



STACY Safe & Together
Addressing ComplexitY

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

September 2020



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Glossary

- All-of-family approach** The all-of-family approach is underpinned by feminist theories that attend to the intersection of multiple drivers of domestic and family violence (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 refers to inclusive practices informed by an understanding of child development and wellbeing that consider the child's experiences of, and perspectives on, how fathers' use of violence and coercive control toward their family, either or both parents' substance misuse and/or mental health issues, impact the child.
- Coercive control** This phrase refers to both physical and non-physical actions that constrain the behaviour of others, undermining their liberty, self-determination, and choices that they can make, attacking their quality of life, physical and emotional safety. Coercive control creates significant fear in adult and child survivors and thus harms the functioning of a family and a community. Perpetrator tactics include instilling fear by actual or threatened 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 and interfere with the mental health and/or substance misuse vulnerabilities in survivor-victims. Regardless of the perpetrator's intention, coercive control 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. It is imperative that practitioners focus on the impact of the behaviour rather than on the reported intention of the perpetrator.
- 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.

Intersections	<p>Intersections between domestic and family violence, mental health and substance misuse refer to how one of those issues shapes the contours of the other issue, e.g. how DFV perpetrators' behaviours create the context for the survivors' substance use patterns and related recovery challenges. Or how mental health issues may be treated as the primary issue by providers whilst the perpetrator's violence is ignored or considered a symptom.</p> <p>The term is differentiated from intersectional theory (Crenshaw, 1998) which refers women's differential experiences of domestic violence which are influenced by the intersections of interlocking forms of oppression including sexism, racism, ableism, homophobia and other aspects of identity.</p>
Pattern-based	<p>This phrase is used as a distinction to an '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 can become de-contextualised and reduced to a 'single event', usually of physical violence. The trauma lens that this can frame may lose the attention to the wider undermining of family functioning which is equally important. While incidents may be important, 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 can be frequently misidentified by police attending a DFV 'incident' as the primary aggressor or offender.</p>
Perpetrator	<p>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 and a term which has broad usage across systems e.g. criminal justice and child protection. We also are focusing on the dominant gendered pattern of men's violence against women and children.</p>

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Safe & Together Addressing Complexity

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

PRACTICE GUIDE

Introduction

The STACY (*Safe & Together Addressing Complexity*) 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 parental issues of mental health and/or substance misuse co-occur. The expertise of practitioners was harnessed through Communities of Practice, which were capacity built through training and coaching provided by the Safe & Together Institute's resources and consultants. Researchers worked alongside participants in the Communities of Practice in three states (NSW, QLD and VIC) to research and drive changes in professional practice, inter-agency working, and organisational change to sustain continued development. Project Advisory Groups in each state made up of senior managers were integral to develop and sustain improvements in collaboration and practice in this complex area.

An intersectional lens informs this practice guidance and is critical to understanding parenting in the context of DFV, AOD and MH. Whilst the majority of DFV is committed by men against women and their children (Cox, 2015), DFV also occurs within LGBTQI communities. Men can also be survivor-victims, women can use force (Kertesz et al, 2019), and young people can be abusive towards parents and other family members (Condry & Miles, 2014). In heterosexual relationships, however, women's use of violence rarely involves coercive control (a term described in the glossary). Coercive control results in more frequent, more severe injuries and death and is more likely to leave victims feeling afraid (ABS, 2005; Home Office, 2001, 2007).

This practice guidance is pitched toward the dominant gendered pattern of fathers' use of violence and coercive control against adult and child survivors. In referring to the 'perpetrating parent' and the 'non-offending parent', we aim to shift the focus of attention away from 'mother-blaming' and gender-blindness to mothers' protective capacities towards assessments of each parent's behaviours. This means assessing fathers' parenting according to the same criteria that mothers' parenting is assessed.

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. We cannot provide a practice guide that attends to the diversity of Aboriginal and Torres Strait Islander communities, for example; however, we ask practitioners to think about the specific context in which they may adapt the guidance here to the specific needs of each client, family and community they work with. We hope senior management in organisations specifically run by and for Indigenous, ethno-specific, gender and sexual diverse and LGBTQI and disability advocacy bodies may consider the usefulness of adapting these guidelines for their own communities.

A glossary of terms appears at the front of this document; we encourage you to read it first.

The Safe & Together™ Model: working at the intersections

The Safe & Together Model originated 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 underpinned the STACY project and are reproduced with permission in Figures 1 and 2 below. The Model is an all-of-family way of working where there is DFV.

The Safe & Together Model prioritises the safety and wellbeing of children and young people. The work aims to keep children 'safe and together' with the non-offending parent (the adult 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 abusive behaviours. The STACY project focused on a particular aspect of the Critical Components Model, namely, the intersection of mental health issues and/or substance misuse and DFV (Figure 2). The STACY Project focused on shifting practice from merely focusing on co-occurrence to exploring the ways the perpetrator's use of violence and coercive control can be kept in view when considering the relationship of DFV with substance misuse and/or mental health issues.

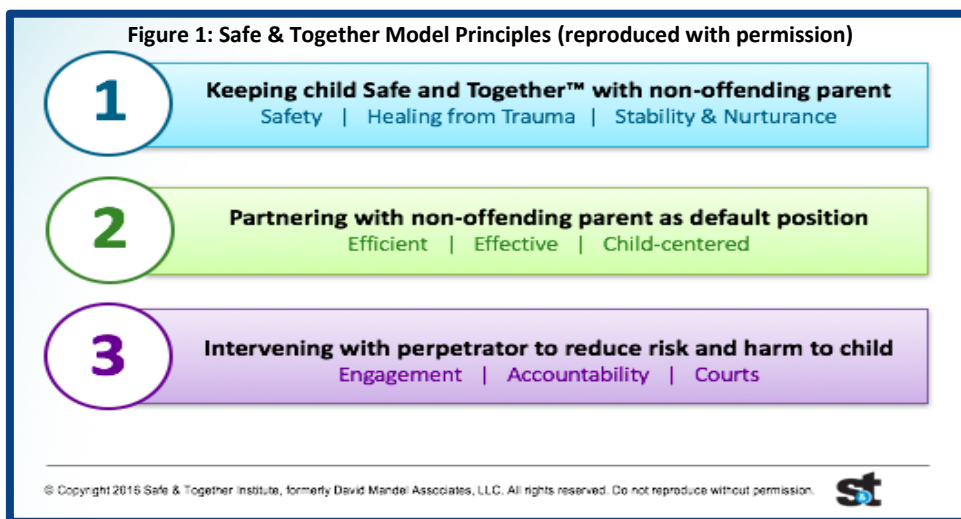
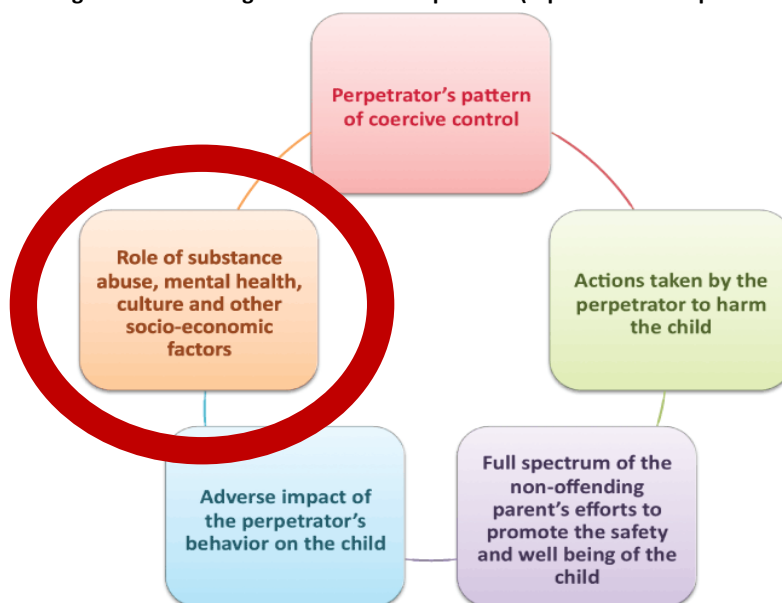


Figure 2: Safe & Together Critical Components (reproduced with permission)



This Practice Guide

This Practice Guide is structured around the following six themes that were identified in the STACY research project through discussions with practitioners, Project Advisory Group members, Safe & Together consultants and researchers:

1. Partnering with women
2. Working with men
3. Focusing on children and young people
4. Working collaboratively
5. Working safely
6. Influencing organisational practice change and capacity building

Practitioner guidance is provided in relation to how each theme can be addressed within the context of complexity. These are the complexities arising from the intersections of DFV, parental substance misuse and/or mental health issues. The guidance contains reflective questions to build capacity in the six themed areas, as well as, practice tips, quotations and case studies that were developed through conversations held with Safe & Together consultants, researchers and professionals involved in the STACY Project. Where case studies are used, care has been taken to de-identify and anonymise participants and service users.

