. While a strong evidence base exists about the relationship between alcohol misuse and family violence, less is known about the role of substances other than alcohol in family violence and this is a gap in our knowledge that needs to be addressed.

The capacity of AOD services to respond to family violence needs to be enhanced. Alongside this, there is a clear need for improved coordination and collaboration between AOD services and family violence services including Men's Behaviour Change Programs. Cross-sector capacity needs to be built not only between AOD and family violence services but more broadly across a range of community services and including Child Protection Services to ensure more joined-up responses.

VAADA looks forward to the findings of the Royal Commission and to working with the Victorian Government to help respond more effectively to family violence.

Recommendations

In particular, VAADA makes the following recommendations to the Royal Commission:

1. Future policy frameworks, strategies and action plans across AOD and family violence fields include greater recognition of the association between family violence and AOD misuse, including actions and priorities to address the co-occurrence.

2. Research be funded to build the evidence base on the relationship between AOD misuse, particularly substances other than alcohol, and family violence in the Australian context. The specific needs of diverse communities should be considered including Aboriginal, CALD and LGBTIQ communities and rural and regional differences in experience.

3. The Existing Protocol between AOD services and Child Protection be updated.

4. Adequate and ongoing resourcing be made available to allow for the continuation and further development of family inclusive programs within AOD services. This is in recognition that enhanced responses to family violence in AOD services should be embedded within a broader framework of family inclusive practice.

5. Ensure appropriate opportunities for the Victorian Aboriginal Community Controlled Health Organisation and ACCHOs, as well as local Aboriginal communities and cooperatives, to provide input into culturally appropriate interventions and strategies to address the association between AOD misuse and family violence within Victorian Aboriginal communities.

6. Safe and appropriate accommodation options be made available for women experiencing family violence who also experience AOD issues.

7. Opportunities to formalise the roll-out of existing clinical guides and resources such as *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence*, be explored and appropriately funded, as well as evaluated for their effectiveness in improving responses to family violence in AOD services.

8. A comprehensive whole-of-sector capacity building project be funded by the Victorian Government and developed and delivered by representative peak bodies to enhance responses to family violence in AOD services.

9. A cross-sector capacity building project be funded by the Victorian Government to enhance collaboration and cooperation between community services dealing with family violence. This should include, but not necessarily be limited to, AOD services, family violence services and Men's Behaviour Change Programs, Child Protection services and mental health services. It should include:
    - Enhancement of referral pathways between AOD and Family Violence Services, specialist women's services and Men's Behaviour Change Programs and other relevant services
    - Opportunities and incentives for formal partnerships to be established between services to enhance coordination of responses for both victims and perpetrators of violence

- Development and delivery of innovative programs and delivery models which address the co-occurrence of AOD misuse and family violence and provide opportunities for addressing the co-occurrence in a coordinated way.

Introduction

VAADA welcomes the Royal Commission into Family Violence as a vital step towards addressing the significant and pervasive problem of family violence in Victoria. The personal and social costs of family violence are devastating, yet have long been neglected as a priority public health and social justice issue. VAADA believes the Royal Commission will make tremendous progress towards addressing this long-standing neglect.

The impacts of family violence are far-reaching. Women who are victims of family violence may experience a myriad of other problems including impacts on their mental health and wellbeing, the development of anxiety and depressive disorders, post-traumatic stress disorder, pain syndromes and a range of other medical problems (Department of Health 2011). They are also likely to experience problems maintaining social relationships outside of the family and can find themselves increasingly socially isolated. Evidence also highlights the cumulative impacts of family violence as particularly devastating. For children, the impacts of experiencing family violence, or being exposed to family violence, include the development of mental health concerns such as depression, anxiety and emotional problems and trauma responses.

Figures from the Victorian Crime Statistics Agency point to the enormity of the problem, with over 68,000 family incidents[1] reported to Victoria Police in 2014; a rise of 8.2% from the previous year. This amounts to a family incident rate of 1,168 per 100,000, an increase of 70.3% since 2010. Just this week the newly appointed Chief Commissioner of Victoria Police highlighted family violence as a key focus for Victoria Police noting that police respond to more than 600 incidents a day.[2]

VAADA supports the Royal Commission's definition of family violence as "..[including] a broad range of behaviour, often continuing over a long period". We also agree that family violence is not limited to physical or sexual violence but includes emotional and psychological abuse; economic abuse; and a range of threatening, controlling or coercive behaviour which make a family member fear for their wellbeing or safety, or the safety and wellbeing of others." Family violence also "includes conduct which exposes a child to abusive behaviour" (The Royal Commission 2015, p.3).

VAADA supports the view the family violence, while often involving an intimate partner, can also refer to violence involving other familial relationships between siblings, parents and children and people who are related in other ways. Importantly too, violence occurs in many family contexts including same-sex relationships. It is also be important to note that family violence can be bidirectional between partners.

Nonetheless, VAADA recognises that family violence, particularly violence between intimate partners, is not gender neutral. Overwhelmingly, it is women and children who are subjected to family violence and men who use violence in their family and intimate relationships.

Furthermore, VAADA recognises that some communities may be disproportionately affected by family violence insofar as they find it more difficult to access appropriate supports within the mainstream family violence system (Tayton et al 2014), including Aboriginal and Torres Strait Islander women;

[1] A family incident is an incident attended by Victoria Police where a Victoria Police Risk Assessment and Risk Management Report (also known as an L17 form) was completed see http://www.crimestatistics.vic.gov.au/home/crime+statistics/year+ending+31+december+2014/family+incidents

[2] A family incident is an incident attended by Victoria Police where a Victoria Police Risk Assessment and Risk Management Report (also known as an L17 form) was completed: http://www.crimestatistics.vic.gov.au/home/crime+statistics/year+ending+31+december+2014/family+incidents

culturally and linguistically diverse (CALD) women; lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people; women with disabilities; and older and younger women all face significant barriers to identifying family violence and access appropriate support (FARE 2015). VAADA recognises too that family violence is an underreported crime, an issue which may be more pronounced for some communities.

