ESTIE

Practice Resource

Evidence based guidelines to support the implementation of the Safe & Together approach.

ESTIE
Evidence to Support Safe & Together Implementation and Evaluation

Proudly funded by NSW GOVERNMENT

ESTIE Project team

Professor Cathy Humphreys — University of Melbourne
Dr Margaret Kertesz — University of Melbourne
Assoc. Professor Lesley Laing — University of Sydney
Cherie Toivonen — CLT Byron Consulting, Sydney
Jasmin Isobe — University of Melbourne
Erin Links — University of Melbourne
David Mandel — Safe & Together Institute
Heidi Rankin — Safe & Together Institute
Marlene Lauw — Aboriginal Cultural Safety Consultant
ML Consultancy Services, Coolangatta

For further information

Margaret Kertesz
The University of Melbourne
Department of Social Work
E: mkertesz@unimelb.edu.au
T: 03 9035 8508

Some people may find parts of this resource confronting or distressing.

If you would like to talk to someone, you can call:
1800 RESPECT — 1800 737 732
Lifeline — 13 11 14

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Disclaimer:

The University of Melbourne has prepared this Practice Resource for the benefit of the Prevention and Response to Violence Abuse and Neglect (PARVAN) Unit, Government Relations Branch, NSW Ministry of Health. The views expressed in this document are those of the University of Melbourne research team and do not necessarily reflect the views of NSW Health.

Acknowledgements

We would like to thank all of the committed and enthusiastic practitioners and service managers working in NSW Health and non-government organisations who were integral to the *ESTIE Project*. Their openness to learning and commitment to addressing Violence, Abuse and Neglect (VAN), as well as driving more domestic and family violence-informed practice across the service sectors, has been crucial to this research. Their ongoing dedication to developing a better service system for women, children, men, and families living with domestic and family violence, alongside mental health and/or alcohol and other drug use challenges has been key.

The *ESTIE Project* was only possible with generous support and funding from the Prevention and Response to Violence Abuse and Neglect Unit, Government Relations Branch, NSW Ministry of Health. Their commitment to leading innovation in this space has been critical in building the best practice evidence base.

The research team would like to acknowledge the work of the *STACY Project (Safe & Together Addressing Complexity)* and in particular the *STACY Practice Guide* that was developed as part of that project. The *STACY Practice Guide* was a foundational piece of work on which the *ESTIE Project* and accompanying *Practice Resource* and *Quick Reference Guide* were built.

Acknowledgement of Country

The *ESTIE Project* team and participants in this research recognise Aboriginal and Torres Strait Islander peoples as the First Nations' People of Australia and acknowledge the traditional custodians of the lands on which we undertook the *ESTIE Project* and on which we live and work each day. We acknowledge and thank leaders, past, present, and emerging for their tireless and continuous work in caring for country and community.

Always was, always will be Aboriginal land.

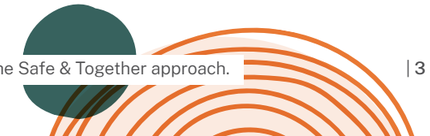
Statement of commitment to Aboriginal and Torres Strait Islander families and communities

We recognise and acknowledge all Aboriginal Australians for their acts of resistance and continuing strength in fighting against oppression and ongoing impacts of racism and colonisation on a daily basis, whilst holding an energy and commitment to keeping families and communities safe.

The *ESTIE Project* acknowledges that individual and collective experiences of trauma, including invasion, colonisation, Stolen Generations, genocide, and assimilation have been and continue to be profoundly harmful. We also acknowledge that systems continue to perpetuate violence and abuse leading to social and economic oppression for Aboriginal people, families, and communities.

The *ESTIE Project* is committed to improving individual and system responses, and recognises the complex relationships between colonisation, trauma and oppression with domestic and family violence, mental health, and drug and alcohol use. We have been privileged and honoured to be able to work in this space with our Aboriginal colleagues and build on collaborative learning from their extensive wisdom and expertise. We value their guidance on ways of healing that can be mediated by Aboriginal-led initiatives and culturally appropriate services that nurture the spirit, resilience and cultural identity of Aboriginal families and communities.

We also acknowledge that while the Safe & Together™ Model has been developed with consideration of colonisation and racism, it does not consider the specific Australian or NSW experience of colonisation, dispossession and institutional racism, and more work is required to understand how the Safe & Together™ Model intersects with local Aboriginal world views, healing frameworks and principles.



Contents

Acronyms

AOD	Alcohol and Other Drugs
CoP	Community of Practice
DCJ	Department of Communities and Justice (the statutory child protection agency in NSW)
DFV	Sector code for services focused on domestic and family violence, including men's behaviour change programs
GP	General Practitioner
LHD	Local Health District
MH	Mental Health
NGO	Non-government organisation
NSW	New South Wales
PARVAN	Prevention and Response to Violence, Abuse and Neglect Unit (part of the NSW Ministry of Health)
STIM	Safe & Together Intersections Meeting
VAN	Violence, Abuse and Neglect services (in NSW)

A note on language

This *Practice Resource* uses language that reflects the gender-based nature of violence perpetration and victimisation, and we acknowledge the many and multiple ways people of different genders, sexualities, abilities, and cultural backgrounds experience and perpetrate violence and abuse. We also acknowledge that the very nature of experiences at the intersection of domestic and family violence, alcohol and other drugs, and mental health means that language is often unable to capture or communicate fully the complexity or realities of people's lived experience.

The importance of shared and explicit language is noted throughout this report, and in the interests of working towards this, a comprehensive list of key terms and concepts that underpin the *ESTIE Project* and *Practice Resource* is included in the Glossary at the end of this document.

This *Practice Resource* respectfully uses 'Aboriginal', rather than 'Aboriginal and Torres Strait Islander' in the narrative of this document. However, we acknowledge that concepts of cultural safety are fundamental to outcomes for all Aboriginal and Torres Strait Islander Peoples in Australia, and for Indigenous Peoples globally.

