STACY Safe & Together Addressing ComplexitY

THE UNIVERSITY OF MELBOURNE

POSTERA CRESCAM LAUDE

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

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Image source: ABC Behind the News, Coonalpyn Silo Art. Broadcast Tuesday April 4, 2017. Accessed at: https://www.abc.net.au/btn/classroom/coonalpyn-silo-art/10523170

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Abbreviations and acronyms

AOD   alcohol and other drugs

CIS   critical interpretive synthesis

CoP   Community of Practice

CP   child protection

DFV   domestic and family violence

DV   domestic violence

FS   family services

FV   family violence

JS   justice services

MH   mental health

OS   other health services

NGO   non-government organisation

NSW   New South Wales

PAG   Project Advisory Group

QLD   Queensland

S&T   Safe & Together

UoM   University of Melbourne

VIC   Victoria

Glossary

All-of-family approach	The all-of-family approach is underpinned by feminist theories that attend to the intersection of multiple drivers of DFV including sexism, racism, colonisation, ableism, homophobia and other forms of oppression. The approach involves working with each family member in the context of their family, extended family or community. The Safe & Together Model is an exemplar of this approach, and provides a high-level, ethical and transferable framework for conducting holistic and collaborative work across services and sectors. At a practitioner and organisational level, it involves: keeping children safe and together with the non-offending parent; building an alliance with the non-offending parent by recognising and supporting her care and nurturance of children; and intervening with the perpetrating parent to reduce risk of harm to adult and child survivors and holding him to account for his use of violence and coercive control.
Child-focus	This phrase is used to refer to practices that are informed by an understanding of the risks to children from fathers who use violence and coercive control toward their family and from either or both parents' substance misuse and/or MH issues.
Coercive control	This phrase refers to non-physical forms of DFV that cause significant fear to adult and child survivors and thus harm the functioning of a family and a community. Perpetrator tactics include instilling fear by threatening violence (to family members, partners, others, animals) or suicide, intimidating, humiliating, isolating, and micromanaging (such as constant surveillance of) the daily lives of survivor-victims. It is a relentless form of abusive behaviour that is easily manipulated so as to exacerbate, interfere with, or cause mental health and/or substance misuse in survivor-victims. It can be a particularly egregious and effective way of isolating adult survivors from family, friends, community and professionals, undermining the mother-child relationship, and contributing to system abuse of survivors.
High expectations of men as fathers	Irrespective of men's mental health and/or substance misuse struggles, their parenting capacity should be assessed to the same standard of expectations as mothers. This means practitioners who work with fathers need to explore and document his care-giving role within the family, including the impact of his parenting choice in using DFV, on family functioning and, in particular, on children. It is highlighted as a way of counteracting the gender bias that informs interventions and systems, in which mothers and fathers are often treated differently. Setting a higher standard for fathers as parents than is usual merely means assessing them on the same criteria that mothers are assessed. The point here is to develop a gender responsive service system.
Pattern-based	This phrase is used in distinction to 'incident-based' or 'single incident' approach when referring to a father's pattern of behaviours that he chooses to use to harm and control adult and child members of his family. In an 'incident-based' approach, the perpetrator's pattern of behaviour becomes decontextualised and reduced to a 'single event'. There is always a danger that practitioners miss the full extent of his violence and coercive control so that it becomes invisible or diminished with dangerous consequences for adult and child survivors. Adult survivors are frequently misidentified by police attending a DFV 'incident' as the primary aggressor or offender.
Perpetrator	This descriptor is used frequently through the report to refer to men or fathers who use violence and coercive control toward their family and community. We recognise that it is preferable to separate 'the man' from his 'behaviours', however, at times the use of the phrase 'fathers who use violence and coercive control' is cumbersome. We use 'perpetrator' as a shorthand term. We also are focusing on the dominant gendered pattern of men's violence against women and children.

Table of Contents

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 5 of 106

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 6 of 106

List of Figures

List of Tables

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 7 of 106

Executive Summary

The *Safe and Together Addressing ComplexitY (STACY) Project* was undertaken in the states of New South Wales (NSW), Queensland (QLD) and Victoria (VIC) from mid-2018 to the end of 2019.

The Project was an action research study that simultaneously investigated and developed practitioner and organisational capacity to drive improvements in collaborative and holistic service provision for children and families living with domestic and family violence (DFV) where there are parental issues of mental health (MH) and/or alcohol and other drug use (AOD) co-occurring.

An intersectional lens informed the work undertaken in the Communities of Practice (CoPs) and in the development of a key output of the project: the *STACY Project's Practice Guide: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues*. The practice guide is pitched specifically toward the intersections of DFV, MH and AOD and the dominant gendered pattern of fathers' use of violence and coercive control against adult and child survivors. We ask practitioners to consider the specificity of the diverse client 'settings' in which they are working and remember that their clients may have significant, wider family, community and cultural considerations that play a role in the intersecting complexities of DFV, substance misuse and/or mental health issues they live with.

Background

The co-occurrence of DFV with problems of MH and AOD is well established (Gilchrist, Hegarty, Condras, Herman & Gunn, 2010; Trevillion, Oram, Feder & Howard, 2012). Together and separately, they create problems for children who live (or have considerable contact) with one or both parents. This project focused on the nexus of DFV with problems of MH and AOD when children are involved and stems from the practice issues for child protection (CP) and family services (FS) workers intervening with children and their families where there is DFV (Humphreys, Healey & Mandel, 2018). While DFV is often the issue bringing children to the notice of CP or FS, a case reading of files indicates that the source of the DFV harm (usually male perpetrated) sinks to the background while the mother's MH and/or AOD issues becomes the focus of attention (Humphreys et al., 2018).

Research suggests that there is recognition of the need to expand inquiry to all family members in order to identify appropriate intervention and rectify the entrenchment of practice that leads to the invisibility of domestically violent fathers, mother-blaming discourses for 'failure to protect' children, and endless spiralling between services for adult and child survivors as a result (Radcliffe & Gilchrist, 2016; Humphreys, Regan, River & Thiara, 2005; Frederico, Jackson & Dwyer, 2014; Loeffen, Daemen, Wester, Laurant, Wong & Lagro-Janssen, 2017). It is here questions need to be raised about the safety of the service system response and whether it is replicating abusive tactics or providing an appropriate response to safety and wellbeing for women and children survivors (Heward-Belle, Humphreys, Laing & Toivonen, 2018).

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 8 of 106

Research aims

The expertise of practitioners was harnessed through Communities of Practice (CoP), which were capacity built through the training, resources and coaching provided by the US-based, Safe & Together Institute's resources and consultants. Researchers worked alongside participants from statutory and non-statutory organisations and a Safe & Together consultant in the CoPs in three states (NSW, QLD and VIC) researching and driving changes in professional practice, inter-agency working, and organisational change to sustain continued development. Project Advisory Groups (PAG) in each state made up of senior managers were integral to developing and sustaining improvements in collaboration and practice in this complex area.

In addition to the CoP and PAG developmental work, two further, albeit related, components were included in the STACY project. A small case study component involved 21 interviews with clients of some of the organisations participating in the project and who were living with DFV and where either or both parents had MH and/or AOD issues. This included 12 clients who are adult survivors, four young survivors aged above 8 years, and five domestically violent fathers. Practitioners from these organisations were also interviewed. The organisations involved in this component of the research were at varying stages of implementing an all-of-family, collaborative approach to protecting children. Three of them were explicitly implementing the Safe & Together Model whilst a fourth, the Jannawi Family Centre in NSW, had developed an all-of-family approach to working with children and families over a 20-year period. The second, related additional component involved a process evaluation of Jannawi, a summary of which is incorporated into this report, along with drawing on interview material. Jannawi participated in the STACY Project CoPs and PAG and had been involved in the two multi-state research projects that preceded the *STACY Project* (*Invisible Practices* and the *PATRICIA (Pathways and Research In collaborative Inter-Agency Working*) Projects. It was evaluated as an exemplar of best practice in providing a holistic, all-of-family response to DFV.

Analysis of the collective work of the project led to the development of a practice guide for practitioners and their organisations in working with children and families where there are intersecting complexities of DFV, MH and AOD.

An all-of-family approach to working and the Safe & Together™ Model

The Safe & Together Model was developed by David Mandel who has over 30 years of experience in the DFV and child protection fields. It is an approach to protecting children that is centrally informed by an understanding of: the dynamics of DFV where there are intersecting complexities, such as MH and substance misuse; the risks posed by perpetrating parents to child and adult survivors; and the need to manage perpetrator risks.

The Model includes a suite of resources that supports practitioners and their organisations to offer DFV-informed interventions and to develop multi-disciplinary, multi-agency collaboration across the service system with the aim of keeping children safe and together with the non-offending parent; to 'partner' with the non-offending parent as the default position, supporting their efforts to care for and nurture the safety and wellbeing of children; and to intervene with the perpetrator as parent to reduce the risk of harm to the child and hold the perpetrator to account for the use of violence and coercive control. These ways of working are the bedrock of the Model's Principles and Critical Components; they are the reason it can be described as an ethical framework for an all-of-family approach to working where there is DFV and intersecting complexities.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 9 of 106

The Practice Guide

The Practice Guide is structured around the six themes that were identified by project participants as specific areas of work to be undertaken or considered. We cannot provide a practice guide that attends to the full diversity of family situations. Practitioners need to think critically about adapting the guidance to the specific socio-cultural contexts and needs of each client, family and community they work with. We hope senior management in organisations specifically run by and for Indigenous, ethno-specific, disability, sexual and gender diverse and LGBTIQ advocacy bodies may consider the usefulness of adapting these guidelines for their own communities.

Practice tips appear as critical questions followed by a case study to illustrate aspects of how to approach the work. The themes, including more case studies (anonymised, either abridged or written as composite narratives), are discussed in detail in Section 4 on 'findings' in the full report but this discussion is condensed into techniques and practice tips in the Guide itself:

1. *Partnering with women at the intersections*. Techniques for 'partnering' include: affirming her experiences; asking respectful, culturally-informed, questions; assessing for safety and wellbeing; validating her feelings and concerns; and collaborating with survivors.

2. *Working with men at the intersections*. This involves: increasing the visibility of fathers who use violence and coercive control (specifically, their patterns of behaviour); developing practices that hold men accountable for their use of violence and coercive control, irrespective of factors that increase the complexity of their lives; and engaging men who use violence and coercive control within a context of complexity.

3. *Focusing on children and young people at the intersections*. Techniques to increase the focus on children relate to: keeping children and young people visible and heard; connecting the dots between the perpetrator's pattern of DFV, including substance misuse and/or MH issues and the impacts on children and young people; and validating and supporting children and young people.

4. *Working safely*. This is discussed in relation to the numerous threats to the safety and wellbeing of practitioners working at the intersections of CP, DFV, MH and AOD. Practical strategies provided focus on attending to physical safety; and promoting emotional and psychological wellbeing through high quality professional supervision and organisational mandates to establish safe working environments.

5. *Working collaboratively.* Techniques within a context of complexity includes: identifying and breaking down silos in service delivery; and considerations of organisational leadership and the formalisation of protocols to guide, for example, information sharing and timely communication within and between agencies.

6. *Influencing organisational practice change and capacity building*. Techniques for influencing organisational practice change and building capacity to work and collaborate at the intersections of DFV, substance misuse and/or MH issues include exploring key areas, key strategies and key barriers and facilitators for practice change and capacity building.

Research sites and participants

Research sites were established in three states: NSW, QLD and VIC. The participation of organisations from each site was differently configured. In keeping with our ethics agreement to protect anonymity, we have not identified the specific agencies that were involved in this project, other than Jannawi Family Centre, which was the subject of the process evaluation. In NSW, AOD, MH, statutory child protection, family support services (including Jannawi), and specialist DFV workers were involved. In QLD, the research site involved a strong multi-agency partnership driven by statutory child protection with practitioners from specialist DFV services, family services, justice services, with AOD & MH services also involved. In VIC, statutory child protection, AOD, MH, family services and specialist DFV workers were involved. All participating organisations supported the research by ensuring that senior managers or CEOs were represented on each site's Project Advisory Group (PAG). In addition, peak body representatives were involved in the VIC PAG.

As illustrated in Figure 1, participants included: the Safe & Together consultants, researchers and Chief Investigators from each state (collectively forming the team that drove the project); a Project Advisory Group comprised of senior representatives from government and NGO representatives of participating organisations; senior practitioners from participating organisations in each CoP; and a group of workers ('secondary participants') that the practitioners chose to influence with the emerging practices from their CoP learning.

Figure 1: STACY Project participants

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 11 of 106
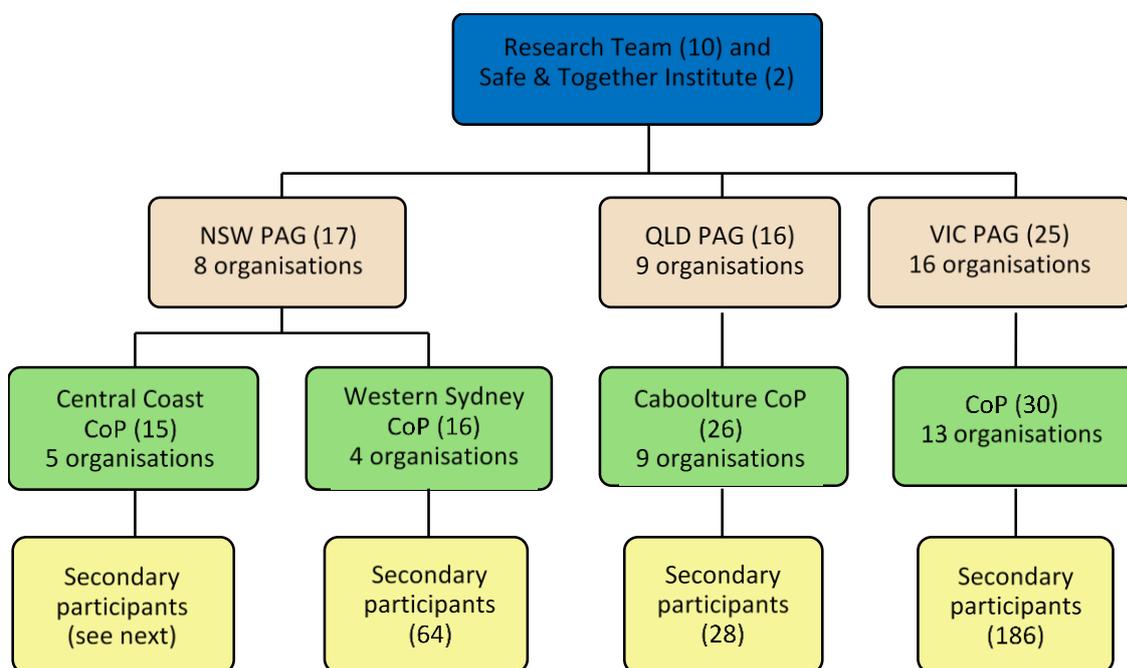
Research questions

The research questions and the methods used to explore them are illustrated in the following table.

Number	Research question	Source of data
1.	How does research into the intersection of DFV, MH and AOD inform practice with children and families?	Literature review using Critical Interpretive Synthesis
2.	How do workers, as part of case management, assess and manage the complexity of the intersections of MH, AOD and DFV while maintaining the DFV focus?	Communities of Practice and Program Advisory Group meetings and associated activities including: focus groups, participant online questionnaire, a personal practice and organisational assessment of practice change before and after involvement and interviews with practitioners
3.	What formal collaborative arrangements are required for workers and their organisations to intervene where DFV, MH and AOD intersect?	
4.	In what ways does the Safe & Together Model inform worker practice where there are issues of complexity?	
5.	How do individual family members - who are clients of an organisation that is implementing a collaborative and holistic approach to working with children and families living with DFV and where there are parental issues of MH and AOD use co-occurring - experience the interventions they receive?	Interviews with clients of four services (including Jannawi) who have been supported by workers who participated in the STACY Project and have been implementing the Model
6.	How have practitioners experienced the implementation of the collaborative Safe & Together Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?	Interviews with practitioners from five services (including Jannawi) who participated in the STACY Project and have been implementing the Model

Methodology

An overall action research (practice-led or co-designed) methodology, using mixed method qualitative and quantitative data collection informed the iterative process of evidence gathering and developing practice change. Informed by a literature review (using Critical Interpretive Synthesis), data was drawn from several sources, including: communities of practice, focus groups, participant online questionnaire, a personal practice and organisational assessment of practice change before and after involvement, a process evaluation of an exemplar organisation that had developed an all-of-family approach to working with all family members, and a case study component involving interviews with clients (mothers, young people and fathers) and practitioners whose organisations were implementing an all-of-family approach to working with children and families where there was DFV, MH and AOD. Ethics authorisation was sought and provided by: UoM HREC ID 1852605.2; UoM HREC ID 1954087.2; University of Sydney HREC ID 29019/189; and the QLD Government's Hospital and Health Service (Metro North) HREC/18/QPCH/46628.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 12 of 106

Key findings

- Research into the intersection of DFV, MH and AOD indicates that gendered, DFV-informed, and child-focussed adult services are yet to emerge as prominent drivers of practice with children and families.

- DFV, AOD, MH and other services need to shift the adult-focus of their services towards greater recognition that their clients (including offenders) are parents. This is about shifting adult-focussed services to becoming more child-focussed (or child-sensitive).

- Agencies which are not child-focussed need to engage in closer collaborative work with agencies which have a well-developed child-focus. This will improve responses to children as it will allow agencies to gain a greater understanding to the risks to children and allow children's views to be incorporated into responses.

- In order to 'partner' with the mother, 'pivoting' requires gathering information about a domestically violent man from numerous sources, other than necessarily 'engaging' with him in a direct conversation.

- There are intersecting complexities such as the trauma histories of Indigenous, refugee and asylum-seeker parents, the presence of disabilities in either or both parents, security of employment, housing instability, cultural considerations, and impoverished circumstances in addition to those of AOD and MH to consider when working with children and families living with DFV.

- Child-focussed work includes engaging directly with young people in age appropriate ways and including them in decision making processes. Examining what young people's participation looks like in practice while partnering with mothers in a manner that does not exacerbate disempowerment of mothers requires further development, especially where the needs of mother and child survivors differ.

- Practice needs to shift from recognising the co-occurrence of problems to exploring the intersections between DFV, MH and AOD.

- Instituting an all-of-family approach to working with families living with the intersecting complexities of DFV, MH and AOD involves intervention that goes beyond simply enhancing individual professional practice with clients. Rather, it involves organisational change and a complex, system-wide intervention to bring diverse services and professional interventions into agreed upon ways of working collaboratively.

- All 21 clients interviewed spoke of positive experiences with their service, including significant changes in their families and of being treated respectfully by workers. Many spoke of the practitioners who worked with them as providing a service that contrasted dramatically with previous service interactions.

- Practitioners who were interviewed reported significant changes for children and families with whom they worked as a result of the all-of-family approach they were adopting and implementing.

- All CoP participants either 'agreed' or 'strongly agreed' that exposure to the Model during the STACY Project improved their practice and/or management of staff. This represented 100% of CoP participants who responded to this item (n=44) in the confidential, online questionnaire undertaken after the completion of the CoP phase of work.

1. Introduction, background and research questions

1.1. Project aims

The *STACY Project* aimed to investigate and develop practitioner and organisational capacity of statutory and non-statutory organisations to work collaboratively and holistically in the provision of services to children and families living with domestic and family violence (DFV) where there are parental issues of mental health (MH) and alcohol and other drug use (AOD) co-occurring. The expertise of practitioners was harnessed through Communities of Practice (CoP), which were capacity built through training and coaching provided by the US-based, Safe & Together Institute's resources and consultants, David Mandel and Kyle Pinto. Researchers worked alongside each series of CoP meetings in each of the three states involved (NSW, QLD and VIC) to support and investigate changes in professional practice, inter-agency working, and the organisational change necessary to support ongoing development. The expertise of Project Advisory Group (PAG) members situated in each state was drawn on to develop practitioner and organisational guidance for improved collaborative working in this complex area.

1.2. The Safe & Together™ Model: working at the intersections

The research team's interest in the Model has its roots in the practice issues for child protection and family services' workers intervening with children and their families where there is DFV (Humphreys, Healey & Mandel, 2018). The Safe & Together Model (the Model) was developed to guide practitioners and their organisations - where child protection issues are paramount - toward policies and practices that are 'DFV-informed'. The Safe & Together Model's Principles and Critical Components are reproduced with permission in Figure 1 and Figure 2 below.

Figure 1: Safe & Together™ Principles (reproduced with permission)

1 Keeping child Safe and Together™ with non-offending parent
Safety   Healing from trauma   Stability and nurturance

2 Partnering with non-offending parent as default position
Efficient   Effective   Child-centered

3 Intervening with perpetrator to reduce risk and harm to child
Engagement   Accountability   Courts

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 14 of 106

Figure 2: Safe & Together Critical Components (reproduced with permission)

Source: https://safeandtogetherinstitute.com/safe-together/safe-together-overview/assumptions-principles-critical-components/
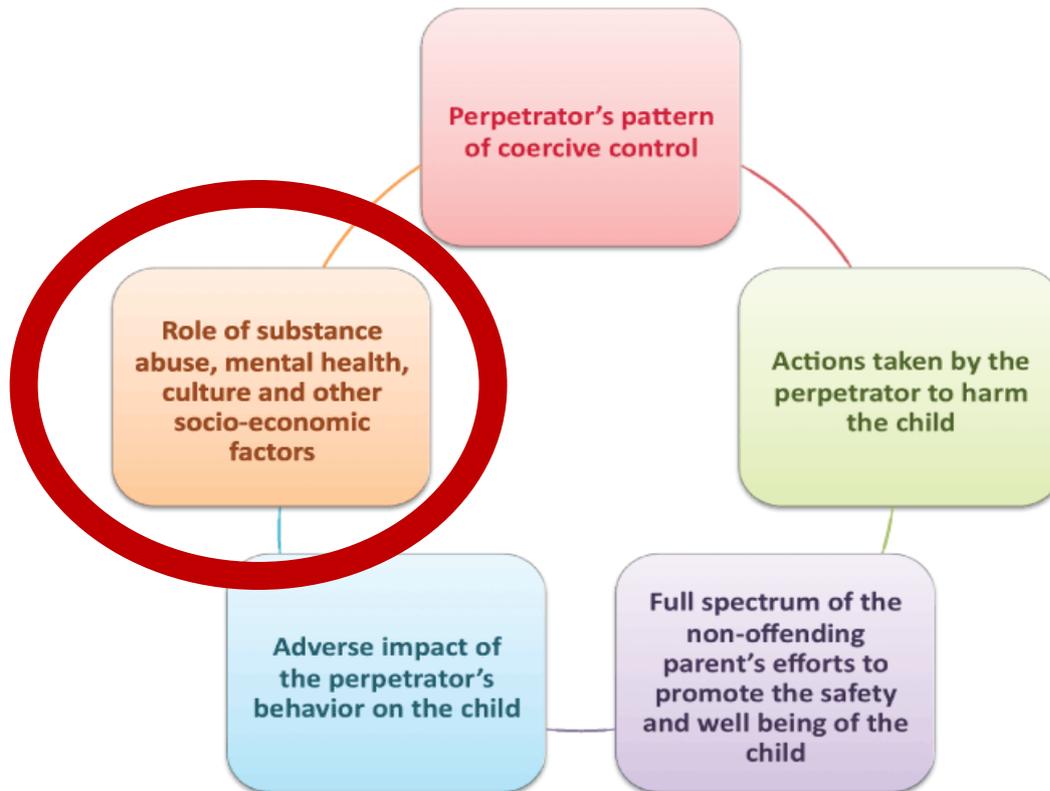
The Model is customised to ensure that the safety and wellbeing of children living with DFV is at the core of practice and its three key principles (see Figure 1). It means keeping children 'safe and together' with the non-offending parent (the adult victim/survivor who is usually the mother); partnering with her and being involved with the perpetrator in ways that strengthen the safety and wellbeing of children whilst holding him to account for his use of violent and controlling behaviours. It means intervening with the perpetrator in order to reduce the harm and risks to children.

Intervening with the perpetrator is often referred to as 'pivoting to the perpetrator' in 'Safe & Together language'. Pivoting occurs in a multitude of ways in practice; it should never be undertaken without keeping children's safety and wellbeing in view and thus without 'partnering'. Pivoting does not always involve direct contact or engagement with the perpetrators themselves, but it does consistently involve keeping a focus on perpetrator patterns of behaviour throughout discussion and questioning of cases, working within established systems, in documentation, and in collaborative working across programs and services. In practice and philosophy, the Model represents a child-focussed, ethical and complex system intervention which is explicit in situating worker DFV skill enhancement alongside organisational change.

In the *STACY Project*, there was an explicit focus on the 'intersections' critical component of the Safe & Together Model; specifically, work at the intersection of DFV, MH and AOD (see ringed component in Figure 2). This is more than a focus on co-occurrence of these issues but targets the way in which DFV and the parent perpetrating coercive control and abuse is kept in view and impacts on the issues of AOD and MH.

As the research team of this *STACY Project* found in the previous projects undertaken with the Safe & Together Institute (the *PATRICIA* and *Invisible Practices* projects), the primary appeal of the Safe & Together Model lies in the customisation to the child protection context, in working with families where there are

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 15 of 106

complex, intersecting issues, such as AOD and MH, and in the provision of a helpful shared language and vision to support collaborative working across diverse statutory and non-statutory organisations (Humphreys & Healey, 2017; Healey, Humphreys, Tsantefski, Heward-Belle & Mandel, 2018). This is also borne out by promising results from evaluation studies of the Ohio child protection services (Chaney Jones & Steinman, 2014), the work of the Florida Coalition Against Domestic Violence (David Mandel & Associates, 2010), and Queensland's Walking With Dads program (Meyer, Hine, McDermoot & Eggins, 2019).

Two tools that were developed by Safe & Together (S&T) are referred to throughout the latter sections of this report and in the accompanying practice guides. The first is the Mapping Perpetrators' Patterns Practice Tool. It was developed for use by practitioners from diverse disciplinary, service and program backgrounds in order to facilitate pivoting to the perpetrator when working with clients. Most particularly, it is helpful in documenting perpetrator's patterns of abusive and controlling behaviours and their interrelationship with MH and AOD issues (see Figure 3). The second tool is a complementary one for use in partnering with survivors. Called the Mapping Survivors' Protective Capacities Tool, it can be used to shift from a 'failure to protect' approach to a strengths- and evidence-based approach when working with survivors to support them toward greater safety and wellbeing of their children (see Figure 4).

Figure 3: Safe & Together's five step Mapping Perpetrators' Patterns Practice Tool
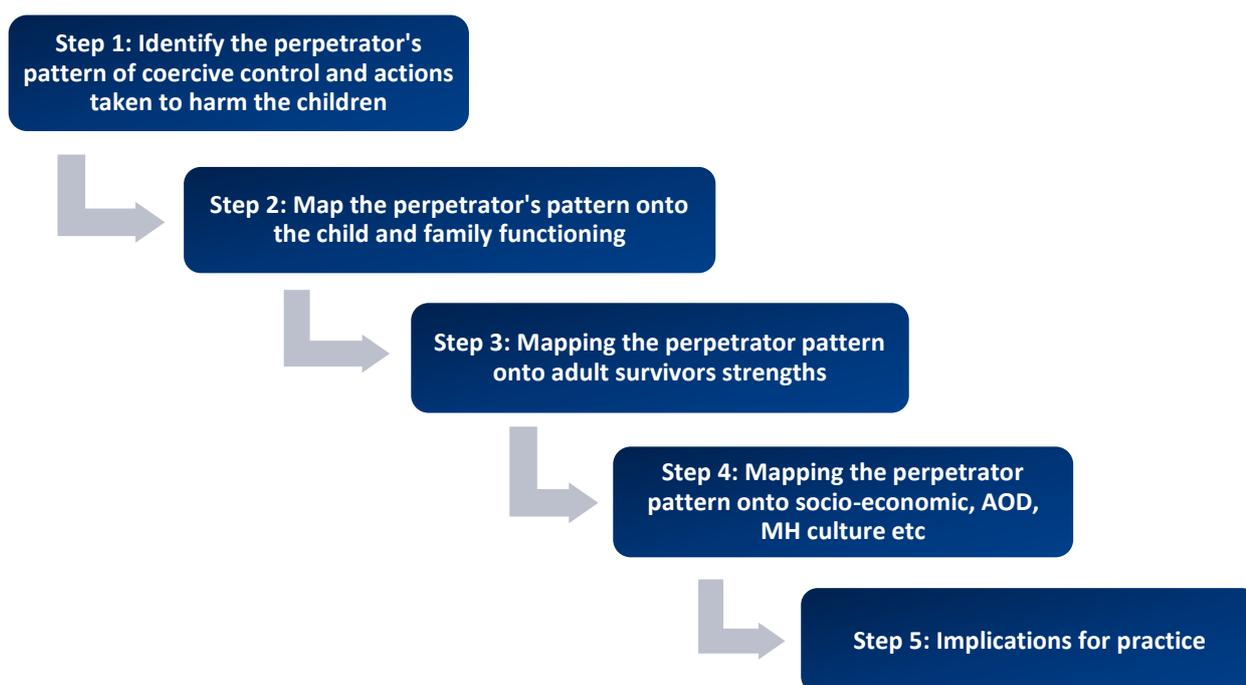
Figure 4: Safe & Together's Mapping Survivors' Protective Capacity Tool

Step 1: Identify the perpetrator's pattern of coercive control and actions taken to harm the children

Step 2: Identify the protective factors of the DFV survivor

Step 3: Identify socio-economic, AOD, MH or other complicating factors

Step 4: Implications for practice
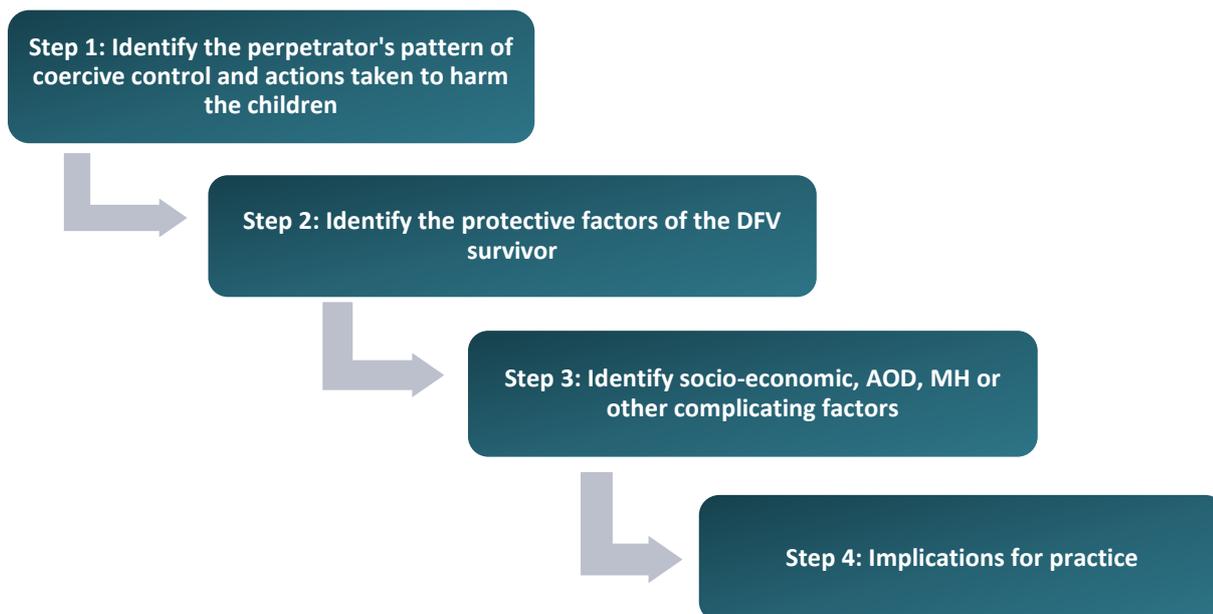
1.3. Background: the intersection of DFV, AOD and MH

The co-occurrence of DFV with problems of MH and AOD is well established (Gilchrist, Hegarty, Condras, Herman & Gunn, 2010; Trevillion, Oram, Feder, & Howard, 2012). Together and separately, they create problems for children who live (or have considerable contact) with one or both parents. This project was focussed on the nexus of DFV with problems of MH and AOD when children are involved, and stems from the practice issues for child protection and family services workers intervening with children and their families where there is domestic and family violence (Humphreys, Healey & Mandel, 2018). We observed that while DFV was often the issue bringing children to the notice of child protection or family services, that a case reading of a file would see domestic violence (usually male perpetrated) sink to the background while the mother's mental health or drug and alcohol issues would become the focus of attention (Humphreys et al, 2018). This is not a new observation, but it does suggest that practice in this area has become entrenched.

