# Position Paper

## Strengthening the Role of the Alcohol and Other Drug (AOD) Sector in Responding to Gendered Violence

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## Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

## About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. Our vision is a Victorian community in which AOD-related harms are reduced and well-being is promoted to support people to reach their potential. VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- Providing leadership on priority issues
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drugs and related services

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*VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.*

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# Contents

# Introduction

This paper outlines the AOD sector's contributions and leadership in strengthening men's behaviour change responses, and identifies clear, actionable recommendations aligned with the Victorian Government's reform priorities. Developed in partnership with a cross-sector advisory group, it recognises the importance of early intervention and healing-informed approaches that centre children, young people, and structurally marginalised communities.

Not all people who use substances use family violence, and substance use alone does not determine whether someone will choose to perpetrate harm. However, when gendered and intersectional drivers of family violence are present, substance use consistently acts as an amplifier. It increases the frequency, severity and lethality of behaviours used to control, dominate or remove another person's autonomy. These patterns are compounded for women, children, young people, First Nations peoples, gender and sexually-diverse people and others who may experience structural disadvantage.

# Background

The Victorian Alcohol and Drug Association (VAADA), together with AOD service providers and the Specialist Family Violence Advisor (SFVA) program, is leading state-wide engagement to define the role and expectations of the AOD sector in responding to family violence. This includes addressing the needs of people who use violence and experience substance use, particularly within Men's Behaviour Change Programs (MBCPs). An advisory group comprising experts from across disciplines in AOD, family violence, and mental health has guided this work, grounded in healing-informed, child-aware, and intersectional approaches to risk, recovery, and accountability.

Historically, MBCPs have excluded people who use substances, despite clear and consistent evidence linking substance use and the perpetration of family violence. In Victoria, around two-thirds of intimate partner homicide offenders report either high levels of alcohol or drug use before, or around the time of the offence[1,2,3], and 80% of homicide-suicides involve substance use[2]. Eriksson et al. (2020) reported that 38.8% of homicide offenders had histories of alcohol dependence, and 30.8% reported drug use histories in the year before the offence. In a follow-up study by Boxall et al. (2022), 43% of homicide offenders reported drinking alcohol immediately beforehand.[4]

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1 Crime Statistics Agency Victoria. (2022). *Family violence data portal* [Data dashboard]. https://www.crimestatistics.vic.gov.au/family-violence-data-portal

2 Australian Domestic and Family Violence Death Review Network. (2022). Data Report: Intimate Partner Violence Homicides 2010–2018.

3 Eriksson, L., Bryant, S., McPhedran, S., Mazerolle, P., & Wortley, R. (2021). Alcohol and drug problems among Australian homicide offenders. Addiction, 116(3), 618-631.

4 Boxall, H., Doherty, L., Lawler, S., Franks, C., & Bricknell, S, (2022). The "Pathways to intimate partner homicide" project.

National forensic toxicology data confirms this relationship, that 20% of homicide offenders had consumed alcohol, and 12% had used other drugs at non-therapeutic levels at the time of the incident[3]. Laslett et al. (2010) found substance use present in 41.8% of intimate partner violence and 45.1% of other violence cases.[5] These figures suggest that substance use can influence the dynamics and risks of violence and therefore must be better integrated into prevention and intervention efforts.[5,6]

Despite this evidence, MBCP Minimum Standards permit excluding participants who use substances.[5] This reflects a stigma-informed response that limits opportunities for meaningful change. Compounding this, there is no requirement for facilitators to undertake AOD training, which undermines the reliability and safety of readiness and risk assessments and leads to missed intervention opportunities, particularly in cases involving parenting and child safety.[6]

Exclusionary practices, especially in the absence of AOD-specific expertise, reinforce siloed responses and leave significant gaps in early intervention.[7,8] This stands in stark contrast to the principles of accountable practice upheld in the AOD sector, where the focus is on creating the conditions for change, not perpetuating exclusion by ensuring that systems remain accountable to safe, non-stigmatising, equitable, and inclusive practice.

