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Acknowledgement of Country

ANROWS acknowledges the traditional owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present and future; and we value Aboriginal and Torres Strait Islander history, culture and knowledge.

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Establishing the connection [between alcohol and other drug use and sexual victimisation]: State of knowledge paper

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This work is part of the ANROWS Landscapes series. ANROWS Landscapes (State of knowledge papers) are medium length papers that scope current knowledge on an issue related to violence against women and their children. Papers will draw on empirical research, including research produced under ANROWS's research program, and/or practice knowledge.

This report addresses work covered in ANROWS research project 1.4 "*Establishing the connection*" [between alcohol and other drug use and sexual victimisation]". Please consult the ANROWS website for more information on this project. In addition to this paper, an ANROWS Horizons and ANROWS Compass will be available at a later stage as part of this project.

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Introduction

In the last two decades researchers, service providers and policy makers have endeavoured to understand the relationship between sexual victimisation and a range of adverse outcomes, including problematic substance use. Indeed, as demonstrated in this review, the available research evidence shows a consistent association between sexual victimisation and problematic alcohol and other drug use. Although this association is complex, evidence demonstrates that child and adolescent sexual abuse and adult sexual assault may lead to problematic alcohol and other drug (AOD) use for a variety of reasons.

Further, problematic AOD use may lead to sexual re-victimisation in adulthood as a result of related and contextual individual, interpersonal, community and social factors (Stathopoulos, 2014b). However the therapeutic and service needs of victim/survivors of child sexual abuse and/or adult sexual assault who also have, or have had, substance use problems have not always been well served by existing service systems. Often times, the alcohol and other drugs (AOD) sector and the sexual assault sector are not well coordinated, making it difficult for service users with multiple and concurrent needs to access the range of relevant services. Other times, for those presenting at AOD treatment services, the impact of trauma may not be fully acknowledged either by themselves or by the service. This can have an impact on both referral pathways and treatment outcomes. At the same time the relationship between sexual victimisation and problematic alcohol and other drug use is complex. In this context, the Australian Institute of Family Studies, the Forum for Centres Against Sexual Assault and AOD service provider ReGen have partnered to build the capacity of the sexual assault and alcohol and other drug sectors to respond more effectively to the needs of affected women, their families and communities. This review helps to set out the current evidence base on the relationship and consider implications for service need/provision.

Focus of review

The review explores:

- the prevalence of sexual violence and alcohol and other drug use (AOD) in Australia;
- the association between alcohol and other drug use and severity of, or vulnerability to, sexual violence and re-victimisation;
- correlations between child sexual abuse and subsequent alcohol and other drug use, and adult sexual abuse and subsequent alcohol and other drug use; and
- current practice around identification, assessment, response and referral pathways between AOD and sexual assault services.

Out of scope in this review is the research on alcohol and drug-facilitated sexual assault. Based on the research and characteristics of service users in the sexual assault/AOD sectors, the issues presented in alcohol and drug facilitated sexual assault are of a more situational nature. This has implications not so much for therapeutic and clinical/treatment services but more so for community education campaigns and situational crime prevention.

Methodology

This state of knowledge paper is based on a review of the scientific and grey literature conducted during February to April 2015. We utilised a variety of databases and catalogues, as well as key parameters and search terms that defined the inclusion and exclusion criteria, as outlined below. Overall, over 195 documents were identified, accessed and compiled into an Endnote reference library. The majority of the peer-reviewed literature was non-Australian, primarily from the United States, the United Kingdom and Canada. Reports and policy documents were predominately Australian.

Key parameters

- Australian and international scientific (peer-reviewed) literature.
- Grey literature (reports and policy documents) from both the sexual violence sector and alcohol and other drugs sector.
- Peer-reviewed literature published since 2000.

As the research questions related to the prevalence and association between sexual violence/victimisation and AOD use, our search was inclusive of the following methodological approaches:

- meta-analyses and systematic reviews;
- population-based samples;
- prospective/longitudinal studies; and
- clinical and community samples.

Databases and catalogues

A range of databases was searched for relevant literature, including EBSCO social science databases and Informit databases, SocIndex, PsychInfo and PubMed. Grey literature, books and policy documents were sourced through Google and Google Scholar searches of relevant key words, outlined below. In addition, the extensive catalogue of the Australian Institute of Family Studies was searched for relevant literature, including work published by the Australian Centre for the Study of Sexual Assault (ACSSA) and Child Family Community Australia (CFCA).

Search terms and keywords

An initial keyword search undertaken included variations and combinations of identified keywords to form the basis of the literature that would be accessed for this state of

knowledge paper. The main key words and combinations that were used initially included:

- co-morbidity of substance mis/use, alcohol and drug mis/use + child sexual abuse;
- co-morbidity of substance mis/use, alcohol and drug mis/use + adolescent sexual abuse;
- co-morbidity of substance mis/use, alcohol and drug mis/use + sexual assault (rape);
- dual diagnosis of substance mis/use, alcohol and drug mis/use + above abuse terms; and
- co-occurring of substance mis/use, alcohol and drug mis/use + above abuse terms.

In order to identify how treatment and support services identified AOD and sexual assault trauma we also included searches for:

- screening and/or assessment;
- therapeutic needs and/or service needs; and
- policy documents related to both sectors.

Keywords were altered to reflect how the literature defined various concepts (e.g., “problematic AOD use”) and new searches were subsequently undertaken with the reworked keywords.

Key terms

In general, we use the following terms in this review. They are based on definitions found in health or victimisation survey literature in line with the context of this research, namely based in clinical and therapeutic environments.

There are no standard definitions for child sexual abuse or sexual assault. Sexual assault definitions used in victim/survivor counselling settings focus on a wider range of behaviours, contexts and impacts compared to the definitions used in sexual offences legislation.¹ Given this state of knowledge review is focused on the therapeutic service responses, we have elected to use more experiential definitions.

Child sexual abuse: The World Health Organization (WHO, 2014) defines child sexual abuse as the involvement of a child in sexual activity that:

- the child does not fully comprehend, cannot give informed consent to or is not developmentally prepared for and cannot give consent; and/or
- involves activity between a child and an adult, or another child who by age or development is in a relationship of responsibility, trust or power.