VAADA uses the term 'family violence' throughout this submission, except where referring to particular research studies where we have adopted the term used in that study for accuracy.

People who have experienced family violence, or who have been exposed to it as children, may use alcohol or other substances to cope with some of the effects of the violence and trauma, which in turn can lead to other health and social problems (ANCD 2006; WHO 2006; Fare 2015). We also know that AOD use is one of a number of factors contributing to family violence. Both of these issues are explored throughout this submission.

Whilst this submission focuses on AOD misuse and family violence, VAADA recognises that mental health problems are often an important part of the picture for people experiencing, or at risk of, family violence. Similarly, those who perpetrate violence may experience co-occurring issues with substance use and mental ill-health. Many people accessing AOD treatment services have co-occurring mental health concerns, often referred to as 'dual diagnosis' and much work has been undertaken across the AOD and mental health sectors to build capacity of both sectors to respond to people experiencing these issues. Families experiencing violence are also likely to be dealing with multiple, complex and inter-related issues which can include AOD issues and mental health problems.

VAADA's submission focuses on the association between AOD misuse and family violence; opportunities to build capacity and enhance responses to family violence within the AOD sector as well mechanisms to improve linkages and coordinated responses between AOD and family violence services and other community services and sectors.

However, achieving substantial and sustained change requires a whole-of-community approach and a whole-of-government coordinated response. It will be difficult to achieve meaningful change without a significant injection of funding for community services working with people affected by, or at risk of, family violence.

The relationship between AOD misuse and family violence

The relationship between AOD misuse[3] and family violence is complex, multifactorial and contested (Braaf 2012; FARE 2015; Humphreys et al 2005; Nicholas et al 2012; White et al 2013). To date, the majority of research on the links between AOD misuse and family violence has focused on alcohol.

These studies have shown:

- Alcohol use can be both a consequence of and precursor to relationship stress and violence (FARE 2015; Nicholas et al 2012)
- Alcohol has been estimated to be involved in 50% of all violence between partners in Australia (and 73% of all physical assaults perpetrated against a partner (Laslett et al 2010)
- Around 44% of all intimate partner homicides in Australia between 2000-2006 involved alcohol, with either one or both partners drinking (Dearden & Payne 2009) with a stronger correlation for Indigenous homicides where the figure for alcohol-related homicide rose to 87% (Dearden & Payne 2009)
- Alcohol outlet density, particularly packaged liquor licences, has been positively associated with rates of domestic violence in Melbourne (Livingston 2011)
- Alcohol use is often used by the perpetrator as a reason or excuse for their violence (Graham et al; Nicholas et al 2012)
- Alcohol use affects cognitive and physical functioning making it harder for people to problem solve or see another persons' perspective, potentially making the drinker more impulsive and emotional (see for example, Braaf 2012; Dearden & Payne 2009;)
- Alcohol use may affect behavioural changes such as 'alcohol myopia' or 'alcohol short-sightedness' whereby alcohol use causes people to focus on the immediate situation with limited regard for the consequences of their actions (Dearden & Payne 2009, p.1)
- The risk of violence increases when alcohol is involved as does the severity of injuries (FARE 2015; Graham et al 2011) with international research showing significantly higher numbers of physically violent incidents where one or both partners had been drinking, compared with incidents in which neither partner was drinking (Graham et al 2011 cited in Braaf 2012)
- Experiencing family violence can increase a person's likelihood of using AOD as a coping mechanism for dealing with the consequences of violence such as trauma (Braaf 2012)
- Alcohol use by a victim of family violence can make it more difficult for them to seek help from police; reduce their capacity to implement safety strategies; increase the likelihood they will be blamed for the violence and exclude them from support services such as women's crisis support accommodation or refuges (Nicholas et al 2012,p.5)
- Children are affected by exposure to family violence and can become victims of abuse, maltreatment or neglect themselves and intergenerational effects can occur where children may be more likely to develop AOD problems in later life and are at greater risk of using violence themselves (Battams & Roche 2011; Nicholas et al 2012)

[3] The term AOD misuse has been used throughout this submission as is often used in the literature in this area. It is consistent with much of the literature in the area. Given the focus of this submission is on responses to family violence within AOD services, it is important to recognise that people entering treatment are likely to be using alcohol and/or other substances at levels that are risky or harmful and fall into the category of misuse. However, VAADA recognises a range of terms are often used, sometimes interchangeably, to describe AOD issues including misuse, abuse and problematic substance use.

A cross-cultural study of 13 diverse countries examined *how alcohol affects violence* by investigating the association between severity of physical aggression towards a partner and alcohol consumption. The authors found "alcohol consumption may serve to potentiate violence when it occurs, and this pattern holds across a diverse set of cultures" (Graham et al 2011, p.1504). That is, alcohol consumption was found to be associated with more severe aggression when either one or both partners had been drinking. The authors concluded "clinical services for perpetrators and victims of partner violence need to address the role of drinking practices, including the dynamics and process of aggressive incidents that occur when one or both partners have been drinking" (Graham 2011, p.1504).

Substances other than alcohol should not be ignored in The Royal Commission's examination of the links between AOD misuse and family violence. To date, research into the relationship between drug use and family violence has been limited, particularly in the Australian context. Poly-drug use (meaning people are using more than one substance) is common in Victoria, and across Australia, yet poly-drug use has not been examined in the literature. VAADA believes this is an important gap is our knowledge that should be addressed.

