SaxInstitute

Evidence Check

Integrated approaches for domestic and family violence, mental health issues and alcohol and other drug use

An Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health—September 2020

An Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health.
September 2020.

This report was prepared by Natalie Townsend, Isabelle Barnes, Emma Byrnes, Amy Anderson, Suzanne Lewis, Nicholas Goodwin, Frances Kay-Lambkin, Deborah Loxton. University of Newcastle.

Enquiries regarding this report may be directed to the:

Manager
Knowledge Exchange Program
Sax Institute
www.saxinstitute.org.au
knowledge.exchange@saxinstitute.org.au
Phone: +61 2 91889500

Suggested Citation:

Townsend N, Barnes I, Byrnes E, Anderson A, Lewis S, Goodwin N, Kay-Lambkin F, Loxton D. Integrated approaches for domestic and family violence, mental health issues and alcohol and other drug use: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2020.

doi:10.57022/zdgz6467

Disclaimer:

This Evidence Check Review was produced using the Evidence Check methodology in response to specific questions from the commissioning agency.

It is not necessarily a comprehensive review of all literature relating to the topic area. It was current at the time of production (but not necessarily at the time of publication). It is reproduced for general information and third parties rely upon it at their own risk.

Integrated approaches for domestic and family violence, mental health issues and alcohol and other drug use

An Evidence Check rapid review brokered by the Sax Institute for the NSW Ministry of Health. September 2020.

This report was prepared by Natalie Townsend, Isabelle Barnes, Emma Byrnes, Amy Anderson, Suzanne Lewis, Nicholas Goodwin, Frances Kay-Lambkin, Deborah Loxton. University of Newcastle.

Contents

Definitions and abbreviations

Definitions

Term	Definition
Integration	The provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma-informed approach, and is designed around the holistic needs of the individual throughout the life course.[1]
Trauma-informed	A program, organisation, or system that is trauma-informed: • Realises the widespread impact of trauma and understands potential paths for recovery. • Recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system. • Responds by fully integrating knowledge about trauma into policies, procedures, and practices. • Seeks to actively resist re-traumatisation.[2]
Domestic and family violence	Domestic and family violence refers to violence between family members, typically where the perpetrator exercises power and control over another person. This includes violent behaviour between current or previous partners, as well as abuse between parents and their children.[3]

Abbreviations

AOD	Alcohol and other drugs
DFV	Domestic and family violence
DVDRT	Domestic Violence Death Review Team
IPARVAN	Integrated Prevention and Response to Violence and Neglect
MH	Mental health
PTSD	Post Traumatic Stress Disorder
VAN	Violence and Neglect

Executive summary

Purpose and aims

This Evidence Check aims to increase understanding of international and Australian policies, programs and models of practice for integrated, trauma-informed responses for domestic and family violence (DFV), mental health (MH) issues, and/or alcohol and other drug (AOD) use and dependence.

This Evidence Check responds to the following three questions:

Question 1: What policies, programs or models of practice have been effective in supporting the delivery of integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Question 2: Summarise the alignment of these policies or programs (from Question 1) to the system design principles set out in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

Question 3: What are the key barriers to, and enablers of, integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Summary of methods

The Research Centre for Generational Health and Ageing, a priority research centre at the University of Newcastle, and its collaborators undertook this Evidence Check. This Evidence Check was approached systematically, guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) protocols. The research team conducted a systematic search of four electronic databases (Medline, Cochrane Library, PsycInfo, and Sociology Source Ultimate) to capture relevant peer reviewed literature. Four key journals which are not included in academic databases were also searched (Journal of Family Violence, International Journal of Integrated Care, Journal of Integrated Care, and International Journal of Care Coordination). Grey literature sources were also searched to identify additional relevant information.

Articles identified for inclusion underwent data extraction. The quality of the included evidence was assessed using the National Health and Medical Research Council's FORM grading system. Relevant

information was compiled and summarised, programs and models were analysed for effectiveness, relevance to the NSW setting, and strengths and limitations based on the reported evidence (Question 1). The programs and models were also mapped to the system design principles of the Integrated Prevention and Response to Violence, Abuse and Neglect Framework (IPARVAN Framework) (Question 2). Finally, the barriers and enablers to integrated, trauma-informed responses to DFV, MH issues and/or AOD use and dependence were extracted from the articles, and a thematic analysis was undertaken (Question 3).

Key findings

Overall, the quality assessment of the evidence base was rated as poor, due to the quality and design of the included studies. The consistency and clinical impact components were rated as not applicable, as these elements are used to assess the consistency of results and the clinical impact of a measured treatment, such as medication. The generalisability and applicability of the included literature were rated as good, indicating that the results can be generalised to the identified population groups and are applicable in the Australian and NSW context. There are some issues with using an objective rating scale such as this when assessing DFV, such as the high ratings of randomised controlled trials, which may not be safe or ethical in the DFV context.

Question 1

- What policies, programs or models of practice have been effective in supporting the delivery of integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Overall, 22 articles described 15 policies, programs, or models of practice that were found to be relevant for supporting the delivery of integrated, trauma-informed responses where DFV, MH issues and/or AOD use co-exist: three policies, programs, or models of practice where DFV, MH issues and AOD use co-exist; 10 policies, programs, or models of practice where DFV and MH issues co-exist; and two programs where DFV and AOD use co-exist:

- Integrated Domestic and Family Violence Service Program
- Integrated Post Crisis Response Service Model
- The Massachusetts Child Trauma Project
- Child FIRST: A comprehensive home-based intervention translating research into early childhood practice
- Sobriety Treatment and Recovery Teams Program
- The Stella Project Young Women’s Initiative
- Arkansas Initiative
- Project Kealahou
- Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study
- Women's input into a trauma-informed systems model of care in health settings (the WITH Study): the Health Systems Implementation Model
- Domestic Violence and Mental Health Pilot Project

- Northern Area Mental Health Service Partnership Project
- Specialist Family Violence Advisor Capacity Building Program
- Trauma Informed Child Welfare Systems Change Initiative
- Treatment of Complex Trauma in Young Children Program

The level of evidence for the efficacy of many programs was a major limitation of the literature reviewed. Although evaluations had been conducted for most programs, only three included robust comparison methods, and all of these were located in the USA, with limited applicability to the NSW context.

Mixed methods approaches that incorporate pre/post-tests can help to overcome some of the limitations of relying solely on collecting follow-up data, which can be problematic. Project Kealahou and the Integrated Domestic and Family Violence Service Program both used mixed methods to evaluate their programs, leading to results that were superior in quality to those obtained by simple reflexive or descriptive methods, which do not allow for a reasonable assessment of service provision.

Taking the quality of evidence into account, the most robust results were provided by the Massachusetts Child Trauma Project, Child FIRST and Women with Alcohol Drug Abuse and Mental Health Disorders who have Histories of Violence Study. All of these studies demonstrated positive impacts of the interventions used. Of these three, Child FIRST also demonstrated a large number of strengths and few limitations, although the program was developed in Connecticut USA, which might limit its applicability to the NSW policy and practice context.

Both of the mixed methods studies demonstrated positive results. Elements of Project Kealahou could be examined for use in the NSW context; however, may be of limited utility. The Integrated Domestic and Family Violence Service Program was developed in NSW and demonstrated very clear positive effects for clients and practitioners, and had many strengths, with its main limitation being the lack of incorporation of AOD services in its model. The Specialist Family Violence Advisor Capacity Building Program did include AOD services and offered many of the same elements as the Integrated Domestic and Family Violence Service Program but did not report any evaluation as to efficacy.

The Integrated Domestic and Family Violence Service Program was the only reviewed program that evaluated and reported on integration of services, with findings indicating positive results. Referrals to the program from NSW Health services were lower than referrals to other services. This may indicate opportunities for increased collaboration with these services. The addition of AOD services is feasible and would benefit this program and its client base. The other limitations of this program could similarly be addressed by expanding sector specific training to be reciprocal in nature and taking geography into account by scaling programs up to consider inland rurality.

The Safe & Together Model was identified as an additional model that provides a set of core principles and components that can be used to underpin integrated care program development. The model has been used to facilitate development of several programs in Australia; of most relevance to the current Evidence Check is the Safe and Together Addressing ComplexitY (STACY) Project, which aimed to build worker and organisational capacity in working with families at the intersection of DFV, AOD, and MH. Unfortunately, at the time of writing, the STACY Project final report was not yet available. However, it would be worthwhile to consider the project's findings once they are published.

Question 2

- Summarise the alignment of these policies or programs (from Question 1) to the system design principles set out in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

All of the 15 policies, programs and models of practice identified in Question 1 reported aspects of their work that aligned to some extent with the system design principles as described in NSW Health's IPARVAN Framework. Only one program described elements that aligned with all five relevant principles: the Integrated Domestic and Family Violence Service Program. Seven programs or models reported components that aligned with four principles; five noted elements that aligned with three principles; and two described facets that aligned with two system design principles.

Twelve of the programs and models of practice described person- and family-centred, holistic and seamless care which prioritised the safety, well-being and unique needs and preferences of the person and their family. Eleven of the programs and models of practice recognised and valued recovery from trauma as a primary outcome, and the four that did not explicitly prioritise trauma recovery could be seen as valuing recovery as a potential outcome, either explicitly or implicitly.

Five of the programs and models of practice prioritised early intervention. As such, programs and models were least likely to be aligned with this principle. For some of the programs and models that did not align, the focus was on recovery from complex trauma over the long term, some implicitly prioritised early intervention (e.g. child protection services), and others were focused on building capacity where early intervention was not specified.

Ten of the programs and models of practice were reported to provide equitable, accessible, and/or consistent service responses. It is important to note that the lack of information about equity, accessibility, and consistency in the remaining five programs and models does not mean they were inequitable, inaccessible, or inconsistent. As would be expected, given the inclusion criteria for this Evidence Check, 13 of the 15 programs aligned with the principle of collaboration to support people and their families to access the most appropriate service response (the two that did not align were embedded within mental health and trauma services).

Question 3

- What are the key barriers to, and enablers of, integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

The 22 articles which described the included 15 programs and models of practice were thematically analysed to identify barriers and enablers of integrated, trauma-informed responses to DFV, MH issues and/or AOD use and dependence. Specific barriers or enablers for priority populations were also identified. The barriers and enablers identified from the reviewed literature were provided to complement those already determined by The Case for Change: Integrated prevention and response to violence, abuse and neglect in NSW Health [4] a summary of key findings from research and clinical literature that underpins the IPARVAN Framework.

Six key barriers to integrated, trauma-informed responses for DFV, MH issues and/or AOD use and dependence were identified: time and cost; conflict between agencies; logistics; disclosure and

identifying complex needs; addressing and prioritising complex needs; and burden of providing trauma-informed care.

Six key enablers of integrated, trauma-informed responses for DFV, MH issues and/or AOD use and dependence were identified: building and maintaining relationships with partners to support integration; communication between partners; structure; supporting and training staff; embedding the needs and perspective of the target population; and leadership and advocacy.

Very limited barriers and enablers were found for priority populations, and were focused on the need for cultural safety, recognising the impact of disempowerment and the need for empowerment, and practical enablers such as transport and outreach programs.

An overarching theme when discussing barriers to and enablers of integrated, trauma-informed responses to DFV, MH issues and/or AOD use and dependence is the need to work in partnership across sectors and with clients. Common core understandings can facilitate the building of relationships, and the system design principles articulated in the IPARVAN Framework [1] can be utilised for this purpose. Adequate funding is also needed. While this is not specifically mentioned in the reviewed reports, it is implicit in some of the structural barriers and would support the instigation of enabling factors. Finally, the information on barriers and facilitators requires more detailed investigation, particularly in the NSW context, in order to be applicable and of sufficient quality to warrant further investment into enabling factors.

Conclusions and recommendations

The most consistently sound and quality program was the Integrated Domestic and Family Violence Service Program. Its major limitations would be easily dealt with by an expansion of its consideration of geography (to incorporate remote and inland areas), and by adding AOD services. The Integrated Domestic and Family Violence Service Program was also the only program to align with all five of the IPARVAN Framework [1] system design principles, which may lie at the core of its successful outcomes. An assessment of the sustainability of the Integrated Domestic and Family Violence Service Program is warranted, as the program has demonstrated promising results.

Gaps in the evidence

A clear theme of the current Evidence Check was the lack of high quality evidence for the effectiveness of programs, and in some cases a lack of any reported evidence for efficacy. It is recommended that consideration be given to the following:

- Including a mandatory requirement for evaluation reports with any publicly funded program designed to address DFV, MH issues and AOD use and dependence
- Using mixed methods approaches and a pre/post-test design as a minimum standard for program evaluation (as conducted by the Integrated Domestic and Family Violence Service Program)
- Inviting experts in the field to peer review reports before they are released

Many programs indicated training AOD and MH workers in the impact of DFV, however cross training should be reciprocal to allow DFV workers to benefit from increased understanding of MH issues and AOD use and dependence.

There was a notable lack of evidence with regard to priority populations concerning the identification of barriers and enablers to service access. Targeted research is needed to identify community specific barriers to and enablers of integrated service delivery for DFV, MH and AOD issues.

Very few of the reviewed programs reported the inclusion of perpetrators in their services. Those that did, provided little information as to efficacy. The focus of integrated care in the context of DFV appears to be on those who have been abused, rather than on the abuser. It is likely that a broader investigation into perpetrator intervention programs, not limited to integrated approaches, might uncover elements of program delivery that could be incorporated into an integrated approach. The Safe & Together Model could be helpful in guiding an approach that is more inclusive of perpetrator behaviour.

While the associations between DFV, MH issues and AOD use are robust, the nature of these associations remains opaque. Findings suggest that most of these associations are bidirectional and have the capacity to precede further incidents of DFV, worsening MH and increased AOD use. The programs and models of care described in this Evidence Check have sought to address DFV, MH and/or AOD use, with varying degrees of demonstrated success.

Background

This Evidence Check aims to increase understanding of international and Australian policies, programs and models of practice for integrated, trauma-informed responses for domestic and family violence (DFV), mental health (MH) issues, and/or alcohol and other drug (AOD) use and dependence. It directly responds to a previous NSW Domestic Violence Death Review Team (DVDRT) recommendation.[5] The DVDRT analyses domestic violence related deaths and makes findings and recommendations for implementation by government and non-government agencies to reduce the incidence of these deaths and to facilitate system and service improvement.

By systematically reviewing international and Australian policies, programs, and models of care for integrated, trauma-informed responses to the co-occurrence of MH issues, AOD use and DFV it will support progression of NSW Health's Violence, Abuse and Neglect (VAN) Redesign Program and other policy and practice development,

To support this, the alignment of identified programs, policies and models of care to the relevant system design principles of the NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework (IPARVAN Framework) [1] will also be examined. Finally, this Evidence Check will summarise available evidence for enablers and barriers to integrated, trauma-informed responses to DFV, MH issues, and/or AOD use.

The review aims to address the following three questions:

Question 1: What policies, programs or models of practice have been effective in supporting the delivery of integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Question 2: Summarise the alignment of these policies or programs (from Question 1) to the system design principles set out in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

Question 3: What are the key barriers to, and enablers of, integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Domestic and family violence in Australia

Australian statistics indicate that one in six Australians have experienced violence perpetrated by an intimate partner since the age of 15, including one in four women and one in 13 men. Furthermore, in Australia, approximately one woman is killed each week by an intimate partner.[6]

Between 2000 and 2014, one in four victims of domestic violence homicide in NSW were children. Similarly in NSW, between 2012-13 and 2016-17, one in four children reported to child protection services as at risk of significant harm, were experiencing or exposed to DFV.[7]

Domestic and family violence often occurs alongside AOD use or dependence, and/or MH issues.[3, 8] Mental health problems and AOD use are common both among perpetrators of DFV.[8-10] According to the Australian Institute of Health and Welfare (AIHW) [3], approximately one in three people seeking homelessness services due to DFV have problematic AOD use and/or a MH issue. The co-occurrence of these issues reflects a complex and multi-fold set of associations that can have long-lasting impacts on individuals and families.[11-13] Such complexity requires an integrated approach to respond to these issues.

Co-existing domestic and family violence, mental health issues, and alcohol and other drugs use and dependence

Domestic and family violence and alcohol and other drug use and dependence

Alcohol and other drug use has been associated with violence [8, 9, 14], with estimates indicating that alcohol is involved in 35% of family violence incidents in NSW.[15] AOD use has been associated with both the perpetration and experience of DFV. However, as noted by the NSW DVDRT, a causal relationship cannot be assumed: *"…many people in the community who use drugs or alcohol do not have problems with violence, and many people who use violence do not have issues with drugs and alcohol"*. [16]

In 2018, approximately half of all perpetrators of DFV homicide were reported as being under the influence of alcohol, other drugs, or both.[3] In studies of both violence and AOD use, co-occurrence rates of 25-50% have been reported among perpetrators.[17] At the height of this range, one study reported that approximately half of the men in AOD treatment programs had perpetrated intimate partner violence [18], and another reported that half of the men in perpetrator intervention programs had tendencies towards alcohol dependence.[19] Drug use has been associated with both violence towards partners [8, 9] and child maltreatment.[9] Notably, a recent meta-analysis of nearly 300 studies highlighted evidence of associations between partner violence perpetration and the use of amphetamines, cocaine, and marijuana.[8]

Consistently high odds of problematic alcohol use have been reported for those who have experienced DFV.[8, 14, 20] Experiences of DFV have also been significantly associated with the use of amphetamines, cocaine, and marijuana.[8] Moreover, longitudinal data demonstrate a bidirectional relationship between the experience of DFV and AOD use. That is, there is evidence that AOD use can increase vulnerability to abuse, and at the same time experiences of DFV often precede increased AOD use.[20, 21] Together, these results show that a potential response to the trauma of DFV (increased AOD use) might lead to further experiences of violence. However, the nature of DFV research means that while temporal modelling can be undertaken, causal associations cannot be determined. Further qualitative research is needed to fully understand the complexity of the relationships between DFV and AOD use, and the responses to trauma that occur in the context of DFV.

Domestic and family violence and mental health issues

In addition to AOD use, DFV has also been strongly related to other MH problems.[22] Among perpetrators, mental ill health is common [10, 23-25], with strong evidence supporting the link between DFV perpetration and mood and anxiety disorders.[10] A systematic review of 42 studies reported DFV perpetration prevalence rates of: 18% among men with depression; 20% among men with generalised anxiety disorder; and 14% among those with panic disorder. Similar rates have been reported among female perpetrators with regard to depression (19%) and panic disorder (23%).[10]

Among those who have experienced DFV concurrent DFV and MH issues have been well documented [22]. Estimates from a systematic review of 42 studies suggested that more than 30% of psychiatric patients had experienced domestic violence.[26] The extent of these associations varied across different disorders; however, robust evidence supported the link between experiences of DFV and depression, anxiety, and post-traumatic stress disorder.[22, 27] A meta-analysis of 41 studies of women who had experienced intimate partner violence reported prevalence rates of 46% for depression, 28% for anxiety, and 61% for post-traumatic stress disorder. High rates of co-occurrence were also observed among males who had experienced DFV, however, these studies were assessed as lacking in both quantity and quality.[22]

The impact of co-existing domestic and family violence, alcohol and other drug use and dependence, and mental health issues

The co-existence of DFV, AOD use, and MH issues can have a detrimental impact on health and quality of life.[3, 11, 12] In addition, the effects of AOD use and poor MH can be long lasting and present further challenges for recovery, even after the violence has ceased. The Australian Longitudinal Study on Women's Health reported significant MH deficits in women who had experienced domestic violence, which persisted for 16 years. [28] Among children, experiences of abuse and neglect can lead to ongoing poor MH and AOD use in later life.[29-31] This impact extends to children who witness domestic violence, mental ill health, and/or substance use in the family of origin.[29] While causal links between these complex factors will likely never be established, the evidence for co-occurrence is robust and points to the need for a multifaceted response to facilitate DFV prevention and the recovery of those who have been impacted by DFV, AOD use and MH issues.

The need for an integrated approach

The NSW Domestic Violence Death Review Team (DVDRT) Report 2017-19 [16] makes 34 recommendations for improving the response to DFV in NSW. Recommendation 20 recognises the importance of drawing together responses to DFV with those aimed at AOD use and MH issues; through the leadership of NSW Health, as part of Phase 2 of the Violence Abuse and Neglect Redesign Program. This recommendation is in line with recommendations of the World Health Organization clinical and policy guidelines, the Victorian Royal Commission into Family Violence and the report of the Special Taskforce on Domestic and Family Violence in Queensland for integrated health system responses to violence.[32-34] NSW Health's IPARVAN Framework, defines integrated responses for violence, abuse and neglect as:

> *"The provision of service responses in accordance with a person-centred approach that provides seamless care across multiple services, adopts a multidisciplinary and trauma*

informed approach, and is designed around the holistic needs of the individual throughout the life course."[1]

The NSW DVDRT Report 2017-19 [16] documents barriers to effective DFV prevention and service delivery that occur when AOD use and MH issues are also present. For example:

- AOD use led to DFV 'victim blaming' and inadequate service responses to reports of DFV
- AOD use on the part of the perpetrator led to mitigated sentencing due to perceptions of diminished responsibility due to AOD use
- stigma and discrimination associated with AOD use and MH issues further complicated responses by discrete services, which were not equipped or trained to deal with complex cases outside their areas of expertise.

While provision of integrated care will assist in meeting these challenges, recommendation 21 of the NSW DVDRT Report highlights the additional need for training across services to increase knowledge and understanding of the intersections between DFV, AOD use and MH issues.[16]

The *Not Now, Not Ever* report produced by the Queensland Taskforce [32] identified similar challenges to service delivery, although stressed diversity and geography more than the complexity of cases at an individual level. Nevertheless, the report concluded that a 'one size fits all' approach to DFV service delivery leads to service gaps, and also recommends an integrated care service delivery model.

Further, both the Queensland Taskforce and the Victorian Royal Commission [33] noted that those experiencing DFV often seek assistance for other needs through the health system, offering a 'soft entry' point for service delivery, and this is a frequently missed opportunity for DFV prevention or intervention. The Victorian Royal Commission [33] also found that system navigation was a barrier to service access, leading to the conclusion that, *"All services must be responsive to (DFV) victims' needs."* (p. 8) Recommendation 22 of the NSW DVDRT Report [16] provides further impetus towards integrated care by proposing that general practitioner, AOD and MH services are more clearly linked in the context of DFV.

Other research has also highlighted opportunities to improve service responses to DFV, AOD use, and MH issues.[13, 35-37] A recent review examined service intersections and highlighted the poor practice that can occur when sectors are 'siloed' from each other, leading to a focus on one issue to the exclusion of other related issues.[36] Recent studies have recognised the need for enhanced training of professionals in identifying DFV [38, 39], as well as clearer referral pathways.[40] Similarly, within Australia, several key guidelines exist for MH and AOD service providers to enhance responses to patients who may be experiencing DFV.[41-45] While these efforts show potential, truly integrated approaches must involve strengthened intersections, clear policies and procedures, and a continuous collaborative effort between key organisations.[36]

NSW Health's Violence, Abuse and Neglect Redesign Program aims to strengthen the delivery of trauma informed integrated responses to violence, abuse and neglect, including DFV, and is supported by the IPARVAN Framework [1], This Framework includes a number of initiatives that should support the design and implementation of integrated, trauma-informed responses to DFV, MH issues, and/or AOD use.

Methods

This Evidence Check was conducted systematically, guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) protocols, particularly with regard to the development of inclusion and exclusion criteria, search strategies, and data extraction procedures.[46] The quality of the included evidence was assessed using the National Health and Medical Research Council's (NHMRC) FORM grading system.[47] This section includes the criteria for inclusion and exclusion of articles and reports, followed by descriptions of the search strategies and results; firstly, for the peer reviewed literature, and secondly, for the grey literature. Finally, the method used for quality assessment of the included evidence is described.

Inclusion criteria

Inclusion criteria were determined by the NSW Ministry of Health proposal. Articles and reports from peer reviewed and grey literature were included if published in English, between 2010 and 31 March 2020, and provided information relevant to the Evidence Check questions. The proposal, which outlines the scope and definitions for questions one to three, is included in Appendix 1.

Exclusion criteria

Exclusion criteria were developed using the NSW Ministry of Health proposal, and in consultation with the NSW Ministry of Health. Peer reviewed and grey literature were excluded when reports or articles were:

- Not available in English
- Involved non-human studies (e.g. animal studies)
- Focused on screening tools for DFV, MH issues, or AOD use and dependence
- Focused in detail on barriers associated with sharing information across services or sectors
- Not comparable to the Australian population
- Unavailable in full text
- Editorials, books, commentaries, conferences, opinion articles or practice guides
- Unrelated to MH or AOD in relation to DFV
- Not focused on DFV
- Not related to an integrated policy/program/model of care
- Not descriptive of the policy, program or model as trauma-informed
- Not based on a policy, program or model of practice

Peer reviewed literature

Databases and journals

The following databases were searched for Australian and international peer reviewed literature using available filter, Medical Subject Heading (MeSH) terms, and keyword search functions:

- Medline
- Cochrane Library
- PsycInfo
- Sociology Source Ultimate

The following additional key journals which are not included in academic databases were searched for Australian and international peer reviewed literature using available filter and keyword search functions:

- Journal of Family Violence
- International Journal of Integrated Care
- Journal of Integrated Care
- International Journal of Care Coordination

Search strategy

Six main subject topics were used to identify search terms: 1) domestic or family violence; 2) policies, programs, or models of practice; 3) integrated approach; 4) trauma-informed care; 5) mental health; and 6) alcohol or other drugs.