SECTION ONE

Introduction

Who is this Practice Resource for?

This *Practice Resource* is designed for any worker practising at the intersections of domestic and family violence, mental health, and alcohol and other drug use, with families who are challenged by any or all of these issues. It applies to those working in acute and longer-term therapeutic settings, community organisations and the broader health sector. This resource provides detailed guidance, examples, and tips, and is intended to support workers in their foundational knowledge and understanding for practice at these intersections. It can be used, for example, in training and supporting staff, as a foundational reference for practice development, and continuous improvement.

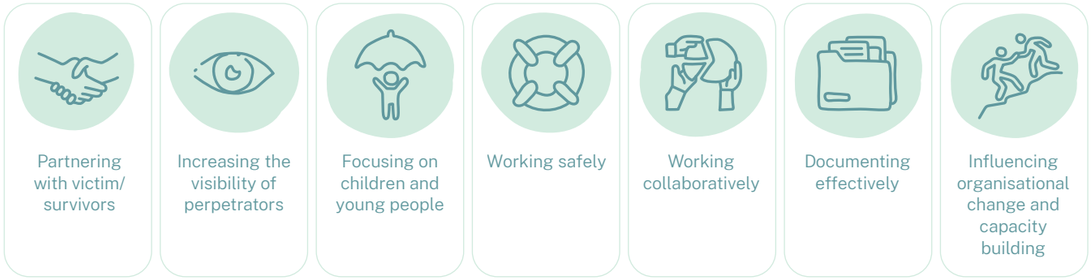
The *Practice Resource* is more than a revised edition of the *STACY Practice Guide*. Although some of the information is similar in both documents, the *ESTIE Practice Resource* is based on the *ESTIE Project*, and includes significant new information throughout (see particularly the themes on Working Safely and Documenting Effectively) and is substantially re-structured for accessibility.

The accompanying *Quick Reference Guide* is a shorter, more practice-oriented tool. It is intended as an accessible reference resource to assist workers and clinicians to implement the Safe and Together™ Model by keeping the core components at the forefront of practice. It is essential that the *Quick Reference Guide* is used in conjunction with the *Practice Resource*.

How to use this Practice Resource

The *Practice Resource* is intended to be used alongside the *ESTIE Quick Reference Guide* and the *ESTIE Final Research Report*. This *Practice Resource* is structured to provide a background to the *ESTIE Project* and Safe & Together™ Model (Section Two), introduction and foundational content relating to the intersections of domestic and family violence, mental health and alcohol and drug use (Section Three), and themed guidance for practice across these intersections (Section Four).

Section Four addresses the following thematic areas of practice:



Within each themed section, guidance is provided on:

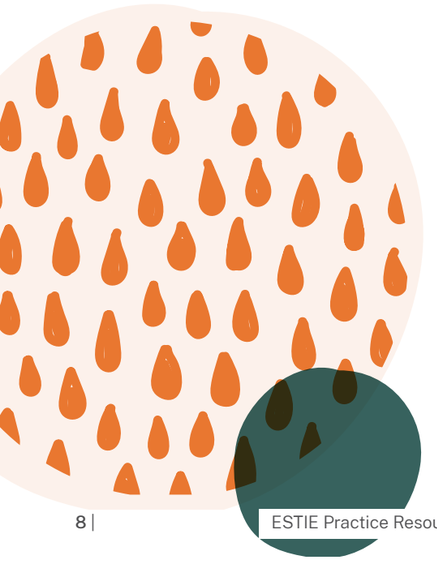
- How the theme can be addressed within the context of complexity arising from working at the intersections of domestic and family violence (DFV), parental alcohol and other drug use (AOD) and/or mental health (MH) issues.
- Exploring barriers to help-seeking and service access for those from priority populations.
- Considerations for working with First Nations people in relation to that theme.

Each themed section also contains reflective questions to help workers build their own capacity, as well as practice tips, links, quotations, insights from practitioners, and case studies gathered as part of the *ESTIE Project*. Where case studies are used, care has been taken to de-identify and anonymise participants and service users. Please refer to the section on use of language and concepts used in this resource to make sense of the terminology.

The *Practice Resource* should be used in conjunction with the worker's professional structured judgement or decision-making approach and is to be used alongside your own service's policy and practice guidance. The resource does not replace your agency's policy or procedures but rather aims to enhance practice towards being more domestic and family violence informed.

A note on case studies and examples

The quotations, case studies and examples in the Practice Guide are drawn from real presentations and discussions conducted as part of the *ESTIE Project*. In many cases, examples are provided to show how perpetrators manipulate, use and subvert systems and efforts to hold them to account. Similarly, examples of problematic and harmful practice with victim/survivors are included. Where examples of problematic or harmful practice have been included, they are considered powerful examples of practice in need of urgent change and attention – their inclusion is not indicative of endorsement or approval.



SECTION TWO

The ESTIE Project

and Safe & Together™ Model

The ESTIE Project

The *Evidence to Support Safe & Together Implementation and Evaluation (ESTIE) project* was an action research study that simultaneously explored and developed worker and organisational capacity to work collaboratively across services for children and families living with domestic and family violence where there were co-occurring parental issues of mental health and alcohol and other drug use (attending to one of the Safe & Together Critical Components, see next section). The project concentrated on shifting practice from focusing on co-occurrence to exploring and building health workers' understanding of how perpetrators of domestic and family violence use alcohol and other drugs, and/or mental health issues, as an integral part of coercive control. Simultaneously, the *ESTIE Project* generated research evidence to contribute to the knowledge base in this area. Workers were supported to respond effectively through training and a series of Community of Practice meetings which drew on the Safe & Together™ Model and approaches to build practitioner and service capacity. The expertise of workers was harnessed through Communities of Practice and was critical in the development of this resource.

