SUPPORTING WOMEN WITH COMPLEX NEEDS

The relationship between substance use and domestic and family violence

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womenscouncil.com.au

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

It was a pleasure meeting with Women's Council representatives when visiting Western Australia in August 2009, to discuss the Australian and Canadian responses to the inter-connections among violence, trauma, mental health concerns and substance use problems for women.

We agreed that we have much yet to learn about the links and interactions among experience of violence and trauma, mental health concerns and substance use problems and how we can best respond to women with complex needs. At the local level, our service systems have often been characterized by service fragmentation, compartmentalization, and competing and contradictory service approaches. Women report being turned away from services for having more than one presenting issue, or they hide the complexity of their health issues to receive services in sequential instead of integrated ways. The lack of attention to effects of trauma and woman abuse and their connection to alcohol, tobacco and other drug use and mental illness can lead to misdiagnosis, extended suffering and even retraumatization. The cost is significant for individual women, their families and for service systems. Key international reports have identified opportunities for addressing barriers and for developing an integrated and coordinated service response. Yet we have a way to go towards building a seamless, compassionate, integrated response.

This resource is an important first step in clarifying how service providers can work in collaborative and respectful ways with women who have experienced violence and who have substance use concerns. It identifies how common it is for women to experience both concerns and therefore how critical is it for service providers to assist women to make the links and to determine paced and achievable paths to change, growth and safety. It succinctly outlines how doable an informed and integrated response can be, and gives us all hope in our ability to meaningfully assist women to see improvement in their health as doable as well.

I hope we can keep open our international dialogue on this important work.

Nancy Poole
British Columbia Centre of Excellence for Women's Health
Victoria, BC, Canada

MYTH Alcoholics and drug addicts are nothing like me, my family or friends.

FACT There is no one type of drug or alcohol user, in fact they are extremely diverse and can be well functioning and high profile people.

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BACKGROUND

The Supporting Women with Complex Needs project was developed in response to concerns expressed by Refuge Managers about the increasing numbers of women presenting with substance use issues to Women's Refuges. To address these concerns the Women's Council for Domestic and Family Violence Services, in partnership with the WA Network of Alcohol and other Drug Agencies, applied for funding from the Department for Communities, WA Grants for Women Program and the Alcohol Education Rehabilitation Foundation.

The Supporting Women with Complex Needs Project was developed as a three stage project:

Stage 1 – Roundtable Discussion: The Women's Council held a Roundtable Discussion at Parliament House on 27th March 2009 to discuss the best way to address the increasingly complex needs of clients. The Roundtable Discussion was attended by 30 key stakeholders representing a variety of alcohol and other drug (AOD), domestic and family violence (DFV) and mental health services. Representatives of various minority groups were also in attendance including people representing women with disabilities, culturally and linguistically diverse (CaLD) and Indigenous groups.

Stage 2 – Training Event: Two days of training were hosted by the Women's Council on the 30th and 31st of July 2009. The training was held at the Subiaco Arts Centre and was attended by over 60 people from more than 40 agencies. The training was focused on women experiencing domestic and family violence who also use substances and provided information and practical strategies for workers to improve service provision to this group. The training also acted as a great networking opportunity for workers to meet people from other sectors and develop contacts.

Stage 3 – Resource: This resource is the third and final stage of this project. The aim of this resource is to provide readers with an introduction to supporting women who have experienced domestic and family violence and who are misusing alcohol or other drugs.

This is a basic resource aimed at frontline workers. The Women's Council will continue to work in collaboration with WA Network of Alcohol and Other Drug Agencies to further the work of this project.

MYTH If a drug is legal it can't be harmful.

FACT Legal drugs, such as alcohol, tobacco and prescription medications can be even more dangerous than illicit substances. Indeed, the majority of women who misuse substances, misuse 'legal' drugs.

ABOUT THIS RESOURCE

Many women who experience domestic and family violence have multiple and complex needs including alcohol and other drug concerns, mental health issues, child protection challenges and histories of abuse and trauma (to name just a few). Despite the fact that these issues are inter-related (causing, contributing to or resulting from one another) service responses to address these diverse needs are often fragmented, requiring women to access multiple services to obtain the support they need.

The complexity of client needs can also be demanding and challenging for service providers who specialise, or are funded in, one particular area, as their efforts to support clients with complex needs may be directly related to or dependent upon another service's work with that same client.

Take for example a woman with a long and severe history of domestic and family violence accessing an alcohol or other drug service. The substance use (alcohol and cannabis) started as a means to cope with the violence but the woman is now dependent upon alcohol to function day to day. The woman has sought help from an alcohol and other drug service but is reluctant to engage with domestic violence services as she is scared of her partner and worries that she could not cope on her own if she were to leave.

A trauma informed system of care would support that when addressing the substance use issues, the links with violence and abuse be acknowledged, that she be helped to see these connections, and that services not re-traumatize her. So what does this mean for that AOD service?

- *Should they make support and care of the woman conditional on exiting the violent relationship?*
- *Should they attempt to address the substance use issues while she remains in the violent relationship?*
- *Should they breach confidentiality and report the partner to the Police and Child Protection services?*

Say the woman does decide to exit the violent relationship, she is in fear for her own and her children's safety and seeks accommodation at a Refuge. The Refuge policy is abstinence only. The woman is a dependent drug user, without the support of an AOD service, abstinence is not a realistic option at this time.

What is the woman and Refuge to do?

In the very basic scenario provided above just a few of the complexities in supporting a client with complex needs were illustrated. What if we were to add mental health issues to this scenario, a history of childhood sexual abuse, homelessness or issues with child welfare services?

It is imperative that service providers work together to provide an integrated response to domestic and family violence so that the complexities inherent in many women's experiences of violence can be appropriately identified and addressed with minimal fragmentation and discontinuity and so that women's and children's safety is prioritised.

This resource aims to provide the first step towards a better integrated service response by providing information about co-occurring domestic and family violence and alcohol or other drug misuse and some good practice suggestions for workers in both sectors.