All MeSH terms [48] were searched in Medline for the initial search, limiting articles to those published in English in the past 10 years. MeSH terms and other relevant terms were searched as keywords in a second phase of the search to capture articles which had not yet been indexed using MeSH terms (i.e. limited by publication status: In-process; Pubmed NOT Medline; Publisher). Examples of MeSH terms and keywords used in the Medline search can be found in Appendix 2. The additional databases were searched using MeSH terms and/or the journals' corresponding subject headings. The four journals were searched using broad keywords.

Terms within each of the six main subject topics listed below were connected by an 'OR' Boolean operator. The main subject topics were searched using the following search string:

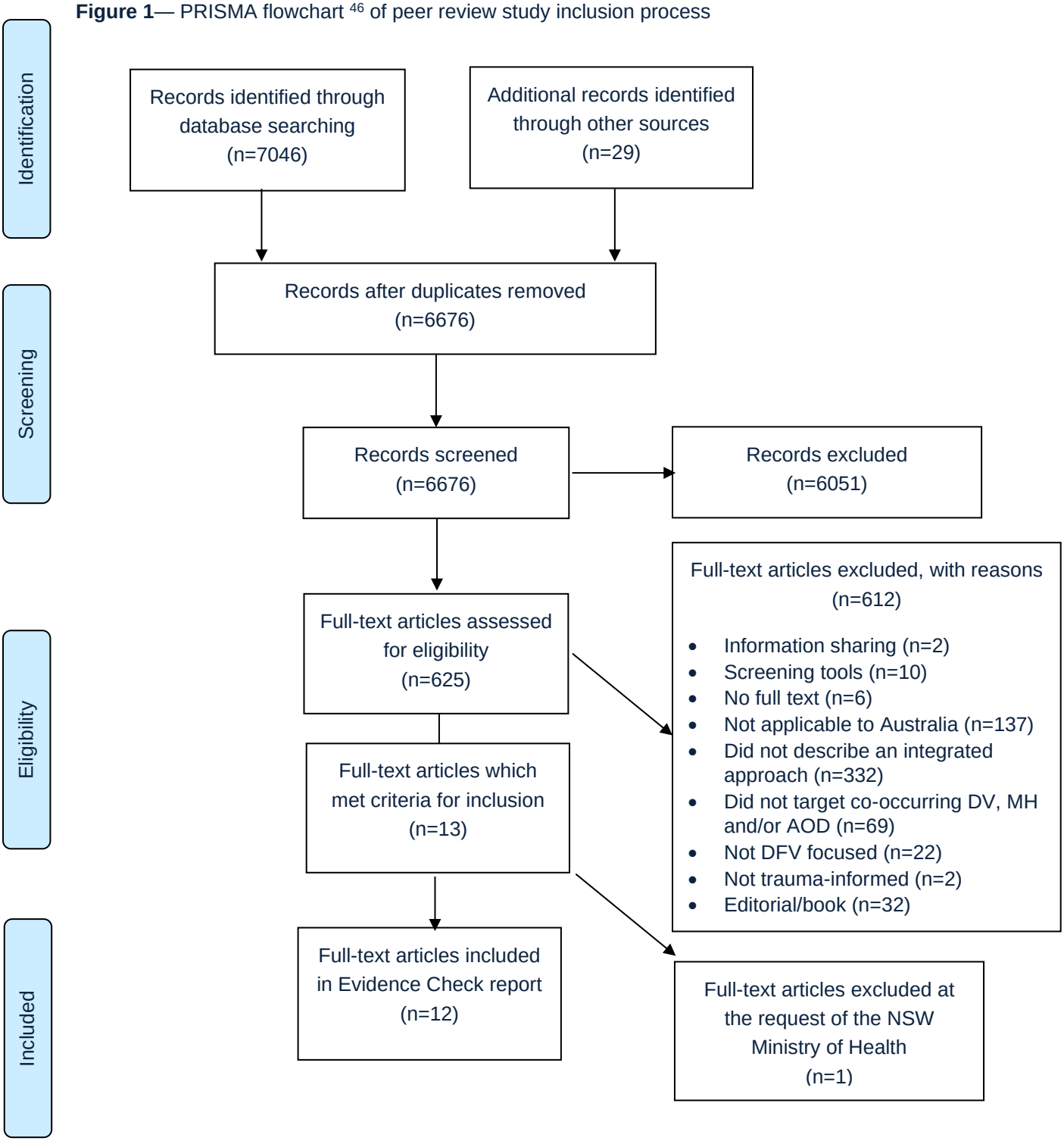
> (1 Domestic or family violence) AND [(2 Policies, programs, or models of practice) OR (3 Integrated approach) OR (4 Trauma-informed care)] AND [(5 Mental health) OR (6 Alcohol or other drugs)]

Results

In total, 7075 records were initially identified, including 7046 from the four databases and 29 records from other sources (searching the additional four journals and examining reference lists). **Error! Reference source not found.**Figure 1 shows the PRISMA flowchart of the article inclusion process, which resulted in 13 articles meeting full eligibility for inclusion.[46] The ADOPTS Program [49] was

initially included within the findings of questions one, two, and three. However, this program was removed at the request of the NSW Ministry of Health. After the article describing this program was removed, 12 articles remained.

Figure 1— PRISMA flowchart [46] of peer review study inclusion process



Grey literature

Databases and search engines

The following databases, search engines, and websites were searched for Australian and international grey literature using available filter and keyword search functions:

- Analysis and Policy Observatory
- OpenGov NSW
- ANROWS publications suite
- ANROWS violence against women publications library
- Our Watch
- NSW Ministry of Health
- Australian Institute of Health and Welfare
- Australian Institute of Family Studies Library Catalogue
- Australian Institute of Criminology
- National Child Protection Clearinghouse
- Health Justice Australia
- Informit
- New Zealand Government Ministry of Health Publications
- New Zealand Family Violence Clearinghouse
- National Health Service England Publications
- Canadian Women's Health Network E-library
- Canadian Women's Foundation
- Open Grey Europe
- WHO Institutional Repository for Information Sharing
- The King's Fund
- Nuffield Trust
- The Health Foundation
- The International Foundation for Integrated Care
- Improving Frontline Responses to High Impact Domestic Violence Consortium
- National Center on Domestic Violence, Trauma & Mental Health (US)
- Against Violence and Abuse
- ProQuest
- Google search

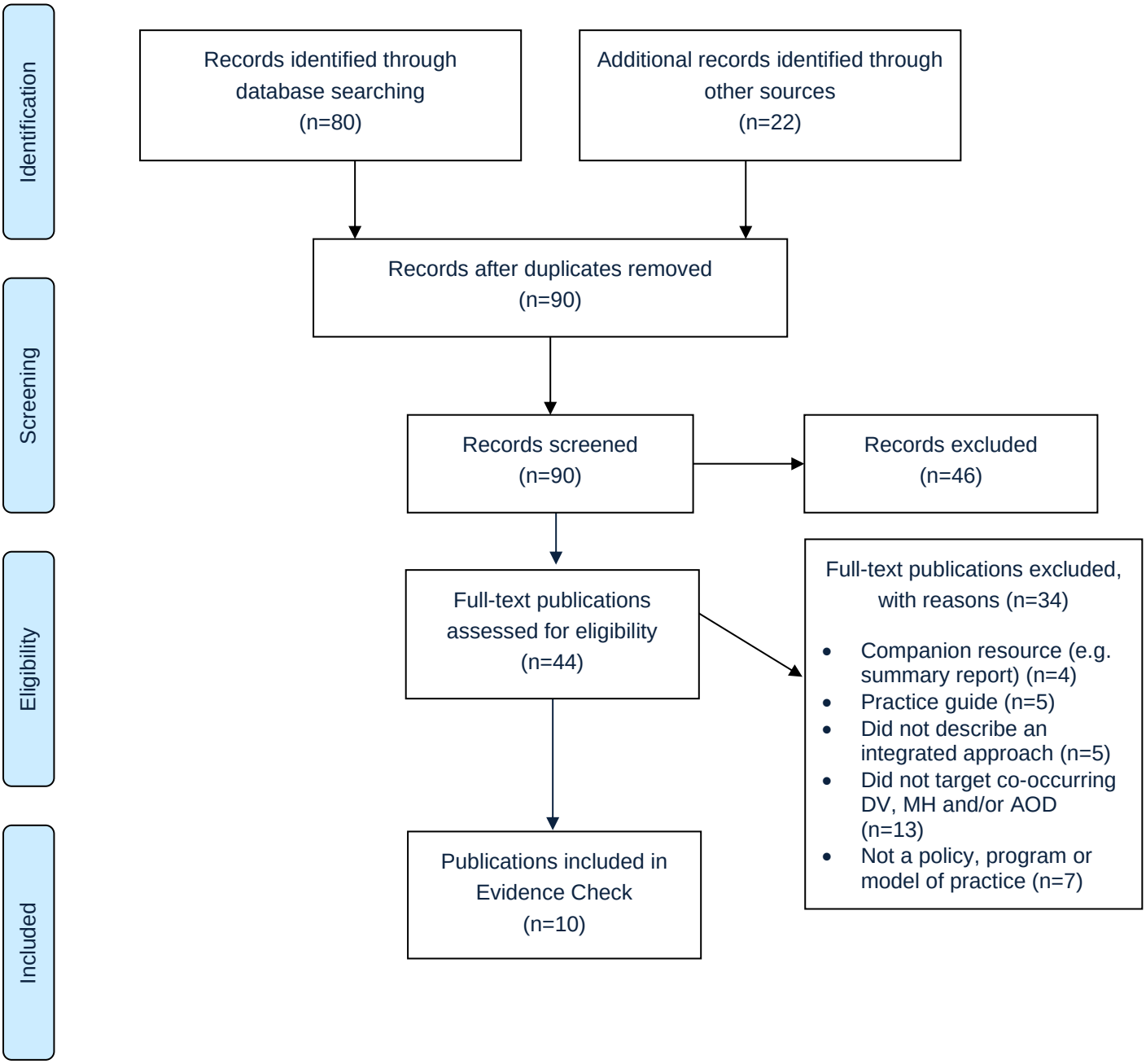
Results

In total, 102 records were identified: 80 records were identified through searching, 12 records were identified as key articles for inclusion by the NSW Ministry of Health, and 10 records were identified through citation searching, by examining the reference lists of included publications.

Of the 102 identified records, 12 were duplicate records and were removed. The remaining 90 records were subjected to a title and summary screen, during which a further 46 records were excluded. The remaining 44 publications were assessed for inclusion by reading further information available in the body of the document.

In total, 10 grey literature publications met the inclusion criteria and underwent data extraction. Figure 2 shows the PRISMA flowchart of the inclusion process.

Figure 1— PRISMA flowchart [46] of grey literature inclusion process



Analysis of literature

Articles identified for inclusion underwent data extraction, where relevant information was compiled and summarised as per the instructions provided by the NSW Ministry of Health (Question 1). The articles were also mapped to the IPARVAN Framework [1] (Question 2). Finally, the barriers and enablers to integrated, trauma-informed responses to DFV, MH issues, and/or AOD use and dependence were extracted from the articles, and thematic analysis was undertaken (Question 3).

Evidence grading

Identified articles which met the inclusion criteria were evaluated using the NHMRC's FORM grading system.[47] The first step in this process was to assign a level of evidence to each of the included articles and reports (see Table 1). Two additional levels of evidence (Level V and Level VI) were added to ensure all the included articles could be assigned a level of evidence. The next step was to summarise the body of evidence, using the NHMRC's body of evidence matrix (see Table 2). Each of the key components (evidence base, consistency, clinical impact, generalisability, and applicability) was given a rating (excellent, good, satisfactory, or poor). The strength of the evidence base for each barrier and enabler identified in Question 3 was also rated (see Appendix 6), according to the evidence base component described in Table 2.

Table 1—Levels of evidence

Level of Evidence	Study Design
I	A systematic review of Level II studies
II	A randomised controlled trial
III-1	A pseudo-randomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls (i.e. non-randomised experimental trials, cohort studies, case-control studies, interrupted time series studies with a control group)
III-3	A comparative study without concurrent controls (i.e. historical control study, two or more single arm studies, interrupted time series studies without a parallel control group)
IV	Case series with either post-test or pre-test/post-test outcomes
V	Other peer reviewed literature
VI	Grey literature

Table 2— Body of evidence matrix

Component	A	B	C	D
	Excellent	**Good**	**Satisfactory**	**Poor**
Evidence base[A]	Several Level I or Level II studies with low risk of bias	One or two Level II studies with low risk of bias or a systematic review or multiple Level III studies with low risk of bias	Level III studies with low risk of bias, or Level I or Level II studies with moderate risk of bias	Level IV, Level V or Level VI studies, or Level I to Level III studies with high risk of bias
Consistency	All studies consistent	Most studies consistent and inconsistency may be explained	Some inconsistency reflecting genuine uncertainty around clinical question	Evidence is inconsistent
Clinical impact	Very large	Substantial	Moderate	Slight or restricted
Generalisability	Population/s studied in body of evidence are the same as the target population in question	Population/s studied in the body of evidence are similar to the target population in question	Population/s studied in body of evidence differ to target population in question but it is clinically sensible to apply this evidence to target population	Population/s studied in body of evidence differ to target population and hard to judge whether it is sensible to generalise to target population
Applicability	Directly applicable to Australian context	Applicable to Australian context with few caveats	Probably applicable to Australian context with some caveats	Not applicable to Australian context

[A] Level of evidence determined from the NHMRC levels of evidence as in Table 1.

Findings

Twelve peer reviewed articles and ten grey literature reports were included, with specific descriptors of interest covered in Question 1 of this section (details of these studies are described in Appendix 3). Question 2 includes the alignment of the programs, policies and models of practice described in the literature to the IPARVAN Framework.[1] Question 3 provides an assessment of the barriers and enablers to integrated, trauma-informed responses to DFV, MH issues, and/or AOD use and dependence, as reported in the included literature.

Evidence quality

Overall, the quality assessment of the evidence base was rated as poor, due to the quality and design of the included studies (see Appendix 4). The consistency and clinical impact components were rated as not applicable, as these elements are used to assess the consistency of results and the clinical impact of a measured treatment, such as medication. These elements are, therefore, not applicable to this particular Evidence Check, which has multiple questions across a broad topic area and is not focused on a particular treatment. The generalisability and applicability of the included literature were rated as good, indicating that the results can be generalised to the identified population groups and are applicable in the Australian and NSW context.

This quality assessment indicates that while the programs and models of care included in the review might be highly effective (or not), the quality of the evidence for efficacy is poor. There are some issues with using an objective rating scale when assessing DFV, such as the high ratings of randomised controlled trials, which may not be safe or ethical in the DFV context. The quality of the evidence for program efficacy is discussed in more detail in the effectiveness section below.

Table 3— Body of evidence matrix

Component	Rating
Evidence base	Poor
Consistency	Not applicable
Clinical impact	Not applicable
Generalisability	Good
Applicability	Good

Question 1

What policies, programs or models of practice have been effective in supporting the delivery of integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Overall, 22 articles described 15 programs or models of practice that were found to be relevant for supporting the delivery of integrated, trauma-informed responses where DFV, MH issues and/or AOD use co-exist: three programs or models of practice where DFV, MH issues and AOD use co-exist; 10 programs or models of practice where DFV and MH issues co-exist; and two where DFV and AOD use co-exist.

Domestic and family violence, alcohol and other drug use, and mental health issues

The three programs or models of practice identified to be relevant for supporting the delivery of integrated, trauma-informed responses where DFV, MH issues and AOD use and dependence co-exist were described in four reports from the grey literature. No peer reviewed literature covered all of the areas of interest.

The articles which describe these programs or models of practice are summarised below. Of the three programs or models of practice identified, one targeted people living in rural and remote areas as a priority population [50-52].

Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study [50-52]

Aim	To generate empirical knowledge on the development of comprehensive, integrated service approaches, and the effectiveness of these approaches for women with co-occurring MH issues and substance abuse disorders who have experienced trauma.
Description	The program developed and implemented a cross-site framework for service intervention across local DFV, MH, and AOD service sites. At the clinical level, integration efforts focused on the content of service delivery and the ways in which MH, substance abuse, and trauma interventions are combined to enhance client outcomes. Service systems integration efforts were focused on linkages between core agencies and the full array of other agencies that need to be involved for the intervention to be comprehensive.
Evaluation	A quasi-experimental treatment outcome study was conducted from 2001 to 2003 at the nine study sites using data on 2,026 women (1,018 in the intervention group and 1,008 in the usual-care comparison group). Substance use problem severity, MH symptoms, and trauma symptoms were

	measured at baseline, six months, and 12 months. Follow-up data were analysed with prospective meta-analysis and hierarchical linear modelling. Also tested was whether intervention effects at 12 months varied by key program characteristics at each of the sites. The 12-month effect sizes for MH and trauma symptoms showed small but statistically significant improvements for women in the intervention group, relative to those in the comparison group. The effect on mental health symptoms doubled from .09 to .18 between six and 12 months, and the effect on trauma symptoms increased from .11 to .16. The two substance use severity outcomes showed no improvement over the corresponding values at six months. Analysis of key program elements across different intervention sites indicated that integrating substance abuse, MH, and trauma-related issues into a counselling service yielded greater improvement than delivering numerous core services separately.
Within sector and cross-sectoral collaboration	Across DFV sector (e.g. specialist DFV services), MH sector, AOD sector, criminal justice, health, child protective services, and welfare. Sites included multi-service agencies providing integrated care, and individual service providers (e.g. MH service, DFV housing service) working together.
Referral pathways	Coordinated procedures for referral between services (details not reported).
Staff capabilities and training	Staffing: Consumer/survivor/recovering (C/S/R) roles were held by women who had experienced abuse. These women were involved in all aspects of service intervention. Training: • Early and repeated cross-training across services, and education in the work of making services, programs, and systems more integrated. • Training provided at all levels (policymakers, administrators, providers) to address internal and external barriers to change (e.g. program philosophies, policies).
Processes to support identification, assessment and responses to domestic and family violence	• Integration and coordination at both the service system level (i.e. agencies) and clinical level (i.e. multiple services utilised by consumers), with cross-site service intervention. • Each site provided a core set of services: outreach and engagement, screening and assessment, treatment activities, parenting skills, resource coordination and advocacy, trauma-specific services, crisis intervention, and peer-run services. • C/S/R incorporated consumer experiences and perspectives into intervention design, development and implementation. All sites required C/S/R involvement in planning, management, service delivery, and research.

Resource requirements	Staffing, costs, training.
Location	Sites located in the following US cities and states: Los Angeles, California; Stockton, California; Metro-Denver, Colorado; Washington, DC; Central Florida; Boston, Massachusetts; Cambridge, Massachusetts; Greenfield, Massachusetts; and New York, New York.
Priority population(s)	People living in rural and remote areas.

Integrated Post Crisis Response Service Model [53]	
Aim	To provide a range of longer-term, women-centred case management and support options for women and children who have experienced family violence and are in the process of rebuilding their lives.
Description	The service model was built on research undertaken on the long-term support needs of women and children in overcoming the impact and effect that family violence has had on their lives. The content of the model was also informed by core policy documents and key research reports, and prepared in consultation with a number of community sector organisations working with women and their children who have experienced family violence, with oversight from policy and practice experts.
Evaluation	No evaluation available.
Within sector and cross-sectoral collaboration	Family violence services, other women's specialist services (e.g. women's health services), homeless/housing services, legal services (e.g. courts and police), and primary health services (e.g. GPs, community health).
Referral pathways	Referral sources: specialist family violence services, women's health services, homeless/housing service, courts, police, and primary health services (e.g. GPs, community health). Post-crisis services referred to as part of the integrated response: public housing authorities, women and children's specialist counselling services, the courts and legal system, Indigenous health and housing services, CALD services and information centres, disability services, MH and AOD services, children's services, parenting programs, and community health services.

Staff capabilities and training	Service coordination must be undertaken by staff who are appropriately skilled, qualified, experienced, supervised and supported.
Processes to support identification, assessment and responses to domestic and family violence	• A clearly defined focus on post-crisis support: – Early identification – Extended, long-term support • A women-centred approach to support: – Women-centred practice – A focus on children • Flexible brokerage: – Timely financial support – Targeted and effective assistance • Community capacity building: – Peer-support – Facilitated group work • The development of strategic partnerships and linkages facilitate an integrated approach, such as: – Collaborative partnerships – Specialist services
Resource requirements	Staffing, facilities.
Location	Victoria, Australia.
Priority population(s)	None.

Specialist Family Violence Advisor Capacity Building Program [54]	
Aim	The objectives of the program were to: • Strengthen networks and collaboration between agencies and across the three sectors; • Enhance referral pathways to provide a more coordinated and collaborative health and human service system response to family violence;

	• Increase capacity within the MH and AOD sectors through access to specialist family violence expertise and advice in identifying, recognising, and responding to family violence, • Facilitate earlier recognition of, and response to, family violence situations for patients/clients of mental health and alcohol and other drug services; and • Enhance quality and consistency of the service response to victims, survivors, and perpetrators of family violence at whatever point they access the health and human services systems.
Description	The 5-year program saw the placement of Specialist Family Violence Advisors in auspice family violence agencies, MH services and AOD agencies. The advisor roles worked with senior management to increase capacity of services to respond to family violence. Advisors were involved in providing systemic and organisational responses, and the development of secondary consultation.
Evaluation	No evaluation available.
Within sector and cross-sectoral collaboration	Collaboration between and within specialist family violence services, MH services and AOD services. This included the following stakeholders: program auspice agencies, Specialist Family Violence Advisors, Domestic Violence Victoria, statewide coordinator, MH services, AOD services, AOD and MH sector peak bodies/representation, and the Domestic Violence Resource Centre Victoria.
Referral pathways	As part of the program, the Specialist Family Advisors identified and mapped local referral pathways (including eligibility criteria) through desk-top research, available catchment planning and/or local subject matter expertise. They also clarified existing referral pathways and other connections across the area, and identified approaches to enhance these. These were communicated to MH and AOD agencies.
Staff capabilities and training	The Domestic Violence Resource Centre Victoria provided subject matter expertise, program support, and resource development. This included developing and delivering training and professional development activities to other key stakeholders. Auspice agencies recruited and appointed appropriately skilled workers to the Specialist Family Advisor position, and delivered ongoing mentoring, support and leadership.
Processes to support identification,	There were several key elements of this service model:

assessment and responses to domestic and family violence	• The auspice agency could provide professional and peer support, professional development and supervision, and ensure the Specialist Family Advisor maintained current family violence expertise and engagement in activities • The Specialist Family Advisor was accessible to workers at the agency level, to facilitate the provision of family violence expertise, identify capacity building initiatives, and enhance relationship development • A robust governance model operating at two levels: a statewide Steering Committee provided strategic direction and ensured alignment of the program with government policy and the priorities of each sector; and area-based Implementation Committees provided oversight and supported the implementation of the program through local agency-level collaboration.
Resource requirements	Cost, staff, training, facilities.
Location	Victoria, Australia.
Priority population(s)	Not reported.

Domestic and family violence and mental health issues

Overall, 14 articles described 10 programs or models of practice that were identified as relevant for supporting the delivery of integrated, trauma-informed responses where DFV and MH issues co-exist. Of these 14 articles, 10 were from the peer reviewed literature, and four were drawn from the grey literature. The articles which describe the programs and models of practice are summarised below.

Of the 10 programs and models of practice identified, 9 targeted priority populations: seven targeted children [55-65], three targeted Aboriginal people [57, 66, 67]; two targeted people with disability or mental illness [57, 67]; three targeted culturally and linguistically diverse people, migrants and refugees [57, 66, 67]; one targeted young women and children [67]; and one targeted lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) people.[66]

The Massachusetts Child Trauma Project [55, 59, 60, 62]	
Aim	The primary goal of the Massachusetts Child Trauma Project was to improve well-being and permanency outcomes for children with complex trauma in Department of Children and Families care, through the implementation of evidence-based treatments in community MH, and the enhancement of trauma-informed casework practice in child welfare.