An important issue of intervention where there is domestic violence is to pivot the practice to ensure: that the perpetrator is kept in view (Mandel, 2014); that the behaviours and patterns of coercive control are explored; and the impact of this violence on the non-offending parent and children is understood. In the first instance, this means that domestic violence needs to be identified and appropriate responses provided. Research suggests that there is recognition of the need to expand inquiry to all family members in order to identify appropriate intervention. However, the literature in this area suggests that there is reluctance from many professionals, particularly in the AOD and MH areas, to make the most basic enquiries about the man's relationship (Radcliffe & Gilchrist, 2016, p.135-136). Some professionals recognise that organisations supporting people with substance use problems are well placed to respond to men who use violence given the co-occurrence of their substance use with their use of violence (Hashimoto, Radcliffe & Gilchrist, 2018), and the associated increase in severity of violence when they are using drugs or alcohol (Humphreys et al, 2005).

The research literature highlights a significant focus on the mother's mental health and its impact on her ability to look after their children, with children's wellbeing often linked to their mother's when there are

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 17 of 106

issues of domestic violence (Connelly et al, 2010; Hegarty et al, 2013; Holden et al, 2012; Howarth et al, 2016; Howell et al, 2015; Loeffen et al, 2017; Perera, Short & Fernbacher, 2014; Prosman, Lo Fo Wong & Lagro-Janssen, 2014; Rizo et al, 2018; Taft et al, 2011; Zlotnick, Capezza and Parker, 2011). However, as Sullivan (2007) points out, the intervening variable is more likely to be the violent man that both the women and children are living with and whose behaviour is creating fear and trauma in both women and children. It is an area where the invisibility of perpetrator behaviour is particularly marked. The focus on women's mental health reified from the violence that they have experienced is a particularly strong pattern, though one which is now being consistently identified in the literature as problematic (Humphreys & Thiara, 2003; Sidebotham & Retzer, 2018).

A toxic spiral for women can be a concerning aspect of the intersection between DV, AOD and MH. While there are some programs that have developed supportive responses to women living with co-occurring problems (Taft et al, 2011; Tsantefeski et al, 2015), the reports from women are that they have an immense fear of the removal of their children should they disclose the complexity of problems they are experiencing (Macy, Renz & Pelino, 2013). Child protection workers are often perceived to be monitoring the woman's mental health, use of substances, and ability to protect their children from the perpetrator of violence (Frederico, Jackson & Dwyer, 2014; Tsantefski, Humphreys & Jackson, 2014), rather than providing support and actively intervening with the perpetrator of violence. Some professionals then blame women for not proactively seeking help and are perceived as difficult and uncooperative (Loeffen et al, 2017). Under these circumstances, the isolating tactics associated with domestic violence are compounded at both the level of the service system and the women and children's informal networks. It is here questions need to be raised about the safety of the service system response and whether it is replicating abusive tactics or providing an appropriate response to safety and wellbeing for women and children victim survivors (Heward-Belle et al, 2018).

1.4. Research Questions

The literature in this area has highlighted gaps in the knowledge, skills and support for professionals working at the intersection of domestic and family violence, mental health and alcohol and other drugs when children are involved. It has led to the following research questions:

1. How does research into the intersection of DFV, MH and AOD inform practice with children and families?

2. How do workers, as part of case management, assess and manage the complexity of the intersections of MH, AOD and DFV while maintaining the DFV focus?

3. What formal collaborative arrangements are required for workers and their organisations to intervene where DFV, MH and AOD intersect?

4. In what ways does the Safe & Together Model inform worker practice where there are issues of complexity?

5. How do individual family members - who are clients of an organisation that is implementing a collaborative and holistic approach to working with children and families living with DFV and where there are parental issues of MH and AOD use co-occurring - experience the interventions they receive?

6. How have practitioners experienced the implementation of the collaborative Safe & Together Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

2. Literature review

The *STACY Project* is informed by a systematic literature review undertaken by researchers at UoM using a critical interpretive synthesis (CIS) methodology (Dixon-Woods et al 2006). It identifies key research that contributes to and advances our knowledge relating to practice with children and families at the intersections of DFV, MH and AOD. The literature review was submitted in December 2018 as a discrete report. This section outlines the CIS methodology adopted and provides a summary of the key findings and discussion from the review.

2.1.   Introduction

The co-occurrence of domestic and family violence (DFV) with problems of mental health (MH) and alcohol and other drugs (AOD) is well established (Gilchrist, Hegarty, Condras, Herman & Gunn, 2010; Trevillion, Oram, Feder, & Howard, 2012), and much previous research has focussed on these issues in relation to women (Mason & O'Rinn, 2014). Previous research examining these issues in relation to families and children has found that while DFV is often the issue bringing children to the notice of child protection (CP) or family services, there is evidence of (usually) male-perpetrated DFV sinking from view as the mother's MH or substance use become the focus of attention (Humphreys et al, 2018). This review focussed on the complex nexus between DFV, MH and AOD for families, specifically when children are involved, and explored issues for practice.

2.2.   Adopting CIS methodology

Following a pilot phase using scoping review methodology, CIS methodology was adopted for this review. This methodology enabled the researchers to avoid or replicate the notions of 'multi-problem families' or 'troubled families' where DFV, AOD and MH co-occur, and to apply a critical 'DFV lens' in conducting the review. This is key to the project's understanding of complexity for families as intersections rather than co-occurrence of these issues, and will be explored in following sections of this report.

A CIS combines conventions of qualitative research inquiry and systematic review methodology to enable a synthesis and critique of qualitative and quantitative evidence and discourse. CIS reviews lead to synthesising arguments, rather than descriptive or aggregative conclusions, and are therefore well-suited to interrogate literature relating to complex topics (such as access to healthcare by vulnerable groups (Dixon-Woods et al, 2006) and child sexual abuse (McGibbon, Humphreys & Hamilton, 2015)).

The critical orientation adopted in CIS methodology recognises diverse understandings of the issues under investigation and enables a synthesis that includes authors' reflexive voices. CIS reviews include questioning of the gaps, contradictions and constructions of the literature, and while this inherently reduces the replicability of some aspects of the review, a CIS is grounded *in* the literature and is complementary to conventional systematic approaches.

CIS methodology begins with a question established at the outset, that acts as 'a compass rather than an anchor' (Dixon-Woods et al, 2006, p.37). The review question guiding the CIS for this project was:

> *How does research into the intersection of domestic and family violence with mental health and alcohol and other drugs inform practice with children and families?*

In addressing this review question, conventional systematic review techniques were initially employed through a structured search strategy of *CINAHL, Family & Society Studies Worldwide, MEDLINE, PsycINFO* and *SocINDEX* databases (see Table 1 below for an example of the search terms used). Collection of research literature from expert colleagues, searching of key author bibliographies, and reference checking were also employed following Dixon-Woods et al (2006). This allowed for a rigorous search that did not exclude

potentially relevant research not accessible through a database search protocol alone. The search was limited to titles and abstracts, English language, and publication between 2010 and 2018.

Table 1: Example search terms and combinations used to identify potentially relevant studies – PSYCINFO record

1. (((domestic or family or interpersonal or intimate partner) adj (violen* or abus*)) or violence against women or gender-based violence or (batter* adj wom#n)).ab,ti.
2. (alcohol* or drug* or addict* or "alcohol and other drugs" or AOD or SUD or (substance adj (abus* or addict* or use* or depend*))).ab,ti.
3. (mental health or mental illness or mental disorder* or mental health service* or MH or post-traumatic stress or PTSD or mood disorder* or stress disorder* or depress* or anxiety).ab,ti.
4. ((dual diagnos* or comorbidity or co-occur* or syndem* or (parental adj (mental ill-health or mental health or issue* or violen* or substance abuse)) or mother* or women or father* or men) not HIV).ab,ti.
5. ((social adj (work* or practice* or service* or intervention* or support program)) or social work practice or best practice* or practitioner response* or practitioner perspective* or ((work* with or partner* with) adj2 (offending parent or non-offending parent or mother* or women or father* or men or victim* or survivors* or perpetrator* offender* or abuser*))).ab,ti.
6. ((collaborat* or cooperat* or integrat* or network* or coordinat*) adj2 (work* or approach* or service* or practice* or intervention* or care or system* or initiative* or agency or multidiscipline*)).ab,ti.
7. 2 or 3
8. 1 and 7
9. 4 and 8
10. 5 or 6
11. 9 and 10

In line with Dixon-Woods et al (2006), searching, sampling, critique and analysis proceeded concurrently[1]. All search results were screened to determine potential inclusion in the synthesis, using broad selection criteria (see Table 2)[2]. Forty articles are included in the final synthesis (see Table 3). These include qualitative and quantitative studies, systematic reviews, and conceptual papers (See Figure 5), that included perspectives from clients, practitioners and researchers.

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[1] The nature of analysis and the "creative", interpretive processes involved' (Dixon-Woods et al, 2006, p.40) do not lend themselves to replicability. The collaborative processes used in selection and analysis of the literature instead required the authors to engage critically and reflexively with each other in the process of constructing a synthesised interpretation of the literature.

[2] Grey literature which describes practice initiative was not included and stands as a limitation of the review. Because articles that did not mention DFV are excluded, there is a lack of literature that concerns dual diagnosis and the learnings and insights from the extensive collaboration between the AOD and MH sectors (Glasby & Lester, 2004; Mastache et al, 2008).

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 20 of 106

Table 2: Inclusion and exclusion criteria used in screening and selection of papers

Inclusion	Exclusion
• **Addressed the intersection of domestic and family violence with parental issues of alcohol and other drugs, or mental health** • **Addressed elements of practice at this intersection** • **Addressed these issues in the context of working with children and families** • **Context of research being relatable to Australian context** • **Refereed journal articles**	• Did not address intersection of domestic and family violence with parental issues of alcohol and other drugs or mental health • Did not focus on elements of practice at this intersection i.e. had no focus on practice, or made only brief recommendations for practice • Did not address the family context i.e. focussed only on women or men without children (explicitly, or implicitly without mention of children as a factor for participants) • Contextually disparate from Australian context • Protocol papers, books, book reviews, newsletters, poster presentations, grey literature

Table 3: Papers for inclusion in final synthesis

Reference	Title of paper	Source	Methodology
Blythe, Heffernan & Walters (2010)	Best Practices for Developing Child Protection Workers' Skills: Domestic Violence, Substance Abuse, and Mental Health	Database search	Qualitative
Charles (2011)	Obstetricians and violence against women	Database search	Critical analysis
Choenni, Hammink & van Mheen (2017)	Association Between Substance Use and the Perpetration of Family Violence in Industrialised Countries: A Systematic Review	Expert recommendation	Systematic review
Coates (2017)	Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: inter-agency collaboration	Expert recommendation	Qualitative
Connelly et al (2010)	A Model for Maternal Depression	Database search	Model description
Darlington, Feeney & Rixon (2005)	Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers.	Expert recommendation	Quantitative
Featherstone & Fraser (2012)	Working with Fathers around Domestic Violence: Contemporary Debates.	Reference chaining	Mixed methods

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 21 of 106

Reference	Title of paper	Source	Methodology
Frederico, Jackson & Dwyer (2014)	Child Protection and Cross-Sector Practice: An Analysis of Child Death Reviews to Inform Practice When Multiple Parental Risk Factors Are Present	Database search	Mixed methods
Galvani (2015)	'Drugs and relationships Don't Work': Children's and Young People's Views of Substance Use and Intimate Relationships	Database search	Qualitative
Ghaffar, Manby & Race (2011)	Exploring the Experiences of Parents and Carers whose Children Have Been Subject to Child Protection Plans	Database search	Qualitative
Hashimoto, Radcliffe & Gilchrist (2018)	Help-seeking Behaviours for Intimate Partner Violence Perpetration by Men Receiving Substance Use Treatment: A mixed Methods Secondary Analysis	Database search	Mixed methods
Hegarty et al (2013)	Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial	Database search	Quantitative
Holden et al (2012)	Depressive Symptoms, Substance Abuse, and Intimate Partner Violence among Pregnant Women of Diverse Ethnicities	Database search	Quantitative
Holly & Horvath (2012)	A question of commitment – improving practitioner responses to domestic and sexual violence, problematic substance use and mental ill-health	Bibliography search	Mixed methods
Howarth et al (2016)	IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE): an evidence synthesis	Database search	Mixed methods
Howell et al (2015)	Strengthening Positive Parenting Through Intervention: Evaluating the Moms' Empowerment Program for Women Experiencing Intimate Partner Violence	Database search	Quantitative
Humphreys & Thiara (2003)	Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'	Expert recommendation	Qualitative
Lalayants (2013)	Multidisciplinary Collaboration on Child Protective Clinical Consultations: Perceptions of Best Practices	Database search	Qualitative
Laracuente (2017)	Therapeutic Engagement With Partner-Abusive Fathers	Database search	Critical analysis
Loeffen et al (2017)	Mentor mother support for mothers experiencing intimate partner violence in family practice: A	Database search	Qualitative

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 22 of 106

Reference	Title of paper	Source	Methodology
	qualitative study of three different perspectives on the facilitators and barriers of implementation		
Macy & Goodbourn (2012)	Promoting Successful Collaborations Between Domestic Violence and Substance Abuse Treatment Service Sectors: A Review of the Literature	Expert recommendation	Systematic review
Macy, Renz & Pelino (2013)	Partner Violence and Substance Abuse Are Intertwined: Women's Perceptions of Violence-Substance Connections	Reference chaining	Qualitative
Perera, Short & Fernbacher (2014)	"It's Not That Straightforward": When Family Support Is Challenging for Mothers Living With Mental Illness	Database search	Qualitative
Prosman, Lo Fo Wong & Lagro-Janssen (2014)	Support by trained mentor mothers for abused women: a promising intervention in primary care	Database search	Quantitative
Radcliffe & Gilchrist (2016)	"You can never work with addiction in isolation": Addressing intimate partner violence perpetration by men in substance misuse treatment	Database search	Qualitative
Rizo et al (2018)	A Novel Intervention for System-Involved Female Intimate Partner Violence Survivors: Changes in mental Health	Database search	Quasi-experimental
Rose et al (2011)	Barriers and facilitator of disclosures of domestic violence by mental health service users: qualitative study	Reference chaining	Qualitative
Sidebotham & Retzer (2018)	Maternal filicide in a cohort of English Serious Case Reviews	Database search	Mixed methods
Stover (2013)	Fathers for Change: A New Approach to Working With Fathers who Perpetrate Intimate Partner Violence	Database search	Intervention description
Stover, Carlson & Patel (2017)	Integrating intimate partner violence and parenting intervention into residential substance use disorder treatment for fathers	Database search	Mixed methods
Stover & Kiselica (2015)	Hostility and Substance Use in Relation to Intimate Partner Violence and Parenting Among Fathers	Database search	Quantitative
Stover, Meadows &	Interventions for Intimate Partner Violence: Review and Implications for Evidence-Based Practice	Bibliography search	Literature review

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 23 of 106

Reference	Title of paper	Source	Methodology
Kaufman (2009)			
Taft et al (2011)	Mothers' AdvocateS In the Community (MOSAIC) – non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomised trial in primary care	Database search	Quantitative
Templeton et al (2009)	Young people living with parental alcohol misuse and parental violence: 'No-one has ever asked me how I feel in any of this'.	Reference chaining	Qualitative
Tsantefski, Humphreys & Jackson (2014)	Infant risk and safety in the context of maternal substance use	Database search	Qualitative
Tsantefski, Jackson & Humphreys (2015)	A delicate balance: intervention with mothers with dual diagnosis and their infants	Database search	Longitudinal mixed methods
Webber, McCree & Angeli (2011)	Inter-agency joint protocols for safeguarding children in social care and adult mental-health agencies: a cross-sectional survey of practitioner experiences	Reference chaining	Mixed methods
Welland & Ribner (2010)	Culturally Specific Treatment for Partner-Abusive Latino Men: A Qualitative Study to Identify and Implement Program Components	Database search	Qualitative
Willis et al (2010)	Children Who Witness Violence: What Services Do They Need To Heal?	Database search	Qualitative
Zlotnick, Capezza & Parker (2011)	An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study	Database search	Quantitative

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 24 of 106

Figure 5: Paper selection process

	Database search	Expert recommen-dation	Bibliography searching	Reference chaining	
Identification	1760 papers identified through searching of academic databases and Google Scholar	85 papers identified by expert colleagues	15 papers identified through purposive bibliography searching	27 additional papers identified through reference list checks	Search strategy developed to target complex literature and applied to databases and Google Scholar. Limits applied included publication between 2010 and 2018, and English language.

Duplicates removed

1085 titles and abstracts screened for inclusion

Screening and sampling	88 papers included in long list	14 papers included in long list	4 papers included in long list	9 papers included in long list

115 papers on long lists discussed, and exclusions made

	32 papers selected for full text download	6 papers selected for full text download	3 papers selected for full text download	7 papers selected for full text download

Titles and abstracts screened and long listed through a collaborative process. Papers address practice with families and children at the intersection of DFV and AOD/MH, unless they provide significant insight into working at this intersection and the systems issues present.

48 papers selected for full text download and appraisal

	4 papers excluded	1 paper excluded	1 paper excluded	2 papers excluded
Eligibility				

40 papers included in final synthesis

Included

Papers read in full. Critique and exclusions based on relevance and contribution towards the review question progressed concurrently with coding to emergent themes in mutually informing processes. Screening criteria applied at full text level.

Analysis and synthesis were undertaken in a similar way to that used in qualitative research, and involved iterative reading and coding of each text within NVivo 11. Broad themes relating to the review question were generated following completion of first pass reading, and refined though consideration and iterative critique of emerging subthemes within the literature.

2.3.   Findings: Working and living at the intersection of DFV, AOD and MH

Three mutually informative areas of synthesis and critique emerged through analysis of the forty articles included in this CIS: differences in theoretical approaches and client focus; complexity of system's collaboration; and practices converging on mothers. Together, they facilitated the development of a synthesising construct: *strengthening intersection between DFV, AOD, and MH sectors*. A brief outline of each area of synthesis and critique is provided with comment on how it contributes to our synthesising construct. A summary of the discussion is then provided with concluding comments.

2.3.1.   Strengthening intersection between DFV, AOD, and MH sectors

The synthesising construct was developed with the view to addressing our review question, and applies on a theoretical, organisational and practical level. On a theoretical level, strengthening of the intersection between DFV, AOD and MH sectors includes an understanding of the differences in approaches and priorities across and within each discrete area of practice. These differences influence and contribute to the second of this review's three main areas, complexity of system's collaboration. On a practitioner and client level, manifestation of the theoretical and systematic issues results in a convergence on mothers, this review's third area of synthesis and critique.

2.3.2.   Differences in theoretical approach and priorities

Engagement with the discourses across DFV, AOD and MH sectors revealed two main areas of difference: whether a gendered or de-gendered theoretical approach informed client provision, and differences according to whether practice was adult or child-focussed. These two key areas of difference influenced the siloed way services interact on client issues of DFV, AOD and MH and have ramifications for practice at their intersection.

Approaches to DFV, AOD and MH as separate issues have historically been adult-focussed, with children and child protection organisations only recently emerging as a priority within practice for these sectors (Holly & Horvath, 2012). Adult-focussed approaches to DFV incorporate a gendered lens in order to identify who did what to whom, and in what circumstances, coached in the well-documented gendered pattern of DFV in which men are the dominant perpetrators of violence against women. A DFV-informed approach acknowledges the accruing impacts of perpetrator actions on the survivor's mental health and substance use (Frederico, Jackson & Dwyer, 2014, p.106), and highlights the need to shift problematic attitudes and beliefs when working with women experiencing DFV (Welland & Ribner, 2010). Approaches that lack a gender lens, often in the AOD and MH sectors, do not conceptualise clients as parents, as well as individual adults, and this is particularly pronounced when applied to men who are fathers. Recognition of violent men as fathers is beginning to be addressed (Frederico, Jackson & Dwyer, 2014), however, there is a distinct lack of focus on gender and fatherhood when it comes to programming for men with substance issues with some exceptions (Stover, 2013; Stover; Carlson & Patel, 2017). Diagnostic medical models often lack nuance (Rose et al, 2011), fail to recognise women's 'symptoms of abuse' (Humphreys & Thiara, 2003), and do not attend to impacts on children. As one young person put it, "no one has ever asked me about how I feel in any of this" (Templeton et al, 2009, p.145).

However, there are some promising signs of young people's views being considered and their voices brought to the conversation (Galvani, 2015; Templeton et al, 2009). In addition, there are promising programs for women as mothers with substance issues (Tsantefski, Jackson & Humphreys, 2015), programs targeting

maternal mental health and amelioration of the mother-child bond in the context of DFV (Connelly et al, 2010; Howell et al, 2015; Rizo et al, 2018; Taft et al, 2011; Zlotnick, Capezza & Parker, 2011).

Although DFV is often the catalyst for involvement with child protection services, the focus on child safety is often at odds with effective service engagement for women as the focus on the children solidifies (Sidebotham & Retzer, 2018; Tsantefski, Jackson & Humphreys, 2015, p.86). A heightened focus on children living with the intersecting complexities of DFV and parental AOD and MH emerges as attention towards women's needs and wellbeing is diminished (Frederico, Jackson & Dwyer, 2014; Radcliffe & Gilchrist, 2016; Tsantefski, Jackson & Humphreys, 2015). Assessments of the risks to children in the context of their parental and familial circumstances is missing, particularly as it relates to a disregard for father engagement and assessment of the impact of violence on family functioning and the child.

2.3.3. Complexity of system's collaboration

Much of the literature recognizes the need for better integration across diverse programs and services (Stover, Meadows & Kaufman, 2009) and the need for stronger collaborative relationships. Important areas of collaborative practice appeared in terms of benefits (Blythe, Heffernan & Waters, 2010; Lalayants, 2013), with the challenges of siloed sectors an equally strong theme from both client and practitioner perspectives (Coates, 2017; Frederico, Jackson & Dwyer, 14; Tsantefski, Humphreys & Jackson, 2014; Webber, Mcree & Angeli, 2013). There was recognition that no one strategy was effective; rather, in an area of complexity, multiple strategies were required (Macy & Goodbourn, 2012), and often dependent on senior management involvement with the necessary authority to make decisions to change practice or establish partnerships (Darlington et al, 2005; Lalayants, 2013)..

2.3.4. Practices converging on mothers

Practices converging on mothers is manifested on multiple levels from the theoretical and systems issues to specific practices (Radcliffe & Gilchrist, 2016). Research focussed on women's MH linked to outcomes for their children (Connelly et al, 2010; Hegarty et al, 2013; Holden et al, 2012; Howarth et al, 2016; Howell et al, 2015; Loeffen et al, 2017; Perera, Short & Fernbacher, 2014; Prosman, Lo Fo Wong & Lagro-Janssen, 2014; Rizo et al, 2018; Taft et al, 2011; Zlotnick, Capezza & Parker, 2011), and in contrast, interventions and practice with fathers featured less prominently and for the most part concerned DFV and AOD, and the potential for AOD programs to inquire and begin to address DFV perpetration by fathers (Hashimoto, Radcliffe & Gilchrist, 2018; Laracuente, 2017; Radcliffe & Gilchrist, 2016; Stover, 2013; Stover, Carlson & Patel; Stover & Kiselica, 2015; Welland & Ribner, 2010).

The relative lack of engagement with fathers is noted and discussed in terms of gender bias, resulting in increased compliance and assessment of "protectiveness" and monitoring of mothers, with little engagement towards her wellbeing (Frederica, Jackson & Dwyer, 2014, p. 110).

Laracuente (2017 p.384) provides a stark assessment:

> *This maternal focus in IPV intervention, although useful and necessary, reinforces victim blaming and leaves partner-abusive fathers free from taking responsibility*.

Under the intense gaze of child protective services, fear related to disclosure of DFV or AOD issues emerged as a concern of some parents including those perpetrating abuse (Hashimoto, Radcliffe & Gilchrist, 2018). It was also a consistent theme across non-offending parent accounts (Loeffen et al, 2017; Macy, Renz & Pelino, 2013). Mothers expressed fear of being disbelieved, and of increased violence (Rose et al, 2011), but above all fear of child removal (Ghaffar, Manby & Race, 2011; Macy, Renz & Pelino, 2013; Tsantefski, Humphreys & Jackson, 2014).

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 27 of 106

Some interesting examples emerged of successful, non-professional mentoring of women with babies and young children struggling with MH and DFV issues (Loeffen et al, 2017; Taft et al, 2011). The importance of programs and services specifically for children and young people that are based on respect and support (Willis et al, 2010), that uphold the resilience of children and respond to their needs as individuals (Templeton et al, 2009) was also emphasised.

2.4. Summary of discussion and concluding comments

The contributions from each of our three main themes highlight that strengthening mutual understanding between sectors at the theoretical, organisational and practice level enables collaborative practice that keeps perpetrators of violence in view, supports mothers and their children, and addresses families' intersecting issues. This CIS particularly explored the ways in which the gendered dynamics of DFV informed AOD and MH practices. These included: keeping the domestic violence perpetrator in view; supporting the safety and wellbeing of survivors including their strategies of resistance to violence and abuse; and recognising the harm to children flowing from the perpetrator's tactics of abuse, including the undermining of the child's relationship with their mother (Humphreys, Healey & Mandel, 2018a).

An important issue of intervention where there is DFV is to pivot the practice to ensure that the perpetrator is kept in view (Mandel, 2014), that the behaviours and patterns of coercive control are explored, and the impact of this violence on the non-offending parent and children is understood. The need to expand inquiry to all family members in order to identify appropriate intervention was recognised in the literature, however, reluctance from many professionals was evident, particularly in the AOD and MH areas, to make the most basic enquiries about the man's relationship to his family members (Radcliffe & Gilchrist, 2016, p.135-136).

Exploration of parental MH was focussed on women (Perera, Short & Fernbacher, 2014, p.173). Despite many standardised DFV risk assessment tools including items on perpetrator MH (e.g. SARA, DVRNA), no mention of father's MH issues and how they interact with perpetration of DFV against family members was included in this CIS. The issues for children when their fathers are both violent and struggling with MH issues are rarely mentioned in the literature under review in this CIS, and this is an urgent area where the intersection between DFV, AOD and MH sectors needs to be strengthened.

While there is significant focus on mothers' MH and its impact on their ability to care for their children and uphold wellbeing (Connelly et al, 2010; Holden et al, 2012; Howarth et al, 2016; Loeffen et al, 2017; Perera, Short & Fernbacher, 2014; Prosman, Lo Fo Wong & Lagro-Janssen, 2014; Zlotnick, Capezza and Parker, 2011), there is very little engagement with the common variable that is the perpetrator of DFV affecting both adult and child survivor (Sullivan, 2007). While this is identified as problematic (Humphreys & Thiara, 2003; Sidebotham & Retzer, 2018), meaningful practice change requires a refocussing towards the ways in which women resist the violence to which they and their children are subjected, such as in the Safe & Together™ Model (Mandel, 2014) or Practice-Based Response (Wade, 1997). This must include addressing gendered practices that focus disproportionately on mothers living at the intersection DFV, AOD and MH issues, that can compound perpetrator tactics of isolation. This is where questions need to be raised about the safety of the service system response and whether it is replicating abusive tactics or providing an appropriate response to safety and wellbeing for women and children survivors (Heward-Belle et al, 2018).

The ways children respond to living with DFV (Kimball, 2016; McTavish et al, 2016) show similar symptoms to children living with substance use (Kroll & Taylor, 2008). It is here that the number of Adverse Childhood Experiences (ACEs) that children experience is relevant (Oral et al, 2016), particularly when it is recognised that living with DFV is the strongest predictor of other adverse experiences (McGavock & Spratt, 2017). The

issues which confront children highlight the need for a more proficient and nuanced response to intervening where there are complex, intersecting problems with their mothers and/or fathers.

The review of the literature points to areas in which there are some promising practices emerging in responding to the co-occurrence of DFV, AOD, and MH (Holly & Horvath, 2012; Laracuente, 2017; Stover, Meadows & Kaufman, 2009; Taft et al, 2011). It is also clear that the service system response is at a relatively early stage in managing complexity especially given the absence of a gendered, DFV-informed, child-focussed approach to understanding the risks to children in the context of parental AOD and/or MH problems. The impact of DFV too easily disappears when other problems emerge, particularly when these involve the child's mother. The absent presence of the perpetrator of violence (Thiara & Humphreys, 2017) needs to be addressed wherever he appears within the service system. Until practices are developed in MH and AOD services to identify and respond to DFV - specifically fathers who use violence - the lives of women and children may not improve. Strengthening the intersections between DFV, AOD, and MH practice with particular attention to keeping the perpetrator of violence in view is critical to overcoming the poor practice that can occur when service sectors are siloed from each other.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 29 of 106

3. Research sites and methodology

3.1.   Research sites

Research sites were established in three states: NSW, QLD and VIC. The participation of organisations from each site was differently configured. In keeping with our ethics agreements to protect anonymity, we have not identified the specific agencies that were involved in this project. In NSW, AOD, MH, statutory child protection, family support services (including Jannawi Family Centre), and specialist DFV workers were involved. In QLD, the research site involved a strong multi-agency partnership driven by statutory child protection with practitioners from specialist DFV services, family services, justice services, with AOD & MH involvement. In VIC, statutory child protection, AOD, MH, family services and specialist DFV workers were involved. All participating organisations supported the research by ensuring that senior managers or CEOs were represented on each site's Project Advisory Group (PAG). In addition, peak body representatives were involved in the VIC PAG.