DOMESTIC AND FAMILY VIOLENCE

Domestic and family violence is when someone intentionally uses violence, threats, force or intimidation to control and manipulate a family member, partner or former partner. It is characterised by an imbalance in power whereby the perpetrator uses abusive behaviours and tactics to obtain power and control over the victim. The violence is intentional and systematic, and often increases in frequency and severity the longer the relationship goes on.

(Carrington, & Phillips, 2003; Tually, Faulkner, Culter, & Slatter, 2008).

FAMILY VIOLENCE

Many Indigenous and Culturally and Linguistically Diverse communities prefer the term ‘family violence’ which includes all forms of violence within intimate and family relationships.

This is the preferred term since it is not only partners, wives, or de-factos who are victims of violence and abuse but also mothers, sisters, aunties, children, some men, extended family and community *(Hegarty, Hindmarsh, & Gilles, 2000).*

Domestic and family violence transpires within each and every one of the socio-economic and cultural groups within Australia *(Easteal 1996)*

Types of abuse include:

- **Physical abuse** – any behaviour that is intended to cause harm e.g. pushing, slapping, punching, choking, kicking;
- **Sexual assault/abuse** – forcing someone to participate in any kind of sexual activity that they are not comfortable with or do not want to do. Can also include denying sex;
- **Financial abuse** – taking or limiting money, stealing;
- **Social isolation** – keeping the victim away from friends and family, or other social opportunities (e.g. work);
- **Verbal** – threats, put downs, insults, shouting;
- **Emotional** – mind games, manipulation, humiliation, making the person feel worthless and no good;
- **Spiritual deprivation** – keeping someone away from places of worship, forcing them to participate in spiritual/religious practice that they do not want to be involved with;
- **Property damage** – smashing objects in the home; and
- **Intimidation/stand over tactics** – stalking, following, making the person feel scared.

Other forms of abuse that happen to many women and children include:

- Threatening to harm or actually harming/killing pets;
- Threatening to commit suicide;
- Withholding medical treatment; and
- Driving dangerously with the intent to cause harm or fear.

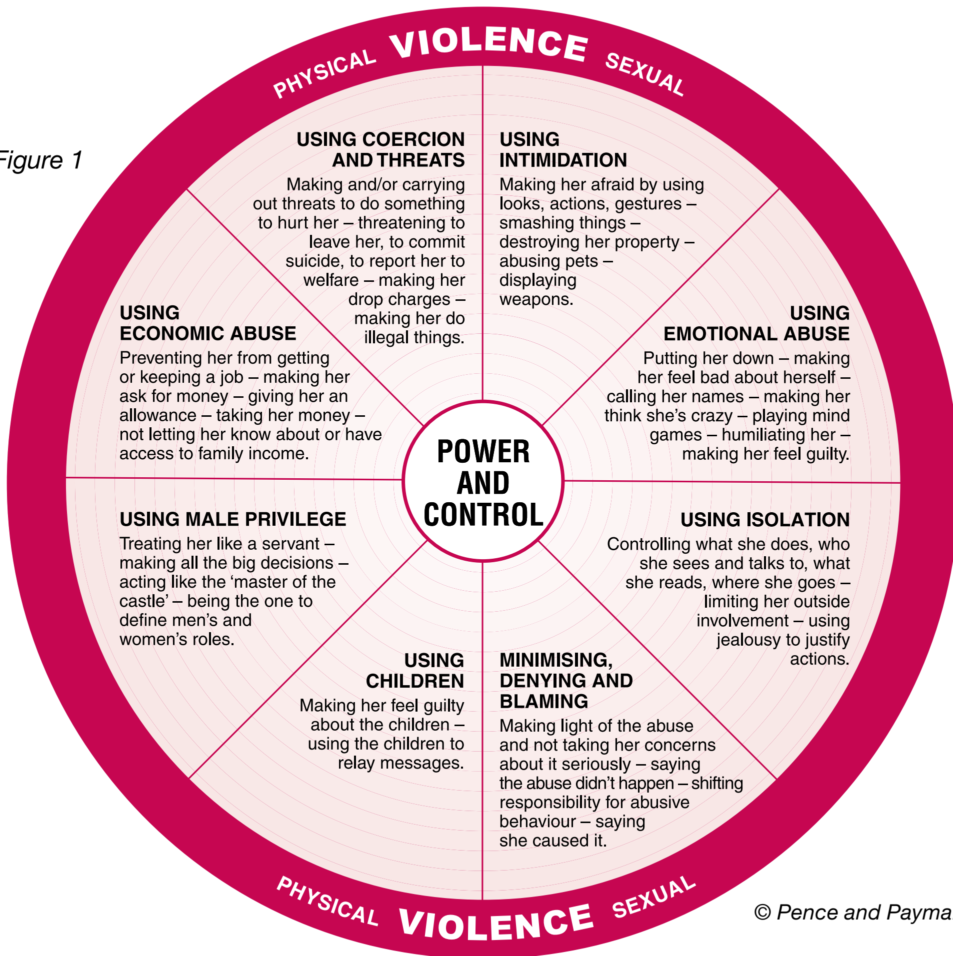
Source: Carrington & Philips, 2003; Tually, et al, 2008.

It is important to note that in most cases more than one form of abuse is used and that the list above is by no means exhaustive – an abusive behaviour is anything that is intended to harm, create fear, belittle or demean.

MYTH Victims who use alcohol or other drugs deserve or provoke violence from their partner.

FACT Victims often use alcohol or other drugs to cope with the physical and emotional pain. No one deserves or asks to be abused.

