Navigating the intersection of domestic and family violence and alcohol and other drug services

Practice considerations for staff

THE UNIVERSITY OF SYDNEY

I recognise and pay respect to the Elders and communities- past, present and emerging- of the lands that I work, live and walk on.

THE UNIVERSITY OF SYDNEY

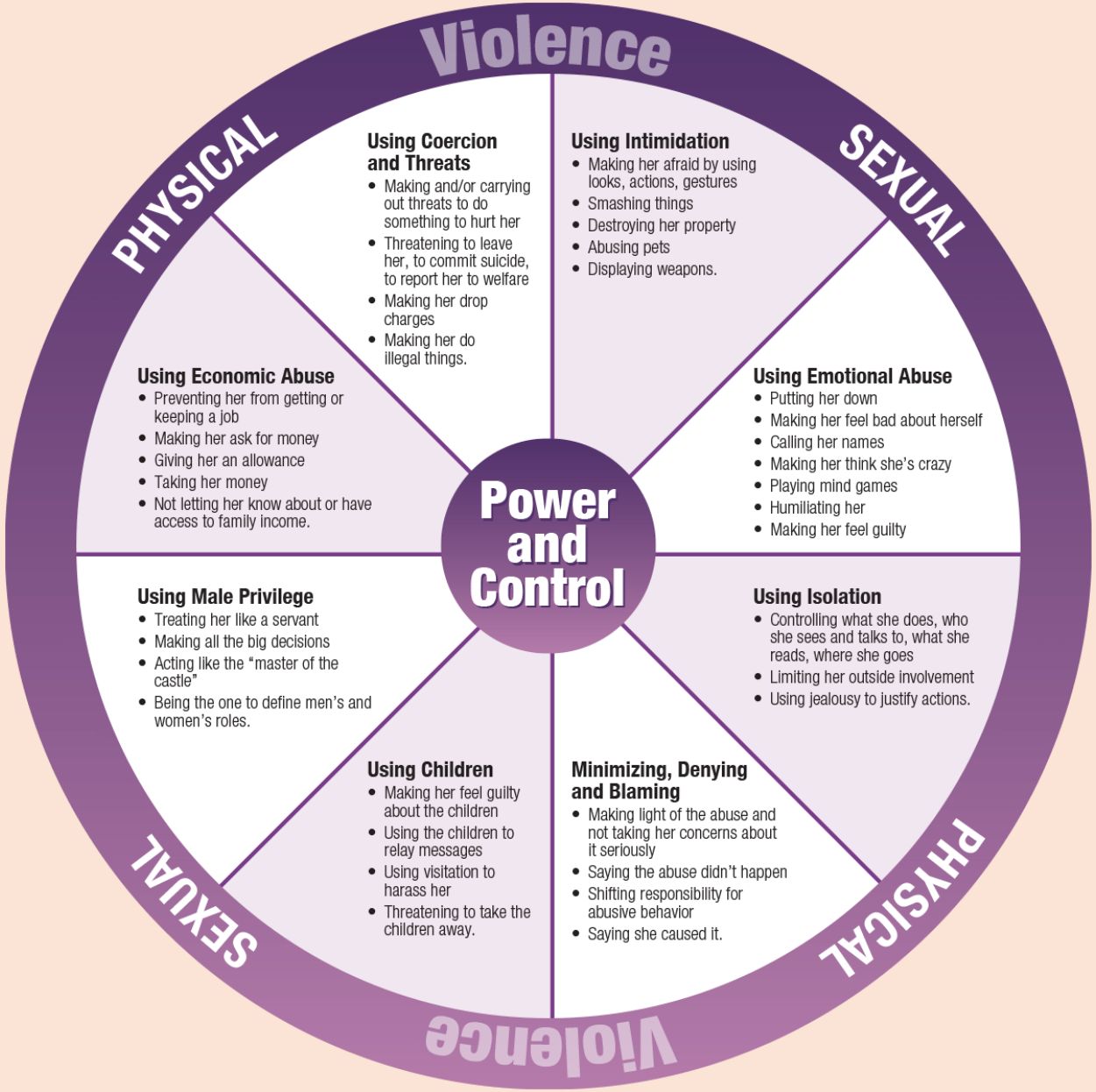
A bit about me

This is the first in a 2-part series

- This session introduces the ideas and explores working with people experiencing violence
- A second webinar will explore working with people who use violence