This can include:

- the inducement or coercion of a child to engage in any unlawful sexual activity;
- the exploitative use of a child in prostitution or any unlawful sexual activity; and
- the exploitative use of a child in a pornographic performance and materials” (World Health Organization, 1999, p. 62).

Sexual assault: refers to adults and includes sexual or sexualised activity and interactions in circumstances in which the other person is not fully or freely participating; has not freely agreed to; has been intimidated or coerced into, or is unable to agree to (e.g. cognitive impairment; intoxication) and which makes the person feel afraid, humiliated, pressured, harmed, distressed or exploited. This definition is informed by and draws on behaviours, contexts and consequences described in other definitions of sexual assault (Australian Bureau of Statistics (ABS), 2003, 2004, 2013).

1 For legal definitions of offences against children in Victoria please see: <https://www.legalaid.vic.gov.au/find-legal-answers/sex-and-law/sexual-assault>. For legal definitions of rape in Victoria please see: <https://www3.aifs.gov.au/acssa/pubs/sheets/rs1/rs1appendix.pdf>

Sexual victimisation: refers to unwanted sexual experiences that have occurred in both childhood and adulthood (e.g. child sexual abuse, sexual assault, rape), including victimisation perpetrated by an intimate partner.

Problematic alcohol and other drug use: Alcohol and other drug (AOD) use and associated consequences are variously defined in the literature to include terms such as, misuse, abuse, risky, excessive, hazardous, harmful, disorder, and dependence. In Australia, the term “problematic alcohol and other drug use” is often used. Problematic AOD use typically refers to a pattern of consumption that is associated with adverse physical and/or psychological health or social consequences for the user or others around them.²

It should be noted that terminology used in this paper depends on the measures and definitions used by the researchers cited.

2 E.g. see Foundation for Alcohol Research and Evaluation. (2015). *Policy options paper: Preventing alcohol-related family and domestic violence*. Sydney: Foundation for Alcohol Research and Evaluation; Spooner, C., & Hetherington, K. (2004). *Social determinants of drug use*. Technical report no. 228. Sydney: National Drug and Alcohol Research Centre, University of New South Wales; National Centre for Education and Training on Addiction (NCETA) Consortium. (2004). *Alcohol and other drugs: A handbook for health professionals*. Australian Government Department of Health and Ageing.

Sexual victimisation and substance use: Prevalence and association

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

Prevalence data

Prevalence of sexual abuse and sexual assault

Data sources

The main sources for sexual abuse and assault victimisation data are administrative and victimisation surveys. Administrative surveys collect data on official systems that respond to sexual victimisation, such as the criminal justice system, corrections and treatment and support services (Tarczon & Quadara, 2012). Victimisation surveys seek data directly from the population in question, in this case victim/survivors. Data can come from those who have reported their abuse experience to official systems, and those who have not. The main sources used for this review of sexual victimisation prevalence within Australia are drawn from work conducted by the Australian Bureau of Statistics (ABS), including the following data collections:

- Personal Safety Survey (PSS);
- Recorded Crimes – Victims Australia survey; and
- Crime Victimization Survey Australia.

In addition, we include findings from the Australian component of the 2002/03 International Violence Against Women Survey and reviews from the Australian Institute of Family Studies.

Population-wide prevalence statistics of child, adolescent sexual abuse and adult sexual assault are notoriously difficult to capture. Due to the shame, fear and guilt that victims/survivors often experience as a result of sexual victimisation, researchers acknowledge that underreporting is likely to be quite high (Australian Bureau of Statistics, 2013; Foster, Boyd, & O'Leary, 2012). Many victims of child sexual abuse do not disclose their abuse for many years and often decades, if at all. Non-reporting of child sexual abuse may occur for a number of reasons, including not recognising their experience as a sexual violation, not considering it a serious enough act to report to police, or being conflicted about their relationship to the perpetrator (Price-Robertson, Bromfield, Vassallo, & Scott, 2013). Others may also be concerned at the treatment they may receive at the hands of the criminal justice system (Parkinson, 2010).

Prevalence of sexual abuse and sexual assault in Australia

Child sexual abuse³ can include sexual activity between an adult and a child who has not yet reached the age of consent (approximately 16 years old in Australia⁴), or sexual activity between a child under 18 with an adult who is in a position of authority such as a faith leader, teacher or swimming coach (Price-Robertson et al., 2013). Child sexual abuse can also be defined as non-consensual sexual activity between two minors (Price-Robertson et al., 2013). A range of behaviours constitutes sexual activity ranging from voyeurism to penetration.

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

Recent Australian studies⁵ examining prevalence of non-penetrative sexual abuse of children under the age of 16 found rates at:

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

The rates for penetrative sexual abuse were estimated at:

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

Adolescent sexual abuse is quite complex to measure and can be defined and measured under child sexual abuse, sibling or peer sexual abuse or abuse of a person under 18 by an adult who is an authority figure. The Personal Safety Survey (PSS), a victimisation survey, actually captures data on adolescent sexual abuse because it asks about women's and men's experiences of physical and sexual violence since

the age of 15. For the most recent iteration of this survey, 13,307 women and 3,743 men were surveyed (ABS, 2013).

Data were collected in 2012 and the analysis released the following year. Based on their survey, the ABS calculated population estimates, indicating the following prevalence of sexual victimisation among those aged 18 years and over:

- 17 percent (1,494,000) of all women (1 in 5) experienced sexual assault since the age of 15; and
- 4 percent (336,000) of all men (1 in 22) experienced sexual assault since the age of 15.

The most recent International Violence Against Women Survey (IVAWS) (conducted in 2002/3) (Australian component) working with a sample of 6677 women indicated that 34 percent, or 2283 participants reported having ever experienced sexual violence. A total of 731 women, or 11 percent of the sample had experienced sexual violence⁶ in the last five years, and 242 women or four percent of the sample had experienced sexual violence in the past 12 months. The survey also found that nine percent of women reported sexual violence, only, as opposed to physical and sexual violence (Mouzos & Makkai, 2004).

A summary release from the 2013 Recorded Crimes – Victims, Australia survey reported that there were “just under 20,000 sexual assault victims recorded by police” in Australia during that year, making it the highest number of cases in four years (Australian Bureau of Statistics, 2013b; para 2). An overwhelming majority of victims were female, with two-thirds being 19 years of age or younger (Australian Bureau of Statistics, 2013b).