Of those studies which have considered substances other than alcohol, some findings include:

- Around half of respondents to a survey of UK domestic violence agencies claimed either themselves or their partners had used substances in problematic ways in the past five years (Budd 2003 cited in VAADA 2012)
- One study found the likelihood of male to female aggression doubled on days when men misused alcohol or cocaine (although not cannabis or opiates) (Fals-Stewart et al 2003)
- A US study of women using crack cocaine found 40-60% of women reported regular physical assaults by a current partner and 75% reported being assaulted by a partner of former partner on at least one occasion (Bury 1999 cited in VAADA 2012)
- Use of methamphetamines has been associated with violence, in particular the effects of methamphetamine on impulse control and decision making have been noted as possible contributors to violence. However it is not clear whether methamphetamine can be isolated from other co-occurring factors such as alcohol use, mental health issues, personality traits and other lifestyle and environmental factors in contributing to violence (Nicholas et al 2012)

Anecdotal and emerging evidence implicates the substance crystalline methamphetamine (generally referred to as Ice) in an increasing number of family violence incidents in Victoria and other parts of Australia. Moreover, an increase in the severity of injuries sustained by victims has been attributed to perpetrator's use of ice in recent media reporting.[4] This view was supported by one family violence service provider with whom VAADA consulted for the purposes of developing this submission. However, there is a dearth of evidence on the relationship between illicit substance use and family violence and we need to address this gap in our knowledge base.

The Victorian Government acknowledged the substantial harm caused by Ice in the development of the *Ice Action Plan* released in March 2015. The Plan emphasised the need for further support for families and noted that 'ice [sic] fuels family violence' but the document made no further reference to addressing any association between the two.

[4] See for example, 'Ice the drug of violence', *Herald Sun* 16 May 2015; 'Ice and domestic violence: Indigenous community in NSW town of Brewarrina faces two-fold epidemic' SBS; 'Family Violence Increase Linked to Drug Abuse', *The* Courier,22 August2014

Victoria's Action Plan to Address Violence Against Women and Children was released in 2012. While it acknowledges most men who use substances do not use violence against women, it identifies alcohol and drug misuse as a known risk factor for men perpetrating family violence (Department of Human Services 2012). Beyond that, there is limited mention of the co-occurrence, besides acknowledgement of initiatives to make AOD treatment services more family-inclusive and to extend the Family Violence Risk Assessment and Risk Management Framework (commonly referred to as CRAF) into AOD and mental health services.

VAADA believes that better recognition of the relationship between AOD misuse and family violence is needed within overarching policy frameworks and strategies across both the AOD and family violence fields. We also need to build the evidence base about the relationship between drugs and family violence given the bulk of research has focused on alcohol.

Recommendation: Future policy frameworks, strategies and action plans across AOD and family violence fields include greater recognition of the association between family violence and AOD misuse, including actions and priorities to address the co-occurrence

Recommendation: Research be funded to build the evidence base on the relationship between alcohol and other drug misuse, particularly substances other than alcohol, and family violence in the Australian context. The specific needs of diverse communities should be considered including Aboriginal, CALD and LGBTIQ communities and rural and regional differences in experience.

A note on causation

VAADA does not believe that AOD misuse is a cause of family violence, although we acknowledge the association between AOD misuse and family violence and believe it can be contributing factor to family violence.

It is, however, important to recognise and acknowledge that many people consume alcohol and other substances, even at harmful or problematic levels, and do not use violence, while others may cease substance use and continue to use violence and other controlling or coercive behaviours in their relationships.

AOD misuse has been largely rejected by the family violence sector as a 'cause' of family violence on the basis that this would remove accountability from the perpetrator of violence for their actions and behaviour (Braaf 2012). To attribute causality to any single factor is to diminish the complexity of the issue. Factors that are known to increase the risk of a man perpetrating violence include AOD misuse alongside controlling behaviours, threats of violence or previous use of violence against a current or former partner, children or other family members, among others.

Increasingly though, it is acknowledged in both research literature and in our public conversation, that gender inequality and attitudes towards are women are key factors in understanding why men use violence against their female partners. As argued by Braaf (2012) in a paper published by the Australian Domestic & Family Violence Clearinghouse:

> "Among key theories about [the association between alcohol and domestic violence], one that best aligns with our knowledge of relationship violence proposes that where alcohol misuse co-occurs with attitudes and behaviours supportive of violence against women, abuse is more likely to escalate" (Braaf 2012,p.1).

AOD misuse and victims of family violence

Women who have experienced family violence are well represented in AOD treatment settings in Australia, as are men who have experienced family violence or abuse as children (ANCD 2006, p.4). In a comprehensive literature review titled *Breaking the Silence: Addressing Family and domestic violence problems in alcohol and other drug treatment practice in Australia*, the authors detail the evidence on the relationship between people (particularly women) who experience family and domestic violence and problematic AOD use (Nicholas et al 2012). They outline two key issues in this regard:

- A person's own problematic AOD use (they refer in particular to problem drinking) can increase the likelihood of being a victim of family violence and/or compound or perpetuate problems by impairing judgement, increasing financial dependence on an abusive or violent partner; reducing capacity to seek help from police (due to issues such as shame or memory problems); increasing the likelihood they will be blamed or the violence or reducing the likelihood they will be believed; excluding them from vital support services like women's crisis centres and refuges as well as increasing the risk of losing custody of their children (Nicholas et al 2012, p.5)
- Problematic AOD use can be a response to the experience of family violence and the associated stressors. AOD use can be a coping mechanism to help a person experiencing violence deal with physical and emotional pain and trauma associated with the violence

For women in particular, the authors emphasised a complex intra-generational cycle of violence and problematic AOD use which can begin with early childhood abuse (particularly sexual and physical abuse) and perpetuate over a lifetime into adulthood (Nicholas et al 2012,p.6). It appears that the problems of AOD misuse and family violence can involve a reciprocal relationship for women in particular, whereby one problem can increase the risk of the other (Bennett & O'Brien 2007, cited in Nicholas et al 2012).

It is therefore imperative that women attending AOD treatment services are routinely screened for current and past experiences of family violence, as discussed below.

It is also important to note that family violence may be a barrier to seeking treatment for AOD issues for some people (Nicholas et al 2012) however it is not known the extent to which this is an issue.