3.2.   Methodology

A mixed method research design provides the framework for the project. The mixed methodology of qualitative and quantitative data drawn from several sources has been found to be most useful when researching the area of violence against women (Sullivan, 2007) both from practitioner perspectives (Healey, Humphreys, Tsantefski, Heward-Belle & Mandel, 2018) and that of clients, DFV survivors and perpetrators alike (Heward-Belle, 2015; Lamb, Humphreys & Hegarty, 2018).

The *STACY Project* Research Questions are explored through the following methods. Question 1 is explored through the international literature review presented in section 2. Questions 2, 3 and 4 are explored through data collection associated with the Communities of Practice (CoPs) and the Program Advisory Group (PAGs), presented in subsequent sections. Questions 5 & 6 are explored through interviews with practitioners and clients of services who have been supported by workers who have participated in the *STACY Project* and have been implementing the Model, presented in subsequent sections.

3.3.   Action research framework

Regardless of whether they are conceptualised as practice-led (Cook & Wagenaar, 2012), co-designed (Evans & Terrey, 2016), or action research (Ison, 2008) most iterative research processes begin by clearly identifying the characteristics of a given problem or situation for improvement. The *STACY Project* is no different in this regard. It is underpinned by an action research framework, a combined strategy for inquiry (research and learning) and development (practice and action) that involves movement through iterative cycles of reflection and review to enable simultaneous contribution to evidence gathering and practice change (Ison, 2008).

The challenges facing practitioners in managing the complexity of the intersections of MH and AOD while maintaining the DFV focus (thereby keeping the adult and child victims/survivors safe and intervening effectively with the perpetrator of violence and coercive control) were documented. Strategies identified by practitioners to address the challenges in working collaboratively across the services were also documented. At the same time, a process of continuous reflection about what approaches work and why was undertaken and recorded. These insights guided an ongoing iterative process and informed the **development of practitioner guidance[3]** from work undertaken with participants during the CoPs, PAG meetings, and in each state's final workshop (the latter of which used a world café methodology with CoP

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[3] Text in bold identifies data collection methods, outputs of the project, or is used to emphasise a point.

participants (e.g. http://www.theworldcafe.com/key-concepts-resources/design-principles/) at the end of the CoP phase). Insights as to what is required from organisations to support collaborative working where there is DFV occurring in the context of AOD and/or MH issues from either or both parents were also gathered. This process also means that each aspect of the research was analysed separately in the first instance, and the data from each research method (the case study interviews, the Communities of Practice, the focus groups, the questionnaires, the statements of change and modest goals for participant organisations, participants' assessments of DFV-informed practice, and the process of evaluation) was used to triangulate the data collection and analysis processes before a final synthesis was developed.

The participants in the action research include: the Safe & Together consultants, researchers and Chief Investigators from each state (who collectively form the team that drives the *STACY Project*); a Project Advisory Group (PAG) comprising senior government and NGO representatives from organisations participating in the project; practitioners from each organisation participating in a Community of Practice (CoP); and a group of workers ('secondary participants') that the practitioners have chosen to influence with the emerging practices from their learning in the CoP (See Figure 6).

Figure 6: STACY Project participants
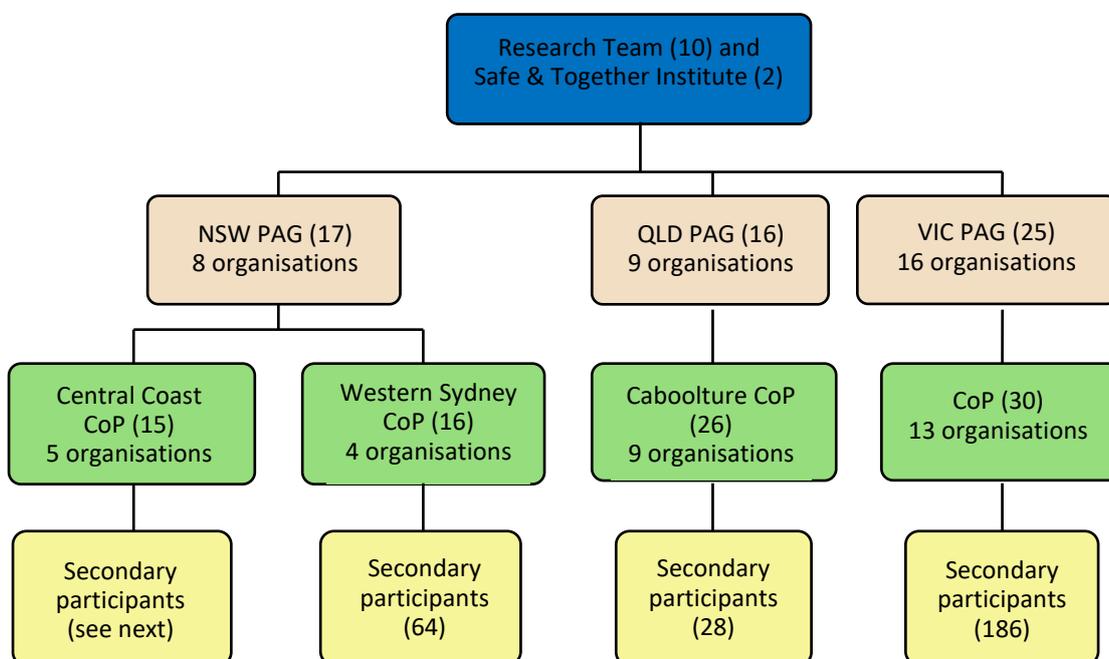
3.4. Ethics

Four ethics applications were undertaken and duly gave authorisation to the research:

- UoM HREC ID 1852605.2 (title: The STACY Project: Safe and Together Addressing ComplexitY);

- UoM HREC ID 1954087.2 (title: Safe & Together: An all of family approach to practice);

- University of Sydney HREC ID 29019/189 (title: Evaluation of the Jannawi Family Centre); and

- QLD Government's Hospital and Health Service (Metro North) HREC/18/QPCH/46628.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 31 of 106

3.5. Communities of Practice and associated activities

3.5.1. Preparing for Communities of Practice: Safe & Together Training & e-learning

In preparation for the Communities of Practice (CoP), Kyle Pinto of the Safe & Together Institute provided three days' training in the Safe & Together Model in each of the three participating states in November 2018. Participants attending were CoP practitioners from each site's participating organisations. On a first-come-first- served basis, up to five additional places were offered to any Project Advisory Group (PAG) members wishing to attend the training. PAG were all invited to attend the introductory session on the Model on the first day. This training laid the groundwork for organisational and practice development that would be further supported through coaching from the Safe & Together Institute trainers via video conferencing during the CoP phase.

Part of the work of all participants (including 'secondary participants') was to complete online e-learning modules provided by the Safe & Together Institute. Prior to training, CoP and PAG members were encouraged to complete two of the three online e-learning modules to be offered by the Safe & Together Institute: *Introduction to the Safe & Together Model* and *Multiple Pathways to Harm*. A third, newly-developed module, *Intersections: When Domestic Violence Perpetration, Substance Abuse, and Mental Health Meet* became subsequently available to all CoP, PAG and 'secondary participants' during the CoP phase of the project. Secondary participants were asked to complete the introductory and intersections modules only.

3.5.2. STACY Communities of Practice

The project involved practitioner participants meeting regularly over a period of months to receive training and participate in a series of six CoPs in each of the three participating state sites (NSW, QLD and VIC). In QLD and VIC, the research team (with one of the Safe & Together consultants) each facilitated a series of CoPs involving up to 30 participants. In NSW, two series of CoPs, involving approximately 15 participants in each (a total of 30 participants) were facilitated by the research team members based in NSW together with a Safe & Together consultant. Practitioner participants were senior staff working in statutory CP agencies and NGO family services.

Members of the research team audio-recorded and took detailed notes of the de-identified cases presented for discussion as well as details of participants' change agent work (see section 3.5.3 for description of this component). This data (as with all qualitative data collected) was identified and coded into themes, facilitated by using NVIVO software. Themes were developed inductively by the research team, and a common coding template drawn up to reflect the themes and sub-themes for the team to use across all research sites. Data was extracted and analysed for similarities and differences across, for example, research sites, or programmatic identifiers (e.g. participant from an AOD, MH or another program).

Communities of Practice (CoPs) were held from December 2018 to July 2019 in each of the participating states (NSW, QLD and VIC), operating as an effective way to share knowledge and acquire skills (Wenger, 1998). The CoP meetings were structured in similar ways across the sites. The structure involved debriefing with participants about their change agent work within their respective organisations and partnerships; a discussion with participants, facilitated by the research team, about examples of case practice with families where there were parental issues of AOD and substance misuse in the context of DFV in relation to the meeting's topic (listed below). Up to four or five practitioners presented their case and question(s) to a Safe & Together consultant (via teleconference), whereupon an hour-long cycle of questions, discussion, coaching and reflection occurred, led by the consultant. This was followed by a final debrief and reflection on the meeting's key issues and heralding of the next meeting's topic of discussion. Topics were as follows:

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 32 of 106

CoP 1	*When attending to the <u>non-offending parent's (mum's)</u> AOD and/or MH issues, how do we avoid the perpetrator becoming more powerful and diminishing her?*
CoP 2	*When the <u>perpetrator</u> has AOD and/or MH issues, how do you work to <u>not</u> use these as an excuse or diminish the attention to his use of DFV?*
CoP 3	*How do we keep attention to children and impacts on them (immediate and cumulative) when services become preoccupied with adult issues of MH, AOD and DFV?*
CoP 4	*What agreements are there between organisations and/or programs that are helping to facilitate integrated and inter-disciplinary working?*
CoP 5	*How do workers manage the different therapeutic/service models, the different approaches across organisations <u>and</u> keep the DFV and children in view?*
CoP 6	*How do we embed the S&T framework into organisations, partnerships and programs to ensure worker safety, and DFV-informed screening, risk assessment and management?*

Summaries of each session were written up by a member of the research team from each site following each CoP session. These included an outline of the topic under discussion, summaries of case discussions and insights from the Safe & Together consultants, and synthesis of the change agent work and reflections discussed by participants. These 'CoP Summaries' were periodically provided to participants to facilitate additional reflection and learning to take to subsequent sessions as well as into their everyday practice. Parts of these summaries have been used illustratively in the following sections of this report.

3.5.3.   Change agent 'influencing' work

During the CoP phase, participants invited colleagues or staff they supervised to become 'secondary participants' in the project. Whilst CoP participants' change agent work may be broad and involve presentations and briefings to large numbers of practitioners or senior staff across organisations and partnerships, they were expected to work with a small number of practitioners or senior staff by introducing them to the Model and thereby influencing their work according to its principles.

3.5.4.   Focus groups

An hour-long focus group was held at the end of each of the last CoP meetings with participants in each state. The focus groups collected data from participants, including reflections, on:

- Elements of change that the participant could identify in their intra-organisational and/or inter-organisational practice as a result of their involvement in the *STACY Project* and exposure to the Safe & Together resources;
- Examples of language and/or concepts that the participant sought to share across disciplinary and organisational boundaries as a result of their involvement in the project (e.g. moving from incident-based descriptions of DFV to a pattern-based descriptions of a perpetrator's behaviour); and
- Descriptions of the strengths and limitations of this project as an organisational learning model (e.g. through the Communities of Practice and change agent work of teaching and coaching others in the Safe & Together Model).

3.5.5.   State-based workshop

Following the CoP phase, final state-based workshops were held at each research site. The state-based workshops brought together each state's PAG and CoP participants and aimed to gather their views on practitioner guidance based on a discussion of a case scenario.

CoP and PAG participants had the opportunity to discuss continued implementation of the Model beyond the life of the *STACY Project* as well as continued involvement in using the CoP model as a way to encourage further capacity building of systems for learning and practice improvement.

The schedule for the day was constructed around two objectives:

1. To discuss the development of practitioner guidance drawing on the experiences of the CoP and PAG participants in implementing the Safe & Together Model.

2. To conduct a joint activity involving CoP and PAG participants together in a discussion about the pedagogy of the CoP model in contributing to capacity building systems for learning and practice improvement.

The workshops were held across the research sites at the end of June and beginning of July, 2019.

3.6.   Practice and organisational change

Practice and organisational change were explored throughout the project activities, and specifically through the online questionnaire (see section 3.6.1) and tool adapted from the Safe & Together Domestic Violence-Informed Continuum of Practice (see section 3.6.2).

3.6.1.   Online questionnaire

The *STACY Project* questionnaire was developed through consultation with the state teams and drawing on the *Invisible Practices* project questionnaire. The overall purpose of the *STACY Project* questionnaire was to aid in assessment of the impact of the Safe & Together Model on the work and professional practice of primary and secondary participants in the *STACY Project*. This questionnaire also served as a mechanism to provide participant feedback on the e-learning module to the Safe & Together Institute.

The questionnaire contained both multiple choice and open-ended questions, collecting quantitative and qualitative data, and was estimated to take roughly 20minutes to complete depending on how much respondents wished to write in open ended questions.

Sections included in the questionnaire were:

1. Demographics
2. Participation in the *STACY Project*
3. Assessment of the coaching model
4. Accessing the online Safe & Together Modules
5. Assessment of agency, team or partnership work

The questionnaire was programmed into Survey Monkey and hosted online for participants to complete electronically. CoP and secondary participants in all sites were asked to complete the questionnaire as part of their involvement with the *STACY Project* between August 6th, 2019 and September 9th, 2019. Response rates and brief demographics are presented below in this section, with relevant findings from the questionnaire presented in section 4 along with findings from other data sources.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 34 of 106

Questionnaire completion rates and respondent demographics

All primary participants who attended the Communities of Practice (CoP), and all secondary participants, or 'influencees', from all three research sites were asked to complete the questionnaire.

CoP participant numbers were established between August and November 2018. Influencee numbers were established between October 2018 and April 2019 in an iterative process as CoP participants identified their influencees and began working with them. Table 4 below shows initial participant numbers at the time these process were complete. By the time the *STACY Project* questionnaire was distributed, minor participant attrition had occurred, resulting in the below number of participants eligible to complete the questionnaire (Table 5)[4].

Table 4: Initial STACY Project participant numbers

Research site	CoP participants	Influencee participants	Total participants
Site 1	25	67	92
Site 2	38	62	100
Site 3	28	187	215
Total across sites	**91**	**316**	**407**

Table 5: Participants eligible to respond at time of questionnaire distribution

Research site	CoP participants	Influencee participants	Total participants
Site 1	22	62	84
Site 2	37	55	92
Site 3	28	175	203
Total across sites	**87**	**292**	**379**

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[4] These numbers are calculated based on formal notification through the site teams of participant attrition, and also take into account other eligibility considerations received through automated or specific replies to the initial questionnaire distribution email. These included that the participant: was no longer in the position/working at the organisation; was on leave for the entire time and past the closure date; or did not receive the questionnaire link due to email delivery failure.

Figure 7: Number of CoP & influencee questionnaire respondents

50 CoP members

93 Influencees

Of the 379 eligible participants across all sites, 143 provided a response to the questionnaire[5], representing an overall response rate of 38%. Of the 143 total respondents, 50 (35%) were CoP members, and 93 (65%) were influencees (see Figure 7).

Fifty of the possible 87 CoP members, and 93 of the possible 292 influencees provided responses to the questionnaire.

This gives a response rates of 57% for CoP members, and 32% for influencees. For a more detailed breakdown of response rates by participant type and site, see Table 6 below.

Table 6: Response rates by site and participant type

Research site	CoP participants	Influencee participants	Total participants
Site 1	68% (15/22)	26% (16/62)	37% (31/84)
Site 2	43% (16/37)	31% (17/55)	36% (33/92)
Site 3	68% (19/28)	34% (60/175)	39% (79/203)
Total across sites	**57% (50/87)**	**32% (93/292)**	**38% (143/379)**

Demographics revealed participant gender was overwhelmingly female (see Figure 8 below). Ninety per cent of CoP respondents and 80% of influencee respondents identified as female, 83% of the total respondents. Response options were provided to participants to identify as other gender identity categories, but no responses were received for these options.

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[5] Complete and partial responses are included in this figure, as demographic data was provided, and in some cases, participants elected not to answer some questions. Response numbers for each question are provided in the results.

Figure 8: CoP & influencee respondent gender
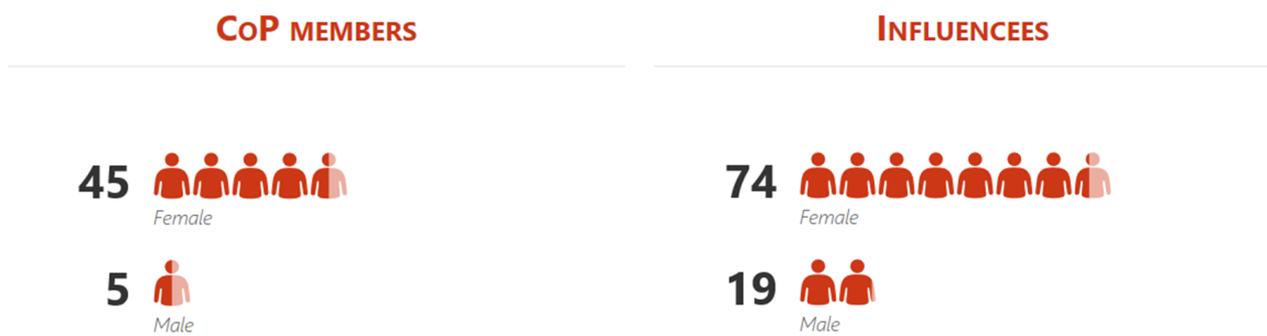

Respondent service areas

Respondents were asked to identify their service areas. CoP participants were assigned a sector ID at the beginning of their involvement with the STACY project, and were asked to select the option that corresponded to this. Influencee participants were asked to select the option that best described their broad service area (e.g. AOD, alcohol and other drugs). Figure 9 shows the overall spread of respondent service areas, with a more detailed breakdown by type of participant and site provided in Figure 10.

Major service areas represented across all sites were AOD, CP, FS, and DFV. Given the focus of the project on the intersection of DFV, AOD and MH, recruitment targeted AOD and MH as major service areas for representation and recruitment of participants. While the respondents to the questionnaire represent only a portion of the overall participants in the project, a notable lack of MH representation can be seen in Figures 9 and 10.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 37 of 106

Figure 9: Respondent service areas – all sites

46	AOD - Alcohol and other drugs
31	CP - Child protection (includes specialist MH, AOD, Indigenous, legal and WWD)
21	FS - Child and family services
26	FV - Family violence (includes men's services, specialist women's FV, Orange Door
5	JS - Justice services (includes police, corrective services/probation and parole)
6	MH - Mental health
8	Other (please specify)

Total = 143
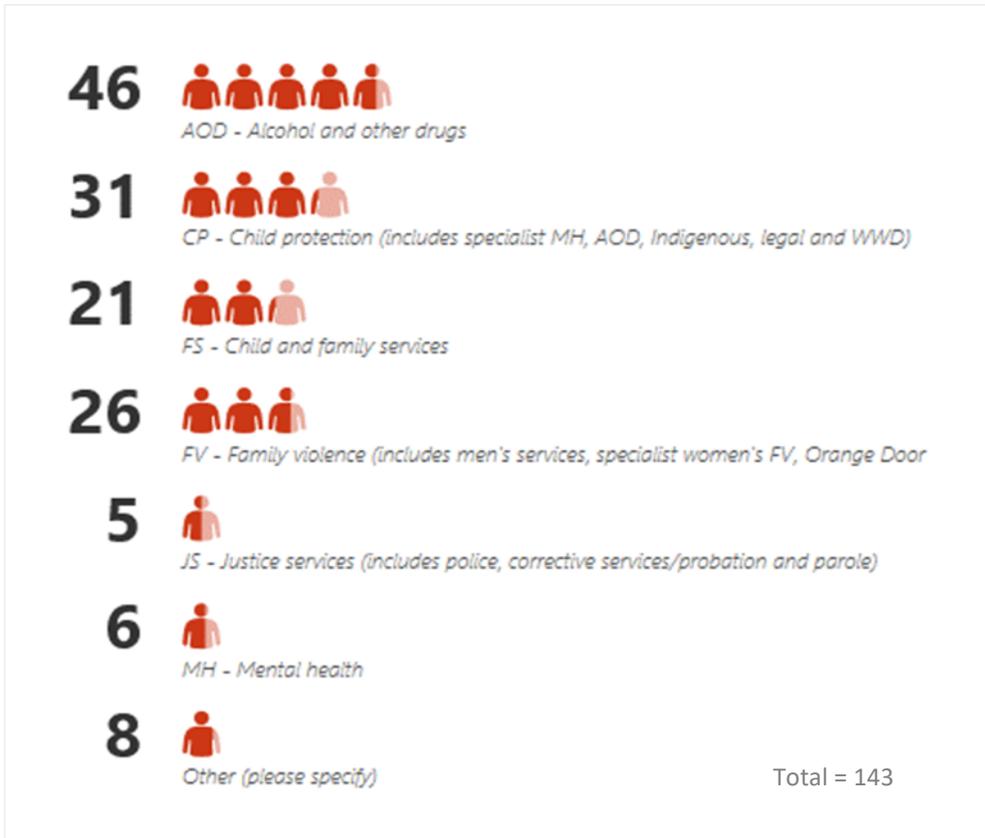
Figure 10: CoP and Influencee respondent service areas by site

CoP and Influencee service areas by site

Legend:
- AOD - Alcohol and other drugs
- CP - Child protection (includes specialist MH, AOD, Indigenous, legal and WWD)
- FS - Child and family services
- FV - Family violence (includes men's services, specialist women's FV, Orange Door
- JS - Justice services (includes police, corrective services/probation and parole)
- MH - Mental health
- Other

Total n= 143; CoP n=50; Influencees n=93

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 38 of 106

3.6.2.   DFV-Informed Continuum of Practice

During the CoP phase of the project, the research team drew on the Safe & Together Domestic Violence-Informed Continuum of Practice, and learnings from the *Invisible Practices* project, to create an exercise for CoP and PAG members. This exercise involved a matrix with four dimensions of practice assessed along a simple numeric rating of 1 to 5 with 1 representing the least developed implementation of an all-of-family way of working and 5 representing the most developed stage. This numeric rating therefore replaced the S&T-devised scale moving from destructive practice to proficient practice.

The continuum exercise was administered as a 'reflective, looking-back, exercise' at where they saw their personal practice and that of their organisation to be at the beginning of the *STACY Project* and a 'current assessment' at the end of the CoP phase at the time of administering the exercises. PAG members were asked to self-assess their organisational practice only. The purpose of this exercise was to explore where participants perceived changes in their or their organisation's practice in different dimensions, contributing to the project's overall exploration of capacity building practice change at the intersection of DFV, AOD and MH. Findings from this exercise are reported in subsequent sections.

Participants were asked to provide ratings on four dimensions of practice, or four scales, described below.

Scale 1	***About the adults ↔ Integrated with children/other CPS issues***
	Scale 1 moves from practice that is all about the adult survivor and their responsibility to protect children from violence, to practice where child protection (welfare) and safety is informed by a clear understanding of domestic violence and its impacts on children and other family issues, such as AOD and MH.
Scale 2	***"Failure to protect" ↔ Perpetrator pattern***
	Scale 2 begins with practice operating within a 'failure to protect' framework, where parental efforts (particularly mothers') to protect their children are judged as either sufficient or insufficient, to practice that is focussed on how the perpetrator's pattern of abuse and coercive control impacts the adult survivor's efforts to parent in the context of DFV and explores resulting impacts on the children.
Scale 3	***Fathers invisible ↔ High standards for fathers***
	Scale 3 concerns practice in which fathers and their actions towards family functioning are invisible, in terms of impacts and accountability, on one end, and on the other, practice that holds fathers to the same high standards that mothers are held to in regard to family functioning and impact on children's safety and wellbeing. This includes practice that views the use of violence as a parenting choice.
Scale 4	***Child versus adult survivor ↔ Child safety and wellbeing tied to adult survivor***
	Scale 4 moves from practice that views children, including their needs and rights, as separate and often in opposition to their mother's, to practice in which both adult and child survivor safety and wellbeing are addressed holistically and in the context of one another and their surrounding family functioning.

3.7.   The case study component

This component of the *STACY Project* involved one-on-one, semi-structured interviews with clients and practitioners who provided (or were providing) interventions to clients in six organisational research sites across the three state sites. Strict protocols were developed by the research team to address ethical concerns and ensure the anonymity and safety of client interviewees and their families. Interview data has provided qualitative information about how services are operating and experienced. Data from the interviews has been combined to develop composite stories, examples or case studies that have been written into this report and are used illustratively in the development of practice guidance for dissemination.

Interviews conducted as part of this component are presented in Table 7 below.

Table 7: Interviews conducted as part of the case study component

Interviewees	Site 1	Site 2	Site 3	Total
Mothers	5	5	2	12
Fathers	-	4	1	5
Children/young person	2	1	1	4
Workers	2	8	18	28
Total	**9**	**18**	**22**	**47**

3.8.   Process Evaluation of an all of family approach: Jannawi Family Services

A component of the *STACY Project* was to conduct a process evaluation of the Jannawi Family Centre, an all-of-family, therapeutic child protection service. This process evaluation aims to understand the extent to which, and how, the Jannawi Family Centre in NSW addresses the complexity of family and community circumstances, particularly where DFV, AOD and MH are involved and how they provide a service that enables children to be kept safe and at home. Jannawi was chosen for the evaluation as an exemplar of best practice in providing a holistic, all-of-family response to DFV. Jannawi had participated in the two multi-state research projects that preceded the *STACY Project*, *Invisible Practices* and the *PATRICIA (Pathways And Research In Collaborative Inter-Agency working) Project*. Jannawi staff also participated in the *STACY Project* communities of practice and their director was invited to be on the NSW Project Advisory Group due to her expertise in the field of DFV.

Jannawi Family Centre is a specialist therapeutic child protection service that works with vulnerable children, families and communities in South-West Sydney. The centre has been operational since 1978 when it opened as the Wiley Park Centre. Jannawi is a non-government organisation, auspiced under the Uniting Church through the Lakemba Church. The service currently receives most of their funding from the NSW Department of Communities and Justice.

Jannawi maintains a multidisciplinary team of staff consisting of 12 part-time workers. Jannawi provides two distinct programs. The Family Program is a holistic child protection service for families with children aged 0-12 years who have experienced or are at risk of abuse, violence and neglect. Families are referred to this service by statutory child protection workers from the NSW Department of Communities and Justice. The Community Connections program is a bilingual support service for families with young children from

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 40 of 106

culturally and linguistically diverse backgrounds. In addition to their work with families, Jannawi also has a long-standing role in providing training and consultation to its partners in the community sector and developing specialised resources to build capacity in other agencies to respond to children and families experiencing abuse and trauma, including as a result of DFV. Jannawi also engages in a considerable amount of advocacy work through which they aim to educate and influence policy and legal reform to improve system responses to vulnerable children and families.

3.8.1.   Evaluation aims

The evaluation aimed to answer the following questions:

- What are the key components of an all-of-family approach to domestic and family violence, where there are additional complexities of substance use and mental health?
- How does Jannawi partner with and build resilience of mothers experiencing domestic and family violence?
- How does Jannawi engage with fathers who are perpetrators of domestic and family violence?
- How does Jannawi provide child-centred services and support children and young people in their recovery from violence?
- What are the structural facilitators and barriers reported by Jannawi staff, clients and key stakeholders in effective service responses to domestic and family violence, where there are additional complexities of substance use and mental health?

3.8.2.   Evaluation design and methodology

The methodology for the evaluation was developed to be responsive to several factors including the aims of the Jannawi Family Centre, the desire to capture the nature and impact of the complex work they do, and the broader aims of the *STACY Project*. Also taken into consideration was methodologies used in other Australian evaluations of CP and DFV. Finally, the methodology was designed to be reflective of Australian and international literature on effective practice with children and families living with DFV. It is hoped this evaluation will begin to fill in some of the gaps identified in the literature review stage, in terms of the effective components of an all of family approach to DFV, in particular where there may be co-occurring complexities of parental substance misuse and MH.

The evaluation incorporated principles of co-design and practice-led knowledge building which underpinned the *STACY Project* and the evaluation of the Jannawi Family Centre. Co-design in research and services has been demonstrated to be useful in developing ideas of what constitutes 'effective' practice, particularly in areas where practice is under-developed or requires change. The vision for this evaluation is to provide a platform for the perspectives of 'on the ground' practitioners and families accessing services about their experiences of the CP sector, and their ideas for how the system could better respond to DFV. There is a mandate for both researchers and practitioners to be accountable to women and children living with men's violence and place their safety as the primary goal for any intervention.

This research was designed to be primarily a qualitative process evaluation, while also including some elements of an evaluation of outcomes. A non-experimental research design was also chosen as this is more common in complex areas such as DFV and CP, where it is not possible to isolate and manipulate a single variable. A process evaluation framework was therefore selected based on an understanding of the complex dynamics of DFV that preclude more traditional pre- and post-intervention outcomes measures. A qualitative methodology was also selected in order to capture the subjectivity, complexity and heterogeneity of experiences of DFV. As part of the evaluation, data was collected from multiple sources,

which is triangulated to build a picture of how a service operates from the perspective of both those receiving and providing the service. A process evaluation has also been identified as formative rather than summative, and focussed on providing a rich, in-depth description of service responses.

The evaluation aims to measure proximal outcomes for families engaged with the service. Some of these include: number of referrals to the service, length of time families stayed with the service, the number of families who stayed together in their home, nature of referrals made by the service, types of support provided (risk assessment, safety planning, case management, monitoring) and types of practical needs addressed. At the time of writing this report, the research team are working closely with the Jannawi Family Centre and Professor Cathy Humphreys (Melbourne University) to agree on the quantitative data sources for the evaluation, and how the data will be interrogated and analysed.

In terms of outcome measures, the evaluation included several process-oriented questions. Some of these include: improvements in safety, improvements in parenting, impact on statutory child protection services and impact on any legal proceedings. The research team spent two days at the centre supporting the design of the service's program logic model with David Gallant (University of Melbourne) and Karalyn Davies from the Centre for Family Research and Evaluation (VIC). This model will be used as part of the data collected for the process evaluation.