Description	The Massachusetts Child Trauma Project was a 5-year state-wide systems-improvement initiative designed to: • Improve identification and assessment of children exposed to complex trauma • Build service provider capacity for the delivery of trauma-specific, evidence-based treatments in agencies serving child welfare involved children • Increase linkages with and referrals of children to evidence-based trauma treatment • Increase caregivers' understanding of and sensitivity to child trauma. The Massachusetts Child Trauma Project focused on three central activities: training in child welfare, evidence-based treatment dissemination, and systems integration.
Evaluation	Preliminary multi-method implementation evaluation including surveys, records reviews, and individual child assessments to measure both process and outcome.[62] Single group pre-test/post-test training evaluation and interviews with 32 Trauma Informed Leadership Teams leaders and 25 senior leaders in learning collaboratives were also undertaken.[59] A comparison of outcomes for 55,145 children who received the Massachusetts Child Trauma Project intervention and 36,108 who did not was also done.[55] Results indicated an increase in child abuse reports [55], and learning collaboratives were linked to improvements in trauma-informed individual and agency practices.[59] The Massachusetts Child Trauma Project's approach was associated with positive child outcomes across multiple symptom domains. From onset of an evidence-based treatment to six months (or less) of treatment, children's internalising, externalising, and total problem behaviours were significantly reduced.[59]
Within sector and cross-sectoral collaboration	Partnership between the state's child welfare agency, the Department of Children and Families, and agencies within the health sector (behavioural health agencies and medical centres).
Referral pathways	Referrals from child welfare services to evidence-based treatments by community MH services.
Staff capabilities and training	• MH staff trained in three trauma-focused evidence-based treatments: Attachment Self-regulation and Competency, Child-Parent Psychotherapy, and Trauma-Focused Cognitive-Behavioural Therapy. • Child welfare workforce trained in basic trauma-informed care, with some of the workforce receiving advanced trauma training (following SAMHSA's concept of a trauma-informed approach [68]).

	• Senior managers, clinical supervisors, clinicians, and data managers received one-year training, including face-to-face learning sessions and intensive evidence-based treatment consultation.
Processes to support identification, assessment and responses to domestic and family violence	• Capacity building and implementation of trauma-informed, evidence-based treatments within community MH services. • Capacity building to enhance trauma-informed child welfare casework practices in child welfare services: – Improving identification and assessment of children exposed to complex trauma – Fostering trauma-sensitive practices among child-serving agencies – Increasing trauma training and sensitivity of caregivers – Improving linkages and referral rates to evidence-based treatments – Building state-wide service provider capacity for three trauma-focused evidence-based treatments: Attachment Self-regulation and Competency, Child-Parent Psychotherapy, and Trauma-Focused Cognitive-Behavioural Therapy • Improve referral pathways to evidence-based treatments via cross-sector collaboration between child welfare and MH sectors. • Implement Trauma-Informed Leadership Teams to facilitate collaboration across systems by representing holistic needs of child (e.g. education, primary care, and legal services).
Resource requirements	Training, staff.
Location	Massachusetts, USA.
Priority population(s)	Children.

Child FIRST: A comprehensive home-based intervention translating research into early childhood practice [56]

Aim	To identify children in families with high cumulative risk as early as possible and to intervene to prevent or remediate serious emotional disturbance, developmental and learning problems, and abuse and neglect. Child FIRST was designed to address both prevention and intervention, to avoid fractured care.

Description	The Child FIRST model was formulated with two complementary core components: • Connection to comprehensive, integrated services and supports through a 'system of care' approach to decrease psychosocial stress and promote positive outcomes. • Promotion of responsive, nurturing caregiving through a relationship-based psychotherapeutic approach to enhance social, emotional and cognitive development. Child FIRST demonstrated improvements for parents and children, including improved parental mental health, and child social functioning, emotional functioning, and language development. A decrease in child abuse and neglect was also evident.
Evaluation	A randomised, controlled trial was designed to document the effectiveness of a home-based, psychotherapeutic, parent–child intervention embedded in a system of care. At enrolment there were 78 children in the Child FIRST intervention group and 79 in the Usual Care control group. 64 Child FIRST and 67 Usual Care families participated at the six month follow-up (82% and 85% overall retention, respectively). 58 Child FIRST and 59 Usual Care families participated at the 12 month follow-up (74% and 75% retention, respectively). Results indicated that compared to usual care, the intervention had a strong effect on increased service access, improved child language and externalising symptoms, reduction in parenting stress, and reduction in parental psychopathology.
Within sector and cross-sectoral collaboration	Across multiple child and adult service sectors, including MH, health, early care, early intervention, education, child protection, and social and community services.
Referral pathways	Families were referred to the Child FIRST intervention by participating community providers (e.g. paediatric care within hospitals). Referral processes were incorporated into the Child FIRST intervention based on families' individual needs. Other services accessed through intervention included: child MH, child development, early education, family support, adult MH, social services, medical services, adult education, and concrete needs.
Staff capabilities and training	Each family was assigned a clinical team consisting of: • A Masters level developmental/MH clinician, whose primary responsibility was therapeutic assessment and intervention with child and parent. • A care coordinator/case manager, who usually reflected the ethnic diversity of the family and spoke the language of the family's choosing,

	and had expertise in community resources to facilitate family engagement in community services. Training: Staff were trained to approach families with warmth, empathy, and respect, and to communicate, in words and deeds, that they were there as partners and advocates.
Processes to support identification, assessment and responses to domestic and family violence	• Weekly home visits of 45-90 minutes by clinical team • Comprehensive assessment of child and family to identify and involve all other necessary service providers • Therapeutic services predominantly delivered in the home • Fundamental goals of engagement and building trust • Family-targeted intervention to involve all family members and important individuals in child's life.
Resource requirements	Staff, training, costs (estimate of USD $4,000 per family).
Location	Bridgeport, Connecticut, USA.
Priority population(s)	Children.

Northern Area Mental Health Service Partnership Project [69]	
Aim	To develop an understanding of the practices, successes, and challenges of cross-sector collaboration between MH, sexual assault, and family violence agencies.
Description	The project involved a cross-sector partnership arrangement between key MH, DFV, and sexual assault agencies in Victoria, overseen by a project manager. This partnership included coordinated referrals, sharing of client information, joint activities, secondary consultation, and cross-sector training and professional development.
Evaluation	No evaluation available.
Within sector and cross-sectoral collaboration	Across MH, sexual assault, and DFV agencies.
Referral pathways	Not reported.

Staff capabilities and training	A Project Manager coordinated the partnerships and regular communication between key agencies. Liaison roles were also developed between services to coordinate referrals across the sectors. Professional development programs were delivered to inform staff on the issues of family violence, sexual assault, and mental illness. These targeted each of the participating organisations' needs.
Processes to support identification, assessment and responses to domestic and family violence	Processes that supported the collaborative approach to responding to those with trauma histories and MH issues: Regular meetings and mailing list updates to maintain broad representation from agencies across the region over time. Structured processes for information sharing about each of the organisations, through formal presentations included in agenda of meetings. The Project Manager took lead responsibility for planning, convening, recording, and acting on decisions made at project group meetings, and distributing information to those who were and were not in attendance.
Resource requirements	Staffing, costs, training/professional development.
Location	Northern metropolitan area of Melbourne, Victoria, Australia.
Priority population(s)	None.

Integrated Domestic and Family Violence Service Program [57]	
Aim	To improve outcomes for adults and children affected by DFV, by: • Supporting the provision coordinated services, at adult and child victims, • "Supporting more proactive and co-ordinated responses by a range of agencies including justice agencies and support services, • Improving co-ordination and integration of the local service systems responding to domestic and family violence, and • Providing community education and awareness."
Description	The program provided a multi-agency, integrated, and coordinated response to DFV among high-risk target groups and in targeted communities. The core service provided through the Integrated Domestic and Family Violence Service Program was integrated case management, whereby case managers worked with the client to assess needs and risk, plan multi-agency

	service delivery (including referral to both program funded services and external services) and monitor results.
Evaluation	A mixed-method inquiry combining a synthesis of service monitoring data and validated scales and measures, as well as qualitative interviews and focus groups. The quantitative evaluation component was a retrospective data analysis based on program service delivery (portal) data for the 24 months from July 2015 to June 2017, covering two complete financial years (2015-16 and 2016-17). The qualitative evaluation component took place between February and July 2017 at each of the program sites, and included interviews and focus groups with 36 frontline staff, 21 stakeholders, and 45 clients. Results indicated a significant improvement in client wellbeing from the time of program entry to the time of program exit, with a mean Outcome Rating Scale reduction of 12.5, from levels indicative of psychological distress to a non-clinical healthy range. Client and staff survey results and qualitative interviews indicated high satisfaction with the program and clients' improvement in feelings of safety and wellbeing. The following good practice elements were also identified across all program sites: Local context, holistic response, working with women who remain in the relationship, client driven and focused on needs, flexible duration and intensity of support, information sharing and risk assessment, and flexibility of local partnerships addressing specific population group needs.
Within sector and cross-sectoral collaboration	Cross-sectoral collaboration across women's centres, children's centres, women's refuge services, other specialist DFV services, perpetrator programs, MH services, NSW Health community housing, courts, legal services, police, Centrelink, educational institutions, Family and Community Services child protection helpline, ageing, disability, and home care.
Referral pathways	Program referral sources: Police, self-referred, Family and Community Services Centre, Women's Domestic Violence Court Advocacy Service, NSW Health, Child Wellbeing Unit, women's refuge services, Centrelink, internal referral, family support service, family or friend, hospital, housing, and local court/legal service. Referral to other services: Community housing NGO, counselling services, police, legal advice and representation, Housing NSW/community housing, perpetrator program, Women's Domestic Violence Court Advocacy Service, other NGOs, Staying Home Leaving Violence, Centrelink, and DFV group work sessions.
Staff capabilities and training	Staff had specialist knowledge on DFV and its impacts, useful local services, and the various resources and programs available to clients.

Processes to support identification, assessment and responses to domestic and family violence	• Integrated case management to assess needs and risk using the Domestic Violence Safety Assessment Tool, plan and coordinate service delivery from other agencies, and monitor the results by 'tracking' the client's progress. • Formal partnership approaches and referral pathways involving multiple agencies, including those who are often first point of identification. The service worked with victims who remained in the DFV relationship or felt unable to leave at the point of service entry, focusing on maximising safety for this particular group of women and their children. • Flexible, open-ended, comprehensive support to address both immediate and longer-term needs. • Partnerships established and services offered at each site reflected the local geographic context. • Local context, holistic response, client driven and focused on needs. • Holistic service provision for victims, families, and perpetrators of DFV. • Service responses focused on client's individual needs based on assessment. • Information sharing between the services. • Local partnerships designed to address specific needs of a population cohort.
Resource requirements	Staffing, specialist DFV knowledge, costs ($7.3 million in 2015-16 and 2016-17), facilities.
Location	Eleven Integrated Domestic and Family Violence Services operating across the following locations in New South Wales, Australia: Bankstown; Bondi; Cabramatta; Central Coast; Eastlakes, Green Valley; Mt Druitt; Mullumbimby; Nowra; Port Macquarie Hastings; Taree.
Priority population(s)	Aboriginal people; children; people with disability or mental illness; culturally and linguistically diverse people, migrants and refugees.

Domestic Violence and Mental Health Pilot Project [67]	
Aim	The Domestic Violence (DV) and MH position was developed from the Towards Better Practice research, whose aim was to improve collaboration between the MH and DV sectors.
Description	The Australian Research Council funded research project *Towards Better Practice* (2005-2007) found that, in the absence of collaboration across the DV and MH sectors, interventions fail to address the complex interaction of DV and MH issues, often leaving women in unsafe situations where their MH issues are exacerbated. The Domestic Violence and Mental Health Pilot

	Project addressed this through the appointment of a DV and MH worker, who provided ongoing case work, counselling, advocacy, and general support to women, and training and education to service providers. This position was established by, and located within, a specialist DFV service.
Evaluation	A mixed-methods inquiry, collecting and analysing a range of data. Data sources included: • Semi-structured, in-depth interviews with clients and service providers, with the interview schedule based on previous Australian research into collaborative responses to DV • Case file audits undertaken between August 2008 and January 2010, for client demographics, referral sources, DV and MH issues, and the nature and scope of interventions • Case studies collated in consultation with the worker, to provide an understanding of the complex nature of the work • Audits of engagement with service providers using discussions with the DV and MH worker and project reports • Service provider telephone snapshots, which provided a record of all phone calls received by the DV and MH worker from other service providers during the month of October 2009. Results indicated highly positive experiences from clients and staff involved in the program. In particular, the MH/DV training delivered to police by the DV and MH worker was noted. All women interviewed had left the DV relationship and reported improvement in their MH.
Within sector and cross-sectoral collaboration	Primarily across DV and MH sectors.
Referral pathways	Referral sources: MH inpatient and crisis teams, community MH, DV service, community health, hospital, self/family member, DV hotline. Referrals to other services: various refugee and women's centres, health services (e.g. GPs, counselling, nurses, massage therapy).
Staff capabilities and training	A designated DV and MH worker was appointed to improve collaboration between the MH and DV sectors. Extending cross-sector collaboration was a core focus of the position. Formal training sessions for staff included: • A presentation for MH staff on healthy relationships, the impact of an abusive relationship on MH, and self-care • An in-service for the Psychiatric Emergency Critical Care team about the integrated service

	• Training with police on responding to women who experience MH concerns and DV.
Processes to support identification, assessment and responses to domestic and family violence	Key activities for which the DV and MH role was responsible included: • Responding directly to inpatient MH units for crisis counselling, case conferences, referrals, and follow-up • Facilitating the process and supporting women through MH assessments with crisis MH teams • Home visits • Jointly supporting women and referring to other services; • Court support and advocacy with the police and magistrates when women were establishing ADVOs against their partners; • Advocacy and support in relocating women to housing; • Crisis support and ongoing counselling • Provision of specialist consultancy to other service providers in the area (e.g. information and advice about legal procedures, practice guidance, how to advocate for women trying to negotiate the system).
Resource requirements	Staff (DV and MH worker), training, facilities (DV and MH services).
Location	Liverpool, New South Wales, Australia.
Priority population(s)	Aboriginal people; young women and children; people with disability or mental illness; culturally and linguistically diverse people, migrants and refugees.

Women's input into a trauma-informed systems model of care in health settings (the WITH Study): The Health Systems Implementation Model [66]	
Aim	The WITH Study aimed to understand how to promote and embed a trauma-informed systems model of care, responsive to women and practitioners, into the complex system of MH and sexual violence services.
Description	The WITH Study conducted participatory research to inform the development of the Health Systems Implementation Model. Qualitative interviews and multimedia digital storytelling workshops were conducted with 67 women who had experienced MH problems and sexual violence. Workshops on health systems change were then conducted with 72 health service staff, which were co-facilitated by two survivors.

Evaluation	No evaluation available.
Within sector and cross-sectoral collaboration	Across MH and sexual violence sectors.
Referral pathways	Not applicable.
Staff capabilities and training	Not applicable.
Processes to support identification, assessment and responses to domestic and family violence	The Health Systems Implementation Model was a trauma- and violence-informed framework, underpinning a woman-centred approach and a practitioner- or staff-centred service. The model focused on four main building blocks to implement this care into MH and sexual violence services: • Relationship building (talk, time, trust, and shared language between services) • Integrated coordinated care (clear roles, referrals, policies, and champions) • A reflective system (women's and practitioners' voices, audits) • Environment and workplace scan (space, time, culture, and data systems).
Resource requirements	Data systems, staffing, costs, time (i.e. for relationship building), governance, educational resources, training.
Location	Victoria and New South Wales, Australia.
Priority population(s)	Aboriginal people; lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) people; culturally and linguistically diverse people, migrants and refugees.

Trauma Informed Child Welfare Systems Change Initiative [60, 63]	
Aim	The primary purpose of the Michigan Children's Trauma Assessment Center's Trauma Informed Child Welfare Systems Change Initiative is to develop a framework and protocol for implementing the Trauma Informed Child Welfare Systems Change Initiative at the local community level in a "bottom-up" or grassroots approach. The main aims of the initiative were to:

	• Determine prerequisites for implementation of the Trauma Informed Child Welfare Systems Change Initiative at the local level • Identify system areas and methods necessary for capacity building • Initiate and sustain the processes necessary for system integration of trauma language, assessment, identification, treatment, and decision-making across all systems involved in child welfare.
Description	The initiative is built on the principles of trauma-informed care and is a National Child Traumatic Stress Network site, which recognises the impact of childhood adversity and trauma (e.g. maltreatment and neglect, parental mental illness, domestic violence), as well as mitigating the impacts and facilitating resilience and recovery from trauma and secondary trauma. The six building blocks which were identified as critical for initiating and maintaining the Trauma Informed Child Welfare Systems Change Initiative include: • Development and support of a project champion; • Trauma identification • Comprehensive assessment of traumatic impact • Evidence-based trauma treatment • Establishing a common trauma language • Trauma-informed decision making.
Evaluation	Qualitative and quantitative evaluation including baseline evaluation of the current state of trauma-informed practices and readiness to change, and one year follow up (n=631); as well as eight interviews of key personnel and secondary data (court neglect/abuse file) reviews (53 files representing 112 children). Post-test results after one year revealed a statistically significant increase in the extent that policy had become more trauma-informed. Agency practice also a showed statistically significant improvement in trauma-informed care.
Within sector and cross-sectoral collaboration	Within nine child welfare agencies from Michigan, and cross-sectorial collaboration with Department of Human Services, Community Mental Health, Family Court, and Intermediate School District.
Referral pathways	Given the different resources allocated in each county, referral pathways varied. In some instances, multidisciplinary teams composed of personnel from collaborating agencies, including professionals from Community Mental Health and the Intermediate School District, made referrals. Two assessment teams and a community protocol for triaging referrals were developed, and provided assessments for children who had been traumatised.

	In other counties, a same-discipline (mental health) assessment team of trained therapists to assess for trauma was developed. For those children assessed as having potential sensory, speech/language, and other special needs, referrals were routinely made to other community professionals not involved in the assessment team.
Staff capabilities and training	• Training to become champions of the Trauma Informed Child Welfare Systems Change Initiative was identified as a part of the program for community members. • Three teams of professionals were trained in a transdisciplinary neurodevelopmental assessment protocol. • Clinicians from three county systems were trained in Trauma-Focused Cognitive Behavioural Therapy and/or Real Life Heroes, which involved two-day training with a year-long consultation protocol, including monthly phone consultation and quarterly in-person consultations. During Year 3, Trauma-Focused Cognitive Behavioural Therapy training was provided for 22 therapists, with 19 continuing with follow-up consultation. • Establishment of Common Language Using Trauma-Informed Instruments: specific trauma training provided to courts, schools, medical personnel, and caregivers, to infuse trauma into agency and interagency discussion of children.
Processes to support identification, assessment and responses to domestic and family violence	• The adoption of screening and identification of trauma in children at intake, with one MH agency completing 4500 screens. • Training of professionals in trauma-informed evidence-based practice and language. • Development of documents highlighting legal trauma knowledge, decision-making processes, and essential elements for attorneys to address issues of secondary trauma and decision-making regarding removal of children from biological parents and placement changes.
Resource requirements	Training, staff, capacity building with the wider community.
Location	Michigan, USA.
Priority population(s)	Children.

Treatment of Complex Trauma in Young Children Program [58, 60]	
Aim	The Attachment, Regulation and Competency framework was theoretically grounded in attachment, trauma, and developmental theories, and was specifically aimed at addressing three core domains impacted by exposure to chronic, interpersonal trauma: attachment, self-regulation, and developmental competencies.
Description	The Treatment of Complex Trauma in Young Children Program used the Attachment, Regulation and Competency framework in a MH setting. The Attachment, Regulation and Competency framework specifically addresses three core domains impacted by exposure to chronic, interpersonal trauma: attachment, self-regulation, and developmental competencies. The Attachment, Regulation and Competency framework was a flexible, component-based intervention for treating children and adolescents who had experienced severe and prolonged interpersonal abuse and neglect (e.g. impaired caregiver, domestic violence, neglect, emotional abuse, physical abuse, sexual abuse). Application of the Attachment, Regulation and Competency framework with young children grounds treatment within the caregiving relationship in three ways: • Increasing caregiver attunement to build a secure attachment base to support the development of competencies • Enhancing the caregiving system's ability to support the child in the implementation of effective self-regulation strategies; and • Teaching and encouraging caregivers to support the child's development of a positive sense of self and mastery.
Evaluation	Naturalistic pre-test/post-test program evaluation of treatment outcomes and placement stability in 93 children treated using Attachment, Regulation and Competency Model (26 completed the intervention). The average drop in Child Behaviour Checklist scores, which indicate the extent of behaviour problems, for children completing treatment was 19 points; subsequently, 90% of children moved to permanent placements, compared to the usual 40%.
Within sector and cross-sectoral collaboration	Cross-sectorial collaboration with children in the child protective system treated through the Alaska Child Trauma Centre and community MH services.
Referral pathways	Not reported.

Staff capabilities and training	Not reported.
Processes to support identification, assessment and responses to domestic and family violence	The Attachment, Regulation and Competency framework facilitates tailored treatment for each individual client. Some of the processes to support identification, assessment and responses to DFV for children who have experienced trauma include: the assessment of vulnerabilities associated with traumatic exposure that can interfere with healthy development, building routines into therapy, and in the home to help to restore the child's sense of safety.
Resource requirements	Not reported.
Location	The Attachment, Regulation and Competency framework therapeutic intervention was delivered at an outpatient clinic in the USA (Alaska Child Trauma Center at Anchorage Community Mental Health Services).
Priority population(s)	Children.

Arkansas Initiative [60, 61, 64]	
Aim	The Arkansas Initiative used a trauma-informed training program, with the aim of increasing awareness among child welfare workers of the effects of trauma on children's emotional, behavioural, academic, and social development; to promote evidence-based screening, assessment, and treatment for children exposed to trauma; and to coordinate care with other service agencies to minimise placement disruptions and additional trauma.
Description	The Arkansas Building Effective Services for Trauma group collaborated with leaders of the Division of Child and Family Services (the state's child welfare agency), lead trainers for the MidSOUTH Training Academy (Division of Child and Family Services' training partner), and the Arkansas Academic Partnership in Public Child Welfare. This Partnership was a state-wide consortium between the Division of Child and Family Services and faculties of nine Arkansas universities that educate and train students for employment in the child welfare system. The trauma-informed training program focused on nine essential elements: • Maximise the child's sense of safety • Assist children in reducing overwhelming emotions • Help children make new meaning of their trauma history

	• Address the impact of trauma and subsequent changes in the child's behaviours, development, and relationships • Coordinate services with other agencies • Utilise comprehensive assessment of a child's trauma experience and the impact on the child's development and behaviour to guide services • Support and promote positive and stable relationships in the life of the child • Provide support and guidance to the child's family and caregivers • Manage professional and personal stress.
Evaluation	Pre-test/multiple post-tests evaluation of training with 102 Division of Child and Family Services leaders (follow-up: immediately after training then at three months with 78% retention) [64] and with child welfare staff (n=438, follow-up immediately after training, retention 93%) and a random sample of child welfare staff (n=161, three-month follow-up, retention 88%).[61] The results revealed a significant effect for trauma-informed knowledge, indicating significant knowledge gain from pre- to post-test with child welfare staff. The results for trauma-informed practices from pre-test to three-month follow-up indicated that use of trauma-informed practices increased significantly, however, the magnitude of the change was small [61]. Results for the Trauma-Informed Knowledge Scale for Division of Child and Family Services leaders increased significantly from pre-test to post-test, as did the Trauma-Informed Practice Scale. Similarly, results from the analysis of the Trauma Assessment scale indicated a significant increase in reported use of trauma assessment from pre-test to the three-month follow-up [64].
Within sector and cross-sectoral collaboration	Cross-sectoral collaboration with Arkansas state child welfare system and MH professionals.
Referral pathways	Child welfare workers received trauma-informed training and MH professionals received trauma-focused cognitive behavioural therapy training. The main purpose of this training was to maximise capacity for assessment and treatment referrals and assessment. The initiative also incorporated training on coordinating with other agencies. Although the initiative aimed to maximise capacity for referrals, specific referral pathways were not described.
Staff capabilities and training	Area directors and supervisors in the state's child welfare system attended a two-day training course using National Child Traumatic Stress Network content. Child welfare workers attended a one-day workshop led by social workers, and were asked to create an action plan for using trauma-informed child welfare practices based on the “Bringing It Back to Work” tool, available in The Child Welfare Trauma Training Toolkit. After child welfare workers

	completed their training, 150 MH professionals across the state of Arkansas received training in trauma-focused cognitive behavioural therapy.
Processes to support identification, assessment and responses to domestic and family violence	Trauma-informed training for child welfare workers and MH professionals increased trauma-informed knowledge and trauma-informed care practices. Specifically, the training incorporated information on responding to DFV (e.g. assisting children in processing experiences of abuse, addressing the impact of abuse). Training on the comprehensive assessment of a child's trauma experience and the impact on the child's development and behaviour were also a part of the state-wide training plan, including the Child Welfare Trauma Training Toolkit, The Child Welfare Trauma Training Toolkit Comprehensive Guide, and the Child Welfare Trauma Training Toolkit Supplemental Handouts developed from the National Child Traumatic Stress Network. Promotion of evidence-based screening, assessment and treatment for children who have experienced trauma was also covered in the training program.
Resource requirements	Training, staff.
Location	Arkansas, USA.
Priority population(s)	Children.