The *ESTIE Project* resulted in three main outputs, of which this *Practice Resource* is one. It is accompanied by a detailed *Final Research Report*, and a *Quick Reference Guide*. Accompanying outputs are available from the research team or at https://vawc.com.au/estie-the-evidence-to-support-safe-and-together-implementation-and-evaluation-project/.

Cultural safety in the ESTIE Project

The *ESTIE Project* acknowledges Aboriginal and Torres Strait Islander people living in NSW whom this project, and implementation of a Safe & Together Model, may impact both positively and in ways that can be improved upon. This includes the necessity of developing further understanding of how the Model intersects with local Aboriginal world views, healing frameworks and principles, and how domestic and family violence-informed practice is implemented across services and sectors.

The *ESTIE Project* team have been privileged and honoured to be able to work in this space with our Aboriginal colleagues and build on collaborative learning from their extensive wisdom and expertise. In recognition of the need to ensure cultural safety for Aboriginal participants of the project, the *ESTIE Project's* Aboriginal cultural consultant worked collaboratively with the research team, the Community of Practice participants, and the Safe & Together Institute to inform the *ESTIE Project* and its outputs, including this resource. This process positively impacted the overall *ESTIE Project*, including the following:

- Developing an understanding of the importance of having First Nation's voices embedded in all of the work: documentation, programs, and practice with families.
- Continued development of the research team's cultural knowledge and competency.
- Cultural learnings being fed directly back to the Safe & Together Institute, which has further informed their work, taking into account the specific NSW context and reminding the Safe & Together team that Australian First Nations people are unique and diverse.
- Prioritising cultural respect for participants through a spirit of learning and feedback.

Collaboration with Aboriginal participants allowed for local cultural knowledge, understanding and voices to be amplified. Having a cultural broker not only built collaboration and safety but allowed for trust to be built with First Nations participants. This allowed for the development of shared learning and connection, that could provide the foundations for the development of a reciprocal relationship of trust. This process highlighted that when done successfully, trust can flow to the ongoing work of creating change.

The Safe & Together™ Model: working at the intersections

The Safe & Together™ Model was developed in the United States by the Safe & Together Institute[1], with the goal of guiding workers and their organisations towards policies and practices that are domestic and family violence-informed, with a particular focus on child safety, protection, and wellbeing. The Model's primary appeal lies in its applicability to working with families where there are complex, intersecting issues, and in the provision of a helpful language, vision and practice tools to support collaborative working across diverse statutory and non-statutory organisations. The Model is underpinned by Critical Components that drive attention and action across family functioning and context, and that guide workers in their efforts to address intersecting and co-occurring issues). The figure below highlights how the Safe & Together principles and critical components underpin the *ESTIE* themes and practices.

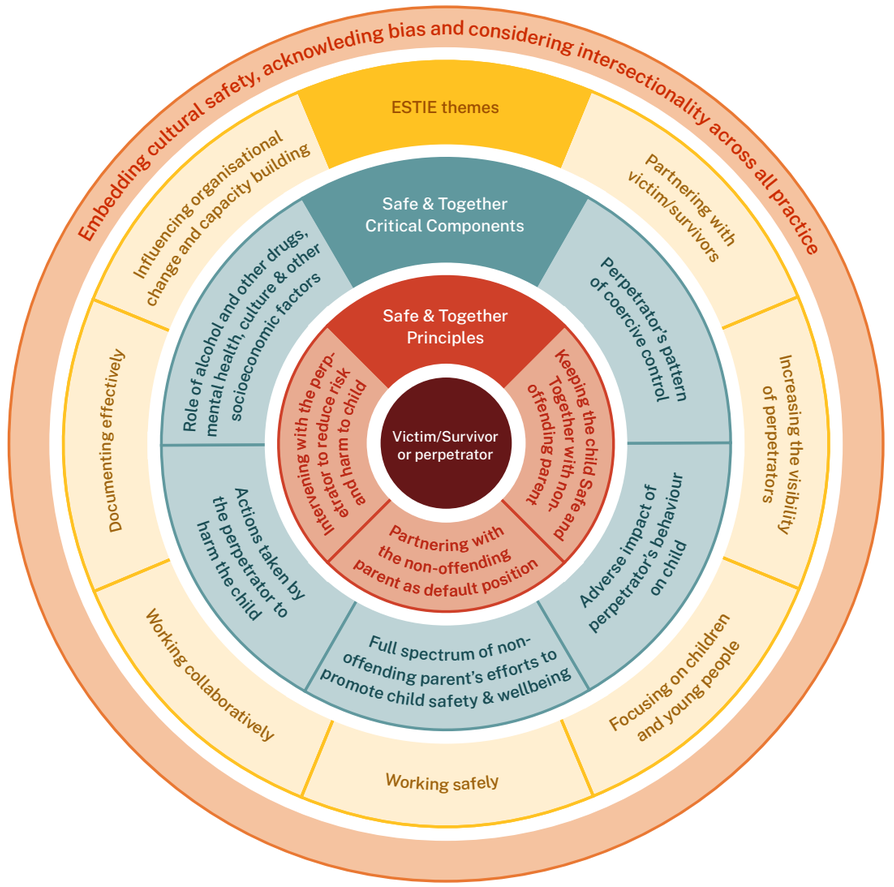


Figure 1: The Safe and Togther™ Model as central to *ESTIE* themes and practices.

The Model highlights the importance of an 'all-of-family' response to DFV and promotes the visibility of men as fathers, and focuses attention on supporting children and their mothers through the following key principles:

1. keeping children safe and together with their non-abusive parent;
2. partnering with the non-abusive parent as the foundation from which children are protected; and
3. keeping the perpetrator visible as the source of risk and harm to children as well as holding them accountable as a parent for their use of violence and coercive control.