Women survivors of DFV have higher rates of substance misuse and/or mental health problems. It is vitally important to consider the context in which survivors' substance misuse and/or mental health issues develop. Perpetrators who subject women to repeated violence and coercive control can cause, exacerbate and interfere with women's attempts to address mental health problems and/or substance misuse. It is crucial that practitioners acknowledge women's inherent strengths and attempts to resist becoming overwhelmed by intimate partner violence.

Techniques for 'partnering with women' at the intersections

Practical strategies for 'partnering with women' within a context of complexity include:

- ✓ Affirming her partner's responsibility for his violence even when the use of substances or mental health issues may be present
- ✓ Asking respectful, specific questions about the nature of the perpetrator's abusive behaviours particularly in relation to substance use, mental health issues and recovery
- ✓ Assessing for safety and wellbeing and her protective efforts
- ✓ Validating her feelings and concerns
- ✓ Collaborative planning with survivors around their safety and well-being as well as their children
- ✓ Documenting her strengths and the perpetrators patterns of behaviour to the degree that is safe and appropriate for the setting

The following reflective questions may be useful to guide practice in your agency while 'partnering with women' at the intersections of DFV, substance misuse and mental health issues.

Questions for consideration when partnering with women

- Do we explore and document how the perpetrator of violence targets his partner's substance use and/or mental health issues in order to exert power and control over her?
- Do we consider how the perpetrator leverages the survivor's substance misuse and/or mental health issue in order to manipulate professionals into believing that she is an 'un-protective' or 'unfit' mother?
- Do we consider how the perpetrator's pattern of abuse might exacerbate/cause/interfere with the adult survivor's struggles with mental health and/or substance misuse?
- Do we consider how the perpetrator's pattern of abuse might exacerbate/cause/interfere with the adult survivor's attempts at recovery?
- Do we routinely document the non-offending parent's pattern of protective behaviour, making apparent the full spectrum of her efforts to promote the safety and wellbeing of her children and resist the violence and abuse?

1. Affirming the perpetrators' responsibility for the choice to abuse

Many women survivors who have substance misuse issues or mental health challenges are highly vulnerable to perpetrators for many reasons, including societal stigma around substance misuse and/or mental health problems. They may also experience unique barriers to treatment and support, which are related to her substance misuse/diagnosis due to the perpetrator's pattern of abusive and coercive behaviours. Engaging with mental health, alcohol and other drug treatment professionals, child protection practitioners, and other professionals takes courage in this context. Professionals who can engage with women survivors in a manner that validates their experiences are more likely to establish trusting relationships to address safety and wellbeing concerns for their children and themselves. It is important to communicate to survivors who have substance misuse issues or mental health challenges that they, are not the cause of their partners' choice to be abusive and violent. This affirmation of the perpetrators' responsibility can be critical step to building trust, creating emotional safety and unwinding a narrative that implies that she is not worthy of respect and safety if she has substance use or mental health challenges.

Irrespective of the complexity of survivors' lives the following reflective questions are useful to consider in your practice and your agency's processes:

- Do we routinely consider and document the context in which women's substance misuse and/or mental health issues originated, are exacerbated, and the circumstances that challenge her recovery?
- Do we send a clear message verbally and in case notes that women do not provoke men into using violence and coercive control?
- Do we send a clear message that we believe women and children in our conversations and documentation?

Practice Tip

Many men who use violence use emotional and psychological abuse to coerce women survivors into adopting the view that the survivor's mental health issues and/or substance misuse provoke male violence. Women that you work with may have adopted a mindset that they are responsible for DFV and their children's resultant behaviour problems. Affirm the perpetrator's responsibility for his choice to be abusive. Ask questions that encourage her to consider her right to be safe and that encourage her to see that feeling safe has therapeutic benefits. This can help women to resist adopting the perpetrator's construction of them as a 'bad mother'.

Examples of affirming statements

- "Your drinking is no excuse for his violence and abuse towards you."
- "Your anxiety doesn't make him get abusive."
- "Your childhood abuse background doesn't justify him treating you poorly."
- "His violence and abuse doesn't help you be sober. It may even make it harder for you to be sober."

2. Asking respectful questions about the perpetrators' pattern of abuse

Affirming women survivors' experiences and asking respectful questions can facilitate a shared understanding of the perpetrator's patterns of abuse, and the association with substance misuse and/or mental health issues. Asking questions that respect the woman survivor and where she is at, can help the practitioner and survivor to better understand the connections between DFV, substance misuse and/or mental health issues. Integrating motivational interviewing techniques with DFV-informed respectful questioning can facilitate the development of new insights into how perpetrators may use substance abuse and/or mental health coercion as an excuse to abuse or as a tactic of power and control.

Irrespective of the complexity of survivors' lives the following reflective questions are useful to consider in relation to your practice and your agency's processes:

- Do we ask respectful questions that allow us to map DFV including substance abuse and/or mental health coercion patterns?
- Do we use a mapping tool that enables us to assess and document the myriad ways that the survivor is actively protecting and caring for her children in a context of abuse, adversity and complexity?
- Do the questions that we ask make women feel more or less responsible for DFV? Do they contribute to making her feel more or less safe?
- Do we routinely formally assess/universally screen all clients for DFV?
- Do we routinely integrate and ask specific questions related to DFV into assessment/diagnostic procedures?
- Do we focus on a single incident of violence or do we contextualise incidents within broader patterns of abusive behaviour?

Practice Tip

The Safe & Together Model contains a mapping tool that practitioners from various fields of practice internationally and nationally find to be extremely helpful. The **Perpetrator Pattern Mapping Tool** guides practitioners through a series of assessment domains which aim to establish a comprehensive picture of the tactics used by perpetrators to exert power and control over women and children. This involves detailing the specific behaviours used by the perpetrator to harm women and children.

- *Ensure that assessments for mental health issues and substance misuse include specific, behavioural questions related to abuse, violence and control.*
- *Do not assume that abuse and violence are symptoms of substance use or mental health issues. Assess, treat, and monitor those behaviours separately from mental health or substance misuse.*
- *It is also essential that someone within the multi-disciplinary team maps the perpetrator's pattern of substance misuse and its association with harm to women and children. Consider how his pattern of using connects with the severity and frequency of his violence and abuse? For example, is he more violent when coming down off substances or when he is using?*

3. Assessing for safety and survivors' protective efforts and strengths

Irrespective of your field of practice, you have a part to play in increasing women's and children's safety and wellbeing. Secrecy is a dynamic of abuse that best serves the interests of people who harm women and children. Gathering and documenting information from multiple sources about perpetration patterns including substance abuse coercion and mental health coercion can improve safety and wellbeing outcomes for women and children.

Practitioners can mistakenly assume that survivors don't have protective strategies or safety plans and therefore not engage them in conversations that seek out information about the myriad ways women protect themselves and their children. It is important that practitioners elicit information about protective efforts and safety planning in relationship to the perpetrator's patterns at the intersection of his violence, substance misuse and/or mental health challenges. Practitioners should also elicit information about the relationship between substance misuse, mental health challenges and survivors' protective efforts.