Project Kealahou [60, 65]	
Aim	Project Kealahou was a six-year, federally-funded program aimed at improving services and outcomes for Hawai'i's female youth who are at risk of running away, truancy, abuse, suicide, arrest, and incarceration. Project Kealahou seeks to help Hawai'ian girls who have experienced psychological trauma find 'a new pathway' (kealahou) to a better future by healing past hurts and taking constructive steps toward a more hopeful future.
Description	Project Kealahou allows girls and their families to receive gender-responsive, trauma-informed, culturally-responsive, community-based services, tailored to the individual including intensive case management; community supports by paraprofessionals (i.e. peer support for youth and caregivers); structured group activities; and evidence-based treatments (e.g. Trauma-Focused Cognitive Behavioural Therapy and Girls Circle psychoeducational support groups).

Evaluation	Basic demographic and clinical features at intake of the girls and families (n=100, 69 youth and 31 caregivers). A cost analysis was conducted to compare the types and costs of services Project Kealahou girls and their families received before and during Project Kealahou. Results at the six month follow-up, though preliminary, showed significant improvement from baseline on measures of youth strengths, competence, depression, impairment, behavioural problems, and emotional problems. Cost analysis findings showed the total cost for MH services for the cohort (n=41) during the first six months of Project Kealahou enrolment was over US$365,000, however, this was only slightly higher (US$21,662 more) than the total cost of MH services for Project Kealahou girls in standard care for the six months prior to Project Kealahou enrolment. The cost per service event was lower for Project Kealahou (US$201) compared to standard care (US$205).
Within sector and cross-sectoral collaboration	Cross-agency collaboration among Hawai'i's MH, juvenile justice, education, and child welfare systems.
Referral pathways	Young women were referred to Project Kealahou primarily from the public education, juvenile justice, and MH systems.
Staff capabilities and training	Not reported.
Processes to support identification, assessment and responses to domestic and family violence	Not reported.
Resource requirements	Costs.
Location	Hawai'i, USA.
Priority population(s)	Children.

Domestic and family violence and alcohol and other drug use

Three articles described two programs or models of practice that were identified as relevant for supporting the delivery of integrated, trauma-informed responses where DFV and AOD use and dependence co-exist. Of the three articles, one was from the peer reviewed literature, and two were drawn from the grey literature. One program or model targeted children as a priority population [70], and the other targeted young women and children.[71, 72] The articles which describe the programs and models of practice are summarised below.

The Stella Project Young Women's Initiative [71, 72]	
Aim	To respond to young women in substance misuse treatment who have experiences of domestic and sexual violence; to conduct research to develop the evidence base on the intersecting issues of DV, sexual violence, AOD use, and young age, as experienced by 14 to 25 year old women accessing Violence Against Women and Girls or specialist substance misuse services in two London boroughs; and to evaluate the efficacy of the training and consultancy support provided by the Stella Project Young Women's Initiative, with the intention of improving practitioners' responses to intersecting issues faced by young women.
Description	Training courses on working in partnership with other agencies and working with young people experiencing sexual violence, DV and problematic substance use were delivered to staff from multiple agencies. Borough action plans were also developed with the Community Safety Team and Young People's Substance Misuse Commissioners in both boroughs.
Evaluation	There were three strands to the evaluation, which were each assessed twice (pre- and post-intervention). The post-intervention evaluation data was collected between April and July 2013. • Strand 1: Monitoring data on disclosures of the intersecting issues made by young women accessing services and where referrals are made to partner agencies. • Strand 2: Online questionnaire for frontline staff in the agencies concerned, which covered issues relating to staff confidence, knowledge, and skills in addressing intersecting issues of young women's substance misuse and experiences of DV and sexual violence, and the current partnership work taking place with other specialist agencies and related organisations. • Strand 3: An analysis of the policies and procedures from participating agencies and strategic documents produced by the local borough strategic partnerships. The evaluation data were extremely limited due to challenges with monitoring data on disclosures, low numbers of staff completing the surveys, and a lack of policies and procedures appropriate for analysis. Therefore, it

	was difficult to draw firm conclusions on the effectiveness of the program. However, the reported findings indicated minimal differences in practitioners' preparation or confidence to engage with young women and support them in various ways. Nevertheless, there was an improvement in practitioners' identification of avenues for information sharing.
Within sector and cross-sectoral collaboration	Cross-sectoral collaboration between the Violence Against Women and Girls and substance misuse sectors in two London boroughs, London Borough of Enfield and the Royal Borough of Kensington and Chelsea, with representation from the following agencies: • Domestic and sexual violence advocacy services • Young people's substance misuse services • Drug intervention programmes • Youth offending services.
Referral pathways	Not applicable.
Staff capabilities and training	The research element of the project informed new training courses. The main findings of this research highlighted the complex connection between DV, sexual violence, and problematic substance abuse, and the need for services to address violence and problematic substance use together in a respectful and non-stigmatised way. Between September 2011 and August 2012, three new training courses based on the project research findings were delivered and attended by 126 professionals from 49 agencies: • Working in Partnership • Working with young people experiencing sexual violence and domestic violence and problematic substance use: offered at two levels: – *Basic level 1*: for any practitioner working with young people, or – *Advanced level 2*: for practitioners seeking to take the lead in their agency on these issues. Between September 2012 and August 2013, four days of multi-agency training for both boroughs and tailored workshops for targeted groups of professions (e.g. school nurses) were delivered.
Processes to support identification, assessment and responses to domestic and family violence	Borough action plans were developed with, and agreed upon by, the Community Safety Team and Young People's Substance Misuse Commissioners in both boroughs. An online forum was set up in June 2012 to share information and connect practitioners.

Resource requirements	Training.
Location	London Borough of Enfield and the Royal Borough of Kensington and Chelsea, England.
Priority population(s)	Young women and children.

Sobriety Treatment and Recovery Teams (START) Program [70]	
Aim	The START Program was an integrated treatment program for families with co-occurring child abuse and neglect, and parental substance use disorder, which aimed to simultaneously improve adult recovery and child wellbeing.
Description	The START Program was implemented by child protective services when there was substantiation of child abuse and neglect, and parental substance use disorder, posing primary risk to child safety. The START Program involved pairing a social worker with a family mentor for each family referred to the program. Mentors engaged parents in treatment and services, and coached them on such skills as relapse prevention and sober parenting. A START Program substance use disorder treatment coordinator goal was to provide parents with quick access and retention in intensive substance use disorder treatment.
Evaluation	Prospective-descriptive study methods were utilised, including qualitative focus groups (n=69) with study personnel (e.g. state leaders, parents, substance use disorder treatment providers, community partners, court personnel, START Program staff, and child protective services investigative staff), as well as merged data to measure adherence to service delivery standards and program outcomes. The time from the child protective services report to completion of five drug treatment sessions was reduced by an average of 75 days. Adherence to the timeline standards was achieved within the third year of the program. Sobriety rates for mothers significantly improved, increasing from 47.4% to 66.3%. The proportion of children who remained with their parents throughout START Program increased from 31.7% to nearly 54.9%.
Within sector and cross-sectoral collaboration	Across the child welfare sector and substance use treatment services.

Referral pathways	Referral from child protective services to the START Program within 30 days of child protective services reporting alleged child abuse and neglect.
Staff capabilities and training	A START Program substance use disorder treatment coordinator assessed each parent; tracked progress, and coordinated treatment levels; provided weekly progress reports and drug screen results to the child welfare team; and participated in all team meetings, including family team meetings.
Processes to support identification, assessment and responses to domestic and family violence	• During the initial family team meeting, the treatment coordinator began the substance use disorder assessment. The substance use disorder treatment providers, child welfare team, and the family explored family strengths and identified required resources. • Moving forward, there was shared decision making and accountability between the substance use disorder treatment coordinator, child welfare START Program staff, and other providers, regarding child placement and reunification, child safety, parental capacity, and substance use disorder treatment level of care. • Intensive in-home services for the family and relative child caregivers were provided. • Whenever possible, children were retained in the home using multiple services and supports, creative approaches to using relatives as natural supports, and numerous contacts by the treatment team.
Resource requirements	Staff.
Location	Kentucky, USA.
Priority population(s)	Children.

Other relevant evidence

Guidelines and tools

Several guidelines and tools were identified but excluded due to publication type. These are summarised below. They do not describe policies, programs, or models of care, but offer practical guidance as to how practice settings could better respond to complex issues. Further, these do not describe an integrated approach to care, but were designed to be used in individual sectors to assist organisations and practitioners to identify and respond to issues typically addressed in other sectors. This information was often presented in checklist or stepwise format, intended to identify gaps in organisations' and practitioners' ability to address complex issues. Although these did not meet the criteria for this Evidence Check, these publications may useful resources better identifying and

responding to co-occurring DFV and MH and/or AOD issues in practice settings. In addition, they may inform future programs, policies, or models of care focused on integrating different services.

Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues [73] is a practice guide developed from the STACY Project. The STACY Project is an action research study aiming to improve service provision for children and families with DFV, MH and/or AOD issues. The practice guide was developed through discussions between researchers, practitioners, the Project Advisory Group, and consultants from *Safe & Together Institute*, the institution responsible for the Safe & Together Model [74] which informed the project. The practice guide is pitched towards the gendered-nature of violence, concerning fathers' use of violence and coercive control towards women and children. In doing this, the guide prompts agencies and organisations to consider the perpetrator, in addition to the victims. Heward-Belle et al. [73] identified six key practices for service providers to address within the context of complexity: 1) Partnering with women, 2) Working with men who use violence and coercive control, 3) Focusing on children and young people, 3) Working collaboratively, 5) Working safely, and 6) Influencing organisational change and capacity building.

Victoria's Chief Psychiatrist guideline and practice resource: family violence [43] was developed in response to recommendations made by the Victorian Government Royal Commission into Family Violence. Outlining the expectations of public MH services in Victoria, it provides guidance on responding to those who experience and perpetrate DFV in the MH setting. The guideline content was drawn from direct recommendations from the Chief Psychiatrist, with assistance from the Project Advisory Group, and selected peer-reviewed and grey literature. The guide encourages MH services to consult and engage with DFV specialist services where necessary, while also undertaking professional development training themselves to better understand protocols for responding to disclosures, referrals and information sharing between the two sectors.

Other practice guides and tools identified for use in the AOD sector

Can I Ask? An alcohol and other drug clinician's guide to addressing family and domestic violence, a guide for AOD workers and organisations [42], was produced by the National Centre for Education and Training on Addiction and Odyssey House Victoria, informed by focus groups with DFV survivors, input from AOD staff, and selected peer-reviewed and grey literature. This guide encourages multi-organisation and cross-sectoral work engaging with DFV organisations, child protection services, supported accommodation services, MH services, and other organisations. The guide provides useful direction on sensitive and appropriate basic level responses by AOD workers to disclosures of DFV, and referral to appropriate services.

Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia [75] is a similar report to Can I Ask? produced by the National Centre for Education and Training on Addiction and may be useful in AOD practice or for informing future programs, policies, or models of care. Informed by a literature review, it explores the relationship between AOD and DFV services. The report recognises the following ten principles and strategies as useful in addressing DFV issues among AOD clients: 1) Evidence-based policy and practice responses, 2) Organisational awareness of families' issues, 3) Prioritising safety (for both clients and staff), 4) Coordination of services, 5) Policies and systems that support safe and effective practice, 6) Standard response frameworks, 7) Broad-based interventions, 8) Access to highly skilled practitioners if required, 9) Workforce development, and 10) Monitoring, accountability, and evaluation.

Guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors [76] was prepared by the Australian Institute of Family Studies in partnership with the Victorian Centres Against Sexual Assault Forum and UnitingCare ReGen, as a result of research funded by Australia's National Research Organisation for Women's Safety. The research project Establishing the Connection [77, 78], explored the intersections between AOD use and sexual assault through a literature review and consultation with survivors and staff and key stakeholders from the two sectors. A key finding of this research was the need for resources for enhanced service delivery, which would assist practitioners in responding to co-occurring AOD issues and sexual assault experience. The guidelines are designed to inform AOD and sexual assault staff on the complex association between the two issues, prompt them to explore this with their clients and facilitate access to specialist services via referrals, and encourage cross-sectoral collaboration in order to improve service provision.

Domestic and Family Violence Tools for Alcohol and Other Drug Settings prepared by the Alcohol Tobacco and Other Drug Association ACT aims to provide more effective responses for people who use AOD in harmful ways and either experience DFV and/or are at risk of using DFV.[79] The tools are designed for implementation in the AOD service setting and include a benchmarking tool to assist services in assessing their current responses [41], a practice guide for identifying and responding to DFV issues in AOD settings [44], and a scope of practice for clarifying the roles, responsibilities, activities and decision making capacity of the AOD workforce in relation to DFV responses.[45] Across all resources, cross-sectoral work, including engaging with DFV and MH organisations and services, is encouraged.

Other relevant programs and models

The *Safe & Together Model* was developed by David Mandel and associates from the Safe & Together Institute. This model is intended to better inform child welfare professionals on issues relating to DV. The Safe & Together Model [74] is a well-established model that describes three principles and five components that describe family violence and its impact and can be used to underpin program development.

While the model itself was excluded from the analysis above as it does not explicitly describe an integrated care approach, programs developed with the model at its core are frequently integrated in nature. The three principles of the model are: keeping children Safe & Together with non-offending parent; partnering with the non-offending parent as the default position; and intervening with the perpetrator to reduce risk and harm to child. Incorporation of these principles into practice is supported by consideration of the five critical components articulated in the model: perpetrator's pattern of coercive control; actions taken by the perpetrator to harm the child; full spectrum of non-offending parent's efforts to promote the safety and wellbeing of the child; adverse impact of the perpetrator's behaviour on the child; and the role of substance abuse, MH, culture and other socio-economic factors. The Safe & Together Model is useful in highlighting the need to address MH and AOD issues in conjunction with DFV issues. The model focuses program development through use of its core principles and recognition of its critical components. These can be used within individual practices, or across sectors. In this way, the Safe & Together Model can be effectively used to support the development of an integrated care approach.

The PATHways and Research Into Collaborative Inter-Agency practice (PATRICIA) Project [80] and the Invisible Practices: Interventions with Fathers who use Violence Project [81], reported using the Safe &

Together Model. In these projects, child protection and other statutory and non-statutory workers were trained in the use of the Safe & Together Model and attended communities of practice to embed the way of working. While neither of these projects focused on the MH and AOD component of the Safe & Together Model, the project reports indicate the potential value of the Safe & Together Model. The PATRICIA Project [80] reported that the model promoted practitioner competency in responding to the intersections of DFV and child abuse by shifting practitioners' attention toward actions and use of coercive control used by perpetrators that harm children, including behaviours that harm the adult victim and their relationship with their children. The Invisible Practices Project [81] reported that the Safe & Together Model provided a common framework and shared language for the services involved in this project. Practitioners participating in the Invisible Practices Project reported increased collaboration between statutory child protection agencies and specialist DV services. The potential for the model and tools to be shared with other sectors, such as alcohol and other drug services, was also highlighted.

The *STACY Project* [73, 82] was also underpinned by the Safe & Together Model. Conducted in New South Wales, Queensland, and Victoria, the project aimed to build worker and organisational capacity in working with families at the intersection of DFV, AOD, and MH. The research component of the project saw researchers work in collaboration with practitioners to drive changes in professional practice, inter-agency working, and organisation to improve service provision. The final report on this project has not yet been published, therefore, it was not possible to report on the findings in this Evidence Check. However, the project's aims indicate it is relevant, and future evaluative publications should be reviewed when available. A recently completed practice guide was developed from the STACY Project and was made available to the research team. This is included in the section above on guidelines and tools.

Whole Family Teams [83] is a model of care which aims to improve health outcomes, keep children safe, and improve parenting skills and family functioning. Although excluded from the Evidence Check due to a lack of focus on DFV, the model shows potential in its outcomes relating to children at risk of abuse and/or neglect among families with MH and AOD issues. Implemented as part of the NSW Government Keep Them Safe approach in response to the Wood Commission of Inquiry into Child Protection Services in NSW, a key focus is shared responsibility between families, communities, government and non-government organisations that work together to support and protect vulnerable children. At the time of the evaluation, Whole Family Teams were located in within NSW in the following cities: Gosford, Newcastle, Nowra, and Lismore. Local Health Districts in these areas were funded to deliver Whole Family Teams interventions. The interventions involved multidisciplinary teams of MH and AOD clinicians working together to provide comprehensive assessment and in-home service delivery for individuals and families with complex MH and AOD needs for approximately six months. Partnerships between the following services existed to facilitate referrals to Whole Family Teams and optimise service delivery: Community Health Centres; Child Protection Counselling Services; specialist MH services, AOD services; Aboriginal Health Services; Family and Community Services; Primary Health Care Services and private providers.

A 2014 evaluation reported on the success of Whole Family Teams in delivering against the project objectives, however, this is currently unpublished. It is reported elsewhere [83] that the evaluation found a 58.4% reduction in the mean rate of Risk of Significant Harm (ROSH) reports for children in families who participated in the Whole Family Teams program. Additionally, clinically significant improvements in parental MH and AOD outcomes, as measured by both clinicians and parents, were reported. The successful implementation of the model of care within the NSW locations has been attributed to the

commitment of clinicians, governance structures, and interagency partnerships at state and local levels.

An earlier Evidence Check, Reducing risk for children of parents with mental health and/or drug and alcohol issues [84], synthesised the findings of systematic reviews that examined the impact of parental MH and/or AOD use on parenting capacity. Although many of the interventions within the review did not involve integration, some processes to support the identification, assessment and responses to DFV were detailed, including: clear goals outcomes, and evaluation plans within initiatives; time allowed for planning and completing administrative tasks; adequate funding; prevention and early interventions designed to develop parenting skills among mothers and fathers with MH disorders; peer-support programs in group settings; improved information collection and sharing across services; strong case management for families with complex needs; home-based treatments for families with complex needs; manualised interventions to be implemented more broadly and help to maintain treatment fidelity; establishment of well-developed partnerships between services early on in initiatives; training packages to accompany interventions; and the availability of brief interventions to be readily used.

Analysis

Effectiveness

Of the 15 programs and models reviewed in this Evidence Check, three did not report any sort of effectiveness evaluation (the Integrated Post Crisis Response Service Model, the Health Systems Implementation Model and the Specialist Family Violence Advisor Capacity Building Program (future evaluation is planned)). The remaining 12 offered varying levels of evidence for the efficacy of the programs or model, ranging from reflexive comments to small scale randomised controlled trials.

The Northern Area Mental Health Service Partnership Project [69] report provided insight into the experiences of managers, partners and staff who took part in the project. The report notes that, while the direct impact of the project has not been systematically measured, the responses of the partners consulted suggests that the project has successfully fostered a collaborative approach to practices in each of the agencies.

Two programs offered descriptive evaluations of efficacy.Laing and Toivonen [67] reported that the Domestic Violence and Mental Health Pilot Project bridged the gap that existed between MH and DFV sectors in Liverpool NSW, using a mixed methods approach that included interviews, case note audits and an analysis of project engagement with multiple service providers. The authors reported that the clients had all left the DFV situations and experienced improvements in MH. The authors also reported having reached women from diverse backgrounds through a client record review that focused on demographics, although it was not clear whether reaching women from diverse backgrounds was an overt strategy or whether this result was incidental.

The Sobriety Treatment and Recovery Teams Program [70] reported that, over a four year period, reductions in time spent completing AOD treatment programs were apparent, and that this trend coincided with parents maintaining custody of their children. However, the nature of the evaluation was designed to capture the quality and consistency of the intervention delivery, rather than the outcomes, and so the results must be interpreted with caution and treated as descriptive only.

The Trauma Informed Child Welfare Systems Change Initiative in Michigan was subject to a preliminary evaluation by Henry et al.[63] and Bunting et al.[60] Post-test results taken after one year revealed a statistically significant increase in the extent that policies had become more trauma-informed. Agency practice also showed statistically significant improvements. However, these findings should be considered with caution. Trauma Informed Child Welfare Systems Change Initiative was implemented to produce better child functioning and placement outcomes but these outcomes were not measured due to financial restraints and other structural matters

Five programs collected pre- and post-program data. One of these noted that their findings were limited, and two noted their findings were preliminary. The Stella Project Young Women's Initiative evaluation [72] reported collecting data on disclosures of violence by young women, from staff surveys on competency pre- and post-training, and analysis of policies and procedures from participating agencies and partnerships. The practitioner survey revealed few differences pre- and post-training with regard to preparedness to engage with women about DFV or their confidence in these matters, although staff reported that practitioners seemed more able to share information about women's AOD use and DFV experiences. Evaluation data were noted as being extremely limited due to challenges with monitoring data on disclosures, and low numbers of staff completing the surveys. Therefore, it was not possible to draw firm conclusions on the effectiveness of the program.

The Treatment of Complex Trauma in Young Children Program, which used the Attachment, Regulation and Competency Model, reported positive preliminary findings. This program was evaluated by Arvidson et al.[58], who conducted a pre-post-test to examine treatment outcomes and placement stability in children treated using the Attachment, Regulation and Competency Model in a community-based clinic. Children who completed the treatment achieved a high rate of permanent placement and a significant decrease in Child Behavior Checklist scores, indicative of problematic child behaviour. The authors note that comparative testing of this framework is required to fully assess outcomes, but that this preliminary evidence indicates strong potential.

The three remaining program evaluations that used pre-post-test designs were more robust in nature. The Arkansas Initiative was evaluated by Kramer et al.[64], to examine the effectiveness of this child welfare workers' training program. Trauma-Informed Knowledge Scale scores increased significantly from pre-test to post-test. At the three-month follow-up, results suggested that use of trauma-informed practices and the use of trauma assessment had also increased significantly.Conners-Burrow et al. [61] also evaluated the effectiveness of Arkansas Initiative, and demonstrated improvements in child welfare workers' knowledge and attitudes related to trauma from pre- to post-test.

The Integrated Domestic and Family Violence Service Program [57] evaluation used a mixed methods approach and synthesised service use data and qualitative data from interviews and focus groups in addition to the pre/post quantitative measure of client wellbeing. Of importance to the current Evidence Check, monitoring data on service use and referral sources from a range of services indicated the successful implementation of the integrated nature of the program. The evaluation also reported that the program had reached priority populations such as Aboriginal and Torres Strait Islander people, those born outside of Australia and those with high levels of languages other than English spoken at home, based on analysis of client demographics. However, it is unclear whether there was a strategy for including a diverse population or if this was incidental.

The Project Kealahou had an evaluation component and also used a mixed methods design that incorporated description, pre/post testing, and was the only evaluation that included an economic analysis. Young women's strengths, depression, impairments, and other psychological health

problems were improved six months after baseline measures were taken.[65] Economic analysis revealed lower per service costs associated with involvement in the project ($201USD), compared with standard care ($205USD).

Three programs had been evaluated using intervention methods, two that used comparison groups, and one randomised controlled trial. Barto et al. [55] examined whether The Massachusetts Child Trauma Project was associated with reductions in child abuse and neglect, improvements in placement stability, and higher rates of permanency during the first year of implementation. Maltreatment was reported less often for children in the intervention group, than those in the control group. Children in the intervention group also had more maltreatment reports (substantiated or not), which was potentially related to increased surveillance and reporting of maltreatment and placement issues by the trained child welfare caseworkers and treatment providers.Bartlett et al. [59] demonstrated the effectiveness of the Massachusetts Child Trauma Project's evidence-based treatment strategies to improve well-being and permanency outcomes for children with complex trauma. After six months of evidence-based treatment within the program, children had fewer post-traumatic symptoms and behaviour problems, compared to baseline.

An evaluation conducted by Morrissey et al.[52] demonstrated the effectiveness of the intervention provided as part of the Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study, in improving MH and trauma symptoms. The MH and trauma symptoms of women in the intervention group showed significant improvement after 12 months, relative to the comparison group, although there was no significant improvement in substance use outcomes in the intervention group. Analysis of key program elements across different intervention sites indicated that integrating substance abuse, MH, and trauma-related issues into a counselling service yielded greater improvement than delivering numerous core services.

A randomised controlled trial conducted by Lowell et al. [56] demonstrated that the Child FIRST intervention was effective in achieving a primary program goal of increasing family access to a wide range of community-based services. Families that received the intervention were successfully connected with 91% of needed resources, compared to only 33% for families receiving standard care. The intervention also had a strong effect on improving child language and externalising symptoms, reducing maternal stress and psychopathology.

Relevance for NSW setting

The inclusion criteria allowed for articles from Australian sources and OECD countries similar to Australia, where the evidence base comprised literature which was relevant to the NSW setting, as reflected in the applicability component of the quality assessment (see **Error! Reference source not found.**). Of the 15 included programs, policies, and models of care, six described programs set in Australia (Integrated Domestic and Family Violence Service Program, Integrated Post Crisis Response Service Model, the WITH Study, the Domestic Violence and Mental Health Pilot Project, Specialist Family Violence Advisor Capacity Building Program, and the Northern Area Mental Health Service Partnership Project), one described a UK project (the Stella Project Young Women's Initiative) and the remaining eight were programs based in the USA. While there are elements of the overseas programs that translate quite well to the NSW setting, it must be noted that the health systems and policy environments are different, particularly in relation to the programs located in the USA.