The first principle stresses the goal of keeping children safe with their non-abusive parent (usually the mother in the context of domestic and family violence) and leads in to the second principle involving partnering with that parent as the foundation from which children are protected. The third principle of keeping the perpetrator visible as the source of risk and harm to children requires engagement with the person using violence and coercive control where this is safe and practical. Holding perpetrators accountable also involves working within established systems, including details of perpetrator patterns of abusive behaviour in case documentation, collaborative working across programs and services, and the justice system. The Model focuses strongly on behaviours – actions and their impacts - going beyond 'incidents of violence' towards a behavioural, pattern-based approach to DFV. In practice and philosophy, the Model represents a child-focussed, ethical and complex system intervention which situates worker DFV skill enhancement alongside organisational change. You can find further Safe & Together resources to guide your practice at the end of the document.

SECTION THREE

Understanding the intersections

– domestic and family violence, mental health, and alcohol and other drug use

The intersections between domestic and family violence, mental health, and alcohol and other drug use are complex, multi-dimensional and challenging to identify and address, particularly across sectors and services. In order to effectively engage and practise at the intersections of these issues without causing further harm or colluding with perpetrators, workers must be mindful of how and when mental ill-health and/or use of alcohol and other drugs developed, and whether there is any connection with historic or current violence and abuse.

Perpetrators of domestic and family violence may use alcohol and other drugs and/or their mental health as an integral part of violence, including establishing and maintaining control. A perpetrator's use of violence and control may be minimised by themselves or others, referring to this behaviour as a 'mental health issue', blaming it on drug and alcohol use, or claiming that a partner's behaviour is responsible for either or both the violence and use of alcohol or other drugs.

Case practice example: How a perpetrator uses their mental health issues or use of alcohol and other drugs to condone or excuse violence

A perpetrator has been referred to an outreach drug and alcohol program after being released from custody for assaulting his ex-partner. He consistently reports to workers that he was only abusive when he was drunk, that he was not himself or in control when he was using alcohol, and that he has never considered himself a violent person. He always includes descriptions of how his ex-partner would drive him to use alcohol when he speaks about his assault on her, but insists that he has changed now he is sober. His worker has not had contact with his ex-partner, and is concerned he is 'ticking the boxes' to manipulate services and gain access to his ex-partner again.

Trauma can impact significantly on mental health and many victim/survivors will experience mental health challenges. Survivors may also use alcohol and other drugs to cope with overwhelming feelings related to trauma, including domestic and family violence, and as adaptive responses to neglect or violence and control used against them by perpetrators.

Perpetrators may also use a victim/survivor's mental health and/or alcohol and other drug use against them to exercise or reinforce their control. Children and young people, and their mental health and use of alcohol and other drugs, are also often targets for perpetrators seeking to manipulate systems and control family members.

Perpetrators can directly impact a victim/survivor's mental health and or alcohol and other drug use in three ways: they may **cause** the mental health and or alcohol and other drug use, **exacerbate** existing issues, and/or **interfere** with a victim/survivor's attempts to address mental health problems and/or alcohol and other drug use as part of the violence and control. Concurrently, the perpetrator may use a victim/survivor's mental health issues or drug or alcohol use to **explain away** or undermine their reports of violence or abuse. This might be to the victim/survivor directly, denying the victim/survivor's account of events or issues (commonly known as gaslighting), or others, such as workers and services, or even to themselves to justify their own actions.

It is important for practitioners working with victim/survivors to understand how the perpetrator is using these mechanisms to further the abuse. As will be detailed in the following sections of this resource, this enables workers to more effectively keep perpetrators visible, acknowledge and document the victim/survivor's inherent strengths and attempts to resist these tactics, and contribute to cross-sector collaboration and practice development.

The examples below highlight how a perpetrator might cause, exacerbate, or interfere with the victim/survivor's alcohol and/or other drug use and mental health. Being aware of how these tactics might manifest will help workers understand how to intervene.

Causing alcohol and other drug use or mental health concerns

When a worker is screening for alcohol and other drug use, the victim/survivor initially reports that she drinks to manage her anxiety and insomnia. When the worker takes a further history, she states that these problems started after she met her current partner. She describes how his constant emotional and verbal abuse significantly impacted her. The worker learns that as his violence escalated, she began to experience symptoms of anxiety, and received a diagnosis through her GP based on her description of her symptoms (but not his violence). The worker also learns that in order to cope with her increasing anxiety, she began to drink in the evenings, and this is now a problematic pattern of behaviour for her.

Exacerbating alcohol and other drug use or mental health concerns

The perpetrator has an extensive history of domestic and family violence. His current partner has previously been diagnosed with schizophrenia. Workers are concerned about her mental state deteriorating and she is increasingly described as 'paranoid' when engaging with services, particularly by her partner. When they map out her symptoms, it becomes clear that her mental health is being used by her partner as part of his pattern of coercive control, and she is experiencing increasingly severe impacts on her wellbeing and sense of self as a result of his manipulation and abuse.

Interfering with treatment

A victim/survivor has been working with drug and alcohol services throughout her pregnancy. She started on opioid treatment but workers notice that she doesn't seem to be dosing consistently and is requesting a lot of 'takeaway' doses. Workers learn her partner is stealing her methadone and preventing her from taking it regularly. His behaviours have prevented her from effectively completing treatment and caused her to return to using heroin. There are concerns about the impact on her pregnancy.

SECTION FOUR

Thematic guidance

for working at the intersections of domestic and family violence, mental health and drug and alcohol use

The following thematic sections provide guidance on domestic and family violence-informed practice and implementation of an all-of-family approach. The information here is presented in discrete sections, however, these themes are inherently interrelated. While some areas will be more or less relevant for individual workers or services, the guidance in these sections is intended to support a holistic and collaborative approach.

