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Establishing the Connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse: *Final report*

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Establishing the Connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse: *Final report*

This work is part of the ANROWS Horizons series. ANROWS Horizons (Research reports) are in-depth reports on empirical research produced under ANROWS's Research Program.

This report addresses work covered in ANROWS research project 1.4 "Establishing the Connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse". Please consult the ANROWS website for more information on this project. In addition to this paper, an ANROWS Compass is also available as part of this project.

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Key acronyms and abbreviations

Throughout the body of this report, the following acronyms
and abbreviations are used:

Term	Meaning
ABS	Australian Bureau of Statistics
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
ANROWS	Australia's National Research Organisation for Women's Safety
CASA	Centres Against Sexual Assault
CPTSD	Complex Post Traumatic Stress Disorder
ETC	Establishing the Connection
IVAWS	International Violence Against Women Survey
NASASV	National Association to Services Against Sexual Violence
NDHSH	National Drug Strategy Household Survey
PTSD	Post Traumatic Stress Disorder
SXA	Sexual abuse and/or assault

Executive summary

In December 2014, Australia's National Research Organisation for Women's Safety (ANROWS) commissioned the Australian Institute of Family Studies, in partnership with CASA Forum and UnitingCare ReGen, to undertake the *Establishing the Connection* study.

Purpose of the research

Establishing the Connection was a Victorian-based study to improve understanding of the complex intersections between alcohol and other drug use (AOD) and the severity of, or vulnerability to, sexual violence and revictimisation, and to build the capacity of the sexual assault and AOD sectors to respond more effectively to the needs of affected women and their families.

In order to realise these aims we sought to:

- document existing knowledge (and identify information gaps) on the intersections between sexual assault and alcohol/other drug use/misuse;
- identify and document current assessment and referral processes (and shared approaches) between sexual assault and AOD services across metropolitan and rural/remote locations;
- identify opportunities for greater sector collaboration and enhanced, integrated therapeutic responses to the complexities arising from the intersection of sexual assault and alcohol/other drug use/misuse; and
- build the capacity of individual clinicians and agencies in both sectors to help to minimise the health, social and economic harm to individuals affected by sexual assault and alcohol and other drug co-morbidity.

Findings from the *Establishing the Connection* study informed the development of Practice Guidelines to assist service providers with the identification, assessment, response and referral of individuals and families affected by co-occurring sexual abuse victimisation and substance use issues. The Practice Gudelines are due for release in early 2016.

Research design

The *Establishing the Connection* project comprised four distinct components:

1. A **review of the literature (state of knowledge paper)** regarding the pathways and intersections between AOD use/misuse and sexual assault. Findings from the review demonstrated a consistent association between sexual victimisation and problematic AOD use. Although this association is complex, evidence demonstrates that child and adolescent sexual abuse and adult sexual assault may lead to problematic AOD use for a variety of reasons. The state of knowledge paper by Quadara et al. (2015) is available on the ANROWS website.

2. Semi-structured qualitative **consultation interviews** were conducted during May to August 2015 with 21 practitioners working in the sexual assault and AOD sectors in Victoria. Participants included clinicians, psychologists, counsellor advocates, forensic counsellors, youth workers, nurses, managers and coordinators as well as representatives from the sectors' peak bodies.

3. An **online quantitative survey** of representatives from the sexual assault and AOD sectors was administered during August to September 2015 to augment the qualitative interviews. A total of 94 participants from across the AOD and sexual assault sectors were surveyed. Participants included early career and senior clinicians/practitioners/counsellor advocates, as well as clinical supervisors/managers and individuals in policy and government roles.

4. A **cross-sector consultation forum** for key stakeholders working in the sexual assault and AOD sectors was conducted in September 2015. The forum was attended by sector Chief Executive Officers and executive managers, directors of clinical services, catchment managers, senior clinicians and convenors.

Each component of the research (the literature review, semi-structured interviews, online survey and stakeholder forum) informed the concepts and questions for the subsequent stages, with project recommendations based on findings emerging from all three stages.

Key findings

Key findings from the research are presented in the following thematic groupings:

- interrelationships and shared clients;
- current practices in identification and referral;
- factors that hinder and support collaboration; and
- preferred resources.

Interrelationships and shared clients

Participants from both the AOD and the sexual assault sectors demonstrated a practical understanding of the interrelationship

between drug and alcohol use and sexual victimisation. The overlap between sexual victimisation and alcohol and other drug use was very relevant for AOD and sexual assault counsellors and managers who were aware of the very large numbers of potentially "shared" clients.

Current practices in identification and referral

Current practice in the assessment and intake processes in the AOD and sexual assault sectors varies considerably and reflects both the organisational frameworks that guide practice, as well as the initiative and confidence of individuals in the sectors in referring clients to other services.

The AOD sector in Victoria, having recently undergone extensive restructuring, now has a centralised assessment system using a new suite of alcohol and other drug screening and assessment resources in which eligibility is ascertained and clients are directed to appropriate service locations throughout the sector depending on their service needs.

For the sexual assault sector, victims/survivors usually enquire about support and counselling via telephone first, and are then directed to a service in a convenient geographical location. Some of the service locations may undertake a formal intake process, however this practice is not uniform across the state.

Factors that hinder and support collaboration

In seeking to support the AOD and sexual assault sectors to enhance service delivery to clients who may benefit from both AOD and sexual trauma counselling, the following factors that hinder collaboration were identified:

- insufficient resources;
- uncertainty about how the other sector works;
- lack of communication; and
- role creep, which describes the expansion of demands and activities of a job or role over time that are not balanced by additional resources to support them.

Practitioners and managers alike expressed great interest in expanding their understanding of the other sector through a variety of avenues to build their capacity to engage with and refer clients. Some of the supports to collaboration they identified included:

- shared focus on client-centred care;
- openness to discussion and sharing information;
- previous interagency collaboration; and
- policy and governance support.

Recommendations for resources

Three resources for enhanced service delivery inform our recommendations.

The key resource arising from our research was practice guidelines which will provide information on the intersections between alcohol and other drug use and sexual victimisation, clinical practice information, and contact details for referrals. The information will be arranged in three domains: practice, sector and broader information.

Practice guidelines include:

- how to respond to sexual assault disclosure: minimum response to alleviate role creep;
- risk assessments based on historical or current sexual victimisation; and
- referral and secondary consultation contact details for each sector by region.

Sector guidelines include:

- a brief mapping of the structure of each sector – what services are available (such as one-on-one counselling, group counselling, detox, withdrawal, legal/forensic), client eligibility and potential waiting times;
- funding bodies for each sector; and
- regional mapping of the sectors.

Broader information includes:

- prevalence and patterns of drug use;
- drug effects and information about drug combinations; and
- self care for clinical staff.

Next steps

Next steps may include further collaboration between the AOD and sexual assault sectors on the potential development of cross-sector training and how that may best be operationalised to meet the needs of two sectors who work quite differently, and yet share a client base. There was also strong support for networking in which opportunities for practitioners to build relationships and share information could be formalised, however strong governance structures would be required so that the burden to realise this did not fall on individual practitioners or agencies. The momentum and goodwill built between the AOD and sexual assault sectors as a result of this research can now be harnessed by policy to drive further collaborative interaction through training and networking opportunities.

Introduction

Overview

The relationship between sexual victimisation and adverse outcomes, such as problematic substance use, has been an area of increasing understanding in recent decades, and it is now well established that there is a consistent association between the two. Although this association is complex, evidence demonstrates that child and adolescent sexual abuse and adult sexual assault may lead to problematic alcohol and other drug (AOD) use for a variety of reasons. Further, problematic AOD use may lead to sexual re-victimisation in adulthood as a result of related and contextual individual, interpersonal, community and social factors (Stathopoulos, 2014a).

Despite this enhanced knowledge base, researchers, service providers and policy-makers have struggled to translate this evidence into specific measures for both sectors to adequately meet the therapeutic and service needs of victims/survivors of child sexual abuse and/or adult sexual assault who also have, or have had, substance use problems.

It is within this context that the Australian Institute of Family Studies, in partnership with the CASA Forum (Centres Against Sexual Assault) and AOD service provider UnitingCare ReGen, has been funded by Australia's National Research Organisation for Women's Safety (ANROWS) to improve the understanding of these complex intersections between AOD use and sexual violence and revictimisation through the *Establishing the Connection* study. The study will also help to build the capacity of the sexual assault and AOD sectors to respond more effectively to the needs of affected individuals, their families and communities.

Project scope

Establishing the Connection was a 12-month, qualitative, Victorian-based project. Commencing in early 2015, the study:

- established a partnership with UnitingCare ReGen (alcohol and other drug sector) and CASA Forum (sexual assault sector peak body) to engage and consult on a range of research activities;
- examined the current Australian and international literature demonstrating an interaction and relationship between alcohol and other drug use and sexual victimisation;
- determined how service systems currently operate to respond to and refer clients with co-occurring substance use and sexual victimisation;

- identified gaps in the current service system related to resourcing;
- consulted with sector experts in developing a plan to produce shared guidelines to support interagency referral processes and information sharing (to be delivered in early 2016); and
- provided recommendations and next steps for potential future cross-sectoral engagement.

Findings from *Establishing the Connection* will disseminate practice guidelines to assist service providers with the identification, assessment, response and referral of individuals and families affected by co-occurring sexual abuse victimisation and substance use issues, due for release in early 2016.

Further outcomes include:

- improved understanding of the intersections between sexual assault and alcohol and other drug use/misuse;
- clarity around service provision for both sectors;
- identification of pathways to referral;
- opportunities for identifying training needs; and
- access to any resources, such as guidelines for identification, assessment, responses and referral resulting from the research.

Background

In the last two decades researchers, service providers and policy-makers have endeavoured to understand the relationship between sexual victimisation and a range of adverse outcomes, including problematic substance use. As demonstrated in this review, the available research evidence shows a consistent association between sexual victimisation and problematic alcohol and other drug use. Although this association is complex, evidence demonstrates that child and adolescent sexual abuse and adult sexual assault may lead to problematic AOD use for a variety of reasons. Further, problematic AOD use may lead to sexual revictimisation in adulthood as a result of related and contextual individual, interpersonal, community and social factors (Stathopoulos, 2014a).

However the therapeutic and service needs of victims/survivors of child sexual abuse and/or adult sexual assault who also have, or have had, substance use problems have not always been well served by existing service systems. Often, the alcohol and other drugs sector and the sexual assault sector have not

had the opportunity to become well coordinated, making it difficult for service users with multiple and concurrent needs to access the range of relevant services. Other times, for those presenting at alcohol and other drug treatment services, the impact of trauma may not be fully acknowledged either by themselves or by the service. This can have an impact on both referral pathways and treatment outcomes. At the same time the relationship between sexual victimisation and problematic alcohol and other drug use is complex.

In this context, the Australian Institute of Family Studies, the Forum for Centres Against Sexual Assault and AOD service provider UnitingCare ReGen have partnered to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to the needs of affected people, their families and communities.

An improved understanding of the prevalence of sexual victimisation and substance use in Australia through population-based surveys is the initial step in our journey to a more nuanced understanding of the complex intersections between sexual victimisation and substance use. In examining the prevalence of sexual victimisation we investigate reported child and adolescent sexual abuse, as well as adult sexual assault. We also examine what is known about the prevalence of problematic AOD consumption. Our more specific inquiry relates to the overlapping population of these two groups and a search for any datasets that establish a known prevalence of co-occurring sexual victimisation paired with AOD use. In outlining the prevalence, it is important to acknowledge the broader relational and structural factors that mediate the relationship between sexual victimisation and alcohol and other drug use, which can remain hidden in prevalence statistics. The broader contextual socio-cultural factors also help our understanding of how sexual victimisation is perpetuated.

Prevalence of sexual violence in Australia

One of the foundations for change in the *National Plan to Reduce Violence Against Women and their Children (2010–2022)* (Council of Australian Governments, 2011) is that systems are integrated and information is shared, recognising that sexual abuse and assault against women and children can result in a constellation of complex physical, psychological and social problems. This is a far-reaching problem in the Australian community. Sexual violence is a gendered crime; women make up a very small percentage of all sex offenders (approximately 5%). It is predominately male offenders who perpetrate sexual crimes against women and children (Australia's National Research Organisation for Women's Safety, 2014; Stathopoulos, 2014b) For the purposes of this study, however, a focus is maintained

on the needs of victims/survivors of sexual violence – whether male or female – and their potential need for service provision.

Child sexual abuse[1] can include sexual activity between an adult and a child who has not yet reached the age of consent (approximately 16 years old in Australia[2]), or sexual activity between a child under 18 years with an adult who is in a position of authority such as a faith leader, teacher or swimming coach (Price-Robertson, Bromfield, Vassallo & Scott, 2013). Child sexual abuse can also be defined as non-consensual sexual activity between two minors (Price-Robertson et al., 2013). A range of behaviours constitutes sexual activity ranging from voyeurism to penetration.

A meta-analysis of 331 international studies on child sexual abuse prevalence between 1980 and 2008 which collectively included more than 9.9 million participants found that 18 percent of females and eight percent of males reported a history of child sexual abuse (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). While caution is exercised given differences in definitions and methodologies, these figures are within a similar range to other research.

Recent Australian studies[3] examining prevalence of non-penetrative sexual abuse of children under the age of 16 found rates at:

- 5–16 percent among males; and
- 13–36 percent among females.

The rates for penetrative sexual abuse were estimated at:

- 1–8 percent among males; and
- 4–12 percent among females (Price-Robertson et al., 2013; Table 5).

Adolescent sexual abuse is complex to measure and can be defined and measured under child sexual abuse, sibling or peer sexual abuse or abuse of a person under 18 years by an adult who is an authority figure. The Personal Safety Survey (PSS), a victimisation survey conducted by the Australian Bureau of Statistics (ABS), captures data on sexual abuse in late adolescence because it asks about women's and men's experiences of physical and sexual violence since the age of 15 years. For the most recent iteration of this survey, 13,307 women and 3743 men were surveyed in 2012 (Australian Bureau of Statistics, 2013).

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1   For more information on laws related to and definitions of child sexual abuse, please see: http://www.aic.gov.au/crime_types/in_focus/childabuse.html

2   For a breakdown of age of consent by state and territory, please see: https://www3.aifs.gov.au/cfca/publications/age-consent-laws

3   For more information, please see Table 5 in "Prevalence of child sexual abuse in comprehensive contemporary Australian studies": https://www3.aifs.gov.au/cfca/publications/prevalence-child-abuse-and-neglect

Based on the survey, the ABS (2013) calculated population estimates indicating the following prevalence of sexual victimisation among those aged 18 years and over:

- 17 percent (1,494,000) of all women (one in five) experienced sexual assault since the age of 15; and
- four percent (336,000) of all men (one in 22) experienced sexual assault since the age of 15 years.

The most recent International Violence Against Women Survey (IVAWS) (conducted in 2002/3) (Australian component) working with a sample of 6677 women indicated that 34 percent, or 2283 participants reported having ever experienced sexual violence. A total of 731 women, or 11 percent of the sample had experienced sexual violence[4] in the last 5 years, and 242 women or four percent of the sample had experienced sexual violence in the past 12 months. The survey also found that nine percent of women reported *only* sexual violence, as opposed to physical *and* sexual violence (Mouzos & Makkai, 2004).

Based on prevalence statistics, there is a justified need for therapeutic and counselling services. Police recorded close to 20,000 sexual assault victims in 2013, with women representing the majority of cases (almost two thirds were 19 years or younger) (Australian Bureau of Statistics, 2014). In Victoria, the latest police figures (2013-14) recorded 2177 rape offences – an increase of 3.7 percent from the previous year (Victoria Police, 2014; Section 4.3 Rape) and an overall increase in recorded rape offences in Victoria over the past 5 years.

The second action plan of the National Plan (2013-2016) seeks to support "innovative services and integrated systems" which collaborate in order to bring better services to women who have experienced sexual assault (Australia. Department of Social Services, 2014, p. 29). However, not all victims/survivors of sexual violence will seek out support services or be adequately referred to services that may address their needs. This project supports that goal more broadly by filling a gap in our understanding of how to bridge diverse services to support better health and social outcomes by providing appropriate responses to all those affected by sexual assault or victimisation.

Prevalence of alcohol and other drug use in Australia

Alcohol misuse has become an increasing concern among the Australian population in recent years. The 2010 National Drug Strategy Household Survey (NDSHS) for the Australian Institute of Health and Welfare (AIHW) found that among the women surveyed, 30 percent reported drinking in a pattern that placed them at risk of alcohol-related injury from a single drinking occasion, and 11 percent of women reported drinking alcohol in quantities that put them at risk of incurring an alcohol-related chronic disease or injury over their lifetime. While the more recent 2013 NDSHS (Australian Institute of Health and Welfare, 2015) reported a reduction in overall rates of drinking

for both males and females, the levels of excessive and risky consumption leading to community dysfunction, relationship breakdown and violence had increased and was recognised as requiring further attention from a public health perspective.