AOD misuse, family violence and children

Parental AOD misuse can impact on many aspects of a child's life yet it can be challenging to draw out the effects of parental AOD misuse from broader familial, social and economic issues that may impact on the health and wellbeing of children (White et al 2013; VAADA 2012). The hidden nature of AOD misuse and the associated stigma, together with inadequate data collection systems mean the evidence about the number and characteristics of children affected by parental AOD misuse is limited (VAADA 2010). Whilst AOD use alone does not necessarily warrant involvement of Child Protection Services, it may be factor which minimises a parents' capacity to meet a child's physical and emotional needs or compromise a parents' capacity to protect a child from harm (White et al 2013). Problematic AOD use has been identified as a risk factor for neglect and/or emotional or physical abuse (VAADA 2010).

Evidence shows the impact of witnessing family violence can lead to trauma responses in children and the development of significant short and longer-term problems, including increasing the risk that they will develop problematic AOD use in later life (Trocki et al 2003 cited in VAADA 2012; White et al 2013). When AOD misuse and family violence co-occur, the trauma and harm experienced by children may

be further exacerbated. At the extreme end of the scale, the co-occurence of parental AOD misuse, mental health and family violence present as a trio of key risk factors in children's deaths in Victoria (Frederico, Jackson & Dwyer 2014).

The imperative to respond to the needs of vulnerable children has been recognised by Victorian AOD services and strides have been made in recent years to bring children into the 'AOD lens' by making clinical settings and organisations more family inclusive (VAADA 2010).

While AOD and Child Protection services have a shared responsibility and interest in working with vulnerable families and, in particular, vulnerable or at-risk children, the two service systems have been characterized by differences in operating philosophies, approaches to, and methods of, service delivery (DHS 2002, p.1). One major difference between the two systems is who is seen as the primary client. For Child Protection Services, the child is the primary client and any interventions are focused firstly on child safety and wellbeing. AOD services recognise and work within the *Best Interests Framework for vulnerable children and youth*, but the primary client in AOD settings is most often the parent, and thus treatment has traditionally focused on the goals and needs of that individual.

Where a client of an AOD service is a parent who also has involvement of Child Protection Services, there can be a considerable tension for the AOD clinician in balancing a therapeutic relationship and alliance with their client and the need and expectation to share information with Child Protection Services. While the safety and wellbeing of the child must always prevail, the AOD clinician must strike a balance which prioritises safety of children while supporting and engaging the parent in AOD treatment. This balance can be difficult to achieve and maintain. Particularly when the goals or expectations of Child Protection regarding a parent's substance use may not be clearly articulated, or meet with the goals set by the individual themselves in the context of their AOD treatment. AOD service providers have highlighted the need for clear and proactive referrals from Child Protection which clearly articulate the concerns Child Protection has in relation to the parent's AOD use and their expectations of treatment.

While progress has been made in bringing the two sectors together, and in educating workers across both systems about the roles, priorities and limitations of the others' work, some of the challenges remain. Where AOD use, family violence and vulnerable children intersect, the imperative for responses to prioritise safety of children is even more pronounced.

There is a need for further work to be done to reconcile the different organisational and philosophical differences underpinning AOD and Child Protection services and to build on the existing protocol between AOD and Child Protection which VAADA believes has not been reviewed since 2002.

Recommendation: The Existing Protocol between AOD services and Child Protection be updated

Family inclusive practice in AOD services

In consideration of the issues outlined above, the Victorian AOD sector has initiated some particularly successful programs that have focused on both families and children in recent years. There are numerous sites of strong, innovate practice for and with families currently occurring across the state. Family inclusive practice makes sense and contributes to good outcomes for individuals, families and communities (VAADA 2010). However, given limitations in the current funding model for the delivery of AOD treatment, family inclusive practice is often not embedded within and across services and often relies on funding received from other sources and local 'champions' to promote and maintain holistic family focused interventions.

There are many examples of family inclusive practice across AOD services in Victoria. These include the delivery of brief interventions with family members who contact AOD services via telephone or in-person; through to structured programs which deliver education and support to family members in individual and group-based settings; the employment of specialist family counsellors in AOD treatment settings and the delivery of single-session models of family work to assist and support family members who are impacted by a loved one's substance use.

In 2010, VAADA undertook a sector-wide capacity building project focused on building the capacity of AOD services to better respond to the needs of families. The project brought clinicians and workers from AOD, Child Protection and Family Services together in a series of cross-sector workshops. These workshops explored opportunities to improve understanding of the different cultures and operating philosophies of AOD, Child Protection and Family Services and the need for enhanced collaboration between sectors.

A comprehensive family resource was developed by VAADA with support from key stakeholders across AOD and Child Protection, *Familial needs: working with children and families* and was rolled-out to AOD services across Victoria. The resource included the most up-to-date evidence on treatment models for, and approaches to, family inclusive practice, as well as providing practice tips for AOD clinicians and workers in considering the needs of families and vulnerable children. Unfortunately, due to the nature of the episodic project funding, this work was unable to continue and therefore the interest and momentum generated across the life of the two-year project appear to have been lost.

Ongoing delivery of family inclusive programs can be a challenge for AOD services where programs are funded through one-off grants or supplemented through federal as well as state based funding. In September 2014, the Victorian AOD treatment sector was recommissioned with significant changes to how services are delivered across the state of Victoria. In a recent VAADA survey of the impacts of recommissioning on AOD services, some respondents indicated that due to changes in funding and service delivery models, they were no longer able to offer family services previously available. It is of great concern to VAADA that the work that has progressed in recent years to develop and implement family inclusive programs in AOD services may be diminished due to changes associated with recent recommissioning. We urge the Royal Commission to identify and explore opportunities to build on existing models of good practice in this area.

Recommendation: Adequate and ongoing resourcing be made available to allow for the continuation and further development of family inclusive programs within AOD services. This is in recognition that enhanced responses to family violence in AOD services should be embedded within a broader framework of family inclusive practice.

Responding to the needs of diverse communities

VAADA believes many of the issues discussed thus far may be exacerbated for some members of the Victorian community. It is paramount that the specific needs of Aboriginal communities, CALD and LGBTIQ communities as well as young people are examined by the Royal Commission and that the relationship between AOD and family violence for these communities receives attention.