1. Understanding the intersection

Language and DFV


Violence
PHYSICAL
SEXUAL
PHYSICAL
Violence
SEXUAL
Power and Control
Using Coercion and Threats
• Making and/or carrying out threats to do something to hurt her
• Threatening to leave her, to commit suicide, to report her to welfare
• Making her drop charges
• Making her do illegal things.
Using Intimidation
• Making her afraid by using looks, actions, gestures
• Smashing things
• Destroying her property
• Abusing pets
• Displaying weapons.
Using Economic Abuse
• Preventing her from getting or keeping a job
• Making her ask for money
• Giving her an allowance
• Taking her money
• Not letting her know about or have access to family income.
Using Emotional Abuse
• Putting her down
• Making her feel bad about herself
• Calling her names
• Making her think she's crazy
• Playing mind games
• Humiliating her
• Making her feel guilty
Using Male Privilege
• Treating her like a servant
• Making all the big decisions
• Acting like the "master of the castle"
• Being the one to define men's and women's roles.
Using Isolation
• Controlling what she does, who she sees and talks to, what she reads, where she goes
• Limiting her outside involvement
• Using jealousy to justify actions.
Using Children
• Making her feel guilty about the children
• Using the children to relay messages
• Using visitation to harass her
• Threatening to take the children away.
Minimizing, Denying and Blaming
• Making light of the abuse and not taking her concerns about it seriously
• Saying the abuse didn't happen
• Shifting responsibility for abusive behavior
• Saying she caused it.

The extent of the issue

Intersection with AOD

- Higher prevalence
- Amplification
- Substance use can also be used as part of DFV

AOD as part of violence

The intersection is not always a clear one

Services can disconnect the issues

Staff experiences of violence

2. Navigating the intersection

“Disclosing domestic violence is like having a pap smear on the outside. Women absolutely dread pain. They put their legs apart. They have their most private parts exposed and scraped. And someone looking at them, that's what disclosing domestic violence feels like.

It feels like a pap smear on the outside… it's so embarrassing. It's so shameful, even though it shouldn't be. And when you get those terrible responses, it makes it worse. And then there is the potential for death because of the escalation from the perpetrator because you have told someone… It's really vulnerable position to be in when you do share.”

Routine screening

Initial moment of response is made up of lots of little moments

Validation and belief

Collaboration and support

Advocacy and referral

First

- Acknowledge the trust required to disclose
- Validate the experience without being patronising
- Emphasise belief and your intention of support
- Check what else they want to tell you

Next

- Ask about immediate safety needs and worries
- Explore how they have been keeping safe
- Ask about children
- Be curious about links to health, illness or injury
- Consider cultural needs
- Check what they want to happen now. Offer referral

And then

- Identify what services and formal/informal supports are already engaged or are needed
- Identify how to ensure safe communication with your service
- Refer internally and ensure follow up occurs
- Liaise with your local Violence Abuse and Neglect (VAN) team (during or after the conversation) and NSW Health Child Wellbeing Unit if needed
- Document what women disclose factually, as well as your actions taken. Take care not to disempower or compromise women with your wording
- Discuss next steps with the woman
- Offer available resources if wanted. For DVRS this would be the Z card
- Discuss disclosures with senior clinicians or managers

Identifying risk (understanding safety)

Red flags

Intimate partner sexual violence

History of violence

Non-lethal strangulation (or choking)

Separation

Stalking

Escalation (frequency and/or severity)

Coercive control

Threats to kill

Misuse of drugs or alcohol

Pregnancy and early motherhood

Court orders and parenting proceedings

Victim's self-perception of risk

Perpetrator's access to or use of weapons

Suicide threats and attempts (perpetrator)

Abuse of pets and other animals

Isolation and barriers to help-seeking

If you have serious concerns about a woman's safety, even without red flags, you should seek advice without delay.

Reference: ANROWS (2018). National Risk Assessment Principles for Domestic and Family Violence.
Infographics: Costello, M. & Backhouse, C. (2019a). Avoiding the 3 'M's: Myths, mistakes and misinformation in violence, abuse and neglect statistics and research.

Changing service contexts

“Our relationship with clients has changed. It changed ages ago, but it changed again during COVID, because we started doing stuff on the phone, and we still do stuff on the phone. But then we don't know who else is in the room. We don't know what it is safe to talk about. But also it changed because of a whole lot of other factors. The drugs that we give people to manage withdrawals are different now, people might just come in once a week instead of daily, or they might go to the chemist instead. So when we say ‘case management’, we might actually just be talking about a really brief interaction every three months when they come to see the doctor“

What victim survivors describe

Women want health staff to:

- Understand the dynamics of DFV
- Recognise links between DFV, health and illness
- Focus on building trust and validating experiences
- Use open-ended questions to support agency
- Provide advocacy and support
- Make referrals collaboratively and cautiously
- Follow up
- Document protectively

what a good response looks like:

- Flexible understandings of priorities
- Emphasis on safety and trust
- Validate women's experiences and respect women's choices
- Thinking beyond leaving
- Focus on safety
- Clear expectations of staff
- Recognition of risk factors or 'red flags'
- Clear guidance on when and how to escalate
- Guidance on words to use
- Factual documentation
- Clear follow up plan