Alcohol and other drug use in national-level statistics in Australia is most commonly reported in the context of associated harms, including hospital admissions, injuries and assaults. For example, over 1.7 million participants in the 2013 NDSHS reported physical abuse by an alcohol-affected individual, and 26 percent had experienced harms related to alcohol consumption. In other Australian harms-related research, Laslett et al. (2015) identified a close correlation between alcohol use/misuse and instances of child abuse, domestic violence and sexual violence. Further, a key finding of this study was that a predictor of ongoing alcohol-related harms was past harms from alcohol use.

Harms-related data are less available for illicit and pharmaceutical drug use than for alcohol use; such information is more associated with prevalence rates and crime-related activities linked with illicit drug use. However, in the 2013 NDSHS, 8.5 percent of participants reported being a victim of an illicit drug-related incident. The same study reported an increase in illicit drug-fuelled physical assaults from two percent in 2010 to three percent in 2013. Another issue of increasing concern from a public health perspective is the increase in rates of pharmaceutical drug misuse and associated harms. For example, in 2014, more deaths occurred from pharmaceutical drug use than road accidents (Whitelaw, 2015).

The National Survey of Mental Health and Wellbeing collected information from approximately 8800 Australians aged between 16-85 years to estimate the prevalence of mental health disorders, specifically anxiety, affective and substance abuse disorders (ABS, 2007a). The 12-month prevalence for substance abuse disorders (meaning that individuals met the criteria for a substance use disorder at a point in time) was 5.1 percent or 819,800 people. Broken down into categories, this is expressed as:

- alcohol harmful use – 2.9 percent;
- alcohol dependence – 1.4 percent; and
- drug use disorders – 1.4 percent (ABS, 2007b; Diagram 2).

Harmful alcohol use is defined here as alcohol use that results in psychological or physical harm and dysfunctional behaviour that leads to negative interpersonal consequences or disability (ABS, 2007a). Alcohol dependence relates to a pattern of alcohol use that is a primary priority above all other behaviours for the user. It is usually diagnosed when there is a strong desire to consume alcohol and difficulties in reducing use. Alcohol dependence is also defined as a neglect of other priorities and continued use in the face of negative consequences (ABS, 2007b).

In Victoria, a study on alcohol use and harms across Victorian local government areas between 2000-01 and 2009-10 found the "rates of alcohol-related assaults had increased by over 25 percent" (Matthews, Jayasekara, & Lloyd, 2012, p. 26). From the same study, alcohol-related hospital admissions increased

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4   Sexual violence in this report related to a continuum of unwanted sexual behaviour including unwanted sexual touching, sexual abuse and sexual assault.

by 44 percent between 2003-04 and 2009-10. With increased assaults and hospitalisations, it is perhaps not surprising that within the 10-year period (2000-1 to 2009-10), rates of AOD specialist treatment were also recorded as increasing by 61 percent – with the greatest increase in metropolitan regions (Matthews et al., 2012).

Finally, a challenge for service providers and policy-makers alike is the diversity in definition of problematic and/or harmful AOD use. This is particularly relevant to how service delivery is to be operationalised, especially in the context of dual or co-occurring disorders such as sexual victimisation and associated mental health conditions and problematic AOD use.

Prevalence of co-occurring sexual victimisation and alcohol and other drug use

To better understand where the prevalence of sexual victimisation and substance use intersect, consider a Venn diagram where one circle represents sexual victimisation and the other problematic substance use. The interest is how significant the shared middle section might be. However, data at a nationally representative level are difficult to find. Much of the work produced on this overlapping cohort is based on clinical or treatment populations and other specialised populations such as homeless populations, street-based sex workers and women in custodial settings, which tends to find high rates of overlap between sexual victimisation and substance use, or with convenience samples. It is not clear that this high overlap is present in more representative populations such as national or general community samples.

A recent Australian study examined a number of co-occurring issues, such as sexual victimisation, substance use and mental illness (Rees et al., 2011). Using the nationally representative ABS National Survey of Mental Health and Wellbeing Survey (2007) data, Rees et al. (2011) assessed the presence of both gender-based violence victimisation (measured as physical abuse, sexual abuse, rape and stalking[5]) and mental disorders – including substance use disorders. Over a quarter of women (27.4%) had experienced at least one type of gender-based violence at some point in their lifetime. Of relevance to this review:

- 14.7 percent had experienced sexual assault (in childhood or adulthood);
- 8.1 percent had experienced rape (in childhood or adulthood); and
- 7.8 percent had experienced physical intimate partner violence.

Among women who reported one type of gender-based violence, over 23 percent also reported experiencing a substance use disorder. Where women had experienced more than three types of gender-based violence, 47.1 percent had also experienced a substance use disorder over the lifetime (Rees et al., 2011). The analysis in this study did not separate out the association of each type of gender-based violence with substance use disorders.

5   In this study rape was defined as sexual penetration and sexual assault refers to sexual assault and molestation that was not in the definition provided for rape (p. 514).

Therefore it is unknown what proportion of women who had been sexually victimised also had a substance abuse disorder.

A US nationally representative study that estimated the national prevalence of psychiatric disorders (including substance use disorders) was analysed for the association between child sexual abuse and a range of psychiatric disorders (Molnar, Buka, & Kessler, 2001). The data showed that 13.5 percent of women and 2.5 percent of men reported child sexual abuse. Both women and men who had experienced child sexual abuse reported high rates of substance-related problems. Of relevance to this review, among the women with child sexual abuse histories:

- 52.1 percent reported problems with alcohol, 23.2 percent reported alcohol dependency and 10.6 percent reported severe alcohol dependency; and
- 37.7 percent reported problems with drug use, 18.8 percent reported drug dependency and 13.1 percent reported severe drug dependency.

Smaller, non-representative samples also demonstrate an association between experiences of adult sexual assault and alcohol and other drug use. In a study of 503 victims/survivors of sexual assault, just under half of the sample (44.8%) reported having had a drinking problem in the past year, and a quarter (25.7%) reported having used one of three illicit drugs during that time (Ullman, Townsend, Starzynski, & Long, 2006). Other research demonstrating an association includes research with custodial populations (Abram, Teplin, & McClelland, 2003; Butler & Allnutt, 2003; Forsythe & Adams, 2009; Loxley & Adams, 2009); clinical populations (Boles, Joshi, Grella, & Wellisch, 2005); those experiencing homelessness (Morrison, 2009); and those in the child welfare system (Singh, Thornton, & Tonmyr, 2011).

Strength of the relationship between sexual victimisation and alcohol and other drug use

In addition to research demonstrating the size of the overlap between sexual victimisation and substance use problems, researchers have also sought to demonstrate the strength of that relationship, particularly whether sexual victimisation experiences make having an AOD use problem more likely.

Longitudinal Australian research with over 2,000 high school students found that child sexual abuse was significantly and independently associated with substance abuse at all three data collection points (at ages 13, 14 and 15) (Bergen, Martin, Richardson, Allison, & Roeger, 2004). For girls (age 13) and boys (ages 13-15) who have been sexually abused, the risk of extreme substance use is four times greater than for those who have not been abused.

Forensic medical records of 2688 sexually abused children whose abuse was recorded between 1964 and 1995 were examined and compared to a matched control group of 2677 individuals to determine the rate and risk of clinical and personality disorders (Cutajar, Ogloff & Mullen, 2010). The researchers found child sexual abuse victims had an increased risk for a number of disorders including substance abuse. Compared to the control

group, sexual abuse victims were almost six times more likely (on each item) to have either a known alcohol dependency or known drug dependency. For female victims, this was particularly pronounced: they were almost nine times more likely to have a known alcohol or drug dependency compared to the female controls.

A random sample of British householders was analysed to investigate the association between child sexual abuse, adult sexual assault and a range of psychiatric disorders (Jonas et al., 2011). The final sample for this analysis was 7353. The analysis looked at how much more likely people who had experienced child sexual abuse or adult sexual assault were to have a psychiatric disorder (including alcohol and drug dependence) compared to people who did not have such victimisation experiences. Compared to those without sexual victimisation histories, they found that:

- those who experienced either non-contact or contact forms of child sexual abuse were generally between 1.3 and 1.5 times more likely to have an alcohol or substance abuse disorder, which increased to 3.7 times more likely for alcohol dependence and 5.5 times more likely for drug dependence;
- those who had experienced some form of adult sexual assault (contact or non-contact) were 1.4 times and 1.3 times more likely to have a drug or alcohol dependency respectively, which in terms of non-consensual sexual intercourse, increased to 3 and 2 times for a drug or alcohol dependency respectively; and
- female sexual abuse victims had significantly higher odds of a drug or alcohol dependence than male sexual abuse victims.

Similar trends were documented in a Canadian study on the relationship between five forms of child maltreatment and substance use disorders (Afifi, Henriksen, Asmundson, & Sareen, 2012). For both men and women, physical abuse, emotional abuse and physical neglect were associated with substance use disorders, even after adjusting for socio-economic factors and (non-drug-related) mental health disorders. This relationship was not borne out for male victims of child sexual abuse or emotional neglect: when the analysis adjusted for non-drug-related mental health disorders the relationship between these forms of child maltreatment and drug dependence was no longer significant.

A US study drawing on a nationally representative sample explored how adult sexual victimisation (without a history of child and adolescent sexual abuse) contributed to adverse psychological outcomes including drug abuse. In the representative sample of adults they found 2.5 percent had experienced an adult sexual abuse victimisation at some point, and that psychiatric disorders (including adverse childhood experiences and drug abuse) are both risk factors *and* outcomes of adult sexual victimisation (Xu et al., 2013).

Finally, a New Zealand prospective longitudinal study focused on the developmental antecedents to substance use and dependence of 1265 children and found that substance use from 16–25 years

of age was significantly associated with abuse experiences in childhood (Fergusson, Boden, & Horwood, 2008).

Research with twins offers another way of investigating what role sexual victimisation plays in substance use by victims/survivors. A review of the long-term impacts of child sexual abuse among twins illustrates the co-occurrence of sexual victimisation and negative mental health impacts, including substance use (Miranda, Meyerson, Long, Marx, & Simpson, 2002). For example:

A US exploration of 1411 twin pairs found the strongest effects for poor mental health of the abused twin were substance use and bulimia nervosa (Kendler et al., 2000).

An Australian study of 5995 twin pairs (with 5.9% of the women and 2.5% of the men reporting a child sexual abuse history) found a correlation between child sexual abuse and depression, panic disorders and substance use (Dinwiddie et al., 2000).

An Australian study with 1991 twin pairs found that the twin who had self-reported a history of child sexual abuse had a significantly increased risk for all adverse psychological outcomes tested, including alcohol dependence (Nelson et al., 2002).

These findings on the relationship between child sexual abuse and substance use are supported by meta-analyses of the empirical literature. A synthesis of six review articles published between 1995-2002, which between them reviewed 200 studies on the relationship between child sexual abuse and substance use, indicated a statistically significant[6] relationship between child sexual abuse and substance use disorders (Maniglio, 2011). This finding was consistent for female survivors, although as with the studies above, several reviews did not find that sexual abuse was significantly associated with substance use for male survivors. Maniglio (2011) concluded that a child sexual abuse experience was a statistically significant risk factor for substance use disorders. The reviews as a whole were not able to demonstrate a direct link, suggesting instead that child sexual abuse was associated with a range of adverse mental health outcomes, and that trauma-related symptoms may be connected to substance use. Notably, the research and prevalence studies discussed above have been less able to demonstrate adult sexual assault as an independent risk factor for adult AOD use to the same degree child sexual abuse is a risk factor.

Understanding the relationship between sexual victimisation and alcohol and other drug use

This section considers the relationship between child and adult sexual victimisation and problematic AOD use in greater detail, specifically what factors mediate this relationship (what factors explain how or why there is a relationship between child and adult sexual victimisation and problematic AOD use). The available research literature is a combination of both quantitative empirical studies and qualitative fieldwork with victims/survivors, service users and professionals working in both the sexual assault and AOD sectors. These are complementary

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6   Statistically significant means there is a five percent or less possibility that the finding was result of chance or a random result.

strands of research. Empirical quantitative studies are useful in identifying patterns in the relationship between sexual victimisation and substance use and which of these patterns or pathways appear to be the most prominent. However such research often needs to minimise the effect of broader contextual factors on statistical analyses and so controls for these. As has been noted in violence against women research more generally, the broader context – or social ecology – of victims/survivors' lives and how they experience and make sense of this is vital to having a rich, nuanced understanding of the complex connections between experiences of sexual victimisation and substance use (Breckenridge, Salter, & Shaw, 2012; Chan, 2005; Rose, 2001; Sallmann, 2010). We draw on both sources in the following discussion.

Factors associated with emotion, affect regulation and coping strategies

There is a well-established association between sexual victimisation and a range of negative feeling and cognitive states (Herman, 1992; Whiffen & MacIntosh, 2005). A second strand of research has examined whether victims/survivors use alcohol and other drugs to manage negative emotions and reactions.

Post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) are the key diagnostic constructs used to capture the range of bio-psycho-social impacts of sexual victimisation (Briere & Spinazzola, 2009; Luxenberg, Spinazzola, & Van der Kolk, 2001; Wall & Quadara, 2014). Research has attempted to establish PTSD as a significant mediator[7] in the relationship between sexual victimisation and problematic AOD use. For example, research with 386 women in a jail diversion program found that sexual abuse was strongly associated with PTSD which in turn was associated with both heavy drug use and heavy drinking (Cusack, Herring, & Steadman, 2013). Other research with women in custody who had child sexual abuse histories found that trauma symptoms predicted the severity of substance use (Asberg & Renk, 2012). In research with 212 Aboriginal people living in Western Australia, there were strong associations between experiencing a traumatic event (97.3%), meeting diagnostic criteria for PTSD (55.2%) and meeting the diagnostic criteria for alcohol abuse (91% of those with PTSD also had alcohol abuse problems) (Nadew, 2012). Research with injecting drug users tested the relationship between child sexual abuse, PTSD/depression and injecting drug use (Plotzker, Metzger, & Holmes, 2007). More than half (56%) of the sample had experienced child sexual abuse, which was statistically associated with their injecting drug use. However when the analysis was adjusted for PTSD/depression, the relationship between sexual abuse and risk behaviours regarding injecting drug use and sexual activity (such as unprotected sex) was no longer significant; PTSD/depression mediated or explained the relationship between sexual abuse and risk behaviours.

Researchers in the child maltreatment field have also posited PTSD as one pathway that is connected to problem substance use (rather than the abuse per se)[8] (Hovdestad, Tonmyr, Wekerle, & Thornton, 2011).

Other researchers have sought to understand what other factors may be associated in the relationship between sexual victimisation, PTSD and substance misuse. In research with over 500 victims/survivors, Ullman et al. (2006) found that compared to victims/survivors who only experienced PTSD, victims with PTSD and substance use (either illicit drugs or alcohol) were generally younger and had a greater number of traumatic events. The analysis showed that victims using only alcohol or illicit substance had variations in measures in severity of victimisation experiences, self-blame, negative social reactions from others and avoidance coping. In comparison, victims using both alcohol and illicit substances were more likely to be low educated, unemployed, have low income and/or be heterosexual.

They scored highly on measures of number of traumatic events, severity of child and adult sexual victimisation, revictimisation risk during the follow-up period, and current depression and PTSD symptoms. They also had the highest scores on self-blame, negative social reactions from others, avoidance coping, and tension reduction motives and higher scores on substance use to cope. Thus disadvantaged socio-economic status and other related factors such as housing instability and poorer physical health may also have a role to play in the pathways between sexual victimisation and substance misuse.

Other studies have explored victims/survivors' motives for drinking or substance use. Some research shows that while victims/survivors may drink to cope with negative emotions (predicated by the distress coping model), they may also do so to enhance positive emotions (the emotion regulation mode) (Grayson & Nolen-Hoeksema, 2005).

Broadly this research is seen as supporting the "self-medication" theories, in which individuals use alcohol and other drugs to "dampen" or turn the dial down on the intense feelings of distress, anger, fear and anxiety associated with traumatic experiences (Darke, 2013; Miranda et al., 2002). However the phrase "self-medication" must be used with caution as it risks seeing the functional role of substance misuse as a deficiency on the part of survivors rather than a coping strategy that enables survival (Breckenridge et al., 2012), or of assuming the functional role is the same for all survivors. Qualitative research with survivors of sexual victimisation demonstrates that although there are common reasons for using alcohol and other drugs, such as numbing and managing emotions, the context of their daily lives helps to further understand the relationship between sexual victimisation and substance misuse. For example, substances may be used to manage nightmares and sleep patterns (Breckenridge et al., 2012), to keep memories and flashbacks at bay in chronically unsafe or unstable situations (Padgett,

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7   In statistical analysis a mediator is a variable (in this case PTSD) that describes how things are connected.