Figure 1



© Pence and Paymar (1986)

A GENDERED CRIME

Domestic and family violence is a gendered crime. 95% of the victims are female and over 90% of the perpetrators are male. An explanation as to why domestic and family violence is perpetrated mainly by men against women is provided by Pence & Paymar (1986) in their conceptualisation of the 'power and control wheel' *(see Figure 1 above)*. In this model, the spokes of the wheel are represented by different forms of non-physical assault and the rim of the wheel is represented by physical and sexual violence *(Pence & Paymar, 1986)*. The wheel was developed this way to describe how non-physical assault can be used to effectively dominate and control when there is overarching threat of physical or sexual assault *(Pence & Paymar, 1986)*. In doing this, the model enables the element of fear in domestic and family violence to be acknowledged and represented *(Pence & Paymar, 1986)*. This model is extremely effective for helping to explain why domestic and family violence is predominantly a gendered crime. As although there are women who are emotionally and socially abusive towards their partners, their capacity to assault physically and sexually is significantly less and therefore their capacity to control through fear is also significantly less.

PREVALENCE

- One in three women experience physical or sexual violence in their adult life. The majority of this abuse is perpetrated by someone they know *(ABS, 2006; Mouzos & Makkai, 2004)*;
- One in four children witness domestic and family violence in the home *(Indermaur, 2001)*;
- On average, 129 domestic homicides are perpetrated in Australia every year *(Australian Institute of Criminology, 2002)*; and
- 44,600 women and children accessed crisis accommodation (SAAP) in 2006/07 due to domestic and family violence, an additional 1200 people accessed SAAP because of sexual assault and 5,500 for 'interpersonal conflict' *(AIHW, 2008)*. In addition to those who received supported accommodation it is known that roughly one in two women and two out of three children are turned away from crisis accommodation due to a lack of beds.

The United Nations State of the World Population Report (2005) concluded that in Australia domestic and family violence is the single greatest health risk for women.

WOMEN AT INCREASED RISK

Domestic and family violence is an issue that affects women of all social, economic, cultural and religious backgrounds around the world. However, there are risk factors that make some women more vulnerable to the experience of violence than others, these are:

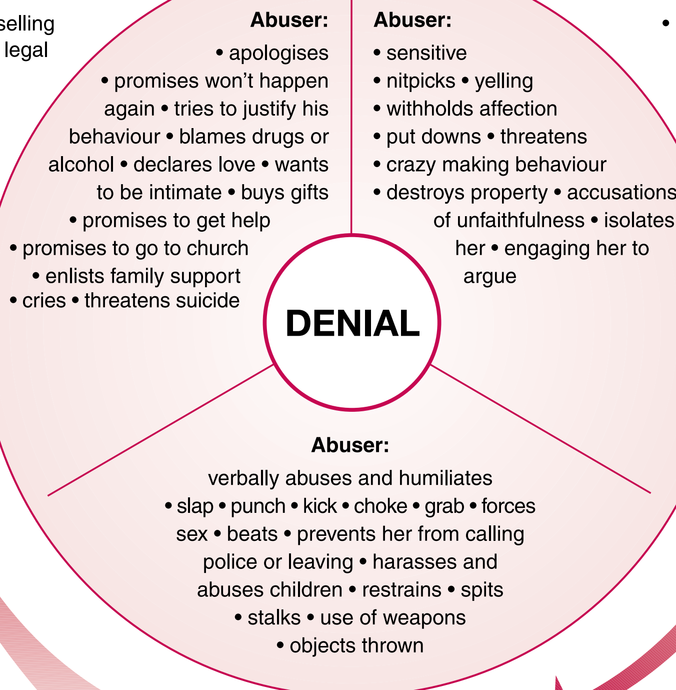
- **Being an Indigenous woman** – Aboriginal and Torres Strait Islander women experience domestic and family violence at rates of up to 45 times higher that non-Indigenous women *(Ferrante, Morgan, Indermaur, & Harding, 1996)*;
- **Age** – young women between the ages of 18-29 are at higher risk of experiencing violence *(Mann, 2007)*;
- **Pregnancy** – pregnancy is often a trigger for violence in the home *(Carrington & Philips, 2003)*; and
- **Isolation** – higher rates of violence are often observed in rural and remote communities *(Carrington & Phillips, 2003).*

CYCLE OF VIOLENCE

In addition to the power and control wheel, the ‘cycle of violence’ is a key model for understanding and explaining DFV. The model was developed by Lenore Walker (1979) who interviewed 1,500 women who had been abused by an intimate partner and found that they all described a similar ‘cycle’ of violence. Using this research Walker developed the model outlined below.

For new couples the relationship usually begins in the ‘honeymoon’ phase. During this time the relationship is ‘okay’ and there is no physical or sexual violence.

Tension Building: The honeymoon phase may only last a short time before everyday life stressors (e.g. bad day at work, pregnancy, job loss, money troubles) contribute to increasing tension in the relationship. It is important to note here that all relationships have periods of tension or disagreement. In healthy relationships, the balance of power between partners



© *Walker (1979)*

means that resolution to disagreements and arguments is amicable and not facilitated by intimidation, threats or fear. In contrast, abusers need for power and control underlies anger and blaming during the tension phase, disputes go unresolved, and the tension continues to escalate. Most survivors describe this time as feeling that they are 'walking on eggshells'.

Standover: Following the tension building phase is 'standover'. During this time the abuser uses tactics to maintain control, such as anger, threats and jealousy. The victim is in fear and is often compliant in an attempt to maintain harmony and prevent violent outburst – this is often ineffective.

Explosion: Following the standover phase is 'explosion' in which there is an incident of physical, sexual, emotional or verbal assault. During this phase the abuser is in total control of his actions, this is NOT an experience of loss of control but rather TAKING CONTROL.

Remorse: During this time abusers often justify their behaviour placing the blame on the victim e.g., "I wouldn't have done it if you hadn't of nagged me" or "if you just had of kept the house tidy I wouldn't of had to get aggro with you". In addition to justifying, abusers also minimise their actions, e.g., "it wasn't that bad, just a little shove" or "you are over-reacting, I didn't hit you that hard". Sometimes perpetrators may also demonstrate guilt during this phase.

Buyback: During the 'buy-back' phase the abuser usually tries to buy-back his partner. This might include gifts, promises that they will change, demonstrations of helplessness e.g., "I can't live without you", and threats (e.g. to harm her, suicide, or take the children).