3.8.3. Preliminary data collection and analysis

Qualitative data collection for the evaluation was conducted between June and October 2019. Data collection included:

- Semi-structured interviews with:
    - 4 fathers who have been clients of Jannawi as DFV perpetrators;
    - 5 structured interviews with mothers who have been clients and are DFV survivors;
    - 1 young person who was a client and a DFV survivors;
    - 8 Jannawi staff;
    - 2 key local stakeholders and informants working in relevant partner organisations;
- Ethnographic data obtained through researcher observations of the Jannawi Family Centre; and
- Analysis of Jannawi Family Centre documents including annual reports, policy submissions and website.

Interviews took place either at the Jannawi Family Centre or by telephone. All interviews were audio-recorded and transcribed verbatim after consent was obtained, before being imported into NVivo (12.0) qualitative data analysis software. Data analysis was conducted based on the framework of thematic coding, with 'nodes' being generated iteratively through multiple readings of each transcript, relevant research and academic literature, and other data collected as part of the broader *STACY Project*.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 42 of 106

4. Findings

To address the project's research questions, findings that were common across the research sites and common threads in practitioners' conversations throughout successive CoP discussions and interviews are presented in this section. It starts with themes that relate to the three key principles of the Safe & Together Model: partnering with the non-offending parent; pivoting to the perpetrator; and focussing on children and young people. This is followed by further themes of significance to the *STACY Project*: worker safety in the context of parents' intersecting complexities; collaborative working at the intersections of DFV, MH and AOD; and key issues arising from the ongoing process evaluation of the Sydney-based organisation, Jannawi. As an exemplar of an all-of-family approach to working with families where there are intersecting complexities, its ethos fits within the ethical framework provided by the S&T Model. The final theme, capacity building practice change, is one that does not relate specifically to a research question in this project but one which is integral to driving and sustaining practice improvement.

In this section, data is drawn mostly from issues raised by practitioners and occasionally from discussions with senior managers who were involved in PAG meetings. Their identities are protected and only indicated by the type of work or program they are engaged in. Insights and case studies, however, provided by mothers, young people and fathers who were interviewed, are also incorporated. Names have been changed and elements of client narratives have also been altered to ensure anonymity. All practitioners whose roles or views are presented within a client's narrative were involved in implementing the Safe & Together Model, even if they were not directly involved in the *STACY Project's* CoPs (for example, they may have been *STACY* 'secondary participants' or exposed to Safe & Together training as a result of participating in the *Invisible Practices* research project or their organisation's commitment to practice change through implementation of the Model).

4.1. Partnering with the non-offending parent/adult survivor

One of the core principles of the Safe & Together Model, and of a DFV-informed approach to child protection issues, involves practitioners partnering with the non-offending parent/adult survivor, most typically the mother, as the default position. Partnering, in and of itself, is a familiar technique to most social work and allied practitioners whose primary work is with survivor-victims of DFV. Whilst statutory child protection is shifting increasingly toward partnering, practice still relapses to a focus on mother's poor parenting, and her struggle with MH and/or AOD issues, with the father's role as perpetrating parent disappearing from practitioners' view. This is particularly so in complex family circumstances where both parents have MH and AOD issues and where multiple agencies are involved. Without partnering, another of the Model's core principles, that children heal and develop best when they are kept safe and together with the non-offending parent, is compromised (Humphreys, Healey & Mandel, 2018). At the same time, partnering must also be undertaken in conjunction with pivoting to the perpetrator, a discussion of which follows (see section 4.2).

In this section, discussion about shifting practice toward partnering more effectively with the non-offending parent, in a move away from 'failure to protect' approaches, is arranged around three sub-themes: holding to process; sitting with risk; and partnering across agencies. Each theme is explored through a case that a practitioner presented for discussion during a CoP. Each case, presented from three different practice perspectives (and edited in the interests of brevity), has been chosen randomly from each research site. The issues were common ones that arose across the sites and throughout the discussions and interviews; each case, therefore, is representative or encapsulates significant techniques required to partner.

4.1.1. Holding to process

Whilst practitioners understood the principle of working in alliance with the adult survivor, the complexity of families' circumstances whilst operating in an imperfect service system was frequently challenging. As one CP practitioner put it,

> *our…dignity-driven practice…fits well with…[the Model]…There is a whole module of training on partnering with non-offending parent and changing practice; not doing our usual thing of swooping in and saying mum's not protective so the kids need to come into care. We are committed to using the framework…* (CoP#1-S2B-CP)

The following case study from an AOD practitioner's presentation illustrates several challenges to holding to the process of partnering and endeavouring to keep children with the adult survivor, if at all possible. At the time of the case presentation, the AOD practitioner had only sketchy information about the patterns of coercive control and actions taken by the perpetrator to harm child and adult members of the family.

The presenting practitioner began with the following information, focussing on Lara's psychiatric history and psychological functioning.

Lara is in her 20s and is in a relationship with Jez who is in his 40s. She has had four children (aged 5, 4 and 7 months old) all of whom have come to the attention of CP. An older child with disabilities (possibly violence-induced) died at the age of seven whilst in care. CP had placed the two current oldest in kinship care with different family members. Lara had experienced DFV in her family of origin as well as from Jez and previous partners. CP has had concerns for her children that relate to parental MH, AOD, DFV and risk of sexual harm. Lara was identified as a 'person causing harm' after allegedly being coerced into performing a sexual act on her (now deceased) child. She had also been diagnosed with PTSD, depression, anxiety and possible borderline personality disorder.

Jez, like Lara, had grown up in a family where there was DFV, MH and AOD and he has a history of violent DFV perpetration towards previous partners with whom he has had several children, as well as to Lara and her children. He has been imprisoned for unknown offences, and has a history of cannabis, opiate, alcohol, and methamphetamine use leading to several hospitalisations for drug-induced psychoses and 'bizarre' behaviour.

Lara and her partner, Jez have only recently begun living together again, with CP approval, after a period of separation owing to his violence and breaches of protection orders, escalated by his AOD use. Lara is now pregnant to Jez, with their second child. Although there are no reports of direct physical harm to the youngest child, a health practitioner has concerns about the safety of and risks to Lara and the baby in utero given that Lara's explanation of the physical injuries do not appear to match the evidence. At the health services behest, Lara disclosed her pregnancy to CP who created a new plan that included referral to family services to work with both parents albeit separately.

Then the practitioner used the Model to present some further information specifically about Jez's patterns of coercive control to harm children and Lara's efforts to promote child safety. In terms of the latter, it included: reframing her history of 'disengaging' from AOD, MH and family services as a protective mechanism for herself and her child when she sensed Jez's escalating DFV; and Lara 'reading' Jez's behaviours and responding carefully in order to keep herself and the child safe and having 'difficult' conversations with Jez by going for a walk to limit eye contact with him so they can go their separate ways if conversation becomes heated.

Through this partnering work, practitioners contextualised Lara's struggles with AOD and MH by highlighting Jez's interference with Lara's life; for example, causing her to miss several MH appointments and interfering with her AOD treatment by providing 'take away' methadone. They were also able to better understand Lara's minimisation of Jez's violence towards her that made it difficult for her to 'engage' with services and be open with the health service about the source of her injuries because Jez made her feel responsible for his use of violence.

(CoP2B-#2-AOD)

Practitioners found the issue of 'mothers' disengagement' from services or their 'disappearance' from contact with services troubling if not challenging. Through CoP discussion, practitioners who might frequently use the language of maternal 'disengagement' began to re-cast their language and thoughts by thinking about what the mother might need to hear to reduce the risk of her disengaging with them. As the case of Lara demonstrates, re-casting their approach enabled them to understand that what was negatively communicated as 'disengagement' might be a protective strength of the mother and thus of her care for her children. Furthermore, as the following participant's words suggest, this re-framing gives a degree of agency to and respect for a mother's difficult circumstance: "…*maybe we need to frame this as 'she's not ready' rather than 'non-engaging'. Giving control back to her [to] reflect her perspectives and reasons…*" (CoP#1-S3-CP)

Discussion about the challenges of partnering with transparency and honesty regarding mothers' often extreme experiences of cumulative trauma owing to intersecting complexities of DFV, MH and AOD (as illustrated in Lara's case) was an ongoing theme across the CoP meetings and in interviews. Child protection practitioners, for example, spoke of the challenge in being clear with mothers about what is 'required' of them:

> *One of the conversations we sometimes have about the drug screening whether someone comes back with a positive screen or not…is…wondering about…what are we asking of the parents? Are we asking them to be abstinent or are we asking them to be not using substances when children are present or to plan for their substance use.* (COP#5-S1-CP3)

> **'Maryam'**
> Maryam, an immigrant to Australia, comes from a strongly patriarchal cultural heritage in which male entitlement drives family (and public) life. Her Australian husband used this to his advantage in his tactics of coercive control. He blamed his MH struggles and lack of career progression, for example, on her failure to provide for his sexual fantasies. For Maryam,
> *…the perpetrator mapping with X [the practitioner] ….was confronting but really helped me understand his strategy and how it was affecting the children and myself. Until then, I understood the cycle of violence but once we started making the map it was…[showing me] the connections and was more visual…I have it [the map]…[it] showed me how I was affected emotionally and really helped me…it was more specified…I wish we'd done it earlier…I have a feeling…it was quite clear [what it showed about the impacts on each of use] ……it helped [in the family court]…*
>
> (I-S3-M-01)

Partnering might involve explaining why the court requires drug screening to be conducted. It might involve communicating to a mother that she might not hold to a treatment plan, that there might be hiccoughs in her progress to reduce her drug use, and that this might be owing to her partner's or ex-partner's sabotage of her efforts to do so. As another CP practitioner said:

> *If you partner with mums, mums will give you a pattern of the [perpetrator's] drug use. And then the impacts and how that intersects with the violence that he is perpetrating against her. We had a mum that would say, 'he would get money on a Saturday, buy drugs, and then when he would come down on Wednesday that is when he would attack, rape me.' … you need more than a drug screen test, you need to see how the behaviours are interacting with that and his pattern [of violence and control].* (COP#5-S1-CP4)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 45 of 106

Practitioners spoke of the value of using the Safe & Together perpetrator mapping tool with the mother as a way of helping her to overcome the sense of guilt that she was in some way responsible for her partner's or ex-partner's use of DFV against the children or herself. As one mother indicated, one of her practitioners used the perpetrator mapping tool as a therapeutic tool, an educational tool to raise DFV literacy, and a tool for advocacy in a family court case that led to her children being returned from living with their father to living with her (see Maryam's case).

4.1.2. Sitting with risk

Practitioners found it challenging to hold to the process of partnering and to sit with risk to adult and child survivors. In implementing the Model, there is a major challenge to hold to the process of partnering because of the imperative to recognise the adult survivor as having expert insight and knowledge into the risks and comparative safety for herself and thus her children. In addition, the different services involved with families tolerate very different levels of risk to family members when working with them.

The following case captures the resistance to and criticism of practitioners operating from different premises. It also captures the different purposes involved, however, in sitting with risk and how the attempt to keep children with the mother can be undermined when partnering across services is insufficiently coordinated and tight.

A child protection worker presented a brief precis of a high-risk case of a family in which multiple services had been involved. The Father's behaviours included: injecting Mum with a variety of substances, raping Mum, getting other men to rape her, physical assault, suffocation, and drug-dealing. He also stopped her from leaving by removing spark plugs from the car and putting sugar in the tank; gaslighting Mum; and an attempt to set her on fire. These behaviours caused a lot of trauma and exacerbated Mum's MH and AOD issues.

Mum had suspicions that her partner was also possibly sexually abusing their daughter and a previous partner of his was reportedly suspicious of him sexually abusing their daughter. Mum discovered ecstasy in her four-year old's mouth, which, according to other men, the Dad had given to her. Mum suspected he was drugging her so he could abuse her.

A protection order was taken out. Dad was incarcerated for periods of time during which time Mum's drug use stopped and her MH improved. As soon as he was released, however, his coercive control led to her resuming drug use and deteriorating MH. The children were removed six months after safety planning and engagement work had been done with Mum.

The practitioner was facing criticism from another department within their agency about the handling of the case. They had been asked why, with such evidently high levels of risk of harm to the children had they not immediately removed the children from the parents and the home; why had they engaged in the months of partnering work only to remove them anyway?

The resulting discussion within the CoP with the Safe & Together consultant focused on the need to create safety and permanency for the children and understand that if the perpetrator in a high-risk case refuses to change their behaviours, the removal of children might be the safest option.

(CoP#1-S1-CP)

The above case shows how hard it is for statutory CP to hold to the process of partnering whilst sitting with high-risk. The consultant reminded them of their primary goals of creating safety and permanency for the

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 46 of 106

children, how difficult it is to reunify children once separated from parents and how, in the reunification process, attention to parental issues of DFV, MH and AOD is subsumed ('lost') under the work involved in creating a permanency plan.

Having an open conversation with the adult survivor about the risks she perceives is essential to partnering with her, however, this must be balanced against putting too much onus on her to manage the risks. In assessing and managing risk, practitioners can only confidently 'sit with risk' when they have the perpetrator in view so that perpetrator risk management is a coordinated task involving practitioners partnering across agencies. Thus, whilst removing children may ensure their safety in the immediate time, as one CP practitioner observed in a CoP discussion, what of the mother when attention to the perpetrator lapses or does not exist:

> …makes me think that no one knows all the things that are happening in the background, which is a travesty in terms of us sharing information because who is now safety planning with that mum?...I have seen in CP where we remove children and it is like 'well what happens with mum now?' Nobody has safety planned with her. And 'the kids are safe that is our primary concern' but now mum is experiencing more violence as the risk has gone up… (CoP-S1-CP4)

4.1.3. Partnering across agencies

Adult survivors who have lived with intense or long-term abuse from a partner (and possibly ex-partners) where there are intersecting complexities of parental AOD and MH are best served by practitioners when they are mindful of how the system has most likely failed them before. It is these survivors who are most likely to be 'lost' to services or 'disengage' because of previous negative experiences. It is also these survivors who have had to manage the risks the perpetrating parent has presented to themselves and children over many years. These are also the cases that require coordinated partnership-working across agencies. The following case represents one such case.

Alex, a woman aged 50, presented at a crisis service. Unable to speak (a symptom of her trauma), Alex communicated in writing. She disclosed long-term physical, sexual and financial abuse and the sexual abuse of her (now adult) son with a cognitive disability, Sam, by her husband. She had wanted to leave the marriage for more than 20 years. The last time she tried leaving her husband, 10 years previously, her husband threatened suicide, stabbing and shooting and an ensuing hostage situation involving police evolved after which Sam, then aged nine, was put into out of home care by CP. Since Sam returned to live with his parents, Alex had been unable to take him into a DFV refuge (given the age restrictions on male children allowed). So, Alex stayed with Peter out of concern for Sam being left with his father.

She wrote about the long-term separate sleeping arrangements and that she was effectively kept prisoner in the house by her husband, though she had managed to jump the back fence to get to the service. She explained she was concerned about the father-son relationship as Peter had been forcing pornographic film watching onto Sam, now 19 years of age and a growing problem of concerning sexual behaviours. Peter was drinking alcohol and using other drugs and Alex herself was struggling with drinking. Peter's role in Alex's drinking was unknown given the short window of contact the service had with Alex and nor was it known if Sam was drinking or using drugs. Alex was concerned about having leaving Sam in the house for too long and left the service before a safety plan could be mapped out with her. She indicated she would come back the next day.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 47 of 106

Meanwhile, a police report came in detailing Alex having lunged at Peter with a knife whilst Peter had been talking to her about her AOD issues. She was excluded from home under a protection order and the case was being heard in court as the practitioner was presenting to the CoP. Alex's whereabouts was unknown, but the presenter had meanwhile learned that Peter had over 100 previous charges and a history of imprisonment. The crisis service had requested a police safety check given she would have returned home worried about Sam. A specialist DFV police unit, specialist women's and men's services, disability and AOD services were being brought in to work on the case with a meeting scheduled for later in the week with an agenda set by integrated legal services.

The practitioner was concerned about how to best represent Alex in terms of working with police especially given her level of trauma and that they did not know where she was.

(CoP#2-S3-DFV)

Practitioners were frequently faced with the challenging task of advocating for adult survivors where police and other practitioners had incorrectly identified them as primary aggressors because they had taken a 'single incident' approach when called to intervene. As one of the S&T consultants said:

> Advocating for mum is not doing the wrong thing…[you need to] sign you're doing the right thing."
> (CoP#4-S3-S&T)

Advocacy here requires practitioners to shift the focus away from such a decontextualized, incident-focussed documentation of what is occurring toward a perpetrator-pattern approach. This advocacy might involve exploring with police how they might write up the case for court so that the family history, the history over the years of the mother's protective actions and her understanding of her son's evolving vulnerabilities, as well as the perpetrator's pattern of behaviour is included. Work with other services, for example, in joint meetings and written communications, will likely involve ensuring that the adult survivor is spoken about as deeply committed to her son's safety. Involving a MH worker and strong legal advocate for the mother in order to keep sight of her trauma as part of her defence and in dealing with the ramifications of being listed as the primary aggressor in a single incident also has implications for practice.

Advocacy of the nature outlined above was understood across the sites as important to hold to when working with agencies and practitioners who see mothers' 'failure to protect or to engage' as opposed to fathers' harmful parenting choices (see the 'boxed' example of Des 'calling this out' in a joint case meeting).. It was a source of tension within agencies where there was insufficient leadership to hold to 'doing the right thing' or 'getting one's house in order' in an imperfect system where child-focussed, DFV- and trauma-informed practice is yet to take hold.

To support Mum in achieving safety, partnering across agencies is critical in order to avoid miscommunication between CP, MH and AOD when working with the mother. CP referrals to AOD and MH services require specific information to be documented and communicated: not 'here is a mum that needs help with substance abuse' but 'here is a mum that has been forced to shoot up by her partner and is in need of help'. AOD workers need this information to fulfil their mission to help her with her substance use; without their understanding that her partner is coercing her into AOD use, their therapeutic efforts will be misdirected. Similarly, the specific perpetrator behaviours that are contributing to her MH issues need to be communicated and documented in the MH referral from CP instead of writing 'here is a mum with trauma'.

> **'Des'**
>
> Des, a practitioner in an NGO that is implementing the Model across their organisation, gave a clear example of holding to the process of partnering in the context of a family case conference with CP. As the practitioner told it:
>
> *…the gains the family had made…had all been undone to a large extent and a lot of it had been undone by the father who was not living in the house. So, at the first instance of CP getting involved, within a matter of weeks of …[our involvement, CP] had a case conference. Dad wasn't there. So, they were immediately…launching into this process of, well, 'what are you doing, mum; why can't you do this, why can't you do that?' So, the whole process of the language. I basically stopped the meeting and said, 'well, okay, where's dad. Why isn't he here [to CP]?' And, the worker said, 'oh, he refused to come. And…mum had told me basically what he…[said]. So, he's told you to 'fuck off', and the worker was a bit flustered. 'Let's call it what it is. If he's telling you to 'fuck off and leave me alone, that's what you need to record…he's making parenting choices; he's chosen a parenting choice not to attend the meeting about his children. He's chosen not to be here to discuss his children's education. So, there's all that kind of stuff…and it changed a bit of a focus on some of the [CP] worker and even the case planner that was chairing the meeting started to think, 'right, we need to actually, there needs to be some specific task being done with him.'*
>
> (I-S3-DFV-09)

A major theme, and further complicating issue that arose in the CoP and focus group discussions, lay with the difficulties of working with MH on DFV given the different language, concepts and philosophies of services as the following quotations illustrate:

> *MH framework takes over everything else, overshadows…. even the way we look at the perpetrator through a trauma lens, we don't look at her victimisation.* (CoP#5-S3-MH)

> *Can I add another thought that keeps perpetrators invisible with MH…[It] is just the temptation to pathologise the victim's experience of DV and put a diagnosis on it and focus specifically from a MH point of view: diagnose, medicate, discharge -which doesn't hold the perpetrator accountable whatsoever?* (FG-S1-MH)

> *I think [MH organisation] needs to change the culture around working with DV. For example, the perpetrator using attempted suicide as a form of control with women. MH workers do not understand what that behaviour means. They are not seeing the patient in the context of DV. Just looking at the presenting issue.* (CoP#4-S2A-OS)

4.1.4.   Summary

In summary, partnering with women as adult survivors with attention to the intersecting complexities of DFV, AOD and MH, involves several areas of practice: (1) affirming that neither she nor the relationship is the source of violence and abuse but rather the result of the perpetrator's behaviours and his choices to use violence and control, which need to include asking about – and documenting - his attempts to exacerbate, cause or interfere with her own struggles with MH and/or AOD; (2) asking her about -and documenting - the perpetrator's pattern of violent and controlling behaviours, their relationship to his own MH and/or AOD issues, the impact they have on each child, and on the functioning of the family; (3) assessing, validating and documenting her protective strengths, in the face of her MH and/or AOD issues, in

caring for the children and keeping the family going; (4) co-planning with her, being guided by her priorities and concerns, including in relation to her MH and/or AOD issues, her assessment of what is safe, and what is appropriate, culturally and economically, for herself and her children; (5) actively advocating on her behalf to other practitioners and agencies about her parenting strengths, based on information gathered from her, and in such a way that there can be no possible space for a decontextualized understanding of violence, for mother-blaming or 'failure to protect' language, or her 'disengagement' from services, particularly given the intersecting complexities of DFV, AOD and MH.

Partnering in a trauma-informed and survivor-focused way, which is integral to the Model, requires pivoting to the perpetrator.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 50 of 106

4.2. Pivoting to the perpetrator

The concept of pivoting to the perpetrator is based upon a perpetrator-patterned based approach, which is another of the three cornerstone principles of the Safe & Together Model and DFV-informed child welfare practice. In relation to reorienting working in this manner, the following three sub-themes were identified and are discussed in this section: invisibility, engagement and avoiding collusion.

4.2.1. Invisibility at the intersections

In the *Invisible Practices Project: Engaging with fathers who use violence*, invisibility was operationalised to include: practitioners' accounts of it, and how, they saw domestically violent fathers, and their perception of their agency's views of the appropriateness of working with this population (Heward-Belle et al, 2019). This construct has been extended as a result of the *STACY Project* to include, practitioners' accounts of if, and how, they saw the intersections between DFV, AOD and MH and whether they assessed for and recognised substance abuse coercion and/or manipulation of partner's MH as discrete tactics of power and control.

Practitioners described many situations where DFV perpetrators were intermittently seen by multiple practitioners who worked in silos, rendering invisible the interconnections between DFV, AOD and MH issues, as the following case study demonstrates:

> Cody was facing criminal charges in relation to recent assaults on his partner and her toddler. He had been repeatedly convicted of DFV offences. He uses methamphetamines (ICE) and cannabis. He has seen an AOD worker in the past mainly to prevent relapse. He has attempted suicide numerous times but there is no clear mental health diagnosis. Mental health professionals have not met with Cody as he has not attended any appointments. Trinh, (mother) has tried to separate but due to Cody's homicidal threats has been unsafe to leave. CPS removed her children and placed them with maternal grandparents. Trinh recently gave birth to a child with Cody and the family was re-reported to CPS. Cody threatened professionals and attempted to strangle the mother while she was pregnant. No services are talking to the perpetrator, only obtaining information through talking with the mother. Presenters believe that Trinh and her infant are at risk but think that their agency's policies preclude them from working with mothers while male perpetrators reside in the family home. All services involved have a different perspective on whether they children should be removed from mother's care.
>
> (CoP#1-S2-CP)

In conversations about how to pivot practice towards working with men who perpetrate domestic violence, there was a tendency to polarise and disconnect notions of perpetrator healing from notions of perpetrator accountability. This resulted in some practitioners, particularly those who worked in the AOD and MH fields, expressing the view that it was not their remit to work with men to address their use of violence and control principally because they delivered a therapeutic service. This sentiment was most strongly expressed by practitioners in the AOD field, as the following example attests:

> *The important thing to remember with the AOD sector is basically we come from a therapeutic framework. We are not there necessarily to assess somebody and talk about their children or whatever. Ours is working with that person therapeutically*. (CoP#1-S1-AOD)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 51 of 106

However, this was a view that significantly changed as the STACY project progressed, with many participants believing that they had a role to play in adopting a perpetrator patterned based approach:

> *Being a psychologist, I haven't actually had a lot of training in DV. Historically it's been a social work area. In past jobs if there was DV, I would flag, call the social worker. This has given me more confidence in how to work with violence, using the language, knowing how to document, and not allowing someone to hide behind mental illness, which I've been guilty of in the past.* (CoP#2-S2A-MH)

4.2.2. Engagement

Family matters presented in the communities of practice illustrated that many practitioners are working with highly complex and high-risk situations within a context of significant under-resourcing. Practitioners identified that despite trying to pivot their work towards a perpetrator patterned based response, they still faced significant challenges in connecting vulnerable people into adequate long term services that are domestic violence informed and provide an all-of-family approach attending to complexity. Despite these challenges, many practitioners indicated that participating in the STACY project had enabled them to make significant changes in their practices that resulted in increased engagement with men who use violence and control, as the following case study demonstrates:

CPS received a report about Sharelle, an unborn baby due to concerns about Leon's (her father's) DFV and mental health issues. Kwielle (her mother) wanted to remain in the relationship and had support from her family, a DFV worker, maternal health service and an IVO. Leon was receptive to receiving help from Aboriginal services (as an Aboriginal man). After Sharelle's birth he began working with a psychologist, a MBCP and a DFV worker. Despite tensions between professionals, they were guided by the principle that the safety of Sharelle and Kwielle were paramount. When differences of opinion existed within the care team, separate meetings and discussion were used to tease this out instead of letting it play out in front of the family, slowly chipped away at services separately. We used a lot of Safe & Together language around choices, perpetrator patterns and how this had brought the case to where it was. The DFV worker engaged both parents in mediations and the IVO was altered to allow unsupervised contact. This changed the direction of the matter to be about supporting and strengthening Kwielle as a mother whilst engaging Leon in his role as a father. Kwielle decided on her own through this process that she actually did not want to stay in a relationship with Leon, that they had very different views around parenting. Leon remained engaged with his care team working towards being a consistent and caring father.

(CoP#3-S3-CP)

Overwhelmingly, practitioners perceived that the Safe & Together perpetrator mapping tool was central to re-orienting their practice towards a perpetrator patterned-based approach. The tool was identified as a vehicle that aids in rendering visible the complex connections between multiple factors. It enabled practitioners to conceptualise and attend to substance abuse coercion and mental health coercion. They described holding this type of analysis in their mind when engaging in perpetrator patterned-based approaches, as the following account from a CP team leader illustrates:

> *I'm working to figure out what is just the alcohol, the drugs, the diagnosis and what is the combination of this with choosing to be violent. We are working on getting the conversations right … it's about having the tools in the model to use in group supervision where hopefully it's helping our*

guys to understand the 'how' of the work, more than just being told what to do, helping them make sense of what we are doing. We are running through the perpetrator's patterns of harm, how we can structure or practice our practice, developing questions for our assessments for our engagement with mum and dad about what's going on. (CoP-S2A-CP)

Participants' perceptions varied in relation to their views about the nature of the complex intersections between DFV, AOD and mental health. As the following quotes illustrate there were many participants who perceived the existence of casual, linear relationships existing across two dimensions – with the most common causal link constructed between DFV and substance misuse:

JS: If you fix the drugs you fix the DV

CP: It can be the other way around

JS: but not on the whole (CoP#1-S1-JS-CP)

As a corollary, practitioners described engaging men differently according to their beliefs about the drivers of DFV. Illustrative of this was an AOD worker who described how the focus of her work with perpetrators of DFV is on unearthing their trauma history rather than mapping their perpetration patterns: "*I think there is some trauma history there … to me, that is more significant in my work with him than his DV in working with his substance use.*" (CoP#1-S1-AOD) Whilst many practitioners held similar viewpoints, collaborative and respectful discussions in the relatively safe setting of a community of practice enabled practitioners to critically reflect on such ideas, particularly in relation to how they may set a context for colluding with perpetrators.

4.2.3.   Avoiding collusion

It is well documented in the DFV literature that many perpetrators of DFV deny, excuse, minimise and externalise responsibility for exerting power and control over women and children. Less attention has been paid to how practitioners can become complicit in colluding with perpetrators particularly in relation to their explanations for using violence and control. Collusion was more likely to occur when practitioners were unclear about the drivers of DFV. For example, practitioners who located the roots of DFV within 'poor relationships' were more likely describe their case plans as being based upon solutions, like individual or couple counselling that aimed to improve relationships or the perpetrator's view of relationships. When practitioners held this view, they were likely to target their interventions toward addressing individual characteristics of the perpetrator, including his 'short fuse', 'lack of emotional regulation', 'anxiety', 'timidity', or 'drug use'. Many practitioners in the AOD and mental health fields expressed a view that they feel like they are "*treading a fine line between people telling their stories and feeling heard, but not colluding - walking a fine line of challenging behaviours while trying to build rapport and engagement.*" (CoP#1-S1-AOD)

Many practitioners indicated that adopting a perpetrator patterned based approach in their work helped reduce the risk of colluding with the perpetrator's world view because it required them to continuously reflect on how the perpetrator's behaviours pave a pathway of harm for his partner, children and significant others. Some indicated that they noticed a significant shift in the way that their colleagues and teams practiced:

The Psychiatric Registrar who previously had a conversation with me about making sure I wasn't damaging the "loving relationship" between husband and wife – that doctor has done a full shift, and has been very supportive and patient. We are not discharging her (mum who was scared to return home), but I have the treating team behind me now and the conversations are entirely different. The

clinical notes are different, the wording is different. The reviews are different, so we are making progress. (CoP#1-S1-MH)

Moreover, practitioners indicated that by increasing the visibility of the complex intersections they believed that they could effect change on reducing the siloed nature of practice that can contribute to secondary victimization of women and children. Siloed practices can make practitioners more vulnerable to colluding with perpetrators because they do not promote collaborative information sharing or collective critical reflection. Many men who perpetrate domestic violence are known to 'groom' their victims, as well as the professionals who attempt to engage them in accountability and change projects. Many participants indicated that they had experienced this, as the following case study demonstrates:

Terry self-referred to a Family Support Service. He described being separated from his partner, Giselle and their children due to her alleged infidelity. Information gathering found that Terry was subject to an IVO, granted after he raped Giselle. Terry was charged with breaching the IVO. Terry's pattern of perpetration also included stalking, threatening, using others to surveil Giselle, and physically and emotionally abusing their children. Terry reported a history of depression and anxiety – for which he receives psychiatric care and medication. During a MBCP, Terry initially acknowledged his DFV and its impact but then concluded that he was the victim. He presented as very distressed, drawing much pity from other group members. He informed facilitators that his psychiatrist had diagnosed him with PTSD caused by Giselle's 'infidelity'. Facilitators observed Terry to use the service system strategically. He was calculated in using distress and suicidal ideation to elicit sympathy – particularly in the context of family court action that he initiated. There was no one body with the information - there was no CPS history, no recorded pattern of behaviour, the mother provided limited information, he was mostly the source.