8   Although as noted earlier, child sexual abuse is particularly associated with both PTSD and substance misuse.

Hawkins, Abrams, & Davis, 2006), or to minimise trigger and startle responses that can make victims feel the world is unpredictable.

Vulnerability, substance use and victimisation

Another strand of enquiry has examined the relationship between problematic alcohol and substance use and vulnerability to sexual victimisation. The majority of this research has looked at the reciprocal relationships between victimisation, revictimisation and substance misuse (Gidycz et al., 2007; Littleton & Ullman, 2013; Messman-Moore, Ward, & Zerubavel, 2013; Ullman & Najdowski, 2009; Walsh et al., 2013; Walsh et al., 2014). This research can inform clinical practice to address self-blame by victims, assisting practitoners and clinicians to identify the physiological symptoms of PTSD for victims which may counteract victims' beliefs that they put themselves at risk of sexual assault.

Recent reviews of the research on sexual revictimisation reported that individuals who had experienced sexual abuse in childhood were two to three times more likely to experience subsequent sexual victimisation in adolescence or adulthood (Classen, Palesh, & Aggarwal, 2005; Stathopoulos, 2014a). Factors associated with this included the intersections between the impacts of victimisation and substance misuse. In research with 489 survivors of sexual violence, Littleton and Ullman (2013) tested pathways between both PTSD and hazardous drinking and subsequent sexual victimisation. Specifically, the researchers hypothesised that hazardous drinking would be associated with incapacitated rape due to alcohol consumption, whereas PTSD would be associated with both forcible rape (rape that involves the use of physical force or restraint) and incapacitated rape. Overall, the study found support for these hypotheses. The researchers suggested that PTSD may have been associated with both types of rape due to the numbing symptoms, which could impact "risk detection" (Littleton & Ullman, 2013, p. 351) or be associated with drinking as a coping strategy. Hazardous drinking may have been associated only with incapacitated rape due to the situational contexts in which such consumption occurred, the physiological effects of alcohol on verbal and physical resistance strategies and to the social attitudes that suggest women who consume alcohol are legitimate targets of sexual violence.

Filipas (2007) surveyed a sample of sexual assault survivors to research how alcohol use and PTSD were associated with subsequent sexual victimisation. Surveys were undertaken at two points. The initial survey was completed with 1084 victims/survivors and 625 of these participants completed a survey one year later. Multiple sexual victimisation experiences (in childhood and adulthood) predicted PTSD symptoms, and this usually came prior to problematic drinking. This study found two pathways: the numbing symptoms of PTSD directly predicted revictimisation, and other symptoms associated with PTSD such as intrusive memories (such as recurrent memories of the abuse, flashbacks and triggering) and hyper-arousal (such as hyper-vigilance, irritability and being easily startled) predicted alcohol abuse, which in turn predicted revictimisation. The

conclusion of this research was that numbing symptoms and alcohol abuse may be independent indicators of a dissociative response that impairs sexual assault survivors' ability to detect risk in their environment, increasing their vulnerability for further victimisation (Quadar a, 2008; p. 620).

Other research has examined the connections between revictimisation, problem substance use and sexual behaviour that increases the risk of further victimisation for populations that are, through circumstances, exposed to higher risks of victimisation such as sex workers, young people in institutional care and homeless women (Parkhill, Norris, & Davis, 2014). However, as noted by Quadara (2008), the associations between these factors are complex. Research indicated that sex workers who are regular or dependent drug users who trade sexual services for drugs rather than money are likely to experience increased levels of violence. This can be interpreted as drug use and its effects leading to a sex worker's decreased ability to assess risk. However a different interpretation, often suggested by sex work organsations, proposes that the economic difficulties associated with securing drugs may play a role. For example if the drug market shifts in relation to price, availability or even policing, individuals may be forced to change their purchasing practices which may involve sex workers agreeing to high risk practices such as allowing a client to take them to an isolated location, agreeing to sex without a condom or agreeing to see a client who is known as violent or dangerous.

Further, much research on revictimisation and problem AOD use focuses on individual and interpersonal level factors associated with the victim while ignoring the strategies used by perpetrators of sexual violence, and more broadly the cultural contributors to revictimisation (Stathopoulos, 2014a). For example, perpetrators of sexual abuse and sexual assault can deliberately target individuals with substance use problems both because of their increased vulnerability and because they may assume the victim will not report to police or will not be believed (Clark & Quadara, 2010). Similarly, while the Australian community as a whole has a reasonable understanding of violence against women and does not endorse attitudes that support violence against women, there are still areas of concern.

Myths that persist about sexual violence include that rape is sometimes the result of men's uncontrollable sexual urges and needs, and that if a woman is raped while intoxicated she bears some of the responsibility for that rape (VicHealth, 2015). This can result in attitudes such as "she asked for it" and a reduced accountability for the perpetrator, as well as provide cultural support for the perpetuation of sexual abuse and assault.

Conclusion

Pathways between substance misuse and sexual vicitmisation appear to be increasingly supported by the available national and international research through the constructs of PTSD, emotional deregulation and coping strategies. Evidence supports the reciprocal relationship between revicitimisation and managing the effects of trauma through substance misuse, increasing the likelihood of subsequent victimisation.

While prevention efforts in the sexual assault sector seek to remedy attitudes and behaviours to alleviate the targeting of vulnerable women in particular, therapeutic service providers in the sexual assault and AOD sectors can work together to alleviate the risks and traumas associated with victimisation and addiction. While there are some limitations in the available literature, there is nevertheless a growing consensus that both sectors share a significant number of clients.

The *Establishing the Connection* study sought to gain an improved understanding of current responses and practices in the sexual assault and AOD sectors and to identify possible barriers and enablers to interagency collaboration to inform effective, integrated service delivery for those affected. The research design and methodology is presented in the next section.

Research design and methodology

Purpose of the research

Establishing the Connection brings together two sectors that support and treat overlapping vulnerabilities in client populations to develop guidance and build capacity for establishing a mutually beneficial understanding of the work of both, and the potential for enhanced collaboration.

Establishing the Connection aims to:

- document existing knowledge (and identify information gaps) on the intersections between sexual assault and alcohol and other drug use/misuse;
- identify and document current assessment and referral processes (and shared approaches) between sexual assault and AOD services across metropolitan and rural/remote locations;
- identify opportunities for greater sector collaboration and enhanced, integrated therapeutic responses to the complexities arising from the intersection of sexual assault and alcohol/other drug use/misuse; and
- build the capacity of individual clinicians and agencies in both sectors to help to minimise the health, social and economic harm to women and families affected by sexual assault and alcohol/other drug co-morbidity.

In order to realise these aims, three main research questions guide the study:

1. What is the association between alcohol and other drug use and the severity of, or vulnerability to, sexual violence and revictimisation among women?

2. What assessment and referral pathways (both formal and informal) currently exist in the sexual assault and AOD sectors that support an enhanced response for women with a sexual abuse victimisation and alcohol and/other drug co-morbidity?

3. How do we build the capacity of both sectors to respond more effectively to the complex intersections between sexual abuse victimisation and alcohol/other drug use, and in turn, improve health outcomes for affected individuals and their families? What are the barriers and facilitators of enhanced communication and cooperation between clinicians, agencies and sectors?

Findings from this research will inform a shared understanding between the sectors and the development of practice guidelines that may guide practice towards the identification, assessment, response and referral of sexual assault victims/survivors toward AOD services, and AOD clients toward sexual assault services.

Research methods

This project used an inductive, mixed-method approach to explore the experiences of clinicians in the sexual assault and AOD sectors. We sought to understand the supports and barriers for collaboration between the two sectors in identifying and referring shared clients. We used a combination of semi-structured interviews, an online survey and a key stakeholder forum to explore the research questions. Each of the methods is described in greater detail below. The use of a mixed-method approach allowed triangulation of the data to explore the same research questions through a number of methods which enhanced the rigour of the data.

The *Establishing the Connection* study had four distinct components:

1. a **review of the literature (state of knowledge paper)** on the pathways and intersections between AOD use/misuse and sexual assault;

2. **semi-structured interviews** with practitioners and clinicans from the sexual assault and AOD sectors;

3. an **online quantitative survey** of representatives from the sexual assault and AOD sectors; and

4. a **cross-sector consultation forum** for key stakeholders working in the sexual assault and AOD sectors.

State of knowledge paper

The state of knowledge paper by Quadara et al. (2015) set out the current evidence base on the relationship between AOD use and sexual victimisation and considered implications for service need and provision. The review examined:

- the prevalence of sexual violence and AOD use in Australia;
- the association between AOD use and severity of, or vulnerability to, sexual violence and revictimisation;
- correlations between child sexual abuse and subsequent AOD use/misuse, and adult sexual abuse and subsequent AOD use/misuse; and
- current practice around identification, assessment, response and referral pathways between agencies related to public health – specifically AOD and sexual assault services.

Findings from the review demonstrated a consistent association between sexual victimisation and problematic AOD use. Although this association is complex, evidence demonstrates that child and adolescent sexual abuse and adult sexual assault may lead to problematic AOD use for a variety of reasons.

The research on pathways between sexual victimisation and substance misuse does appear to suggest that the traumatic impacts of sexual victimisation have a key role to play. The research examines this through the constructs of PTSD, emotional dysregulation or coping strategies. A further reciprocal relationship is suggested by the research on revictimisation: managing the effects of trauma through substance misuse can increase the likelihood of subsequent victimisation. However, qualitative research and research with particular populations points to the importance of acknowledging the broader social and lived contexts in which these relationships are embedded. As noted earlier, much of this research does not take into account the social, relational and structural contexts that may also influence the relationship and survivors' motivations for substance use. Social and structural disadvantage such as housing instability, social isolation, incarceration, and unemployment can both amplify the risk of victimisation and inform the meaning of drug use for victims/survivors. This research tends to be more dispersed due to the disciplinary, policy and service divisions between them.

Although there are methodological limitations in the literature, this review outlines a growing understanding that the sexual assault and AOD sectors do share clients and an effort to integrate or coordinate their services by creating referral pathways is key.

Qualitative interviews

Semi-structured qualitative interviews were conducted during May to August 2015 with 21 practitioners working in the sexual assault and AOD sectors in Victoria. This included nine participants from the sexual assault sector (six metropolitan, three regional) and 12 participants from the AOD sector (11 metropolitan, one regional). Participants included clinicians, psychologists, counsellor advocates, forensic counsellors, youth workers, nurses, managers and coordinators as well as representatives from the sectors' peak bodies.

The proposed recruitment included 15 participants from a metropolitan location and six participants from a regional location. We achieved the ideal total of 21 but were unable to make up the ideal representation by location. As consultation with project partners indicated that recruiting practitioners for an approximately 45 minute one-on-one interview may prove challenging due to time constraints, the possibility of an online survey was introduced to increase response and achieve as much breadth across both sectors as possible.

The partners in this research, UnitingCare ReGen and CASA Forum, were instrumental in identifying potential participants from their respective sectors for participation in the semi-structured interviews. We took this approach with recruitment because our partners were more closely linked with the complex service structure of their sectors and understood the various roles professionals undertake within them, and had close professional relationships with the people in their sectors.

We supported the recruitment process for the consultation interviews by developing recruitment flyers (Appendix A) and responding to participants' enquiries and scheduling interview dates and times. This was usually done via email or telephone. We also provided a Plain Language Statement (Appendix B) to participants in which a more detailed explanation of the purpose of the research was presented.

The semi-structured interview schedules were informed by the earlier state of knowledge review as well as several consultations with our project partners. The interview schedules contained questions based on the themes of interest, including questions about the interrelationships between sexual victimisation and alcohol and other drug use, current assessment and referral practices, and identification of practices and processes of organisations and individuals that both support, and hinder collaboration and interagency interaction and engagement. In addition, these semi-structured interviews provided scope for participants to raise issues or concerns that sat outside the pre-formed themes which researchers were able to explore. In using this approach, we were able to identify similarities and differences in the responses of participants both within and between sectors.

The interviews were conducted face-to-face or over the telephone and on average went for about 30 minutes. The interviews were audio-recorded and transcribed. Copies of the interview schedules are available in Appendix C.

Online survey

A brief, online quantitative survey was administered during August to September 2015 to augment the qualitative interviews. Our project partners led the recruitment process for the online surveys by identifying appropriate practitioners and networks to target, via direct email, flyers and enews alerts to both sectors. AIFS developed and provided the recruitment materials which included an invitation to participate, an explanation of the purpose of the survey as well as a link to the online survey. These materials are available in Appendix A.

We surveyed a total of 94 participants including 50 from the AOD service sector and 44 from the sexual assault service sector. Participants included early career and senior clinicians, practitioners and counsellor advocates, as well as clinical supervisors and managers and individuals in policy and government roles. Almost all participants from the sexual assault sector worked in a specialist sexual assault service, and while most participants from the AOD sector reported working in a specialist AOD service, they also came from community health services, private practice, mental health specialist services and hospital and emergency services.

Survey questions were informed by data emerging from the qualitative interviews, and covered participants' role, service type and location; client assessment practices; referral processes; resources and training requirements; and collaboration. A copy of the online survey questions is in Appendix D.

Stakeholder forum

The stakeholder forum was conducted in September 2015 and an invitation was extended to high-level and executive members of both sectors, including representatives from metropolitan and regional/rural service providers (clinicians, practitioners and management), peak agencies, researchers and health policy analysts. Recruitment for the forum was conducted in collaboration with our project partners (see Appendix A) and we recruited Chief Executive Officers and executive managers, directors of clinical services, catchment managers, senior clinicians and convenors.

The purpose of the forum was to improve understanding of current practice highlighting the different paradigms, knowledge bases and institutional cultures related to both sectors, and to discuss opportunities for capacity building and interagency collaboration to respond more effectively to the complex intersections between sexual abuse victimisation and AOD use. Findings from the first three stages of the research (literature review, interviews and online survey) were presented and participants were given the opportunity to engage in discussions on the project findings, and suggest recommendations for the development of integrated assessment and referral clinical guidelines and tools. The forum also provided an opportunity for key stakeholders from both sectors to network and form collaborations for further work in this area.

Data analysis and dissemination

Each component of the research (the literature review, semi-structured interviews, online survey and stakeholder forum) informed the concepts and questions for the subsequent stages, with project recommendations based on findings emerging from all three stages.

The semi-structured qualitative interviews were audio-recorded and professionally transcribed. All transcripts were read fully by the team and Excel data software was used to thematically code and analyse the data. Multiple coding of interview responses by reviewing the initial coding strategy and interpretation of data was undertaken to enhance the rigour of the research. Interview transcripts were de-identified to protect participant confidentiality and participant codes were used. The key research domains explored during the interviews provided the initial coding framework. From there, analysis of the qualitative data was predominately inductive, that is, we analysed concepts, themes and issues as they emerged from the data, rather than testing for particular hypotheses or themes that were predetermined.

Online survey data were collected using LimeSurvey software. The survey was open to participants for 6 weeks, and once completed, all data was exported for analysis from LimeSurvey to the data analysis software package Stata. Survey data were non-identifiable as names, contact details or other personally identifying information were not collected. Descriptive statistics were used to describe the results of the surveys.

During the stakeholder forum, which was not audio-recorded, AIFS researchers took detailed notes, which were summarised and analysed thematically soon after the conclusion of the meeting. The data from the forum are presented as brief descriptions of discussion rather than as direct quotes. All project-related data have been stored securely on a password-protected server, with access only available to the named researchers.

To inform a shared understanding between the sectors and recommendations for appropriate practical applications of the research, feedback and recommendations from forum participants were synthesised and triangulated with findings from the first three stages of the research. The forum was instrumental in confirming the themes identified in the interviews and the survey. A key outcome of this project is the development of practice guidelines that may guide practice towards the identification, assessment, response and referral of sexual assault victims/survivors toward AOD services, and AOD clients toward sexual assault services.

In addition, AIFS will communicate the findings from this research and analysis to a range of stakeholders, including policy-makers, service providers and the broader community. AIFS will work with ANROWS, CASA Forum and UnitingCare ReGen to ensure that widespread and appropriate dissemination strategies are in place.

Ethics approval

Ethics approval for the research was gained from the Australian Institute of Family Studies Human Research Ethics Committee and was approved under the project code 14/20.

The application provided broad clearance for AIFS to conduct research with professionals working in the sexual assault sector as well as associated sectors, such as alcohol and other drug services, for the purpose of collecting information about but not limited to:

- key issues they are currently experiencing in service provision;
- key elements of their programs and practices that may enable comparative analysis; and
- organisational barriers and enablers to greater interagency collaboration in support of clients with complex service needs.