In the Victorian context, the latest police figures (2013/14) recorded 2177 rape offences; an increase of almost four percent from the previous year (Victoria Police, 2014; Section 4.3 Rape). An increase in rape offences has been recorded in Victoria over the past five years.

The presentation of the above prevalence statistics demonstrates not only that sexual violence is a gendered crime, with women making up the majority of victims/survivors but that a significant number of women (and men) in the Australian population experience child and/or adolescent sexual abuse and/or adult

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

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

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

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

sexual assault. What is not as clear, but demands attention, is that most of the offending, whether committed against men, women or children, is perpetrated by male offenders and this can be an essential factor in service provision. Sexual violence is a gendered crime and although women make up a very small percentage of all sex offenders (approximately 5%), it is predominately male offenders who perpetrate sexual crimes against women and children (Australia's National Research Organisation for Women's Safety, 2014; Stathopoulos, 2014a). For the purposes of this paper a focus will be maintained on the need of victims /survivors of sexual violence – whether male or female – and their potential need for service provision. Based on prevalence statistics there is a justified need for therapeutic and counselling services, however, not all victim/survivors of sexual violence will seek out support services or be adequately referred to services that may address their needs.

Prevalence of alcohol and other drug use

Data sources

To improve understanding of the prevalence of AOD use, we examined the following data sources:

- the Australian Institute of Health and Welfare's (AIHW) National Drug Strategy Household Survey 2013 report (NDSHS) (Australian Institute of Health and Welfare, 2013);
- the Foundation for Alcohol Research and Education's (FARE) 2015 report on alcohol's harm to others. Their report used quantitative and qualitative data and both primary and secondary sources (Laslett et al., 2015);
- an analysis by Eastern Health and Turning Point Alcohol and Drug Centre on alcohol-related harms and use across Victorian Local Government Areas between 2000/01 to 2009/10. Secondary data was analysed including hospital and police data (Matthews, Jayasekara, & Lloyd, 2012);
- The Australian Crime Commission's (ACC) Illicit Drug Data Report (2012 -2013) (Australian Crime Commission, 2014); and
- The Australian Institute of Criminology's (AIC) Drug Use Monitoring in Australia (DUMA) 2009 report (Australian Institute of Criminology, 2015).

Alcohol and other drug use prevalence in Australia

The difference between use and misuse of substances can be tricky to establish. The available literature works with terms such as problematic AOD use, as well as risky and excessive use (Australian Institute of Health and Welfare, 2015; Degenhardt & Hall, 2000). Guggisberg (2010), in her exploration of victimisation, mental health problems and substance use describes harmful and dependent alcohol use as beginning with increasing tolerance and a growing pattern of dependence and moving on a continuum that leads to difficulties ceasing drinking.

The 2013 National Drug Strategy Household Survey (NDSHS) sample consisted of 23,855 people over the age of 14, excluding homeless people and people living in institutions (Australian Institute of Health and Welfare, 2013). In their analysis of population-level data from this latest report, the Australian Institute of Health and Welfare (AIHW) noted that although there has been a decrease in both male and female drinking rates, excessive and risky

alcohol consumption remains a major cause of violence⁷, relationship breakdown and community dysfunction (Australian Institute of Health and Welfare, 2015). AIHW define risky drinkers as those who consume more than two standard drinks per day (and as lifetime risky drinkers if this pattern continues over 12 months or more) (Australian Institute of Health and Welfare, 2015).

Most of the national-level statistical work and measurement of AOD use is based on the associated harms, such as hospital admissions, injuries and assaults. The NDSHS found that the harms related to alcohol consumption affected 26 percent of the Australian population (14 years and over) during the previous 12 months, and over 1.7 million people were reportedly physically abused by someone affected by alcohol in the same period. This was an increase from 1.4 million people reportedly affected in the 2010 survey.

In Victoria, a study on alcohol use and harms across Victorian Local Government Areas between 2000/01 – 2009/10, found the “rates of alcohol-related assaults had increased by over 25 percent” (Matthews et al., 2012, p. 26). From the same study, alcohol-related hospital admissions increased by 44 percent between 2003/04 – 2009/10. In light of increased assaults and hospitalisations, it is perhaps not surprising that within the 10-year period in question (2000/01-2009/10), rates of AOD specialist treatment were also recorded as increasing by 61 percent – with the greatest increase in metropolitan regions (Matthews et al., 2012).

This year, the Foundation for Alcohol Research and Education (FARE) drew on two national survey datasets to analyse alcohol’s harm to others (Laslett et al., 2015). They found that harms such as child abuse, domestic violence, and sexual violence are often precipitated by problematic alcohol use. For example, they reported that alcohol was involved in 12 percent of all cases of sexual harm to children in Victoria between the years 2001 – 2005 (Laslett et al., 2015). It’s important to note that alcohol use is not a causative factor in the perpetration of sexual violence, however it is likely that alcohol and its use “interacts with a range of social and individual factors to influence the perpetration of sexual assault” (Wall & Quadara, 2014b, p. 1). One of the report’s key findings was that past harms from alcohol use are a predictor of ongoing future harms; in other words, excessive alcohol use can be an ongoing problem for individuals, families and communities in Australia (Laslett et al., 2015).

Statistics on illicit and pharmaceutical drug use can also be found in the NDSHS (2013). The NDSHS reveals that approximately 8 million Australians over the age of 14 have ever used illicit drugs and misused pharmaceutical drugs (Australian Institute of Health and Welfare, 2013). Further, it is estimated that 3 million people used illicit drugs during the past 12 months, most commonly cannabis (used by 10 percent of adults), pain killers/analgesics (3.5%), ecstasy (2.5%), meth/amphetamine (2.5%) and cocaine (2%) (Australian Institute of Health and Welfare, 2013). During the same time period (2012-2013), the Australian Crime Commission reported that the largest quantities of imported illicit drugs were (in order from highest to lowest): amphetamine-type stimulants, cannabis, heroin, other opioids, cocaine, and other unknown substances (Australian Crime Commission, 2014).

Since the last NDSHS survey in 2010, there has been a slight but overall decline in the reported use of illicit drugs, but a significant increase in the use and misuse of pharmaceutical drugs. Pharmaceutical drugs include drugs available on the shelf at a pharmacy, as well as over-the-counter and prescription-only medications. In particular, men aged 30-39 and women aged 40-49 made up the substantial increase in the misuse of pharmaceutical drugs.

