SUBMISSION TO THE WOMEN'S SAFETY TASKFORCE

About Us

D&M Consultants have research expertise in alcohol and other drug (AOD) policy and evaluation as well as clinical experience in delivering innovative AOD treatment and working with clients who experience and use family and domestic violence (FDV). Dr Ingrid McGuffog is a psychotherapist and criminologist who has published in peer-reviewed journals and designed and implemented AOD group treatment. As well as being a skilled AOD therapist she has extensive experience as an evaluator and project manager. Amelia De Campo is a social worker with over 10 years of clinical experience in the family law sector operating a supervised contact centre, writing reports for family court proceedings and case-managing complex, high-risk clients with significant backgrounds of FDV. Both Ingrid and Amelia also have lived-experience in addiction and recovery which includes experiencing FDV.

Introduction and Background

The link between family and domestic violence (FDV) and problematic alcohol and other drug (AOD) use has been clearly established in the criminological and public health literature both in Australia and overseas (Hirschel et al., 2010; Klostermann et al., 2010; Meyer et al., 2020; Miller et al., 2016; Thomas et al., 2013; Timko et al., 2012; Vlais et al., 2017). Furthermore, there appears to be agreement across the literature reviewed for this submission that given the well-established correlation between FDV and problematic AOD, there needs to be integrated/combined holistic treatment programs and delivery of services for affected men (Evans, 2020; Meyer et al., 2020; Royal Commission into Family Violence, 2016; Stuart, 2005; Wilson et al., 2014). In this submission we briefly review the available literature on the efficacy of men's behaviour change programs (MBCP) and also the evidence on the few examples of integrated approaches to this complex issue.

Substance use exaggerates pre-existing power imbalances in relationships and hostile sexism in males (Gadd et al., 2019). This is most relevant to intimate partner terrorism (FDV with coercive control) rather than situational couple violence. Research findings support the need for tailored integrated interventions that concurrently address the complex ways that substance use and IPV perpetration intersect (Gadd et al., 2019; Gilchrist et al., 2019; Radcliffe et al., 2019). This submission addresses two discussion questions from the first discussion paper of the Queensland Women's Safety and Justice Taskforce outlined below. We then review the recent literature on the efficacy of MBCPs and follow that with a review of the available evidence on integrated approaches to treating men with co-occurring FDV and AOD issues.

A note on terminology, we use family and domestic violence (FDV) which includes intimate partner violence (IPV). In the USA MBCP's are referred to as batterer intervention programs (BIPs). In this submission we use MBCP's which includes BIPs.

Discussion Questions Addressed in this Submission

This submission addresses two discussion questions from discussion paper 1 'Options for legislating against coercive control and the creation of a standalone domestic violence offence'.

The first question is from the domestic and family violence service systems response section:

> Q9. What could be done to improve the capacity and capability of the service system to respond to coercive control (this includes services to victims and perpetrators)?

The second discussion question we address is from the integrated service response and co-response models section:

> Q16. What are the opportunities to improve integrated responses to victims and/or perpetrators of coercive control to achieve better outcomes?

A Review of the Efficacy Literature on MBCP's

Reviews of research literature to guide best practice requires a systematic evaluation process. The National Health and Medical Research Council (NHMRC) uses levels as a way to quantify the quality of evidence and direct health professionals in what is considered best practice (The Australian Psychological Society, 2018). We adopted this approach when searching for outcome studies of batterer interventions. The highest level of research evidence (I) includes a meta-analysis or a systematic review of level II studies that included a quantitative analysis. Level II evidence includes a study of test accuracy with: an independent, blinded comparison with a valid reference standard (a randomised control trial). Level III evidence includes quasi-experimental or pseudorandomised control trial.

There is limited high quality research available on the effectiveness of MBCP's here in Australia and overseas (Vlais et al., 2017). Stuart (2005) argued over fifteen years ago that 'one of the most important things that we have learned about intimate partner violence in the past 20 years is that violence intervention programs are relatively ineffective' (p.388). We were able to identify two (level I evidence) meta-analytic reviews of the efficacy of MBCPs. Babcock, Green, and Robie (2004) conducted a meta-analysis of 22 batterer intervention studies in which a comparison group was included. They found that the overall effect size for batterer interventions was very small. Another meta-analysis into the efficacy of MBCPs found a positive but non statistically significant effect (Arias et al., 2013). Aria et. al. (2013) concluded that the evidence of the efficacy of MBCPs remains inconclusive. Gadd et al. (2019) contend that at best the evidence is 'mixed'.

Integrated/Combined Approaches to Co-Morbid FDV & AOD Issues

In the Australian context the Royal Commission into Family Violence (2016) argued that: MBCPs 'do not adequately deal with perpetrators who have complex needs' (p281). There is research evidence that supports this assertion. Moreover, there are increasing calls for MBCPs to be better tailored to the individual perpetrator who may experience co-morbid factors such as substance use disorder, trauma and mental health challenges (Aaron & Beaulaurier, 2017; Short et al., 2019). Thomas et al. (2013) examined the intersection of FDV and the misuse of AOD and found that batterers who misuse AOD were not only more violent, they were at higher risk of having trauma and other mental health issues. Indeed, they argue for the need for AOD screening for FDV and FDV screening among AOD abusers.