The application sought approval to undertake these research processes as they relate to a number of projects in which data are collected from professionals working in the aforementioned fields. It is due to the broad nature of the ethics application that we were able to include a quantitative data collection phase mid-way through the project without seeking additional ethics approvals.

Key findings

This research sought to increase understanding of the realities of service provision to shared clients of the sexual assault and AOD sectors and identify ways in which to initiate, if appropriate, interagency collaboration via a resource to enhance service provision and support referral pathways. Based on the literature reviewed, we sought to identify the current work practices as well as any perceived supports or hindrances to collaboration from a range of professionals from both sectors. We conducted 21 semi-structured interviews and 94 online surveys with metropolitan and regionally based clinicians in both sectors in Victoria (Table 1).

Participants in the research included early career and senior clinicians, counsellor advocates, counsellors working in residential withdrawal services and non-residential withdrawal services, youth counsellors, family counsellors and forensic counsellors, senior psychologists, as well as clinical supervisors and managers, directors, Chief Executive Officers and individuals in policy and government roles.

Key findings from the research are presented below and are arranged thematically as follows:

- interrelationships and shared clients;
- current practices in identification and referral;
- factors that hinder and support collaboration; and
- preferred resources.

Under each theme heading, findings from the semi-structured interviews are presented first, followed by findings from the online survey and stakeholder forum (where available).

Interrelationships and shared clients

Participants from both the AOD and sexual assault sectors demonstrated a practical understanding of the interrelationship between drug and alcohol use and sexual victimisation. This reflects current research in which there is a well-established association between sexual victimisation and a range of negative feelings and cognitive states (Herman, 1992; Whiffen & MacIntosh, 2005). Post-traumatic stress disorder and complex post-traumatic stress disorder are the key diagnostic constructs used to capture the range of bio-psycho-social impacts of sexual victimisation (Briere & Spinazzola, 2009; Luxenberg, Spinazzola, & Van der Kolk, 2001; Wall & Quadara, 2014). The use of terms such as trauma, and trauma-informed care is one example of the shared language used by both sectors and concepts that are becoming relevant to current practice with clients.

Research has sought to establish the association between sexual victimisation and AOD use using PTSD as the mediating factor. For example, research with 386 women engaged in an incarceration diversion program found there was a strong relationship between sexual abuse and PTSD, and also a strong relationship between PTSD and heavy substance use (Cusack, Herring & Steadman, 2013). Participants supported this:

> I guess the main thing is a lot of our clients are presenting with drug and alcohol use, which is a form of self-medication for trauma. There are a number of substances, rightly or wrongly, [that] are quite effective at masking pain. (AOD9)

> Heroin is one of the most effective ways in the short-term to mask pain. I've worked with lots of young women who all identify experiences of harm from men in all parts of their lives, you know and say that the only thing that has allowed them to forget has been their drug use. So their drug use, you can see the motivating factor is really obvious and really effective for them. (AOD10)

Table 1: Distribution of research participants across sectors and location by interview and online survey

Location	Interview alcohol and other drug sector	Interview sexual assault sector	Survey alcohol and other drug sector	Survey sexual assault sector	Total
Metropolitan	11	6	41	35	93
Regional/rural	1	3	9	9	22
Total	12	9	50	44	115

More broadly, research supports the "self-medication" theory which outlines how people who experience traumatic events such as sexual abuse may use alcohol and other drugs to numb distressing and intense feelings and memories (Darke, 2013; Miranda et al., 2002). Breckenridge, Salter and Shaw's (2012) caution against using the phrase "self-medication", suggesting it may be misinterpreted as a deficiency on the part of the survivor rather than the legitimate (although potentially harmful) coping strategy it is, is well understood by the participants of this research. Participants noted:

> As some of the people I have worked with have put it "drinking isn't my problem, it's the answer to my problem", i.e. their trauma history. Most people know that excessive drug and alcohol use is not healthy, but is preferable to them rather than constantly intolerable and overwhelming feelings. (SXA4)

> We recognise drug and alcohol use as a coping mechanism, as a strategy and often as a kind of form of self-medication for people and so we reframe drug and alcohol use in those kind of terms. (SXA7)

The prevalence statistics on sexual victimisation as well as those for harmful or problematic alcohol and other drug use are also well established (ABS, 2013; AIHW, 2015; Price-Robertson et al., 2013). In Australia in 2012, 17 percent of all women and four percent of all men had experienced sexual assault since the age of 15 (ABS, 2013). The National Drug Strategy Household Survey 2013 found that harms related to alcohol consumption affected 26 percent of the Australian population (14 years and over) during the previous 12 months and had increased since the previous survey in 2010 (AIHW, 2015).

The overlap between sexual victimisation and alcohol and other drug use was very relevant for AOD and sexual assault counsellors and managers who were aware of the very large numbers of potentially "shared" clients. Participants noted:

> We offer generalist counselling here so a few clients who come through here, we see a lot of sexual assault victims. It's something that comes up a lot in someone's story. (AOD11)

> You know I would hazard a guess that a lot of people who front at AOD services have got a sexual abuse history, a trauma history. (SXA1)

Although there are no definitive Australian statistics for the interaction and help-seeking behaviour for those who experience AOD use and sexual victimisation, a recent Australian study using nationally representative data examined a number of co-occurring issues, such as sexual victimisation, substance abuse and mental illness (Rees et al., 2011) and found that:

- 14.7 percent reported having experienced sexual assault (in childhood or adulthood);
- 8.1 percent reported having experienced rape (in childhood or adulthood); and
- 7.8 percent reported having experienced physical intimate partner violence.

Of those:

- 23 percent of women who reported one type of gender-based violence also reported a substance use disorder; and
- 47.1 percent of women who had experienced up to three types of gender-based violence also experienced substance use disorders over their lifetime.

This overlap was acknowledged by several of the participants, including the few who had worked in both sectors.

> I used to work in the AOD sector and found that I think it was about 60 percent or 70 percent of the women came in and talked about sexual abuse and about 40 percent of the men. (SXA5)

> My background is I worked in residential drug rehab for 10 years and another 5 years in the regional alcohol and drug service and a lot of our clients there that were coming in… there was a massive percentage of them who also were talking about, you know, usually historical sexual abuse as well. (SXA6)

The participants from the AOD and sexual assault sectors clearly acknowledged the relationship between alcohol and other drugs and sexual violence. They were also aware of the potential shared clients that attend their services.

Current practices in identification and referral

We explored the current practices employed by organisations and individuals working in the AOD and sexual assault sectors on identification and referral of clients presenting with AOD use or sexual victimisation. Within this discussion there was an examination of the resources used by professionals when there were no formal mechanisms for identification and referral. It is important to map these practices as they inform us of the format and style that suits the work practices of service providers and managers in both the AOD and sexual assault sectors. Resource seeking practices also demonstrate the ingenuity of service providers in pursuing specialist therapeutic pathways to support their clients.

Identification

The sexual assault sector is currently guided by the framework provided by the National Association of Services Against Sexual Violence (NASASV) who most recently released the second edition of their Standards of Practice Manual (NASASV, 2015) which features an outline of protocols and practices relating to referral to other services. The referrals guidelines do not specify referrals to any particular service, rather they are broad and thus more easily applied in a variety of contexts.

The terms used by the sexual assault sector participants for current practices included assessment, identification and intake. The processes across the six metropolitan and three regional locations varied considerably. Some participants from the sexual assault sector used intake forms that questioned clients directly about alcohol and drug use. One participant noted:

> Currently we have a sort of standard intake form that we go through with each client that calls in wanting a service with us and we wanted to ask them some questions about whether they used any of these strategies that were already common. Some of the common ones were self-medication in the form of using drugs or alcohol, legal or illegal drugs and then that would flag for us to get our drug and alcohol use assessment form that we have where we would ask the client about what substances they used and how often. (SXA8)

Some services ask intake questions related to coping mechanisms, risk and violence, which often unveil alcohol and other drug use. One participant noted:

> We do have quite a formal intake and within that we talk about ways that they've coped and that can be both positive and kind of more on the self-destructive side. Or we ask quite specific questions about risk and sometimes drugs and alcohol stuff can come up within that as well. The service is more direct about asking about violence and sometimes an AOD admission will come from that such as "I carry a knife around because I – you know, I am using and I'm scared that my dealers gunna blah blah. So yeah". (SXA2)

For some services there are no specific mechanisms for identifying if their clients use alcohol and/or drugs but often clients will reveal alcohol and other drug use without being prompted, as one participant noted:

> No specific tools. There is on the duty – like the initial conversations the allocated worker will ask "Is there any mental health concerns?" and that includes drug and alcohol use and issues. But I guess it can – and – but in saying that it can be forgotten because there's no emphasis on AOD really because we haven't got the tools or the training. (SXA9)

Current practice for the alcohol and other drug sector sits within a more structured framework informed by the Victorian Government, which in 2013 launched a new suite of alcohol and other drug screening and assessment resources for implementation across the Victorian AOD sector.[9] The new tools were developed in response to sector consultation which found existing lists could be too long and potentially detrimental to developing therapeutic relationships; there was a perceived lack of mental health assessment in existing instruments; and there were a number of different service types conducting screening and assessment differently (Victoria. Department of Health, 2013). Currently the screening and assessment[10] is conducted centrally and various services in the AOD sector see clients based on the assessment and referral to residential and non-residential withdrawal, rehabilitation, family counselling or forensic environments (UnitingCare ReGen, 2015). Disclosures of sexual trauma in these settings are usually about historical abuse and occur at different points in the therapeutic relationship. Participants noted:

> There isn't a specific mechanism. Most clients would disclose that to us or it could be documented in their current assessment and we'd be aware of it in that manner. I wouldn't have a clue how to go about assessing it and I think the general thought is that the majority of people who come through here, at some point or another, if they've had sexual assault, it's often in childhood. (AOD1)

> I haven't done one of those assessments for a while 'cause I haven't worked in that position for a while. But in the program? No we don't. If someone might say something that indicates to me that that could've happened, but probably I'm not so attuned into that, I'd probably wait for a direct disclosure then I might ask a question that opens that up for

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9   For more information on drug screening and assessment tools please see: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment

10   For the assessment tool currently used in the AOD sector, please see: http://www.directline.org.au/self-assessment

them to disclose that. We develop really close relationships with people because we work with them so intensely for 6 weeks and certainly people have been open with me about talking about that stuff without me prompting them. (AOD2)

Just as with the sexual assault sector, the assessment process in the alcohol and other drug sector involves a clinician asking the presenting client (usually via telephone) a series of questions to capture information on a range of factors such as a sexual victimisation history. It is often not a direct question but rather questions about violence, harm or safety that may elicit a disclosure of sexual abuse victimisation. The practitioner below describes the types of questions that sometimes prompt disclosures.

So look obviously it really varies but if I am doing a comprehensive assessment with them, then obviously we always ask a question about violence but there isn't a question where we specifically ask about the sexual assault but we do ask about harm to the person. We also ask if they feel safe where they are living as well. If they say no, then we'll ask for more details. (AOD4)

We talk about mental health issues as well. We often talk about the history of mental health issues so if someone identifies that they have post-traumatic stress disorder for example, then we might ask them the origin of that. (AOD9)

Both sectors come across clients that have co-morbid AOD use and sexual victimisation trauma but there can also be interrelated issues that clients are experiencing such as domestic and/or other physical violence, risk of harms and mental health issues. There can often exist a complex constellation of issues and harms for individual clients, and service providers might decide these are best attended by specialist practitioners via a referral or secondary consultation.

Findings from the online survey support the qualitative findings regarding current practices in identification and referral (Table 2). Most participants reported assessing sexual victimisation and trauma (AOD workers) or AOD use (sexual assault workers) using open-ended questions or general discussion. Around one-third of AOD workers also reported that they do not usually ask about sexual victimisation or trauma, but that clients will sometimes initiate the discussion.

Online survey participants were also asked how confident they were, or would be, to assess a client's sexual victimisation or trauma history (AOD workers) or alcohol and other drug use (sexual assault workers), summarised in Table 3. Over two-thirds of both sectors reported being confident or very confident in assessing their clients' sexual assault or alcohol and other drug use history (Table 3), typically because they had had sufficient training, or had access to other relevant resources (Table 4).

Table 2: Current practices in client assessment from online survey

In your role do you assess sexual victimisation/trauma (AOD workers) or AOD use (sexual assault workers) among your clients ?	Alcohol and other drug workers (n=50)	Sexual assault workers (n=44)
Yes, using standard screening tools/modules/scales	5	1
Yes, using open-ended questions/general discussion	30	35
I don't ask about sexual assault/alcohol and other drug use but clients will sometimes initiate the discussion	18	3
No, I don't consider it part of my role		4
I don't have direct client contact	4	3

Table 3: Level of confidence in client assessment from online survey

How confident are you/would you be to assess a client's sexual victimisation/trauma history (AOD workers) or AOD use (sexual assault workers)?	Alcohol and other drug workers (n=50)	Sexual assault workers (n=44)
Not at all confident	2	1
Not very confident	13	14
Confident	28	27
Very confident	7	2

Table 4: Reasons for high levels of confidence from online survey

	Alcohol and other drug workers (n=35)	Sexual assault workers (n=29)
I have access to standard AOD use/SXA assessment protocols and procedures	5	1
I have had sufficient training in AOD use/SXA assessment	24	11
I have colleagues in the AOD/SXA sector who I work with/provide support	6	9
I have access to other relevant resources, e.g. websites, other information/referral services	15	12

The main reasons cited for lower levels of confidence in assessing a client's sexual victimisation history or AOD use included not having had sufficient training, and not having standard assessment protocols in place at their organisation (Table 5).

Table 5: Reasons for low levels of confidence from online survey

	Alcohol and other drug workers (n=15)	Sexual assault workers (n=15)
No standard assessment protocols in place at organisation	8	9
I haven't had sufficient training	9	10
Clients' other presentations usually take priority/don't necessarily have time	6	7
Find it difficult asking about because I don't want to upset clients or make them feel uncomfortable	1	
Find it difficult asking because of age/sex/cultural differences between myself and clients	1	
I don't have direct client contact	2	2

Referral and secondary consultation

The Victorian Centres Against Sexual Assault (CASA) Standards of Practice manual contains practice standards for secondary consultation (but not referral) relating to the importance of attending to privacy and consent issues when discussing a client's details with clinicians in other sectors (Victorian CASA, 2014). The standards relate to CASA providing "input and answering questions when professionals from other agencies or organisations wish to discuss a situation or incident they are dealing with that is related to sexual assault" (Victorian CASA, 2014, p. 25). For the sexual assault sector, the concept of referral to AOD services can be a complex one. This is because a priority in trauma therapy centres on establishing safety and stability for the client (Herman, 1992). If, for example, a client is intoxicated during a therapeutic session, there is a substantial risk to establishing and maintaining safety and stability. Beyond this, the client may not be able to engage in any meaningful way with the treatment while intoxicated and may even forget the details of the session.

If the client is not immediately affected by alcohol and drugs there remains a tension between trying to maintain a therapeutic relationship and encouraging the client to seek help for their AOD use in which case the client may drop out of sexual assault counselling. Many of these issues and others arose in our discussion about referral and secondary consultation with practitioners in the sexual assault sector. The counsellors below described the difficulty in supporting young people who present with AOD issues.

> I'll just ring one of them [AOD service]. I'll ring a service until I get someone to answer me. I've always gone through another person and generally speaking when the alcohol and other drug issue gets that big they [the client] do drop out of here. (SXA1)

> Certainly we have people come in too affected by alcohol or other drugs and there's no proceeding with that session and sometimes people might need to go and take care of that if it's really intrusive. The idea would be to get them some support around those issues so they might be referred to the GP, sometimes to the local community health service. (SXA6)

Others described a lack of formal policies and processes for referrals as well as uncertainty about the existence of available resources that might support a referral, leaving the referral process and information gathering up to the individual clinicians should the need arise.

> There's no overall policy, like if a person presents with drug and alcohol issues this is what you… these are the options. I would imagine it would be up to individual workers and their experience of the drug and alcohol sector to where they make that referral. (SXA5)

There was however a general confidence in being able to source support for clients who presented with harmful or problematic AOD use. Practitioners looked to online sources or relied on previous experience in the AOD sector. Others had received training that supported them in helping the client access AOD services. Participants noted:

> I mean I probably access the internet, or ring and consult. I feel personally confident but that might vary within the team. We don't really have formal training [around AOD issues]. (SXA2)

> I feel pretty confident in contacting services. I think that's something that's working well and I think it will continue to develop. I guess on a worker level it's more phone calls and potentially I guess when those workers move on, you've got to build up a relationship with someone else. (SXA3)

> I guess, you know, if it came down to it and there was a specific client and then you'd just do your research and speak to people as you need to. I guess I'd Google really, but I did find DirectLine helpful. (SXA4)

The above quotes demonstrate that practitioners are more than willing to access information and they are able to source the information they require; however there are few formal processes that govern referrals and secondary consultations, and information is not readily available and at hand, meaning application of processes may be ad hoc.