Theme 1: Partnering with victim/survivors

A key component of domestic and family violence-informed practice involves developing a meaningful collaborative partnership with the victim/survivor of violence. This process involves: affirming, asking, assessing, validating, collaboratively planning, and appropriately documenting the pattern of coercive control and violence, as well as the strengths, protective efforts and resistance to the violence from the victim/survivor. Partnering with victim/survivors and their children is a process, including iterations in different configurations, but always underpinned by key practical strategies shown in Figure 2.

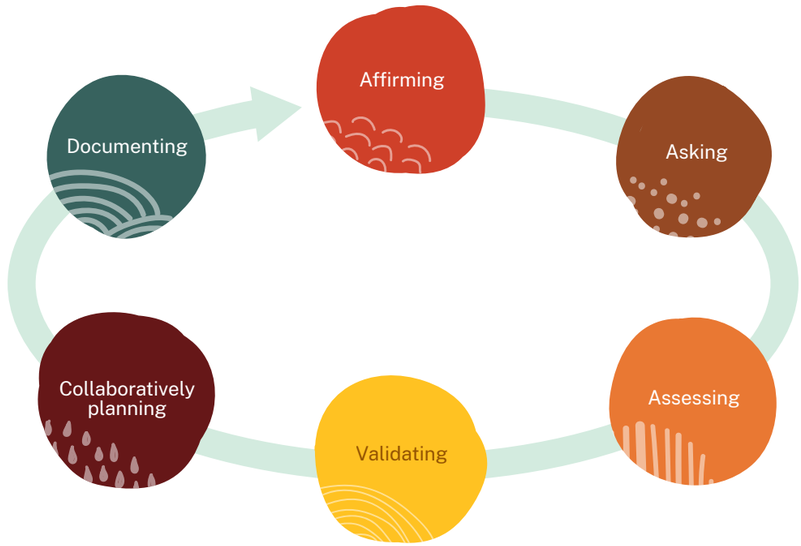


Figure 2: Strategies for partnering with a victim/survivor

Key questions for consideration when partnering with victim/survivors at the intersections

In any approach, it is critical to find foundational guiding questions that inform your practice. These questions lie at the heart of a DFV informed approach. The following reflective questions may be useful to guide practice in your agency while 'partnering with victim/survivors' at the intersections of DFV, alcohol and other drug use, and mental health issues.

- Do we explore and document how the perpetrator of violence targets their partner's alcohol and other drug use and/or mental health issues in order to exert power and control over them?
- Do we consider how the perpetrator leverages the victim/survivor's alcohol or other drug use and/or mental health issue in order to manipulate professionals into believing that they are an 'un-protective' or 'unfit' parent?
- Do we consider how the perpetrator's pattern of abuse might exacerbate/cause/interfere →

with the adult victim/survivor's struggles with mental health and/or alcohol and other drug use?

- Do we consider how the perpetrator's pattern of abuse might exacerbate/interfere with the adult victim/survivor's attempts at recovery?
- Do we routinely document the non-offending parent's pattern of protective behaviour, making apparent the full spectrum of their efforts to promote the safety and wellbeing of themselves and their children and resist the violence and abuse?
- Do we consider contextual factors for those victim/survivors from priority populations and the impact of service and agency involvement?
- Do we consider the perpetrator's pattern of abuse and the victim-survivor's protective behaviours when working with the survivors and other services to assess risk and safety plan?
- Where appropriate and safe to do so, do we consider, the availability of support for the perpetrator as a parallel pathway including mental health, drug and alcohol or men's behaviour change programs?

Techniques for 'partnering with victim/survivors' at the intersections

1. Affirming the perpetrator's responsibility for the choice to abuse

Victim/survivors of DFV who experience mental health concerns and/or use alcohol and/or other drugs often face stigma, judgement, and increased barriers to accessing and receiving treatment and support. Siloed service provision and victim blaming based on the victim/survivor's mental health or alcohol and other drug use, enhances the barriers and in some cases amounts to systems abuse.

Aboriginal women or victim/survivors who are from a priority population[2] experience additional, unique barriers to accessing help and support. These barriers often stem from colonial legacies of oppression and abuse, systemic racism, along with gendered and structural inequalities. Child removal and transgenerational trauma involving social and health services are particularly challenging. For example, the ESTIE Aboriginal Cultural Consultant highlighted how Aboriginal families often report exacerbation of trauma from being in hospital due to previous experiences of racism from health workers and lack of cultural safety when engaging with services. These experiences, in addition to the impacts and effects of trauma, including the strategies and mechanisms that victim/survivors use to cope with them, can make it more difficult for Aboriginal families to seek, access and engage with services. When workers interpret and document this as 'rudeness', 'non engagement', or 'non-compliant behaviour', this in effect places blame on the woman for the impacts of the perpetrator's behaviour as well as leaving systems abuse unaddressed and unacknowledged.

For women living in rural or remote locations, isolation can be a key part of a perpetrator's pattern of abuse and control. For example, living far from any major towns can increase perpetrators' ability to isolate their family from support networks, reduce the visibility of his behaviours, and restrict the ability of services to home visit. Service provision is often limited, and victim/survivors less able to seek prompt assistance even when services are available, given geographical challenges.

These factors can all be exploited by perpetrators as part of their tactics and patterns to manipulate and abuse victim/survivors. To respond to these issues, health workers supporting victim/survivors need to understand how the perpetrator is using mechanisms to further the abuse as well as acknowledging and documenting the victim/survivor's inherent strengths and attempts to resist and survive these tactics. It is important to communicate to survivors that they are not the cause of their partners' choice to be abusive and violent, and that even when perpetrators have mental health or alcohol and drug issues of their own, it is still a choice to use violence and abuse. This affirmation of the perpetrators' responsibility can be a critical step to building trust, creating emotional safety, and unwinding a narrative that implies that the victim/survivor is not worthy of respect and safety if they use alcohol and other drugs or have mental health challenges. Workers can also affirm the victim/survivor's choice to seek help and safety, particularly in the face of structural disadvantages and experiences of broad systems abuse and begin to create a supportive environment of service provision and care. Where perpetrators have exploited systems to further their abusive tactics, practice that includes transparent acknowledgement of this can begin to break down barriers to engagement and future help-seeking.