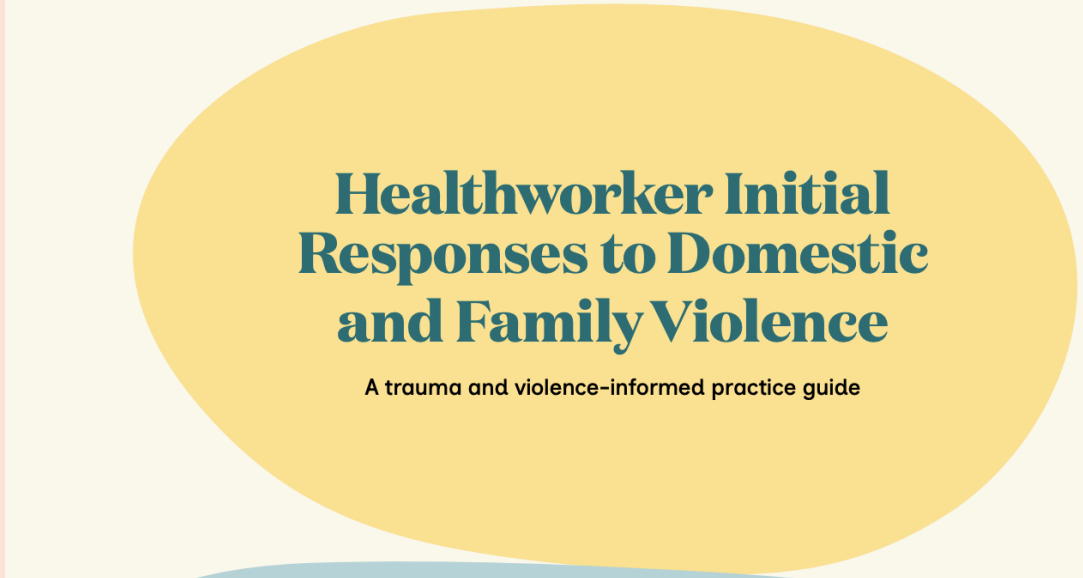
What does it mean to be TI in responding to DFV

“I think we use the words ‘trauma informed’, and I hear that around. But what does that really mean? …A lot of our clients have had trauma their whole lives, you're talking about developmental trauma, attachment trauma, trauma that's playing out in their relationships, it's interwoven with their drug use…We might think about trauma in the context of trying to understand what why people react the way they do. But whose job is it to actually do anything?”

Being trauma *and* *violence* informed

Being trauma and violence informed requires awareness that:	How can you enact this awareness in your initial response to a disclosure?
Violence can take many forms and is often hidden, confusing, and linked to shame.	It is not possible to guess who is experiencing violence, ask without assumption. Some women may not yet recognise their experiences as violence, check understanding and go gently with language. Be shame sensitive. Shame can be reinforced by rushed, invalidating, patronising or thoughtless responses.
Many people have their experiences of trauma and violence disbelieved or invalidated by family, friends, systems and services.	Initial responses can be critical in demonstrating belief, advocacy and support. Be conscious of your body language and the words you use. Identify and validate experiences of violence.
The cycle, pattern and dynamic of domestic and family violence compromises trust and assumptions of safety.	Be transparent and trustworthy. Demonstrate collaborative efforts towards safety. Communicate clearly about any actions.
Violence occurs in a context of misuses of power and control.	You do not need to step in and take control of the situation. Stay conscious of power and work collaboratively on how to deliver your care in ways sensitive to the woman's experience. Whenever possible, women should be informed of any referral or report being made and why.
Disclosing violence is a risk.	Validate the trust taken to disclose. It is important to offer actions within your service context. Check what kind of action the woman wants you to take every step of the way.
Amongst violence there is also strength and acts of resistance.	Ask about what women do every day to keep themselves or their children safer. Do not assume that leaving is the safest option. Build on existing formal and informal resources. Actively recognise and acknowledge strengths.
Violence can intersect with other forms of disadvantage in complex ways. Mental health and substance use can be used against women as part of violence.	Be careful about assumptions regarding the relationship between mental illness, substance use or other psychosocial challenges, and violence. Ask women how they understand it.
Systems and services can become entwined in violence through systems abuse or replication of dynamics of violence.	Collaborate on a plan based on what the woman needs. Be conscious of the dynamics of violence, advocate within your service for awareness, and document protectively.

https://www.health.nsw.gov.au/parvan/domestic-violence/Publications/healthworker-initial-response.pdf



Proudly funded by
NSW GOVERNMENT
THE UNIVERSITY OF SYDNEY

Sophie Isobel
sophie.isobel@sydney.edu.au