For the alcohol and other drug sector the referral and secondary consultation process is also varied. Most of the people we spoke with in the AOD sector were aware of CASA as the peak body and the provider of sexual assault counselling services in Victoria. Many of the participants in this research were aware that it should be the client's choice to participate in sexual abuse counselling. They were also cognisant of the need to facilitate contact to the sexual assault service on behalf of their clients if this was requested. Participants noted:

> I would normally – if it's appropriate – I would actually make the phone call with the client. Otherwise it would be depending on where people are at. Like you know some people are quite ambivalent so it's about giving them the information and saying, you know, "This is what's out there". I personally don't have a particular contact but in the context of counselling I would liaise with their CASA counsellor. (AOD3)

> I've done a lot of secondary consults with CASA as well and then it varies from client to client whether they felt comfortable. I know CASA are really flexible so I know that they really want the client to contact them directly but when a client's found that really difficult I've been there in the room with them or I've made the call. (AOD8)

There were some examples where there existed very formal processes for addressing the need to refer a client to specialist services. One participant noted:

> It goes to the panel, the clinical review and then once it's decided that the client would like that kind of service, we would suggest a service. (AOD5)

Yet for others there was no formal referral process and cases of sexual assault disclosures were dealt with as they came up.

> I'm not sure we do have a protocol for that. (AOD6)

> Even if it ever comes up I'd say the linkages would be pretty ad hoc. (AOD10)

Several participants suggested that a lack of process and/or formality may be because they have not sought one out rather than the process not existing. However it may also reflect issues with training or supervision, the latter which remains an ongoing issue in the AOD sector in relation to expanding policy and treatment mandates (Whittle, Rycroft, Wills, Weir & Rottem, 2013). Regardless of a perceived lack of process, many practitioners in the AOD sector were confident in seeking out information to support their clients or relying on training they may have once received. Participants noted:

> CASA is the service to me that I'm aware of. Like that's probably the only one that I'm aware of and that'd probably be my first point of call. So it'd probably just be getting on their website. Beyond that, I'm not sure. (AOD2)

> I've had a fair few staff do some really good sexual assault training through CASA too in Melbourne. So especially in alcohol and other drugs we know that a lot of our clients have been victims in the past so therefore we wanted to better equip our workers. (AOD11)

A lack of confidence in identification and referral may relate to a lack of experience or just a lack of current training or on-hand resources. Participants noted:

> I felt like if I didn't have the skill to manage that then I'd probably look to referring them to someone who had that experience and those skills. I'd talk to my manager, I'd probably talk to him first and see what he reckons. But I'd also, yeah, looking at something like CASA and do some secondary consultation. (AOD4)

> Obviously clinical experience would dictate the response. I would suggest that it's pretty – that whilst we have a whole lot of clinicians out there that are very experienced and you know and may even have good sort of links with a relevant service, we'd also probably have a whole lot of clinicians in the new space that are not as connected. (AOD10)

Again, as with the sexual assault sector there are practitioners in the alcohol and other drug sector who will seek out information to support their clients. Although many participants in the qualitative interviews reported that they did not have formal processes to fall back on, they were proactive in seeking expertise and resources from both inside and outside their own fields. However, there was uncertainty about how consistently this occurred and differences in clinical experience tended to govern responses.

Findings from the online survey revealed similar uncertainties in client referral processes across both sectors (Table 6). Only around two-thirds of participants reported having referral processes to the other sector in place, and among those who did, most were based on informal arrangements.

Table 6: Referral processes from online survey

Do you have referral processes in place to refer clients to SXA/AOD support/interventions (n)?	AOD- Survey (n=50)	SXA- Survey (n=44)
Yes	32	27
Formal	9	8
Informal	23	21

Collaboration

At the service level, there is an emerging evidence base to suggest that working collaboratively in a network with other services can enhance the sharing of information and knowledge around service users' needs, particular in fields related to violence against women (Breckenridge, Rees, valentine & Murray, 2015).

In identifying the gaps in their resources both sectors turned their attention to interagency collaboration. For this project, the term collaboration came to be adopted and adapted as a function of discussion between ourselves and our partners, UnitingCare ReGen and CASA Forum. Collaboration was the term adopted to describe any efforts we were undertaking to achieve some form of greater understanding between the two sectors – including our own discussions, the planning and production of a resource (guidelines) to support shared knowledge and referral processes. By the end of the data collection, the term had adapted and had come to encompass the possibilities for greater service interaction between the two sectors in the future.

Collaboration was also the term used when we spoke with practitioners in the AOD and sexual assault sector and one that was reflected back in a number of ways including:

- working together;
- sharing information;
- interacting and networking with practitioners from the other sector;
- increasing knowledge about the other sector;
- knowing how the other sector works; and
- formalised referral practices.

Most of the participants in this research acknowledged there was value for the client in the two sectors working more collaboratively. Participants noted:

> I always like to work collaboratively 'cause I prefer it and it's also – there's always better outcomes for clients. And I guess it always works better if people have an understanding about the different systems that they work in. (AOD7)

> There is value in working together. We have a skill set that is presumably similar in some levels to AOD and there'd be clearly specialist skills that each of us would have that the other doesn't. I think we have to stop thinking of ourselves as being so totally separate I suppose, 'cause we're not. We're dealing with the same people. (SXA1)

Participants from both sectors recognise that they share clients with complex needs that may require assistance to access specialist support services for co-occurring sexual trauma and AOD use. In this sense they were already collaborating, but without any formal agreements or referral structures in place. There was acceptance and support for creating pathways that are both clear and easily accessible. As with any collaboration, there can be individual, organisational or sectoral barriers that make it harder to achieve. Conversely there are enablers to collaboration that if identified can ease the process of interagency engagement. The following sections explore participants' reflections on factors that hinder and support collaboration between the sexual assault and AOD sectors.

Factors that hinder collaboration

In seeking to support the AOD and sexual assault sectors to enhance service delivery to clients who may benefit from both AOD and sexual trauma counselling, we asked participants to reflect on what they considered to be personal, organisational and policy related factors that may hinder interagency collaboration. Issues of resources, role creep, understanding of the other sector and communication featured in participants' responses. Role creep describes when a work role expands to include more activities and demands over time which are not balanced with the provision of additional resources, such as training, money or time, to support them. It is perhaps no great surprise that insufficient resources was the most frequently mentioned factor to hinder collaboration, identified by both sectors and a factor that underpinned all other barriers. Participants identified concerns about how long a client could be engaged for, the length of time allocated to follow up a client who may be moving between services and, as mentioned above, role creep.

The importance of capturing information about barriers to collaboration is it supports us to fulfil the aims of this research: namely to provide a set of resources or guidelines that support interagency collaboration through identification and referral of shared clients. The guidelines are required to be practical and able to meet the needs, but also the resource constraints, of both sectors.

Resources

From the sexual assault sector, the lack of time and money was experienced as a constraint on collaborative efforts. Participants noted:

> It's an issue I presume for both sides having the time, the resources and the inclination. (SXA1)

> I couldn't say that leaving Centres Against Sexual Assault incredibly underfunded and with massive waiting lists fosters relationships between drug and alcohol services and the sexual assault sector. (SXA7)

> So I guess, you know, resource constraints can make that difficult because I'm just thinking if we got a request the other way round, like a drug and alcohol service said "Could you come out and meet our clients at our next drug and alcohol appointment?", we wouldn't be able to do that just in terms of our funding targets and we've got to see five clients a day, four clients a day. (SXA8)

The concern over lack of resources and the negative impact that could have on collaborative efforts between the sectors was echoed in the alcohol and other drug sector. Participants noted:

> There's no extra funding for it which is a big obstacle and then the work's not reflected in any of the documentation or the reporting that you do so it's kind of like asking for extra work without putting resources behind it. That's one of the reasons why collaborations fail I think…I mean resources is one of the biggest issues, whether it's money or time. (AOD7)

> Well time is a massive barrier. And I don't know if it's – I know it's a time issue on our end – I don't know if the time issue is also on the CASA end as well. (AOD8)

> Look, I think one of the challenges, the reality and you know we're sick of sort of saying this same thing that around other issues is that – you know the funding capacity of agencies to do this work. We've got a funding model that doesn't support us, you know, doesn't support the rhetoric around integrated and holistic care. (AOD9)

There is a danger that collaboration around referral processes more broadly "may result in a marked reduction in the already limited resources for human service stakeholders…" (Longoria, 2005, p. 124). This may be moderately alleviated however through an initial investment in time toward collaboration that could potentially save time and resources in the long-term if collaborative efforts are effective. Issues of resourcing for potential collaboration in services require quite sophisticated responses from governing organisations such as peak bodies and government departments so services and individual clinicians do not become overburdened.

Role creep

Participants in this research also expressed a concern about role creep, or that collaboration meant creating an overlap between the sectors potentially creating more work when boundaries existed for a reason. One participant noted:

> I could ask how they [client] think [their AOD use] is affecting other people in their lives…I suppose the bottom line is I don't see it as my job. There's things that I could work on people with around developing alternative coping and strategies. But I'd also be really mindful that specialist drug and alcohol counsellors would have more expertise around that. (SXA3)

A concern about role creep was balanced by consternation that the sectors may operate in silos due to ideological difference or resource constraints. Participants noted:

> I think we could do a bit more. Because we're seen to be this specialist service we can almost instil those dominant beliefs of working in isolation and I think we need to challenge that. (SXA9)

> If I refer a client to CASA… I would like there to be conversations between me and the CASA worker identifying the client's needs and what's my role versus what's your role and how do we collaboratively support the client and I know that a lot of times, because of time, clinicians are not able to have those discussions. (AOD8)

Lack of knowledge and communication

Another shared hindrance to collaboration was the lack of understanding of how the other sector works. This can be a feature of many services that work with a vulnerable client base. Agencies and individual clinicians who work with women at risk of, or affected by, sexual victimisation and/or alcohol and other drug use are often focused on supporting clients with their immediate needs and as suggested above, do not have the resources but also the opportunities and skills to address underlying issues. This can also contribute to the siloed approach to client case management that minimises or precludes the benefits of shared understandings and approaches to either treatment or prevention. Not only is there confusion and conjecture (both negative and positive) about what is happening in the other sector, but there are very few formal communication pathways to support information exchange. Lack of communication – whether it be training, networking or less formal forms of interagency communication – is currently at the heart of the lack of cross-sector understanding between the AOD and sexual assault sectors. Participants noted:

> I know that like last time we met with the drug and alcohol service in our local region, I know they're under massive restructure and you know, speaking to you now I realise I don't really know what the outcome of the restructure was. I don't know how drug and alcohol services are funded so I don't know where there's overlap or we have overlapping borders or what we have. (SXA6)

> Yeah 'cause I don't think people do know how much our waiting period is blown out and we probably don't have the capacity to tell people that, you know. (SXA2)

There were similar issues from the AOD sector concerning an uncertainty about how the sexual assault sector operates. The following quotes demonstrate a lack of cross-sector knowledge sharing.

> I actually don't know what they do, so like a lot of other agencies, I see the client, I know exactly what's gonna happen for them when they get there and what the shape of the treatment's gonna be. I just wish I knew more about um how that [sexual assault] service operates, what their model is that they use when people come in, that would help me as a clinician, but also it would help me talk to clients about allaying some of their fears. (AOD7)

I guess there's been a reform process [in the AOD sector] which has kind of centralised the way things operate so I guess someone to talk them [sexual assault sector] through what the process is of referring someone. But just what the processes are so I guess there's a bit to know about regions and what services are on offer, about how to get clients into treatment. (AOD7)

There is a demonstrated need for both sectors to access information about the other sector. There is also an acknowledgement that there may be a lack of pushing information out about their own processes and operations that could be hindering collaboration.

Our forum participants also expressed the importance of enabling information sharing on service delivery options for both sectors. There is a knowledge gap around particular high risk populations, eligibility requirements for service and the expectations of clinicians in both sectors that implies a lack of cross-sector knowledge and communication. Particular care must be taken in building communication pathways between different sectors so that a shared language exists or is developed that enables clarity and understanding.

Supports to collaboration

Among the participants in this research there was a great deal of positivity and enthusiasm for greater collaboration between the AOD and sexual assault sectors. Practitioners and managers alike expressed great interest in expanding their understanding of the other sector through a variety of avenues in an effort to build their capacity to engage with and refer clients. Some of the supports to collaboration they identified relate to a shared focus on client-centred care. There was a commitment to an openness to discussion and information sharing, and past organisational collaboration across other sectors (and services) that demonstrated an ability to do the work of interagency collaboration. Importantly, both sectors identified the need for governance structures and policy engagement as crucial supports for collaboration.

Professionals in the sexual assault sector communicated a number of personal, organisational and sectoral factors that would support interagency collaboration between their sector and the AOD sector.

I think the [sexual assault] agency as a whole would have a philosophy that it's probably a good idea that we collaborate with other professionals that are involved with the client. Even where there are differences, this is just my own experience of talking with workers, there's an openness to discussing our shared understandings and building rather than a sort of conflict. (SXA3)

I mean there's certainly examples of our service system collaborating with other groups. I mean they collaborate

with family violence, they collaborate with police and it's been done successfully so I don't see why it couldn't be done somehow or other with AOD. (SXA1)

For us, I think we should – we can be approaching the alcohol and other drug services and seeing what opportunities there are for us to work together. (SXA6)

This openness to be proactive and engaged with the AOD service sector to support a shared client base is tempered with broader policy and governance considerations many believed are at the heart of successful collaborative efforts.

I really do think that it needs to come from a policy level to be supported and it needs to be sort of the whole organisation buying into this. (SXA6)

Policy and support systems go some way to alleviate factors that may hinder collaboration, such as role creep and resource constraints. Policy level commitment to collaboration legitimises the work and provides resourcing and an authorising environment that removes the risk of overburdening individual practitioners.

The alcohol and other drug sector also showed similar enthusiasm to learn more from the sexual assault sector that indicates potential support for collaboration. The following quotes demonstrate a desire for greater knowledge and cross-sectoral relationships to support clients' access to other specialist services.

If workers had a better idea or felt confident that they could refer that client to a service that had expert knowledge in that issue, they might feel more confident in bringing it up. Because there's nothing worse than bringing something up with [a client] and going "Oh, my goodness, that sounds like a really big issue" and feeling like you can't do much about it. (AOD2)

Marrying those two up and saying "Well, what's actually in the best interests of the client and how do we – how does the drug and alcohol worker – support someone who's going through some pretty tough sexual assault counselling?" and what does that look like and then what does the sexual assault counsellor need from the AOD clinician to get this client through this particular tough period. I guess just that communication with client consent, but usually clients want workers to work together. (AOD11)

Just as in the sexual assault sector, there was enthusiasm for client-centred care and collaborative approaches with other sectors, while noting the importance of governance so that individual clinicians are not overburdened. The driver needed to affect outcomes in any meaningful way was identified as broader policy support for collaboration. Participants noted:

Clinical governance issues are important to think about if you're wanting people to work collaboratively. (AOD7)

There's no overarching governance system which seeks to identify ways for the sectors to work more efficiently together and everything gets left to the community level or the service level rather than having a governance model that supports integration and collaboration. (AOD10)

We need the authorising environment that state government and policy can provide – rather than leave it all up to the service providers who are already overloaded. Being policy it would need to be funded properly too, so it's also a resource issue. (AOD11)

The aim of this research related to the development of guidelines or other resources that could assist practitioners in each sector to identify and refer clients affected by a sexual victimisation history and harmful or problematic AOD use. Broader policy and governance considerations inform our understanding not only of the energy and goodwill between the sectors to work together, but provide a practical road map for further initiatives beyond the scope of this study that are worthy of consideration and further research efforts.

The forum participants very clearly articulated the need for government support for broader cross-sector collaboration. The AOD and sexual assault sectors are overseen by different government departments which generates questions about leadership and responsibility for building referral pathways and networks between the two sectors. However there was tremendous support for increasing the interaction between practitioners and managers as well as executive level professionals.

The final section of this chapter presents the findings on what resources might increase practitioners' confidence and best support them in identifying and responding to AOD use and sexual victimisation. We sought to identify what works in a practical everyday way to assist clinicians to build their capacity to enhance service delivery to vulnerable clients.