Reflective questions to supporting affirming practices

Use these reflective questions to consider your practice and your agency's processes:

- Do we routinely consider the context in which a victim/survivor's alcohol and other drug use and/or mental health issues originated, are exacerbated, and the circumstances that challenge their recovery? How is this made clear in our documentation?
- Do we send a clear message verbally and in case notes that victim/survivors do not provoke perpetrators into using violence and coercive control?
- Do we send a clear message that we believe victim/survivors and their children in our conversations and documentation?

Practice Tip: Affirming statements

Many perpetrators use emotional and psychological abuse to coerce victim/survivors into adopting the view that the victim/survivor's mental health issues and/or alcohol and other drug use provokes the violence, that it is 'their fault'. Always affirm the perpetrator's responsibility for their choice to be abusive. Ask questions that encourage the victim/survivor to consider their right to be safe. Consider and affirm acts of resistance and how the victim/survivor creates safety on a daily basis. Use affirming statements such as:

- *'Your drinking is no excuse for their violence and abuse towards you.'*
- *'Your anxiety doesn't make them abusive.'*
- *'Your childhood abuse background doesn't justify them treating you poorly.'*
- *'Their violence and abuse don't help you be sober. It may even make it harder for you to be sober.'*

Case practice example: How to respond in an acute setting

A young woman presented frequently to the Emergency Department with suicidal ideation. Each time she was discharged quickly once the level of risk appeared to decrease. On one occasion, the social worker used the Safe & Together approach to ask more questions about her current relationship and an extensive pattern of DFV was identified. The social worker affirmed that the violence was not her fault and acknowledged the enormous stress the victim/survivor was under. The victim/survivor then spoke more openly about her partner's abuse and connected to ongoing DFV services, leading to fewer future presentations to hospital.

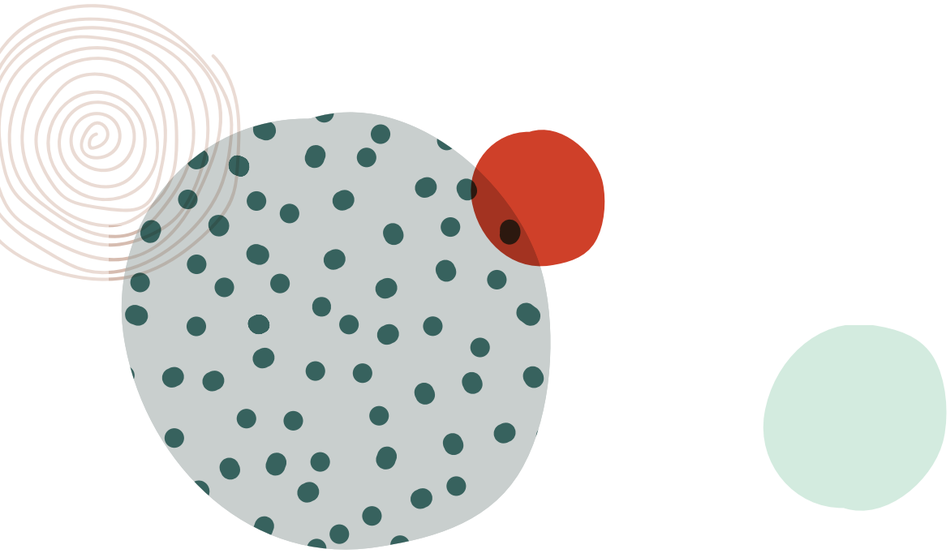
2. Asking questions about the perpetrators' pattern of abuse

Asking questions that respect the victim/survivor and their situation can help the worker 'connect the dots' between the intersecting issues and to develop an understanding of the pattern of abuse. Considerations of cultural safety and appropriate questions for Aboriginal women and families, which take into consideration the ongoing impact of intergenerational trauma caused by colonisation and racism, are critical. The type of questions asked can be applicable in both acute and non-acute health settings.

Reflective questions to supporting affirming practices

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 historical and current alcohol and other drug use and/or mental health coercion patterns?
- Do the questions that we ask make victim/survivors feel more or less responsible for DFV? Do they contribute to making them feel more or less safe, including in relation to cultural safety?
- Do we routinely formally assess/universally screen all female 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? How do we document that?
- Do we contextualise the experiences of Aboriginal people within the broader context of state-perpetrated violence, systemic racism, harmful racial stereotypes relating to alcohol and other drug use, abuse and neglect, and intergenerational trauma?
- Are we aware of the additional types of abuse faced by those from priority populations?
- Do we ask about rules and punishments attached to activities controlled by the perpetrator?



Practice Tip: Using the *Perpetrator Pattern Mapping Tool*

The Safe & Together Institute's *Perpetrator Pattern Mapping Tool*[3] guides workers 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 the victim/survivor and their children. This involves detailing the specific behaviours used by the perpetrator to harm. When using this tool, it is important to think of how a perpetrator may use their own mental health or alcohol and other drug use as an excuse for the violence and coercive control.