Strengths and limitations

In assessing the strengths and limitations of the programs described in the included reports, the following aspects were considered, based on key findings noted in the NSW DVDRT, Victorian Royal Commission and Queensland Taskforce reports. The findings of these reports support that an ideal program or model would incorporate an integrated approach as defined in the IPARVAN Framework [1], that addresses both diversity and geography and is supported by: cross-sector training; clearly articulated referral pathways that make the best use of soft entry points, which may facilitate early intervention; and clear policies and procedures for continual cross-sector collaboration that place the individual at the centre of the process. Further to these goals and implicit in the literature reviewed, are needs for sustainability and demonstrated efficacy through regular program evaluations with a mandate for continual improvement.

Programs dealing with DFV and both AOD use and MH issues

Only three programs or models dealt with DFV and both AOD use and MH, with all three using an integrated person-centred approach to service delivery, including clearly articulated referral pathways and policies for collaboration. The Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study incorporated most aspects identified as important, although was limited in its approach to diversity, and did not make use of soft entry opportunities. With regard to sustainability, Moses et al. reported that difficulty in obtaining mainstream funding prevented the implementation of sustainability plans, in particular, coordinator positions and financial support for groups and training were not supported.[50] The Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study also considered geography (rurality), but the applicability of this and their systems modelling to the Australian context is limited.

The two Victorian programs, by contrast, are readily scalable to NSW, but unfortunately have not reported evaluations of their efficacy. At face value, the strengths of the Integrated Post Crisis Response Service Model include cross-sector collaboration beyond the health ministry, consideration of diversity, and a partnership program across services. However, the Integrated Post Crisis Response Service Model appears limited in its approach to training and rurality, which are not mentioned. Similarly, the Specialist Family Violence Advisor Capacity Building Program does not appear to consider geography, which is a critical component of service delivery in Australia. However, this program is still in the implementation stage, and information is currently limited; the program might have more breadth than is apparent in the available documentation.

The Specialist Family Violence Advisor Capacity Building Program includes training and mentorship as core elements of its program, with DFV experts embedded into AOD and MH services. While this does provide an opportunity for the AOD and MH service providers to deliver trauma-informed support, this does not appear to be a reciprocal arrangement. That is, DFV service providers are not afforded the same opportunity to learn from embedded AOD or MH practitioners. The Specialist Family Violence Advisor Capacity Building Program has a very well-developed person-centred approach, although an evaluation is needed to ascertain the outcomes for clients. Of the three programs that addressed DFV and both AOD and MH issues, the Specialist Family Violence Advisor Capacity Building Program was the only program to target perpetrators in its client base and the only one that considered the opportunity afforded by soft entry points to services for those experiencing DFV. As noted in the section above, the Safe & Together Model [74] does offer an approach that

automatically incorporates a perspective that is inclusive of perpetration of DFV, which could be used to support system and practice responses.

Programs addressing DFV with AOD use or MH but not both

A significant limitation of the remaining programs was their inclusion of MH or AOD issues, but not both. The high rate of comorbidity between AOD use and MH problems, particularly in the context of DFV, suggests that focusing on either MH or AOD, rather than both, might lead to fractured rather than integrated care. Again, the Safe & Together Model [74] offers a potentially useful approach in its inclusion of AOD and MH issues as a critical component of the model. Nevertheless, there were strengths among programs that took this approach. For example, eight of the 10 MH and DFV programs and models of care, and both AOD and DFV programs and models had been evaluated, and while of varying quality, evaluations permit assessments of utility to be made.

Several approaches that were examined exemplified a strong person-centred approach (e.g. Child FIRST, Integrated Domestic and Family Violence Service Program, Domestic Violence and Mental Health Pilot Project, WITH Study, Project Kealahou), many of which included caseworkers; while others were more focused on training practitioners in trauma-informed care (e.g. Massachusetts Child Trauma Project, Trauma Informed Child Welfare Systems Change Initiative, Treatment of Complex Trauma in Young Children Program, Arkansas Initiative, START Program). The person-centred focus is more in line with avoiding a 'one size fits all' approach, and often encompasses trauma-informed care.

The Integrated Domestic and Family Violence Service Program had many strengths, including staff having extensive specialist DFV knowledge, and clear referral pathways within the program, and policies for ongoing collaboration. An expansion to include AOD services and to consider inland rurality would enhance this model of care substantially. Similarly, the promising results of the Domestic Violence and Mental Health Pilot Project, which also used a client-centred approach and consideration of diversity, would have been enhanced by the formal integration of AOD services.

Consideration of 'soft entries' into support services via usual health services was mainly comprised of training health professionals in trauma-informed care approaches for both the MH and DFV, and AOD and DFV programs. As mentioned in the context of DFV, MH and AOD combined approaches, training was frequently one-way. For example, the Domestic Violence and Mental Health Pilot Project reported training MH professionals in the impact of DFV, but did not report training DFV workers in MH issues. Likewise, the program reported training police in the impact of DFV and MH, but there was no reported reciprocal training concerning law enforcement aspects of DFV and MH for DFV and MH workers. A similar approach was noted in the Chief Psychiatrist and AOD clinician's guides, which, while helpful for MH and AOD professionals to know how to reach out for guidance from DFV service personnel, did not offer much in the way of guidance for DFV personnel needing assistance with MH or AOD issues among their client base. A lack of reciprocity in cross-sector training is a limitation of the reviewed programs, as this is a missed opportunity for increased understanding and collaboration between sectors.

The majority of the literature discussed programs and models that addressed the needs of those who had experienced DFV, rather than those who had perpetrated DFV. Two MH programs and one AOD program mentioned the need to be able to have discussions about DFV perpetration and had referral pathways in place (Integrated Domestic and Family Violence Service Program, Child FIRST, START Program). Evidence concerning effective interventions with perpetrators of DFV is not as developed,

and there is a need for further evidence on effective interventions and programs with perpetrators. It is likely that continued collaborative work along the lines of the STACY Project will shed light on this area, as it has utilised the Safe & Together Model [74] that specifically highlights perpetration as a core component.

The geography of Australia is unique. Those living outside of metropolitan areas and particularly those living in inland regions are at particular risk of poor service access. A limitation of the reviewed Australian programs was a lack of reported program provision for those living in rural and remote locations.

Program strengths

A major strength of most reviewed programs and the adjunct practice guides and models was the consideration given to those who had experienced DFV in the development of their models of service provision. Most programs had articulated policies that highlighted how collaboration would take place and with whom, which reinforced their capacity to establish ongoing networks. In turn, this assists with sustainability. The major limitation of most reviewed programs and models was a lack of ongoing independent evaluations, which threatens efficacy, validity, and continual improvement. The importance of ongoing evaluations was best demonstrated by the Whole Family Teams program, where key elements of their successful implementation were highlighted alongside a quantifiable improvement in risk from harm.

Discussion and conclusion

Key findings

- Taking the quality of evidence into account, the most robust results of effectiveness were provided for:
  - the Massachusetts Child Trauma Project
  - Child FIRST
  - Women with Alcohol Drug Abuse and Mental Health Disorders who have Histories of Violence Study
- While there are elements of the 11 overseas programs that translate quite well to the NSW setting, health systems and policy environments are starkly different, particularly in relation to the programs located in the USA
- The major limitation of most reviewed programs and models was a lack of ongoing independent evaluations, which threatens efficacy, validity, and continual improvement
- A major strength of most reviewed literature was the consideration given to those who had experienced DFV in the development of their models of service provision.

Evidence of effectiveness

The level of evidence for the efficacy of many programs was a major limitation of the reports reviewed. Although evaluations had been conducted for most programs, only three included robust comparison methods, and all of these were located in the USA. However, it must be acknowledged that the nature of DFV is such that withholding the best possible interventions for evaluation or

research purposes is fraught with safety and wellbeing issues to the point that maintaining comparison or control groups can be impossible.

Pre/post-test designs offer a viable alternative to randomised controlled trial designs, although obtaining follow-up data can be problematic, as demonstrated by the Stella Project Young Women's Initiative. Mixed methods approaches that incorporate pre/post-tests can help to overcome some of the limitations of relying solely on collecting follow-up data. Project Kealahou and the Integrated Domestic and Family Violence Service Program both used mixed methods to evaluate their programs to good effect. Mixed methods led to results that were superior to those obtained by simple reflexive or descriptive methods, which do not allow for a reasonable assessment of service provision.

Taking the quality of evidence into account, the most robust results were provided by the Massachusetts Child Trauma Project, Child FIRST and Women with Alcohol Drug Abuse and Mental Health Disorders who have Histories of Violence Study. All of these models or programs demonstrated positive impacts of the interventions used. Of these three, Child FIRST also demonstrated a large number of strengths and few limitations, although the program was developed in Connecticut USA, which might limit its applicability to the NSW policy and practice context.

Both of the mixed methods studies demonstrated positive results. Elements of Project Kealahou could be examined for use in the NSW context; however, the project was designed with young Hawai'ian women in mind, and may be of limited utility. The Integrated Domestic and Family Violence Service Program, by contrast, was developed in NSW and demonstrated very clear positive effects for clients and practitioners. Furthermore, the program was found to have many strengths, with its main limitations being the lack of incorporation of AOD services in its model, and a lower relative number of referrals from health services compared to other services. The Specialist Family Violence Advisor Capacity Building Program did include AOD services and offered many of the same elements as the Integrated Domestic and Family Violence Service Program but, as it did not report any evaluation as to efficacy, it is not possible to consider this as a best practice model. The Integrated Domestic and Family Violence Service Program was the only reviewed program that evaluated and reported on integration of services, although the USA-based Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study did indicate that offering a one-stop-shop approach led to higher improvements in MH, compared to accessing services independently. Positive evaluation on integration of services was reported for the Integrated Domestic and Family Violence Service Program. This result suggests that the addition of AOD services within locally established partnerships would benefit this program and its client base. The other limitations of this program could similarly be addressed by expanding sector specific training to be reciprocal in nature and taking geography into account by scaling programs up to consider rurality.

Question 2

Summarise the alignment of these policies or programs (from Question 1) to the system design principles set out in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.

All of the 15 programs and models of practice identified in Question 1 reported aspects of their work that aligned to some extent with the relevant system design principles as described in NSW Health's IPARVAN Framework [1] (see Table 4): one described elements that aligned with all five principles; seven reported components that aligned with four principles; five noted elements that aligned with three principles; and two described facets that aligned with two system design principles.

In the context of this Evidence Check, it must be noted that although each of the programs and models of practice have reported components that align with the system design principles, no direct evaluation of the programs and models of practice was undertaken. The information provided in this section is reliant upon the reports that were reviewed at Question 1, and these were assessed as providing a poor level of evidence. Results in this section should be viewed within that context.

A summary table of the results for Question 2 is included below (see Table 4). Details of the aspects of each program, policy, and model of practice that align with the five relevant system design principles of the IPARVAN Framework [1] are included in Appendix 5.

Table 4— Alignment with key system design principles

	System design principles				
Policy, program, or model of practice.	**Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family**	**Recovery from trauma is recognised and valued as a primary outcome of responses**	**Early intervention is prioritised**	**Equitable, accessible and consistent service responses are provided**	**Collaboration to support people and their families to access the most appropriate service response**
Integrated Domestic and Family Violence Service Program [57]	✓	✓	✓	✓	✓
Integrated Post Crisis Response Service Model [53]	✓	✓	✓	X	✓
The Massachusetts Child Trauma Project [55, 59, 60, 62]	✓	✓	X	✓	✓
Child FIRST [56]	✓	X	✓	✓	✓

START Program [70]	✓	x	✓	✓	✓
The Stella Project Young Women's Initiative [71, 72]	✓	✓	x	✓	✓
Arkansas Initiative [60, 61, 64]	✓	✓	x	✓	✓
Project Kealahou [60, 65]	✓	✓	x	✓	✓
Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study [50-52]	✓	✓	x	x	✓
WITH Study [66]	✓	✓	x	x	✓
Domestic Violence and Mental Health Pilot Project [67]	✓	✓	x	x	✓
Specialist Family Violence Advisor Capacity Building Program [54]	x	x	✓	✓	✓
Trauma Informed Child Welfare Systems Change Initiative [60, 63]	x	✓	x	✓	✓
Northern Area Mental Health Service Partnership Project [69]	x	x	x	✓	✓
Treatment of Complex Trauma in Young Children Program [58, 60]	✓	✓	x	x	x

Analysis and discussion

Only one program, the Integrated Domestic and Family Violence Service program, demonstrated alignment with five system design principles. Four programs or models reported incorporating four principles, five reported incorporating three principles, and two reported incorporating only two of the five principles. However, it must be noted that the reviewed articles might not always include the

information needed to assess their alignment with principles such as those described here. Where possible, implications of alignment have been noted in the discussion below.

Twelve of the programs and models of practice described person- and family-centred, holistic and seamless care which prioritised the safety, well-being and unique needs and preferences of the person and their family. As expected, this is in line with person-centred and trauma-informed perspectives covered in Question 1. Reports from the three programs or models that did not specify this principle focused on capacity building (Specialist Family Violence Advisor Capacity Building Program), the support of child welfare (Trauma Informed Child Welfare Systems Change Initiative), and building partnerships across sectors (Northern Area Mental Health Service Partnership Program). While the articles which were reviewed did not overtly articulate this core principle, the program goals suggest that components of this principle are implicit drivers of the work being carried out.

Eleven of the programs and models of practice recognised and valued recovery from trauma as a primary outcome of responses. The four program or models that did not incorporate this principle focused on early intervention for children at risk (Child FIRST), recovery from AOD dependence (START Program), and capacity or partnership building (Specialist Family Violence Advisor Capacity Building Program, Northern Area Mental Health Service Partnership Program). While recovery from trauma was not the primary goal of these services, recovery from trauma could be seen as being valued as a potential outcome, either explicitly or implicitly.

Five of the programs or models of practice prioritised early intervention. As such, programs were least likely to be aligned with this principle. For some programs or models that did not align, the focus was on recovery from complex trauma over the long term (Massachussetts Child Trauma Project, the Stella Project Young Women's Initiative, Arkansas Initiative, Project Kealahou, the Women with Alcohol, Drug Abuse and MH Disorders who have a History of Violence Study), rather than on early intervention. Two USA-based programs focused on different aspects of child protection where early intervention was implied but not specified (Trauma Informed Child Welfare Systems Change Initiative and Treatment of Complex Trauma in Young Children Program). Others were focused on building comprehensive models of care and capacity building, where early intervention was not specified (WITH Study, Domestic Violence and Mental Health Pilot Project, Northern Area Mental Health Service Partnership Program).

Ten of the programs and models of practice were reported to provide equitable, accessible, and/or consistent service responses. It is important to note that the lack of information about equity, accessibility, and consistency in the remaining five programs or models does not mean they were inequitable, inaccessible, or inconsistent. There is simply a lack of information on these issues provided by the reviewed literature, although the use of trauma-informed care principles imply the promotion of equity in service provision.

Fourteen programs and models of practice included collaboration to support people and their families to access the most appropriate service response. The Treatment of Complex Trauma in Young Children Program did not explicitly report collaboration. However, this program used the USA-based Attachment, Regulation and Competency child protection framework, which is embedded within MH services, and a child trauma centre.

As discussed in Question 1, the Integrated Domestic and Family Violence Service program is comprehensive and addresses many aspects of DFV that have been identified in the reports by the NSW DVDRT, the Queensland Taskforce and the Victorian Royal Commission as needing attention.

This was the only program reviewed here that overtly aligned with all five design principles. Initiatives such as the STACY Project, which are aimed at embedding the Safe & Together Model into system and practice responses to the intersections between DFV, AOD and MH issues, will likely align with many (perhaps all) of the principles assessed here. The Safe & Together Model, which underpins the STACY Project, incorporates a person-centred, whole of family principle, similar to principles one and five above. It would be prudent to incorporate an assessment of the STACY Project and its use of the Safe & Together Model once the STACY Project report is available.

Question 3

> What are the key barriers to, and enablers of, integrated, trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

The 22 articles which described the included 15 programs and models of practice were thematically analysed to identify barriers and enablers of integrated, trauma-informed responses to DFV, MH issues and/or AOD use and dependence. Specific barriers or enablers for priority populations were also identified. The key barriers and enablers to integrated, trauma-informed responses which were found are described below. The barriers and enablers identified from the reviewed literature are provided to complement those already determined by The Case for Change: Integrated prevention and response to violence, abuse and neglect in NSW Health [4].

Analysis

Barriers

Six key barriers to integrated, trauma-informed responses for DFV, MH issues and/or AOD use and dependence were identified in the literature outlined in Question 1.

1. Time and cost
2. Conflict between agencies
3. Logistics
4. Disclosure and identifying complex needs
5. Addressing and prioritising complex needs
6. Burden of providing trauma-informed care

These six identified barriers are outlined below. The strength of the evidence base for each barrier was rated as poor, reflecting the overall quality ratings for the evidence base when considering integrated, trauma-informed responses to co-occurring DFV, MH issues and/or AOD use and dependence (see Appendix 6 for details).

Time and cost

Providing integrated, trauma-informed responses was reported to be time consuming, as time was needed to establish infrastructure [63, 70] and build relationships with other agencies. [50, 51, 62, 64, 69, 70] Integrated, trauma-informed care also required extra staffing and increased funding. [56, 66, 70] Bartlett et al. [59] also noted ongoing support was required to sustain established integrated, trauma-informed responses, including additional time and resources. It was noted that some frontline staff, such as caseworkers, had additional time-based barriers given they already have extremely high caseloads, thus making it difficult to have adequate time to meet basic case requirements, let alone trauma-informed care strategies. [61, 64]

Conflict between agencies

Zmudzki et al.[57] found competition between partnering services impeded service delivery, and Huebner et al.[70] reported that confrontation and blaming occurred between agencies when something went wrong. Differences in philosophical approaches and paradigms between partnering services was also identified as a barrier. [50, 51, 66]

Logistics

The logistics of working with other agencies was identified as a barrier. For example, referral pathways between agencies were reported as being under-developed [57, 66]. Henry et al. [63] noted that individual agency mandates were extremely different, and therefore, a focus on the clients' trauma needs were often secondary to maintaining agency obligations and boundaries. Difficulties with maintaining consistent engagement and communication with clients across services were also noted.[50, 51, 64] Some clients also reported that their engagement with integrated and trauma-informed services were logistically challenging (e.g. organising childcare and transportation). [50, 51]

Disclosure and identifying complex needs

A further barrier found to impede trauma-informed, integrated responses was identification of clients who had experienced, or were experiencing, DFV, MH issues and/or AOD use and dependence. To identify these complex needs, clients had to disclose experiences of DFV, MH issues and/or AOD use and dependence. However, a number of barriers stopped clients from disclosing these complex needs. Confidentiality and privacy concerns were a barrier to DFV disclosure for young women.[71] Clients also reported that they did not want to access services due to fear of losing custody of their children.[50, 51] Participants who had experienced DFV and had MH issues were reluctant to access integrated services due to concerns that their MH problems might be used by the DFV perpetrator as a weapon to control them.[67]

Addressing and prioritising complex needs

The sheer complexity of prioritising needs was identified in five articles as being a barrier to integrated, trauma-informed responses. Ensuring all needs are addressed was reported as difficult when one need might be more pressing than another, making systems-based approaches challenging. [61, 63, 66, 67, 72]

Burden of providing trauma-informed care

Some aspects of providing trauma-informed care were reported as being burdensome for staff, which acted as a barrier to integrated service delivery [50, 51, 59, 63]. For example, Substance Abuse and Mental Health Services Administration [51] and Moses et al. [50] reported that employing people who had experienced DFV to contribute to the provision of trauma-informed care had actually created burdens for those staff, including stigma and a perceived lack of credibility. Bartlett et al. [59] indicated that secondary traumatic stress of staff was a burden of delivering trauma-informed care.

Enablers

Six key enablers of integrated, trauma-informed responses for DFV, MH issues and/or AOD use and dependence were identified in the literature reviewed at Question 1.

1. Building and maintaining relationships with partners to support integration
2. Communication between partners
3. Structure
4. Supporting and training staff
5. Embedding the needs and perspective of the target population
6. Leadership and advocacy

The identified enablers are outlined below. The strength of the evidence for all six enablers was rated as poor (see Appendix 6).

Building and maintaining relationships with partners to support integration

The strength of the relationship between partners and the level of collaboration across sites was reported as a key enabler of integrated, trauma-informed service delivery. [50, 51, 53, 55, 59, 62, 65, 66, 69, 71] It was reported as critical that the relationship building process was established early in the partnership, and that there was a major focus on building a collaborative relationship between partners. [50, 51, 66, 69] For example Moses et al. [50] and Substance Abuse and Mental Health Services Administration [51] described the establishment of planning committees across sites, which assisted with collaboration between the services.

Communication between partners

Clear and consistent communication between partners was considered an enabler of integrated and trauma-informed responses. [50, 51, 57, 59, 62, 63, 69] Regular emails, meetings, video conferencing, and presentations assisted with communication. [62, 69] A shared understanding of roles across organisations also assisted with clear communication.[66] A position dedicated to communication across sites was also reported to enable greater communication. [67, 69] The development and utilisation of a ‘common language’ regarding trauma-informed responses was also noted as important for collaboration in some agencies. [63]

Structure

A well-defined structure was identified as an enabler. A clear governance structure and strong leadership were reported as essential to successful integration. [50, 51, 54, 66] This facilitated the coordination of referrals [66] and the monitoring and evaluation of the project. [55, 66]

Supporting and training staff

Ongoing support and supervision of staff were identified as key enablers for integrated, trauma-informed interventions. [50, 51, 56, 59, 61-64, 66, 71] Ensuring staff felt supported and confident in providing the required services and support was essential to providing integrated care.[56]. Bartlett et al. [59] also noted the importance of managing secondary traumatic stress of staff through approaches such as wellness classes (e.g. mediation and yoga), support groups, a self-care committee, a 'wellness room', and a survey to screen staff for secondary trauma. Attention to competence and upskilling of staff, as well as continuous and targeted training across services and disciplines, were also reported as facilitating integrated responses. [50, 51, 53, 55, 59, 61-64, 66, 67, 69, 71] For example, Barto et al. [55] reported that the staff involved received training, which facilitated the development of a shared language between different services and disciplines, and increased understanding of the involved partnering services. Family Safety Victoria [54] identified that services across the health system must be better resourced and practitioners better skilled to effectively respond to those needing specialist support for multiple issues.

Embedding the needs and perspective of the target population

Embedding the perspective and needs of the target population within the policy, program or model of practice was identified as an enabler of trauma-informed, integrated service delivery. [50, 51, 56-58, 65, 71] For example, the Stella Project Young Women's Initiative [71] reported the importance of having age appropriate opening times and a safe and supportive location for their service. Moses et al. [50] and Substance Abuse and Mental Health Services Administration [51] described having a position within the program for a consumer (a woman who had experienced DFV), which ensured that the program was trauma-informed and sensitive. Both the Treatment of Complex Trauma in Young Children Program [58] and Project Kealahou [65] are underpinned by culturally responsive theoretical positions, thus ensuring the cultural needs of their populations are being catered for. Relationship building with clients was also noted as important, including the compassion of staff, their ability to build trust and listen, be respectful and warm, and provide validation to clients. [56, 67]

Leadership and advocacy

The importance of active, multi-level leadership and advocacy in providing integrated, trauma-informed responses to those with complex issues was reported. For example, Laing and Toivonen (67) reported that a mental health and domestic violence worker was responsible for helping women navigate complicated health and welfare sectors, including the legal system, health services, and government agencies. This practical support was intended to meet the needs of women who would have otherwise 'fallen through the gaps' of service provision. Women valued this guidance and 'active involvement' in their cases.[67] Kramer et al. [64] reported that the initiative was 'championed' by key administrators who identified the need and obtained 'buy-in' from the full leadership team. This was seen as a strength and contributed to the success of the training program. The Integrated Domestic and Family Violence Service Program also saw case managers advocate for clients through determining and coordinating referral pathways based on clients' needs.[57] Advocacy was also highlighted in the Integrated Post-Crisis Response Service Model as a part of a women-centred approach to support. [53]

Priority populations

Barriers

Barriers for three priority populations were identified: Aboriginal and Torres Strait Islander people; people living in rural and remote areas; and young women and children. The strength of evidence for all barriers for priority populations included here was found to be poor. These barriers are outlined below.

Aboriginal and Torres Strait Islander people

A lack of cultural safety was identified as a barrier to integrated, trauma-informed responses to DFV and MH issues for Aboriginal people. Several stakeholders involved in the Integrated Domestic and Family Violence Service Program [57] described unsuccessful referrals and activities that were attributable to the absence of an Aboriginal worker within services.