Preferred resources and tools

To respond with the appropriate therapeutic needs of affected women and their families and to inform effective, integrated service delivery, participants from both sectors were asked to reflect on their preferred resources in supporting referrals and information needs. They provided insights about a number of resources they thought would build their capacity in the area of accessing knowledge and referring clients to the other sector. Having a set of guidelines that provided information on the interactions between alcohol and other drug use and sexual victimisation, clinical and practice information, and contact details were all explored as was cross-agency training. Beyond that, networks and working groups were also suggested as were multidisciplinary centres – even though they may require greater investment and support from a policy context and were beyond the scope of this research to provide.

Guidelines

The sexual assault sector participants named guidelines with easily accessible information as the most preferred resource to fulfil their needs on alcohol and other drugs. The information needs they mentioned included:

- secondary consultation and referral information (names and contact details);
- service options in the AOD sector and entry points;
- clinical guidelines;
- drug types, use, interactions and impacts; and
- matched up service regions.

Participants noted:

I mean we could probably benefit with some really evidence-based research around, you know, that intersection, what the research is showing around trauma and drug and alcohol use and what works, what models might work in supporting the client. (SXA2)

Particularly with drugs like ice and I guess…having ways that we would keep on top of what a lot of the drugs people are commonly using and some greater understanding of what their effects could be. (SXA3)

I think it's incredibly useful to kind of know what the central kind of access and information points are. I would find it useful to have a resource that broke things down by region so to avoid a situation where victims/survivors contact one service and kind of had to then contact another and contact another and so kind of speak with authority around that. And any kind of resource that also kind of maps, really, the structure of drug and alcohol services in the state. (SXA6)

The AOD sector participants interviewed for this research nominated guidelines and factsheets as a practical day-to-day support in referring AOD clients to the sexual assault sector. In particular, they were interested in being able to quickly and easily source information regarding:

- referral and secondary consultation information (names and contact details);
- practical interventions, education and information while clients waited to access sexual assault services;
- waiting list times;
- interaction and relationship between alcohol and other drugs and sexual victimisation; and
- how the sexual assault sector operates.

Guidelines would provide a clear and concise boundary around what is appropriate and relevant for AOD practitioners to do if a client discloses sexual abuse. Participants noted:

> A set of guidelines, like a "What do I do?". How do you ask those difficult questions? And then when someone discloses, what do you do is a difficult question. (AOD11)

> We delivered a sort of master class to senior clinicians around some of that but that doesn't mean people can go back and embed it into practice. If you want the sort of resources, look, practice guidelines, protocols and that would be useful. (AOD10)

> If you're getting information for clients, you know, maybe even a resource that would be drug and alcohol and sexual assault, you know, looking at that sort of co-morbidity and co-occurrence. (AOD3)

Training

In-house and cross-sectoral training were also nominated as effective ways to increase knowledge and understanding of the AOD sector and support client referrals. Cross-sectoral training can be operationalised in a number of ways and below the participant defines it as the sexual assault sector providing sexual assault specific training to AOD sector clinicians, and AOD sector clinicians providing AOD specific training to sexual assault counsellors and advocates. Training is also a way in which the sexual assault sector already contributes knowledge to other sectors and in the community through their training schedule.[11]

> Yeah, I mean cross-training. We provide training, community education to drug and alcohol workers and that could work both ways I could, you know, see really easily. They provide it to us, we provide it to them. (SXA7)

> Some training through the workforce development program that we have could, would probably be useful. (SXA1)

However training for practitioners needs to be targeted to their existing expertise levels. The participant below describes a training session provided by a sexual assault service when they themselves were working in the AOD sector:

> It just didn't really give you any detail. It was just really an overview of what sexual assault was about and gave you no actual practice theories or practice tools. I just walked away thinking I've just wasted a whole day here. (SXA5)

Several participants echoed the need for trainers to customise training for a professional audience that includes relevant and practical information that would be useful in a clinical setting.

Training and information sharing was another avenue toward knowledge transfer and supporting shared clients for the AOD sector, particularly if and when it is appropriate to elicit a disclosure and how to respond to a disclosure. Participants noted:

> I think again training for the drug and alcohol sector. Just sort of because it's such a delicate – can be such a delicate area – and knowing if we're approaching it in the right manner by not asking directly and waiting for it to be disclosed. You know, people are just really doing what they think is the right thing. (AOD2)

> I think it's absolutely necessary to have some training, some actual training and if it was possible some training that was specific to young people and particularly to young women because I'm working with a lot of young women who are at risk. So I'd really value that, because - yeah I feel it's really important that I have the resources to be able to understand how to respond to someone when someone is disclosing sexual assault to me. And look, I know how to do it now but if I had some really solid training and a really good approach behind me to unpack all that, yeah. (AOD4)

Networks and workshops

Finally, there were some suggestions that the most effective way to maintain interagency relationships and information sharing was through direct contact and face-to-face interaction. Networking opportunities and interagency workshops are thought to be effective in keeping momentum going when attempting to create pathways for sharing information in support of vulnerable populations (Winkworth & White, 2010). The ability to transmit new evidence, practices and models, and to customise training based on face-to-face consultation as well as build and maintain important relationships that underpin access to secondary consultations and referrals was considered an ideal resource.

> I mean I think it would be useful that drug and alcohol services and CASA, were aware of each other in the first instance so there were kind of – some kind of joint working group or network. (SXA6)

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11   For an example of a CASA training schedule please see http://www.gcasa.org.au/assets/Events/GCASA-2014-Training-Calendar.pdf

Networking was also nominated as an important and strategic complement to guidelines and training.

> And you know, it would be great if we had some more opportunity to actually meet workers from some of those other services so we can put a face to the name and to support options so we are kind of aware of what's out there, so you know. I just think networking opportunities are great and the more people you can meet and talk to about the jobs that they do, then the more collaboration you're kind of inviting. (AOD4)

Online survey participants were also asked about the types of resources and/or training they have used in the past, or would like to use, to support their assessment of sexual victimisation or AOD use among their clients (Table 7; data is presented by sector and current level of confidence in client assessment).

Similar to findings from the qualitative interviews, many participants nominated practice guidelines or factsheets as important resources to guide their work. Face-to-face and interagency training were also commonly reported, as were partnerships with experts (a call a friend approach) in the other sector.

Forum participants were positive about the possibility of guidelines for practitoners to use in their day-to-day practice. In particular they suggested information that was able to clearly identify the boundaries around roles so that practitioners were able to quickly identify how to respond to a client with co-occurring AOD use and sexual victimisation without feeling uncertain about their obligations. Echoing the findings of the qualitative interviews and online survey, the forum participants suggested that having referral and secondary consultation details on guidelines, as well as interagency training opportunities, would enable relationships to develop and be maintained, creating a suite of resources to enhance service delivery.

Table 7: Preferred resources for guiding practice from online survey

What resources and/or training have you/would you use to support your assessment of SXA/AOD use among your clients?	HIGH confidence Alcohol and other drug workers (n=35)	HIGH confidence Sexual assault workers (n=29)	LOW confidence Alcohol and other drug workers (n=15)	LOW confidence Sexual assault workers (n=15)
Practice/clinical guidelines	19	18	8	9
Factsheets	13	20	9	10
Online training	7	5	6	7
In-house face-to-face training	16	12	1	
Cross-sector/interagency (SXA & AOD sector) training	19	17	1	
Partnerships with experts in the SXA/AOD sector ("call a friend")	16	20	2	2

Discussion and recommendations

The relationship between sexual victimisation and adverse outcomes, such as problematic substance use, has been an area of increasing understanding in recent decades and it is now well established that there is a relationship between the two. Although this relationship is complex, evidence demonstrates that sexual abuse and assault may lead to harmful alcohol and other drug use for a variety of reasons. Similarly, harmful AOD use is one risk factor that may lead to sexual revictimisation in adulthood as a result of related and contextual individual, interpersonal, community and social factors (Stathopoulos, 2014b).

However, researchers, service providers and policy-makers have struggled to translate this evidence into concrete measures for both support sectors to adequately meet the therapeutic and service needs of victims/survivors of sexual abuse and assault who also have, or have had, substance use problems. Historically, the AOD and sexual assault sectors have not worked together to bridge their services in support of clients who might require referrals between them. This has resulted in service users with multiple needs experiencing difficulty in navigating these services which can have an impact on both referral pathways and treatment options. With an increasing recognition of the need for "trauma informed" service delivery across the human services sector, these traditionally siloed approaches are no longer sustainable if the service and support needs of those with co-morbid conditions are to be adequately addressed.

This research provides a greater understanding of the particular resource needs of practitioners in the AOD and sexual assault sectors related to supporting and referring shared clients. Evidence suggests that there is a desire for greater interagency collaboration between AOD and sexual assault services; clarity on the forms this can take will guide the development of a resource that works within sectoral constraints while leveraging sectoral supports for collaboration.

Intersections and shared clients

This research project was unique in seeking to explore the service and referral needs of shared clients as identified by professionals working in both the AOD and sexual assault sectors. The results of this research encourage greater value to be placed on linking services in a collaborative effort to support those clients who might usually "fall through the gaps".

Participants from both the AOD and the sexual assault sectors articulated insightful understandings of the relationship and complex intersections between alcohol and other drug use and sexual abuse and assault. Their understanding of the nature of the relationship included knowledge of the factors that mediate the relationship, such as post-traumatic stress disorder and complex trauma, which reflects current research in this area.

There was a recognition that clients may be self-medicating and this was understood by practitioners in both sectors as an adaptive coping mechanism that might eventually lead to the need for specialist services to alleviate trauma and/or access support to minimise the harm of AOD use, or both. Both sectors recognised that the clients most likely to be self-medicating were those who had experienced (historical) child sexual abuse.

The available literature, as outlined earlier in this report, demonstrates quite clearly the consistent association between sexual victimisation and problematic alcohol and other drug use. Although this association is complex, professionals in both the AOD and sexual assault sectors acknowledged that a large proportion of their clients may be eligible for service responses from both sectors, and more formal processes and practical resources may support the sectors in attending to these complex client needs.

At what point during the therapeutic relationship this should be addressed and referrals made depends on the client and their interaction with the practitioner. Practitioners and clinicians as well as forum participants expressed a need for what might best be called minimum standards for supporting clients that could be carried out without additional training. The issue of how alcohol and other drug workers can provide information and supports on the impacts of trauma in the context of dealing with alcohol and other drug issues, and how sexual assault workers can provide information and supports on the impacts of alcohol and other drug use in the context of dealing with trauma will be outlined more clearly in the practice guidelines.

Current practices

Identification and referral

Current practice on the assessment and intake processes in the AOD and sexual assault sectors varies considerably. The AOD sector in Victoria, having recently undergone extensive restructuring, now has a centralised assessment system using a new suite of alcohol and other drug screening and assessment resources in which eligibility is ascertained and clients are directed to appropriate service locations throughout the sector depending on their service needs. The new Victorian *Adult Alcohol and Other Drug (AOD) Screening and Assessment Tool* involves a 3-step approach (a client self-complete initial screen; a clinician-completed comprehensive assessment; and a review), in addition to 11 optional assessment modules.

Two questions specifically related to the experience of sexual assault have been included in the new suite of tools:

1. Comprehensive Assessment (Turning Point Alcohol & Drug Centre, 2013; p. 8):

   Harm to or from others (history of violence to or from others including assaults, family violence, children present, threats to kill, sexual)

   • In the past four weeks have you been violent (incl. domestic violence) towards someone?

   • In the past four weeks has anyone been violent (incl. domestic violence) towards you?

   • Are dependent children safe?

2. Optional Module 3, Mental Health (Turning Point Alcohol & Drug Centre, 2013; p. 5):

   Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include serious accidents; sexual or physical assault; terrorist attack; being held hostage; kidnapping; fire; discovering a body; sudden death of someone close to you; war; natural disaster.

Factors that may hinder the AOD assessment reaching the (optional) screening tools related to sexual violence histories amongst AOD treatment seekers relates to the issue of time in an already time pressured environment. This may be why the identification of a sexual victimisation history might frequently occur later during the counselling phase in a variety of service contexts.

Once the counselling process is underway in the alcohol and other drug sector – either four sessions for "standard" clients or 14 sessions for "complex" clients (with assessment based on the complexity of their needs), a sexual victimisation history may be disclosed at any time and depending on the needs of the client, the confidence and experience of the worker and the resources available, a client may be informally referred to a sexual assault service.

For the sexual assault sector, victims/survivors usually enquire about support and counselling via telephone first, and are then directed to a service in a convenient geographical location. Some of the service locations may undertake a formal intake process, however this practice is not uniform throughout Victoria. If the process is undertaken, a number of drug and alcohol use related questions are asked and generally cover the following themes:

• current frequency of alcohol and/or other drug use;

• types of substances used;

• previous attendance at AOD services; and

• drug related risk taking behaviour taken from the Drug and Alcohol Assessment Form provided by WestCASA.

The AOD assessment form used by some sexual assault services also seeks consent and agreement from the client not to use drugs or alcohol prior to a therapeutic session. If a client is intoxicated, it is not always possible for trauma therapy to take place, however for some services this might be negotiated depending on the intoxicant. Finally, the clinician makes an assessment about the client's capacity to reach their therapeutic goals based on the effect of their AOD use.

Unlike the AOD sector, there are no set number of sessions for sexual assault therapy; however clients may move in and out of the service as required or depending on what is safe and possible for them. In cases where the worker may detect or is told of problematic AOD use during a counselling session, there may be an informal referral to a service that specialises in AOD issues, but more likely a balanced approach is undertaken to manage the alcohol and other drug use in a sensitive way that supports the safety and stability required to undertake trauma therapy.

In the sexual assault sector there are guidelines related to secondary consultation which relate broadly to the importance of adhering to privacy and consent issues. Beyond these however, there are no formal or standard protocols for how to approach an AOD use issue and there is a great deal of variability within the sector. This is underpinned by a variety of factors such as the counsellor or advocate's experience in the field, their experience of the AOD sector, informal relationships with AOD workers and their formal training such as their tertiary qualifications.

Current practices in the AOD and sexual assault sectors vary considerably and reflect both the organisational frameworks that guide practice, as well as the initiative and confidence of individuals within the sectors in referring clients to other services.

Collaboration

The notion of AOD and sexual assault sector interagency collaboration as a destination is a new concept for those working in those sectors but one that shares support among the participants of this research. However for other human service systems, particularly child protection and child welfare, the effectiveness and implementation around interagency collaboration has been the subject of much research and debate in recent years. Collaboration is an intense activity that requires a great deal of commitment from both partners that ideally results in a type of organisational culture change based on adopting advanced ways of operating (McDonald & Rosier, 2011). The AOD and sexual assault sectors have tentatively begun this process as a function of this research and hope to continue toward enhancing their service response to their shared client base. Barriers such as difficult work environments represented by lack of resources, overburdened practitioners, high staff turnover and a lack of guidance or supervision for staff engaged in collaborative service can be overcome if attention is given to appropriate frameworks that enable trust and reciprocity (Lee, Benson, Klein & Frank, 2015). Developing shared goals and formalising them through contractual obligations and administrative processes backed by adequate resources are all crucial to effective collaboration and are vital processes to consider in supporting vulnerable clients with complex needs via a collaborative approach (Bromberg & Henderson, 2015; McDonald & Rosier, 2011).

Factors that support and hinder collaboration

There is an increasing expectation that human service agencies will work in collaboration with one another to support clients who have complex needs (Price-Robertson, 2012) that otherwise might see clients "fall through the gaps" of services or ricochet through systems only to "drop out" due to the complexity of traversing multiple systems that work in silos (Breckenridge et al., 2015). This expectation for linked services that provide client-centred support is one that service providers in the AOD and sexual assault sectors would like to see come to fruition. Interagency collaboration versus the single agency approach is the topic of much debate in the current service systems literature, particularly for vulnerable children in the childcare and family court system (Wall et al., forthcoming). For the purpose of this project collaboration can be considered most effective when it helps to address the needs of vulnerable people who experience multiple and complex problems and are at heightened risk of revictimisation (Wall et al., forthcoming).

Price-Robertson (2012) explored the common causes of collaborative inertia that may befall community service sectors and names partnership fatigue, disagreement over common aims, power imbalances and lack of trust as four common barriers. Collaboration is a difficult task, and identifying and acknowledging barriers can be an important effort towards alleviating them. Interestingly, while a lack of resources did not feature on Price-Robertson's list, this research identified a lack of resources – namely time and money – as a prominent potential barrier to collaboration. It should be noted that an initial investment in collaboration may actually prove advantageous if collaborative efforts are proved to work effectively.

The issue of time and money underpinned other identified factors that may hinder collaboration such as role creep – a term that describes doing more, or providing more service, or being asked to do more with less time and money. Similarly this concern relates to skills – practitioners do not want to provide a service that is the domain and remit of other service professionals. The guidelines developed as a result of this research support this concern by providing clarity for sexual assault and AOD practitioners in the most effective ways to respond to clients who present with AOD use and sexual trauma respectively.