In the AOD sector, accountable practice refers not only to supporting clients to drive and be accountable for their recovery, but also ensuring that systems supporting practice remain accountable to safe, non-stigmatising, equitable and inclusive engagement.[7,8] It is about creating conditions for change, not perpetuating exclusion.

Across Victoria, the AOD sector is delivering therapeutic, evidence-informed programs that support behaviour change and promote safety, many of which have been evaluated and are ready to scale. To realise their full potential, however, we need system-wide support: improved integration, greater resourcing, and stronger AOD literacy across related workforces. At present, the system is not sufficiently equipped to enable the kind of holistic, cross-sector responses that complex lives require.

The AOD sector brings experience in working relationally, creatively, and in partnership with the community. Our services have a strong history of codesign, ensuring that interventions are grounded in the lived expertise of those most affected.

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5 Laslett, A.-M., Room, R., Ferris, J., Wilkinson, C., Livingston, M., & Mugavin, J. (2010). *The Range and Magnitude of Alcohol's Harm to Others*. Fitzroy, Victoria: AER Centre for Alcohol Policy Research, Turning Point

6 Family Safety Victoria. (2006). *Men's behaviour change minimum standards*. State of Victoria.

7 Ritter, A., Berends, L., Chalmers, J., et al. (2014). *New Horizons: The review of alcohol and other drug treatment services in Australia*. Drug Policy Modelling Program, UNSW.

8 Ritter, A., & Stoove, M. (2016). Alcohol and other drug treatment policy in Australia. *Medical Journal of Australia*, 204(4), 138.e1. https://doi.org/10.5694/mja15.01001

As reform efforts evolve, there is a clear opportunity to embed approaches that are not only evidence-informed but community-aware and led, shaped by the needs, strengths, and experiences of structurally marginalised communities. These gaps and the weight of the evidence underscore the urgent need to integrate AOD expertise into the design and delivery of interventions for people who use family violence.

# Key Messages

## 1. Addressing substance use is one of the most effective ways to reduce the frequency and severity of family violence, yet AOD expertise remains underutilised.

The Alcohol and Other Drug (AOD) sector plays a critical role in preventing and responding to family violence, as substance use significantly affects impulse control, emotional regulation, and behavioural decision-making. While not all people who use substances perpetrate family violence, the relationship is well-evidenced and reducing substance use alone can lower the risk of harm from family violence.[7,8] Our expertise is grounded in behavioural change. The AOD workforce is trained in motivational interviewing, the Stages of Change model, trauma- and violence-informed care, harm reduction, and strengths-based practice. These approaches equip us to engage with people using substances, whether for enjoyment or as a response to trauma, grief, mental health distress, or systemic disadvantage. Reducing substance use, even without other interventions, can reduce the risk of violence, but this requires accessible, supportive pathways to treatment.[7,8,9] Restrictive or exclusionary responses are unlikely to reduce harm without also investing in evidence-informed, trauma- and violence-aware care.[9,10]

We already work with complexity and accountability. AOD services are actively aligning with the Multi-Agency Risk Assessment and Management (MARAM) Framework, identifying risk, disrupting cycles of harm, and engaging people who use violence through supportive, non-punitive, and change-focused frameworks. Our systems work with individuals navigating multiple intersecting challenges, including substance use, mental health distress, housing insecurity, social isolation, and parenting responsibilities and do so in ways that recognise safety, accountability, and long-term recovery as interdependent. This aligns with recent parliamentary findings highlighting the need for evidence-based responses across all parts of the system, including AOD, to address the underlying drivers of family violence.[8]

9 Victorian Legislative Assembly Legal and Social Issues Committee. (2025). *Building the evidence base: Inquiry into capturing data on people using family violence in Victoria*. Parliament of Victoria

10 Victorian Alcohol and Drug Association (VAADA). (2024). *Submission to the Inquiry into Capturing Data on Adults Who Use Domestic and Family Violence in Victoria*.