People living in rural and remote areas

Moses et al.[50] identified several barriers to integrated, trauma-informed responses for people living in rural and remote communities. A general lack of services in rural areas was observed. Domestic violence shelters, and MH and AOD services were limited or unavailable in many locations, and rural sites were also more likely to offer services separated by large distances. This presented challenges for those with travel burdens, including little-to-no public transportation, severe weather, and poor road conditions. Geographic distance and isolation were found to hinder outreach efforts for those in rural and remote communities, due to difficulties in communicating service information. Arvidson et al. [58] also noted distance between services and travel costs were barriers to integrated, trauma-informed responses for people living in rural and remote communities.

Young women and children

The Stella Project Young Women's Initiative [71, 72] identified several barriers faced by young women, which present challenges for accessing and engaging with integrated, trauma-informed services. Young women who experience MH issues may have anxieties related to travelling to access services. Moreover, young women may not be able to afford to travel beyond locations within walking distance of their homes. It was also recognised that younger women experience an inherent lack of power and agency in society, due to their age, and the Stella Project Young Women's Initiative [71] suggested that this was amplified for those with multiple disadvantages, such as DFV, poor MH, and AOD issues. This lack of power and agency was reported to impact on the ability of younger women to engage with services.

Enablers

Enablers for two priority populations were identified: people living in rural and remote areas, and young women and children. Potential enablers were also identified for two additional priority populations: Aboriginal and Torres Strait Islander people, and children. The strength of the evidence for the enablers identified in this section was rated as poor. The enablers are outlined below.

Aboriginal and Torres Strait Islander people

Enablers of trauma-informed, integrated responses for Aboriginal and Torres Strait Islander people were not identified in the literature. However, Zmudzki et al. [57] recommended prioritising employing Aboriginal workers, as well as providing training on cultural safety and competency to other staff, which may enable delivery of integrated services.

Children

Enablers of trauma-informed, integrated responses for children were not identified in the literature. However, Zmudzki et al. [57] recommended that consideration be given to funding specific workers with practice skills in working with children affected by DFV, which may enable improved integrated service delivery for children in this position.

People living in rural and remote areas

Many of the Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study [50] sites employed methods to overcome identified barriers to trauma-informed, integrated service delivery, which highlight potential enablers for people living in rural and remote areas:

- Service availability: Sites offered services and drop-in centres in many locations throughout rural communities.
- Reducing the travel burden: Some sites provided transportation with agency vans or taxi vouchers for clients.
- Aggressive outreach efforts: Engagement through mailings, posters, newspaper and radio advertisements, and one-to-one contact. Information was provided to local service providers, courts, churches, businesses, and social groups.

Young women and children

The Stella Project Young Women's Initiative [71, 72] highlighted potential enabling factors to support responses to younger women:

- As mentioned above, lack of power and agency was identified as a potential barrier for younger women in engaging with services to address DFV, poor MH, and AOD issues. To address this, it was recommended that young women worked in partnership with providers, including shared decision-making about their own lives.
- Age-appropriate opening times: For young women in school and/or early employment roles, negotiating time off to attend appointments can be difficult. Services need to be open late afternoons and evenings to enable access for young women in these positions.
- Flexible, safe and youth-friendly locations: Services should consider that telephone and online communication methods may be young women’s preferred methods of contact; however, providers also need to recognise that young women are less likely than adults to have access to a private space to talk at home or in shared accommodation, so face to face services should also be provided as an option.
- Partnerships with ‘generic services/institutions’ may provide an opportunity to serve the needs of young women. For example, for those still in education, existing relationships between specialist services and schooling institutions may improve the accessibility of support to young women.

Discussion

While the identified barriers and enablers have sound face validity, the quality of the available evidence was rated as poor. This issue is reflected in the literature reviewed throughout this report, and will be addressed further in the conclusion. Barriers encompassed structural and individual factors, which also acted upon each other. For example, conflicts between agencies can occur for structural reasons, such as competition for funding, but can also influence relationships between individuals and increase care provider burden. Interestingly, enablers were all structural in nature. This may reflect a need for further investigation into factors that individuals could contribute to enabling integrated service provision.

Structural barriers included time, costs, logistics, and complex needs. It is noteworthy that although time, costs, and logistics were mentioned as barriers, the provision of more resources to address these barriers was not reported as a potential enabling factor. Enablers did include relationship building and maintenance, communication, and clear governance structures, which could help with simplifying the structural barrier of logistics and in preventing and mitigating the structural barrier of conflict between agencies. Many programs and models had developed tools that were used across different services. Although these were not evaluated, they are likely to facilitate communication. The individual barrier of care provider burden might be alleviated by the enablers of staff support and leadership, just as the adequate articulation of client needs might assist service providers to encourage and support disclosure among their clients. Cultural safety and rurality featured as additional barriers among priority populations, where some specific enablers were noted: transport, outreach programs, and other flexible service delivery options. There was a lack of information about enabling factors for Aboriginal and Torres Strait Islander peoples and young people.

An overarching theme when discussing barriers to and enablers of integrated, trauma-informed responses to DFV, MH issues and/or AOD use and dependence is the need to work in partnership across sectors and with clients. Common core understandings can facilitate the building of relationships, and the system design principles articulated in the IPARVAN Framework [1] can be utilised for this purpose. Similarly, the core principles of the Safe & Together Model [74] could potentially create shared understandings and lead to a common language, as was reported by Invisible Practices. Adequate funding is also needed. While this is not specifically mentioned in the reviewed reports, it is implicit in some of the structural barriers and would support the instigation of enabling factors. This is also evident in the summaries presented in Question 1, where staffing, facilities, training and costs were frequently mentioned as needed resources. Finally, the information on barriers and facilitators requires more detailed investigation, particularly in the NSW context, in order to be applicable and of sufficient quality to warrant further investment into enabling factors.

Conclusion and recommendations

The most consistently sound and quality program was the Integrated Domestic and Family Violence Service Program, which demonstrated many of the strengths indicated by the NSW DVDRT, Victorian Royal Commission and Queensland Taskforce reports. In addition, this program has overcome many of the identified barriers to service delivery through application of enablers and consistent consultation between partners. Its major limitations would be easily dealt with by an expansion of its consideration of geography (to incorporate remote and inland areas), and by increased partnerships and collaboration with AOD services. Referrals to the program from NSW Health services were lower than referrals to other services, which may indicate opportunities for increased collaboration with these services. Its major limitations would be easily dealt with by an expansion of its consideration of geography (to incorporate remote and inland areas), and by increased partnerships and collaboration with AOD services.

The Integrated Domestic and Family Violence Service Program was also the only program to demonstrate alignment with all five of the relevant IPARVAN Framework [1] system design principles, which may lie at the core of its successful outcomes. More detailed consideration and assessment of the program's capacity and effectiveness in providing an integrated response to DFV where mental health and AOD co-exist is warranted as the program has demonstrated very promising results.

A clear theme of the current review was the lack of high-quality evidence for the effectiveness of programs, and in some cases a lack of any reported evidence for efficacy. While it is acknowledged that the highest levels of evidence are problematic for safety, wellness and ethical reasons, there are measures that can be taken to increase the number of evaluations undertaken, and to improve the quality of the evidence provided by such evaluations. It is recommended that consideration be given to the following:

1. Including a mandatory requirement for evaluation reports with any publicly funded program designed to address DFV, MH and/or AOD
2. Using mixed methods approaches and a pre/post-test design as a minimum standard for program evaluation (as conducted by the Integrated Domestic and Family Violence Service Program)
3. Inviting experts in the field to peer review program reports before they are released

Sustainability of programs is enhanced by ongoing funding models. However, it is also important to continue to demonstrate program efficacy. Routine evaluations offer an opportunity to refine processes, identify and mitigate existing and new threats to efficacy, and provide evidence of the validity of programs.

An interesting finding to emerge from the reviewed reports was direction of training programs and an apparent lack of reciprocity in training between services. It is possible that this occurred due to the methods used in the review, but it is worth noting that training MH and AOD staff in DFV is valuable, but that the reverse is also true. As noted in the NSW DVDRT Report [16], training across sectors can mitigate discrimination and stigma associated with DFV and MH problems and AOD use that, in turn,

interferes with the ability of the individual to obtain support through appropriate services. This may be less effective if training is a one-way street.

Priority populations were included in many of the reviewed programs, sometimes incidentally, but for others as a result of consultation and collaboration, such as the WITH Study (which has unfortunately not been evaluated). The most notable lack of evidence with regard to priority populations concerned identification of barriers and enablers. It is likely that more nuanced and targeted research is needed here to identify community specific barriers to, and enablers of, integrated service delivery for DFV, MH and AOD issues.

Very few of the reviewed programs or models reported the inclusion of perpetrators in their client base. The Integrated Domestic and Family Violence Services Program offered services to perpetrators at some sites, although they were not explicitly targeted. The Specialist Family Violence Advisor Capacity Building Program was the only program to specifically target perpetrators of DFV. Little information as to the effectiveness of these programs for perpetrators was available.

The focus of integrated care in the context of DFV appears to be on those who have been abused rather than on the abuser. It is likely that a broader investigation into perpetrator intervention programs, not limited to integrated approaches, might uncover elements of program delivery that could be incorporated into integrated approaches. It is noteworthy that the Safe & Together Model [74] does, through its whole of family approach, consider the patterns of perpetrator behaviour as a core component. As has been previously mentioned, it will be important to consider the outcomes of the STACY Project, and to further investigate emerging evidence for the utility of the Safe & Together Model.

While the associations between DFV, MH issues and AOD use are robust, the nature of these associations remains opaque. Findings suggest that most of these associations are bidirectional and have the capacity to precede further DFV, worsening MH and increased AOD use. The programs described in this Evidence Check have sought, with varying degrees of demonstrated success, to prevent these escalations.

References

1. NSW Ministry of Health. Integrated Prevention and Response to Violence, Abuse and Neglect Framework. 2019.
2. Substance Abuse and Mental Health Services Administration. Trauma-informed USA 2020 [Available from: www.integration.samhsa.gov/clinical-practice/trauma-informed].
3. Australian Institute of Health and Welfare. Family, domestic and sexual violence in Australia: Continuing the national story 2019. Canberra: AIHW; 2019.
4. NSW Ministry of Health. The Case for Change: Integrated prevention and response to violence, abuse and neglect in NSW Health. Sydney: NSW Ministry of Health 2019.
5. Domestic Violence Death Review Team. NSW Domestic Violence Death Review Team Report 2015-2017. 2017.
6. Our Watch. Key statistics on violence against women in Australia [Available from: https://www.ourwatch.org.au/].
7. Education Centre Against Violence and NSW Health. Fact Sheet: Avoiding the 3 'M's: Myths, mistakes and misinformation about violence, abuse and neglect. 2019.
8. Cafferky BM, Mendez M, Anderson JR, Stith SM. Substance use and intimate partner violence: A meta-analytic review. Psychology of Violence. 2018;8(1):110-31.
9. Choenni V, Hammink A, van de Mheen D. Association between substance use and the perpetration of family violence in industrialized countries: A systematic review. Trauma, violence & abuse. 2017;18(1):37-50.
10. Oram S, Trevillion K, Khalifeh H, Feder G, Howard LM. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. Epidemiology and Psychiatric Sciences. 2014;23(4):361-76.
11. Hameed MA. The tripartite tragedy: Alcohol and other drugs, intimate partner violence and child abuse. Children Australia. 2019;44(1):32-41.
12. Bromfield L, Lamont A, Parker R, Horsfall B. Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems. Australian Institute of Family Studies; 2010.
13. Mason R, O'Rinn SE. Co-occurring intimate partner violence, mental health, and substance use problems: A scoping review. Glob Health Action. 2014;7:24815-.
14. Noonan P, Taylor A, Burke J. Links between alcohol consumption and domestic and sexual violence against women: Key findings and future directions. Sydney: ANROWS; 2017.
15. Foundation for Alcohol Research and Education. National framework for action to prevent alcohol-related family violence. Canberra: FARE; 2015.
16. Domestic Violence Death Review Team. NSW Domestic Violence Death Review Team Report 2017-2019. 2020.
17. Mackay E, Gibson A, Lam H, Beecham D. Perpetrator interventions in Australia: State of knowledge paper. Sydney ANROWS; 2015.
18. Fals-Stewart W, Kennedy C. Addressing intimate partner violence in substance-abuse treatment. Journal of substance abuse treatment. 2005;29(1):5-17.
19. Gondolf EW. Characteristics of Court-Mandated Batterers in Four Cities: Diversity and Dichotomies. Violence Against Women. 1999;5(11):1277-93.
20. Devries KM, Child JC, Bacchus LJ, Mak J, Falder G, Graham K, et al. Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis. Addiction (Abingdon, England). 2014;109(3):379-91.
21. Ayre J, Lum On M, Webster K, Gourley M, Moon L. Examination of the burden of disease of intimate partner violence against women in 2011: Final report. Sydney: ANROWS; 2016.

22. Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. PloS one. 2012;7(12):e51740.
23. Breet E, Seedat S, Kagee A. Post-traumatic stress disorder and depression in men and women who perpetrate intimate partner violence. Journal of Interpersonal Violence. 2016;34(10):2181-98.
24. Friedman SH, Loue S, Goldman Heaphy EL, Mendez N. Intimate partner violence victimization and perpetration by Puerto Rican women with severe mental illnesses. Community mental health journal. 2011;47(2):156-63.
25. Shorey RC, Febres J, Brasfield H, Stuart GL. The prevalence of mental health problems in men arrested for domestic violence. J Fam Violence. 2012;27(8):741-8.
26. Oram S, Trevillion K, Feder G, Howard LM. Prevalence of experiences of domestic violence among psychiatric patients: Systematic review. The British journal of psychiatry : the journal of mental science. 2013;202:94-9.
27. Lagdon S, Armour C, Stringer M. Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. European journal of psychotraumatology. 2014;5.
28. Loxton D, Dolja-Gore X, Anderson AE, Townsend N. Intimate partner violence adversely impacts health over 16 years and across generations: A longitudinal cohort study. PloS one. 2017;12(6):e0178138.
29. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. The Lancet Public health. 2017;2(8):e356-e66.
30. Jaffee SR. Child maltreatment and risk for psychopathology in childhood and adulthood. Annual review of clinical psychology. 2017;13:525-51.
31. Vonderlin R, Kleindienst N, Alpers GW, Bohus M, Lyssenko L, Schmahl C. Dissociation in victims of childhood abuse or neglect: A meta-analytic review. Psychological medicine. 2018;48(15):2467-76.
32. Queensland Taskforce. Not now, not ever: Putting an end to domestic violence in Queensland. 2016.
33. State of Victoria. Royal Commission into Family Violence: Summary and recommendations, Parl Paper No 132. 2014-2016.
34. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva, Switzerland: WHO; 2013.
35. Hegarty K. Acting on family violence: How the health system can step up: The Conversation; 2015 [Available from: https://theconversation.com/acting-on-family-violence-how-the-health-system-can-step-up-45592].
36. Isobe J, Healey L, Humphreys C. A critical interpretive synthesis of the intersection of domestic violence with parental issues of mental health and substance misuse. Health & Social Care in the Community. 2020.
37. Stephens-Lewis D, Johnson A, Huntley A, Gilchrist E, McMurran M, Henderson J, et al. Interventions to reduce intimate partner violence perpetration by men who use substances: A systematic review and meta-analysis of efficacy. Trauma, violence & abuse. 2019:1524838019882357.
38. Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. The British journal of psychiatry : the journal of mental science. 2011;198(3):189-94.
39. Trevillion K, Hughes B, Feder G, Borschmann R, Oram S, Howard LM. Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. Int Rev Psychiatry. 2014;26(4):430-44.
40. Trevillion K, Howard LM, Morgan C, Feder G, Woodall A, Rose D. The response of mental health services to domestic violence: A qualitative study of service users' and professionals' experiences. Journal of the American Psychiatric Nurses Association. 2012;18(6):326-36.
41. Jenner L, Lee N, Alcohol Tobacco and Other Drug Association ACT. Domestic and family violence capability assessment tool: For alcohol and other drug settings. Canberra: ATODA; 2017.
42. White M, Roche AM, Long C, Nicholas R, Gruenert S, Battams S. Can I ask...? An alcohol and other drug clinician's guide to addressing family and domestic violence. Flinders University, Adelaide, SA: National Centre for Education and Training on Addiction (NCETA). 2013.

43. Victoria Health and Human Services. Chief Psychiatrist's guideline and practice resource: Family violence. 2017.
44. Jenner L, Lee N, Alcohol Tobacco and Other Drug Association ACT. Practice guide: For responding to domestic and family violence in alcohol and other drug settings. Canberra: ATODA; 2017.
45. Jenner L, Lee N, Alcohol Tobacco and Other Drug Association ACT. Scope of practice: For working with service consumers in alcohol and other drug settings who experience or use domestic and family violence. Canberra: ATODA; 2017.
46. Moher D, Liberati A, Tetzlaff J, Altman DG, The Prisma Group. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. PLOS Medicine. 2009;6(7):e1000097.
47. Hillier S, Grimmer-Somers K, Merlin T, Middleton P, Salisbury J, Tooher R, et al. FORM: An Australian method for formulating and grading recommendations in evidence-based clinical guidelines. BMC Medical Research Methodology. 2011;11(1):23.
48. National Library of Medicine. Medical subject headings 2019 [Available from: https://www.nlm.nih.gov/mesh/meshhome.html].
49. Hodgdon HB, Blaustein M, Kinniburgh K, Peterson ML, Spinazzola J. Application of the ARC model with adopted children: Supporting resiliency and family well being. Journal of Child & Adolescent Trauma. 2016;9(1):43-53.
50. Moses D, Huntington N, D'Ambrosio B. Developing integrated services for women with co-occurring disorders and trauma histories: Lessons from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study. 2004.
51. Substance Abuse and Mental Health Services Administration. The women, co-occurring disorders and violence study and children's subset study: Program summary. SAMHSA.
52. Morrissey JP, Jackson EW, Ellis AR, Amaro H, Brown VB, Najavits LM. Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. Psychiatric services (Washington, DC). 2005;56(10):1213-22.
53. Desmond K. Filling the Gap Service Model: Integrated post crisis response for women and children who have experienced family violence. 2011.
54. Family Safety Victoria. Specialist Family Violence Advisor Capacity Building Program Stage 1 Program Guidelines.; 2018.
55. Barto B, Bartlett JD, Von Ende A, Bodian R, Noroña CR, Griffin J, et al. The impact of a statewide trauma-informed child welfare initiative on children's permanency and maltreatment outcomes. Child abuse & neglect. 2018;81:149-60.
56. Lowell DI, Carter AS, Godoy L, Paulicin B, Briggs-Gowan MJ. A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. Child development. 2011;82(1):193-208.
57. Zmudzki F, Breckenridge J, Newton BJ, Delaney M, Valentine K. Evaluation of the Integrated Domestic and Family Violence Service Program: Final report prepared for NSW Department of Family & Community Services. Sydney: Social Policy Research Centre, UNSW; 2018.
58. Arvidson J, Kinniburgh K, Howard K, Spinazzola J, Strothers H, Evans M, et al. Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model. Journal of Child & Adolescent Trauma. 2011;4(1):34-51.
59. Bartlett JD, Barto B, Griffin JL, Fraser JG, Hodgdon H, Bodian R. Trauma-Informed Care in the Massachusetts Child Trauma Project. Child maltreatment. 2016;21(2):101-12.
60. Bunting L, Montgomery L, Mooney S, MacDonald M, Coulter S, Hayes D, et al. Trauma informed child welfare systems: A rapid evidence review. International journal of environmental research and public health. 2019;16(13).
61. Conners-Burrow NA, Kramer TL, Sigel BA, Helpenstill K, Sievers C, McKelvey L. Trauma-informed care training in a child welfare system: Moving it to the front line. Children and Youth Services Review. 2013;35(11):1830-5.
62. Fraser JG, Griffin JL, Barto BL, Lo C, Wenz-Gross M, Spinazzola J, et al. Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. Children and Youth Services Review. 2014;44:233-42.
63. Henry J, Richardson M, Black-Pond C, Sloane M, Atchinson B, Hyter Y. A grassroots prototype for trauma-informed child welfare system change. Child welfare. 2011;90(6):169-86.

64. Kramer TL, Sigel BA, Conners-Burrow NA, Savary PE, Tempel A. A statewide introduction of trauma-informed care in a child welfare system. Children and Youth Services Review. 2013;35(1):19-24.
65. Suarez E, Jackson DS, Slavin LA, Michels MS, McGeehan KM. Project Kealahou: improving Hawai'i's system of care for at-risk girls and young women through gender-responsive, trauma-informed care. Hawaii J Med Public Health. 2014;73(12):387-92.
66. Hegarty KL, Tarzia L, Rees S, Fooks A, Forsdike K, Woodlock D, et al. Women's input into a trauma-informed systems model of care in health settings: The WITH study final report. Sydney, NSW: ANROWS; 2017.
67. Laing L, Toivonen C. Bridging the gap: Evaluation of the Domestic Violence and Mental Health Pilot Project - Joan Harrison Support Services for Women. Sydney: University of Sydney; 2010.
68. Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach Retrieved from Rockville, MD: Substance Abuse and Mental Health Services Administration. 2014 [Available from: https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf.].
69. Jean Cameron Consulting. Northern Area Mental Health Service Partnership Project final report. 2011.
70. Huebner RA, Posze L, Willauer TM, Hall MT. Sobriety Treatment and Recovery Teams: Implementation Fidelity and Related Outcomes. Substance use & misuse. 2015;50(10):1341-50.
71. Against violence and abuse: The Stella Project Young Women's Initiative. Commissioning for multiple disadvantages: Developing effective services for young women experiencing domestic and sexual violence who have substance use and mental health problems. AVA.
72. Horvath MHA, Rogers SA, Adler J.R. Final evaluation report for The Stella Project Young Women's Initiative. Forensic Psychological Services, Middlesex University; 2013.
73. Heward-Belle S., Healey L, Isobe J, Roumeliotis A, Link E, Mandel D, et al. Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues. Practice Guide from the STACY Project: Safe & Together Addressing Complexity. Melbourne, Australia: University of Melbourne; 2020.
74. Safe & Together Institute. Companion document: the safe & together model and domestic abuse perpetrator programmes 2018.
75. Nicholas R, White M, Roche A, Gruenert S, Lee N. Breaking the silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia. Adelaide: National Centre for Education and Training on Addiction, Flinders University; 2012. Report No.: 9781876897505.
76. Australian Institute of Family Studies. Establishing the connection. Guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors 2016 [Available from: https://aifs.gov.au/publications/establishing-connection].
77. Stathopoulos M, Jenkinson R. Establishing the connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse: Key findings and future directions. ANROWS; 2016.
78. Stathopoulos M, Jenkinson R. Establishing the Connection: Interventions linking service responses for sexual assault with drug or alcohol use/abuse: Final report. Sydney, NSW: ANROWS; 2016.
79. Alcohol Tobacco & Other Drug Association ACT. Domestic and Family Violence Tools for Alcohol and Other Drug Settings [Available from: http://www.atoda.org.au/dfvtools/].
80. Humphreys C, Healey L. PAThways and Research Into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report Sydney: ANROWS; 2017.
81. Healey L, Humphreys C, Tsantefski M, Heward-Belle S, Mandel D. Invisible practices: Intervention with fathers who use violence. Sydney, NSW: ANROWS; 2018.
82. ANROWS. Externally-funded research projects: STACY – Safe and Together Addressing Complexity [Available from: https://www.anrows.org.au/project/stacy-safe-and-together-addressing-complexity/].
83. NSW Health Agency for Clinical Innovation. Keep Them Safe and Whole Family Teams - An Integrated Partnership Approach to Health Care 2015 [Available from: https://www.aci.health.nsw.gov.au/ie/projects/keep-them-safe-and-whole-family-

teams#:~:text=Whole%20Family%20Teams%20(WFTs)%20include,interventions%20for%20approximately%20six%20months.].
84. Ross J, Mills KL, Prior K, Slade T, Stapinski L, Chapman C, et al. What is known on reducing risk for children of parents with mental health and/or drug and alcohol issues? An Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health.; 2016.

Appendices

Appendix 1: Evidence Check proposal

Introduction

An Evidence Check review is a rapid review of existing evidence tailored to the individual needs of an Agency. Evidence Check reviews answer specific policy or program questions and are presented as a report in a policy friendly format. Reviewers identify gaps in the evidence but do not undertake new research to fill these gaps.

Background

The intersections between domestic and family violence, mental health and alcohol and other drug issues are multi-fold and complex. Associations between poor mental health and alcohol and other drug use and perpetration of domestic and family violence have been found in multiple studies[1]. Poor mental health and substance misuse are both linked to an increased risk and vulnerability to violence, abuse and neglect[2]. Conversely, the experience of violence, abuse and neglect often has serious health impacts for victims and victim-survivors, including poor mental health and alcohol and other drug misuse. This includes significant health impacts of children who are exposed to domestic and family violence who are at increased risk of poor mental health, behavioural and learning difficulties in both the short and long term[3].