The issue of clinical supervision was not raised as a barrier to collaboration or effective collaborative practice, however issues related to lack of training and governance may be interpreted as pertaining to supervision issues.

What practitioners would like to see is greater communication between the sectors so that they can direct clients to professionals who have the skills to deal with the co-occurring health issue. Currently there is not only confusion and conjecture (both negative and positive) about what is happening in the other sector, but there are very few formal communication pathways to support information exchange. Practitioners are interested in learning about what the other sector "looks like" so that when they send a client "out there" they can, with some authority, advise their client of what they might expect. The AOD and sexual assault sectors work quite differently, underpinned by different paradigms, which is evident in their practice approaches as identified in the key findings chapter. For practitioners to be certain about what their clients, who in many cases are vulnerable and have complex needs, will experience, how long they may have to wait and what services they are likely to need, formal information sharing between the sectors is vital.

Openness to sharing information and practice guidance works to support collaboration. There is enthusiasm from practitioners to provide referral pathways for clients between the AOD and sexual assault sectors using the frameworks already in use with existing partners and collaborations, such as formal agreements and relationships. The AOD sector has most recently been involved in collaborative efforts with mental health services. Professionals from all levels of the AOD sector understand the value to client care as well as to the maintenance of sector relationships of open communication. Similarly, the sexual assault sector has a variety of agreements with organisations

such as Victoria Police and service sectors such as the domestic violence sector and is therefore experienced in working together with other systems to provide client support.

Interagency collaboration relies on the authorising environment that formal and legitimate governance structures and evidence-based policy can provide. Governance structures include supervision in clinical practice and without senior staff engagement, newer or more junior staff are less likely to engage. Governance and professional development issues are crucial to embedding new collaborative practice into existing service systems.

It remains difficult for practitioners and executive level professionals from both sectors to find time to meet face-to-face without an organisational or sectoral mandate. However, the benefits to the AOD and sexual assault sectors in meeting around a table were demonstrated by the stakeholder forum, conducted as part of this research. Professionals shared information, increased their understanding of how the other sector worked, met contacts from similar regions and committed to working together to refer clients and share knowledge. Successfully linking two sectors depends on more than just individual practitioners and organisational commitment to collaboration. A requirement of collaboration is resourcing and proper structures and these can be fostered by policies which support collaboration.

Recommendations for resources

A key resource need arising from the findings is the need for practitioners to be supported in assisting clients with referral information. The range of needs of clients, and the ways in which different clients reveal those needs, means that practitioners require a range of useful information on contact details, waiting times, and an understanding of what types of services are available in the other sector. Practitioners in this research noted that their resource seeking was predominately for text-based information – usually web-based was the closest at hand – and that a set of guidelines with relevant facts, links and contact details would work best to support them to respond to and refer their clients.

The information that may be included in the guidelines was finalised in consultation with executive level professionals from the AOD and sexual assault sectors and guidelines will be delivered in early 2016. Where information is not possible to include, links to sites where the information is readily accessible will be included. Further collaboration with research partners will occur as the guidelines are developed, so they are as useful and practical as possible and reflect the needs of those working in the field.

Guidelines

Guidelines will provide information on the intersections between alcohol and other drug use and sexual victimisation, clinical practice information, and contact details for referrals. Importantly the information included in the guidelines will seek to clarify for practitioners how each service works and how and when it may be best to respond to clients with co-occurring issues. There are three domains in which the information will be arranged: practice, sector, and broader information.

Practice guidelines include:

- how to respond to sexual assault disclosure: minimum response for AOD workers;
- how to respond to AOD use: minimum response for sexual assault workers;
- risk assessments based on historical or current sexual victimisation; and
- referral and secondary consult contact details for each sector by region.

Sector guidelines include:

- a brief mapping of the structure of each sector – what services are available (such as one-on-one counselling, group counselling, detox, withdrawal, legal/forensic), client eligibility and potential waiting times;
- funding bodies for each sector; and
- regional mapping of the sectors.

Broader information includes:

- prevalence and patterns of drug use;
- drug effects and information about drug combinations; and
- self care for clinical staff.

The guidelines will provide prompts for practitioners to call services in their local catchment area to make contact and build relationships. This will support them to make decisions when, for example, the client has already established a rapport with either service and might be reluctant to be referred on, when to work collaboratively with the other service supporting the client in tandem, or when to refer on in the best interest of the client.

Guidelines could also be used in the services as a training and induction tool.

Next steps

Further recommendations for resources based on the findings of this research, but beyond the scope of this project to develop and provide, are training and network opportunities. Training was a popular option and many practitioners had a preference for in-house, face-to-face and cross-sector training that takes into account a level of professional knowledge and includes the latest evidence-based clinical practice information to support them in responding to complex clients. Training could be developed for staff across both sectors and include staff providing clinical supervision. Cross-sector training would require operationalising via consultation between the two sectors. The sexual assault sector in Victoria currently runs a training schedule to deliver training in a variety of contexts and throughout the year. This might be used as a framework for delivering training to the AOD sector. However the AOD sector would need to consider the most appropriate format for providing training, and working together with the sexual assault sector to harness what is already in operation may prove beneficial.

Networking and workshop opportunities were also of great interest to practitioners in the field. Forum participants were enthusiastic about making connections and learning more about the other sector and used the forum as an opportunity to form collaborations for further work. There was an acknowledgement that for the AOD and sexual assault sectors to more effectively provide appropriate responses to clients with co-occurring AOD use and sexual victimisation histories, greater understanding of the other sector was necessary. However, a caveat to this enthusiasm and drive to provide greater service relates to the need for policy commitment to underpin any networking efforts. If the responsibility to provide greater service lies only with individual practitioners or agencies, it risks a lack of resourcing and governance that can lead to failure. The momentum and goodwill built between the AOD and sexual assault sectors as a result of this research can now be harnessed by policy to drive further collaborative interaction through training and networking opportunities.

Conclusions

The qualitative interviews with 11 AOD sector participants, and nine sexual assault sector participants, online surveys with 50 AOD sector respondents and 44 sexual assault sector respondents and the stakeholder forum undertaken for this research, all yielded surprisingly consistent responses to questions about an approach to interagency collaboration.

Workers in both sectors were aware of the intersections and shared clients who had experienced sexual victimisation and harmful and problematic AOD use. They were eager to know more about each other and to build their capacity but were concerned about how resourcing and lack of communication might hinder those efforts.

A number of participants had reservations about role creep and believed there was a central role for policy in providing governance and resources while providing an authorising environment for collaboration between the AOD and sexual assault sectors.

In discussing their resource needs, guidelines and training featured as strong choices in meeting the needs of workers and being a good use of resources.

There was also support for networking initiatives and working groups in which collaboration and partnerships could be nurtured and establish a connection between the sectors that could be used to support clients who experience both AOD use and sexual victimisation.

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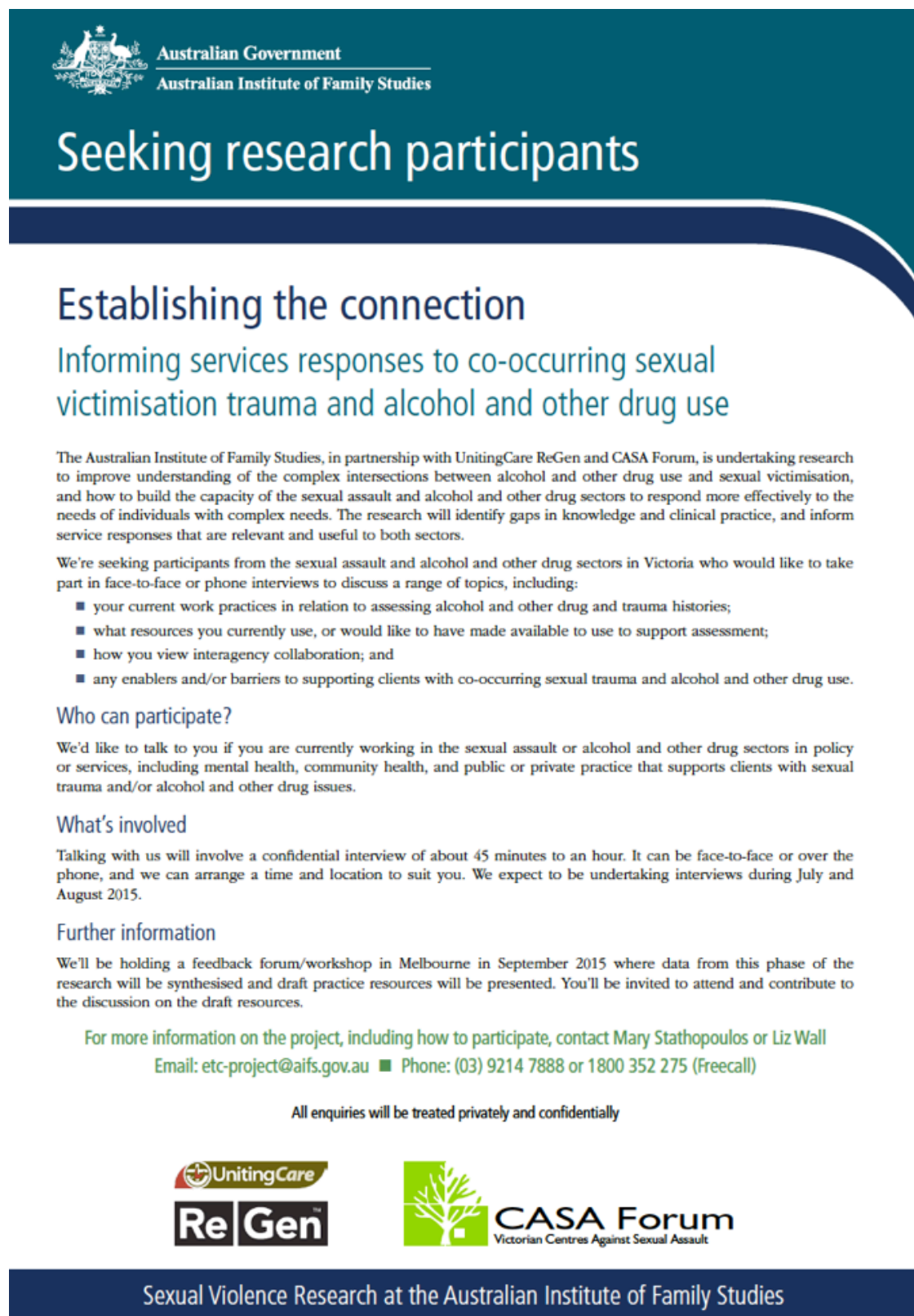
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Appendix A: Recruitment flyers

Interview recruitment flyer

Australian Government
Australian Institute of Family Studies

Seeking research participants

Establishing the connection

Informing services responses to co-occurring sexual victimisation trauma and alcohol and other drug use

The Australian Institute of Family Studies, in partnership with UnitingCare ReGen and CASA Forum, is undertaking research to improve understanding of the complex intersections between alcohol and other drug use and sexual victimisation, and how to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to the needs of individuals with complex needs. The research will identify gaps in knowledge and clinical practice, and inform service responses that are relevant and useful to both sectors.

We're seeking participants from the sexual assault and alcohol and other drug sectors in Victoria who would like to take part in face-to-face or phone interviews to discuss a range of topics, including:

- your current work practices in relation to assessing alcohol and other drug and trauma histories;
- what resources you currently use, or would like to have made available to use to support assessment;
- how you view interagency collaboration; and
- any enablers and/or barriers to supporting clients with co-occurring sexual trauma and alcohol and other drug use.

Who can participate?

We'd like to talk to you if you are currently working in the sexual assault or alcohol and other drug sectors in policy or services, including mental health, community health, and public or private practice that supports clients with sexual trauma and/or alcohol and other drug issues.

What's involved

Talking with us will involve a confidential interview of about 45 minutes to an hour. It can be face-to-face or over the phone, and we can arrange a time and location to suit you. We expect to be undertaking interviews during July and August 2015.

Further information

We'll be holding a feedback forum/workshop in Melbourne in September 2015 where data from this phase of the research will be synthesised and draft practice resources will be presented. You'll be invited to attend and contribute to the discussion on the draft resources.

For more information on the project, including how to participate, contact Mary Stathopoulos or Liz Wall
Email: etc-project@aifs.gov.au ■ Phone: (03) 9214 7888 or 1800 352 275 (Freecall)

All enquiries will be treated privately and confidentially

UnitingCare ReGen

CASA Forum
Victorian Centres Against Sexual Assault

Sexual Violence Research at the Australian Institute of Family Studies

Online survey recruitment flyer

Establishing the connection – online survey

Informing service responses to co-occurring sexual victimisation trauma and alcohol and other drug use

We are undertaking research to improve understanding of the complex intersections between alcohol and other drug use and sexual victimisation, and how to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to the needs of individuals with complex needs.

We're seeking participants from the sexual assault and alcohol and other drug sectors in Victoria who would like to take part in a brief online survey. **It will take approximately 10 minutes** and will cover:

- current practice in assessment of alcohol and other drug or trauma histories;
- what resources you currently use, or would like to have made available to use to support assessment;
- current referral processes; and
- any enablers and/or barriers to supporting clients with co-occurring sexual trauma and alcohol and other drug use.

Visit **www.aifs.gov.au/etc-survey** to complete our quick online survey

This project is funded by Australia's National Research Organisation for Women's Safety (ANROWS)

Sexual Violence Research at the Australian Institute of Family Studies

Stakeholder forum recruitment flyer

Australian Government
Australian Institute of Family Studies

Invitation to participate in a research forum

Establishing the connection

Informing service responses to co-occurring sexual victimisation trauma and alcohol and other drug use

The Australian Institute of Family Studies, in partnership with UnitingCare ReGen and CASA Forum, is undertaking research to improve understanding of the complex intersections between alcohol and other drug use and sexual victimisation, and how to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to individuals with complex needs.

We're seeking participants who work in the sexual assault and alcohol and other drug sectors in Victoria to contribute to a research forum. The forum will provide an opportunity to:

- present findings from the interviews we have undertaken with practitioners in both sectors;
- consult with you about the proposed outcome of the research, which is a set of guidelines or other resource to support practitioners working with clients with co-occurring sexual trauma and alcohol and other drug issues; and
- meet with colleagues who work in the sexual assault and alcohol and other drug sectors and form collaborations for further work in this area.

ESTABLISHING THE CONNECTION – RESEARCH FORUM

DATE: Thursday 24th September, 2015

TIME: 10.00 am to 12.00 pm (morning tea will be provided)

PLACE: Australian Institute of Family Studies, Balluk Room
Level 20, 484 La Trobe Street, Melbourne

RSVP: Please **RSVP by 14 September** via contact details below. Please note places are limited.

For more information on the project, including how to participate, contact Mary Stathopoulos or Liz Wall
Email: etc-project@aifs.gov.au ■ Phone: (03) 9214 7888 or 1800 352 275 (Freecall)

UnitingCare
ReGen

CASA Forum
Victorian Centres Against Sexual Assault

Sexual Violence Research at the Australian Institute of Family Studies

Appendix B: Plain language statement for interviews

Australian Government
Australian Institute of Family Studies
Australian Centre for the Study of Sexual Assault

"Establishing the Connection": *Informing service responses to co-occurring sexual violence and alcohol and other drug use issues*

About the project

Establishing the Connection is a 12-month project funded under the inaugural grant round of Australia's National Research Organisation for Women's Safety (ANROWS). Establishing the Connection aims to improve understanding of the complex intersections between alcohol/other drug use and the severity of, or vulnerability to, sexual violence and revictimisation, and to build the capacity of the sexual assault (SXA) and alcohol and other drug (AOD) sectors to respond more effectively to the needs of individuals affected by sexual violence.

The Australian Institute of Family Studies is conducting the project in partnership with Centres Against Sexual Assault (CASA Forum) and UnitingCare ReGen. This is a qualitative project involving consultation interviews with clinicians and other stakeholders working in the SXA and AOD sectors, and a forum/workshop to bring together the practice knowledge and needs of both sectors.

The research will identify gaps in knowledge and clinical practice, and inform service responses- including the development of practice guidelines- to co-occurring sexual assault and alcohol and other drug use issues.

Your involvement

You are invited to participate in the consultation, which will involve taking part in either a face-to-face or telephone interview, or a focus group discussion. We are seeking input on issues relating to current work practices in assessment and referral of clients across the SXA and AOD sectors, training and skills acquisition, organisational enablers and barriers to collaboration, and broader policy contexts.

We will publish the findings from these interviews and will formally seek your consent to include the information you provide in any relevant publications we produce. Your identity will remain confidential and you will only be identified by your profession or other non-identifying pseudonym.