Aboriginal communities

Aboriginal and Torres Strait Islander people are over-represented in AOD treatment, family and domestic violence and child protection data and as such, those presenting to AOD treatment services

may also have current or past experiences of family violence in addition to their presenting AOD concerns.

Addressing AOD misuse, particularly harmful alcohol use, has been recognised by governments as key to reducing family violence in Aboriginal communities. The Victorian Government's Indigenous Family Violence Primary Prevention Framework *Strong Culture, Strong Peoples, Strong Families: Towards a safer future for Indigenous families and communities Ten Year Plan*. The Framework highlights some of the complex nature of the relationship between AOD misuse, violence, trauma and harm within Aboriginal communities:

From an Indigenous perspective, the causes of family violence are located in the history and impacts of white settlement [and] structural violence of race relations since then such as:

- dispossession of land and traditional culture
- breakdown of community kinship systems
- and Indigenous law
- racism and vilification
- economic exclusion and entrenched poverty
- alcohol and other drug abuse
- the effects of institutionalization and child removal policies
- inherited grief and trauma, and
- loss of traditional roles and status (Department of Human Services 2008)

All of these factors are seen as contributing to high levels of distress within the Indigenous community, which is often demonstrated through destructive behaviours such as substance abuse, self-harm and violence (Aboriginal Affairs Victoria & Department of Planning and Community Development 2008, p.12)

VAADA believes there are a range of organisations and individuals who are well placed to respond to the Royal Commission into Family violence in relation to the specific needs of Victorian Aboriginal families and communities. VAADA strongly supports the Commission consulting widely with organisations such as VACCHO and other ACCHOs across the state, and the Victorian Aboriginal Legal Service (VALS) as well local Aboriginal communities to determine the specific and culturally appropriate needs of Aboriginal peoples and communities experiencing family violence.

Recommendation: The Royal Commission ensure appropriate opportunities for the Victorian Aboriginal Community Controlled Health Organisation and ACCHOs, as well as local Aboriginal communities and cooperatives, to provide input into culturally appropriate interventions and strategies to address the association between AOD misuse and family violence in Victorian Aboriginal communities.

Culturally and Linguistically Diverse communities

The relationship between AOD misuse and family violence within Culturally and Linguistically Diverse (CALD) communities is perhaps less well known. The barriers experienced by women in the general population around disclosing family violence and seeking support may be more pronounced for women from CALD backgrounds.

Research has highlighted that some of these particular obstacles to seeking mainstream support for women from CALD backgrounds include language difficulties, cultural beliefs and a fear that mainstream services will not understand their specific needs (FARE 2015). A 2008 PhD study *Alcohol, tobacco and other drug concerns of newly arrived 'CALD' women in Perth*, found:

- Over 21 % of newly arrived women in the study had been put in fear by someone under the influence of alcohol and/or other drugs
- Nearly 17% had been verbally abused by someone under the influence of alcohol and/or other drugs
- Nearly 15% wanted support for husbands or children who were drinking too much alcohol
- More than one third of women responding to the survey indicated they would like information and support on family violence

Consultations undertaken during VAADA's CALD AOD project, a two-year initiative examining the health needs of individuals and families from CALD communities affected by harmful AOD use, sheds some light on this issue.

While not the specific focus of this project, feedback received from a number of frontline practitioners including workers based at a CALD family violence service in Melbourne highlighted that:

- AOD-related family violence is a key concern for many migrant families, though underreported due to a number of factors (including, but not limited to, a lack of awareness of available supports, language barriers and reluctance to disclose for fear of losing their children)
- In collectivist societies leaving a violent relationship is generally not accepted. To do so is to be ostracized, both within the family and community
- Rather than contacting the police for help, women from CALD backgrounds are more likely to approach community leaders (e.g. religious leaders), some who are ill equipped to respond effectively
- Post migration, as women learn of their rights and choices, the nature of their relationship with partners change

Lesbian, Gay, Bi-Sexual, Transgender, Intersex & Queer communities

In recent years, there has been growing recognition that family violence and intimate-partner violence effects lesbian, gay, bi-sexual, intersex and queer (LGBTIQ) communities as well as heterosexual couples and 'traditional' families. While it is important to consider family violence in the context of same-sex relationships, it has been pointed out that bisexual and transgender people may experience family or relationship violence in the context of same-gender or opposite gender relationships (ACON 2004, cited in Chan 2005). Research examining family violence within same-sex relationships and for those who identify as bi-sexual, transgender, intersex and queer, remains limited and the relationship between AOD misuse and family violence in LGBTIQ may not be well understood.

In 2008, Leonard et al published the *Coming Forward* report which found similar rates of violence within same-sex relationships to that of heterosexual relationships (Leonard et al 2008). In particular, the report found:

- Just under one third of LGBT respondents had been in a same-sex relationship where they were subject to abuse by their partner
- 78% per cent of abuse was psychological and over half (58%) involved physical abuse or being hit
- Lesbians were more likely than gay men to report having been in an abusive relationship with 41% of lesbians and 28% of gay men reporting this (Leonard et al 2008, p.4).

In one of the first studies of its kind, the Australian Institute of Criminology (AIC) utilised data from the National Homicide Monitoring Program to examine intimate partner homicide in same-sex

relationships in Australia. They found around 2% of intimate partner homicides involved partners from a same-sex relationship and that these homicides occurred for many of the same reasons as in opposite-sex relationships (Gannoni & Cussen 2014).

Although, the study found AOD use was more commonly identified among same-sex partner homicides (although predominately due to higher rates of drug use). They concluded there is "a need for a more nuanced approach to violence prevention among same-sex attracted persons. While drug and alcohol misuse, mental disorders and intimate partner violence are associated with both forms of intimate partner homicide, the wider literature suggests that sexual stigma, discrimination and marginalization may be associated with an increased risk of such issues among same-sex attracted persons' (Gannoni & Cussen 2014, p.6.)