The NSW Domestic Violence Death Review Team (DVDRT) has identified these intersections, and opportunities for systems and program improvements when responding to these issues. Ten of the fifteen recommendations where NSW Health is identified as the lead from 2013-15 and 2015-17 DVDRT reports relate to mental health and/or alcohol and other drug needs, systems and responses, including recommendation 16 from the 2015-2017 report:

That NSW Health conduct a literature review and convene a working group within NSW Health to ventilate relevant issues and develop a model of practice around working with complex clients with cumulative alcohol or drug, mental health and domestic violence issues.

The literature review aims to increase understanding about international and Australian policies and programs for integrated, trauma-informed responses, where co-occurrence of mental health issues, alcohol and other drugs use and domestic and family violence are addressed, and their alignment to the system design principles *Integrated Prevention and Response to Violence, Abuse and Neglect*

[1] NSW Health, 2018, *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*
[2] See for example NSW Domestic Violence Death Review Reports 2013-2015 & 2015-2017, NSW Child Death Review Team Report 2015, COAG Advisory Council on Reducing Violence Against Women and their Children Final Report (2016)

[3] NSW Health, 2018, *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health, p.32*

Framework. It will also summarise evidence of enablers and barriers to implementation of these policies and programs.

Purpose and audience

The literature review will support policy and program development within NSW Health. It will also inform planning and discussion of a planned forum to address 16.2 of the DVDRT recommendations "That NSW Health convene an interagency forum including with relevant expertise in drug and alcohol, mental health and domestic violence to develop strategies for improving and coordinating responses to people with mental health, drug and alcohol and domestic violence perpetration or victimisation issues. This may include the development of a coordinated plan of action, referral pathways and complex program interventions across agencies.

The main audience for the review is senior policy makers, forum participants including policy makers, practitioners and academics.

Review questions

The review will answer the following three questions:

Question 1

What policies, programs or models of practice have been effective in supporting the delivery of integrated trauma informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

Scope and definitions

- This question should be answered from peer reviewed and grey literature from OECD countries including from the last 10 years. This should include *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*
- The identification of policies, programs or models responding to domestic and family violence where both mental health and alcohol and other drug dependence exist should be prioritised. However, policies, programs or models of practice include those developed and implemented to address the complex interactions that may exist between domestic and family violence and mental health issues, and/or alcohol and other drug use and dependence
- Policies, programs or models of practice may provide services or supports for victims and/or perpetrators of domestic and family violence, including those targeted at vulnerable families (including children), and carers of people with mental health and/or alcohol and other drug use and dependence (e.g. NSW Family Investment Model pilot)
- "Effective" refers to policies or programs that successfully (as defined by study authors) deliver integrated trauma informed responses, but should be informed by the existing evidence base for integrated practice, as set out in *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*"Integration" should be understood as "the provision of service responses in accordance with a **person-centred approach** that provides **seamless care** across multiple services, adopts **a multidisciplinary and traumainformed approach**, and is designed around the **holistic needs** of the individual **throughout the life course"[4] [see question 2]**.The reviewers should

[4] NSW Ministry of Health, Integrated Prevention and response to Violence, Abuse and Neglect Framework, p. 13

also include policies, programs or models that may not yet be fully evaluated but show promise and may be applicable to the NSW setting.

- Responses to this question should highlight any identified additional strengths or weaknesses or programs or models of practice for responding to priority populations as identified in *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*
- The reviewer should provide a short description of each policy, program or model of practice, including information where provided about:
  - Aim of policy, program or model of practice
  - Within sector and cross-sectoral collaboration
  - Referral pathways
  - Staff capabilities and training
  - Processes to support identification, assessment and responses to domestic and family violence
  - Resource requirements e.g. staffing, facilities, cost.
- Settings - within and across different health care settings (e.g. mental health or drug and alcohol services, emergency departments, inpatient care, primary health care); within and between sectors (e.g. health, justice, employment, social, child protection). Non-government services should be included since they are part of the service delivery system.

Exclusions

This question will not focus on screening tools for domestic and family violence, mental health issues, or drug and alcohol dependence or focus in detail on barriers associated with sharing information across services or sectors.

Question 2

The reviewer is asked to summarise the alignment of these policies or programs (from Question 1) to the system design principles set out in NSW Health's Integrated Prevention and Response to Violence, Abuse and Neglect Framework.[5] These include:

(i) Person and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family
(ii) Recovery from trauma is recognised and valued as a primary outcome of responses
(iii) Early intervention is prioritised as it can change the long-term trajectory of chronic disease and adverse health outcomes for people who have experienced violence, abuse or neglect and their families
(iv) Equitable, accessible and consistent service responses are provided
(v) No wrong door - NSW Health workers will collaborate to support people and their families to access the most appropriate service response.

Question 3

What are the key barriers to, and enablers of, integrated trauma-informed responses where domestic and family violence, mental health issues and/or alcohol and other drug use and dependence may co-exist?

[5] https://www.health.nsw.gov.au/parvan/Pages/van-redesign-program.aspx

Scope and definitions

- This question should be answered from peer reviewed and grey literature from Australian sources and literature identified from searches undertaken for question 1
- The strength of evidence (e.g. strong, moderate, weak, conflicting, or other measure preferred by reviewers) should be clearly provided for each barrier or enabler
- The response is to consider and report themes that hinder or promote the delivery of integrated services for domestic and family violence where there are co-occurring mental health and/or alcohol and other drug issues
- Barriers and enablers may include, for example:
  - Integration between different health services, (including but not necessarily limited to mental health, alcohol and other drugs and Violence Abuse and Neglect services) as well as integration between health services and other services systems including criminal justice, child protection, and family and community services
  - Differences and/or similarities in philosophical and policy approaches between mental health, alcohol and drug and domestic and family violence health services and systems
  - Workforce needs and capabilities
  - Any specific barriers and enablers to support people experiencing domestic and family violence where the violence or risk of violence is identified through the delivery of health services to the perpetrator, including but not limited to court ordered and diversionary treatment programs
- The reviewer is asked to report on any specific enablers for integrated practice for priority populations identified in the *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*
- The response to this question should utilise but not duplicate barriers and enablers identified in *The Case for Change: Integrated prevention and response to Violence, Abuse and Neglect in NSW Health*
- The reviewer is to use thematic analysis to identify, organise, describe and report themes that hinder or promote the delivery of integrated responses for domestic and family violence where there are co-occurring mental health and/or alcohol and other drug issues.

Format and language

A report template will be provided to the review team. Below is general guidance for the report. The review will be organised by review question, in the range of 30 pages not including tables and references.

The review will include the following elements:

- **Table of contents**
- **Executive summary (2 pages)**
- **Background and introduction (4 pages)**

The background section will provide a summary of the prevalence and impact of co-existing mental health and alcohol and other issues and domestic and family violence perpetration, victimisation (for adults and children) and recovery from the trauma. Where there is strong evidence for the co-occurrence of domestic and family violence with specific mental health diagnoses and/or specific drug use and dependence (e.g. methamphetamine) this should be included here.

- **Methods (4 pages)**

This section will include a description of the method used for searching and selecting research papers. A flow chart of the article selection process will be provided e.g. a PRISMA diagram. The method for assessment of quality of evidence will be described. Reviewers can use an existing tool or another scale with clear and explicit definitions of levels of quality that can be mapped to existing standards e.g. NHMRC or similar.

- **Findings (20 pages)**

The review questions will be answered in this section. Papers will be included in one or more tables (not counted in page limit).

An analysis of evidence in relation to the review questions and applicability for NSW will be included here.

- **Reference list in Endnote.** The reviewers will provide the Endnote Library with the final report.
- **Appendices, as required**.

Appendix 2: MeSH terms and keywords used in Medline search

Search #	Search topic	MeSH[a] terms	Examples of additional keywords used in addition to MeSH terms as keywords (note: these terms varied by database)
1.	Domestic or family violence	• Adverse Childhood Experiences • Battered Child Syndrome • Incest • Domestic Violence • Intimate Partner Violence • Gender-Based Violence • Child, Abandoned • Battered Women	• Violence against women • Interpersonal violence • Intimate partner abuse • Relationship violence • Partner abuse • Partner violence • Dating violence • Dating abuse • Spouse abuse • Spousal abuse • Domestic abuse • Abused women • Abused children • Childhood abuse • Child abuse • Child sexual abuse • Childhood adversity • Family violence
2.	Policies, programs, or models of practice	• Policy • Health Planning • Social Control, Formal • Social Work • Social Welfare • Sociology, Medical • Health Services Administration • Evidence-Based Practice • Public Health • Population Health • Mandatory Testing • Health Care Quality, Access, and Evaluation • Government Programs • Primary Prevention • Secondary Prevention	• Intervention • Treatment • Services • Practice • Model of care • Care model • Coordinated care • Care pathways • Program • Evaluation • Best practice • Implementation • Trial

		• Tertiary Prevention • Capacity Building • Health Communication • Health Services • Program Evaluation	
3.	Integrated approach (validated search string)[b]	*Delivery of health care, integrated/ or Integrated care.mp,jw. or (integrated health*.mp. and og.xs.) • Collaborative practice	
4.	Trauma-informed care	Note: All MeSH terms relating to trauma are in relation stress and trauma-related disorders of the individual, rather than reflective of a trauma-informed approach	• "trauma-informed" • "trauma sensitive" • "family-centred" • "family-centered"
5.	Mental health	• Mentally Ill Persons • Child of Impaired Parents • Mental Health • Mental Disorders • Posttraumatic Growth, Psychological • Counseling • Mental Health Services • Psychiatric Rehabilitation • Mental Health Recovery • Self Mutilation	• Post-traumatic stress disorder OR PTSD OR Stress disorder • Affective disorder • Mental disorders • Mental illness • Psycholog* services • Suggested keywords from IFIC: (mental health*[ti] OR psychiatr*[ti] OR anxiety[ti] OR bipolar[ti] OR eating disorder*[ti] OR anorexia nervosa[ti] OR bulimi*[ti] OR mood disorder*[ti] OR depression[ti] OR depressive disorder*[ti] OR schizophreni*[ti] OR psychosis[ti] OR psychoses[ti] OR psychotherap*[ti] OR behaviour*[ti] OR behavior*[ti] OR dually diagnos*[tiab] OR dual diagnos*[tiab])
6.	Alcohol or other drugs	• Alcoholics • Drug Users • Substance Abuse Detection • Drinking Behavior	• Suggested search by IFIC: (Substance use*[ti] OR substance abuse*[ti] OR substance misuse*[ti] OR drug

		• Drug-Seeking Behavior • Substance-Related Disorders • Illicit Drugs • Substance Abuse Treatment Centers • Drug and Narcotic Control	use*[ti] OR drug using[ti] OR drug abuse*[ti] OR alcohol use*[ti] OR alcohol abuse*[ti] OR alcohol dependen*[ti] OR alcohol misuse*[ti] OR alcohol problem*[ti] OR alcoholism[ti] OR alcoholic*[ti] OR problem drinker*[ti] OR addict*[ti] OR methadone[ti] OR opioid dependen*[ti] OR cannabis use*[ti] OR cannabis dependence[ti] OR prescription opioid*[ti] OR cocaine[ti] OR ecstasy[ti] OR opiate addiction[ti] OR heroin[ti] OR injecting drug*[ti] OR "Alcohol and other drug*"[ti] OR marijuana[ti] OR morphine dependen*[ti])

[a] Medical Subject Headings (MeSH) are used by National Library of Medicine (US) to index, catalogue and search health-related information, and they include the subject headings in Medline. More information can be found: https://www.nlm.nih.gov/mesh/meshhome.html

[b] https://integratedcarefoundation.org/ific-integrated-care-search-narrow

Appendix 3: Description of included articles

Peer reviewed literature

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
Bunting, Montgomery, Mooney (59)	USA	Systematic review.	Child welfare systems in the USA.	Meta-analysis not complete. 21 papers reported on evaluations of 17 community-based child welfare initiatives.	Not applicable.	Not applicable.	Training was the trauma-informed care implementation component most frequently evaluated with all studies reporting positive impact on staff knowledge, skills and/or confidence. The development of trauma-informed screening processes, and evidence-based treatments/trauma focused services, where evaluated, all produced positive results.	Not applicable.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
Barto, Bartlett, Von Ende (54)	USA	Comparative study with concurrent controls.	Children who were involved with the state child welfare system (mean age 9.5, age range 0-19 years at the end of intervention).	n=91,253 children Intervention group = 55,145 Comparison group = 36,108.	Children in the intervention group were served by Department of Children and Families area offices that developed and implemented Trauma-Informed Leadership Teams, and where Department of Children and Families workers were trained in the Child Welfare Trauma Training Toolkit. Children received treatment from teams trained in	Children in the comparison group received child welfare services as usual.	Children in the intervention group were 4% more likely to have a substantiated or unsubstantiated maltreatment report and had more substantiated or unsubstantiated maltreatment reports overall.	Intervention group had more substantiated or unsubstantiated maltreatment reports overall. Intervention group had fewer substantiated reports of maltreatment overall, physical abuse, and neglect.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					evidence-based trauma treatment models.			
Fraser, Griffin, Barto (61)	USA	Preliminary multi-method implementation evaluation including surveys, records reviews and individual child assessments to measure both process and outcome.	State-wide Child welfare initiative in Massachusetts.	n=24 Area Office Directors, n=153 clinicians, 645 child welfare and mental health workers involved in training n=17 Trauma-Informed Leadership Teams.	Child welfare staff were provided with Training in trauma informed-care and evidenced based trauma informed strategies. The Trauma System Readiness Tool was administered to Area Office Directors (completion rate = 83%). The Evidence-Based Practice	Baseline data was used as a comparator.	Responses to the Evidence-Based Practice Attitudes Scale results were overall positive and suggested that clinicians did not have a negative attitude towards evidence-based practice. - Scores on the Trauma-Informed System Change Instrument were similarly positive, indicating that at the individual level, clinicians had a strong intention to	This study is on component of the larger intervention. As the initiative progresses, the evaluation will focus on the degree of implementation across the intended audiences (e.g. Department of Children and Families' staff, clinicians, resource parents),

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					Attitudes Scale and the Trauma-Informed System Change Instrument measures were administered to the clinicians response rate = 79.7%). A training evaluation was completed by 645 child welfare and mental health workers (response rate = 59%) and all 17 Area Office Trauma-Informed Leadership Teams		consistently engage in trauma-informed practice. - 80% of workers who completed the training evaluation reported being satisfied or very satisfied with the training. - Feedback from the Trauma-Informed Leadership Teams pointed to the championing role of Area Office managers as the critical factor to successful teams; another key factor was the comfort level in engaging members of the	examining satisfaction with trainings along with knowledge and practice changes reported via post-training surveys.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					completed a self-assessment at the end of year one.		community on their team. - Evidence-Based Practice implementation progress: at the end of the first year of implementation, 298 children were enrolled in Evidence-Based Practice.	
Bartlett, Barto, Griffin (58)	USA	Pre-test/post-test training evaluation and interviews.	State-wide Child welfare initiative in Massachusetts . 	Interviews with n=32 Trauma-Informed Leadership Team leaders and n=25 senior leaders. Evaluation provided to n=190 community	Child welfare staff were provided with training MH staff trained in three trauma-focused evidence-based treatments: Attachment Self-regulation and Competency, Child-Parent	Baseline data was used as a comparator.	Interviews pointed to Trauma-Informed Leadership Teams as key structures for trauma-informed care systems integration participation in Evidence-Based Treatment. Learning collaboratives were linked to improvements in	The results of this study support the notion that a trauma-informed approach in CW necessitates coordination and changes at multiples levels of child and family serving systems that

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
				mental health practitioners n=326 children referred to treatments.	Psychotherapy, and Trauma-Focused Cognitive-Behavioural Therapy. Child welfare workforce trained in basic trauma-informed care, with some of the workforce receiving advanced trauma training.		trauma informed individual and agency practices. The Massachusetts Child Trauma Project's approach to trauma-informed care in general, and to trauma informed Evidence-Based Treatment dissemination in particular, was associated with positive child outcomes across multiple symptom domains. From onset of an Evidence-Based Treatment to 6 months (or less) of treatment, children's internalising, externalising, and	align across implementation domains. After approximately 6 months of Evidence-Based Treatment, children had fewer post-traumatic symptoms and behaviour problems compared to baseline.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
							total problem behaviours were significantly reduced.	
Huebner, Posze, Willauer (69)	USA	Prospective-descriptive study.	Representatives from various agencies (e.g. child welfare, court, substance use disorders treatment providers) and families of parents with substance use disorders.	n=120 agencies. n=441 families (550 parents and 717 children).	A child-welfare-led intervention designed as an integrated treatment program for families with co-occurring child abuse or neglect and parental substance use disorder.	Not applicable.	The time from the child protective services report to completion of five drug treatment sessions was reduced by an average of 75 days. Adherence to the timeline standards was achieved within the third year of program. Sobriety rates for mothers significantly improved from 47.4% to 66.3%. The rate of children who remained with their parents throughout START Program	Not applicable.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
							improved from 31.7% to nearly 54.9%.	
Lowell, Carter, Godoy (55)	USA	Randomised controlled trial	Families of children with social-emotional/ behavioural problems and/ or parents with high psycho-social risk including depression, domestic violence, substance use, homelessness, incarceration, isolation, single and teen parenthood,	n=157 mothers and children Intervention group = 78 Comparison group = 79.	Child FIRST (Child and Family Interagency, Resource, Support, and Training) home-based, psychotherapeutic, parent-child intervention embedded in a system of care.	Usual care (details not reported).	Intervention families had significantly greater numbers of needs met than usual care (child mental health 93% vs. 2%, child development 99% vs. 14%, early education 88% vs. 26%, family support 83% vs. 9%, adult mental health 92% vs. 7%, social services 93% vs. 56%, medical services 98% vs. 78%, adult education 62% vs. 9%, and concrete needs 89% vs. 16%).	Compared to usual care, the intervention had a strong effect on increased service access, improved child language and externalising symptoms, reduction in parenting stress, and reduction in parental psychopathology.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
			education, and employment.					
Arvidson, Kinniburgh, Howard (57)	USA	Naturalistic pre-test, post-test programme.	Preschool and school-aged children in the child protective system treated through the Alaska Child Trauma Centre.	n=93 children treated using Attachment, Regulation and Competency model (only 26 completed the intervention).	Children were delivered the Attachment, Regulation and Competency framework which is theoretically grounded in attachment, trauma, and developmental theories and is aimed at specifically addressing three core domains impacted by exposure to chronic, interpersonal trauma:	Baseline data was used as a comparator.	The average drop in Child behaviour Checklist scores for children completing treatment was 19 points. 90% children moved to permanent placements compared to usual 40%.	The higher success rate of treatment completers in obtaining permanent home placements is a particularly noteworthy outcome of this study.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					attachment, self-regulation, and developmental competencies.			
Henry, Richardson, Black-Pond (62)	USA	Mixed methods qualitative and quantitative evaluation.	Child welfare agencies from nine Michigan counties.	Baseline evaluation of trauma-informed practices and readiness to change, and one year follow up (n=631). Interviews with key personnel (n=8) Secondary data (court neglect/abuse file) reviews (53 files representing 112 children).	The trauma informed welfare system involved various training components t CTAC trained three teams of professionals in a transdisciplinary neurodevelopmental assessment protocol. Clinicians from three county systems were trained in Trauma-	Baseline data was used as a comparator.	Post-test results after one year revealed a statistically significant increase in the extent that policy had become more trauma-informed. Post-test results after one year revealed a statistically significant ($p < 0.05$) increase in the extent that policy had become more trauma-informed, increasing from 2.4 to 2.8 ($p < 0.049$).	Not applicable.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					Focused Cognitive Behavioural Therapy and/or Real Life Heroes. During Year 3 of the grant, a second Trauma- Focused Cognitive Behavioural Therapy training was provided for 22 therapists with 19 continuing with follow-up consultation. Establishment of Common Language Using Trauma-Informed Instruments:		Agency practice also showed statistically significant improvement, increasing from 2.7 to 3.0 ($p < 0.048$).	

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					Specific trauma trainings provided to courts, schools, medical personnel and caregivers to infuse trauma into agency and interagency discussion of children.			
Conners-Burrow, Kramer, Sigel (60)	USA	Pre-test/multiple post-tests evaluation.	State-wide family service, case workers/child protection social workers and other staff in Arkansas.	n=438 training with child welfare staff and a random sample of child welfare staff n=161. n=68 welfare staff were asked to complete a	Training was based on trauma-informed essential elements. Child welfare workers attended a one-day workshop led by social workers. Workers were asked to create an action plan	Baseline data was used as a comparator, no control group.	The results reveal a significant effect for trauma-informed knowledge, indicating significant knowledge gain from pre- to post-test. The magnitude of this effect was large (partial eta sq=.50). The results for trauma informed practices from pre-	Knowledge of trauma-informed practice increased significantly between pre-test and post-test, as did self-reported changes in practice,

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
				longer interview that asked about their success in implementing the their individualised plan.	for using trauma-informed child welfare practices based on the 'Bringing It Back to Work' tool available in The Child Welfare Trauma Training Toolkit. After child welfare workers completed their training, 150 mental health professionals across the state of Arkansas received training in trauma-focused cognitive behavioural therapy.		test to three-month follow-up indicate that use of trauma-informed practices increased significantly, however, the magnitude of the change was small (partial eta sq=.03). 43.3% reported that they were able to fully implement the strategy identified at training, while another 43.3% were partially implemented and 13.4% were unable to implement the strategy.	although effect sizes were small when it came to direct support services for children and moderate for indirect support services.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
Kramer, Sigel, Conners-Burrow (63)	USA	Pre-test/multiple post-tests evaluation.	State-wide family service, case workers/child protection social workers and other staff in Arkansas.	n=102 Child and Family Services leaders.	Area directors and supervisors in the state's child welfare system, attended a two-day training using National Child Traumatic Stress Network content. Training was based on trauma-informed essential elements.	Baseline data was used as a comparator, no control group.	Results for Trauma-Informed Knowledge Scale increased significantly from pre-test to post-test, (p<.001). Results from comparison of pre-test and three-month follow-up results in the Trauma-Informed Practice Scale suggest that use of trauma informed practices increased significantly, (p<.001). Similarly, results from the analysis of the Trauma Assessment scale indicate a significant increase in reported use of trauma assessment	Change in knowledge from the pre-test to post-test was associated with change in trauma-informed actions (from pre-test to three month follow-up) on the Trauma-Informed Practice and Trauma Assessment Scales.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
							from the pre-test to the three-month follow-up, (p<.001).	
Suarez, Jackson, Slavin (64)	USA	Mixed method study involving pre test- post-test and a cost analysis.	The program is positioned in the Department of Health's Child and Adolescent Mental Health Division. Hawai'ian female youth who are at risk for running away, truancy, abuse, suicide, arrest and incarceration.	n=100, 69 youth and 31 caregivers.	Project Kealahou allows girls and their families to receive gender-responsive, trauma-informed, culturally-responsive, community-based services, tailored to the individual including: intensive case management; community supports by paraprofessionals (i.e. peer support for	Baseline data was used as a comparator, no control group.	Follow-up results at 6 month follow-up, though preliminary, show significant improvement from baseline to six-month on measures of youth strengths (p=.024), competence (p=.027), depression (p=.009), impairment (p=.007), behavioural problems (p=.017) and emotional problems (p=.007). Cost analysis findings show for those participants for whom cost data was	Project Kealahou shows significant improvements across multiple clinical and functional domains and financial analysis indicates that these outcomes were obtained with a minimal overall increase in costs when compared to standard care alone. Overall, these results suggest that Project

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					youth and caregivers); structured group activities; and evidence-based treatments (e.g. Trauma-Focused Cognitive Behavioural Therapy and Girls Circle psychoeducational support groups).		also available both before and after the onset of Project Kealahou services (n=41), the total cost for mental health services for the cohort during the first six months of Project Kealahou enrolment ($365,803) was, however, only slightly higher ($21,662 more) than the total cost of mental health services for Project Kealahou girls in standard care for the 6 months prior to Project Kealahou enrolment ($344,141). Thus, the cost per service event was lower for Project Kealahou ($201) compared to	Kealahou may offer a cost effective way to improve access, care, and outcomes for at-risk youth and their families in Hawai'i.