After buyback the couple return to the honeymoon phase. During this time things might be okay between the couple, there is total denial of abuse, and the couple are mutually dependent and socially isolated from friend and family networks. Eventually however the cycle will move on into build-up phase.

***It is important to note here that the longer the relationship goes on the faster couples move through the cycle leading to more frequent and severe explosions.*

In addition, the cycle rarely stops on it's own without some kind of intervention.

PERPETRATORS OF VIOLENCE

The use of violence to control or exert power in a relationship is a choice. This is evident in the planned and systematic nature of the degradation and abuse that occurs, and that many perpetrators are only violent at home and not in any other aspect of their life. The ability of men who use violence to 'change' and present themselves differently depending on the social context demonstrates that the use of violence is very much in their control.

MYTH Perpetrators lose control when they are drunk.

FACT Often abusers themselves will use this as an excuse however, it fails to explain why perpetrators hit their victims in private and often inflict injuries on parts of their bodies that will be covered by clothes, behaviour that demonstrates that they are very much in control.

ALCOHOL AND OTHER DRUG USE

A drug is any substance (with the exception of food and water) which when taken into the body, alters the body's function either physically and/or psychologically. Drugs may be legal (e.g., alcohol, caffeine and tobacco) or illegal (e.g., cannabis, ecstacy, cocaine and heroin)

(Drug and Alcohol Office, 2005).

Drug use (legal and illegal) becomes problematic when it results in harm to the individual user or to the wider community. The range of harms referred to here might include criminal activity (e.g.,stealing), detriment to physical or psychological health, financial costs or disturbances/disruptions to family and social relationships.

Drug use is most likely to negatively impact on an individual's life as tolerance begins to build and/or the person becomes dependent upon the substance. Tolerance develops with regular use of a drug and usually results in an individual needing more of the drug, more frequently, to achieve the same effects that they did when the drug use first began. Dependence occurs when use of the drug becomes central to a persons life e.g., they struggle to cope or function without the drug.

"When an individual persists in use of alcohol or other drugs despite problems related to use of the substance, substance dependence may be diagnosed. Compulsive and repetitive use may result in tolerance to the effect of the drug and withdrawal symptoms will be experienced when use is stopped" (DSM-IV)

Symptoms/indicators of substance dependence include:

- Constant cravings and preoccupation with obtaining the substance;
- Using more of the substance than necessary to experience intoxicating effects; and
- Experiencing tolerance, withdrawal symptoms and decreased motivation for normal life activities.

WHAT IS WITHDRAWAL?

Withdrawal describes a series of symptoms that may appear when a drug on which a user is physically dependent is stopped or significantly reduced. The withdrawal symptoms vary depending on a range of factors including the drug type and tend to be opposite to the effects produced by the drug *(Drug and Alcohol Office, 2005)*. The body is always trying to maintain a state of balance. When the body has become accustomed to the drug for normal function and use is ceased, the body will try to counterbalance for the change producing withdrawal symptoms.

PREVALENCE OF ALCOHOL AND OTHER DRUG USE

In 2004 84% of the population aged 14 and over had consumed at least one serve of alcohol in the last 12 months *(AIHW, 2005).* Two in every five Australians have used an illicit drug at some point in there lives and one in seven have used illicit drugs in the last twelve months *(AIHW, 2005).*

Only a small proportion of people who experiment with substances become addicted or dependent upon the substance.

MYTH Women who use drugs or drink can stop whenever they please.

FACT Drug and alcohol use is entwined with physical and psychological addiction. Withdrawal may require time and medical supervision. She may feel that using substances is fundamental to survival.

WHY DO PEOPLE USE ALCOHOL AND OTHER DRUGS?

Drugs, including alcohol, illicit and prescription medication, are used by people for a variety of different reasons. They can be used experimentally, socially, or as a part of a functional lifestyle *(Rice, Tsianakas & Quinn, 2007; Yeats, 2008)*. They can also be used 'to cope' or as a form of self medication for mental and general health problems *(Rice, Tsianakas & Quinn, 2007; Yeats, 2008)*.

Alcohol and other substance misuse is a cause of significant harm amongst Indigenous communities and is one of the major health concerns facing Aboriginal and Torres Strait Islander people today. The AOD problems experienced in Indigenous communities must be understood in the context of the ongoing impact of colonisation. The trauma from dispossession and disempowerment that has contributed to alcohol and other drug use must be recognised.

WOMEN AND ALCOHOL AND OTHER DRUG USE

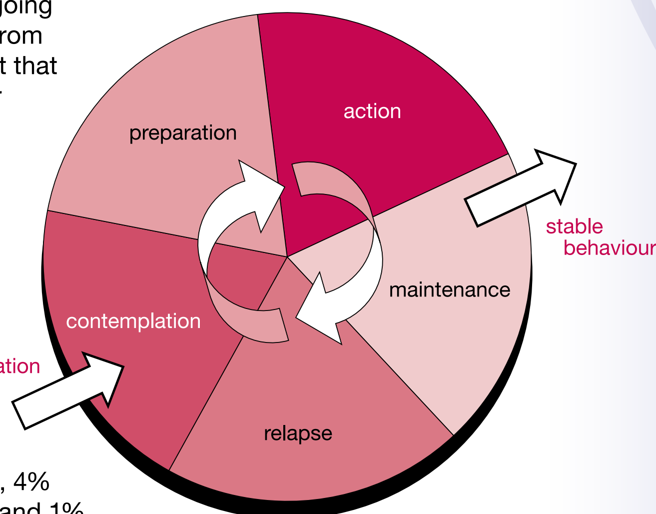
Alcohol abuse is traditionally thought of as a men's health issue. However, alcohol use and binge drinking among girls and women is on the rise. 87% of women report consuming alcohol, 4% of whom do so in a harmful manner and 1% are dependent *(Rice et al, 2007)*. Compared to men the rate of alcohol dependence among women is considerably less.