(CoP#2-S3-FS)

Discussions within the communities of practice and in interviews with practitioners provided opportunities for practitioners to share ideas about how to avoid colluding with domestically violent men, many of whom are highly skilled in manipulation and deception (see Sally's case). The following quote from a senior child protection practitioner provides some ideas in this respect:

Engage in reflexive practice, see if you notice attempts of the perpetrator to collude. If this practice is noticed, usually what happens is trying not to heighten, avoidance and anxiety around asking hard questions. Have an experienced practitioner with younger less experienced investigators … senior practitioners may be better at dealing with and picking up indicators to avoid manipulation. (CoP-S2A-CP)

In the context of communities of practice, participants discussed the importance of mapping the full extent of a perpetrator's pattern of behaviour including how he may incorporate elements of control and coercion that are intricately bound up with substance misuse and/or mental health issues.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 54 of 106

'Sally'

Sally, a DFV practitioner working in a multidisciplinary team described to great effect the power of sharing the perpetrator mapping tool with other services to uncover one father's skilful manipulation of professionals.

…I had this client…[who] was getting panic attacks just from stopping the car at this house to drop the kids off [to their dad]…and seeing him, she would get into a panic and…just go blank and the children really experienced like, 'mum's crazy', you know, she's like very angry, or she, there's something wrong with her….

We were trying to work on her trauma and the panic and…on grounding strategies to help keep her calm, I realised that wasn't working…she was still feeling like she was manipulated and his pattern of coercive control was still really present… she found out…he was taking the kids to see a psychological…and there was a report written about how she was digging her nails into the kids and pinching them and screaming at them and there was this whole report written and sent to child protection. In part of the report, saying that she was unfit as a mum and the children should go and live with dad.

At this point, the practitioner took a call from CP who revealed that the psychologist's report had led to the police filing a DFV incident report to CP in which the mother was identified as the primary aggressor.

I basically sent…[CP] a whole email detailing…this is the pattern of coercive control…here has been marital rape, like sexual abuse all through their marriage, which the kids don't know about so they still think he's a good dad…there is all this sexual stuff as well as the emotional and psychological control that he still has over her.

…the client has been seeing psychologists for years and they've been trying to change her thoughts…so…we did the whole perpetrator map…I sent it to child protection. Child protection went up to interview the kids, interview her, interview the dad as well and I think with all those things, child protection could come back to me and say, actually she's pretty balanced, she never says that she doesn't want the kids to see their dad but still wants them to have a relationship with him…whereas, when they interviewed the dad, the dad was talking about how crazy she is and that she's just very emotionally unstable and…very derogatory stuff towards her.

(I-S3-DFV-08)

4.2.4. Summary

As illustrated in this section, invisibility in the context of complexity manifests in multiple ways including failing to see the connections between DFV, mental health and AOD usage. Rendering visible substance abuse and mental health coercion within the wider context of perpetrator tactics is an essential part of effective case management for practitioners from all fields of practice. Failing to acknowledge and attend to complexity can result in unidimensional safety plans that are based upon partial information. Most STACY participants perceived that they were better prepared to pivot towards a perpetrator patterned-based approach to their practice and felt that they had strategies to reduce the occurrence of collusion with perpetrators.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 55 of 106

4.3.   Keeping children visible

Children and young people are central to the Safe & Together Model in the sense that practice should hold in focus the concerns for a child's safety and wellbeing are (Mandel, 2014). This section examines how practitioners kept a focus on children given the impact of parents' complex lives on them and the difficulty of working at the intersections of DFV, addiction concerns and/or mental health concerns. It lays out findings in relation to the question: to what extent are organisations child-focussed in developing a DFV informed, all of family approach? Throughout the data, keeping a direct focus on children was given less attention by practitioners than engagement with fathers or partnering with mothers. Findings are discussed around three sub-themes: impacts on children; children's voices and collaborative practice; working towards 'safe and together'.

4.3.1.   Impacts on children

Generally, CP practitioners and DFV practitioners acknowledged the impact that DFV has on children, and the ways this may present.

> …we're seeing children going from bright bubbly happy kids to these really quiet, introverted, children, having nightmares, sleeping with a knife under the pillow. That's my struggle. (CoP#6-2A-DFV)

For Daisy, one of the young people interviewed during this research, the ramifications of living with DFV were profound (see boxed text). Her MH and wellbeing, along with her mother's and siblings was threatened by her mother's boyfriend's violence and abuse and their substance use.

Workers from the CP and DFV sectors were cognisant of the impact that DFV can have on mother-child attachment, and the long-term restorative work that may be necessary to rebuild attachment. Conversely, those in services who are not specialist DFV services and whose primary focus is on adult clients, felt that shifts

'Daisy'

Daisy is 16 years old and living independently. She is a middle child with older and younger siblings. Child protection has been involved in their lives since they were very young.

When Daisy first met Georgia, her caseworker, in 2018, she was living with her mum, her mum's boyfriend and her younger siblings. The impact of her mum's boyfriend's violence and abuse was compounded by his and her mum's substance abuse. Daisy stayed up into the night playing video games and consequently found it difficult staying awake at school. Her mental health deteriorated to the point that she disengaged from school and eventually stopped regular attendance.

Daisy's mum began working with a caseworker colleague of Georgia's that led to the mum and younger children re-locating in order to move away from the boyfriend.

This was an intensely difficult time for Daisy, but Georgia worked on stress management strategies for Daisy. She helped her in practical ways; for example, eventually ensuring Daisy's secure entry into TAFE education and in moving into independent accommodation. Whilst this meant premature independence for Daisy, one of the best things about working with Georgia was that she became her "voice" when Daisy didn't feel like she could speak to the numerous service providers involved in her life during this troubling period.

With Georgia's ongoing support, she is happier and believes her mental health to be the most stable it has ever been. She has learnt that her family gets along better when they live separately and she is rebuilding strong, positive relationships with her mother and older siblings.

(I-S3-YP-01)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 56 of 106

were needed to increase worker knowledge on the impacts of DFV on children. As an AOD worker said:

> *I heard yesterday in clinical review, someone asked has the child been directly affected? And then followed up with by being directly hit. I had to point out that they can be affected without even witnessing it. It's all Family Violence. That's going to take a long time to shift.* (FG-S3-AOD)

A DFV practitioner saw the advocacy role as an opportunity to communicate, and thus educate, the impacts on children.

> *It is not just DV on the paper or children witnessing – there are so many things that children do in that situation – they do a whole range of things. When you write the support letter the person will really get a feel about what the women and children have experienced.* (CoP#3-2B-DFV)

Without a good understanding of the impacts of DFV on children, it is difficult to operate within a DFV informed approach, or an all-of-family approach. Even when agencies such as statutory CP have a good understanding of the impacts on children, they can still be held hostage to organisational imperatives that render them vulnerable to the perpetrating parent's manipulations. For example, in one case, the father's attempts to deflect attention away from the harm he posed by making complaints about gender bias and the need to preserve the rights of fathers adds another layer of the harm done to children who are frequently voiceless or unheard:

> *Then you lose sight of the child, amongst all of that, because it gets wrapped around by the bureaucracy and people's views, in the meantime you have children or a child there, and that's when children get lost, it's when those sorts of things happen and we see it all the time, it just overrides that.* (COP#5-S3-DFV)

Children were most frequently discussed in CoP case discussions in relation to being a motivational factor for fathers' engagement or for shifting behaviours, and in relation to their removal from the family home. For example, a DFV practitioner was concerned about how they could reach a father who was 'disengaged' from services and yet had no insight into the interrelationship between and impact of his DFV and dangerous drinking on his partner and two teenage children.

The presenting practitioner described the father as having self-referred to a MBCP and, as part of the initial screening, reported his engagement with an AOD service. He wanted to be with his family but felt they needed to accept the excessive drinking (possible alcoholism) and consequent violent and abusive behaviours.

Towards the end of the MBCP, the father uncontrolled drinking and that his partner was threatening to leave. When the DFV worker said they would contact his AOD worker, he admitted that he had disengaged from the service. The latter, however, had not communicated this to the MBCP. The latter were concerned that he did not consider the children as a part of his life and that he was not taking responsibility for his drinking or for the allied abusive and controlling behaviours towards his partner and children. Whilst he owned his drinking and controlling behaviour toward his partner, he said it's been going on so long (two decades) that he doesn't know any other way. The practitioner quoted him as saying that this was "*their dynamic…so just accept it*" (with his partner).

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 57 of 106

The ensuing discussion in the COP focussed on hypothetical conversations to have with the father about the impact of his abuse of his partner and the children. Part of this conversation centred on the S&T consultant suggesting to practitioners that all practitioners involved with him, whether AOD or DFV, needed to be talking about his children; that he is staying in the relationship for his family so when he's abusive and drinking he needs to connect the interrelated impacts of these behaviours on his children. In other words, *"the children are the one way in"* to reach that part of him that might begin to think about changing.

(CoP#6-S1-DFV)

Only a few case examples were provided by practitioners detailing their direct interactions with children. The examples that were included were of interacting with children in early to middle adolescence, and included interviewing to understand children's behaviours, advocating for children in schools, and working with children's wishes around contact and reunification thereby ensuring child participation in decision making. For infants too young to participate in decision making, practitioners described working in their best interests.

In an extreme case, a CP practitioner described feeling under threat from the Children's Court to take a nine-month-old infant to 'meet' their imprisoned father for the first time. He is contesting contact with this child for whom he has shown no interest until he went to prison. He is now extending the exercise of his power and control to CP in a bid to bring the child to prison. This is a father who has been described as extremely violent with no regard for other people and no empathy for another child he almost killed, for which he was charged but never went to trial for lack of witnesses. His control over the mother is so extreme that she refused to give evidence in relation to the child out of fear of reprisal. With police and child protection in the mother's life, investigating the abuse of another child no longer in the mother's care, the mother has missed the opportunity to raise the nine-month-old at least in part owing to the father's violence and abuse.

(CoP#6-S3-CP)

The workers outlined their concerns about the risks to an infant, including that the infant was not familiar with any workers accompanying them, and the potential for the baby to experience psychological trauma from the experience. The workers aimed to vary orders to halt the prison visit, however if they were unsuccessful they planned to take steps for the baby to meet a clinician prior to the visit, who would then accompany the child. This case further highlights the opportunities presented to practitioners to collaborate more closely with child specialist mental health professionals to improve safety for children.

4.3.2. Children's voices and collaborative practice

Hearing and acting upon children's and young people's voices is critical to implementing the Model but their absence from practitioners' presentations was a source of concern. In response to a question about how to bring children's perspectives and voices into the process of working with the Model, one of the S&T consultants observed,

> If the child can say "this is how I feel" and that person [the perpetrating father] is able to sit and listen, not react, not respond and not judge or push-back, then we can have that child there to start heal that relationship. But our work is consistently [about] the child's voice… You want the child's voice to be present in all the conversations, but the perpetrator has to think about it, maybe talk to the children. On the [adult] survivor's side, the child's voice is absolutely present in how we operate. If the child has an opinion, we must respect that opinion and be honest with them at any age. "We know you love your dad, and at this time his behaviour is actually putting you at risk. We are trying to work with him to change his behaviours to make you safer." When it comes to working with the survivor it comes to connecting that voice with her; "What have your children said?" (CoP#3-S1-S&T)

The worth of providing a space within which children and young people can voice their views was articulately put by Elijah (see boxed text). Elijah was commenting on the difference between his experiences of interventions from the current agency working with him compared with previous experiences of practitioners not informed by the S&T Model or an all-of-family approach.

Opportunities were identified by researchers when reviewing case descriptions for workers to collaborate more closely with child mental health

'Elijah'

Elijah is 14 years old and lives with his father, stepmother and siblings. All are supported by practitioners in an agency that has developed an all of family approach and have been trained in the S&T Model.

His parents separated when Elijah was a young child and, in his words, "*do not get along*". His mother lives in a nursing home owing to a chronic illness and Elijah sees her once a month when Zoe, his support worker, helps him visit.

Elijah really appreciates the support he gets from the workers because of the way they provide advice, explain his options and respect his autonomy in making decisions. He reported that "*they are not the people that are just gonna force you to do something; that's what I like about X [agency]."* He values the fact that they treat him like a capable person rather than a child and he feels that they have helped him to improve his decision making.

In comparison to statutory CP interventions, he believes the current agency has improved his family relationships, saying that *"they made us a very happy family"*. He believes the agency has helped improve all of his relationships extending to friends, school and extended family relationships.

He attributes these improvements to the communication style of the workers in *"advising you, not telling you"*. He came to trust Zoe after just 3 sessions with her because he felt she genuinely cares (after all, she would still get paid even if she didn't care).

(I-S2-YP-01)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 59 of 106

specialists, especially in relation to including children's perspectives in responses. Case descriptions highlighted that child psychologists were linked in with children, but were not utilised in collaborative work. Questions were raised by practitioners about the specialist DFV knowledge of child psychologists, especially in relation to understanding the dynamics of coercive control. Few references to working with children were made by adult mental health specialists participating in the study. This may be an opportunity for future collaborative work, with practitioners expressing a desire to form closer ties with child and youth mental health services. Specialist child mental health worker involvement may also improve court outcomes. For example, the CP participant who presented the case where a baby was under court order to be taken to visit his imprisoned father was concerned that the best interests of the child was being lost within the complexity of the work addressing adult issues (see case sourced from CoP#6-S3-CP above). The worker was making good progress keeping the care team child-focused but had unsuccessfully attempted to get the child's mental health assessment included in the court process. The court representatives and parent representatives were opposed to including the assessment of an infant. Collaborative work between CP and specialist child mental health practitioners, that focuses on the infant while partnering with the mother, may have seen the mother in this case more comfortable with the idea of an assessment.

Future collaborative work could also involve work with schools. Cases presented by practitioners highlighted the risk to children from perpetrators in school environments, including abductions from school, disruption to schooling either directly from the perpetrators' behaviours, or indirectly from children's behavioural responses to trauma, was commonly reported.

A CP practitioner related the circumstances of seven-year-old Michael who lives with his mum after separating from her partner (Michael's father, Mahmud) who is extremely dangerous and who has serious MH illnesses and several diagnoses. Michael himself was described by the practitioner as:

> *socially behind, highly anxious, diagnosed with ADHD, ODD, and conduct disorder, and being reviewed for ASD..*

Further, Michael is

> *…terrified he [his father] can come to the school at anytime and force him away…*

> *…has heard his dad say he will kill …[his mum] if she calls police…has seen his mum scared and worries about her all the time.*

> *…feels scared when his dad yells and screams.*

Mahmud will

> *…physically force Michael into his car when Michael doesn't want to spend time with him. Michael will cry and scream, "I want mummy"…[his mum] is watching but cannot intervene.*

> (CoP#4-S2A-CP)

Participants stated that some responses from schools were blaming of mothers for children's non-attendance, with threats of substantial fines.

> *Education had threatened [the mother] …with.. [a substantial fine] …Complex situation. CP caseworker was changed and caseworker advocated for him to not attend school as he had a chronic health condition and if he got an infection, because he was on immuno-suppressant treatment, it would not*

be good for his health. But the son took advantage of it, had difficulties transitioning to high school. He also had a change of school and came back to mum with threat of fine. Also risk that her own medical needs not being met (CoP#6-S2A-FS-AoD).

Working closely with schools may be an important opportunity for collaborative work, as part of a child-focussed response.

Information sharing between agencies is now legislatively made easier if there is a risk to children (for example, under Queensland's Child Protection Act and the Victorian, Family Violence Protection Amendment (Information Sharing) Act 2017 (the Amending Act). However, this was not widely known amongst external agencies. The lack of focus on children by non-DFV specialist services with adult clients was seen by practitioners as symptomatic of a siloed system.

> *This is quite indicative of the siloed system. We didn't have anyone come forward in our AOD group to give any case examples of keeping children in mind which is a problematic area in our area or work, not keeping children in mind.* (CoP#3-S3-AOD)

For practitioners who have an already established a child-focus, there was a sentiment that their advocacy work for children's safety could be better achieved if they had a stronger understanding of the ways other agencies worked. For example, a CP practitioner gave the following comment on struggling to align their focus on parenting with suitable methods to judge parenting capacity in relation to AOD usage.

> *One of the conversations we sometimes have about the drug screening, whether someone comes back with a positive screen or not... Because you don't know anything about their parenting or parenting capacity. They could be managing their drug use alongside their parenting. So I think in the practice area people are saying 'what do we do with this?* (CoP#5-S1-CP3)

While the worker aimed to keep a focus on parenting, and subsequently the child in their intervention, their lack of knowledge around the specifics of the drug use and its relationship with parenting inhibited the intervention. This highlights a need to partner with AOD agencies to gain a better understanding of how a client manages, or does not manage, their drug use in relation to parenting. For AOD agencies, developing understandings around their clients parenting practices may assist in developing a child focus more substantively into their approaches.

4.3.3.   Working towards 'safe and together'

Gaps between child focused services and adult focused services were still highlighted in practitioner frameworks and/or descriptions of their agency mandate. For example, a CP practitioner gave this statement in outlining what a good outcome looks like.

> *That the child is safe is a good outcome. I think you have to go back to CP's mission; the child is safe and maybe mum is willing but she has not got the capacity to do it. But in the end the child is safe. If you focus on that. Sometimes you gave such intense hard multiagency work all the way through.* (CoP#5-S1-CP1)

Mission statements such as the one above highlight, the need to unpack concepts of safety, and what the phrase 'the child is safe' means to different workers, especially in the context of child removal. Some CP practitioners showed an awareness that removing children may mean that mothers are less safe and of the need to be aware of how they will keep the mother safe once the children are removed. The discussion highlights ongoing tensions in the collaborative work between agencies around whose safety is prioritised. However, there were also good examples of partnering with mothers in the context of removals in the

datasets. For example, workers described reiterating to mothers that the removal was necessary because of the perpetrators' behaviours, to mitigate feelings of responsibility of the removal from mothers.

> *That is one of those really hard cases where, at the end, the children had to be removed. But in the end you do get mum's to start to see that actually it isn't because of CP but because of his behaviours. And I think that is where we have got to with this case and with others, where we have absolutely let mum know it's not her fault that we have removed the children, and after we have done that we have kept on partnering.* (COP#5- S1-CP4)

While mothers understood that it was their partner's behaviours that led to their children removed, this did not lessen feelings of trauma and guilt at the time of removal.

Descriptions of removal were where a focus on children was most commonly reported in CoP discussions. Descriptions of removal by practitioners were far more common in relation to cases with intersecting adult complexities, than descriptions of reunification. Practitioners showed awareness that removal of the child is often positioned as the 'easier option' in their agency responses; for example,

> *It's about 'sitting with risk', and domestic violence is not okay for children to be exposed to, but we also know that we can do something rather than just taking the child out of their normal environment and placement in foster care. And there are no kinship carers or relatives to care for the child. I could have solved the problem by removing the child, I just write a care application to the court, I had the evidence…* (CoP#4-2B-CP)

Akin to the comment made above, practitioners felt that statutory CP responses contain organisational policies and foster cultures that suggest to workers that it is easier to remove children than maintain ongoing work within the family home. The S&T representative reiterated to participants that removing children actually increases the workload in cases, as the worker as to continue to monitor risk and safety to ensure reunification, but with less information about the perpetrators' behaviours, as there are fewer opportunities to interact with him.

Case descriptions across sites contained reference to unruly, abusive and violent adolescent behaviours. In some cases these behaviours were aimed at mothers, in others intimate partners of the young person. Practitioners were interested in applying the S&T Model to the violence perpetrated by young people. The S&T consultant encouraged the practitioners to instead keep a focus on the adult perpetrated DFV. The adolescent use of violence was consistently occurring in a context where adult perpetrated DFV was, or had previously occurred. Adolescents' use of violence varied across case descriptions, with some cases including behaviours with a high-level of coercive control and demonstrating a gendered behaviour pattern. While these cases had similarities with adult male perpetrated DFV, the S&T consultant encouraged participants to be aware of the power differentials between adults and children, and discouraged labelling young people as perpetrators. The consultant encouraged participants to unpack the young person's behaviours with them and to link their behaviours to their values.

Child sexual abuse (CSA) was referenced in case examples brought by practitioners. Often this was not presented as the main concern of the case, but referenced in the description of past behaviours, or in relation to rumours or concerns that CSA was occurring, but without confirmation. Descriptions highlighted that this occurred in cases with complex intersections. Following the repeated references to CSA in cases, a discussion was held with one CoP in relation to the co-occurrence of CSA in DFV cases. One practitioner articulated that this is an area of practice improvement.

> *For us, I don't think we do that well. We don't identify it [CSA], and we get confused around it. And we see it separate from DFV. So we don't see it in the context of DV. I don't know if other people*

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 62 of 106

think that, but it is certainly something we can get better on in partnering in all parts with that. I think that is something that we struggle with. I think also when the sexual abuse is occurring we can often blame her. She knew about it, and not see that she is a victim as well. And at certain training that… I did, there was quite a heated debate in relation to her responsibility. And I think it's hard because people go 'oh she is involved in it as well', in a case where mum is involved in the actual abuse. But seeing that it was his harm that actually caused her to do the sexual abuse of the child, because if she didn't there would be physical violence. So, in mum's mind that was better than the child really being physically hurt. (CoP#4-S1-CP4)

This quote highlights that there is a need to better embed an understanding of the coercive control occurring in CSA cases in CP practice. This will lead to better practice, with a more equitable focus on responsibility for the abuse. The need to document aspects of coercive control used by the perpetrator in relation to CSA was seen as an area of practice that could be improved by a practitioner.

I think from a CP perspective we are quite good at seeing all the disadvantage. I was thinking of a case… where she had a cognitive impairment and he coerced her into being part of the sexual abuse and she actually went to prison over that. And I think we can see … [all the disadvantage] but we don't document it well. So, what happens is it is almost like there is a multiple disadvantage for them to protect their children. (CoP#4-S1-CP4)

CSA cases need to be understood through a lens that recognises the fear and coercive control present that impact mother's capability to protect and may silence mothers in speaking out.

4.3.4.   Summary

Children were most visible in the data in comments made by CP practitioners, with lesser visibility in commentary from those working in AOD, MH and other services. CP and DFV practitioners demonstrated a good understanding of the impacts of DFV on children.

This section highlighted a concern amongst participants that practitioners lost sight of children when working on DFV cases with intersecting mental health and addiction issues. Children were kept in focus through language used with perpetrators to engage them in shifting their violent behaviours, and in highlighting the use of violence as a parenting choice. Using specific language in interviewing and documentation assisted practitioners in keeping a focus on children when partnering with mothers and engaging fathers. For example, using phrases like 'family functioning', assists practitioners in keeping an all-of-family approach. Similarly, engaging fathers by characterising their use of violence as a parenting choice. This keeps a focus on children and utilises children as a motivational factor in behaviour change.

4.4. Worker safety

Workers across sectors face numerous threats to their psychological and physical safety and wellbeing when working at the intersection of child protection, DFV, MH and AOD. These threats are interrelated and stem from factors within client families, the individual worker, the organisation, and the wider community. This section details risks to workers and their efforts to ensure their own safety and that of the women and children with whom they work. It begins by outlining some of the risks being experienced. It then discusses these risks in relation to worker attributes, organisational factors and the contribution of the wider community.

4.4.1. Worker safety: threats and managing risk

It is clear from STACY practitioner participants that worker safety is inseparable to the safety of women and children. Workers experiencing threats to their physical and psychological safety has implications for how they undertake and respond to their work. Social media and other forms of technology are being used to harass and intimidate workers, creating new challenges for workers' safety and increasing their anxiety:

> *One of the men is stalking one of the [agency name] members on Facebook. He's been charged in the past for stalking on Facebook; that's been one of the worker safety issues. She thought she had all privacy covered on her FB profile. He's been sharing photos of her to men in the group.* (CoP-S3-DFV)

The full use of worker names makes it easier for perpetrators to track them through social media. As reported by a family violence worker:

> *I was talking to a male perpetrator over the phone and I had him read out the resume* [interview summary] *to me over the phone…It was because I used my full name. So, my workplace's response to that was I no longer had my full name on anything; they even had to change my email address because it has my full name in it.* (CoP-S1-DFV)

Using full names is also practiced in meetings with perpetrators present and is likely to be increasing risks to workers:

> *I was at a case consult recently and was asked by the person taking minutes to give my last name, which is really distinctive, with the client sitting there, and it really didn't feel okay for me.* (CoP-S1-DFV1)

A worker from a men's behaviour change program described a similar practice:

> *If you come and observe we don't introduce you…there have been instances where the facilitator thought it was harmless to say, 'This is (name), she works at blah, blah, blah', then the client… three days later, rings them at work to ask them questions.* (CoP-S1-FV-2)

Fears were expressed about the use of tracking devices and text messages to and from non-offending parents to stalk workers. However, technology is being used not only by perpetrators of violence to threaten and harass, it is being utilised by services to support the safety of women, children and workers. For example, ankle-bracelets used to track perpetrators movements are allowing information to be conveyed about perpetrator whereabouts. One worker noted that effective use of technology is reliant upon the worker remembering to use equipment properly and argued that a buddy system was more effective in promoting safety.

Threats to workers can deter them from visiting vulnerable children and families. A CP worker noted:

> *I've met him on three occasions and since he threatened me…horrifically, I haven't gone there again*. (CoP-S2-CP)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 64 of 106

These threats can be graphic and specific:

> *He told me he'd kill me, told me he knew how to get me, that I wouldn't even see it coming.* (CoP-S2-CP)

Avoidance is not always based on conscious decisions: *It might not be a conscious issue, but it is definitely an underlying one.* (FG-S1-CP1) However, CP workers are consciously placing themselves in unsafe situations in order to ensure the safety of children:

> *What we want to do is make sure the kids are safe but that does sometimes put us in dangerous situations…if we didn't, then we are going home not knowing what is happening to the kids; that is worse.* (CoP-S1-CP1)

As previously discussed, the Safe & Together Model encourages partnering with women rather than holding them responsible for 'failure to protect', a position more likely to result in child removal. However, allowing children to remain in the home raises workers' fears and anxieties and drives reactive practice. As reported by a CP worker:

> *We get angsty and revert to status quo and things don't change. For us, that's when we take kids into care that we don't need to.* (CoP-S2-CP).

Removing children and taking "*power out of the victim's hand*" is also emotionally taxing (CoP-S3-CP):

> *When people are using the (Safe & Together) Model and working collaboratively and doing their best and the children are still taken away, that feels heavy.* (CoP-S1-CP-1)

4.4.2.   Individual differences in managing risks to worker safety

A range of factors within the individual were seen to be implicated in experiencing threats and managing physical and psychological safety. Workers' own assumptions and values were seen to potentially increase risk through over-estimating their own power and ability to manage a difficult or dangerous situation, rather than acknowledging that a task may be better or more safely performed by another worker. Some practitioners suggested that workers' own childhood experiences contribute to the risk of emotional or psychological harm. For example, an AOD practitioner stated

> *This particular worker had a really traumatic upbringing and he could see his dad's behaviour in this father, very controlling and manipulating in this space, emotionally quite violent.* (CoP-S3-AOD)

Gender was noted as a factor in worker safety. The presence of a male worker can engender jealousy in a male perpetrator who may respond with increased hostility toward an individual worker. Male workers can also feel safer in undertaking work with perpetrators of violence: "*I always feel safe, but that might be a privileged position as well; being a male, I can feel a bit safe.*" (FG-S1-AOD). It was noted that assumptions can be made that female workers may not be able to equally hold male perpetrators of violence accountable; however, this was disputed in CoP discussions with some countering such a view by arguing that strategies can be learned to engage with men.

Anxiety was reported to be higher among young workers who lack skills in engaging with men: "*When you are an inexperienced worker…you don't want to create more harm*." (CoP-S1-FV-2) While theories, training, supervision and discussions with supervisors and team leaders are helpful, safely engaging with perpetrators of violence was seen to be largely dependent on experience acquired on the job, which takes time. As one practitioner sad:

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 65 of 106

At the end of the day, it is one of those things you have to learn on the job. How far can you push that conversation and when you have to pull it back in to make it safe for women and children. (CoP-S1-FV-2)

Psychological harm for some workers arises from "*racism on a weekly basis*", (CoP-S3-CP), which was described as "*happening but hidden.*" (CoP-S3-CP)

4.4.3.   Organisational factors in managing risks to worker safety

Workers at the intersection of CP, DFV, MH and substance use conduct their duties in a range of settings. These include offices, which were seen to be safe, prisons, which can confer some safety, and homes, which are understandably considered a risky environment. There was acknowledgment by practitioners that CP workers are more at-risk, largely due to role and mandate, which includes the need to conduct home visits. An AOD practitioner reported:

There may not be as many situations arise where we have to feel threatened or unsafe because we're not making any direct challenges, we're not threatening to take away any children. (FG-S1-AOD)

Similarly, a DFV practitioner stated: *We are in the safe end of it, really; we have so much around us that keeps us safe*. (CoP-S1-FV-1)

Workers use protocols for physical safety and implement a range of strategies such as keeping in touch with each other, holding meetings with perpetrators of violence in the office, and locking doors when alone in the office. However, adherence to protocols was seen to largely depend on resourcing, including the availability of colleagues:

The CSO [community service organisation] was going to go, but could not go, so I went by myself. He [perpetrator of violence] had an ankle bracelet and I'm thinking, gee, I don't know if I should be here by myself. (FG-S1-CP)

In additional to physical safety, differences in psychological safety were evident within and between organisations, depending on the role undertaken. As noted by a worker from a DFV service:

I think it is different for those who work in the crisis team. The kids' team, we work with the children, but we aren't always hearing all the stories. (FG-S1-FV-1)

The psychological impact of the work was seen to accumulate with time. Anxious workers may not be given adequate opportunity to debrief with supervisors:

How do I know he doesn't know where I live now? There was no debriefing about it. If anything, it was a bit like, 'just settle down'. (CoP-S1-CP)

Such silencing of experiences was seen to stem from organisational attempts to control anxiety among staff:

On the ground, it's probably not communicated or shared because it is a taboo subject. Across the state there are so many stories of police sieges, parents coming out with guns with child protection are there, lockdowns…and nobody really shared it and I think that contains some of the angst around worker safety. (CoP-S1-CP-1)

A culture of acceptance of violence towards workers in CP work was compared with responses from other government services with lower levels of tolerance:

You go to places like Centrelink and there are posters saying, 'We expect respect'. Then it's just commonplace at child protection to be in lockdown and you can't go to the bathroom. (CoP-S1-CP-1)

Staff who have been in their roles longer may contribute to an organisational acceptance of threats to safety: "*The ones who have been here longer just go, 'Oh yeah, it's part of the job'.*" (CoP-S1-CP-1)

Casualisation of the workforce compounds workers' reluctance to express concern for their own safety when engaging with perpetrators of violence. As reported by a child protection worker:

They are all temporary positions, so if they cause too much angst, they are going to lose their jobs when the next contract person comes in. (CoP-S1-CP-4)

Silencing of workers is not limited to CP organisations; a similar comment was made by a DFV worker:

I have spoken out fairly boldly over the years as I've been shocked about the absence of safety for workers and have been shot down in flames. (CoP-S1-FV-1)

While the imposing of boundaries was understood to be a means of containing anxiety, denial of workers' experiences does little to allay fear and/or anxiety. A MH worker reported:

We were very unsettled by that experience; it was awful. It was frightening. We didn't know if he was watching us the whole time. When we came back and told supervisors it was a bit like, 'That didn't really happen.' It wasn't taken seriously; certainly, the team leader didn't. (CoP-S1-MH)

Vicarious trauma is also reportedly not discussed. Inhibiting discussions about workers' experiences and feelings was considered to contrast with trauma-informed principles and practices and to act as a barrier to learnings that could potentially improve safety: "*They miss that other side of it by containing and not sharing that information.*" (CoP-S1-CP2) Some participants reported that they thought senior management and team leaders needed to fully understand the experiences of staff: "*They need training, they need to get informed about what it's like on the ground.*" This practitioner argued that this training should be extended to human resources departments so that staff understood the nature of the work being done by their organisational colleagues.