VAADA believes LGBTIQ communities may experience multiple barriers to identifying family violence and in accessing support services. One of the most commonly identified barriers to reporting family violence is the fear of not being taken seriously by police (and other professions) when identifying family violence (Leonard 2008). Furthermore, the predominant understanding of family violence as being largely gendered impacts on the experiences of people who identify as LGBTIQ when seeking support. There is a need for greater understanding of and sensitivity to the needs of LGBTIQ communities across all services associated with the family violence service system.

VAADA believes there are a range of organisations well placed to further elaborate on the complexity of these issues and identify appropriate strategies and systemic improvements to better support people from LGBTIQ communities who are experiencing family violence where AOD misuse may also be part of the presenting issue. It is also critical that programs for perpetrators of family violence address the specific needs of LGBTIQ communities as well.

Young People

The Royal Commission should specifically consider the experiences and needs of young people. The period of adolescence is a time of transition as young people enter into early adulthood and may be entering higher education or employment. Experiencing family violence during adolescence can have profound impacts on a young person's life including increased risk of developing mental health concerns, problems with AOD use, disengagement from education and employment and the increased risk of becoming violent themselves.

Relationship or dating violence is a particular form of violence that has received increased attention in recent years. The Australian Domestic and Family Violence Clearinghouse state "promoting health and respectful relationships among young people is a key focus of the *National Plan to Reduce Violence against Women and their Children*". They note that young people's understanding of family and relationship violence can be quite limited and they can be confused about causes of family violence, viewing alcohol as one of a number of key causes (Sety 2012). It appears that many young people are not well informed about relationship violence, and may not identify it nor associate it with the broader issue of family violence. Young people may be less likely to engage with family violence support services and age-appropriate support and care for young people experiencing violence is needed.

Furthermore, VAADA recognises that young people may direct violence towards other members of their families, including parents and siblings. This issue should be considered by the Royal Commission as well as examining the complex intersection between young people's use of violence, AOD issues and mental health concerns.

Responding to family violence within AOD services

AOD service providers with whom VAADA consulted in the development of this submission recognised that family violence is likely to feature in the lives of a substantial proportion of people accessing AOD treatment services, particularly women.

However, it is also likely that some men entering AOD services may have used violence in their family and intimate relationships. Approximately two thirds of AOD people seeking support from AOD treatment services are male, thereby providing an opportunity to engage with men who may use violence in their family relationships (White et al 2013).

It is clear that there is an important role for AOD services in responding to both victims and perpetrators of family violence, however it is less clear what the nature of that response should involve. While AOD workers may be well aware of the high prevalence of family violence among their clients, and deal with it every day, there has been limited specific information to guide this work and to develop system-wide responses to the issue.

Any enhanced responses to family violence within AOD services require adequate workforce development, resourcing and capacity building across the AOD sector.

Identifying and screening for family violence

The evidence of the association between AOD misuse and family violence warrants routine screening for the issue for all people seeking support from AOD services.

People seeking treatment and support for AOD services in Victoria are routinely screened at the point of first contact with an Intake & Assessment provider. This process may identify concerns about the welfare of dependent children and these issues alongside broader issues around the use and experiences of violence are covered in greater detail at the point of a comprehensive assessment.

Importantly, the Comprehensive Assessment tool that is used across AOD services includes a section on 'Risk'. Specifically, the clinician undertaking the Assessment is prompted to ask the client about their experience of violence within the last month, including family violence. They are also prompted to explore whether the person has been a victim or perpetrator of violence.

However, acording to AOD service providers, there is variability in the confidence and skill levels of AOD staff in asking questions about violence and exploring the issue of family violence, not only in the assessment setting but in other treatment spaces, particularly in relation to the use or perpetration of violence.

The challenges of having an initial conversation and questioning an individual presenting to an AOD service about possible family violence may be more difficult in circumstances where phone assessment are undertaken. Furthermore, where AOD clinicians may ask these questions and explore the issue of family violence, the individual seeking AOD support may be unlikely to disclose that information in the context of an initial meeting or telephone contact. It may only be once rapport and a relationship has been built that that a person feels able to disclose their experience of family violence, either as a victim or perpetrator.

The Clinicians' Guide for *Adult AOD Screening and Assessment Instrument* (June 2013) reproduces content from the *Department of Human Services Family Violence: Risk Assessment and Risk Management Manual* (often referred to as the common risk assessment framework or CRAF) provides some guidance to AOD clinicians on indicators of family violence in adults and advice on how to initiate a discussion and ask questions about possible family violence. It provides a series of prompting

questions for use with adults and children and includes a flow-chart of response options for mainstream services (such as AOD) in the identification of family violence, including when to refer to Specialist Family Violence Service for full assessment and when to refer to Child Protection.

Where an AOD clinician identifies family violence, or where a client discloses violence, a Family Violence Module is available as part of a suite of Optional Modules that can be completed by AOD services during the Assessment process. Optional Module 10: Family Violence (DHS Identifying Family Violence Recording Template) is available to record the experiences of family violence. However, the module notes that it should only be completed by clinicians who have been trained or feel confident in identifying family violence.

VAADA supports the inclusion of family violence within mainstream AOD assessment documents and believes the information provided in the accompanying Clinician Guide is a useful starting point. However, we believe AOD clinicians need to be better supported through training and workforce development to allow them to carry out this important work. Building confidence and skill among the AOD workforce to identify family violence and know where to refer for specialist assistance is paramount. We understand training on identifying family violence and the application of the CRAF is still available to mainstream services, including AOD services. Promotion of this training may be one useful mechanism to facilitate identification of family violence within AOD services. It is equally important that AOD clinicians are skilled in asking client's about their use of violence in family relationships and in facilitating access to appropriate supports for people who are responsible for perpetrating family violence. This issue is discussed further in the final section of this submission which considers opportunities for enhanced responses to family violence and improved collaboration between AOD and specialist family violence services.