The same study found an estimated 8.5 percent of the Australian population reported being the victim of an illicit drug-related incident with an increase in illicit drug-fuelled physical assaults rising from two percent in 2010 to three percent in 2013 (Australian Institute of Health and Welfare, 2013). Harms from pharmaceutical drugs have increased this year, as recent research indicates there were more deaths in Victoria from pharmaceutical drugs ($n = 384$) than from road accidents ($n = 248$) in 2014 (Whitelaw, 2015).

For data on substance use relating to specific populations, the Australian Institute of Criminology (AIC) undertakes the Drug Use Monitoring in Australia (DUMA) program. The work is shared in partnership between the AIC, police services around the country and researchers (Australian Institute of Criminology, 2015). The data are mainly concerned with the link between drugs and crime. A 2009 report, *Women, drug use, crime: Findings from the Drug Use Monitoring in Australia program*, indicated that drug use is detected amongst female police detainees in higher numbers than male police detainees (Loxley & Adams, 2009). Female detainees’ drug patterns (detected via positive urine test results) reflected greater use of amphetamines,

⁷ Violence includes physical and sexual violence (Australian Institute of Health and Welfare, 2013)

methyl amphetamines, and benzodiazepines, whereas for men, drug-related police detention was concentrated around cannabis, amphetamines and methyl amphetamines (Loxley & Adams, 2009). A high percentage of both sexes reported AOD use in the previous 12 months prior to detention. From a sample of 17,858 detainees (15,045 males and 2813 women):

- 59 percent of women had used alcohol;
- 55 percent of women had used amphetamine/methyl amphetamine;
- 67.5 percent of men had used alcohol; and
- 46.5 percent of men had used amphetamine/methyl amphetamine. (Loxley & Adams, 2009, p. 12)

When women detained by police were compared with women in the community, they were much more likely to have used both alcohol and other drugs in the previous 12 months and across their lifetime (Loxley & Adams, 2009).

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

- Alcohol harmful use – 3 percent;
- Alcohol dependence – 1.5 percent; and
- Drug use disorders – 1.5 percent. (Australian Bureau of Statistics, 2007a; Diagram 2)

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

Drug-use disorders were defined as being present when a person had continued the use of pharmaceutical drugs without the endorsement of a health professional, had

overused medicines and used medicines for purposes other than for which they are prescribed (Australian Bureau of Statistics, 2007a). In relation to illicit drug use, a disorder is reported to be present in the event of psychological or physical harm, impaired judgement, dysfunctional behaviour and adversely affected relationships.

The various definitions of problematic or harmful alcohol and drug use are relevant to the issue of how service delivery may be operationalised, particularly when there are co-occurring disorders such as sexual victimisation, which is explored in the following section.

Prevalence of co-occurring sexual victimisation and AOD use

In order to better understand where the prevalence of sexual victimisation and substance use intersect, we might imagine a Venn diagram. One circle would represent sexual victimisation, the other problematic substance use. Our interest here is how significant the shared middle section might be: however, it is these very data at a nationally representative level that are difficult to find. Much of the work produced on this overlapping cohort is based on clinical or treatment populations and other specialised populations (e.g. homeless populations, street-based sex workers, women in custodial settings, which tends to find high rates of overlap between sexual victimisation and substance use), or with convenience samples. It is not clear that this proportion of overlap would be present in more representative populations such as national or general community samples.

A recent Australian study using nationally representative data examined a number of co-occurring issues, such as sexual victimisation, substance use and mental illness (Rees et al., 2011). Using the aforementioned ABS National Survey of Mental Health and Wellbeing Survey (2007) data, they assessed the presence of both gender-based violence victimisation (measured as physical abuse, sexual abuse, rape and stalking)⁸ and mental disorders – including substance use disorders. Over a quarter of women (27.5% had experienced at least one type of gender-based violence at some point in their lifetime. Of relevance to this review:

- 14.5 percent had experienced sexual assault (in child- or adulthood);
- Eight percent had experienced rape (in child- or adulthood); and
- Eight percent had experienced physical intimate partner violence.

Among women who reported one type of gender-based violence, over 23 percent also reported experiencing a substance use disorder. Where women had experienced more than three types of gender-based violence, 47 percent had also experienced a substance use disorder over the lifetime (Rees et al., 2011). The analysis in this study did not separate out the association of each type of gender-

based violence with substance use disorders. Therefore, it is unknown what proportion of women who had been sexually victimised had also had a substance use disorder.

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

- 52 percent reported problems with alcohol; 23 percent reported alcohol dependency; and 10.5 percent reported severe alcohol dependency; and
- 37.5 percent reported problems with drug use; 19 percent reported drug dependency; and 13 percent reported severe drug dependency.

Smaller, non-representative samples also demonstrate an association between experiences of adult sexual assault and alcohol and other drug use. In a study of 503 victims/survivors of sexual assault, just under half of the sample (45%) reported having had a drinking problem in the past year, and a quarter (25.5%) reported having used one of three illicit drugs during that time (S. E. Ullman, Townsend, Starzynski, & Long, 2006). Other research studies demonstrating this includes research with: custodial populations (Abram, Teplin, & McClelland, 2003; Butler & Allnut, 2003; Forsythe & Adams, 2009; Loxley & Adams, 2009); clinical populations (Boles, Joshi, Grella, & Wellisch, 2005); those experiencing homelessness (Morrison, 2009); and those in the child welfare system (Singh, Thornton, & Tonmyr, 2011).

⁸ In this study rape was defined as sexual penetration and sexual assault refers to sexual assault and molestation that was not in the definition provided for rape (p. 514).

Strength of the relationship between sexual victimisation and substance use

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

Longitudinal Australian research with over 2000 high school students found that child sexual abuse was significantly and independently associated with substance abuse at all three data collection points (at ages 13, 14 and 15) (Bergen, Martin, Richardson, Allison, & Roeger, 2004). Increased risks of extreme substance use in sexually abused girls (age 13) and boys (ages 13–15) are more than fourfold, compared to those who had not been abused.