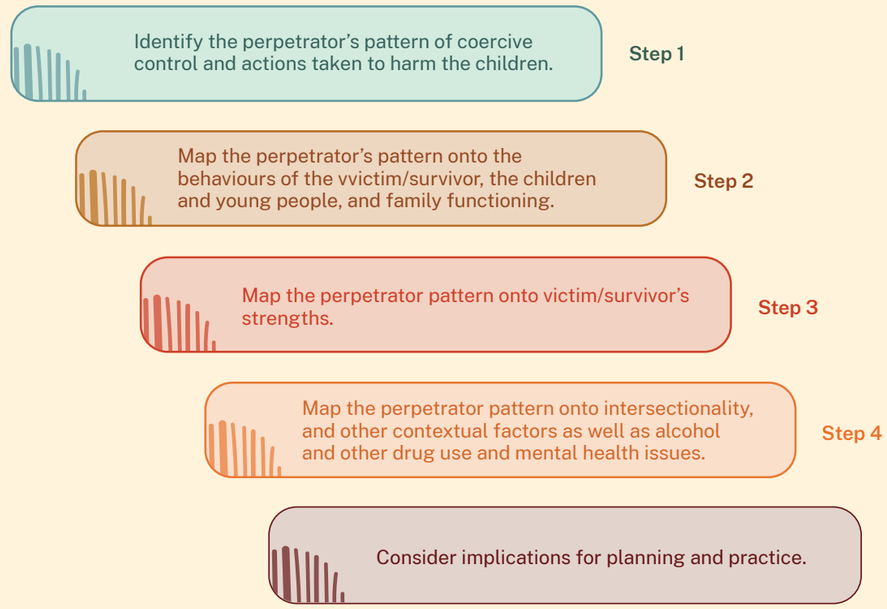


Figure 3: Safe & Together five-step Perpetrator Pattern Mapping Tool

For those working in alcohol and other drug services, mental health or broader health or community services, the additional following practices are useful:

- Do not assume that the perpetrator's abuse and violence are secondary issues to a primary issue of symptoms of alcohol and other drug use or mental health issues. Those behaviours should be assessed, treated, and monitored separately from mental health issues and the use of drugs and alcohol.
- Ensure that assessments for mental health issues and alcohol and other drug use include specific, behavioural questions related to abuse, violence, and control.
- It is essential that someone within the multi-disciplinary team maps the perpetrator's pattern of alcohol and other drug use and its association with harm to victim/survivors and their children. Consider how this pattern of use connects with the severity and frequency of his violence and abuse. For example, are they more violent when coming down off drugs or when using drugs?

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

Whether you work in an acute setting responding to crisis presentations or you provide longer-term therapeutic interventions, you have a part in supporting victim/survivors and their children's safety and wellbeing. You may not know at which point in a victim/survivor's journey your practice is placed, but you can work to ensure your engagement with them upholds their dignity, increases their current safety and wellbeing where possible, and lays positive groundwork for future engagement and safety.

Victim/survivors think about and actively work on protective strategies for themselves and their families. This is true even when victim/survivors are not in a position to separate from the perpetrator, often due to poverty, homelessness, visa or community considerations. Listening to women and other victim/survivors, and acknowledging them as the experts on their own situation, including perpetrator and relationship dynamics is critical. The victim/survivors' self-assessment of their current situation and likelihood of experiencing future violence are good predictors of risk, and workers should take them into consideration as they formulate their own risk assessments.[4]

Alongside asking questions about naming and documenting perpetrator patterns, it is important that workers explore and elicit information about protective efforts and acts of resistance. Workers should also explore with the victim/survivor the relationship between alcohol and other drug use, mental health challenges and the victim/survivor's protective efforts.

Practice Tip: Respectful questions about protective efforts

Below are examples of respectful questions which may elicit information about a victim/survivor's protective capabilities:

- *'You have obviously managed to care for your children and keep the family going day to day, whilst experiencing their violence, drinking, drug use and mental health issues. How have you managed to do this?'*
- *'Sometimes parents have difficulty identifying all the things that they do to shield their children from the effects of their partner's violence and their drug and alcohol use. Can we talk together about some of the ways you've been able to do this for your children?'*
- *'You are the one who knows best what you and your children need to feel safe and supported. Can you tell us what that looks like and how we can best help support you?*
- *'What are some of your biggest concerns and fears when coming here to access our service? What do you need from me to make you and your children feel supported and safe?'*

Case practice example: Working with Aboriginal victim/survivors

An Aboriginal mother and baby were seen by hospital social workers after she gave birth. Her partner was non-Aboriginal and prevented her from attending appointments alone. The hospital social workers observed that he strategically used his partner's poor mental health, alcohol and other drug use and past trauma to persuade workers that she 'couldn't cope' without him. He prevented his partner from visiting their child in the hospital, leading to concerns that she wasn't attached to, or bonding with, her baby. Practitioners interrupted his pattern of control through clear documentation of his behaviours, multidisciplinary planning, and the involvement of Aboriginal Liaison Officers to support cultural safety and develop trust with the mother. An Aboriginal Social Worker advocated with the hospital to allow workers to support the mother when she visited her baby. Workers took care to document the mother's strengths and worked to ensure her safety by affirming her experience and responding to the domestic and family violence.

Reflective questions to support assessment practices

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 victim/survivor's mental health and/or alcohol and other drug use issues and the perpetrator's use of violence?
- How are we assessing and documenting the full range of protective actions that the adult victim/survivor is engaging in to protect themselves and their children including when they use alcohol and other drugs or have mental health challenges?
- Do the questions that we ask provide information that contributes to making victim/survivors and children survivors safer? How would we know?
- How could we find out about how a victim/survivor protects their children around their partner's patterns of alcohol and other drug use or mental health issues as they intersect with abusive behaviours?

Practice Tip: Using the *Mapping Survivor's Capacity Tool*

As a companion tool to the *Perpetrator Mapping Tool*, the *Mapping Survivor's Protective Capacities Tool*[5] contains examples of respectful questions that illuminate the connections between domestic and family violence, alcohol and other drug use and/or mental health issues that help to inform practice. The tool aims to capture the key protective strategies used by the victim/survivor that enhance ongoing safety. It is important to capture this work through appropriate documentation in both acute and non-acute settings, remembering that documentation will follow and stay with the client across systems and over the course of their service engagement journey.

Mapping Survivor's Protective Capacities is a structured process for identifying the protective efforts of the adult survivor and building on them to develop the strongest possible partnership around the safety and well-being of the children. This mapping process begins by looking at how the perpetrator might be interfering with a survivor's parenting, then moves to identifying protective efforts then validation, collaborative safety planning and documentation and presentation of information.