Irrespective of the complexity of survivors' lives the following reflective questions are useful to consider in relation to your practice and your agency's processes:

- Are we assessing the relationship between the adult survivors' mental health and/or substance misuse issues and her history of victimisation?
- How are we assessing and documenting the full range of protective actions that the woman survivor is engaging in to protect herself and her children even when she has a pattern of substance misuse or mental health challenges?
- Do the questions that we ask provide information that contributes to making women and children survivors safer? How would we know?
- How are we seeking to learn about how she protects her children around her partner's patterns of substance use or mental health issues as they intersect with abusive behaviours?

Practice Tip

The Safe & Together Model contains a mapping tool that practitioners from various fields of practice internationally and nationally find to be extremely helpful. The **Mapping Survivor's Protective Capacities Tool** contains multiple examples of respectful questions that illuminate the connections between DFV, substance misuse and/or mental health problems and help to inform relational practice that aims to build trusting relationships between practitioners and women survivors.

Examples of respectful questions

- "What do you do to care for your children and keep your family going on a day to day basis in the face of his violence and his drinking, drug-taking, mental health problems?"
- "Sometimes women have difficulty identifying all the things that they do to shield their children from the effects of *their partner's violence, drinking, drug-taking, let's work together to look at some of the ways you've been able to do this for your children.*"

4. Validating her feelings and concerns

Many women survivors of DFV who have mental health and/or substance misuse issues will have received poor responses from professionals in the past. Women may have experienced judgemental attitudes, mother blaming and/or outright disbelief. These experiences may make it difficult for open and honest communication to occur. Validating her feelings and concerns can go a long way towards establishing trust and building therapeutic relationships.

The following questions are useful to consider when partnering with women survivors:

- Do we convey the message that we believe women survivors of DFV? Do we challenge the popular discourse that women (and particularly those who have mental health and/or substance misuse issues) lie about DFV?
- Do we convey the message in our conversations with survivors that that we believe that she is doing the best she can for their children especially when she may be struggling to cope with their own substance misuse and/or mental health issues?
- Do we name specific actions and behaviours that we have identified as protective and as strengths?
- Are we validating her protective efforts, feelings, beliefs in our case file notes in a manner that acknowledges the complexity of the context that she is parenting in?
- Does my agency support my efforts to build relationships with women based upon trust and validation especially when this takes time given the complexities involved?
- Do we advocate for women survivors whose substance use and/or mental health symptoms may be decontextualised from DFV by colleagues or other professionals?

Practice Tip

Validating a woman survivor's experience can have therapeutic benefits as it can help establish trusting relationships based on mutual understanding. Validating her experience can signal to her that you understand the complexities of her life and are willing to help her journey towards increased safety.

Examples of validating comments:

- *"I see how hard you have been working to minimise the impact of his drinking on the kids by sending them to your mother's house on the weekends."*
- *"It's amazing that given his violence and the chaos caused by his methamphetamine use you have kept the children going to school every day."*

5. Collaborating with survivors

Developing relationships and learning from DFV and/or women's refuge workers is a good way to improve your practice in working collaboratively with women. Feminist based approaches strive to empower survivors to regain the sense of personal agency and control that perpetrators of DFV attempt to take away. Explore what has worked and hasn't worked and what she thinks may make things better. Practitioners can add to the women's resources through active listening and collaborative planning. Critically reflecting on how they use professional power can decrease the potential for secondary victimisation of DFV survivors.

The following reflective questions are useful to consider when working collaboratively with survivors:

- Do we critically reflect on how we use our professional power when engaging with survivors of DFV? Do our actions close or open up help-seeking possibilities?
- How do we use our resources to help her achieve her vision of safety and a better life for herself and her children?
- How are we advocating for her with other systems that she is involved with?
- If we are DFV providers, are we sharing information, with her permission, with her mental or substance abuse providers about the perpetrators' patterns and her strengths as parent?
- If we are statutory child welfare, how we developing plans that account for the potential for the perpetrator to sabotage the survivors' recovery and treatment efforts?
- Do we aim to build strong alliances with women and children that honours their expertise gained through lived experiences? Do we use 'power over' or 'power with' approaches in our work with survivors?
- Are we aware of our agency or the wider service system might be replicating the dynamics of power and control perpetrated by men who use violence and control?

Practice Tip

Take every opportunity to work collaboratively with women survivors. Some **questions** that you may find useful to use in order to improve collaboration are:

- *"What would you want to see change in your household to make it a stronger, healthier family?"*
- *"What would help you and the children be safer when your partner is using drugs?"*
- *"Since part of my job is to work with the whole family, what would you like to have me talk to your partner about?"*
- *"What do you think your kids would say about what would make the situation better?"*

Some examples of collaborative case planning:

- *Calling up her substance abuse program after she has been kicked out due to absences caused by her partner and advocating for her return to the program*
- *Working with her to address housing issues created by the perpetrator's substance misuse.*

Siobahn's story

A mother with three children has been engaged with DFV services for the past five years. She has previously been engaged with mental health and alcohol and other drug treatment services. She has a history of suicidality since adolescence and severe postnatal depression. She is in recovery and stable on an opiate treatment program. She is separated from her ex-partner and the father of her children. Referral paperwork notes an attempted strangulation by her ex-partner, characterising it as an isolated incident, but importantly one correlated with an increased risk of lethality or domestic homicide.

Practitioners partnered with Siobahn, focused on mapping the perpetrator's behaviours and were able to document that her partner engaged in a systemic pattern of coercive control exercised through emotional and psychological abuse. Siobahn disclosed that he became more violent after the birth of their first child. She reported he isolated her from family and friends, and would go out and leave her responsible for all the children. She reported he would call her "crazy" and a "drug addict". It was noted that he is very articulate and intelligent and often contacts services working with the mother to try and sabotage her treatment. He had previously made malicious reports to child protection and in the family court which were retaliation for her not letting him see the children.

The DFV service have supported her while she was trying to make the relationship work, as well as when she decided to leave her ex-partner. The referral was initially made by statutory child protection services. The DFV service have supported her through counselling, case management, court support, playgroups, parenting groups and financial assistance. The DFV service took the family to a refuge when she first left her ex-partner and helped her obtain a subsidy on a private rental for herself and her children after this. She was fearful of her children being removed from her care, but the DFV service has helped advocate for her and her children have stayed with her.

Services also helped her feel more confident in her own parenting and focused on her strengths as a mother. They explored with her the ways that her ex-partner had undermined her parenting and created instability for the family. They asked questions about the context of her mental health and substance misuse and were able to connect the dots between these issues and her partner's violence, particularly how he has sabotaged her attempts at treatment. They noticed that when he is 'out of the picture', she stops using substances and her mental health improves.

Her ex-partner had previously attended counselling and completed a men's behaviour change program. She reported things were better after this. However, he again became violent during her most recent pregnancy and physically assaulted her on several occasions during this pregnancy. Knowing that incidents of violence perpetrated during pregnancy post high levels of risk to women and unborn children, the DFV service facilitate contact between him and the children at the centre once a month. The mother has reported that he 'hates' the DFV service because they know about his violence.

Working with fathers at the intersections of DFV, parental substance misuse and mental health issues involves ‘pivoting to the perpetrator’. This concept requires a perpetrator-pattern based approach, as opposed to the ‘single DFV incident’ focus. Pivoting is one of the three cornerstone principles of the Model and a child-focussed, DFV-informed, all-of-family approach to child protection.

Techniques for ‘pivoting’ at the intersections

Practical strategies for ‘pivoting to the perpetrator’ within a context of complexity include:

- ✓ increasing the visibility of fathers who use of violence and coercive control
- ✓ developing practices that hold men accountable for their use of violence and coercive control, irrespective of factors that increase the complexity of their lives
- ✓ engaging men who use violence and coercive control within a context of complexity

To guide practice while ‘pivoting to the perpetrator’ at the intersections of DFV, parental substance misuse and/or mental health issues, the Safe & Together approach emphasises that the following reflective questions be kept in mind.