Challenges & opportunities

Women's shelters and refuges are at capacity and, for women who experience an AOD or mental health issue, it can be difficult to find refuge or supported accommodation with these multiple and complex needs and vulnerabilities. VAADA is concerned there is a need for women with AOD issues to have options for accessing crisis accommodation yet at the present time, this appear to be limited. This potentially leaves some of the most vulnerable women without alternative accommodation options when seeking to leave a family violence situation. There is a clear need for Government to invest in accommodation options for women experiencing family violence and this includes safe and appropriate accommodation options for women who are also experiencing problematic AOD use.

Recommendation: Safe and appropriate accommodation options be made available for women experiencing family violence who also experience AOD issues.

One of the barriers to responding to family violence in AOD treatment settings may be a limited understanding of the interconnection between the two issues among AOD clinicians and limited organisational capacity to build workforce understanding and clinical skill in this regard. Moreover, the benefits of treating this co-occurrence have not been well-known or understood. Historically, family violence has not been considered part of 'core business' for the AOD sector in Victoria or Australia, an experience that appears to be true in international settings as well. A recent study from the United States found:

> "Currently, the largest obstacle for health care providers in the reduction of both substance use disorders and intimate partner violence, is the lack of recognition of the interconnected problem and the benefits of the concurrent treatment (Capezza 2015, p.85)

Where the interconnection is increasingly recognised, anecdotal feedback from AOD service providers suggests a lack of confidence among AOD staff in asking direct questions about clients' experiences of family violence, particularly where a person may have used violence in a family context. This points to a need for further opportunities to build skill among the AOD workforce in screening people for family violence; identifying family violence and knowing how to respond to disclosures of family violence.

However, it has been suggested by some AOD service providers that more comprehensive and targeted training and workforce development opportunities be made available to staff in AOD services to assist them with responding to family violence. To this end, a number of useful resources have been developed to assist AOD clinicians to work with family violence within an AOD setting.

In 2012 and 2013, Odyssey House Victoria and Australia's National Research Centre on AOD workforce development (NCETA) published two valuable resources addressing the issue of family violence and AOD misuse. A comprehensive review of the literature was first published *Breaking the silence: Addressing family and domestic violence in alcohol and other drug treatment in Australia* followed by a detailed Clinical Guide in 2013 *Can I ask…?An alcohol and drug clinician's guide to addressing violence family and domestic violence*. VAADA endorses this resource as a key practical guide to enhance responses to family violence in AOD services at both a practitioner and service/organisational level (White et al 2013).

In relation to individual practitioners, the guide proposes a hierarchy of practitioner responses to family violence, from basic level response offered by all AOD workers; enhanced responses by frontline and counselling staff and intensive responses able to be provided by specialist AOD/FDV staff (White et al 2013, p.ix). It provides guidelines for asking questions about family violence; 'tips' and 'traps' in working with clients who have experienced family violence; advice for safety planning and guidance for working with perpetrators (and importantly for avoiding inadvertent collusion).

The guide was launched in 2013 and made available to AOD agencies across Australia. It is not known the extent to which AOD agencies utilised the resources nor is it known how widely these guidelines were implemented within agencies. The project scope did not involve formal roll-out or funding for monitoring or evaluating implementation within AOD services and agencies. VAADA believes these resources could be promoted and better utilised across the AOD sector in Victoria and opportunities to support agencies in applying these and other available resources should be considered.

Recommendation: Opportunities to formalise the roll-out of existing clinical guides and resources such as the *Can I ask…? An alcohol and drug clinician's guide to addressing family and domestic violence* be explored and appropriately funded as well as evaluating their effectiveness in improving responses to family violence in AOD services.

Building capacity within the AOD sector

Training and skills-based workforce development, while important, will not directly translate to enhanced responses to family violence in AOD settings in the longer-term. Training and workforce development needs to be accompanied by organisational capacity building, clinical supervision processes and the embedding of newly acquired skills and knowledge into practice.

VAADA believes a comprehensive whole-of-sector capacity building project for the AOD sector be funded by the Victorian Government and be developed and delivered by representative peak bodies. A comprehensive capacity building exercise would contain a training and workforce development stream which focuses on building AOD workers' capacity to:

- Screen for family violence, identify family violence and conduct appropriate risk assessments, develop safety plans and facilitate access to family violence supports
- Work more effectively with AOD clients presenting with co-occurring AOD and family violence issues. This could include incorporation of techniques and measures aimed at enhancing perpetrator accountability

Any training needs to recognise that the AOD workforce may come into contact with both victims of family violence and perpetrators of family violence. Responding to the needs of these groups are fundamentally different and require different approaches and skill-sets, which should be considered in any training package.

For sustained change, any training and workforce development needs to be embedded within a broader framework and therefore VAADA believes a comprehensive capacity building project would necessarily incorporate measures such as the identification of a statewide steering group drawn from AOD, family violence and other sectors. This group would provide expert input and guide implementation efforts. VAADA believes the identification of project 'champions' who can progress capacity building efforts across AOD services will be necessary to drive and sustain change over the longer-term.

Recommendation: A comprehensive whole-of-sector capacity building project be funded by the Victorian Government and be developed and delivered by representative peak bodies to enhance responses to family violence within AOD services.

Building capacity *across* sectors

The AOD and Family Violence sectors have largely operated in isolation of one another. This has been the result of factors such as resourcing limitations, funding arrangements and service delivery targets (FARE 2015) but also different operating philosophies and frameworks and a lack of understanding of 'the other issue' (Nicolas et al 2012). As noted by VAADA in a 2012 Position Paper 'Governments have invested in prevention and responded to both issues but these responses have been siloed and have not supported strategies such as building the capacity of AOD and family violence workforces, to address the co-occurrence" (VAADA 2012,p.1).