There are both sex and gender-based differences in substance use. Due to being different physiologically, women experience harms after lower levels of alcohol, tobacco and other drug use, and after shorter length of heavy use. Women are more likely than men to use drugs to improve mood, reduce tension and cope with problems whereas men are more likely to use drugs recreationally. Another difference between men and women is in misuse of prescription medications. Women are much more likely to be prescribed and to experience harms from prescription medications compared to men. Research suggests that this is because prescription drug use is more recognisable, portion controlled and easier to legitimise compared to illicit drugs *(Yeats, 2008)*.

In addition to gender based differences in patterns of substance use there are also differences between Indigenous and non-Indigenous women. Indigenous women are more likely to use alcohol and cannabis whereas non-Indigenous women are more likely to be regular users of drugs other than cannabis *(Johnson, 2004)*.

THE CYCLE OF CHANGE

People move through stages of change when reducing and/or stopping the use of substances. Service providers can be most helpful when they tailor their response to the person's stage of readiness. Resistance to change is not something inherent in the person with the substance use problem, but in the relationship, where the intervention is not tailored to readiness.



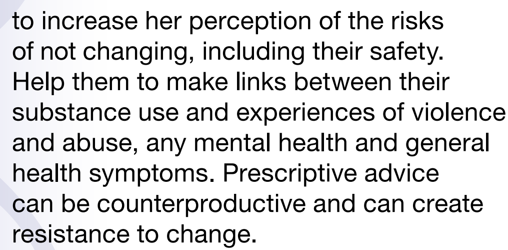
Stages of change model

Characteristics of each stage of the cycle and helpful supports geared to each stage are listed below.

Pre-contemplation

Being unaware of a problem with the perceived benefits of continued substance use outweighing the consequences. Denial and minimising the problem is common with many women in this stage making excuses for their continued substance use. An individual at this stage of the cycle, not considering change, is unlikely to take action.

How to help?
Raise awareness about the problem in a non-judgemental manner and emphasize the possibility of change. Help the woman



to increase her perception of the risks of not changing, including their safety. Help them to make links between their substance use and experiences of violence and abuse, any mental health and general health symptoms. Prescriptive advice can be counterproductive and can create resistance to change.

Contemplation

Substance users may be aware of some negative consequences of their substance use however they are hesitant to change. They are likely to change their mind between considering and rejecting change.

How to help?
Work with the woman to weigh up the pros and cons of addressing her substance use trying to tip the balance towards change. This can be supported by using the woman's language, spending time building a relationship, normalising her indecision and emphasising her freedom to choose whichever option is best for her. Having knowledge about local alcohol and drug agencies and being able to talk personally and positively about the workers can also help to break down some of the barriers to help seeking.

Decision

Women have decided to make change and are looking for ways to change. At this stage, this decision may only last a short time.

How to help?
Acknowledge the significance of the decision. Provide the woman with choices for support and action and help the woman to decide which is most appropriate. If she is scared of accessing services suggest the use of outreach support from an alcohol and other drug service provider.

Action

The woman has and is taking action to change. This stage can be thought of as a therapeutic process however support is necessary to continue along this path.

How to help?
Providing support and encouragement for the changes women are making. Articulate that the process is not easy and she should talk about any issues or concerns as they arise. Review the goals that led to change and let the woman know that relapse is not unusual and will not jeopardise her relationship with you.

Maintenance

The change is maintained on a long term basis. This is often associated with substantial improvements in her quality of life and the learning of new skills to prevent relapse.

How to help?
Helping women to identify strategies to prevent relapse and assist them to make changes in other key life areas as necessary.

Relapse

The woman returns to a pattern of behaviour that she has been trying to change and returns to one of the first three stages. The challenge is to use this stage as an opportunity to grow.

How to help?
Help women to prepare for relapse prior to this stage, and to have strategies for getting back on track when they do. Elicit from them what can be learned from their experience of relapse.

In summary

When working with women with possible substance problems, it is important to listen for her stage of readiness and to elicit her ideas for change, not to impose your take on her situation. Working collaboratively with her, noticing strengths over problems, honouring the many paths to growth and change, are all elements of a women-centred, trauma and substance-informed approach.

MYTH Domestic violence is a private matter between couples.

FACT Domestic violence is not a private issue, it is a crime.

DOMESTIC AND FAMILY VIOLENCE AND SUBSTANCE USE

PREVALENCE OF CO-OCCURRENCE

Golding (1999) in a meta analysis of intimate partner violence and mental health issues found that women experiencing domestic and family violence were almost six times more likely than non-abused women to misuse alcohol (18.5% compared to 4.6%) and were 5.5 times more likely to misuse drugs. Similarly, Keys Young (1998) found that in a study of women who had experienced intimate partner violence many had resorted to substance use to cope with the violence.

Other compounding factors that increase the likelihood that domestic and family violence and alcohol and other drug use will co-occur are witnessing domestic and family violence as a child, childhood sexual abuse and parental alcohol use.

EXPERIENCES OF WA SERVICE PROVIDERS

At the Western Australian Supporting Women with Complex Needs Training domestic and family violence and alcohol and other drug service providers estimated that up to 60% of their clients presented with both alcohol and other drug and domestic violence issues.

THE LINKS BETWEEN SUBSTANCE USE AND DOMESTIC AND FAMILY VIOLENCE

Although it has been repeatedly demonstrated that substance use does not cause family and domestic violence there is an established relationship between the two including that:

- Alcohol and other drug use lowers inhibitions and can escalate the severity of violent incidents;
- Alcohol and other drug use can reduce victims' capacity to recognise warning signs in potentially violent situations and can therefore reduce their ability to escape before a violent situation eventuates;
- Individual and societal beliefs that alcohol causes aggressive behaviour can lead to the use of alcohol as preparation for involvement in violence, or as a way of excusing violent acts;
- Experiencing or witnessing violence can lead to the use of alcohol and other drugs as a way of coping or self-medicating. This coping mechanism can become harmful or result in addiction;
- Victim's alcohol and other drug use can reduce their ability/desire to seek help or to report the crime due to shame, difficulty remembering or recalling events, and fear of being forced to abstain from their alcohol and other drug use;
- Perpetrators of violence might force alcohol or other drugs on their victims to increase their control over them; and
- Victims might be reluctant to separate from their violent partner if their partner is the supplier of their alcohol or other drugs. *(Chan, 2005; Taft, 2003; WHO, 2006).*

ALCOHOL AND OTHER DRUGS AND RISK

The Australian component of the International Violence against Women survey found that in 2003/04 76% of the intimate partner homicides in the Indigenous community and 33% of homicides in the non-Indigenous community occurred when the victim, perpetrator or both were under the influence of alcohol *(Mouzos, 2005)*. Similarly, up to 43% of people presenting to emergency departments in Australia with assault related injuries tested positive for alcohol (WHO report) and up to 49% of police call outs for domestic violence incidents are in cases where the perpetrator is under the influence of alcohol. *(Mann, 2007)*.