Questions for consideration when working with men

- What role does parental substance misuse and/or mental health issues play in exacerbating the perpetrator’s danger to the family or harm to the children?
- Are we making clear connections between parental substance misuse and/or mental health issues and risk, safety and/or protective factors related to the perpetrator’s use of violence and coercive control?
- Are we integrating safety considerations into the treatment of parental substance misuse and/or mental health issues for adult and child survivors?
- Are we exploring how the perpetrator may interfere with or undermine the adult survivor’s treatment or recovery as a tactic of coercive control?
- Do we excuse the perpetrator from taking responsibility for abusive behaviours through diagnostic and treatment procedures and documentation practices?
- Are we engaging in ‘siloed practice’ that separates the perpetrator’s use of violence and coercive control from substance misuse and/or mental health issues of the perpetrator or survivor?

1. Increasing the visibility of fathers who use violence and coercive control

The approach is to build confidence in working with men generally, and specifically with men who use DFV and who have substance misuse and/or mental health issues. Consider how to increase the visibility and accountability of domestically violent men and their impact on women and children within your service setting. Mental health, men's behaviour change programmes, and mental health treatment programs often ignore or minimize a men's role as father in their service delivery. This allows perpetrators as parents to remain invisible in these services.

The following reflective questions are useful to consider in relation to your practice and your agency's processes:

- Do we approach families in manner that communicates that we consider the fathers' behaviours and choices particularly in relation to the use of substances and violence and abuse important to how the family functions day to day?
- Do we routinely ask men about their role as fathers within families?
- Do we routinely engage women in conversations about their partner's or ex-partners' the nature of their contributions to the family as parents?
- Do we routinely engage children and young people in conversations about their fathers' parenting, behaviour toward the other parent, and their relationship with him?
- Do we ask men about how they can act to strengthen the functioning of the family and the children?
- Do we devote a significant amount of time in our substance abuse, DFV or mental health programs to men's role as fathers and the intersection of their issues with fathering behaviour?
- Do we explore fathers' concerns for their children and their identity as a father as a potential motivator for change?

Practice Tip

Ask men who engage with you and/or your service questions about their families. Practice working in a manner that sends a message that you and your service have high expectations of men as fathers irrespective of their mental health and/or substance misuse issues. It may not be safe for women and children to have ongoing relationships with men who are deemed to present too high a risk. When this is the case, it will be useful to engage men in conversations about how they can still meet their responsibilities as a father in other ways, including meeting financial obligations.

Focus on the children

- *How are you supporting their education, their development?*
- *How are you engaging with, protecting, taking care of the kids?*
- *How do you talk about your children?*
- *How often do you spend time with them? What do you do with them that they enjoy?*
- *What specifically do you do to provide for your children?*
- *What do you do to support your partner or ex-partner as a mother?*

2. Holding men accountable for their use of violence and coercive control in a context of complexity

The response that men who use violence and coercive control receive from practitioners can significantly influence the safety and wellbeing outcomes for women and children. Perpetrators who receive a response that encourages them to take responsibility for their violence and coercive control, irrespective of their mental health and/or substance misuse issues can increase safety for women and children, and promote positive behaviour change. Alternatively, professional responses that excuse or justify men's use of violence and coercive control can place women and children at significant risk of harm.

Irrespective of the complexity of fathers' lives the following reflective questions are useful to consider in relation to your practice and your agency's processes:

- Do we map the perpetrator's patterns of coercive control to separate their use of violence and coercive control from their substance misuse and/or mental health issues?
- Do we send a consistent message that men who use violence and coercive control are 100% responsible for their use of abusive behaviours?
- Do our substance use and mental health assessments integrate questions about perpetration of abuse and integrate results into treatment recommendations?
- Do we hold men as fathers to the same parenting standards of accountability that we hold women to as mothers?
- Do we send a clear message that perpetrators are making a parenting choice when they use violence and coercive control within families?
- Are we taking advice from the survivor about the safest and best way to approach and engage him?

Practice Tip

Avoid engaging in practices that inhibit domestically violent men from leaning towards becoming accountable for abusive and controlling behaviour. Critically reflect on explanations that are provided by domestically violent men, family members and professionals to explain abuse and coercive control. Be careful to avoid practicing in a manner that holds women responsible for men's abusive behaviours. Be careful not to make causal connections between domestic violence and mental health problems and/or substance misuse issues. Instead of labelling women as mutually responsible for violence or colluding with the perpetrator's explanations for violence, redirect your line of questioning to focus on his pattern of abusive behaviour.

"It doesn't matter if it is a diagnosed mental health issue. He has threatened to kill his family and has killed animals ... He has refused medication and help and treatment plans. The threats need to stop. The police had it right and kept him in saying he is too dangerous. It is rare for those with a trauma history to be so smart about how they threaten and threaten to kill their family. They are normally more chaotic. His behaviours are simply him using coercive control." (STACY Participant)

3. Engaging men who use violence and coercive control in a context of complexity

Men who use violence and coercive control and who have mental health and/or substance misuse issues often deny, minimise and justify their abusive behaviours by blaming their partners, mental health issue, substances, trauma histories, life circumstances, etc. Men who use violence and coercive control are often highly skilled at grooming and manipulating those around them. For example, it is common for perpetrators to adopt a victim stance and try to convince professionals that they are the victims within their relationships.

Responsive engagement requires practitioners to be well informed about the research evidence showing the gendered nature of domestic violence, in order to avoid colluding with perpetrators of domestic violence. Practitioners from all fields can benefit from adopting a perpetrator patterned based mapping tool to guide their work with men who use violence, as well as, with adult and child survivors.

Irrespective of the complexity of fathers' lives the following reflective questions are useful to consider in relation to your practice and your agency's processes:

- Do we use a mapping tool that enables us to assess and engage domestically violent men in conversations about their perpetration patterns, mental health and/or substance misuse issues?
- Do we feel confident in our knowledge about the drivers of domestic and family violence?
- Do we balance our therapeutic role with men who use violence and control with our ethical obligations to ensure the safety of women and children?

Practice Tip

Build confidence in engaging with men who use violence and who are seeking your assistance to address their substance misuse and/or mental health issues. Providing therapeutic assistance does not preclude gathering information about perpetration patterns and/or engaging men in a project to address their use of violence and coercive control. However, keep in mind that engaging men in a process of change must always be secondary to ensuring women's and children's safety.

Are we assessing for danger to others when someone presents as depressed or suicidal and has history of violence? Similarly, are we assessing for patterns of manipulation around mental health issues, e.g. clients using their mental health diagnoses as an excuse for violence or a way to manipulate a partner to stay with them?

How are we building behaviour change goals related to abuse and control into plans for perpetrators with substance use or mental health challenges?

Daryan's story

Child protection (CP) workers have been engaging with a family for approximately 18 months. The couple migrated to Australia as refugees and have two children under the age of 5. A report alleged physical and verbal abuse, including assault and attempted strangulation, by her husband, Daryan. Their children had experienced their father's violence and control in multiple ways.

CP workers initially spoke with the mother about Daryan's violence and asked her what she would like services to do. She said, "I want you to get him to stop". She said that she would like to remain at home with her husband and children, and the CP worker made the decision to support this and work with the family to prevent any children being removed. The CP worker described how he had to convince other workers that this was the right decision and the importance of being able to hold risk collectively as a team rather than an individual. The CP worker noted that historically services would have engaged only with the mother and blamed her for 'allowing' children to witness domestic violence. The worker noted that several services had attempted to work with the family, but none had engaged with the father and held him accountable for his use of violence. CP used both a male worker and a bilingual worker with specialist cultural knowledge to engage the family. CP workers were able to engage the father by being persistent and not giving up, calling and attending the home on several occasions to contact him. The father blamed his violence on the trauma he had experienced as a refugee and claimed that violence against women is a part of his culture. He also criticised his wife's parenting, in particular strategically highlighting that she has a mental illness and is using cannabis and opiates.

Workers maintained a respectful approach, while challenging his justifications for violence and explained that their role was to support him to change. They helped him to understand how his children were impacted by the violence and explored his ideas around gender roles. They validated the things that he was doing well in terms of parenting and his motivation to be a good father. The father reported that he saw himself as protecting the family and they were able to challenge his perception of himself as a caring dad in light of the fact that his children were afraid of him. They described how they had to try many different angles and strategies to support the father to see that he was responsible for his actions.