You will be asked to verbally consent at the time of the interview or focus group, and this verbal consent will be recorded. Regardless of this verbal consent, you are still welcome to withdraw your participation from the research at any time up until the researchers anonymise the data (this is usually a week after the interview).

Further information

We'll be holding the feedback forum/workshop in Melbourne in September 2015 where data from this phase of the research will be synthesised and draft practice guidelines will be presented. You'll be invited to attend and contribute to the discussions on the draft guidelines.

Contact

If you are interested in participating, or just have any questions about the research, please contact:

Mary Stathopoulos or Liz Wall on

Phone: 03 9214 7888

Email: etc-project@aifs.gov.au

Ethics approval has been granted for this research, and any queries can be directed to the above details or the AIFS Ethics Committee Secretariat on 03 9214 7888 (project 14/20).

Appendix C: Interview schedules

Alcohol and other drug sector

Establishing the Connection

Proposed interview themes and questions: Alcohol and other drug sector

General

1. Can you please tell us a little about your organisation and the services you provide?
2. What is your role in the organisation?
3. What is your relationship or interaction with AOD clients?

AOD & SXA intersections and current work practice

1. How do you currently, if at all, assess a clients' experience of SXA? Is there a mechanism for this? (Is it referral based or related to collecting health and behavioural information?)
2. What does the mechanism consist of (check list, conversation, guidelines)? How useful do you find it?
3. When is this information sought (if at all) in the therapeutic relationship? (intake? as the relationship progresses?)
4. Do you often get clients/people who use your service either presenting with or discussing their experience with sexual violence un/prompted? How do you respond?
5. What other current work practices do you have for responding or referring clients who have experienced sexual violence?
6. When would you continue to work with a client with sexual assault trauma? When would you not?

Resources and training

1. Do you feel comfortable assessing SXA trauma among your clients?
2. Have you had any training related to approaches to take when working with SXA trauma?
3. What resources do you turn to when you need information about SXA issues related to your clients?
4. What would best support you to have that knowledge within your own organisation? Do you think it's necessary?

Collaboration

1. Do you have any formal or informal relationships or contacts with the SXA sector for secondary consultation or referral?
2. What do you think is the value in identifying, responding to and referring clients with SXA issues to specialist services? (helping the client?)
3. What can your org/the AOD sector more broadly do to achieve collaboration between the two sectors? What would this look like to support you the most?
4. What could the SXA sector do to support you and your organisation toward potential collaboration? And do you think there are particular similarities in the two sectors that might enable that? (approaches, paradigms)

5. What would be a barrier to this type of collaboration? (approaches, paradigms of either SXA sector or AOD sector, resources)

6. What would you say is the most important consideration for the SXA sector to recognise about AOD clients or the AOD sector?

7. How do you think the SXA sector might best identify, respond and refer their clients who present with issues related to AOD issues? Do you think they are doing that at the moment?

8. Do you have cooperative agreements (formal or informal) with other sectors (mental health, primary health) that support shared client assessment and referral? Are you happy with how this works, could this be improved? How could what works with that org/sector work for SXA assessment/identification and referral?

9. What should be considered in helping clients with concurrent issues/needs for these services seeking access to treatment?

Policy

1. Are there current policies for your sector that you think support collaboration between these two sectors/more broadly?

2. Are there current policies for your sector that are barriers to collaborations between these two sectors/more broadly?

Finish

1. Is there anything else you'd like to add before we finish up?

2. Are you able to suggest other individuals/agencies worth speaking with, including other service providers, policy-makers?

Thank you for your participation.

Sexual assault sector

Establishing the Connection

Proposed interview themes and questions: Sexual assault sector

General

1. Can you please tell us a little about your organisation and the services you provide?
2. What is your role in the organisation?
3. What is your relationship or interaction with victims of sexual violence?

SXA & AOD intersections and current work practice

1. How do you currently, if at all, assess a clients' problematic AOD use? Is there a mechanism for this? (Is it referral based or related to collecting health and behavioural information?)
2. What does the mechanism consist of (check list, conversation, guidelines)? How useful do you find it?
3. When is this information sought (if at all) in the therapeutic relationship? (intake? as the relationship progresses?)
4. Do you often get clients/people who use your service either presenting with or discussing their issues with alcohol and/or drugs un/prompted? How do you respond?
5. What other current work practices do you have for responding or referring clients experiencing problematic AOD use?
6. When would you continue to work with a client with AOD issues? When would you not?

Resources and training

1. Do you feel comfortable assessing AOD use among your clients?
2. Have you had any training related to approaches to take when working AOD use?
3. What resources do you turn to when you need information about AOD issues related to your clients?
4. What would best support you to have that knowledge within your own organisation? Do you think it's necessary?

Collaboration

1. Do you have any formal or informal relationships or contacts with the AOD sector for secondary consultation or referral?
2. What do you think is the value in identifying, responding to and referring clients with AOD use issues to specialist services? (helping the client?)
3. What can your org/the sexual assault sector more broadly do to achieve collaboration between the two sectors? What would this look like to support you the most?
4. What could the AOD sector do to support you and your organisation toward potential collaboration? And do you think there are particular similarities in the two sectors that might enable that? (approaches, paradigms)
5. What would be a barrier to this type of collaboration? (approaches, paradigms of either SXA sector or AOD sector, resources)
6. What would you say is the most important consideration for the AOD sector to recognise about victims of sexual violence or the sexual assault sector?
7. How do you think the AOD sector might best identify, respond and refer their clients who present with issues related to sexual victimisation? Do you think they are doing that at the moment?

8. Do you have cooperative agreements (formal or informal) with other sectors (mental health, primary health) that support shared client assessment and referral? Are you happy with how this works, could this be improved? How could what works with that org/sector work for AOD assessment/identification and referral?

9. What should be considered in helping clients with concurrent issues/needs for these services seeking access to treatment?

Policy

1. Are there current policies for your sector that you think supports collaboration between these two sectors/more broadly?

2. Are there current policies for your sector that are barriers to collaborations between these two sectors/more broadly?

Finish

1. Is there anything else you'd like to add before we finish up?

2. Are you able to suggest other individuals/agencies worth speaking with, including other service providers, policy-makers?

Thank you for your participation.

Appendix D: Online survey

Establishing the Connection - online survey

Informing service responses to co-occurring sexual victimisation trauma and alcohol and other drug use.

About the study

The Australian Institute of Family Studies, in partnership with UnitingCare ReGen and CASA Forum, is undertaking research to improve understanding of the complex intersections between alcohol and other drug use and sexual victimisation, and how to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to the needs of individuals with complex needs. Australia's National Research Organisation for Women's Safety (ANROWS) is funding the project.

How you can help

We're seeking participants who are currently working in the sexual assault and alcohol and other drug sectors in service provision or policy roles, including mental health, community health, and public or private practice that supports clients with sexual trauma and/or AOD use issues.

The survey will take approximately 10 minutes and will cover:
- current practice in assessment of alcohol and other drug or trauma histories;
- what resources you currently use, or would like to have made available to use to support assessment;
- current referral processes; and
- any enablers and/or barriers to supporting clients with co-occurring sexual trauma and alcohol and other drug use.

Your privacy

Your privacy is very important to us. The information that you provide is confidential and no names or other personally identifying information will be collected. The survey data will be stored securely for a minimum of 7 years in accordance with the National Health and Medical Research Council (NHMRC) research guidelines on a password-protected server at the Australian Institute of Family Studies. Only members of the research team will have access to these files.

Ethical conduct

Ethics approval has been granted for this research, and any queries can be directed to the AIFS Ethics Committee Secretariat on 03 9214 7888 (project 14/20).

Further information

For further information on the project please contact Mary Stathopoulos or Liz Wall. All enquiries will be treated privately and confidentially. Email: etc-project@aifs.gov.au Phone: (03) 9214 7888 or 1800 352 275 (Freecall).

How you can take part

If you would like to participate in the survey, please click the "Submit and proceed" button below:

There are 25 questions in this survey.

Your current role, service and location

Which sector do you (primarily) work in?

Please choose only one of the following:
- ○ Sexual assault sector
- ○ Alcohol and other drug sector

Which of the following best describes your workplace?

Please choose **only one** of the following:
- ○ Sexual assault specialist service
- ○ AOD specialist service
- ○ Mental health specialist service
- ○ Hospital/emergency service
- ○ Community health service/centre
- ○ General practice
- ○ Private practice
- ○ Other

Which of the following best describes your current role?

Please choose **only one** of the following:
- ○ Early career clinician/practitioner/counsellor advocate
- ○ Experienced clinician/practitioner/counsellor advocate
- ○ Senior clinician/practitioner
- ○ Clinical supervisor/manager
- ○ Policy/government role
- ○ Other

Which best describes your location?

Please choose **only one** of the following:
- ○ Metropolitan
- ○ Regional
- ○ Other

Client assessment

In your role do you assess alcohol and other drug (AOD) use among your clients?

Only answer this question if the following conditions are met:

Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:
- ○ Yes, using standard screening tools/modules/scales (please specify which tools in "other" text box below)
- ○ Yes, using open-ended questions/general discussion
- ○ I don't ask about AOD use but clients will sometimes initiate the discussion
- ○ No, I don't consider it part of my role
- ○ I don't have direct client contact
- ○ Other:

How confident are you/would you be to assess a clients AOD use?

Only answer this question if the following conditions are met:

Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose the appropriate response for each item:
- ○ Not at all confident
- ○ Confident
- ○ Very confident
- ○ Other:

Does your low level of confidence in assessing AOD use among your clients relate to any of the following?

Only answer this question if the following conditions are met:

Answer was "Not at all confident" *or* "Not very confident" at question "6 [A5]" (How confident are you/ would you be to assess a client's AOD use? *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:
- ○ There are no standard AOD assessment protocols in place at my organisation
- ○ I haven't had sufficient training in AOD assessment
- ○ Clients' other presentations usually take priority in our consultations and we don't necessarily have time to discuss AOD use
- ○ I find it difficult asking about AOD use because I don't want to upset clients or make them feel uncomfortable
- ○ I find it difficult asking about AOD use because of age, sex, language or cultural differences between myself and my clients
- ○ I don't have direct client contact
- ○ Other:

In your role do you assess sexual victimisation/trauma among your clients?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:
- ○ Yes, using standard screening tools/ modules/ scales (please specify which tools in "other" text box below)
- ○ Yes, using open-ended questions/ general discussion
- ○ I don't ask about sexual victimisation/trauma but clients will sometimes initiate the discussion
- ○ No, I don't consider it part of my role
- ○ I don't have direct client contact
- ○ Other:

How confident are you/would you be to assess a clients sexual victimisation/trauma?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose the appropriate response for each item:

- ○ Not at all confident
- ○ Confident
- ○ Very confident
- ○ Other:

Does your low level of confidence in assessing sexual victimisation/trauma among your clients relate to any of the following?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Not at all confident" *or* "Not very confident" at question "9 [B5]" (How confident are you/ would you be to assess a clients sexual victimisation/trauma?)

Please choose **all** that apply:

- ○ There are no standard sexual victimisation/trauma assessment protocols in place at my organisation
- ○ I haven't had sufficient training in sexual victimisation/ trauma assessment
- ○ Clients' other presentations usually take priority in our consultations and we don't necessarily have time to discuss sexual victimisation/trauma
- ○ I find it difficult asking about sexual victimisation/trauma because I don't want to upset clients or make them feel uncomfortable
- ○ I find it difficult asking about sexual victimisation/trauma because of age, sex, language or cultural differences between myself and my clients
- ○ I don't have direct client contact
- ○ Other:

Resources and training

What resources, and/or training would increase your confidence in assessing AOD use among your clients?

Only answer this question if the following conditions are met:

Answer was "Not at all confident" *or* "Not very confident" at question "6 [A5]" (How confident are you/would you be to assess a clients AOD use *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:

- ○ Practice/clinical guidelines
- ○ Factsheets
- ○ Online training
- ○ In-house face-to-face training
- ○ Cross-sector/interagency (AOD and sexual assault sectors) training
- ○ Partnerships with experts in the AOD sector ('call a friend')
- ○ Other:

Does your high level of confidence in assessing AOD use among your clients relate to any of the following?

Only answer this question if the following conditions are met:

Answer was "Confident" *or* "Very confident" at question "6 [A5]" (How confident are you/ would you be to assess a clients AOD use? *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:

- ○ I have access to standard AOD use assessment protocols and procedures
- ○ I have had sufficient training in AOD use assessment
- ○ I have colleagues in the AOD sector who I work with/ provide support
- ○ I have access to other relevant resources, e.g. websites, other information/referral services (please specify in "other" text box below)
- ○ Other:

What resources, and/or training have you/do you/would you use to support your assessment of AOD use among your clients?

Only answer this question if the following conditions are met:

Answer was "Confident" *or* "Very confident" at question "6 [A5]" (How confident are you/ would you be to assess a clients AOD use? *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:

- ○ Practice/clinical guidelines
- ○ Factsheets
- ○ Online training
- ○ In-house face-to-face training
- ○ Cross-sector/interagency (AOD and sexual assault sectors) training
- ○ Partnerships with experts in the AOD sector ('call a friend')
- ○ Other:

What resources, and/or training would increase your confidence in assessing sexual victimisation/trauma among your clients?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Not at all confident" *or* "Not very confident" at question "9 [B5]" (How confident are you/would you be to assess a clients sexual victimisation/trauma?)

Please choose **all** that apply:

- ○ Practice/clinical guidelines
- ○ Factsheets
- ○ Online training
- ○ In-house face-to-face training
- ○ Cross-sector/interagency (AOD and sexual assault sectors) training
- ○ Partnerships with experts in the sexual assault sector ("call a friend")
- ○ Other:

Does your high level of confidence in assessing sexual victimisation/trauma among your clients relate to any of the following?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Confident" *or* "Very confident" at question "9 [B5]" (How confident are you/would you be to assess a clients sexual victimisation/trauma?)

Please choose **all** that apply:

- ○ I have access to standard sexual victimisation/trauma assessment protocols and procedures
- ○ I have had sufficient training in sexual victimisation/trauma assessment
- ○ I have colleagues in the sexual assault sector who I work with/ provide support
- ○ I have access to other relevant resources, e.g. websites, other information/referral services (please specify in "other" text box below)
- ○ Other:

What resources, and/or training have you/do you/would you use to support your assessment of sexual victimisation/ trauma among your clients?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Confident" *or* "Very confident" at question "9 [B5]" (How confident are you/would you be to assess a clients sexual victimisation/trauma?)

Please choose **all** that apply:

- ○ Practice/clinical guidelines
- ○ Factsheets
- ○ Online training
- ○ In-house face-to-face training
- ○ Cross-sector/interagency (AOD and sexual assault sectors) training
- ○ Partnerships with experts in the sexual assault sector ("call a friend")
- ○ Other:

Referral processes

Do you currently have any processes in place to refer clients to AOD support interventions?

Only answer this question if the following conditions are met:

Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?

Please choose **only one** of the following:

- ○ Yes
- ○ No
- ○ Other

Are the referral processes formal or informal?

Only answer this question if the following conditions are met:

Answer was "Yes" at question "17 [A10]" (Do you currently have any processes in place to refer clients to AOD support/ interventions?) *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **all** that apply:

- ○ Formal
- ○ Informal
- ○ Other:

Please briefly describe your referral processes:

Only answer this question if the following conditions are met:

Answer was "Yes" at question "17 [A10]" (Do you currently have any processes in place to refer clients to AOD support/ interventions?) *and* Answer was "Sexual assault sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please write your answer here:

Do you currently have any processes in place to refer clients to sexual victimisation/trauma support/ intervention?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?)

Please choose **only one** of the following:

- ○ Yes
- ○ No
- ○ Other

Are the referral processes formal or informal?

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Yes" at question "20 [B10]" (Do you currently have any processes in place to refer clients to sexual victimisation/trauma support/intervention?)

Please choose **all** that apply:

- ○ Formal
- ○ Informal
- ○ Other:

Please briefly describe your referral processes:

Only answer this question if the following conditions are met:

Answer was "Alcohol and other drug sector" at question "1 [X1]" (Which sector do you (primarily) work in?) *and* Answer was "Yes" at question "20 [B10]" (Do you currently have any processes in place to refer clients to sexual victimisation/trauma support/ intervention?)

Please write your answer here:

Collaboration

What are the organisational/sector/policy barriers to any potential collaboration between the sexual assault and the AOD sectors?

Please write your answer here:

What are the organisational/sector/policy enablers to any potential collaboration between the sexual assault and the AOD sectors?

Please write your answer here:

Are there any other comments you would like to make?

Please write your answer here:

Thank you so much for your time!

Submit your survey.

Thank you for completing this survey.

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ANROWS