BARRIERS TO HELP SEEKING

Many people blame victims of domestic and family violence believing that they must have provoked or caused the assault or are deserving of abuse for not leaving the relationship.

Unfortunately this culture of victim blaming fails to recognise the power and control dynamic of domestic and family violence and the institutional, political, social, cultural and emotional barriers that women who are experiencing violence are faced with when attempting to safely exit abusive relationships.

These barriers include:

- **Fear** – women who live with domestic and family violence fear for their lives and the lives of their children *(Anderson, et al, 2003)*.
- **Power and control** – The power and control dynamic in abusive relationships can lead to learned helplessness and self-doubt in ones ability to cope and live on their own *(Pence & Paymar, 1986)*.
- **Denial** – As a coping or protective mechanism some women minimise or deny the abuse that they are experiencing *(Parkinson, et al, 2004)*. This means that some women may not even recognise that they are in violent and abusive relationships.
- **Shame and embarrassment** – Many women experience intense shame and embarrassment regarding their experience of domestic and family violence. This can be brought on by internalisation of blame, feeling that the abuse reflects a flaw in their character or signifies failure in their role as wife and mother.
- **Self-blame** – is common among women experiencing violence and is often caused by the perpetrator blaming the victim for his behaviour *(Anderson, et al, 2003)* .
- **Lack of exit pathways** – Many women want to leave and try to leave, however, due to a lack of exit pathways they are often forced back into violent relationships *(Anderson, et al, 2003)*.
- **Economic dependence** – Due to financial control, and/or control over whether a woman works or not, victims of domestic and family violence are often economically reliant on their partner *(Anderson, et al, 2003; Parkinson, et al, 2004)*.
- **Low self-esteem** – The emotional abuse including constant criticising, put downs and blame leave many women with very little self-confidence and low self-esteem creating self-doubt as to whether they will be able to cope on their own *(WHO, 2000)*.
- **Post-separation violence** – Almost 90% of survivors experience ongoing abuse and harassment after separation *(Sheehan & Smyth, 2000; Stubbs, & Tolmie 2003)*. This can be extremely frightening and demoralising leaving some to question – what's the point?
- **Family or social pressure** – For some women there is pressure from family, friends or community to return to the partner.
- **Visa implications** – Women who are from overseas who are not permanent residents in Australia may fear that they will be deported if they separate from their partner *(Erez, 2000; Immigrant Women's Speakout Association, 2000)*.

The experience of substance misuse in addition to domestic and family violence adds further complexity and barriers to women's decisions to seek support and/or leave. Some of these additional barriers include:

- Fear of the involvement of statutory authorities such as Police or Child Protection;
- Additional shame and embarrassment related to substance misuse;
- Fear that if they seek help for one issue then the other will be uncovered; and
- Fear that if they leave the violence they will be unable to fund their substance use and unable to access their drug of choice.

GOOD PRACTICE

TRAUMA INFORMED CARE

Trauma informed care is now being proposed as a framework to assist women's services in the provision of care for women who are likely to have histories of violence and abuse. Put simply, this approach refers to working from:

- an understanding of the neurological, biological, psychological and social effects of trauma and violence on the individual; and
- an appreciation for the high prevalence of traumatic experiences in persons who receive alcohol and other drug and mental health services *(Jennings, 2004).*

Trauma informed care advocates that 'treatments' or 'support' provided to clients be done so with an understanding that they may have experienced violence in the past or be victims of violence in their current living/family situation. Trauma informed care does not require disclosure of this experience of violence, and has a central goal of ensuring safety and not retraumatizing *(Huckshorn, Stromberg & LeBel, 2004)*.

This does not mean that service providers must become experts at dealing with or supporting traumatised clients but rather be mindful that the informational resources, case planning/management, safety planning, harm minimisation strategies or referral need to consider the possible relationship between domestic and family violence and substance use *(Huckshorn et al, 2004)*.

Information about safety planning and harm minimisation strategies for women with complex needs are outlined below in addition to information about establishing working partnerships with local service providers in the domestic violence and alcohol or other drug sectors.

SAFETY PLANNING

A focus on safety is critical for service providers working with women experiencing or escaping domestic and family violence. One of the best ways to do this is to assist the woman to establish a safety plan.

When planning for you and/or your children's safety, it is important to think about the following:

During an Incident:

- Practice how to get out safely. What doors, windows, elevators, staircase or fire escapes would you use?
- Keep your purse and car keys ready and in a safe spot so you are always able to leave quickly.
- Tell trusted friends and neighbours. Let them know that you have fears for your safety and ask them to watch out and ring the police if they hear anything. You could set up a code that will tell the neighbours you are in trouble e.g. ring, hanging up, ring again.
- Teach your children how to use the phone to contact police or other emergency services.
- Think about where you can go if you have to leave (at least two places).
- If you suspect you are going to have an argument move to a low risk space. Try to avoid places like the garage, bathroom, kitchens or a room without an outside door.
- Trust your judgement and intuition.