Workers maintained the focus on his violence and were careful not to collude with him in criticising his wife. They could see that her depression, anxiety and substance use was her way of coping with his violence and that he had caused and exacerbated these issues, including supplying her with addictive substances.

CP were transparent with the father about their expectations, including that he enroll in a Men's Behaviour Change Program (MBCP). CP workers began by driving him to each session and made sure to communicate with the MBCP to track his progress. They also continued to meet with the mother and the children to make sure they were safe and to check if they were seeing changes in the father's behaviour. CP were ultimately able to close the case after 18 months as there were no further reports of violence. The family are continuing to engage with other services.

The safety and wellbeing of children and young people must always be the paramount consideration driving practice with families that contain men who use violence and coercive control. In the midst of significant complexity arising from DFV, substance misuse and/or mental health issues, which are often nested within other forms of oppression such as racism, sexism, and poverty, adult's problems can override considerations about children and young people.

Techniques for focusing on children's safety and wellbeing at the intersections

Practical strategies to increase the focus on children within a context of complexity include:

- ✓ Keeping children visible and heard
- ✓ Connecting the dots between the perpetrator's pattern, including substance misuse and/or mental health issues and the impact on children
- ✓ Validate and support children and young people

To guide practice to ensure a strong focus on children's safety and wellbeing at the intersections of DFV, substance misuse and mental health issues, the following reflective questions can be kept in mind:

Questions for consideration when focusing on children's safety and wellbeing

- Do we participate in case plans that have the ultimate goal of ensuring that all efforts are undertaken to enable children and young people to live safely together with their non-offending parent?
- Do we make a concerted and persistent effort to engage, interview and validate child survivors who experience parental substance misuse, DFV, and/or parental mental health issues?
- Do we advocate for children's and young people's voices to be heard and for their lived experiences to be taken seriously?
- Does my agency or community invest sufficiently in services to help children living in complexity to heal and enjoy their full citizenship rights?
- Do we seek to contextualize children's behavioural, mental health or substance use issues back to the perpetrator's behaviours?
- Does our treatment plan for children consider how the perpetrator may attempt to sabotage or interfere with their recovery or treatment efforts?
- Do we consider counselling options that include the mother to encourage the mother-child relationship that can be damaged by his abuse?

1. Keeping children and young people visible and heard

Children and young people are often the unseen victims of DFV, and this reality can be exacerbated when their parents have substance misuse and/or mental health issues. Historically, children and young people have been considered the ‘secondary victims’ within families characterised by male violence and additional complexities. A significant body of research has disrupted the idea that children are passive and unaffected by DFV, parental mental health issues and/or substance misuse. Research has shown that practitioners must make a concerted effort to maintain a strong focus on the safety and wellbeing needs of children and young people. A perpetrator pattern-based approach, which assesses for both coercive control toward the adult survivor and abuse and control toward children, can help keep children visible and heard. A focus on a family functioning approach, which considers how the perpetrator’s actions changes the way the family functions day to day, can really help make visible how the perpetrator is harming children and impact normal developmental activities.

The following reflective questions are useful to consider in relation to your practice and your agency’s processes:

- Do we routinely engage children in conversations about their experiences of living with DFV, parental substance misuse and/or parental mental health issues?
- Do we encourage children and young people to share their worries and concerns with you that may relate to both the non-offending parent and the perpetrating parent?
- Are we familiar and up-to-date with the research about how children can be impacted by DFV, parental substance misuse and/or parental mental health issues?
- Are we assessing and documenting the full range of risk factors, protective factors and strengths that exist in children’s and young people’s lives?

Practice Tip

Remember that children and young people do not have to be direct recipients of physical abuse or sexualized violence to be adversely affected by DFV. Similarly, they do not have to be physically present and witness to incidents of violence or abuse to be adversely affected by DFV. The ripple on effects of DFV are pervasive and can adversely affect many aspects of children’s health and development, as well as, the family’s ecology. Smashed walls, broken furniture, ongoing tension, anxiety and fear, maintaining secrets and experiencing divided loyalties are all part of living with fathers who use violence and control. Practitioners need to assess and listen to the full spectrum of experiences that children and young people have. They may also need to advocate for the rights of children to be heard and understood, which may mean influencing colleagues.

- *Are we assessing the possible connections between children’s symptoms and issues to the perpetrator’s behaviour pattern?*
- *Does our plan to work with children account for the potential for sabotage from the perpetrator?*
- *Do we seek to understand the continuing influence, and even danger, posed by a perpetrator who is a non-custodial parent?*

2. Connecting the dots

In order to focus on children's safety and wellbeing, it is vital to 'connect the dots' between the perpetrator's pattern of violence and coercive control, and other risk factors such as mental health issues and substance misuse when considering outcomes for children and young people. Children and young people who experience domestic violence and other forms of child maltreatment are more likely to exhibit internalising and externalising behaviour problems, as a result of the perpetrator's harmful patterns and violent examples. Practitioners must be mindful to assess children's behaviour problems by paying attention to the wider traumatic context that the perpetrator established.

Irrespective of the complexity of their parents' lives, the following reflective questions are useful to consider in relation to understanding children's responses to trauma:

- Do we connect children's behaviours to the perpetrator's patterns of violence and coercive control, linked with parental substance misuse and/or mental health problems?
- Do we consider how children's behaviours may serve to protect them and/or their mothers and siblings from further violence or abuse from their fathers?
- Do we help children and young people make sense of abuses of power occurring within their families? Do we 'set the record straight' and help children understand they neither they, nor their mothers, are responsible for DFV?
- Do we clearly illuminate the 'pathway to harm' that connects the perpetrator's pattern of violence and control to children's behaviours? Is this clearly articulated in our documentation and advocacy with other service providers working with the family?

Practice Tip

Avoid using terms like 'child-initiated violence' or 'adolescent perpetrator' as these can serve to blame children and fail to account for the myriad reasons that they may use abusive behaviours, including protecting themselves or others from parental violence. We often think, wrongly, that children are passive witnesses to their abuse of their parent. We need to assess their safety strategies as much as we assess the strategies of an adult survivor. Be aware that mental health frameworks that emphasize children's feelings in reaction to abuse may miss the ways they are active in their own and others safety efforts.

- Assess a child's behaviour in reaction to their parent's violence and abuse?
- Assess how a child works with a parent and/or other siblings to increase the safety for all family members?
- Assess for how a child might be the target of manipulation or enrolment of the perpetrator toward their "side?"

3. Validating and supporting

Children and young people who experience DFV and other trauma associated with parental mental health issues and/or parental substance misuse issues have their own particular needs for protection, understanding and support that are separate to the needs of the adults in their lives.

Irrespective of the complexity of their parents' lives, the following reflective questions are useful to consider in relation to your practice and your agency's processes:

- How do we work towards keeping children safe and together with the non-offending parent?
- Do we convey the message that we believe children survivors of DFV?
- Do we convey the message that we understand and support the complex and conflicting feelings that children may have for both parents?
- Do we validate the child's family in a way that promotes their dignity and acknowledges the complexity of the context in which they live?
- Does my agency support efforts to build relationships based upon trust and validation especially when this takes time given the multiple complexities involved?

Practice Tip

It is important to remember that many children and young people who live with DFV and other complexities are not passive victims. On the contrary, many children and young people are active agents in their families – keeping siblings safe, attempting to placate a violent father, providing comfort and reassurance to mothers' post violence, maintaining the family 'secret' within the wider family and/or community. Practitioners must be mindful to gather information about the child's role within the family and be sensitive to their sense of agency. Helping children understand that they are not responsible for DFV, parental substance misuse and/or mental health issues is imperative. A staged approach to reducing parentified behaviours in children may be necessary to avoid compounding children's feelings of losing control that are symptomatic of experiencing DFV.

If there any history of DFV in a family, ensure that any diagnosis of child considers that history as a factor in making the diagnosis.

Consider how to include safely or exclude a domestic violence perpetrator in any family work with children.

Consider that children can be scapegoated by perpetrators who seek to keep the focus on a child that is a survivor, not on themselves and their behaviour.