The capacity of our sector to influence is constrained by systemic barriers. Despite our critical role, the AOD sector's endorsement and capacity to respond to family violence are limited by siloed data, fragmented integration, and insufficient resourcing. Recent inquiries highlight that system-wide responses often fail to capture the complexity of people using violence or to embed AOD expertise effectively. [8,9,10]

## 2. Behavioural change is a core function of the AOD sector in Victoria.

Our practice frameworks acknowledge that interpersonal and structural issues, including racism, poverty, and intergenerational trauma, contribute to patterns of substance use and, in some instances, escalate the risk of harmful behaviours, including violence. [11]

Behavioural change has always been a core function of the AOD sector. Our interventions are grounded in compassionate, healing-informed, and non-punitive approaches that recognise substance use and dependence as a response to trauma, structural disadvantage, unmet needs, and enjoyment, not a moral failing. [12]

We recognise that accountability and empathy are not mutually exclusive. AOD practitioners are skilled at navigating this balance, engaging people in meaningful change while maintaining safety and responsibility, particularly where parenting roles and family connection are involved. [13]

AOD services are uniquely positioned due to their multidisciplinary staffing profiles, which include lived and living experience, therapeutic interventions, clinicians, nurses, psychologists, addiction GPs and psychiatrists, and, importantly, Specialist Family Violence Advisors. This enables holistic, flexible support responsive to the complexity of people's lives. [14]

Our systems are designed to engage people navigating intersectional complexity, including parenting while experiencing overlapping challenges such as substance use, mental health distress, housing insecurity, family violence, and social isolation. With the right recognition and integration, the AOD sector could significantly improve engagement outcomes for people who use violence and reduce harm to families and communities. [15]

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11 Expert Panel (2024). *Unlocking the Prevention Potential: Accelerating Action to End Domestic, Family and Sexual Violence*. Department of the Prime Minister and Cabinet

12 Victorian Department of Health. (2023). *Alcohol and other drug program guidelines*. Retrieved from https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines

13 Family Safety Victoria. (2023). *MARAM Consolidated Annual Report 2022–23*. Retrieved from https://www.vic.gov.au/annual-report-implementation-family-violence-risk-assessment-and-management-framework-2022-23

14 Victorian Alcohol and Drug Association (VAADA). (n.d.). *Family Violence*. Retrieved from https://www.vaada.org.au/project/family-violence/

15 VAADA. (2024). *Submission to the Legislative Assembly Legal and Social Issues Committee: Inquiry into capturing data on adults who use domestic and family violence in Victoria*.

## 3. We are already doing the work—but without visibility or funding.

The AOD sector plays a critical, under-recognised role in responding to family violence, particularly in working with men who use violence. While most men will never voluntarily engage with a Men's Behaviour Change Program (MBCP), many do engage with AOD services. For some, this is the only service with sustained involvement. This positions the AOD sector uniquely—and powerfully—to invite reflection, offer support, and build trust around behaviour change and accountability. [14]

Approximately 65% of AOD clients are men, many of whom are parents or caregivers. Practitioners often report fatherhood as a strong motivator for change, offering an opportunity to disrupt intergenerational harm through tailored, non-punitive conversations. [15]

MARAM-aligned AOD services already identify risk, disrupt patterns of perpetration, and strengthen practice accountability. However, although strengthened and empowered by the Specialist Family Violence Advisor Capability Program, this work remains largely unfunded and siloed. [16]

Analysis by Odyssey Victoria suggests that MARAM and Safe and Together implementation has resulted in a 40% increase in time spent on engagement, documentation, and referrals—critical safety and compliance tasks not adequately resourced. [15]

## 4. A scalable, evidence-informed model already exists

The AOD sector is already delivering a range of evidence-informed, intersectional responses that support people who use family violence. Despite their success, these programs remain largely unrecognised and underfunded within mainstream family violence reform. This includes therapeutic models that centre parenting and recovery, challenge harmful behaviours, and offer safety-oriented interventions aligned with both the MARAM and Safe and Together Frameworks.

Windana's U-TURN program is an embedded MBCP within AOD rehabilitation settings, delivering tailored, therapeutic interventions to people who use family violence, many of whom identify as parents or carers.