When Preparing to Leave:

- Find yourself a support person who you can talk to.
- Leave money, an extra set of house and car keys and any important documents with someone you trust so you can leave quickly.
- Open your own bank account with a separate postal address and try and save some money.
- If you have no money, you may be able to get a benefit. If you are in a violent relationship and your partner is not supporting you financially or emotionally, then you may be able to apply for a benefit as though you were single. Talk to a Centrelink customer services officer.
- Find out any emergency numbers you may need (doctor, women's refuge etc.) and keep change for phone calls or a phone card on you at all times. If possible get a mobile phone and keep it with you.

- Check with friends/relatives to see who would be able to let you stay with them or lend you money if you need it.
- If it's safe, you could apply for a violence restraining order (see a Women's Refuge or lawyer for advice). Children can also be covered within a VRO.
- Think about ways you can protect pets (contact the RSPCA etc).

This is intended as a guide only Women's Refuge advocates can support you and help you with everything that is listed here. They can still help you while you are living with the violent person.

For further information or support please contact the Women's Domestic Violence Help Line on (08) 9223 1188 or 1800 007 339 (country).

The above was taken from *Fresh Start* a self-help book, produced in Western Australia, for women in abusive relationships and the *Personalised Safety Plan* developed by DVAS Central and the Department for Communities.

For a copy of the *Fresh Start* book contact Pat Giles Centre (08) 9300 0340.

Some additional safety issues to bear in mind for women using substances include:

Safety for women while using substances

- Drug and alcohol use can make it difficult for women to assess the severity of the violence they are experiencing;
- They may be too ashamed or embarrassed about their substance use to access domestic and family violence services;
- Consider how they will implement their safety plan when they have been using substances; and
- How might the client's substance use impact upon her ability to protect herself (e.g., they may be more likely to fight back, receive worse injuries).

Perpetrators alcohol and other drug use

- Helping women identify strategies to keep safe when the perpetrator has been using substances;
- If their partner is withdrawing from substances consider what extra safety and support measures both she and her partner may need to put in place;
- Help negotiate how women and their abusive partners can receive separate and safe support from alcohol and/or other drug services;
- The perpetrator often wants their partner to continue their dependency to substances and may interfere with any treatment provided. This can be used to assist women to contemplate change; and
- If they are considering leaving it may be helpful to talk about how they will access to drugs/alcohol as it is often the perpetrator who facilitates this.

(Adapted from the Stella Project – domestic violence, drugs and alcohol good practice guidelines (2007)).

HARM MINIMISATION STRATEGIES

Similar to the above descriptions about how help women who are experiencing or escaping domestic and family violence be as safe as possible, harm minimisation can be a key approach to improving the safety of women misusing substances.

Harm minimisation strategies are pragmatic and immediate approaches which address the health and wellbeing of the individual, their family and the community.

The following topics/areas may be helpful in establishing the risks associated with the woman's substance use and strategies for reducing harm:

- **Frequency of use**;
- **Children** – where are they when the mother is using substances;
- **Safety of the woman and children during substance use** – might include where the woman is while using substances, who she is with and the safety of the environment e.g., risk of violence, how she gets home;
- **Health** – does she have any physical health problems are impacted by substance use?;
- **Nutrition** – does she and her children have adequate food;
- **Safe drug use** – e.g., clean syringes and mechanism for disposal of injecting equipment; and

- **Finances** – money for basic needs – woman and child.

Examples of harm minimisation strategies that might be suggested or discussed with the client include:

- Encouraging the woman to cut down on her substance use;
- Talking to women about what steps they are/could take to keep their children safe while they are drinking or using drugs;
- Letting them know about their local needle and syringe exchange program and the dangers of sharing injecting equipment;
- Encouraging them to see a medical professional for a general check up and about any health problems they may be experiencing; and
- Discussing the importance of adequate nutrition, and vitamin intake to mitigate the harms associated with substance use.

Collaborative discussion of risks and how harm minimisation strategies are working should be ongoing, and will change depending on the woman's health and successes.

LOCAL PARTNERSHIPS

The best way to ensure effective and collaborative service responses for women experiencing domestic and family violence who are also have substance use problems is to establish close working relationships between domestic violence and alcohol and other drug services.

Close working relationships can be established informally via regular phone calls, morning teas, exchanging service brochures or service information and shared training opportunities. It is important that contact is made regularly to maintain the working relationship and to keep abreast of staff turnover.

The benefits of having a good working knowledge about local alcohol and other drug or domestic violence services are that:

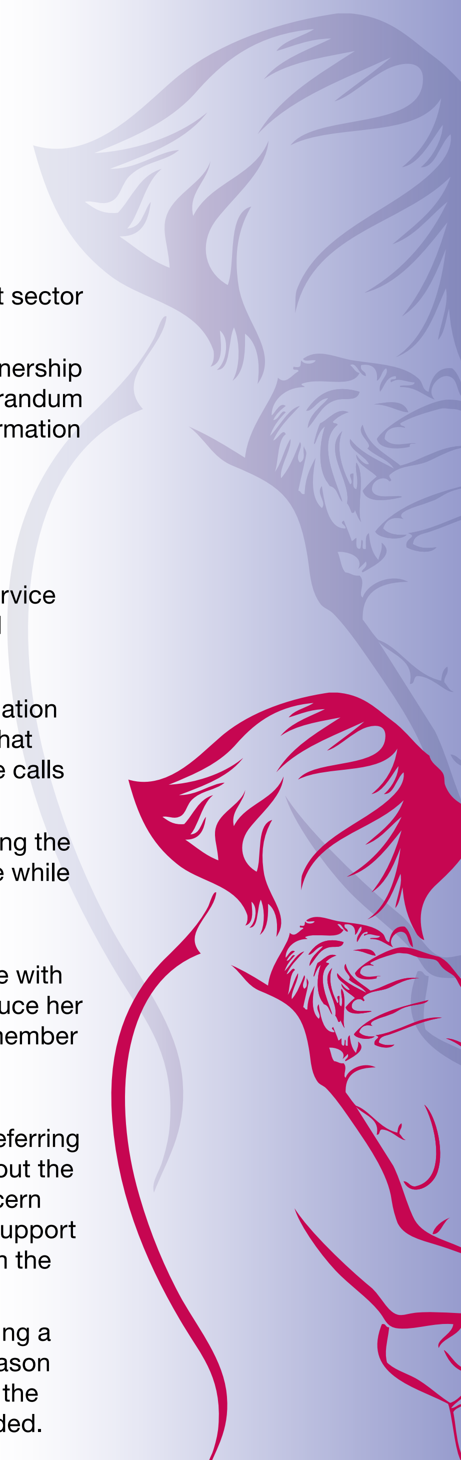
- You can provide a detailed description of the service and staff to clients when discussing referrals;
- You can seek information and advice about handling different issues or concerns;
- It easier to follow up referrals;
- It is easier to keep informed about sector or legislative developments; and
- It could make formalising the partnership easier when establishing a Memorandum of Understanding to facilitate information sharing.