Hector's story

A family service has been working with several members of a family over the past year. The service has worked with all three children in the family, who are aged between 7 and 14. They all currently live with their mother. Their father has a history of being violent towards their mother, including after they had separated. Their mother remains the primary carer for their father who has a number of mental health diagnoses including schizophrenia and post-traumatic stress disorder. He is currently incarcerated for assaulting retail staff while under the influence of methamphetamines.

The children had previously been removed from their mother's care due to DFV in the home, parental substance use and mental health, and risk of neglect. The workers were able to identify that the children in the family were not being seen or heard by many services and understand that each child has a different perspective on what is happening for the family. In particular, they found that in the past child protection and the legal system had made decisions without properly consulting the children. The children were recently restored to the mother's care largely due to the advocacy of the family service who spent time talking to the children and were able to share the children's perspective and preference to live with their mother.

The eldest child in the family is 14 and has previously been given diagnoses of oppositional defiant disorder and social anxiety. He sees a counsellor at the family service and they have connected these behaviours to the environment that his father created. Workers have asked the children questions around what happens when their father shows up, how they felt and what goes on in their minds when they see him yelling at and hurting their mother. The counsellor noticed that he worries about the safety of his mother and younger siblings. In the past, their father has tried to forcibly remove his children from the school playground and they have witnessed him threatening to kill their mother on several occasions. Family services reported they could understand that these 'diagnoses' were really the impacts of his father's violence and have shared this perspective with the other services involved, including child protection. They also have documented the ways the mother is keeping the family safe and that she is worried for her children's safety. They have been clear with her that they don't have concerns about her parenting and that the threats to her family's safety and wellbeing are entirely from their father.

Workers have also seen the younger children in the family and are able to be flexible in their services depending on the age of the child they are seeing. The younger children have been supported through counselling, play therapy and early childhood services. The family service has also seen the mother for counselling, advocacy and casework support. All of the family, including the children, have been involved in safety planning. The family is continuing to engage with services and the service has been able to adjust to reflect the children's needs as they get older.

The intersections of child protection, DFV, mental health and substance misuse is a complex area of practice in which practitioners across various sectors face numerous challenges to their physical, psychological and emotional safety. These threats are interrelated and stem from factors within client families, the individual worker, the organisation and the wider community.

Techniques for focusing on worker safety and wellbeing at the intersections

Practical strategies to increase the focus on children within a context of complexity include:

- ✓ Attending to physical safety
- ✓ Promoting emotional and psychological wellbeing

The following reflective questions may be useful to consider when attending to worker safety at the intersections of DFV, substance misuse and mental health issues:

Questions for consideration in focusing on worker safety

- How do we assess and manage perpetrator risks to workers engaging in families where there is DFV, mental health problems and/or substance misuse?
- How do we share information and collaborate with other professionals to ensure worker safety when multiple agencies are engaging with the family?
- What role does substance misuse and/or mental health issues play in exacerbating the risks to workers?
- How are workers and organisations considering psychological and emotional safety to promote wellbeing?
- How do senior managers support practitioners working in a frustrating environment where there is a lack of resources for their clients particularly in relation to housing and impoverishment (for example, having to 'choose' between putting food on the table and paying for mental health treatment)?

1. Attending to physical safety

Considerations about working safely are intertwined with considerations about the safety of women and children. It is primarily incumbent upon organisations to ensure that worker physical and emotional safety considerations are prioritised. Threats to worker safety made by men who use violence and control are not uncommon and need to be taken seriously by practitioners and managers. In our increasingly digital age, workers must also be mindful of how perpetrators can use technology facilitated abuse to exert power and control over others. Worker safety fears for themselves and the family may be one of the most significant barriers to implementing domestic violence-informed work including partnering with survivors and intervening with perpetrators.

The following reflective questions are useful to consider in relation to promoting worker safety in your practice and your agency's processes:

- What steps does our organisation take to mitigate risks to workers resulting from abuse (including technology facilitated abuse), threats, harassment, and intimidation from men who use violence, misuse substances and/or have mental health concerns?
- Prior to meeting with domestically violent men, do we ensure that we have gathered information about their perpetration patterns, substance misuse patterns, and mental health status?
- When making arrangements to meet with men who use violence and/or other family members, do we meet with managers and colleagues to plan how to best approach the meeting – including the development of worker safety plans?
- Do we hold meetings in locations that are deemed to be safe?
- Do we have opportunities to participate in training that focuses on enhancing worker safety? Could our agency have 'worker safety' as a regular agenda item at team/staff meetings?
- Does our agency consider intersectionalities when we assessing worker safety, e.g. how perpetrators may target workers based on race, ethnicity, gender or other factors?
- Do we create a safe environment where workers can talk about how their experiences of violence (personal and professional) may be shaping their practice?

Practice Tip

The following suggestions were made by practitioners who participated in Communities of Practice regarding how to attend to physical safety:

- *Have protocols and good working relationships with police.*
- *Share information about factors that increase the risks to workers.*
- *Conduct home visits in pairs.*
- *Always inform management and colleagues of your whereabouts when in the field.*
- *Organisations should ensure that the office space/physical environment promotes worker physical safety.*

2. Promoting emotional and psychological wellbeing

Working with families at the intersections of DFV, mental health and substance misuse can be emotionally and psychologically taxing. Practitioners require high quality professional supervision and organisational mandates that aim to establish a safe working environment. For many practitioners, the emotional impact of this work is compounded by working within a risk adverse culture prone to blaming workers when things go wrong.

Irrespective of the complexity of service users' lives, the following reflective questions are useful to consider in relation to promoting worker safety in your practice and your agency's processes:

- What steps does our organisation take to promote the wellbeing of workers and to collectively share responsibility for decisions made about women's and children's safety within a context of complexity?
- Do we regularly debrief with team leaders and/or trusted colleagues?
- Does our organisation ensure that professional supervision is not narrowly reduced to discussions of task-based activities, but contains space to critically reflect on workers' emotional responses to dealing with uncertainty, safety concerns and risks?
- Do we take regular holidays? Have lunch away from our desks? Avoid taking work home?
- Does our organisation promote collective, relationship-based approaches to worker care that inspire a sense of solidarity in addressing and preventing oppression against women and children?

Practice Tip

The following statements by practitioners who participated in Communities of Practice are illustrative of workers' perceptions of their needs in relation to worker safety:

- *"Worker safety should be seen as a priority and not the last thing on the list."*
- *"We need to hold risk collectively as a team, and even between agencies, not just as individual clinicians."*
- *"We need to reduce the blame-game when there is a critical incident. Workers are often blamed for perpetrator behaviours in the same way that women who are victims are."*
- *"Rather than self-care, it should be a culture of care. It shouldn't be something you talk about in orientation of new staff and is then forgotten a few months later."*
- *"There needs to be top-down support. Managers need to understand the reality of work on the frontline."*

Giselle's story

A number of services had been engaged with a family for over three years. The initial concerns were about the mother's mental health and DFV in the home and a referral to child protection (CP) was made. When CP began working with the mother she disclosed severe violence from her husband, including physical and sexualized violence. He has threatened to kill her if she leaves the relationship and has got his family members to monitor, threaten and assault her. CP workers have observed his extensive collection of weapons inside the home and obtained his lengthy criminal record from police. He is using cannabis, methamphetamines and alcohol and has on several occasions become violent and erratic as the result of drug-induced psychoses.

When CP began working with the family, they were advised by police to 'back off' due to the risk from the father. Red flags were raised by the father's previous assault on an ambulance worker who was called to the home by one of the children out of concern for their mother. CP decided to continue working with the mother and children given the risk to their safety and are supporting the children to remain at home. They have documented the mother's protective strategies and resilience and her willingness to work with services despite the risks involved. The children are protective towards their mother and have been observed to be afraid of their father, not speaking to workers when he is present.

Most other services had ceased working with the family due to the risk. The father had a history of threatening workers, including detailed threats to kill the CP workers involved. The CP worker described how her workplace supported her by increasing the security of the case and making sure that if the father calls or attends the office he is unable to speak to the workers he has threatened. The CP worker met with police about getting a protection order, however noted that she would have to give personal details and a statement which he would see, and that she didn't feel safe to do this.