In relation to improved integration and joined-up responses between AOD and Family Violence services, FARE write:

> "The idea that the alcohol and domestic violence sectors should collaborate is a relatively new one. Work is needed to develop best practice strategies and this should commence as a matter of urgency. At a rudimentary level, domestic violence agencies need to communicate that they acknowledge the possibility of co-existing alcohol issues among both victims and perpetrators and take these issues seriously, and vice versa for alcohol treatment agencies. A 'no wrong doors' approach to support services must be provided by both domestic violence and alcohol treatment sectors so that victims are not turned away from services. For example, a woman seeking refuge should not be turned because of problems with alcohol. Instead a formalised process is needed, whereby domestic violence and alcohol treatment services work together to determine the most appropriate support mechanisms for the victim, whether based in the alcohol treatment service or the domestic violence service (FARE 2014, p.4)"

Recent research has suggested that treatment outcomes for both AOD and family violence will be improved if programs addressed both issues at the same time: "By focusing on only one problem at a time, treatment programs may fail to provide clients with all the necessary tools to achieve the best

possible outcomes" (Capezza 2015, p.86). While much of this submission has focused on where capacity could be built within AOD services and agencies to enhance responses to family violence, VAADA believes it is also important that capacity be built within Family Violence services, including Men's Behaviour Change Programs, to enhance responses to people experiencing problems with alcohol and other drugs. One mechanism to support this is cross-sector capacity building and opportunities for working collaboratively to address the co-occurrence.

Addressing the systemic barriers to working jointly on the issue will take time. Yet, there are some initial improvements that could be made to assist clients to achieve better outcomes for both their AOD use and family violence.

For instance, one identified barrier for AOD services in responding to perpetrators of family violence is identifying and navigating appropriate referral pathways into men's support services such as Men's Behaviour Change Programs and a fear of long waiting lists in which men may lose motivation to make changes to their use of violence. At present, VAADA understands that waiting lists for Men's Behaviour Change Programs can be up to six months. It can be particularly difficult to access programs in some regional areas and growth corridors of Melbourne. It has also been noted that capacity for Men's Behaviour Change Programs to accept self-referrals, or referrals from community based organisations such as AOD services, is limited due to the high demand placed on these programs from mandated referrals originating in criminal justice settings.

In a recent paper published by *No to Violence* (the Male Family Violence Prevention Association), the need to tailor Men's Behaviour Change Programs to individual risk and need was noted. The *No to Violence paper* recommended an individualised case planning approach be adopted as part of the minimum specifications of men's behaviour change programs. There is opportunity to develop more individualised responses within the context of men's programs and this could involve greater collaboration between AOD service providers and Men's Behaviour Change Programs where an individual is engaged with both settings, or where one service identifies the need for involvement, or support from, the other.

VAADA understands there are examples where AOD services and Men's Behaviour Change Programs have worked together to bring a greater focus on AOD issues into the context of a Men's Behaviour Change Program, but it is our understanding that this does not occur on a routine basis. VAADA believes there is an opportunity to explore how Men's Behaviour Change Programs could be enhanced to consider AOD issues and assist participants in these programs to understand the relationship between their AOD use and violent behaviour. We also believe opportunities for innovative partnerships between AOD and Men's Behaviour Change Programs need to be explored and appropriately resourced. The specialist skill-set of both sectors needs to be retained yet closer working relationships between the two sectors could provide for more individualised responses to men who attend Men's Behaviour Change programs, and for secondary consultation between the two areas of specialisation and more joined-up responses.

AOD service providers have suggested that referral pathways need to enhanced between the AOD and specialist family violence services, together with opportunities to work more collaboratively to support women experiencing family violence in addition to AOD issues. AOD service providers have highlighted that relationships are often stronger between the two service systems in settings where AOD and family support or family violence workers are co-located, such as in some community health settings.

AOD service providers also highlighted that family violence issues may be more thoroughly considered and sensitively addressed within longer-term AOD residential settings, such as residential rehabilitation services, where a client has time to address their substance use alongside consideration of other issues including mental health concerns and family violence. They may be able to plan for a safe and supported exit from the residential service back into the community and have time to establish linkages to specialist family violence support services.

There may also be benefit in co-locating AOD, mental health and family violence workers in some settings to support women who are experiencing multiple issues. This could include co-location of AOD workers in specialist family violence settings where that might be identified as appropriate.

As an example of a multi-agency response is the RAMP (Risk Assessment Management Panel) project which is being piloted in a number of regions across Victoria where particularly high rates of family violence have been identified. The project brings together Victoria Police, Corrections, Child Protection, women's family violence services, Men's Behaviour Change Programs, Mental Health services, housing, AOD services and others to identify and coordinate interventions for families at high. At the current time, AOD services who are involved in this model report some good outcomes. VAADA understands this model is likely to be expanded to other regions and we look forward an evaluation of the project to provide greater insight into its strengths.

Given the complex and seemingly intractable problem of family violence in Victoria, VAADA believes it requires a whole-of-government and whole-of-community approach. VAADA is of the view that any response must expand the capacity of the community sector, including AOD services, to respond to the issue. Joined-up and collaborative approaches are needed which draw on the specialist skill-sets of workforces across community services to provide a more integrated response to family violence.

There is also a need for improved pathways between the justice system and appropriate community-based services and systems. For instance, linkages to community services, including AOD, could be facilitated through the Family Violence Division of the Melbourne Magistrates Court in recognition that AOD issues may be a concern for both victims and perpetrators of violence. Given we do not know if family violence can be a barrier to accessing treatment for AOD issues; offering linkages to AOD services in this setting could enhance overall access to AOD treatment and support for both victims and perpetrators of violence.

With this in mind, VAADA recommends a cross-sector capacity building project be funded, focusing on capacity-building across a number of community services dealing with family violence. This includes AOD services.

Recommendation: A cross-sector capacity building project be funded to enhance collaboration and cooperation between community services dealing with family violence. This should include, but not necessarily be limited to, AOD services, family violence services and Men's Behaviour Change Programs, Child Protection services and mental health services. It should include:

- **Enhancement of referral pathways between AOD and Family Violence Services, specialist women's services and Men's Behaviour Change Programs and other relevant services**
- **Opportunities and incentives for formal partnerships to be established between services to enhance coordination of responses for both victims and perpetrators of violence**

- **Development and delivery of innovative programs and service delivery models which address the co-occurrence of AOD misuse and family violence and provide opportunities for addressing the co-occurrence in a coordinated way.**

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