Forensic medical records of 2688 sexually abused children in a 43 year follow up study (1964 – 1995) were examined and compared to a matched control group of 2677 individuals to determine the rate and risk of clinical and personality disorders (Cutajar et al., 2010). The researchers found child sexual abuse victims had an increased risk for a number of disorders including substance abuse. Compared to the control group, sexual abuse victims were almost six times more likely (on each item) to have either a known alcohol dependency or known drug dependency. For female victims, this was particularly pronounced; they were almost nine times more likely to have a known alcohol or drug dependency, compared to the female controls.

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

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

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

A US study drawing on a nationally representative sample explored how adult sexual victimisation (without a history of child and adolescent sexual abuse) contributed to adverse psychological outcomes including drug abuse. In the representative sample of adults they found 2.5 percent had experienced an adult sexual abuse victimisation at

some point, and that psychiatric disorders (including adverse childhood experiences and drug abuse) are both risk factors *and* outcomes of adult sexual victimisation (Xu et al., 2013).

Finally, a New Zealand prospective longitudinal study focused on the developmental antecedents to substance use and dependence of 1265 children and found that substance use from 16–25 years of age was significantly associated with abuse experiences in childhood (Fergusson, Boden, & Horwood, 2008).

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

- In a U.S. exploration of 1411 twin pairs the strongest effects for poor mental health of the abused twin was substance use and bulimia nervosa (Kendler et al., 2000).
- An Australian study of 5995 twin pairs (with 10% of the women and 2.5% of the men reporting a child sexual abuse history), found a correlation between child sexual abuse and depression, panic disorders and substance use. (Dinwiddie et al., 2000).
- An Australian study with 1991 twin pairs found that the twin who had self-reported a history of child sexual abuse had a significantly increased risk for all adverse psychological outcomes tested, including alcohol dependence (Nelson et al., 2002).

These findings are supported by meta-analyses of the empirical literature. A synthesis of six review articles published between 1995 and 2002, which, between them, reviewed 200 studies on the relationship between child sexual abuse and substance use, indicated a statistically significant⁹ relationship between child sexual abuse and substance use disorders (Maniglio, 2011). This finding was consistent where female survivors were concerned, although as with the studies above, several reviews did not find that sexual abuse was significantly associated for male survivors. Maniglio concluded that child sexual abuse is a statistically significant, although general and

nonspecific, risk factor for substance-related disorders. In other words, the reviews as a whole were not able to demonstrate a direct link, suggesting instead that child sexual abuse was associated with a range of adverse mental health outcomes, and that trauma-related symptoms may be connected to substance use. Notably, the research and prevalence studies discussed above have been less able to demonstrate adult sexual assault as an independent risk factor to the same degree.

Limitations of survey data

Prevalence data indicate significant rates of sexual victimisation in the Australian population. Similarly, large-scale studies that explore rates of substance use indicate high rates of alcohol and other drug use in this country. The use of alcohol and other drugs, particularly problematic use, can lead to adverse consequences linked to violence and other psychological and physical harms to the user and others. The co-occurrence of sexual victimisation and problematic substance use is also evidenced in large-scale studies. Although not all of the above studies are based on nationally representative populations, they do include large samples and robust methodologies including longitudinal studies, which not only demonstrate the overlap between sexual victimisation and substance use, but also demonstrate that women with sexual victimisation experiences are significantly more likely to report problematic AOD use histories.

Some studies have been able to control for other variables such as socio-economic background or other mental health problems to establish sexual victimisation as an independent contributor in problematic AOD use. These analyses, however, are unable to tell us about the reasons for this association, whether sexual victimisation is causally related to problematic AOD use, and/or what the mechanisms for this connection are (Cashmore & Shackel, 2013; Sartor, Agrawal, McCutcheon, Duncan, & Lynskey, 2008).

⁹ Statistically significant means there is a five percent or less possibility that the finding was result of chance or a random result.

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

This section considers the nature of the relationship between sexual victimisation and problematic AOD use in greater detail, looking specifically at what factors mediate this relationship (i.e. what factors explain how or why there is a relationship between sexual victimisation and problematic AOD). The available research literature is a combination of both quantitative empirical studies and qualitative fieldwork with victim/survivors, service users and professionals working in both the sexual assault and AOD sectors. These are complementary strands of research. Empirical quantitative studies are useful in identifying patterns in the relationship between sexual victimisation and substance use and which of these patterns or pathways appear to be the most prominent. However such research often needs to minimise the effect of broader contextual factors on statistical analyses and so will control for these. As has been noted in violence against women research more generally, the broader context – or social ecology – of victims/survivors' lives and how they experience and make sense of this is vital to having a rich, nuanced understanding of the complex connections between experiences of sexual victimisation and substance use (Breckenridge, Salter, & Shaw, 2012a; Chan, 2005; Rose, 2001; Sallmann, 2010). We draw on both sources in the following discussion.

Factors associated with emotion, affect regulation and coping strategies

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

Post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (CPTSD) are the key diagnostic constructs used to capture the range of bio-psycho-social impacts of sexual victimisation has (Briere & Spinazzola, 2009; Luxenberg, Spinazzola, & Van der Kolk, 2001a; Wall & Quadara, 2014a). Research has attempted to establish PTSD as a significant mediator¹⁰ in the relationship between sexual victimisation and problematic AOD use. For example, research with 386 women involved in a jail diversion program to test the associations between PTSD and substance use found that sexual abuse was strongly associated with PTSD and that PTSD in turn was associated with both heavy drug use and heavy drinking (Cusack, Herring, & Steadman, 2013). Other research with women in custody who had child sexual abuse histories found that trauma symptoms predicted the severity of substance use (Asberg & Renk, 2012). In research with 212 Aboriginal people living in Western Australia, there were strong associations between experiencing a traumatic event (97.5%), meeting diagnostic criteria for PTSD (55%) and meeting the diagnostic criteria for alcohol abuse; 91 percent of those with PTSD also had alcohol abuse problems (Nadew, 2012). Research with injecting drug users tested the relationship between child sexual abuse, PTSD/depression and injecting drug use (Plotzker, Metzger, & Holmes, 2007). More than half (56%) of the sample had experienced child sexual abuse, which was statistically associated with their injecting drug use. However when the analysis was adjusted for PTSD/depression, the relationship between sexual abuse and risk behaviours regarding injecting drug use and sexual activity (e.g. unprotected sex) was no longer significant; PTSD/depression mediated (or explained) the relationship between sexual abuse and risk behaviours.

¹⁰ In statistical analysis a mediator is a variable (in this case PTSD) that describes how things are connected.