The safety of the workers involved was maintained through safety planning around use of transport, meeting with the mother at the children's school and careful use of technology. The worker noted that the case had also impacted on her emotional and psychological safety at work, in particular her fears that the father will follow through on his threats to kill his family. She reported that she has discussed the case at length in supervision and reviews with the team and management. She reported that she will continue to work the case despite the risk, because the mother had felt able to disclose the extent of the violence and "If I don't work with her, who will? What kind of message does that send if we back out?"

CP continue to work with the mother and children. Although they are not working with the father directly they are communicating with services that do have contact with him (police, justice services and health services) to keep him visible and gather information. They continue to periodically re-assess risks to both the family and workers as per the agency's policies and protocols.

Historically, DFV, child protection services, alcohol and other drug services and mental health services have been siloed from each other, despite the fact that they have often been working with the same service users. In order for organisations to work collaboratively, it is vital that siloed service delivery is identified and attempts to develop holistic services that attend to the multiple and complex needs of families are established. Working collaboratively with family members, and the non-offending parent in particular is a vital part of good practice that leads to improved safety and wellbeing outcomes. Women who experience DFV are pivotal players in the multi-disciplinary team and workers need to collaborate at all phases of the intervention process with them. In parallel, when services collaborate around interventions with perpetrator, using shared information and a common framework around accountability and change, outcomes can improve for families.

Techniques for working collaboratively at the intersections

Practical strategies for working collaboratively within a context of complexity include:

- ✓ Identifying and breaking down silos in service delivery
- ✓ Leadership and formalisation of protocols for information sharing

The following reflective questions may be helpful to guide practice while working collaboratively at the intersections of DFV, substance misuse and mental health issues:

Questions for consideration when working collaboratively:

- Do we consider women survivors to be pivotal members of the multi-disciplinary team who have lived experience expertise in relation to the safety and wellbeing needs of their children and families?
- Do we identify aspects of the service system that are fragmented and advocate for more joined-up services?
- Are services coordinating around interventions with perpetrators?
- Where do we rate our agency on the Safe & Together continuum of domestic violence-informed practice?
- What can we do to move our agency towards domestic violence proficient practice?

1. Identifying and break down silos

Men who use violence and coercive control can have multiple issues that need to be addressed. For example, it is common for men who use violence to have substance misuse and/or mental health issues. Multiple issues can translate into multiple, disconnected or siloed services with very little or no communication between services. In the face of such complexity, practitioners and their agencies can adopt a narrow focus on a single issue and render his DFV invisible. For example, a mental health practitioner may focus predominantly on the man's symptoms of mental illness and recovery plan paying little to no attention to his use of violence and coercive control towards his partner. The following reflective questions are useful to consider in relation to your practice and your agency's processes:

- When men who use violence and coercive control are referred to multiple services, what is the level of communication (information sharing) and coordination between these services?
- Does our agency or other agencies in our community provide any combined or integrated services that address DFV, substance misuse and/or mental health issues?
- Does mental health and substance misuse service staff understand the intersection of DFV perpetration, substance misuse and mental health issues?
- If you work in the fields of mental health and/or substance misuse does your agency routinely undertake formal, universal screening for DFV for all clients? ie. Do we routinely integrate and ask specific questions related to DFV within our assessment/diagnostic procedures?
- Does our agency encourage us to hold the view that it is beyond our remit to engage in work with fathers who use violence and coercive control? Do we see it as our role to engage in a perpetrator patterned based response to our practice?
- Do agencies that only work with men proactively seek to partner with agencies working with women in order to gain information regarding her perceptions of safe engagement, safety and evidence of change?

Practice Tip

Irrespective of your field of practice, you can play an important role in keeping women and children safe. Your intervention may also be instrumental in encouraging fathers who use violence to seek help to develop non-violent and non-controlling ways to relate to family members. Preventing and responding appropriately to people who use violence, and adult and child survivors is everybody's business. It is important for mental health and alcohol and other drug professionals to be tuned into perpetration patterns throughout their diagnostic or assessment processes. Make it your business to consider the perpetrator's patterns of behaviours in context through clarifying questions with other clients and colleagues.

Refer clients with indicators of coercive control and abuse to specialized family violence services.

Use a DFV informed assessment framework. For example, when DFV is present, a suicidal gesture or depression needs to be assessed from the potential for self-harm, harm to others and/or attempt to manipulate others.

2. Leadership and formalisation of protocols

Leadership is required to shift organisational cultures to become more domestically violence informed. Strategies to embed cultural changes within organisations need to be supported by senior management who believe them to be necessary. Leadership in substance misuse, mental health and child protection needs to understand the implications of DFV-informed proficiency for their bottom-line missions. Formalised protocols, particularly to guide information sharing can enhance communication within and between agencies. Sharing relevant information that enhances the ability of practitioners to make judgements about safety and risk is vital. Having a shared language and a shared vision is an important foundation for information sharing that can be enhanced through formalised practice and policies. Building trusting relationships within and between agencies who have historically engaged in siloed practices backed by fragmented policies and legislations takes time. STACY participants who were champions of change offer a positive working model to enhance collaboration.

The following reflective questions are useful to consider in relation to agency leadership and processes:

- Is there one change that our agency could make in its policies or practices (forms, assessments, protocols) that might improve domestic violence informed practice related to the intersection of DFV and substance misuse and/or mental health issues?
- Are we aware of all relevant domestic violence legislation, policies and protocols that exist to guide practice, and particularly to guide information sharing and collaboration within and between agencies?

Practice Tip

Leadership to shift organisational cultures is vital, particularly if agencies have historically held the view that responding to domestic violence is not within their remit.

STACY participants offered the following suggestions for building in opportunities to improve practice:

- *Substance misuse and mental health agencies should map out how DFV impacts their clients and their service delivery with eye toward changes that enhance their mission.*
- *Review substance misuse and mental health programs intake and assessment forms for questions regarding DFV.*
- *Child protection should evaluate the siloed nature of funded program.*
- *Consider multi-disciplinary meetings focused on cases involving DFV and mental health and/or substance misuse.*

Georgia's story

Multiple services are involved with a family with a 6-month-old baby. The mother is young and with diagnosed cognitive impairment and several mental health diagnoses. The father is 20 years older and little was known about his history. This is her first child, he has at least two from previous relationships, unsure about contact and who they live with. Child protection (CP) removed the baby with mother's consent for a three-month period, due to an incident whereby, she was assaulted by her partner while holding the child. They are working to restore the child to the mother's care. The most recent DFV incident involved sexualized violence and her partner threatening to inject her with drugs if she didn't comply with his demands to gratify himself. In response to this she assaulted him and fled the home. Police charged her with DFV and placed a protection order against her. A number of services are now involved – child protection, women's DFV services, men's DFV services, AOD, MH, justice and legal services. The mother has reported to her CP caseworker, Georgia that she wants to continue the relationship out of fear for the consequences of not remaining in it.

All the services have only recently become involved and are trying to understand how they can work collaboratively to support the family. CP facilitated an interagency meeting and identified that the mother has been wrongly identified as the primary aggressor and they wish to have the protection order against her removed. During this meeting, Georgia facilitated a mapping exercise with services to share information about the perpetrator's patterns of behaviour and violence. Different services were found to have different 'pieces of the puzzle' and they were able to gather more information – that he has a lengthy history of extreme DFV towards his partners, including physical, sexual, verbal and emotional abuse. This mapping tool was then shared with the legal services working with the mother who are planning to use it in court proceedings. The services realised some of the ways they were making the mother responsible for the violence by focusing on her trauma history and trying to educate her about healthy relationships. Mapping the perpetrator behaviours led to an increased focus on how they could engage with the father and have higher standards for him.

Discussing the case in an interagency setting also allowed the participants to share information about the ways the father had sabotaged the mother's ability to engage with services. The services involved reported it was helpful to know who else was working with the family and to have everyone in the same room to talk. They noticed some limitations in terms of their own agency protocols for sharing information and have looked into having these reviewed. The services involved said one of the reasons the interagency meeting went well is because they had mostly completed Safe & Together training and so had a shared language and framework for understanding DFV.