MAKING REFERRALS

Once solid relationships with local service providers are established some good practice tips for making referrals are:

- To provide the woman with information about the service, the staff and what they are likely to ask her when she calls to make an appointment;
- If the client is nervous about making the call allow her to do it in your office while you are there to offer support;
- If the client continues to feel apprehensive offer to walk or drive with her to the local service and introduce her to the counsellor/advocate/staff member who will be seeing her;
- If the client consents (and it is appropriate) offer to provide the referring agency with some information about the woman's presenting issue or concern and some information about the support being provided to the woman from the referring agency; and
- Offer the client the option of seeking a different referral if for whatever reason she doesn't feel comfortable with the first service suggestion you provided.

REMEMBER: Women cannot be forced to accept referrals it has to be their own choice!!



RESOURCES

DOMESTIC AND FAMILY VIOLENCE

Women's Council for Domestic and Family Violence Services (WA)
Provides information about domestic and family violence, new resources, sector developments and support service information.
9420 7264
www.womenscouncil.com.au

HURT Project
HURT is an interactive website that contains video clips of women, children and men describing their experiences of domestic and family violence.
www.hurt.net.au

Domestic and Family Violence Community Education Book
This can be ordered from the Women's Council website. The booklets cost $3.00 each or three for $5.00.
www.womenscouncil.com.au

Same Sex Domestic Abuse Group
www.ssdag.org.au

WESNET
National peak body for domestic and family violence services.
www.wesnet.org.au

Australian Domestic Violence Clearinghouse
A clearinghouse for domestic violence research, resources, good practice and publications.
www.austdvclearinghouse.unsw.edu.au

ALCOHOL AND OTHER DRUGS

WA Network of Alcohol and Other Drug Services
Provides information about alcohol and other drug services, resources and publications and sector developments.
9420 7236
www.wanada.org.au

Directory of WA Alcohol and Other Drug Services
www.wanada.org.au

Needle and Syringe Exchange Program
www.waaids.com/Needle-Syringe-Exchange-Program/

Drug and Alcohol Office WA
www.dao.health.wa.gov.au

Drug Info Clearinghouse
Provides easy to access information about alcohol and other drugs and drug prevention.
www.druginfo.adf.org.au/

National Organisation for Fetal Alcohol Syndrome Related Disorders
www.nofasard.org.au

WA Substance Users Association (WASUA)
www.wasua.com.au

CO-OCCURRENCE OF DOMESTIC AND FAMILY VIOLENCE AND ALCOHOL AND OTHER DRUGS

The following web links provide further information about supporting women who are experiencing or escaping domestic and family violence and are misusing substances.

Freedom From Violence Manual
A comprehensive toolkit for supporting women experiencing domestic and family violence who also misuse substances or have a mental health disorder.
www.endingviolence.org/publications/manuals

BC Women's Hospital and Health Centre
Provides a number of resources about supporting women with complex needs including information about establishing partnerships between services and best practice information.
www.bcwomens.ca Services/HealthServices/WomanAbuseResponse/Resources.htm

The Stella Project
Separate Issues Shared Solutions – provides information and resources about supporting women who have experienced domestic violence, misuse substances and/or have mental health issues.
www.gldvp.org.uk/C2B/document_tree/ViewACategory.asp?CategoryID=73

Linking Research, Practice and Policy
This website offers information sheets and weblinks on key women's substance use issues, including the results of virtual discussions held by representatives of anti-violence and addictions services on how our responses to women with complex needs can be improved.
www.coalescing-vc.org

REFERRALS

IN AN EMERGENCY:

Police 000

Ambulance 000

Crisis Care (24hr) 9223 1111 or 1800 199 008 (country)

Sexual Assault Resource Centre (24hr) 9340 1828 or 1800 199 888 (country)

DOMESTIC AND FAMILY VIOLENCE:

Police 131 444

Women's Council for Domestic and Family Violence Services 9420 7264

Directory of WA Domestic Violence Services
www.womenscouncil.com.au/default.aspx?ContentID=6

Women's Domestic Violence Helpline (24hr) 9223 1188 or 1800 007 339 (country)

Men's Domestic Violence Helpline (24hr) 9223 1199 or 1800 000 599 (country)

ALCOHOL AND OTHER DRUG SERVICES:

Alcohol and Drug Information Service (24hr) 9442 5000 or 1800 198 024 (country)

WA Network of Alcohol and Other Drug Agencies 9420 7236

Directory of WA Community Alcohol and Other Drug Agencies
www.wanada.org.au

OTHER:

Mental Health Emergency Response Line (MHERL) (24hr)
1300 555 788 (metro); 1800 676 822 (country)

Translating and Interpreting (TIS) Service (24hr) 131 450

Women's Information Service 6217 8230 or 1800 199 174 (country)

MYTH Alcohol and other drugs cause domestic violence.

FACT Alcohol or other drug use does not cause domestic and family violence. Lowered inhibitions can lead to an increase in the frequency and severity of assault however men who use violence while drunk or high are also violent when they are not affected by drugs and/or alcohol.

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WOMEN'S COUNCIL

FOR DOMESTIC & FAMILY VIOLENCE SERVICES (WA)

womenscouncil.com.au