Integrated Substance Use & FDV Interventions

We identified three RCTs that examined integrated approaches to the treatment of co-occurring AOD issues and FDV.

The first ever randomised clinical trial (RCT) evaluated the efficacy of an integrated substance abuse domestic violence (SADV) group therapy program for 75 alcohol-dependent men with histories of FDV (Easton et al., 2007). The participants were randomly allocated to either the SADV group or a twelve-step facilitation group (TSF). The authors reported two major findings. The first was that the SADV group had significantly more days of abstinence compared with the TSF. Secondly, participants in the SADV group experienced greater reductions in frequency of physical violence from pre- to post-treatment as compared with participants in the TSF. This was the first RCT to evaluate an integrated approach to FDV and AOD misuse and suggested that the SADV group therapy approach is feasible and has promise at reducing both AOD use and violence.

The second RCT (Kraanen et al., 2013) investigated the relative effectiveness of integrated treatment for Substance abuse and Partner violence (I-STOP) compared with CBT substance use treatment as usual plus 1 session of partner violence. Completers in both conditions significantly improved on both substance use and FDV, and after 8 weeks both groups had almost fully abstained from FDV.

The third and most recent study (Chermack et al., 2017) investigated an Integrated Violent Prevention Treatment (IVPT). This was a randomised control trial that included both men (70%) and women (30%) who were in AOD treatment. Violence significantly decreased, and there was a significant decline in alcohol use. Chermack et. al. (2017) concluded that 'IVPT is a promising intervention (feasible, appears to impact drinking, an important factor related to violence) but that additional continuing care approaches may be indicated to sustain positive outcomes' (p.581).

In the only meta-analysis we could find that included studies that integrated AOD and MBCPs, the authors found that integrating substance use & FDV into one intervention was more effective at reducing violence than addressing IPV alone (Karakurt et al., 2019). Karakurt et. al. (2019) concluded that treatment strategies that address highly comorbid issues such as substance abuse and trauma issues may work more effectively in preventing violence.

A key limitation of the current approach to treatment for men who use coercive control is that the impact of adverse childhood events (ACEs) and trauma is not addressed in current MBCPs (Short et al., 2019; Voith et al., 2020). ACEs and trauma both increase the likelihood of developing AOD issues and increase the likelihood of using violence. A holistic approach would address the siloed nature of service provision which results in treatment programs that emphasise the issue that the organisation is funded to address.

Discussion & Recommendations

The evidence reviewed here demonstrates that FDV and problematic AOD use are highly co-morbid and the interplay between the two is complex. This has important implications for treatment interventions as well as in the service system's response to FDV. We contend that it is vital that the comorbidity between FDV and problematic

AOD use become a central feature of screening and assessment in respective specialist FDV and AOD treatment services. Moreover, we believe that there needs to be relevant training for frontline workers in both the MBCP and AOD treatment sectors. Finally, the creation of an integrated and holistic approach to service delivery requires collaboration across sectors and the development of integrated treatment programs.

Our specific recommendations in response to discussion questions 9 and 16 are:

Q9. What could be done to improve the capacity and capability of the service system to respond to coercive control (this includes services to victims and perpetrators)?

Based on this brief review of the published literature it seems clear a number of recommendations can be made that could improve capacity and capability of the service system response. A *key barrier is the siloed nature of service delivery* across these two sectors:

- FDV and AOD frontline workers need training in the co-morbidity and the dynamics between coercive control and problematic AOD.
- Workers in both sectors need a greater understanding about the role of the other, through targeted training and workforce development.
- Collaboration between the sectors needs to be developed – for example through joint symposia, special funding for collaborative projects and the development of integrated education and training.

Q16. What are the opportunities to improve integrated responses to victims and/or perpetrators of coercive control to achieve better outcomes?

We argue in this submission that *FDV treatment needs to be integrated with or delivered in collaboration with AOD treatment services*. The literature demonstrates a clear need for better integration and communication between drug and alcohol services, and MBCP providers.

- Specialist FDV services need to routinely include assessment/screening for problematic AOD use.
- Specialist AOD services need to routinely include assessment/screening for coercive control.
- Integration and communication between drug and alcohol treatment services, and MBCP program providers when delivering treatment.
- Development of trauma-and-violence informed alcohol and drug treatment programs to be delivered in collaboration with specialist FDV services

In order to address these recommendations D&M Consultants are able to undertake the following activities:

- We have the capacity and experience to conduct a more comprehensive review of the existing literature with the purpose of establishing a knowledge base on integrated AOD and MBCPs.
- Develop and test an integrated assessment instrument for respective AOD and FDV services.
- Develop the appropriate evidence-based trainings for frontline workers in the two sectors.

- We have close ties with a specialist FDV service and practitioners and would collaborate to develop an integrated violence and trauma informed treatment program.
- Conduct a demonstration pilot where we implement the integrated program and conduct a program evaluation and follow-up.

D&M Consultants is in a unique position to not only deliver an integrated trauma-and-violence informed AOD treatment service, we also have the capacity to deliver appropriate AOD training to services already delivering men's behaviour change programs.

We would welcome the opportunity to meet with the Taskforce to discuss any proposed recommendations which relate to the contents of this submission. Please do not hesitate to contact us at [ask@dmconsultants.com.au] or by phone on [1300 841 080].

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