Research in the child maltreatment field also posits PTSD as one pathway that is connected to problem substance use (rather than the abuse per se)¹¹ (Hovdestad, Tonmyr, Wekerle, & Thornton, 2011).

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

- low educated;
- unemployed;
- have low income; and/or
- heterosexual.

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

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

Broadly this research is seen as supporting the “self-medication” theories, in which individuals use alcohol and other drugs to “dampen” or turn the dial down on the intense feelings of distress, anger, fear, anxiety associated with traumatic experiences (Darke, 2013; Miranda et

al., 2002). However it is worth exercising caution in the use of this phrase, which runs the risk of seeing the functional role of substance misuse as a deficiency on the part of survivors rather than a coping strategy that enables survival (Breckenridge, Salter, & Shaw, 2012b), or of assuming the functional role is the same for all survivors. Qualitative research undertaken with survivors of sexual victimisation demonstrates that although there are common reasons for using alcohol and other drugs, such as numbing and managing emotions, the context of their daily lives helps to further understand the relationship between sexual victimisation and substance misuse. For example, substances may be used to manage nightmares and sleep patterns (Breckenridge et al., 2012b), to keep memories and flashbacks at bay in chronically unsafe or unstable situations (Padgett, Hawkins, Abrams, & Davis, 2006), or to minimise trigger and startle responses that can make victims feel the world is unpredictable.

¹¹ Although as noted earlier, child sexual abuse is particularly associated with both PTSD and substance misuse.

Vulnerability, substance use and victimisation

Another strand of enquiry has examined the relationship between problem alcohol and substance use and vulnerability to sexual victimisation. The majority of this research has looked at the reciprocal relationships between victimisation, re-victimisation and substance misuse (Gidycz et al., 2007; Littleton & Ullman, 2013; Messman-Moore, Ward, & Zerubavel, 2013; Ullman & Najdowski, 2009; Walsh et al., 2013; Walsh et al., 2014).

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

Filipas (2006) undertook research with a sample of sexual assault survivors to see how alcohol use and PTSD were associated with subsequent sexual victimisation. Surveys were undertaken at two points. The initial survey was completed with 1084 victims/survivors and 625 of these participants completed a survey one year later. Multiple sexual victimisation experiences (i.e. in childhood and adulthood) predicted PTSD symptoms, and this usually came prior to problematic drinking. Filipas (2006) concludes:

This study found two pathways: 1) the numbing symptoms of PTSD directly predicted re-victimisation and 2) other symptoms associated with PTSD such as intrusive memories (e.g. recurrent memories of the abuse, flashbacks, and triggering) and hyper-arousal (e.g., hyper-vigilance, irritability, being easily startled) predicted alcohol abuse, which in turn predicted re-victimisation. The conclusion of this research was that numbing symptoms and alcohol abuse may be independent indicators of a dissociative response that impairs sexual assault survivors’ ability to detect risk in their environment, increasing their vulnerability for further victimisation. (p. 620)

Other research has examined the connections between re-victimisation, problem substance use and sexual behaviour that increases the risk of further victimisation for populations such as sex workers, young people in institutional care and homeless women that are, through circumstances, exposed to higher risks of victimisation anyway (Parkhill, Norris, & Davis, 2014). However, as noted by Quadara (2008), the associations between these factors are complex. In the case of sex workers, research showing that sex workers who are dependent on drugs and who trade sexual services for drugs rather than money experience much higher levels of violence might lead to the interpretation that a drug’s properties lead to sex workers’ diminished ability to assess risk. However, another interpretation offered by sex work organisations relates to the economic pressures associated with securing illicit substances. When the illicit drug market changes (e.g. price, product availability/scarcity, or policing practices), individuals alter their purchasing practices. This could involve agreeing to practices to which the worker would not usually agree, such as sex without a condom, taking on risky, “dodgy” looking clients, or agreeing to locations that are isolated. Further, much research on the re-victimisation and problem AOD use focuses on individual and interpersonal level factors associated with the victim, while ignoring the tactics that perpetrators use to target vulnerable people and the broader socio-cultural context that may contribute to sexual re-victimisation (Stathopoulos, 2014). Perpetrators of sexual abuse and sexual assault can deliberately target individuals with substance use problems both because of their increased vulnerability and because they may assume the victim will not report to police or will not be believed (Clark & Quadara, 2010).

Implications for service responses

Users of health services may require referral to specialised services for any number of health related issues. Government health departments refer to this as the “no wrong door” approach which indicates a commitment by health and other service providers toward an openness to identifying, assessing and referring service users to other services within the health system (Department of Human Services, 2007). The non-government sector is equally attuned to the importance of referral policies and practices that support service users to be connected with community services in which they may receive specialised care for ongoing health concerns (Queensland Council of Social Services, 2015). Referral guidelines by community organisations refer to the importance of attending to privacy issues when referring, how to instigate emergency procedures and the value in evaluating the benefits to clients of referrals (Queensland Council of Social Services, 2015).

The literature pertaining to trauma-informed care supports the notion that users of any type of service may have a history of trauma and would potentially benefit from services that are cognisant of the potential for re-traumatisation (Kezelman & Stavropoulos, 2012). Trauma sufferers, as outlined in earlier sections of this report, can find themselves shaped by their trauma experiences and subsequently face challenges in respect to self-esteem, feelings of safety, and issues in relating to others (Mills, 2015). Therefore, referral processes and practices can take trauma informed policies into consideration¹² that can be applied to training, environment and processes within the workplace. Indeed, guidelines by Kezelman and Stavropoulos outline the following considerations if services are to acknowledge complex trauma in service delivery:

- committed to safety, trustworthiness, choice, collaboration and empowerment;
- have considered systemic components in acknowledgement of the role violence plays in the lives of service users;
- apply the understanding to service system design to avoid re-traumatisation; and
- have close collaborative relationships with other relevant services (Kezelman and Stavropoulos as quoted in Wall, 2012; para 11).

12 Another State of knowledge paper specifically discusses trauma-informed care in mental health settings. Please see Quadara, A. (2015). *Implementing trauma-informed systems of care in health settings: State of knowledge paper*. ANROWS Landscapes, July 2015.