U-TURN is not currently funded through family violence streams, despite its success, yet its expansion would allow for a scalable, integrated intervention aligned with MARAM and therapeutic best practice. [16]

Additional programs already in use across AOD settings, such as Caring Dads, and Odyssey's KODY and 'Our Relationships' programs offer relational, healing-informed and child-centred responses, aligned with contemporary family violence practice principles. These programs demonstrate the sector's readiness to deliver integrated and scalable behaviour change interventions.

16 Windana. (2023). *U-TURN Program Overview and Evaluation Summary*.

## 5. Substance use is a critical risk factor for family violence and should never be a barrier to opportunities for change.

MBCPs must not remain inaccessible to people who use substances, when two-thirds of family violence homicides are perpetrated by someone who was substance-affected at the time.[17]

While not everyone who uses substances causes harm, we also know that substance use contributes to a range of violent behaviours, including sexual violence, physical assault, and abuse across all relationship types. [3,17,18]

The AOD sector is already engaging with people who use family violence, including in parenting roles and can manage risk, support accountability, and foster sustained change through a gendered, healing-informed, and child-centred lens.

# Recommendations

1. **Recognise and resource the AOD sector as a key partner in family violence reform**, including through access to the Housing Platforms, Housing Establishment Fund (HEF), Emergency Relief Packages, and participation in cross-sector initiatives such as collaborative risk management and care team responses. These supports are critical to risk management, as well as enabling engagement in therapeutic, behaviour change, and healing-focused work
2. **Expand and resource Windana's U-TURN program as a statewide model,** embedding therapeutic Men's Behaviour Change Programs (MBCPs) within AOD services. This model responds to the intersection of substance use and family violence, addressing risk from both (and interrelated) substance use and family violence.

   Estimated cost: $4 million per annum statewide, based on current implementation at $250,000 per AOD region
3. **Establish dedicated AOD Advisor roles within the family violence sector**, mirroring the success of the Specialist Family Violence Advisor (SFVA) program in AOD and mental health. These roles would build AOD literacy, embed intersectional practice, and support consistent cross-sector governance.
4. **Expand the Specialist Family Violence Advisor (SFVA) Capability Program across AOD and mental health**, in response to significant statewide demand and based on local needs.
5. **Invest in codesigned responses led by the communities most impacted by systemic inequity, including First Nations peoples, LGBTIQA+ communities, and people with disability**. This includes building on existing

17 Crime Statistics Agency Victoria. (2022). *Family violence data portal* [Data dashboard]. https://www.crimestatistics.vic.gov.au/family-violence-data-portal

18 Australian Domestic and Family Violence Death Review Network. (2022). *Data Report: Intimate Partner Violence Homicides 2010–2018.*

initiatives led by Bendigo & District Aboriginal Co-operative, Jesuit Social Services, and others that centre healing, accountability, and family connection.

6. **Enhance capacity building and workforce development across family violence and AOD services** via cross-sector training and shared frameworks, including the incorporation of family violence content in the AOD Skillset.
7. **Fund cross-sector stewardship and governance infrastructure to restore and sustain a family violence capability-building function in AOD**. There is currently no funded, dedicated AOD sector-wide stewardship mechanism to support consistent implementation of reform, maintain alignment with MARAM, or ensure accountability for cross-sector integration. Investment here ensures that practice reforms translate into durable systems change and measurably safer outcomes.

# Conclusion

The AOD sector remains central to improving community safety, enabling long-term behaviour change, and addressing the complex intersection of substance use and family violence. Strategic investment in leadership, treatment capacity—including co-designed bespoke program development, and evidence-informed MBCP models like U-TURN is critical to achieving sustainable, integrated responses to family violence in Victoria. While we acknowledge that not all people who use substances perpetrate family violence, the interrelation is so significant that evidence suggests reducing substance use alone can reduce the risk of harm associated with family violence.

Our healing-centred, gender-informed practice positions us to improve safety for people impacted by family violence and substance use, whether their own or someone close to them.


## With thanks to our Steering Group representatives from:

- Bendigo and District Aboriginal Cooperative
- Windana
- The Centre for Mental Health Learning
- Jesuit Social Services
- Bendigo Community Health Services
- Sunraysia Community Health Services
- Odyssey Victoria
- Anglicare Victoria