Influencing organisational practice change and capacity building

PRACTICE GUIDE

Influencing organisational practice change and capacity building is complex work and requires both a ‘top down’ and ‘bottom up’ approach involving individual practitioners, senior management and governance. To gain traction it is important to start small – set realistic and achievable targets that can be embedded into sustainable change in the long term. Work together with like-minded people who are equally committed to supporting organisational change and capacity building initiatives. Being part of a team that has a collective vision and purpose fosters enthusiasm and momentum collaboration towards improved practices.

Techniques for influencing organisational practice change and capacity building at the intersections of DFV, AOD and MH

Techniques for influencing organisational practice change and building capacity to work and collaborate at the intersections of DFV, substance misuse and/or mental health issues include:

- ✓ Explore key areas for practice change and capacity building
- ✓ Explore key strategies to influence practice change and build capacity
- ✓ Explore key barriers and facilitators

The following key questions are useful to consider:

Questions for consideration when influencing organisational practice change and capacity building

- Where is our practice (organisationally) in terms of implementing a child-focussed, DFV-informed, all-of-family approach to working at the intersections?
- What are the key areas that need to be addressed in our organisation when working towards a DFV-informed approach to practice at the intersections?
- What is our capacity to influence the practice of others within our organisation and collaborating agencies?
- Are we using consistent DFV-informed messaging across all our interactions with colleagues, collaborating organisations and clients?
- Are we willing to be flexible in how we approach implementing practice change to build the capacity of workers and organisations to be DFV-informed when working at the intersections?
- Are we setting realistic, achievable practice change goals that have a cumulative effect towards a complex system’s change?

Influencing organisational practice change and capacity building

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1. Explore key areas for practice change and capacity building

Explore key areas to focus on within your organisation and develop collaborative partnerships in order to influence broader practice change and build capacity in the service system. Key areas to focus on in order to improve service delivery include: improving systems and processes, implementing targeted training and coaching toward new practice, developing opportunities for collaboration, improving processes to share information and collaboratively assess risk; using consistent language and documentation processes; and developing strong leaders who can establish the authorising environment to sustain improvements and build capacity.

Regardless of which sector you work in, the following reflective questions are useful to consider in relation to your work towards influencing organisational practice change and capacity building in any of the key areas above:

- Is our senior leadership supportive of organisational practice change and capacity building at the intersections?
- Does our organisation have clear and understandable processes to guide information sharing in complex family matters?
- Are we using a common language within our organisation, and do we have a shared language with our partner agencies build on principles such as partnering with the non-offending parent, maintaining the focus on children and holding perpetrators accountable?
- Does our agency supervisors have the authorisation, skills and experience to guide workers in new practice?
- Are we developing short- and long-term goals and plans to develop and sustain practice improvements?
- Are we adapting our organisation's practices to work towards providing DFV informed, child-focussed, all of family approaches that are based on evidence?

Practice Tips

Explore whether your senior leadership has a good sense of a child-focussed, DFV-informed, all of family approach and how it can enhance practice at the intersections of DFV, parental substance misuse and/or mental health issues. Having the support and authorising environment to pursue change and build capacity from both the top down and bottom up is essential to effective and sustainable change.

Exploring current practices around information sharing, such as what gets shared with who, how this is done and in what contexts is important to understanding the implications of sharing information and building trusting relationships between organisations.

Targeting documentation and policy changes in your organisation is a great way to ensure practice change is embedded and sustained. Look at how you can update key documents, intake, assessment and referral forms with items that bring DFV to focus and facilitate a pattern-based approach.

Influencing organisational practice change and capacity building

PRACTICE GUIDE

2. Influence practice change and build capacity

Explore key strategies that you could use to influence practice change within your agency and wider service system. These will need to be relevant and tailored to your organisation and context but could address aspects of any key area of organisational change and capacity building. Use your knowledge and understanding of your organisation and collaborative relationships and think creatively about strategies. A perpetrator pattern-based approach, or a “pivot to the perpetrator” is key to unlocking the puzzle around organisational change while maintaining a commitment to an agency’s core mission. In organisations that demonstrate domestic violence-informed practice, this perspective is present in case presentations, assessments, cross system meetings and even in the approach to survivors. Without this focus, any increased focus on DFV may not reach its full potential, and is more likely to produce negative effects for survivors.

The following reflective questions are useful to consider:

- Have my fellow practitioners been exposed to a child-focussed, DFV-informed, all of family approach, such as the Safe & Together Model, and if not, is there opportunity to organise formal or informal training for them?
- How can we go beyond training to enable ongoing engagement and application of learnings to embed practice change and build capacity within our organisation?
- Are we connecting the dots between a child-focussed, all of family approach and our current practice to become more DFV-informed when working at the intersection of DFV, parental substance misuse and/or mental health issues?
- Can we update our documentation, procedures and systems to enable more focus on the intersections of DFV, parental mental health issues and/or substance misuse?
- Are we actively developing collaborative partnerships with other organisations to work together to support clients living with intersecting complexities?
- Are we using language, including asking key questions, to shift from an incident focus to a more pattern-based approach? Are we paying attention to the language other organisations use, and could this be more explicit about behaviours, contexts and implications?

Practice Tips

Developing or organising cross agency tailored training is a great way bring people together and develop a shared vision and language. This could involve visiting a collaborating agency and presenting on how your agency is developing towards more DFV informed practice. Think about how you can embed practice changes to ensure they are sustainable and outlast personnel changes.

Language and how we describe things is crucial to how we understand issues and events – remember to keep conversations focused on patterns and behaviours and use explicit descriptions of how men who use violence and control have established fear and danger in their homes. Pay attention to how adult and child survivors are constructed in our documentation and conversations. Consider if the ways that they resist being overcome by the perpetrator’s behaviours is documented and factored into assessments and case plans. Pay attention to how you use language, but also to how collaborating organisations frame their work and interactions – ask them key questions to help them shift away from constructing women and children as passive victims who need to be rescued by ‘experts’.

Influencing organisational practice change and capacity building

PRACTICE GUIDE

3. Explore key barriers and facilitators

Pay attention to the things that are helping to build capacity and improve practice, as well as to barriers that you may be encountering. Oftentimes practice challenges result from poor policy. Think about whether there are broad issues that need to be changed in order to improve practice and consider who you can collaborate with to address such barriers. Regardless of which sector you work in, the following reflective questions are useful to consider in thinking about the barriers and facilitators to your efforts to influence organisational practice change and capacity building:

- If I am in a leadership role, am I providing my team with support and an authorising environment to implement practice change and build our capacity?
- Have we established ongoing time and space for practitioners to reflect, discuss and develop their learnings and collaborative relationships?
- Have we examined how we are assessing all clients who are fathers for their positive and negative impact of their behaviors, especially DFV, substance misuse and mental health challenges on child and family functioning?
- Are we utilising tools and real-life examples to connect theory to practice and help embed change and build capacity to work at the intersection of DFV, parental substance misuse and/or mental health issues?
- Are we banding together to effect change on broader social issues that perpetuate violence against women and children?
- Are we harnessing practitioner and organisation excitement and interest in changing their practice and building their capacity?

Practice Tips

Remember to use tools and examples when exploring DFV-informed approaches. Tools and real-life examples help connect theory and every day practice, and can be powerful when advocating for practice change, and for clients, workers or organisations who are not familiar with DFV-informed practice. Tools like the Safe & Together mapping tools are particularly useful to show the impact of shifting from an incident focus to a pattern-based approach can look like, regardless of which sector you work in.

Create and maintain specific times and spaces for practitioners to reflect, discuss and develop their work. Having this time is critical to strengthening a deeper understanding of the issues and intersections of DFV, parental substance misuse and/or mental health issues and contributes to build confidence in practitioners to embed and spread practice change within and across organisations.

Take advantage of excitement and interest from practitioners and organisations and use any opportunity to build on this. Working with a network of eager individuals at a range of levels will create a sense of momentum towards organisational practice change and capacity building.

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