Referrals from generalist health services to AOD and sexual assault services

The Centres for Disease Control and Prevention (CDC) in the US outline the effective but often underused referral of hospital patients to alcohol and other drug services when practitioners consider it necessary. Their guidelines for health professionals suggest that they ask patients about their drinking; speak with them in plain language regarding what might be harmful about their drinking; provide options on how to reduce their intake or to seek specialised help; and to close the discussion on positive terms, even if the service user chooses not to seek a referral immediately. These processes can result in increased help seeking by patients with substance use issues (The Centres for Disease Control and Prevention, 2014). The CDC also suggests building these protocols into normal medical practice so that the identification of substance use is part of a plan of standard service (The Centres for Disease Control and Prevention, 2014).

Primary health professionals are also uniquely positioned to ask service users about a possible sexual victimisation history and to support victims/survivors to access specialised services that can address trauma from sexual assault directly. Wall (2012) has outlined a clear rationale and process for asking women about intimate partner violence, particularly sexual violence which she suggests can often be the most difficult for women to disclose and which exposes women to specific dangers. An issue addressed in the resource for health professionals relates to the possible embarrassment and discomfort that health professionals will need to overcome if they are to support victims/survivors of sexual violence to access specialised support. Wall suggests that the following supports may need to be present if health services are to create supportive environments:

- privacy;
- naming the sexual violence;
- believing;
- compassionate and respectful responses;
- being trauma-informed;
- non-judgemental response;
- knowledge; and
- referral. (Wall, 2012, pp. 6-7)

Just as it is important for generalist services to refer service users to more specialised services, it is also important for specialised services to recognise the need to refer to other specialist services, such as referrals between the sexual

assault sector and the AOD sector. This acknowledgment comes from the evidence base related to the complex needs of health service users (Women's Council REF) as well as the demonstrated relationship between sexual violence and AOD use. The following sections will outline some more specific guidelines for assessments and referrals that currently exist in both the sexual assault and AOD sectors.

Current practice in the sexual assault sector for responding to AOD use

The National Association of Services Against Sexual Violence (NASASV) recently released the second edition of their Standards of Practice Manual (2015) featuring an outline of protocols and practices for referrals to other services. The referral guidelines do not specify referrals to any particular service and are therefore broad and easily applied. Minimum practice expectations include service providers:

- maintain information on relevant services that enable personalised referrals where appropriate;
- build relationships with other services and key stakeholders;
- provide a broad range of information to offer service users with which to empower them to make an informed choice; and
- obtain verbal or written consent from the service user for a referral and for the sharing of service user's information. (National Association of Services Against Sexual Violence, 2015)

The manual also suggests follow-up contact with service users where appropriate, particularly if the referral is a complete transfer from one service to the other.

Beyond the NASASV guidelines, which support the sexual assault services to structure their referrals, there are few resources related to referrals to AOD services. This is not to suggest that these do not exist, rather that they may be internal documents that are not publicly available or that referral processes are informal. As the focus of this state of knowledge paper is available and accessible information, we determined that sourcing internal guidance documentation was out of scope. However, an aim of this project is to document what these processes are within the Victorian context.

In acknowledging the sometimes complex needs of women

who are clients of family and domestic violence services, the Women's Council for Domestic and Family Violence Services in Western Australia have identified some processes that are relevant for sexual assault services. These processes, listed below, are related to the "cycle of change" (Newbiggin & Legget, 2009, p. 11) a client may be moving through in their substance use.

1. **Pre-contemplation:** a service user may yet be unaware of the consequences of continued substance use and may be using substances as a form of self-medication. Raising the service users awareness to possible issues in a non-confrontational way may shift their perception but any judgement may be met with resistance.
2. **Contemplation:** there may be a heightened awareness of the negative consequences of their use but a reluctance to commit to definite consideration to cease use. Supporting the services user to see the balance in favour of ceasing use is appropriate at this time. This requires trust and a stronger relationship with the service user. An ability to describe the workings of the drug and alcohol sector may familiarise the service user with the concept.
3. **Decision:** the service user has taken a decision to receive support in ceasing their substance use – although this is subject to change. This is the time to be positive and provide information and support in accessing alcohol and other drug services.
4. **Maintenance:** changes are maintained and improvements are noted. Provide resources to support maintenance including strategies that prevent relapse.
5. **Relapse:** the service user relapses into substance use and other patterns of behaviour associated with their substance use. Engage strategies to get back to earlier stages (contemplation and decision) that were identified during maintenance. Identify strengths and use the relapse as a stepping stone for learning (Newbiggin & Legget, 2009).

There may be several issues impacting a service user's decision to cease her substance use at any given time, related to her safety, housing, employment and intimate relationships. Therefore, a sense of support and assessment of her readiness to change will support her more effectively than a prescriptive and urgent approach (Newbiggin & Legget, 2009).

Current practice in the AOD sector for responding to sexual assault

A number of AOD resources and guidelines have been developed by individuals and groups associated with the alcohol and other drug sector (e.g. state government departments, research, treatment and education bodies and clinicians), to assist clinicians and practitioners with screening, assessment and management of AOD clients in AOD treatment settings. Resources include general handbooks, which outline advice on how to work with clients who have problematic AOD use (Connolly & Roeg, 2004; Marsh, O'Toole, Dale, Willis, & Helfgott, 2013); a series of clinical treatment guidelines for working with a diverse range of AOD related issues such as poly drug users, how to manage difficult and complex behaviours, how to prescribe for those experiencing drug withdrawals, working with families and preventing relapse (Turning Point Alcohol and Drug Centre, 2015); and resources to support the management of concurrent substance use issues and mental health disorders, which includes trauma-related mental health issues (Mills et al., 2012; New, 2012).

Within these resources, only limited information is provided regarding the definitions, nature and estimated prevalence of sexual victimisation in Australia, or about specific assessment and referral pathways for AOD clients with sexual victimisation histories. Instead, child and adolescent sexual abuse and adult sexual assault typically fall under the umbrella of "trauma" (along with events such as combat exposure, being in a place of war, experiencing a natural disaster, or being in a life-threatening accident) (Mills et al., 2012).