It was noted that worker safety and child safety occur in a time-consuming, pressurised environment in which workers, "*…don't get a chance to step back and think of other things that would be helpful*." (CoP-S3-CP) Some of this is due to excessive workload, "*…driven by the Department and their expectations*" (CoP-S1-FV-1), which compounds difficulties for workers and leads to burnout, but this is not sufficiently acknowledged "*at the top.*" (FG-S1-FV-1). It was also sometimes noted that front-line practitioners were working in a context where there were few resources for their clients. This included lack of social housing, lack of employment opportunities, inadequate social security benefits, few services to refer to particularly in rural and remote areas. The frustrations of working in these contexts can also undermine the wellbeing of workers and can mean that they have little materially to offer the families with whom they are working.

Despite the challenges, positive organisational responses were also commented upon. Some organisations provide staff with external supervision and access to free counselling, which were seen to be helpful in reducing work strain. Some workers reported feeling well-supported by their managers and senior management. This support includes resources such as use of different cars to drive home in order to make tracking of workers more difficult for perpetrators of violence. A justice worker commented: "*I've never had a particular issue with how we manage safety here.*" (CoP-S1-JS-2)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 67 of 106

4.4.4. Collaborative efforts in promoting worker safety

Members of the research team asked CoP participants about how safety is negotiated, particularly in collaborative efforts when working with women who are not in a position to leave partners who use violence and control. However, privileging worker safety can sometimes be at the expense of adult and child survivors' safety, as the case in the boxed text illustrates. In this instance, collaborating with CP and police might have enabled the midwives to ensure the wellbeing of mother and child post-caesarean, provided useful information for assessing and managing perpetrator risks to the family, and avoided potential deepening of the new mother's isolation.

Collaboration with police can be instrumental in promoting worker safety, yet threats are not always reported or acted upon and effectiveness can be undermined when cases are transferred, and information is not conveyed. As a CP practitioner said:

> *The case got transferred and then the parent actually assaulted a worker, down here, outside on a supervised contact. He assaulted the worker; that information [about the violence of the perpetrator] was not passed on*. (CoP-S1-CP-2)

Current court processes are problematic in that they require a statement to police by workers, which includes their full name:

> *They (police) explained they could get a … [protection order]… not just for me but for the agency, but I would have to make a statement, which he would be given, and aware of who made the statement, and he would know my details, so that I'm not protected. We were advised not to do it.*

Lack of feedback and poor documentation are additional barriers in communication with police that potentially increase risk to workers.

4.4.5. The role of the wider community in managing risks to worker safety

The emotional impact of the work was seen to also stems from perceived criticisms and judgments directed at workers by sections of government, including the courts, and the wider community. A culture of blame for adverse outcomes, such as the death of a child, can propel workers to take risks with their own safety. This 'blame ideology' tends to be directed at specific sections of the workforce, most notably child protection

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Home-visiting: negotiating worker safety without endangering survivors

A CP practitioner reflected on the following case in which a mother had given birth by emergency caesarean. During her stay in hospital, she revealed that her partner was violent and abusive towards her, which was made worse by his use of drugs (unspecified).

On release from hospital, midwives refused to visit her at home because of the DFV she had disclosed. She had no other family and she had no car, as her partner had taken it. When she needed to return to the hospital two days after discharge, she had to come with her newborn by public transport.

The practitioner was concerned by the catch-22 situation: concern for the mother's and baby's safety in the face of safety protocols that the midwives were required to abide by and which prevented them from home visiting.

The question raised in discussion was: why could not two workers and police, for example, have accompanied the midwives to do a home visit for this mother?

(CoP#5-S3-CP)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 68 of 106

services. It was noted that, in such instances, workers may not have the support of their organisation: "*People do get blamed when things go wrong.*" (CoP-S1-CP-3)

4.4.6. Improving practice: worker safety and wellbeing

Numerous suggestions for improving staff physical and emotional safety were made. Consideration for physical spaces such as the design of office spaces and provision of parking spaces away from where workers could easily encounter perpetrators of violence could improve safety. More widespread application of the practice of making photographs of perpetrators available to workers could be helpful, particularly on home visits where the identity of people may not be known.

Understanding perpetrator tactics and patterns of behaviour, core features of the Safe & Together Model, were also considered instrumental in containing worker anxiety and in not being manipulated by perpetrators of violence into taking inappropriate or untimely actions, which could jeopardise the safety of workers or the women and children they seek to protect. Sharing of information and debriefing with colleagues were regarded as important for emotional wellbeing. Debriefing can de-escalate anxiety by allowing perpetrator patterns of behaviour to be understood: "*She was being tracked…so we broke it down and focussed on whether he tracked anyone else besides her (partner) and he wasn't.*" (CoP-S1-CP) While debriefing was considered important, it was reportedly not supported "*from the top down*". (CoP-S1-CP) The support of team members was seen to be effective in supporting worker physical and emotional safety and in reducing staff turnover:

> *If you think of other services in other areas that don't have that really strong team support, that debriefing and coping, you see a high staff turnover.* (CoP-S1-CP2)

Extending partnering to interagency collaboration, much in the same way that the Safe & Together Model promotes partnering with women or non-offending parents was recommended as a strategy for improving worker safety. The consensus within one CoP discussion was:

> *If we were to extend that … [partnering notion] further and partner with each other, not just communicate, collaborate, but really partner, we might gain some traction.* (CoP-S1-RT)

4.4.7. Summary

The safety and wellbeing of workers are primary considerations for effective work at the intersection of DFV with the issues of MH and AOD. A number of issues need to be addressed to increase the sense of security that workers need to work with the different members of the family where violence and abuse is present. These strategies could include: policies and procedures for dealing with stalking and harassment via social media and the induction programs and staff training to ensure implementation. Collaboration with police will also need to be more fully considered as current processes can increase worker visibility and risk. The suggestion that photographs of perpetrators of violence are made available to workers was one which held resonance with practitioners. Similarly, the protection of staff identities through not using their full names including on legal documents that would be shared with perpetrators of abuse was also highlighted.

The important role that organisations held to ensure worker safety and wellbeing was emphasised by practitioners who could cite many cases where they felt that senior managers minimised the risks to their safety and wellbeing.

4.5.   Collaborative working at the intersections of DFV, MH, and AOD

The STACY project explored the intersection of DFV, MH, and AOD problems through the case examples bought by senior practitioners to Communities of Practice. In particular, the focus of the STACY project explored how the perpetrator of domestic and family violence could be held in view when there were other problems of AOD and/or MH. Furthermore, was it possible to recognise the impact on children in primarily adult focused services?

This section of the report focuses on developments, facilitators and enablers of collaborative practice at the intersection of DV, MH and AOD using the Safe & Together Model where children are involved. A framework for collaborative practice developed through the PATRICIA project is used to explore the issues which were of central importance to practitioners working with these complex families (see Appendix 6.2).

It was clear that the work between organisations lay on a continuum, with a starting point that recognised that these problems may co-occur, through to active forms of collaboration. Alcohol and Other Drug agencies and MH services were not involved in the STACY project unless they recognised that domestic violence was a feature of many of the families they worked with, hence there was some assumption of co-occurrence.

> *Being a drug and alcohol counsellor, would you deal with it like you would a habit around drug and alcohol? If you want to break that habit, you have to notice it [DV].* (FG-S1-AOD)

> *I think that every man that we work with there's some intersectionality [sic] with that man around AOD and FV.* (CoP#4-S2B-DFV)

However, co-occurrence did not necessarily lead to collaboration with other services, nor taking on the different perspectives that might inform practice, particularly in relation to working with DFV. The case example that follows demonstrates there is co-occurrence of DFV and MH issues, but little collaboration at the intersection of DFV and MH. This was owing to the fact that the DFV perpetrator was ignored in the face of the woman's MH issues.

A woman had been referred to a mental health service and had been seeing a counsellor for five months. She had been given an ultimatum by her partner to stop opiate replacement even though she was stable when taking this. He had stopped using opiates a few years earlier. The woman had made several suicide attempts since adolescence. She had a suicide pact with her mother when she was 18 in which her mother died but she did not. She was well engaged with the service system.

There had been a serious incident of domestic violence where her partner strangled her. This has been described as an isolated incident, however the presence of historical and ongoing emotional and psychological abuse is constantly noted. The couple have two sons aged three and five-years-old. The partner is very academic and articulate. He gets involved and is very controlling of her treatment, frequently contacting her workers. He focuses on her suicidality and risk, and the impact of this on their children. Possible issues with him and his parenting are noted, but he constantly shifts focus to the mother's suicidality. He tracks her movements and doesn't allow her to go out without knowing where she is. he gives ultimatums frequently, focusing on her MH, deficits and inability to function as both a mother and a partner.

(CoP#1-S3-AOD-case4)

The case illustrates the ease with which perpetrators of violence can shift the focus when organisations do not see themselves as engaging with the issue of domestic violence, and specifically its perpetration. It is equally clear from the case that both the woman's life and that of the children may be profoundly affected by coercive control and at least one incident of serious violence. These issues are not being addressed in the understanding of the women's mental health issues, nor in the lives of the children involved.

4.5.1.   Leadership

Leadership to shift organisational culture to become more domestically violence informed was not necessarily the most commonly cited issue, but it provided the essential backdrop to reform:

> But [a] strength has been [senior manager who], is extremely enthusiastic, living and breathing, pulling [AOD worker] and me along. Have you followed up etc.... The exec manager, he says, 'Yes roll it out to all staff, mandated training, going with it'. It been a breeze... I can't believe how hard we are willing to work to keep this going. (CoP#5-S3-AOD)

While leadership was considered to be central, it was not the only way of shifting organisational culture:

> We just happen to have in this region the right RED (Regional Executive Director) ...they are the people that are really pushing S&T, so we had the right supporters from the top, but we also have lots from the bottom. We are really quite bottom up in this office as well, so it's taken both the top and bottom to really support the CoP and S&T... (FG-S1-CP)

The importance of senior leadership was highlighted when workers did not feel they were supported by senior leadership:

> Debriefing around the frustrations in changing the culture of practice is difficult and challenging. Senior leadership is important, and I don't feel I have this right now. Oversight at a senior level is lacking. (CoP#2-S3-CP)

Strategies were used to embed cultural change in organisations and could only be undertaken with senior management support. It was notable that internal changes were easier to achieve than those between organisations.

> Yeah, we've made it [S&T model] a monthly team agenda item. So the idea is to bring what can be talked about here [CoP] and feed it back to the team. But it is also a chance for our team to speak as a whole connecting to the system. (Qld CoP1 – AOD)

An issue for leadership lay in whether change could be sustained beyond changes in champions for the reform.

> So, if the 4 of us weren't working anymore –would the culture remain? And what steps can we put in place to ensure that goes beyond those who are in this CoP, and those who haven't had the opportunity to get to know each other. We are going to have a 6-8 weekly catch up where the leadership team commit to meeting and having that strategic conversations and giving each other updates on each other's service. (CoP#3-S1-CP)

Interestingly, there were few examples provided of meetings between senior managers in different organisations to develop collaborative strategies between DV, CP, MH and/or AOD. Joint training between DV workers in one organisation and AOD workers in another was an exception rather than common practice.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 71 of 106

4.5.2.   Information Sharing

Information sharing was the collaborative strategy that most engaged practitioners, significantly outweighing all other facilitators and barriers that were discussed at the CoPs and focus groups. One of the S&T consultants highlighted the issue succinctly:

> *Who has eyes on the perpetrator and how are we approaching that perpetrator? Even though I might be the person responsible for mum, or for the child, I think it is a responsibility for every organisation, every agency to have some knowledge of who is connected, and who has eyes on the perpetrator and who is collecting information on the perpetrator* (S&T consultant).

Many examples of the dangers of lack of information sharing and separation of services were provided in CoP discussions across the sites. This suggested some recognition of co-occurrence but not of collaborative practice. As the following practitioners observed:

> *The only thing is that … [letter from AoD] has a lot of value in a court setting. So, in this case, this dad actually had this child in his care. And if you look at his behaviours you would be amazed this child would be in his care. At that point we were worried about CSA. And what they … [the Court/AoD] are saying is 'well Dad is going to counselling and has recently abstained from drugs'. So, in that case that was all it took to get the Court on his side.* (CoP-S1-CP)

> *I was talking about how mum presented at the MH ward, and we didn't have any communication with the MH ward, so they didn't know she was in danger from her ex-partner and there was no information sharing around that. So, they were dealing with her thinking it was an AOD case and not realising that she had been living with this coercive control for years and is terrified of this man.* (CoP#2-S1-CP)

Early collaborative efforts may involve sharing only limited information and a DV-informed perspective.

> *We are good at giving information … [agreed by FV1] so we are generally fine with getting information back from other services. But AOD is our barrier. Just because of the different focus of AoD. We definitely find that's a barrier for us.* (FG-S1-CP)

Sharing information was also configured by building levels of trust between organisations and understanding the purpose or key elements of information that needed to be shared in relation to AOD, DFV, MH and children:

> *Our … [sharing] was more about building working relationships really between the DV service and us. Knowing what each other does and trusting what each other does. How that looks around referrals and safety around referrals.* (CoP#4-S1-AOD)

> *So, I think in regard to sharing, particularly in regards to AOD or MH, we may have to frame the behaviours or whatever in a way that's going to look and help them in their line of work. We have to make that connection.* (CoP#4-S1_CP)

> *It is information sharing, but the right information. So, patterns of behaviour, because sometimes people will be sharing about Mum's mental health and behaviour, but nothing about the patterns* [of perpetrator behaviour]. *It's sharing the right info. The high risk teams really help us with that. We're already doing that, and the CoP has helped us with really cementing that now.* (FG-S1-CP)

It was also raised on several occasions that information sharing needed to be reciprocal and again this highlighted a continuum of practice:

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 72 of 106

What I was thinking is we need the information as well. So, it is not just about AoD sharing with CP but we need to know what is happening with CP when we actually see that client. And that referral needs to be a full disclosure about what you guys know so we know what we are working with and we can explore those behaviours. Because let's face it if we are doing our assessment, most clients aren't going to divulge that they are committing DV. But, if we have the information in the referral we can actually explore that with them. (CoP#4-S1_AOD)

I asked specifically, but they haven't sent anything. I got completely different information to what we asked for. I asked for the safety and risk assessments. I emailed the manager, because part of making a referral should be including the safety and risk assessments. The caseworker said absolutely I'll do it, but never did. (CoP#2-S2B-AOD)

Fears were raised about information sharing and the ways in which it may compromised safety. For example, in one CoP (CoP#5-S1), extensive and useful work was undertaken with a mother using the perpetrator mapping tool. However, during legal proceedings a copy of this tool with all information was given to the perpetrator. Concerns were raised about documentation that may have far-reaching and negative effects with technological developments.

Yesterday in a team meeting we were discussing whether child protection involvement should become an alert on [X database]. … The worry a lot of people have at the moment is that if there is an alert entered it will never go away. [X database] can be seen by the viewer, the viewer can be seen by GPs and then go onto My Health Record….So people are particularly concerned about adding information as an alert on [X database] because we don't know where My Health Record is going to go and who can access it. (CoP#1-S1-MH)

And when we do inaccurate documentation it is almost systems abuse. Because it is not accurate, but in the court material she is seeing it through a document and it is there forever, the kids could see it again. (CoP#5-S1-CP)

Unfortunately, I've just been working in the child deaths review team and when there is a child death that is exactly what comes out. The families have touched all these different points and you can see that nothing has been shared. Once you get together and the mapping has been done, you can see all the high-risk indicators. (CoP#4-S1-CP)

Challenges were consistently raised about the relationship-based nature of collaboration. Workers across agencies talked about information sharing when a relationship had been built between practitioners, only to be undermined with a change of staff.

When you get someone new they don't get it straight-away, so you don't get the information which then makes things more difficult, so unless it's up the top and brought down, we'll always continue to have that because we've got people in both industries, most industries, that go after a couple of years. (FG-S1-CP)

In some ways AOD is an easier area to tackle than MH, MH is such a big beast, it's messy…and unpredictable] And newbies, to get in contact with them it's much harder..(FG-S1-CP)

Alternatively, there was a view that opportunities lay with newer staff.

Such a shift of culture in our organisation. Talk about how I did it in the past and how I'm doing it now. It makes change more okay. It is good to reflect on the complex journey. We should target the newer staff, as there is less to change. If you have been around longer, it involves shifting the bigger patterns. (CoP#4-S3-CP)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 73 of 106

The structure of MH organisations was also reported to make the engagement across services and thus information-sharing more difficult.

> *Such a hierarchy in the medical model. Our advisors are SW trained, there's not as much street cred as the medical model. There are lots of layers within MH and I think that silo is really hard, and I've found that a particular challenge*. (FG-S3-DFV)

> *I was just saying it would be helpful, as clinicians we get told do this and do that, this is a new concept and a new theory, get upskilled, which is great. But sometimes It doesn't go anywhere because managers, CEOs, executives aren't part of it. We are like puppets who get stuff to do but no one at the top is doing it, to funnel it down. It should start at the top with them*. (CoP#6-S3-MH)

4.5.3.   Shared Language and Shared Vision

A shift to a shared language including in documentation also emerged as an important foundation to information sharing.

> *I went to a (AOD) conference and there was a presentation on FV, MH and AOD and all of the differences in language between the sectors. The AOD sector comes from the psychological model, the MH sector uses the medical model, the FV draws on the feminist model. My practice is 15 years in AOD. How can we be influencing people in this space? Our use of language needs to change*. (CoP#3-S3-AOD)

> *It does, it sounds like it's broadened the focus for us. We're looking at all the elements involved, and using more descriptive language, like when we're case noting. Actually, describing what's going on rather than using broad terms, like "history of family violence". It's been a really significant shift. Probably one of the more useful things that's come out of this*. (FG-S3-AOD)

> *Having Indigenous home service here –it's really good –they're learning the [S&T] language. They invited me to speak at their women's group. I've been down and worked with their men, Aboriginal men, so I think we can develop that a bit more…They're very keen but it's about trying to get it past management level and higher up….She has two people above her that approve it and hopefully that will happen*. (FG-S1-CP)

The shared language reflected shared concepts and a different orientation particularly focused on patterns of perpetrator behaviour.

> *Two points used in CoP, help people to get accustomed. It denotes a process by using that language. 'Pattern' encourages the use of model. Has it been a single incident? …. The enquiring mind is looking for a pattern, and a parenting choice. It is a different way of speaking*. (FG-S3-CP)

> *It is a two-pronged approach. You have to learn the principles before using the model, then day to day real time conversations to use the language*. (FG-S3-CP)

> *Within my Divisional area, we have worked with a FV sector partner to create a list of family violence informed language. We have focused on integrating this language into court reports, case notes and discussions*. (FG-S3-DFV)

> *Not to confront her but to say, as an open door, highlighting that the reason things are becoming unstable is not her MH or substance use. You were saying she was sober, then he came back. She was getting treatment, then he came back. Problem is not her mental health or substance abuse, it's this guy*. (CoP#6-S2B-S&T)

However, there was a continuum and new language was proving difficult to embed.

I see mum's failure to protect written all the time in material. So, it goes back to the culture of the organisation and it's really hard to break that. (CoP#3-S1-CP)

4.5.4.   Formalisation of Practice and Policy

It was understood that formalising the processes associated with information sharing and other aspects of the S&T Model provided foundations which could go beyond individuals. It was particularly noteworthy that two sites had recently passed explicit information sharing legislation in the domestic violence area. The training and knowledge of these legislative changes was still at an early stage.

It really helped with that common language, the understanding, and then the legislation changes about info sharing with DV, has supported the practice we wanted to do (agreement from others). In the [Invisible Practices project] … we were 'well we can't share anything' whereas, now, we actually can … AOD weren't even aware of the legislation changes. (FG-S1-CP)

At the moment, there's still barriers around. People are concerned about legislation sharing and confidentiality. That all needs to be clarified at a higher level and say, "We're allowed to come together and do this". This is what the legislation says. (FG-S1-CP)

…And there are a number of provisions…that allow you to share information not just with government partners but with service providers around families as well. So, they really broadened that for the allowing of sharing of information. (CoP#4-S1-CP).

Legislation had just changed and workers getting heads around new legislation and how to tell clients. Counsellor maybe tried to explain it, but maybe hadn't quite got the message across. (CoP#5-S3-AOD)

Along the continuum of information sharing, there were examples of agreements for information sharing that had been formally agreed: "*We already have a process in place*" CoP#5-S1-CP) in relation to Intensive Family Services. However, vulnerabilities were recognised in keeping new staff informed of procedures that had been agreed.

It was not only legislation that was important to underpin information sharing. There were also procedures which were developing between some agencies re information sharing at referral.

Set up warm referrals between [DV service and AOD service], giving FV info to AOD before they come in rather than having to get the info again. Already got the background before assessment. Working with AOD to potentially provide [reciprocal] service as well, to ease the referral process so people aren't scared of referring and have us to bridge the services. Needs to happen more, ideal if that could happen with AOD and FV in [whole] catchments. (CoP#5-S3-AOD)

It was clear that when information sharing was unambiguous, such as when there was a high-risk team involved that collaboration was more straightforward.

Certainly, for the high-risk then everyone is covered under the legislation to try and share as much information as they can. And then knowing from there what can be shared back to the victim. (CoP#1-S1-DFV)

However, even when a high-risk team was involved, information was not necessarily shared appropriately.

It is supposed to be a coordinated response. But I am confused. Plans are made in the [high risk] meeting and we are working with the client and have no idea about it. The feedback loop is not happening. (CoP#1-S2A-FS)

I called our health coordinator of … [the high risk team and] was told health policy is that she couldn't tell me about who was spoken about, because if it goes into the notes her safety can't be guaranteed. So health policy is not to share information or put clients on our system (CoP#6-S2B-DFV)

While there was a focus on the issues for the intersections with MH and AOD services, there remained problems between the statutory services which seemed to require further clarification:

We cannot get orders at the moment because police are saying we don't own them, the court owns them, trying to get the matter to court and actually having evidence of the existence of a DVO, we're struggling to actually get a copy of an order. (FG-S1-CP)

We are not allowed to document that information revealed at the …[high risk meeting]. … [government health department] keeps things secret and siloed. We need to understand that and develop good responses to DV. (CoP#6-S2A-OS)

Gaining a focus on children was also an important issue that services grappled with.

*I think there is a fear of sharing confidential information, and the clients involved in doing that. But a lot of the services that are involved with parents that is their client, and their primary focus is working with their client rather than looking at the bigger picture which is the protection of children as CPs is. (*CoP#4-S1-CP)

The notion that information sharing was 'everybody's business' was clearly a cultural shift built over time and through the development of trust.

I was in the first CoP for Invisible Practices [project]*, so we started the process in that. I think that the change in our practice and everyone working together really started to change then, where we started to partner more with the police, DV services, the behaviour change programs. This one [STACY project], for me, added onto something that was already started in relation to how we actually branch that out to include AOD and MH What has changed is the partnership has changed, we are trying to get better at our info sharing, and we work together as opposed to everyone just thinking it's … [a CP] problem*. (FG-S1-CP)

So really when it comes down to it, it's going back to our team and wrestling with what is our responsibility for at least incorporating information about each member of the family? Each member includes, if I am AOD and I'm working with dad on his AOD issues, do I have a responsibility to ask him about his children? And to ask him about how his drug use and possible violence impacts his children? Yes. If I'm a MH worker and I'm working with mum do I have the obligation/responsibility to talk to mum about 'asking specifically what your partner has done to support you? What are some of those behaviours?' We are all spending a lot of time committed to this project/process –we must believe that at some level we should be incorporating DFV knowledge about each family member. (CoP-S2-S&T)

A final and important point was made about the value of collaboration from a member of the research team.

So we talk about communication and collaboration, but the missing step is that with the S&T model we have learnt the importance of partnering with women, if we were to extend that further and partner with each other, not just communicate, collaborate but really partner, we might gain some traction. That might help us be more confident in our own knowledge and in worker safety. (CoP#5-S1-RT)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 76 of 106

This section concludes with an example of a practitioner giving an update on a case they had presented at the first CoP meeting. It is a good example of how 'holding to the process' of implementing the Model and practice improvement led to greater collaboration and recognition of DFV:

Just an update on a case already presented. So I am still working with that same mum. She is still on the ward with the MH unit. What I have seen is a shift in the treating team and their perceptions. They have been really patient. The Psych Reg that had that conversation with me about making sure I wasn't damaging the "loving relationship" between husband and wife –that doctor has done a full shift, and has been very supportive and patient. We are not discharging the patient until we have found somewhere with survivor support. So, we are getting to the pointy end now. She is due for discharge tomorrow, with nowhere to discharge to –but that is ok, we are working on it. But I do have the treating teams behind me –and now the conversations are entirely different. The clinical notes are different, the wording is different. The reviews are different, so we are making progress. …. my confidence has grown and my ability to speak up, even when it is the doctors. So, I think I'm more confident to trust my own assessment and speak up and advocate for people.

(CoP#3-S1-MH)

4.5.5.   Summary

The intersections between DFV and AOD and MH required organisations and their workers to move beyond the acknowledgement of co-occurrence to addressing important elements in the development of greater collaboration between and within services. Processes identified in the PATRICIA project (see Appendix 6.2) were equally relevant to the STACY project. These included: the importance of champions or committed leaders who would support the change processes and back their workers in that process; clear processes for information sharing between organisations that allowed the perpetrator of DFV to be kept in view; the development of a shared language and vision which reflected a more domestically violence informed and child focused practice; and the formalisation of policies and procedures, such that collaborative work could continue even when key leaders moved on.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 77 of 106

4.6. Jannawi: an all-of-family approach

The following section outlines some key findings from the initial round of data collection, which is ongoing.

4.6.1. Mothers' experiences of violence from partners and/or ex-partners

Each mother interviewed had her own story of experiencing ongoing violence and control from the father of their children. All of the mothers interviewed were either separated or divorced from their ex-partners however, all reported that the violence and/or its effects were ongoing. Each of the mothers had between 2 and 3 children. All had ongoing contact with their ex-partners and all of them reported their children had regular contact with their father. Participants reported experiencing a range of physical, verbal, emotional, psychological and financial abuse from their ex-partners both during and after the end of the relationship. Participants described the ways in which their partners exercised control over their lives including isolating them from friends, subjecting them to lengthy court cases in the family and criminal courts, preventing them from working or studying and damaging their property. All mothers interviewed reported their partners had undermined their parenting and impacted on the ecology of the family. They described how their children's fathers would refuse to pay for basic necessities, refuse to participate in daily household tasks like cooking and cleaning, and leave the mothers entirely responsible for the care of their children. Mothers also described how their children's father would coerce and manipulate their children into harming their mother through physical assaults, verbal abuse and damage to property.

Several mothers commented on how their children's father had manipulated, exacerbated and interfered with their mental health and wellbeing. They reported having received diagnoses of depression, anxiety and post-traumatic stress disorder. They reported high levels of stress, hyper-arousal and hyper-vigilance and noted this impacted on their physical and mental health. They reported their partner's violence had led them to access mental health services or to commence psychiatric medication. Some of the mothers also described being called "crazy" and detailed the ways in which their partner would strategically leverage their mental health against them, particularly in making allegations to statutory child protection agencies and in court proceedings.

4.6.2. Fathers' experiences of being abusive towards their partners

The fathers interviewed described the range of ways that they were violent and abusive towards the mothers of their children. All of the fathers interviewed were separated from their ex-partners however they described their ongoing contact with the children and their children's mother. Violence was occasionally named as as 'violence' but it was also often colloquially referred to as 'my problems', 'a problem between me and my wife', 'arguments', 'mistakes I made', 'my personality problem', 'not being patient', 'my guilt and anger', 'my temper', 'raising my voice', 'being negative', 'being sick', 'fighting', being 'upset', being 'grumpy'. They described their physical and verbal assaults on their partners and their children, including incidents where police and/or statutory child protection agencies were called to the home. The fathers interviewed portrayed themselves as breadwinners, both describing how they studied, worked and earned an income with the aim to provide for their family.

The fathers interviewed described ambivalent and often contradictory perspectives on their accountability for being violent; at times they accepted responsibility and talked about their desire to change, whereas at other times they mutualised the violence and/or blamed their partners. The fathers interviewed spoke at length about their experiences of fatherhood and their relationship with their children. They were ambivalent about whether their violence towards the mother of their children affected their children's health, wellbeing and development. The fathers interviewed described the ways in which other people, including services, had alleged they had issues relating to their mental health or use of alcohol and other

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 78 of 106

drugs. Two of the fathers interviewed believed this was not true, however one of the fathers discussed at length how his violent behaviours were caused by his use of alcohol and other drugs and his mental health. One father gave his story of being in an inpatient mental health ward in a public hospital after perpetrating physical abuse towards his partner, reporting it was unhelpful and he did not feel he had any mental health issues but that his problems related to anger, his behaviours and his relationship with his wife.

4.6.3.   Children's experience of domestic and family violence and/or abuse

Only one young person had been interviewed at the time of this report, with researchers planning to conduct more interviews in further rounds of data collection. The young person that was interviewed had been placed in out-of-home-care and described his parent's separation and how their issues had affected him. He described that his father had prevented him from seeing his mother for visits until he began working with Jannawi.

4.6.4.   Family's experiences of accessing services for domestic and family violence

Each client interviewed was working with multiple agencies and organisations for support around domestic and family violence. Aside from Jannawi, families described their engagement with statutory child protection services , family support services, men's behaviour change programs, counsellors and psychologists, women's support services and refuges, hospitals, mental health services, drug and alcohol services, legal practitioners and court support workers, immigration services, financial assistance and other forms of practical support. Families described mixed experiences of these services, ranging from unhelpful to harmful to extremely helpful. Several participants described a lack of consistency, collaboration and communication between the services working with their family. All clients interviewed identified Jannawi as a unique service and contrasted the approach of Jannawi workers with other services, and particularly with statutory child protection and other family support services.