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
							standard care ($205).	
Morrissey, Jackson, Ellis (51)	USA	Comparative study with concurrent controls.	Women with co-occurring mental health and substance use disorders who also have a history of physical or sexual abuse, attending services at nine intervention sites located in California, Colorado, Florida, Massachusetts, New York City, and Washington, D.C., USA.	n=2,026 women Intervention group = 1,018 Comparison group = 1,008.	A comprehensive, integrated, trauma informed, and consumer-involved approach to treatment for physical or sexual abuse and mental health and/or substance use disorders. The intervention included eight core services: The intervention included eight core services, such	Usual care (details not reported)	Outcomes were measured at baseline, six months, and 12 months. Mental Health symptoms were assessed with the Global Severity Index of the Brief Symptom Inventory. Trauma symptoms were assessed with the Post-traumatic Symptom Scale of the Posttraumatic Diagnostic Scale. Problematic drug and alcohol use was assessed using the Addiction Severity Index drug composite score and alcohol composite	The 12-month effect sizes for mental health and trauma symptoms showed small but statistically significant improvements for women in the intervention condition relative to those in the comparison condition (.180, 95% CI .090 to .270; .162, 95% CI .070 to .255). The effect on mental health symptoms

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
					as resource coordination and crisis intervention; staff knowledgeable about trauma; holistic treatment of mental health, trauma, and substance use issues; and the involvement of consumers in service planning and provision.		score. The meta-analysis demonstrated small but statistically significant overall improvement in women's trauma and mental health symptoms in the intervention relative to the usual-care comparison condition. No improvement was shown for substance use outcomes. Analysis of key program elements across different intervention sites indicated that integrating substance abuse, MH, and trauma-related issues into a counselling service	doubled from .09 to .18 between six and 12 months, and the effect on trauma symptoms increased from .11 to .16. The two substance use severity outcomes showed no improvement over the corresponding values at six months (.004, 95% CI –.086 to .094; .017, 95%CI –.073 to .107).

Source	Country	Study type	Population / setting	Number of studies / participants	Intervention	Comparator	Outcomes	Direction / magnitude of effect
							yielded greater improvement than delivering numerous core services separately.	

Grey literature

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
Moses, Huntington and D'Ambrosio (49)	USA	Report	A resource based on the Women, Co-Occurring Disorders and Violence Study, which aimed to improve services and systems for women with co-occurring disorders and trauma histories and their children.	Agency directors, front-line service providers, members of county and state agencies concerned with co-occurring disorders and trauma histories.	Lessons learnt from the experiences of organisers, partners, and participants involved in the Women, Co-Occurring Disorders and Violence Study.	Not applicable.

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
Substance Abuse and Mental Health Services Administration (50)	USA	Program summary	A description of the Women, Co-Occurring Disorders and Violence Study.	Not reported.	Not applicable.	Not applicable.
Against violence and abuse: The Stella Project Young Women's Initiative (70)	United Kingdom	Report	A resource based on the Stella Project Young Women's Initiative, which involved a programme of training on responding to young women in substance use treatment who may have experiences of domestic and sexual violence.	Commissioners involved in service delivery of substance use treatment.	Developed from learnings over the three-year project.	Not applicable.
Horvath, Rogers and Adler J.R. (71)	United Kingdom	Report	The final evaluation of the Stella Project Young Women's Initiative.	Not reported.	There were three strands to the evaluation, which were each assessed twice (pre and post intervention). The post-intervention evaluation data was	The evaluation data were extremely limited due to challenges with monitoring data on disclosures, low

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
					collected between April and July 2013. • Strand 1: Monitoring data on disclosures of the intersecting issues made by young women accessing services and where referrals are made to partner agencies. • Strand 2: Online questionnaire for frontline staff in the agencies concerned, that covered issues relating to staff confidence, knowledge and skills in addressing intersecting issues of young women's substance use and experiences of DV and sexual violence, and current partnership work taking place with other specialist agencies and related organisations. • Strand 3: An analysis of the policies and procedures from participating agencies and strategic documents produced by the local borough strategic partnerships.	numbers of staff completing the surveys, and a lack of policies and procedures appropriate for the analysis. Therefore, it was difficult to draw firm conclusion on the effectiveness of the program. However, the reported findings indicated minimal differences in practitioners' preparation or confidence to engage with young women and support them in various ways. However, there was an improvement in practitioners' identification of avenues for information sharing.

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
Family Safety Victoria. (53)	Australia	Report	To provide operational advice to support the planning and delivery of the Specialist Family Violence Advisor Capacity Building Program.	Specialist family violence advisors, program auspice agencies, statewide coordinator, MH and AOD service agencies, sector peak bodies and leadership representatives across MH, AOD and specialist family violence services, regional integration coordinators and principal strategic advisors, Department of Health and Human Services location connections, local cross sector and family violence service partnerships.	These program guidelines were informed by the key themes raised by the Royal Commission into Family Violence: system collaboration, agency-level collaboration, and professional capacity and capability.	Not applicable.
Desmond (52)	Australia	Report	A description of a new service model that will respond to the post crisis support needs of	Service providers responding to women and children who have	Prepared in consultation with a number of community sector organisations working with women and their children who	Not applicable.

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
			women and children who have experienced family violence and are seeking to re-establish their life after the major period of crisis has passed.	experienced family violence.	have experienced family violence, with oversight from policy and practice experts.	
Jean Cameron Consulting (68)	Australia	Report	A report on the history and outcomes of the Northern Area Mental Health Service Partnership Project.	Not reported.	Based on the experiences of project managers, partners, and staff involved in the Northern Area Mental Health Service Partnership Project.	Not applicable.
Zmudzki, Breckenridge, Newton (56)	Australia	Report	An evaluation of the Integrated Domestic and Family Violence Service Program.	NSW Department of Family and Community Services.	A mixed-method inquiry combining a synthesis of service monitoring data, validated scales and measures, as well as qualitative interviews and focus groups. The quantitative evaluation component is a retrospective data analysis based on program service delivery (portal) data for 24 months from July 2015 to June 2017 covering two complete	Results indicated a significant improvement in client wellbeing from the time of program entry to the time of program exit, with a mean Outcome Rating Scale reduction of 12.5 ($p<0.001$), from levels indicative of psychological distress to a non-clinical “normal”

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
					financial years 2015-16 and 2016-17. The qualitative evaluation component took place between February and July 2017 at each of the program sites and included interviews and focus groups with 36 frontline staff, 21 stakeholders, and 45 clients.	range. Client and staff survey results and qualitative interviews indicated high satisfaction with the program and clients' improvement in feelings of safety and wellbeing.
Laing and Toivonen (66)	Australia	Report	An evaluation of the Domestic Violence and Mental Health Pilot Project.	Joan Harrison Support Services for Women, Domestic Violence & Mental Health Project.	A mixed-methods inquiry collecting and analysing a range of data. Data sources included: • Semi-structured, in-depth interviews with clients and service providers with the interview schedule based on previous Australian research into collaborative responses to DV • Case file adults undertaken between August 2008 to January 2010 for client demographics, referral sources, DV and MH issues and the nature and scope of interventions	Results indicated highly positive experiences from clients and staff involved in the program. In particular, the MH/DV training delivered to police by the DV and MH worker was seen as an outstanding achievement. All women interviewed had left the DV relationship and reported an improvement in their mental health.

Source	Country	Publication type	Description / purpose of publication	Intended audience	Data collection / Evidence source / Methodology	Evaluation results
					• Case studies collated in consultation with the worker in order to provide an understanding of the complex nature of the work • Audits of engagement with service providers using discussions with the DV and MH worker and project reports • Service provider telephone snapshot, which provided a record of all of the phone calls received by the DV and MH worker from other service providers during the month of October 2009.	
Hegarty, Tarzia, Rees (65)	Australia	Report	This report outlines the findings of the WITH Study (Women's input into a trauma-informed systems model of care in health settings), and proposes the Health Systems Implementation Model.	Policy-makers, practitioners, and practice managers involved in health service provision.	Research based on a literature review, qualitative interviews and multimedia digital storytelling with 67 women, and discussion groups and qualitative interviews with 72 health service staff.	Not applicable.

Appendix 4: Levels of evidence of included articles

Source	Level of evidence	Study Design
Lowell, Carter, Godoy (55)	II	A randomised controlled trial
Barto, Bartlett, Von Ende (54)	III-2	A comparative study with concurrent controls
Morrissey, Jackson, Ellis (51)	III-2	A comparative study with concurrent controls
Bartlett, Barto, Griffin (58)	IV	Case series with pre-test/post-test outcomes
Conners-Burrow, Kramer, Sigel (60)	IV	Case series with pre-test/post-test outcomes
Kramer, Sigel, Conners-Burrow (63)	IV	Case series with pre-test/post-test outcomes
Arvidson, Kinniburgh, Howard (57)	IV	Case series with pre-test/post-test outcomes
Suarez, Jackson, Slavin (64)	V	Other peer reviewed literature (descriptive study)
Huebner, Posze, Willauer (69)	V	Other peer reviewed literature (descriptive study)
Bunting, Montgomery, Mooney (59)	V	Other peer reviewed literature (systematic review of peer reviewed literature)
Fraser, Griffin, Barto (61)	V	Other peer reviewed literature (descriptive study)
Henry, Richardson, Black-Pond (62)	V	Other peer reviewed literature (descriptive study)
Moses, Huntington and D'Ambrosio (49)	VI	Grey literature (report)
Substance Abuse and Mental Health Services Administration (50)	VI	Grey literature (program summary)
Against violence and abuse: The Stella Project Young Women's Initiative (70)	VI	Grey literature (report)
Desmond (52)	VI	Grey literature (report)
Jean Cameron Consulting (68)	VI	Grey literature (report)
Zmudzki, Breckenridge, Newton (56)	VI	Grey literature (report)
Laing and Toivonen (66)	VI	Grey literature (report)
Hegarty, Tarzia, Rees (65)	VI	Grey literature (report)
Family Safety Victoria. (53)	VI	Grey literature (program guidelines)
Horvath, Rogers and Adler J.R. (71)	VI	Grey literature (report)

Appendix 5: Alignment of programs, policies and models with system design principles

Alignment with five system design principles

Integrated Domestic and Family Violence Service Program [56]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	A flexible, client-centred response was reported as being provided through this program. All involved services aimed to be client driven and interventions were reported as being determined by individuals' and families' needs.
Recovery from trauma is recognised and valued as a primary outcome of responses	The program focused on providing support to escape and recover from abuse.
Early intervention is prioritised	The program aimed to intervene following the identification of DFV in a family, which was facilitated through established referral pathways with police, health services, child protection agencies, and support services where intervention was required.
Equitable, accessible and consistent service responses are provided	The program aimed to provide adults, young people and children who have experienced DFV with support to escape and recover from the abuse. The program also worked with people who remained in DFV relationships, with a focus on maximising the safety of this group.
Collaboration to support people and their families to access the most appropriate service response	The program aimed to provide flexible, open-ended, comprehensive support to address both immediate and longer-term needs. Integration and co-location between government agencies and non-government organisations was designed to ensure that individuals and families could access appropriate services.

Alignment with four system design principles

Integrated Post Crisis Response Service Model [52]	
Person- and family-centred, holistic and seamless care is	The model adopted a women-centred approach, where practitioners worked with women to build resilience and strength.

provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	The model also focused on working within a child-focused framework, with the aim of strengthening and restoring bonds between women and their children.
Recovery from trauma is recognised and valued as a primary outcome of responses	Recovery from trauma formed the basis of the model, which aimed to provide a range of longer-term, women-centred case management and support options for women and children who had experienced family violence.
Early intervention is prioritised	Whilst explicitly focused on post-crisis support, the model prioritised the establishment of referral pathways to support the early identification of women and children who were 'at-risk' of returning to violence, through the referral from family violence specialist and other services.
Equitable, accessible and consistent service responses are provided	Not demonstrated.
Collaboration to support people and their families to access the most appropriate service response	The strategic partnerships and linkages component of the model was designed to ensure that services did not function in isolation. This approach aimed to provide a continuum of care for women and children through supported referral and facilitating access to specialist services.

The Massachusetts Child Trauma Project [54, 58, 59, 61]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	This project focused on alignment across multiple service delivery systems allowing families to receive family specific and appropriate trauma-informed services. Trauma-informed care prioritised individual needs and tailored care and referral pathways based on individual experiences.
Recovery from trauma is recognised and valued as a primary outcome of responses	This project recognised the importance of a trauma-informed approach. MH service staff and child welfare service staff were trained in trauma-informed care evidence-based treatments and practices.
Early intervention is prioritised	Not demonstrated.

Equitable, accessible and consistent service responses are provided	The project was broadly accessible, as it was a state-wide initiative for families accessing child welfare and community MH services. Trauma-informed training of staff facilitated consistent trauma-informed care and evidence-based treatments for participants. It could not be determined if the services were delivered in an equitable manner.
Collaboration to support people and their families to access the most appropriate service response	This project involved a partnership and collaboration between the state's child welfare agency, Department of Children and Families, two behavioural health agencies, and two large, urban medical centres. Child welfare and MH services worked closely to facilitate collaboration across systems and provide holistic care to children and families.

Child FIRST: a comprehensive home-based intervention translating research into early childhood practice [55]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Child FIRST was based on family-centred, two-generational treatment to promote both parent and child well-being. Child FIRST aimed to provide comprehensive assessment from a clinician and care coordinator to facilitate seamless home-based care, unique to each family's needs. Among other services that were reported to be available when needed were MH, health, early care, early intervention, education, child protection, and social services.
Recovery from trauma is recognised and valued as a primary outcome of responses	Not demonstrated.
Early intervention is prioritised	Children were only eligible if they were aged between six months and three years of age. This shows some support for early intervention for the child.
Equitable, accessible and consistent service responses are provided	Child FIRST was predominately a facilitated home-based treatment, providing accessibility for the families to obtain the services they require whilst aiming to remove barriers of stigma, child care, and transportation. Training for Child FIRST staff aimed to support care delivery with warmth, empathy, and respect. This consistent approach to delivery of care was deemed essential to build trust and engagement with participants. It could

	not be determined if Child FIRST was delivered in an equitable manner.
Collaboration to support people and their families to access the most appropriate service response	Child FIRST was built on a system of care approach, which promoted integration of fragmented service systems, and supported agency collaboration at the local level. Child FIRST facilitated a collaborative approach with a clinical team, which aimed to provide comprehensive, coordinated services and support to the child and family.

START Program [69]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	This program was based on the foundations of family-centred care, as it aimed to concurrently improve adult recovery from substance use disorders and child abuse and neglect. Safety and well-being principles were reported as priorities, as the program was initiated by child protection services when there was substantiation of child abuse and neglect, and parental substance use. Through the process of family team meetings (which included a substance use disorder treatment coordinator, child protective services, and the family), the team approach aimed to consider and identify the needs of the family.
Recovery from trauma is recognised and valued as a primary outcome of responses	Not demonstrated.
Early intervention is prioritised	Almost 70% of families included in the program had a newborn child that was 30 days old or less. Therefore, the program highlighted early intervention for the child, but not necessarily early intervention for the parent with a substance use disorder.
Equitable, accessible and consistent service responses are provided	Quick access to intensive treatment for substance use disorders and a variety of in-home services were provided to families. If appropriate, children were able to remain in the home using a variety of strategies, services, and supports. It could not be determined if the program was delivered in an equitable and consistent manner.
Collaboration to support people and their families to	The report of this program emphasised that the intervention was underpinned by collaborative service delivery and integrated treatment. The services were reported to provide collaborative

access the most appropriate service response	care and shared joint responsibility in supporting child wellbeing and parental recovery from substance use.

The Stella Project Young Women's Initiative [70, 71]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	The described approach prioritised safety and productive partnerships based on individual needs. In targeting young women, the approach also aimed to consider the role of the family.
Recovery from trauma is recognised and valued as a primary outcome of responses	Although not stated as a primary outcome of the initiative, the reports described efforts to address the persisting health needs of young women with multiple disadvantages.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	The research informing the Young Women's Initiative highlighted the need for the program to be more accessible for hard to reach young people. This was addressed by the training delivered to practitioners, which encouraged a respectful, non-stigmatised approach to service delivery.
Collaboration to support people and their families to access the most appropriate service response	A skilled and supportive workforce, combined with age-targeted responses and efforts in responding to disclosure, was designed to assist young women in accessing the appropriate services.

Arkansas Initiative [59, 60, 63]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Components of the trauma-informed training placed an emphasis on ensuring the child's sense of safety, and providing support and guidance to the family and caregivers. These components contributed to a person- and family-centred model of care.

Recovery from trauma is recognised and valued as a primary outcome of responses	The program was based on a state-wide training plan on trauma-informed practices, including the Child Welfare Trauma Training Toolkit, The Child Welfare Trauma Training Toolkit Comprehensive Guide, and the Child Welfare Trauma Training Toolkit Supplemental Handouts developed from the National Child Traumatic Stress Network. The Arkansas Initiative used the trauma-informed training program to increase awareness among child welfare workers of the effects of trauma on children's emotional, behavioural, academic, and social development; to promote evidence-based screening, assessment, and treatment for children exposed to trauma; and to coordinate care with other service agencies to minimise placement disruptions and additional trauma.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	The trauma-informed training program was delivered to the Arkansas Division of Child and Family Services, indicating the model provided some accessibility. The training model was delivered to Division of Child and Family Services' directors and supervisors, as well as frontline staff, including Family Service caseworkers, health specialists, Independent Living Program coordinators, and program assistants, indicating some consistency, although the methods of training did vary. Training to a diverse range of services and practitioners will promote consistent service responses
Collaboration to support people and their families to access the most appropriate service response	Child welfare workers and MH professionals received trauma-focused training to maximise capacity for treatment referrals and assessment, and to minimise additional trauma.

Project Kealahou [59, 64]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Project Kealahou facilitated gender-responsive, trauma-informed, culturally-responsive, community-based services tailored to the individual for girls and their families.

Recovery from trauma is recognised and valued as a primary outcome of responses	Project Kealahou emphasised trauma-informed care in serving its target population: females aged 11-18 years who had experienced psychological trauma. Project Kealahou sought to help girls who had experienced psychological trauma to find 'a new pathway' (kealahou) to a better future by healing past hurts and taking constructive steps toward a more hopeful future.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	The program demonstrated some accessibility, given its various referral pathways, which included education, juvenile justice, and MH systems. Consistency and equitability was not demonstrated.
Collaboration to support people and their families to access the most appropriate service response	Project Kealahou was based on a six-year collaborative effort among the MH, education, juvenile justice, and child welfare service sectors to enhance Hawai'i's systems of care for youth with complex needs.

Alignment with three system design principles

Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study [49-51]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Services were designed to be individualised, flexible and empowering, and to provide opportunities for involvement, that is, services were developed to be client-driven.
Recovery from trauma is recognised and valued as a primary outcome of responses	Recovery was a focus of the services' responses to women with complex needs. The involvement of women who had experienced violence across all services ensured interventions were trauma-informed, which would assist with recovery.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	Not demonstrated.

Collaboration to support people and their families to access the most appropriate service response	Service integration processes aimed to ensure women with co-occurring disorders and trauma histories could access appropriate services.

WITH Study [65]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	A woman-centred approach underpinned this model, which involved empowerment and a holistic response based on individual needs. This approach was deemed necessary for women to feel they were entering a safe and supportive health setting.
Recovery from trauma is recognised and valued as a primary outcome of responses	Women's pathways to recovery were a focus of the research that informed the model. The model provided direction for the service responses to address the long-term impacts of abuse.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	Not demonstrated.
Collaboration to support people and their families to access the most appropriate service response	The systems model of care developed through this study highlights the importance of integration at all levels of the system involved in responding to MH and sexual violence issues. In particular, the focus on integrated coordinated care through clear roles and referral pathways intended to ensure access to appropriate services.

Domestic Violence and Mental Health Pilot Project [66]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	A woman-centred advocacy approach was taken by the DV and MH workers involved in this project. This approach involved tailoring flexible responses to individual client needs.

Recovery from trauma is recognised and valued as a primary outcome of responses	Focus was placed on women's 'journey away from violence' and on moving forward from MH issues attributed to experiences of abuse. The long-term improvement of MH was prioritised by this project.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	Not demonstrated.
Collaboration to support people and their families to access the most appropriate service response	Established connections with various MH and DFV services and organisations was reported to facilitate referral to the service from multiple settings. The DV and MH workers could then support clients in navigating systems and accessing appropriate services.

Specialist Family Violence Advisor Capacity Building Program [53]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Not demonstrated.
Recovery from trauma is recognised and valued as a primary outcome of responses	Not demonstrated.
Early intervention is prioritised	One of the five objectives of this program was to 'facilitate earlier recognition of, and response to, family violence situations for patients/clients of mental health and alcohol and other drug services'
Equitable, accessible and consistent service responses are provided	The program aimed to provide consistent support to victims of family violence.
Collaboration to support people and their families to access the most appropriate service response	The Royal Commission into family violence, from which this program was developed, highlighted the need for system collaboration. This program aimed to address this need by enhancing the quality and consistency of the service response to

	victims, survivors, and perpetrators of family violence at whichever point they access health and human services systems.

Trauma Informed Child Welfare Systems Change Initiative [59, 62]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Not demonstrated.
Recovery from trauma is recognised and valued as a primary outcome of responses	The purpose of this study was to build the Trauma Informed Child Welfare Systems Change Initiative with key agencies, including Department of Human Services, community MH, family court, and schools in nine Michigan communities. Trauma-informed theory was the basis for this model, as well as the processes necessary for system integration of trauma, including language, identification, assessment, treatment, and decision-making across all systems involved in child welfare.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	Nine regional counties in Michigan were involved in this intervention, indicating some accessibility. However, additional complexities would need to be considered for larger populations. Given the different resources allocated in each county, referral pathways varied. This indicates varied equitability and consistencies of service providers.
Collaboration to support people and their families to access the most appropriate service response	This initiative involved collaboration within nine child welfare agencies from Michigan, and cross-sectorial collaboration of Department of Human Services, community MH, family court, and intermediate school districts to support the implementation of the Trauma Informed Child Welfare Systems Change Initiative in the wider community.

Alignment with two system design principles

Northern Area Mental Health Service Partnership Project [68]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	Not demonstrated.
Recovery from trauma is recognised and valued as a primary outcome of responses	Not demonstrated.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	This project aimed to develop clear communication between services, among other collaborative efforts, to ensure a consistent approach to service delivery. It could not be determined if the services were delivered in an equitable and accessible manner.
Collaboration to support people and their families to access the most appropriate service response	Established relationships, clear communication, and liaison roles were reported to result in a collaborative approach that allowed consumers with complex problems to access the appropriate services.

Treatment of Complex Trauma in Young Children Program [57, 59]	
Person- and family-centred, holistic and seamless care is provided, which prioritises the safety, well-being and unique needs and preferences of the person and their family	This program prioritised person- and family-ethnocultural considerations. This was critical in the application of the Attachment, Regulation and Competency framework at the Alaska Child Trauma Center, particularly in working with a predominantly American Indian/Alaskan Native population.
Recovery from trauma is recognised and valued as a primary outcome of responses	The program was based on the Attachment, Regulation and Competency framework, which is a theoretically grounded, evidence-informed, practice used to treat complex trauma in children and adolescents. The final Attachment, Regulation and Competency building block, Trauma Experience Integration, supported children in building a coherent and integrated understanding of self, and in addressing and resolving sequelae

	from exposure to traumatic events that continue to intrude on children or undermine their healthy development.
Early intervention is prioritised	Not demonstrated.
Equitable, accessible and consistent service responses are provided	Not demonstrated.
Collaboration to support people and their families to access the most appropriate service response	Not demonstrated.

Appendix 6: Strength of evidence base for barriers and enablers

Barriers

Barrier	Number of articles with theme	Description of evidence base	Strength of evidence base
Time and cost	11	Articles: 1 Level II, 3 Level IV, 3 Level V, 4 Level VI	Poor
Conflict between agencies	5	Articles: 1 Level V, 4 Level VI	Poor
Logistics	6	Articles: 1 Level IV, 4 Level VI, 1 Level V	Poor
Disclosure and identifying complex needs	4	Articles: 4 Level VI	Poor
Addressing and prioritising complex needs	5	Articles: 1 Level IV, 1 Level V, 3 Level VI	Poor
Burden of providing trauma-informed care	4	Articles: 1 Level IV, 1 Level V, 2 Level VI	Poor

Enablers

Enabler	Number of articles with theme	Description of evidence base	Strength of evidence base
Building and maintaining relationships with partners to support integration	10	Articles: 1 Level III-2, 1 Level IV, 2 Level V, 6 Level VI	Poor
Communication between partners	9	Articles: 1 Level IV,2 Level V, 6 Level VI	Poor
Structure	5	Articles: 1 Level III-2, 4 Level VI	Poor

Supporting and training staff	15	Articles: 1 Level II, 1 Level III-2, 3 Level IV, 2 Level V, 8 Level VI	Poor
Embedding the needs and perspective of the target population	6	Articles: 1 Level II, 5 Level VI	Poor
Leadership and advocacy	4	Articles: 1 Level IV, 3 Level VI	Poor

Priority populations

Barriers

Priority population	Number of articles addressing population	Description of evidence base	Strength of evidence
Aboriginal and Torres Strait Islander people	1	1 Level VI article	Poor
People living in rural and remote areas	2	1 Level IV, 1 Level VI	Poor
Young women and children	2	2 Level VI article	Poor

Enablers

Priority population	Number of articles addressing population	Description of evidence base	Strength of evidence
Aboriginal and Torres Strait Islander people	1	1 Level VI article	Poor
Children	1	1 Level VI article	Poor
People living in rural and remote areas	1	1 Level VI article	Poor
Young women and children	2	2 Level VI article	Poor