It is expected that all AOD workers should be able to provide some support (early phase) to clients experiencing trauma (such as creating safety, distress reduction, affect regulation, resource building and cognitive interventions), but that in order not to further traumatise the client, only health professionals with trauma training (and who have clinical supervision and support) work with AOD clients to revisit and re-examine the traumatic events (Mills et al., 2012; New, 2012). With appropriate clinical training, some AOD guides suggest assessing a history of trauma exposure with standardised screening tools such as the Traumatic Life Events Questionnaire (TLEQ), the Trauma History Questionnaire (THQ), or the PTSD Checklist (Mills et al., 2012; New, 2012). In addition, these guides suggest a range of interventions (where appropriate) to be used in conjunction with AOD

harm-reduction and relapse-prevention strategies that may be helpful when working with traumatised clients, including mindfulness, grounding, cognitive interventions, and anger management (Marsh et al., 2013; New, 2012).

In 2013 the Victorian Department of Health launched a new suite of alcohol and other drug screening and assessment resources for implementation across the Victorian AOD sector. The new tools were developed in response to sector consultation which found: existing instruments could be too long and potentially detrimental to developing therapeutic relationships; there was a perceived lack of mental health assessment in existing instruments; and there were a number of different service types conducting screening and assessment differently (Department of Health, 2013a).

The new Victorian adult AOD *Screening and Assessment Tool* involves a 3-step approach: 1) a client self-complete *Initial Screen* (Department of Health, 2013c); 2) a clinician-completed *Comprehensive Assessment* (Department of Health, 2013d); and 3) a *Review* (Department of Health, 2013e) - Steps 1 and 2 are mandated by the Department, while Step 3 is discretionary (Department of Health, 2013a). In addition, 11 optional assessment modules have been developed for use as required, including: 1) *Physical Examination*; 2) *Referral for Neuropsychology assessment*; 3) *Mental Health (Modified Mini Screen)*; 4) *PsyCheck*; 5) *Quality of Life*; 6) *Gambling*; 7) *Goal Setting*; 8) *Assessment of Recovery Capital*; 9) *Strengths*; 10) *Family Violence*; and 11) *The Impact of AOD on Family Members* (Department of Health, 2013b). Two questions specifically related to experience of sexual assault have been included in the new suite of tools:

1. Comprehensive Assessment (Risk Assessment):

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

- In the past four weeks have you been violent (incl. domestic violence) towards someone?
- In the past four weeks has anyone been violent (incl. domestic violence) towards you?
- Are dependent children safe? (Department of Health, 2013d, p. 8)

2. Optional Module 3, Mental Health:

Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual

or threatened death or serious injury to you or someone else? Examples include: serious accidents; sexual or physical assault; terrorist attack; being held hostage; kidnapping; fire; discovering a body; sudden death of someone close to you; war; natural disaster (Department of Health, 2013b, p.5).

There are a number of reasons why comprehensive screening of sexual violence histories among AOD treatment seekers may not occur, including: reluctance to talk about sensitive issues by clinicians; a lack of training and resources to support screening and assessment; additional time in already time pressured environments; lack of knowledge about what to do next; and poor awareness of referral pathways (Foundation for Alcohol Research and Evaluation, 2015).

In considering family and domestic violence more broadly, one of the key policy recommendations arising out of the Foundation for Alcohol Research and Education's *Policy Options Paper: Preventing Alcohol-related family and Domestic Violence* was to:

Improve collaboration between services providing alcohol and other drug services, mental health services, family and domestic violence services and child protection services by supporting a funded model of care which incorporates:

- clear referral pathways between services;
- cross-workforce training on alcohol and family and domestic violence;
- holistic interventions and treatment for people affected by alcohol or family and domestic violence; and
- improved collaboration between service response sectors e.g. integration between specialist alcohol and family and domestic violence courts (Foundation for Alcohol Research and Evaluation, 2015, p. 15).

Given the intersections between AOD use and sexual victimisation, further work is needed to assist AOD clinicians to respond to disclosures of sexual abuse and assault among their client group.

Strengths and limitations of the current evidence

There are a number of methodological issues and limitations in the literature and in our review that are important to note.

First, the differing statistics between the PSS and the International Violence Against Women Survey (above) may mistakenly be read as a decrease in sexual victimisation between 2002 and 2012. The difference is, however, more likely related to methodological differences in survey and interview instruments, interviewer techniques, definitions of sexual violence, sample methods and other variables (Mouzos & Makkai, 2004; Price-Robertson et al., 2013).

Secondly, all large-scale surveys contain limitations and caveats appear in most final reports in respect to claims of data collection and data quality.¹³ For instance, the issue of underreporting and non-disclosure of sexual victimisation remains a live issue for accurate prevalence statistics (Australian Law Reform Commission, 2011). Issues related to stigma and social desirability bias may effect self-reported data, particularly in respect to sexual violence victimisation and alcohol and other drug use (Ullman, 2003). Further, victimisation surveys such as the PSS and International Violence Against Women Survey are unlikely to capture data on particularly vulnerable or hard-to-reach populations such as women with a disability and/or Indigenous women. The International Violence Against Women survey reaches out to participants on landline telephones, automatically excluding those with no landline whether through choice or circumstance (Mouzos & Makkai, 2004) and the ABS does not have the capacity to collect nationally representative data on Indigenous rates of sexual victimisation (they would have to increase their overall sample by tens of thousands) for inclusion in the PSS. Lastly, meta-analyses review studies that offer varying definitions of abuse and assault and use a variety of data collection instruments, which make collation of results challenging.

Thirdly, the different disciplinary traditions mean that research on this issue can be found in the domains of social work, gender studies, mental health, addiction studies, epidemiology, child maltreatment and violence against women. These disciplines have different ways of defining and measuring both sexual victimisation and problematic substance use. They also undertake research with different types of populations (e.g. street based sex worker, homeless women, women in treatment settings). This means that it is possible relevant studies have been missed in our literature search. In terms of the intersections and differences between sexual victimisation and family and domestic violence it means that research studies on women experiencing family and domestic may not have isolated sexual victimisation in their studies and that as such our searches may not have identified potentially relevant studies.

¹³ See for example, Australian Bureau of Statistics Personal Safety Survey 2012 <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4906.0Chapter1002012>

Conclusion

Overall, the research consistently finds that sexual victimisation is associated with problem alcohol and other drug use. While earlier work established the association, more recent research has shown that child sexual abuse, in particular, is a general risk factor for problem substance use.

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

Despite the methodological limitations in the literature, there is growing consensus that the sexual assault services sector and the AOD sector share a significant number of clients and that integrated or coordinated service provision is key.

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