4.6.5.   Services provided at Jannawi

Jannawi provides a holistic, comprehensive and wrap-around service for whole families. Their work with families includes assessment, counselling, case management, safety planning, early childhood and developmental assessments, advocacy, therapeutic services for children and parents, therapeutic and educational groups, educational and recreational programs for children, supervised access visits and practical support such as transportation, financial assistance and court support.

Jannawi services were described as creative, flexible and centred around the needs of each family and person they worked with. Families described the centre as warm, inviting and a safe place they could come for support, advice and assistance. Workers and clients described the capacity of Jannawi to work with a family over a period of several years, and that there are no strict time limits on the period in which they can engage with a family. This allowed Jannawi workers to increase frequency of contact in periods of stress or crisis for a family (up to twice per week) and decrease frequency when families no longer needed such intensive support. Flexibility was also demonstrated in Jannawi staff descriptions of being able to meet families, particularly fathers who use violence, outside of typical office hours, or to conduct sessions over the phone. A key component of Jannawi's approach to domestic and family violence was their capacity to work with a whole family, including perpetrators, women survivors and children survivors. Many clients interviewed reported their partners, children, parents or other significant family members were also attending the service. Families were also able to be seen by multiple workers.

4.6.6.   Impact of Jannawi

Both clients and staff reported significant changes in families that work with Jannawi. Both mothers and fathers reported positive changes in their relationship, with women reporting increased safety and men reporting they better understood the impacts of their behaviour and felt they were less violent and abusive towards their families. Clients and staff also reported Jannawi had assisted them in navigating the statutory child protection system and changed the outcomes for their family. Clients described how Jannawi had supported them to re-establish, maintain and increase contact and access visits with children, especially when children were in out-of-home-care placements. Children being able to remain safe and at home with their families was also identified as a key outcome of involvement with Jannawi.

Key stakeholders from other services all described the impact of Jannawi on not just the families they worked with, but the child protection and domestic and family violence sectors more broadly. Advocacy, submitting to government inquiries and royal commissions, facilitating interagency meetings and networks, and conducting interagency training and professional development were all identified as key components of Jannawi's work in capacity-building other workers to increase their ability to respond to families living with domestic and family violence, particularly where there are additional complexities of parental mental health and substance use.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 80 of 106

4.7. Capacity building practice change

This section discusses findings from the STACY Project Questionnaire, DFV-Informed Continuum of Practice exercise and learnings from the CoPs regarding capacity building practice change. Insights into participants' views on the value of their training, coaching and opportunity to learn from each other through the CoP meetings is useful in and of itself in order to assess the worth of undertaking an action research project such as this but, more importantly, it provides some insights into thinking about how to drive and sustain practice improvement beyond the life of the research project, which will be discussed in the final section of this report.

4.7.1. Exposure to the Safe & Together Model

In the STACY Project Questionnaire, CoP participants were asked whether and how much they agreed or disagreed that exposure to the Safe & Together Model during the STACY Project had improved their practice or management of staff. Figure 11 below shows the overall responses from CoP participants.

All CoP participants who responded to this item (n=44) agreed or strongly agreed that exposure to the Safe & Together Model was improving their practice and or management of staff – none gave a neutral or unsure response, and none disagreed. This shows a positive assessment of the Safe & Together Model and the STACY Project's impact on CoP participants' practice.

Figure 11: All CoP responses - Exposure to the Safe & Together Model during the STACY Project improved practice/management
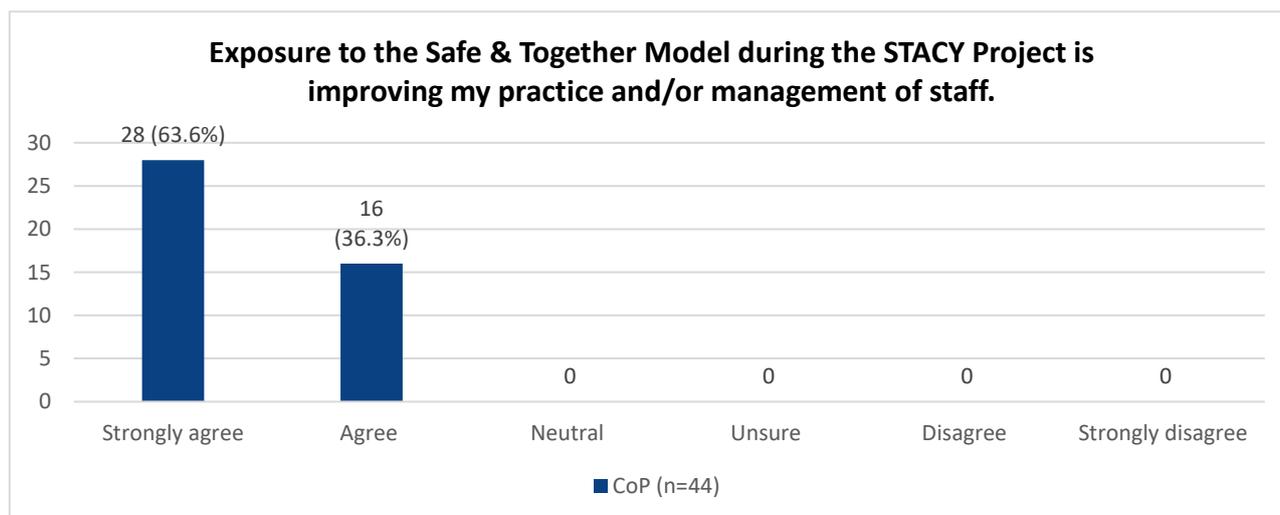
Responses to the same question are shown by program type below in Figure 12. The numbers within each program type are small (and extremely small in the case of justice services); however, in terms of the relative perceived impact of the Safe & Together Model and STACY Project across different types of services, all participants were positive about exposure improving their own professional practice and/or staff management.

Participants from CP, MH and justice services were more likely to 'strongly agree' that exposure improved practice and/or staff management than AOD and DFV practitioners who were evenly divided between 'strongly agreeing' and 'agreeing' to improved practice. Out of all practitioners who were involved, CP assessments were the most heavily weighted towards 'strongly agreeing' that their practice had improved.

Figure 12: Exposure to S&T Model during STACY - CoP responses by program type

CoP responses by program type - Exposure to Safe & Together Model during the STACY Project is improving my practice and/or management of staff

Legend: AOD (n=11), CP (n=13), FS (n=1), FV (n=10), JS (n=2), MH (n=4), Other (n=3)
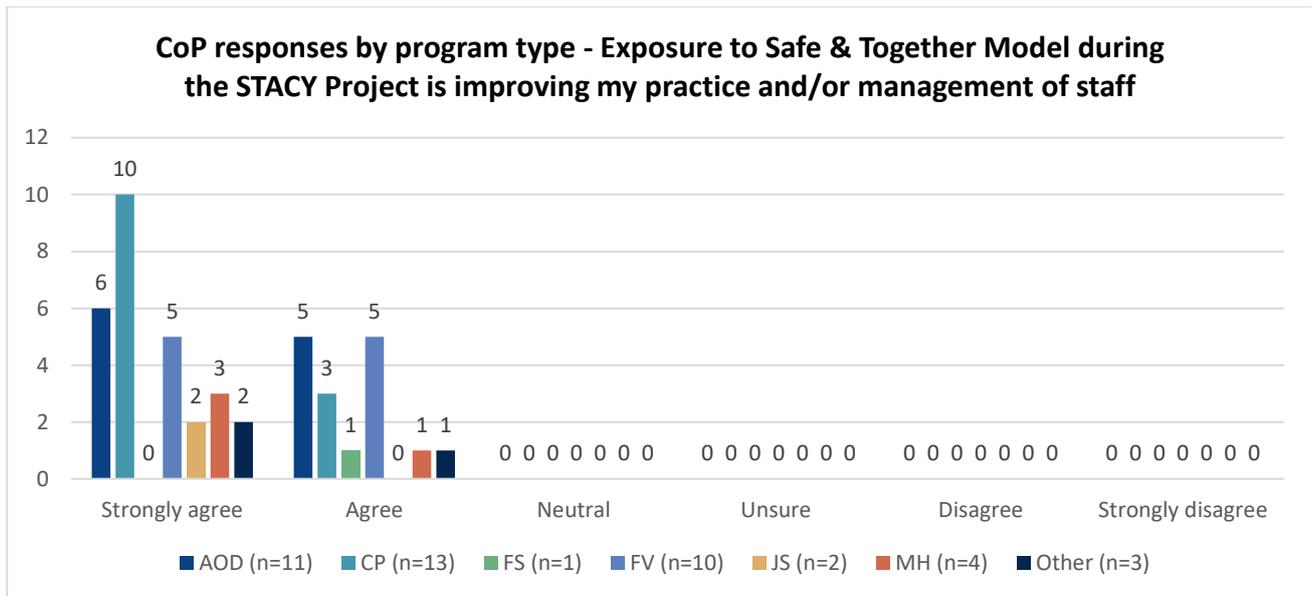
4.7.2. DFV-Continuum: Organisational and personal practice change

The DFV-Informed Continuum exercise conducted with the CoP members in each state (see section 3.6.2 for an explanation of this exercise) provided a measure of the perceived practice change resulting from engagement in the *STACY Project*, and the Safe & Together Model. For reference, the dimensions of practice in each scale were:

Scale 1   ***About the adults ↔ Integrated with children/other CPS issues***
Scale 1 moves from practice that is all about the adult survivor and their responsibility to protect children from violence, to practice where child protection (welfare) and safety is informed by a clear understanding of domestic violence and its impacts on children and other family issues, such as AOD and MH.

Scale 2   ***"Failure to protect" ↔ Perpetrator pattern***
Scale 2 begins with practice operating within a 'failure to protect' framework, where parental efforts (particularly mothers') to protect their children are judged as either sufficient or insufficient, to practice that is focused on how the perpetrator's pattern of abuse and coercive control impacts the adult survivor's efforts to parent in the context of DFV and explores resulting impacts on the children.

Scale 3   ***Fathers invisible ↔ High standards for fathers***
Scale 3 concerns practice in which fathers and their actions towards family functioning are invisible, in terms of impacts and accountability, on one end, and on the other, practice that holds fathers to the same high standards that mothers are held to in regards to family functioning and impact on children's safety and wellbeing. This includes practice that views the use of violence as a parenting choice.

Scale 4   ***Child versus adult survivor ↔ Child safety and wellbeing tied to adult survivor***
Scale 4 moves from practice that views children, including their needs and rights, as separate and often in opposition to their mother's, to practice in which both adult and child survivor safety and wellbeing are addressed holistically and in the context of one another and their surrounding family functioning.

Practitioners rated their personal and organisational practice along a simple numeric rating of 1 to 5 with 1 representing the least developed implementation of an all of family way of working and 5 representing the most developed stage, for each scale.

Using the CoP member ratings (total n=65[6]), a paired-samples t-test was conducted to compare scores on the four scales before the CoPs were run (Time 1) and after they had been completed (Time 2), for both organisational and personal practices. A high-level overview is given here with key results highlighted. See Appendix 6.1 for the detailed statistical results.

Organisational practice

Figure 13 shows the mean values for each scale relating to organisational practice before the CoP phase (time 1) and at the end of the CoP phase (time 2). Table 8 shows the mean difference and significance for organisational practice ratings at Time 1 and Time 2.

**Figure 13: Difference in mean scores for organisational practice, before and after CoP phase**
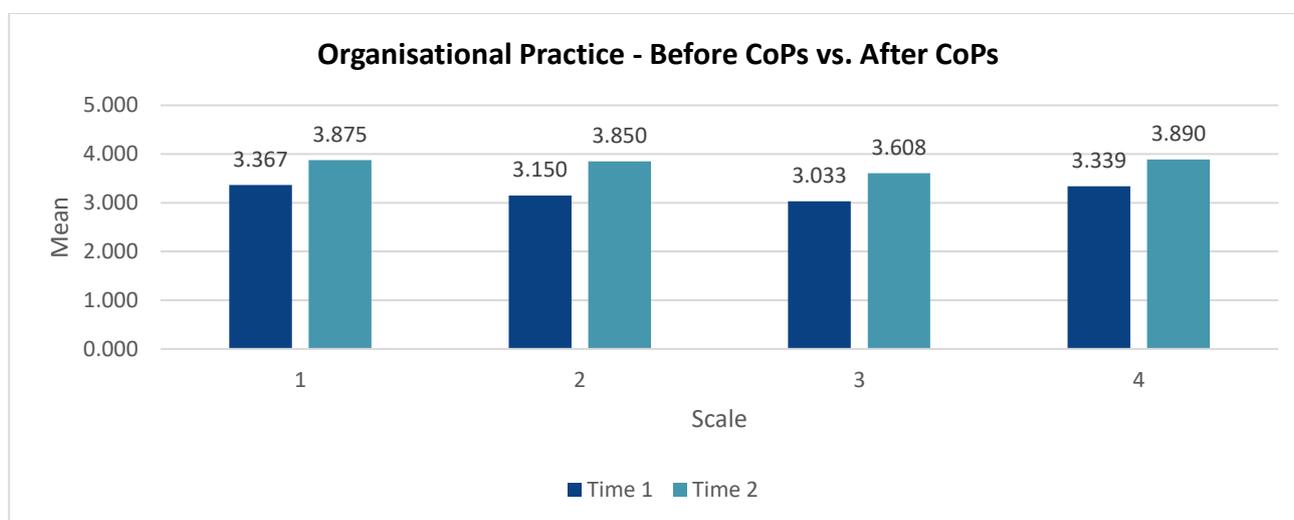
Table 8: Mean difference and significance for organisational practice T1 and T2

Scale	Mean Difference (between time 1 and time 2)	Significance
Scale 1	0.5083	0.000
Scale 2	0.7000	0.000
Scale 3	0.5750	0.000
Scale 4	0.5508	0.000

These results show a perceived improvement in organisational practice at the end of the CoP phase on all four scales, although all scale means sit below a rating that would indicate a fully developed implementation of an all of family approach. Scale 2, which concerns practice moving from a frame of "failure to protect" to practice that utilises a perpetrator pattern approach, showed the largest mean

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[6] Some tests reported with lower total used in calculations due some participants not providing a rating in some instances. See Appendix 6.1 for details on totals used in each test.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 83 of 106

difference in mean value (0.7000), indicating a larger perceived shift in practice in organisations for this dimension of practice. Scale 3 showed the next largest difference (0.5750), relating to practice where fathers are invisible to practice that holds high standards for fathers.

Personal practice

Figure 14 shows the differences in mean values for each scale relating to personal practice before (Time 1) and at the end of the CoP phase (Time 2).

**Figure 14: Difference in mean scores for personal practice, before and after CoP phase**
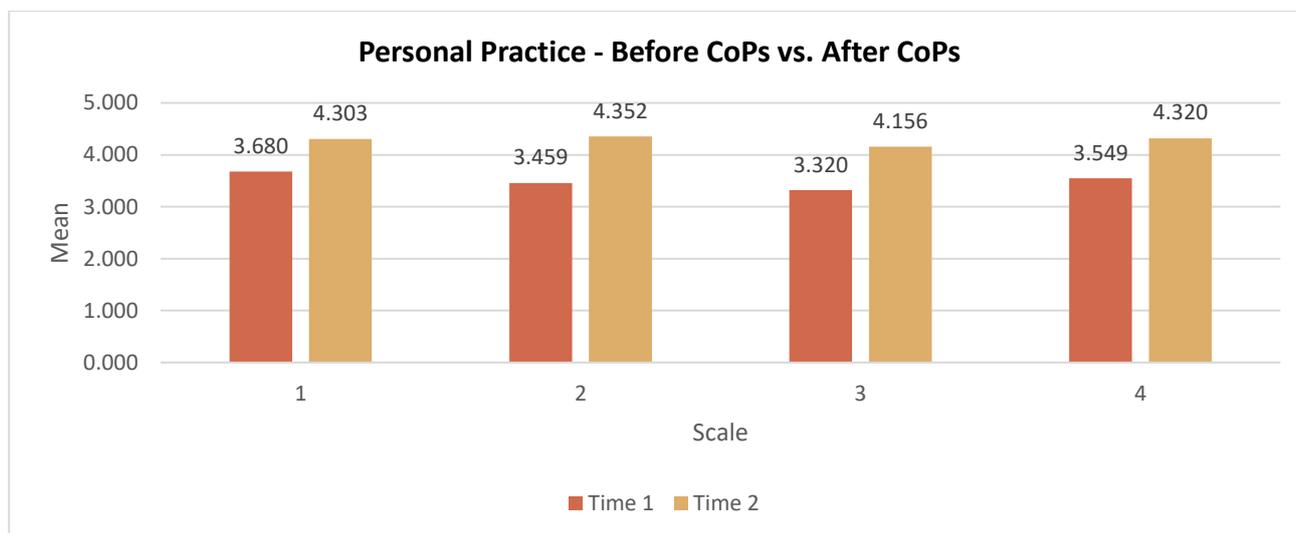
Table 9 below shows the mean difference and significance for personal practice ratings

Table 9: Mean difference and significance for personal practice T1 and T2

Scale	Mean Difference (between time 1 and time 2)	Significance
Scale 1	0.6230	0.000
Scale 2	0.8934	0.000
Scale 3	0.8361	0.000
Scale 4	0.7705	0.000

Like the results for organisational practice above, the increase in the mean values of scores at the end of the CoP phase shows a perceived improvement in personal practice by the CoP participants. Notably, this improvement is larger than that for organisational practice, with a greater significant shift across all four scales towards a more developed implementation of a child-focussed, DFV-informed, an all of family approach between Time 1 to Time 2.

Again, like the results for organisational practice, Scale 2 showed the largest difference in mean value (0.8934), closely followed by Scale 3 (0.8361) (Table 9). This highlights that the shifts in practice that require

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 84 of 106

increased attention to perpetrators' patterns, including their role as fathers in the lives of their children, were particularly salient for CoP practitioners at an organisational level and in their personal practice.

The shift from a framework of 'failure to protect' to a perpetrator pattern approach (Scale 2) is the main tenant of DFV-informed, all of family approach to practice and system's intervention, such as the Safe & Together Model. This involves simultaneously partnering with the non-offending parent, usually the mother, through focusing on her strengths and protective efforts, and 'pivoting to the perpetrator', usually the father using violence, to keep in view the impacts of his behaviours on children, the adult survivor and family functioning. This includes how perpetrator patterns of abuse and coercive control cause, interfere or exacerbate AOD or MH issues for the adult survivor. Seeing the largest perceived shift in practice for both organisational and personal practice along this scale is therefore not surprising. This is encouraging in terms of both practitioners' engagement and implementation of the Safe & Together Model in their practice, and the adoption and embedding of more DFV-informed practice in this area by organisations.

4.7.3.   Comparing organisational and personal practice

In addition to the above, paired-samples t-tests were also conducted to compare scores on the four scales for organizational and personal practices at both time points.

Figure 15 shows the comparison between organisational scores and personal practice scores at Time 1, before the CoP phase. These results show personal practice ratings being higher at the outset than those for organisational practice, across all dimensions of practice. The difference was statistically significant for Scales 1, 2 and3, but not for Scale 4 (see detailed results in Appendix 6.1.).

Figure 15: Comparison between organisational and personal practice mean scores at the beginning of the CoP phase

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 85 of 106
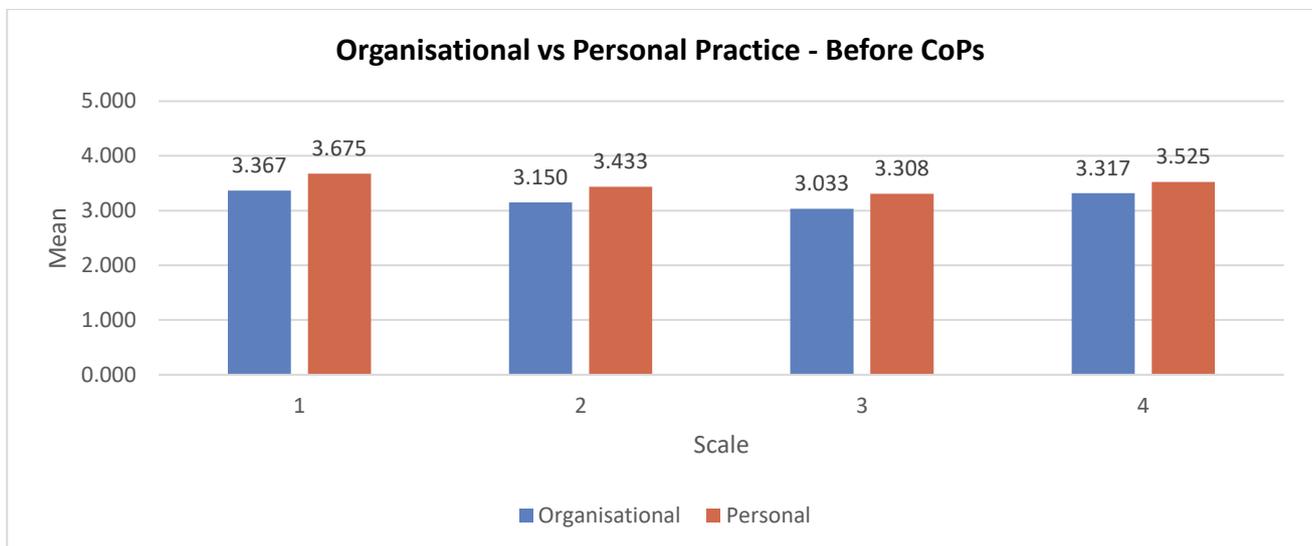
Table 10: Mean difference and significance between organisational and personal practice, T1

Scale	Mean Difference (between organisational and personal practice, T1)	Significance
Scale 1	0.3083	0.002
Scale 2	0.2833	0.019
Scale 3	0.2750	0.029
Scale 4	0.2083	0.054

Comparing these results to those from Time 2, after the CoP phase, there is a greater perceived improvement for personal practice than for organisational practice, as seen in Figures X and Table X below. The differences were statistically significant across all scales at this time point.

Figure 16: Comparison between organisational and personal practice mean scores at the beginning of the CoP phase
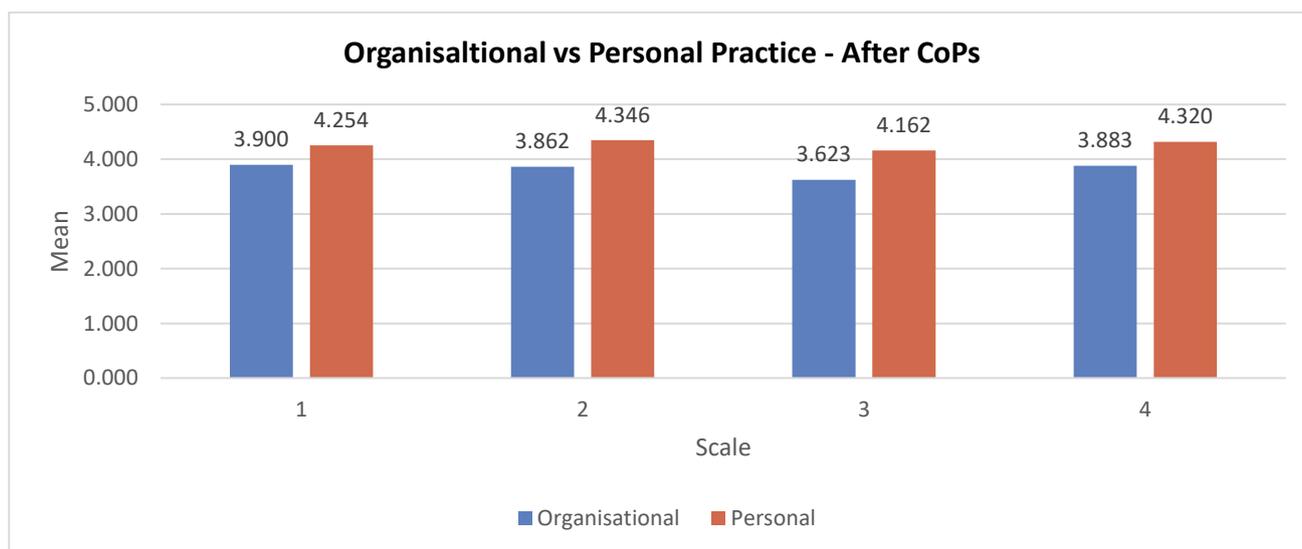
Table 11: Mean difference and significance between organisational and personal practice, T2

Scale	Mean Difference (between organisational and personal practice, T2)	Significance
Scale 1	0.3538	0.000
Scale 2	0.4846	0.000
Scale 3	0.5385	0.000
Scale 4	0.4375	0.000

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 86 of 106

These results show that personal practice was perceived to be more advanced in implementing a child-focussed, DFV-informed, all of family approach to practice than organisational practice. This was true both before the COP phase (Time 1), and after the CoP phase (Time 2).

At Time 1, before the CoPs, the largest mean difference was for Scale 1, concerning practice that was about adults only or integrated with children and other CPS issues. At Time 2, after the CoPs, the largest difference in mean was for Scale 3, concerning invisibility of fathers through to practice that holds high standards for fathers. This suggests that while initially the gap between organisational practice and personal practice was perceived to be the widest in terms of integration of adult and child issues, by the end of the CoP phase, practitioners perceived a wider gap between their organisation's and their individual practice in terms of ability to keep perpetrators visible and accountable as fathers.

4.7.4. Influencing work towards organisational practice change and capacity building

As part of the CoP phase of the STACY Project, CoP participants were asked to identify and work with a small number of colleagues as secondary, or 'influencee', participants of the project. CoP participants aimed to introduce their influencees to the Safe & Together Model and embed its principles into practice, focusing on enabling organisational practice change and capacity building towards child-focussed, DFV-informed practice.

'It's about language. For me, the language is the most important influence.' (CoP-S1-CP)

During each CoP meeting, time was devoted to discussing how CoP participants were progressing with their influencing work. Participants described and shared what their strategies were, and reflected on what the barriers and facilitators might be. The most prominent themes from these discussions are presented below for they relate to capacity building practice change and embedding a child-focussed, DFV-informed, all of family approach like the Safe & Together Model.

Focus areas for influencing practice change

In terms of the complexity of working in DFV, AOD and MH sectors siloed from each other, practitioners identified key structural and procedural areas where they felt change was needed, and where they could focus their efforts. These areas are mutually informative and interwoven.

Information gathering sharing towards collaboration

Information sharing was a critical area for practitioners working in all sectors across the three research sites. Information sharing was identified as an area of practice with huge potential for positive change leading to more positive work experiences for practitioners and better outcomes for families living at the intersection of DFV, AOD and MH. Elements of information sharing that were identified by practitioners for particular focus included:

- *Further clarity within organisations* to enable more successful and productive information sharing, including role and capacity clarity at practitioner and organisational level
- *Active sharing of information outwards* to other practitioners, organisations and sectors, and *active information seeking inwards* from other practitioners, organisations and sectors
- *Understanding implications of information sharing*, particularly to enable safety planning
- *Sustainability* of information sharing and collaborative systems
- *Content and context* of information sharing and collaboration

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 87 of 106

Language and documentation

Practitioners viewed developing their own and influencing others' use of specific language as essential to changing practice and embedding a child-focussed, DFV-informed, all of family approach. Clear, detailed descriptions of perpetrator patterns of behaviour, strengths and protective efforts of non-offending

'It's only as influential as a team leader allows it to be' (CoP-S1-CP)

parents, and how adult actions impact children in interactions such as informal conversations, case discussions and planning, and interagency documentation and policy were seen as equally important and key to embedding a child-focussed, DFV-informed, all of family approach across DFV, AOD and MH sectors. Influencing language and documentation included routinely asking key questions, framed in specific ways, of clients, colleagues, other organisations and reflexively of themselves in order to shift from incident focused practice to a pattern-based approach.

Collaborative relationships and organisational cultures

Practitioners identified relationships as key to their influencing work, and to successful collaboration between practitioners, organisations and sectors. Building trust in these relationships was a key focus area for practitioners, particularly relating to referral of clients between organisations that address DFV, AOD and MH.

Established frameworks and ingrained attitudes

In attempting to influence practice change towards embedding a child-focussed, DFV-informed, all of family approach such as the Safe & Together Model, practitioners identified pre-existing frameworks and ingrained attitudes that needed to be addressed. These included ways of working at a sector level, but also at

'Like a siren going off when I hear mother blaming, I pick it up immediately' (CoP-S2-CP)

individual practitioner or leadership levels, and were particularly salient in relation to mothers and how they are viewed and engaged with. Mother-blaming, 'failure to protect' frameworks were singled out as particularly problematic in work where child protection issues were present, along with frameworks that focused on organisational risk rather than focusing on client voices and needs. This area of focus also included theoretical frameworks such as diagnostic medical models that can struggle to integrate family functioning and relationships into assessment and management of complex intersecting issues.

Leadership

Influencing of practice change equally from top down and bottom up was identified by CoP participants as essential to addressing all other areas and to sustainable capacity building. Participants expressed a desire and need for leadership within and across organisations to provide authorising environments for practitioners to progress their efforts, and to facilitate collaborative engagement at all levels from individual practitioners working directly with clients to senior levels of governance and management.

Strategies used by CoP participants to influence organisational practice change and capacity building

In addressing the areas of focus above, practitioners identified and discussed their strategies towards influencing organisational practice change and capacity building.

Targeted engagement and training in a child-focussed, DFV-informed, all of family approach

Initial steps in influencing practice change and building organisational and worker capacity to be DFV-informed involved training influencees in a child-focussed, DFV-informed, all of family approach, in this case

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 88 of 106

the Safe & Together Model, and targeted engagement of key individuals and positions. CoP members described targeted conversations and presentations to heads of departments, magistrates, corrections staff, utility companies and new graduates and workers that functioned to introduce these people to the Model and establish a baseline of mutual understanding.

As influencing work progressed, organisational and sector collaboration at the intersection of DFV, AOD and MH took the form of cross-sector training and presentation of how the Model applies for each service area. Organisations developed tailored training based on the needs of reciprocating agencies, for example FV practitioners provided tailored training to ADO organisations who in turn presented and trained back into the DFV agency. These sessions fostered mutual learning and collaboration and provided forums for relationship building and establishment of trust between individual practitioners and partnering agencies.

Ongoing engagement with the Model

Following initial training and engagement, CoP participants described a range of strategies they used to work on embedding the practice change in effective, sustainable ways. Many of the CoP participants reported establishing regular meetings based on the community of practice model where their influencees would discuss cases, provide mutual insights and advice, and reflect on progress or issues to be addressed. Discussions at team meetings, internal and between agencies, and between sector or organisational leadership were also reported as targeted spaces for ongoing engagement with a child-focussed, DFV-informed, all of family approach.

Updating procedures and systems

CoP members reported considerable efforts in updating existing systems and procedures, or developing new elements that fit within these, to embed practice change in their organisations. Participants in AOD and MH programs targeted intake, assessment and referral forms, updating and including items to bring DFV and perpetrators' patterns of abuse and coercive control to the forefront, and facilitate reflection on how DFV, AOD and MH were impacting clients and family members. Sections for practitioner reflection and notes were incorporated into documentation templates alongside client information to facilitate critical thinking and questioning and ensure continuity of information and insights.

Encouraging practitioners to seek out and incorporate as many sources of information into their case work as possible included reaching out to extended family members of clients where safe to do so, and exploring which organisations were involved with clients and what information they possess or might need. When working across DFV, AOD and MH issues, obtaining each family member's perspective and insight into how these issues interact and what their cumulative impact on each member of the family was, wherever and however safe to do so, was a key point of focus towards being more DFV-informed.

Developing partnerships

CoP members described efforts to facilitate collaborative working and information sharing between sectors through myth-busting common misconceptions around legislation, organisational protocols, legal requirements, prevalence rates and stereotypes in order to build trust and transparency between organisations and practitioners. Systems of 'warm referrals' were established or tested, where partnering organisations provided detailed, contextual information around clients to each other, and linked service entry pathways. An example of this is an AOD program offering entry into a pilot MBC program if a man disclosed perpetrating FV in an AOD counselling sessions, that could then be extended to full program participation if needed. Another strategy in this area was to facilitate opportunities for inter-sector shadowing, where practitioners from different sectors spent time with those from other areas in their day

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 89 of 106

to day roles. Partnerships between statutory and non-statutory organisations and local community NGOs were targeted in order to better advocate for better resourcing.

A prominent focus for capacity building partnerships concerned establishing joint case management forums, including at the senior level, where case complexities and collaborative arrangements could be reviewed, discussed and agreed on with all parties at the table.

Connecting a child-focussed, DFV-informed, all of family approach to current models of practice and ways of working

An important strategy to influence practice change was for CoP members to connect the Safe & Together Model, as an example of a child-focussed, DFV-informed, all of family approach, to current practice and framework established in their organisations and partnering agencies. This was important in terms of showing workers and organisations that new practices could be adopted into current workloads and role descriptions, enhancing practice to be more DFV-informed through a shift in focus rather than replacing working systems. Examples of this included highlighting compatibility with frameworks such as trauma-informed and dignity-driven approaches and all of family programs. In some cases, the Model provides a high-level framework within which other programs, such as those for fathers perpetrating DFV, might be understood.

Reframing through language

In working to change practice and build capacity for DFV-informed practice, practitioners across all sites and sectors emphasised a focus on language and the importance of reframing established systems, documentation and interaction with clients to be more explicit regarding actions, contexts and implications relating to DFV, AOD and MH. Language was seen as essential to shifting practice from a 'single-incident' focus to developing ways of intervening with perpetrator patterns of abuse and coercive control individually, organisationally and collaboratively. Some examples of the linguistic strategies practitioners reported include avoiding the use of shorthand phrases and acronyms to describe client issues, and instead using rich and specific descriptions to illuminate patterns of abusive behaviour, protective efforts and resistance, and impacts on family members. This included highlighting the intersecting relationships of issues, and not framing DFV, AOD and MH as separate co-occurring issues but rather interacting complex issues that impact on parenting capacities and choices. Reviewing and reframing case discussion, notes and documentation to be explicit about who did what to whom and in what context was highlighted as a powerful strategy for influencing practice change. Providing specific points and questions to keep in mind (either individually or embedded in documentation and templates) contributed to increasing capacity to implement a more child-focussed, DFV-informed approach.

In addition to focussing on their own use of language, CoP members worked towards increasing their and their influencees' awareness of 'red flags' in the language of their clients and other collaborating practitioners and organisations. Examples of these include where perpetrators might be denying or justifying their use of abusive behaviours or shifting the blame onto their victims' actions as triggers, provocations or reasons for their abuse. CoP members also focussed on paying attention to the language used by other practitioners and in communication with other organisations. This included language that might be inherently mother-blaming or culturally or racially stereotyping, particularly around the focus of questions being asked of clients and case workers.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 90 of 106

Barriers to organisational practice change and capacity building

Barriers to implementing the above strategies to influencing practice change and building organisational capacity were consistent across sites. Prominent barriers included:

- Time and resource constraints due to workloads, scheduling and rostering, resulting in loss of momentum
- Challenges relating to geography and location that hindered accessibility of practitioners
- Staff turnover resulting in loss of learnings, key contacts, and collaborative arrangements that rely on specific relationships rather than embedded protocols
- Perceived mismatches between a child-focussed, DFV-informed, all of family approach and established practice
- Improper or dangerous information sharing, including sensitive information about victim survivors being disclosed to perpetrators
- Resistant or disengaged leadership and lack of authorising environment
- Trepidation around working with men, including asking questions of or about perpetrators, worker safety in doing so, and becoming part of legal processes related to them
- Client resistance to disclosures of information and information sharing
- Siloed conceptions of DFV, AOD and MH as issues affecting families and siloed theoretical approaches to address these such as models that only address diagnosis or therapeutic interventions
- Mismatches between language used in collaborative efforts
- Lack of engagement from surrounding sectors and services such as police and education

These barriers are significant, and provide insight into the realities behind the results from the continuum exercise described in section 4.7.2 above that show slower organisational change and implementation of a child-focussed, DFV-informed, all of family approach to working at the intersection of DFV, AOD and MH.

Facilitators to influencing organisational practice change and capacity building

In the face of the barriers identified above, CoP members shared examples of facilitators for successfully implementing their strategies for practice change and capacity building.

Consistent messaging across all interactions, from informal conversations through to formalised presentations and training was highlighted as key to bringing people to a sustainable understanding of the Model and its application in practice.

Use of tools to connect theory to practice was highlighted as a way of illustrating the tangible differences in practice by using resources such as DFV-informed mapping tools, case examples, vignettes, key principles, glossaries and mock documents, prompt cards and posters and supporting documents.

Flexibility and willingness to engage in influencing in diverse ways, including in debriefings, online and virtual meetings, working within existing times when workers come together such as case meetings, all contributed to reducing impact of the identified barriers around time, resources and scheduling.

Having key contact teams, not individuals, created more sustainable and embedded collaborative relationships, reducing

> *'[With] verbal influencing there is risk of person moving on and unless ingrained in the culture, the influence dissipates. Social contagion, but embedding system's processes needed.'* (CoP-S3-AOD)

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 91 of 106

the impact of staff turnover. As one practitioner put it, "*one person is a quick fix, but not sustainable*". (CoP-S1-CP)

Co-located services reduced physical and time barriers, and fostered more collaborative and consultative working between agencies.

Utilising experts and secondary consultations, particularly when cases are highly complex, fosters collaboration across sectors and within organisations around areas such as working with men, and engaging with DFV in AOD and MH sectors.

Supporting other practitioners implementing a child-focussed, DFV-informed, all of family approach such as the Safe & Together Model, within and across agencies builds the potential for critical mass and saturation of practice change, and enables supportive working relationships.

Establishing the support of senior leadership and explicit authorising environments was enabling of all other efforts towards practice change and capacity building.

Establishing dedicated time for reflection, discussion and exploration of the Safe & Together Model through ongoing communities of practice, case consultations and discussions, supervision and coaching. Establishing these opportunities following training helped to create more sustainable and embedded practice change, and foster a sense of collaborative learning and development, particularly where they included practitioners across sectors.

> '*We need to be the ones setting this up, taking the lead, being really powerful in our messaging, but respectful in out manner. Making sure it is sustainable by educating our fellow colleagues.*' (CoP-S1-CP)

Keeping in mind learning and teaching of a child-focussed, DFV-informed, all of family approach like the Model can be simultaneous – not having all the answers fosters discussion and collaborative efforts.

Harnessing excitement and interest of practitioners, organisations and sectors shifting their focus and changing their practice. This was a key point for practitioners, who highlighted the Safe & Together Model being "*something tangible to back up practice*" (CoP-V3-CP) in the face of increasing client complexity.

4.7.5.   Summary

To summarise, all 44 CoP questionnaire respondents 'agreed' or 'strongly agreed' that exposure to the S&T Model improved their personal practice and, to a lesser degree, their organisation's practice. Discussions in the CoP sessions highlighted that practitioners felt a model of working in this way gave them something tangible to hold onto in the face of client complexities and systemic barriers. One participant gave the following feedback: 'I love it, it's the best thing I have ever learnt' (CoP-S2-FS).

When we look at the STACY developed DFV-informed Continuum, CoP participants' assessment of organisational practice improvement lagged behind their assessment of their own personal practice improvement on all four scales. When we look at some of the challenges they faced in undertaking their 'influencing' work (for example, loss of key contacts due to staff turnover, lack of support from organisational leadership), we might surmise that sustaining personal practice change will be difficult without considerable organisational commitment to change and capacity building, particularly in some services, notably MH. That said, particularly positive strategies were the establishment of organisational and cross-sector communities of practice that provided collaborating practitioners with the time, space and support to develop their understanding of a child-focussed, DFV-informed, all o family approach, and

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 92 of 106

targeting of key leverage points within organisations and systems to embed practice change such as documentation.

Practitioners' perception of a positive impact on their practice, as evident in the results from the questionnaire, were translated into the enthusiasm with which they approached their influencing work. Even as the complicating and inhibiting factors to practice change and capacity building a child-focussed, DFV-informed, all of family approach within their sectors became more evident, practitioners made connections between their individual practice change and its contribution to the complex system's intervention needed to improve practice at the intersection of DFV, AOD and MH.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 93 of 106

5. Discussion and concluding comments

This final section discusses key issues (appearing in bold text) and limitations to the research that have been synthesised from the findings. It uses the project's research questions to drive the discussion. The discussion also serves as a prelude to the following practice guidance. Although the practice guidance can be read as a stand-alone document, the intention is for this discussion to flesh out some of the detail that lies behind the strategies and techniques outlined in the practice guide. This section concludes with recommendations for the next steps in continuing the research collaboration with the Safe & Together Institute (which began in 2015) and with interested stakeholders (new and old) in future national action research.

How does research into the intersection of DFV, MH and AOD inform practice with children and families?

The review of literature at the intersection of DFV, MH and AOD indicated that services are in the early stages of considering how to manage the complexity of responding to children and families living with DFV and parental issues of AOD and MH. This was notwithstanding recognition of the fact that this "toxic trio" (Radcliffe & Gilchrist, 2016, p. 133) was a strong theme in the literature (Frederico, Jackson & Dwyer, 2014; Tsantefski, Humphreys & Jackson, 2014; Stover, Meadows & Kaufman, 2009).

Historically, the approaches to DFV, MH and AOD have been characterised by siloed interaction with *adult* clients with each service 'treating' the '*single issue'* and '*single client*', decontextualised from family, culture or community, and socio-economic circumstances. The literature elucidated the complexity of service systems involved but also the sometimes pernicious convergence of attention of child protection concerns on adult survivors (mothers) as 'failing to protect' their children from harm. In applying our synthesising construct to the literature selected for the Critical Interpretive Synthesis – strengthening intersection between DFV, AOD and MH sectors – we explored the extent to which approaches were gendered, and the extent to which they were adult-focussed to the exclusion of impacts on children.

DFV approaches have been gendered in that they have long recognised men as the dominant DFV perpetrator. There has been increasing recognition, also, of the destructive impacts of men's DFV perpetration on women's MH and AOD (Frederico, Jackson & Dwyer, 2014). But, whilst there is growing recognition of the need to intervene with fathers who use violence, the focus on DFV perpetration and the father's AOD issues was found to be less developed (Stover, 2013; Stover, Carlson & Patel, 2017) than the focus on non-offending mothers and their AOD and/or MH struggles. Further, both AOD and MH services have lacked a gender focus.

Further, DFV, AOD and MH approaches have been predominantly adult-focussed as discussed by Rose et al (2011) and Humphreys & Thiara (2003). There are, however, signs of young people's perspectives beginning to inform interventions with parents (Galvani, 2015; Templeton et al, 2009).There are also now promising interventions developing in response to the co-occurrence of DFV, AOD, and MH, with children and child protection agencies (Holly & Horvath, 2012; Laracuente, 2017; Stover, Meadows & Kaufman, 2009; Taft et al, 2011). However, **gendered, DFV-informed, and child-focussed adult services (as informed by an understanding of the risks to children where there are parental AOD and/or MH issues) are yet to emerge as prominent drivers of practice with children and families**.

The invisibility of perpetrating fathers in service interventions in the face of other problems emerging, particularly when they involve the mothers' MH and/or substance use will only be addressed when practice with adult clients becomes DFV-informed and child-focussed. This would then move service interventions toward strengthening the collaborations or intersections of DFV, AOD and MH services to better inform considerations of the impacts of parental issues on child safety and wellbeing.

In what ways does the Safe & Together Model inform worker practice where there are issues of complexity?

The Safe & Together Model has been critical in several key ways in informing worker practice where children and families are living with DFV and where there are parental issues of AOD and/or MH issues. These ways form the practice guidance document that follows. In addition, however, exposure to the Model has also revealed the following insights for participants.

First, the Model highlighted issues at stake for the safety and wellbeing of children and young people in services that are overwhelmingly adult-focussed to the point of rendering invisible the fact that many of their adult clients are parents. CoP participants often struggled to bring into view the impacts of perpetrating fathers' parenting choices in using violence and control towards their children in the face of either or both parents' struggles with AOD, MH and other intersecting complexities. These complexities could include: the trauma histories of Indigenous, refugee and asylum-seeker parents; the presence of disabilities in either or both parents; and their unemployment, housing instability and impoverished circumstances. Guidance and coaching offered by the S&T consultants throughout the CoP phase, and across the three sites, continuously repeated the reminder to participants that **DFV, AOD, MH and other services needed to shift the adult-focus of their services towards greater recognition that their clients (including offenders) are parents. This is about shifting adult-focussed services to becoming more child-focussed (or child-sensitive).** This was not necessarily about adding young people to their organisation's clientele but about considering the harm that men who are fathers as well as perpetrators of abuse are causing their children. It is about considering the mother's protective and nurturing capacities and strengths to incorporate elements of child-sensitivity into their work with adult clients.

Secondly, the Model has helped practitioners to make a useful (and safety-wise) distinction between 'intervening' and 'engaging' with fathers. This is an important distinction to understand the safety implications for adult and child survivors as well as for workers when working with domestically violent men (or 'pivoting to perpetrators'). **In order to 'partner' with the mother, 'pivoting' requires gathering information about a domestically violent man from numerous sources other than necessarily 'engaging' with him in a direct conversation**. This was an important, yet difficult insight, for practitioners to grasp, at times, and erroneous for any practitioner or organisation to equate 'pivoting' with direct communication with a perpetrator unless an informed perpetrator risk assessment has been established through partnering with the non-offending parent, talking with children if possible, with extended family and community members, and other services, as needed (police, probation and parole, statutory child protection, and therapeutic services).

Thirdly, the Model requires workers to understand that **there are intersecting complexities such as the trauma histories of Indigenous, refugee and asylum-seeker parents, the presence of disabilities in either or both parents, security of employment, housing instability and impoverished circumstances in addition to those of AOD and MH.** These need to be considered when working with children and families living with DFV, as suggested in the opening of the practice guidance. The Model, however, can only provide a top-level framework from within which practitioners and their organisations might develop adaptions to suit the specific cultural and other needs for the contexts and communities within which they work. As reported on in the Invisible Practices project (Healey et al, 2018), this is already occurring in its adaption by Indigenous practitioners working with specific communities.

Fourthly, few practitioner examples were present in the CoP discussions that illustrated **direct engagement with young people or that included them in decision making processes.** This was clearly something that Elijah, the 14-year-old who was interviewed, appreciated. **Examining what child participation looks like in practice while partnering with mothers, is an area that requires further development**. Nuanced work could examine how child participation can occur, or to what extent it needs to occur, in agencies with a

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 95 of 106

clear child-focused approach. Particular areas of focus could be how this occurs in micro areas of practice, **especially in situations where the needs of mother and child survivors may differ**, and to examine strategies to encourage child participation **in a manner that does not further disempower mother survivors**.

How do workers, as part of case management, assess and manage the complexity of the intersections of DFV, MH and AOD while maintaining the DFV focus?

Workers involved in the CoPs came to understand that every aspect of case work is affected when working with intersecting complexities of DFV, AOD and MH. Not surprisingly, given the lack of formalised collaborative protocols across different service systems, individual practitioners frequently felt challenged in their case assessments and even more so when trying to implement techniques to manage intersecting issues that involved other services operating from different principles. **Practice needed to shift from recognising the co-occurrence of problems to exploring the intersections between them.** Practitioners in mental health services were particularly challenged as there were sometimes internal clinical protocols related to information sharing or assessment which could override attempts to implement DFV-informed practice without sufficient senior management sanction. Even workers in sites and organisations where there was already commitment to adopting an all-of-family approach found the DFV-informed approach difficult when working with other services. Thus, case management was compromised in two ways: firstly, either senior management was not sufficiently driving organisational change to support the changes at the coalface; and secondly, resistance from external agencies to collaborate such that important information required to inform risk assessments were not being communicated in a timely or effective way. In other words, systemic barriers made DFV-informed case management difficult to overcome.

Nonetheless, at the practitioner level of assessment, participants realised the centrality of focussing on the perpetrator's violence, the pattern of his substance use, the pattern of his mental health issues, and how each intersect with one another. Similarly, they recognised the centrality of focussing on the adult survivor's strengths in caring for herself and the children in relation to her struggle with AOD and/or MH in the face of the violence and coercive control she is subject to from her partner or ex-partner. They did this through incorporating the techniques for pivoting to the perpetrator and partnering with women (such as those outlined in the previous section and reflected in the following practice guidance), and by using structured tools such as the Safe & Together Institute's *Mapping Perpetrators' Patterns* and *Mapping Survivors' Protective Capacities*. They found they were better able to ensure that their service referrals, their 'alerts' to statutory child protection, and reports to courts about adult survivors and perpetrators contained detailed and specific descriptions of the impacts of the intersecting parental issues of MH and AOD in the context of DFV. Sometimes, they were able to report better outcomes, as illustrated in several practitioner and client interviews.

What formal collaborative arrangements are required for workers and their organisations to intervene where DFV, MH and AOD intersect?

Participants insights into their involvement in the *STACY Project* indicated the importance to them of thinking about how to drive and sustain practice improvement beyond the life of the research project. This is a particularly challenging area for practitioner conversation and equally so for senior staff who participated in PAG meetings. This is because **instituting an all-of-family approach to working with families living with the intersecting complexities of DFV, AOD and MH involves intervention that goes beyond simply enhancing individual professional practice with clients. Rather, it involves organisational change and a complex, system-wide intervention to bring diverse services and professional interventions into**

agreed upon ways of working collaboratively. The motivation for doing so lies in being able to demonstrate improved outcomes for clients, their families and communities when living and struggling with intersecting complex issues of DFV, AOD, MH, intergenerational trauma (in the case of Indigenous, refuges and asylum-seeker clients) and other socio-cultural and economic circumstances.

We cannot demonstrate system-wide improved outcomes through this comparatively modest project, but we can point to some demonstrated improvements for individual clients and practitioners (as outlined below) and, possibly, for organisations. In terms of the latter, CoP and PAG participants spoke of their 'influencing' and 'advocacy' work toward organisational practice change and capacity building and thus towards developing formal collaborative arrangements. These were identified through discussion as needing to developing collaborative protocols relating to: risk assessment and risk management, information sharing, case conferences, and referral pathways. Some of this work was being undertaken in participating organisations in tandem with or in efforts to align with external reforms that were being driven by each site's respective state governments. The development of information sharing legislation and guidance which promoted clarity about the sharing of information about perpetrators of abuse was particularly helpful and named by practitioners across states.

CoP participants also spoke of running joint training across sectors (such as between DFV and AOD services), sharing brokerage funding between services (for example, DFV brokerage being used to fund housing for an otherwise homeless adult survivor needing accommodation post-release from an AOD treatment program), and developing agreements about key workers undertaking advisory roles around the intersections of DFV, AOD and MH as well as joint interviewing initiatives.

It is also clear that **agencies which are not child-focused need to engage in closer collaborative work with agencies which have a well-developed child-focus. This will improve responses to children as it will allow agencies to gain a greater understanding to the risks to children and allow children's views to be incorporated into responses**. Further focus on children across systemic responses may be incorporated by strengthening ties with child-focused services without a DFV focus, for example child mental health practitioners and schools.

How do individual family members – who are clients of an organisation that is implementing a collaborative and holistic approach to working with children and families living with DFV and where there are parental issues of MH and AOD use co-occurring – experience the interventions they receive?

The 21 clients who have been interviewed for the STACY Project include 12 mothers, four fathers and four young people. They were all clients who had been supported for some months by organisations that were committed to an all-of-family approach to working with children and families. We cannot report in detail on these interviews in this report for fear of compromising anonymity. They have been incorporated, as intended, as case studies in the findings' section to illustrate key points.

All spoke of positive experiences with the service, including significant changes in their families and of being treated respectfully by workers. For the adult survivors who had the experience of a practitioner working through the perpetrator mapping tool with them, they found the exercise painful but of particular value in helping them understand what had happened to them and their children, including that their MH struggles, was not their fault. **Many clients spoke of the practitioners who worked with them as providing a service that contrasted dramatically with previous service interactions.** That said, some mothers whose children were removed spoke of the devastation and guilt they felt about their children being removed. They understood why their children were removed but the decision had not been made in conjunction with the mother and they had not voluntarily given up their children.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 97 of 106

Survivors, both adults and young people, spoke of being given clear messages about the options available to them and feeling supported by the workers. Clients also spoke of the capacity of the organisation to work with their family over many months; in the case of those being supported by Jannawi workers, this extended to years for some families with the workers able to increase frequency at times of great stress of crisis and at other times to provide occasional support. Clients generally appreciated being able to conduct sessions over the phone. Several clients spoke of other flexible contact arrangements, such as being met outside office hours.

It is important to note that several clients, particularly clients of Jannawi, reported their partners, children and other significant family members were being supported by the service, by multiple workers, and that this was greatly appreciated.

How have practitioners experienced the implementation of the collaborative Safe & Together Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

Practitioners who were interviewed for the project (including the process evaluation of Jannawi), reported significant changes for children and families with whom they worked as a result of the all-of-family approach they were taking. Most CoP participants felt greater confidence in using strategies to reduce the occurrence of collusion with perpetrators and better prepared to 'pivot to the perpetrator' by developing ways to intervene with his pattern of abuse and coercive control while keeping this in view in considering the role of substance misuse and MH issues in his use of DFV.

Several practitioner interviewees commented on the value of using the structured Safe & Together tool that mapped the perpetrator's pattern of abuse and coercive control and the role of AOD and MH in his behaviour as providing a very significant watershed in how they partnered with mothers and kept the harm done to children in view. This tool provided not only a therapeutic and educational opportunity for building a solid relationship of trust and transparency with mothers, even when they were struggling with their own substance misuse and MH issues, but a clear advocacy opportunity that could lead to good outcomes for child and adult survivors, specifically, in keeping or returning children to the safety of being with the non-offending parent.

The 44 CoP **participants who responded to the STACY-developed questionnaire either 'agreed' or 'strongly agreed' that their practice and/or management of staff had improved their practice**; none gave a neutral, unsure or negative response. CoP participants indicated that exposure to the Model itself constituted 'lightbulb' moments for themselves and their colleagues with whom they worked in terms of their own professional practice. For example, insights into the full ramifications of partnering with women as adult survivors and pivoting to the perpetrator helped them be clear-sighted about the safety and wellbeing of children being the ultimate, guiding principle to all their interventions. It helped them to be clear with each parent about the perpetrator's role in being the source of harm to both child and adult survivors. It also helped them in holding to their collaborative communication with other services including: that parents' actions should never be decontextualised from the perpetrator's pattern of abuse and coercive control; that this knowledge of his behaviour patterns must be acquired from partnering across services; and he must be kept in view when considering the role of DFV with substance misuse and/or mental health issues.

In terms of the challenges CoP participants faced in undertaking their 'influencing' work, we noted that sustaining personal practice change may be difficult without considerable organisational commitment to change and capacity building, particularly in some services, notably MH. We might surmise that while they are progressing their own DFV-informed practice change, they are encountering and increasingly facing

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 98 of 106

issues around *sustaining* their practice change if they perceive the gap between their own professional practice and that of their organisation's is widening. This may be particularly so if senior leadership is not committed to facilitating the organisational changes required to become more child-focussed and DFV-informed. It may also be related to external imperatives given that government-driven reforms and legislative changes are occurring through the three state sites of research, particularly regarding child protection.

5.1.   Concluding comments

A significant limitation that we foresaw with this STACY Project and which we are keen to address in future collaboration with the Safe & Together Institute and interested stakeholders is to capacity build Indigenous and non-Indigenous practitioners and organisations in supporting Indigenous children, families and communities where there are intersecting parental complexities not only of AOD and MH in the context of DFV but also of intergenerational trauma, housing instability, and structural disadvantage. Indigenous practitioners and their organisations, some of whom have been participants of previous action research projects (PATRICIA and Invisible Practices) or working in supportive child protection agencies, have become accredited trainers in the Safe & Together Model. Others are beginning to explore the possibility of capacity building their organisations, learning from each other's adaptions of the Model for their own specific community contexts. We see a useful role to play in supporting these important developments towards holistic, all-of-family ways of working with DFV and its intersecting complexities.

The pedagogy of capacity building using a CoP model has proved to be invaluable to participants in the STACY project. The role of the Safe & Together consultants in providing training in each site and regular coaching during each CoP meeting has been a further strength of the project. These two elements combined with the number of participants engaged as active participants giving and receiving practical, accessible resources has been a great achievement of a relatively modest action research project. In all, approximately 450 people have been involved either as CoP participants, as PAG representatives, or as colleagues and peers working in partnership or teams. There are difficulties in evidencing the capacity building when working with complex systems. However, extensive data was collected and synthesised to indicate the value of the action research pedagogy.

There is an African proverb that resonates with the significant collaborations that have been built throughout this complex project: *If you want to go fast, go alone, if you want to go far, go together.* There is no doubt that working at the intersection of DFV, MH and AOD is a complex process in which change is slow, and there remains a long way to go. However, the reflections from practitioners, managers and family members suggest that already significant strides have been made to address the intersection of these issues and to recognise and work with problems associated with siloed practices.

6. Appendices

6.1.   DFV-Continuum exercise – detailed statistics results

Below are the detailed results from the DFV-Continuum exercise paired-samples t-tests, described in section 4.7. Before the CoP phase is to be taken as Time 1, and After the CoP phase as Time 2.

Table 12: Before and after Cop phase: organisational practice

Scale 1	There was a significant increase in the mean value of scores of 0.5083 on Scale 1 at Time 2 (M = 3.875, SD = 0.7899) compared to Time 1 (M =3.367, SD = 0.9427) for organisational practices (t(59) = -6.562, p<0.01).
Scale 2	There was a significant increase in the mean value of scores of 0.7000 for Scale 2 at Time 2 (M = 3.850, SD = 0.7719) compared to Time 1 (M = 3.150, SD = 0.9712) for organisational practices (t(59) = -7.857, p<0.01).
Scale 3	There was a significant increase in the mean value of scores of 0.5750 for Scale 3 at Time 2 (M = 3.608, SD = 0.8930) compared to Time 1 (M = 3.033, SD = 1.0450) for organisational practices (t(59) = -6.534, p<0.01).
Scale 4	There was a significant increase in the mean value of scores of 0.5508 for Scale 4 at Time 2 (M = 3.890, SD = 0.8713) compared to Time 1 (M = 3.339, SD = 1.0964) for organisational practices (t(58) = -6.464, p<0.01).

Table 13: Before and after the CoP phase: personal practice

Scale 1	There was a significant increase in the mean value of scores of 0.6230 on Scale 1 at Time 2 (M = 4.303, SD = 0.6074) compared to Time 1 (M = 3.680, SD = 0.8467) for personal practices (t(60) = -6.733, p<0.01).
Scale 2	There was a significant increase in the mean value of scores of 0.8934 for Scale 2 at Time 2 (M = 4.352, SD = 0.5940) compared to Time 1 (M = 3.459, SD = 0.9717) for personal practices (t(60) = -9.859, p<0.01).
Scale 3	There was a significant increase in the mean value of scores of 0.8361 for Scale 3 at Time 2 (M = 4.156, SD = 0.6742) compared to Time 1 (M = 3.320, SD = 0.9576) for personal practices (t(60) = -8.506, p<0.01).
Scale 4	There was a significant increase in the mean value of scores of 0.7705 for Scale 4 at Time 2 (M = 4.320, SD = 0.6521) compared to Time 1 (M = 3.549, SD = 0.9561) for personal practices (t(60) = -8.401, p<0.01).

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 100 of 106

Table 14: Before the CoP phase: organisational and personal practice

Scale 1	Personal practice scores (M = 3.675, SD = 0.8528) were significantly higher than organisational practice scores (M = 3.367, SD = 0.9427) by 0.3083 for Scale 1 before the CoPs were run (t(59) = -3.216, p=0.002).
Scale 2	Personal practice scores (M = 3.433, SD = 0.9588) were significantly higher than organisational practice (M = 3.150, SD = 0.9712) scores by 0.2833 for Scale 2 before the CoPs were run (t(59) = -2.404, p=0.019).
Scale 3	Personal practice scores (M = 3.308, SD = 0.9615) were significantly higher than organisational practice scores (M = 3.033, SD = 1.0450) by 0.2750 for Scale 3 before the CoPs were run (t(59) = -2.233, p=0.029).
Scale 4	There was no significant difference between personal practice scores (M = 3.525, SD = 0.9452) and organisational practice scores (M = 3.317, SD = 1.1007) for Scale 4 before the CoPs were run (t(59) = -1.969, p=0.054).

Table 15: After the CoP phase: organisational and person practice

Scale 1	Personal practice scores (M = 4.254, SD = 0.6320) were significantly higher than organisational practice scores (M = 3.900, SD = 0.7916) by 0.3583 for Scale 1 after the CoPs were run (t(64) = -3.734, p<0.01).
Scale 2	Personal practice scores (M = 4.346, SD = 0.5858) were significantly higher than organisational practice scores (M = 3.862, SD = 0.7629) by 0.4846 for Scale 2 after the CoPs were run (t(64) = -4.740, p<0.01).
Scale 3	Personal practice scores (M = 4.162, SD = 0.6621) were significantly higher than organisational practice scores (M = 3.623, SD = 0.8662) by 0.5385 for Scale 3 after the CoPs were run (t(64) = -4.954, p<0.01).
Scale 4	Personal practice scores (M = 4.320, SD = 0.6447) were significantly higher than organisational practice scores (M = 3.883, SD = 0.8625) by 0.4375 for Scale 4 after the CoPs were run (t(63) = -4.646, p<0.01).

6.2.   PATRICIA Project Collaborative Working diagram

Source: Humphreys, C., & Healey, L. (2017). PAThways and research into collaborative inter-agency practice: Collaborative work across the child protection and specialist domestic and family violence interface—The PATRICIA Program, Research Report. Sydney: ANROWS.

Final Report: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

Page 102 of 106

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