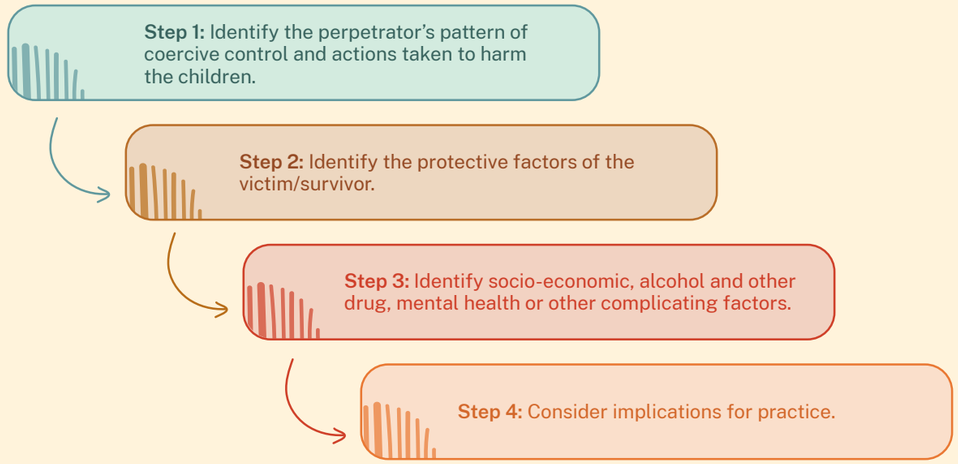


Figure 4: Safe & Together Mapping Survivor's Protective Capacities Tool

4. The importance of providing a validating response

While not all victim/survivors of domestic and family violence will experience them, victim/survivors who have mental health and/or alcohol and other drug use issues may have received poor responses from professionals in the past. Victim/survivors have described judgemental attitudes, mother blaming (failure to protect), and/or disbelief from practitioners in their previous interactions with different services.

For Aboriginal women, they may have experienced racist bias from workers. This includes receiving an inappropriate response due to Aboriginality, workers misinterpreting cultural difference as poor parenting, lack of understanding or recognition of intergenerational trauma from ongoing colonisation, or workers ignoring the barriers to trusting mainstream services. These experiences may make it difficult for open communication to occur. Providing a validating response of belief and understanding can start to establish trust and provide a platform on which to build collaborative partnerships between workers and victim/survivors. This is as critically important in an acute setting as in a longer-term intervention where a therapeutic relationship will start to develop.

Practice Advice from the ESTIE Aboriginal Cultural Consultant

Aboriginal women often face particular barriers to reporting their experiences of domestic and family violence, including fearing the threat of child removal, homelessness and potential isolation from their family and community.

Practising cultural safety and respect can mean the difference between someone continuing with services or disconnecting, feeling like they aren't being heard. For Aboriginal women, cultural safety means they will not be judged on their identity, or have it questioned, and they will not have racist or biased assumptions made about themselves, their children or their family and community.

Safety and wellbeing for Aboriginal women is about family in Aboriginal culture and is closely tied to connectedness and Kinship. In this setting, family structures are pivotal to identity formation, to understanding one's own spiritual and cultural belonging, and assist in establishing strong links with community. Ultimately, family and Kinship are a cohesive force that bind Aboriginal people together. Fear of loss of this connectedness is a significant barrier for Aboriginal women in accessing safety from domestic and family violence. To work effectively with Aboriginal women, practise the following:

- Understand trauma, including transgenerational trauma, and its impact on individuals (such as children), families and communal groups.
- Create environments in which children and young people feel physically and emotionally safe.
- Support victim/survivors of trauma to regain a sense of control over their daily lives and actively involve them in the healing journey.
- Share power and governance, including involving community members in the design and evaluation of programs and integrate and coordinate care to meet children's needs holistically.
- Support safe relationship building as a means of promoting healing and recovery.

Reflective questions to support validating victim/survivor experiences

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

- Do we convey the message that we believe victim/survivors of DFV? Do we challenge the popular discourse that victim/survivors (and particularly those who have mental health and/or alcohol and other drug use issues) lie about DFV?
- Do we convey the message in our conversations with victim/survivors that we believe that they are doing the best they can for their children especially when they may be struggling to cope with their own alcohol or other drug use and/or mental health issues?
- Do we take the time to understand the context in which the abuse the victim/survivor is experiencing is occurring (asking questions beyond an incident)?
- Do we name specific actions and behaviours that we have identified as protective and as strengths?
- Are we validating the victim/survivor's protective efforts, feelings, beliefs in our case file notes in a manner that acknowledges the complexity of the context in which they are parenting?
- Does my agency support my efforts to build relationships with victim/survivors based upon trust and validation even though this takes time?
- Do we advocate for victim/survivors whose alcohol and other drug use and/or mental health symptoms may be decontextualised from DFV by colleagues or other professionals?

Practice Tip: Using validating comments

Examples of validating comments include:

- *'I see how hard you have been working to reduce the impact of their drinking on the kids by sending them to your mother's house on the weekends.'*
- *'It's amazing that given the violence and the chaos caused by their methamphetamine use you have kept the children going to school every day.'*
- *'I know that you've struggled with drinking but it's clear from what you shared with me that right now, for you, your drinking makes it easier to deal with hurt and the anger caused by their violence. And you have a plan with your mum to make sure the kids are taken care of when you drink. You are still making sure your kids are taken care of despite their choice to expose them to violence and the pain it is causing you.'*

"Looking for even in that controlled setting, opportunities to validate mum. Where she is minimised to be invisible, are there ways to make her more visible, to help her understand that we see her." — CoP participant.

When survivors' behaviours don't make sense, very often the answer is not about better trying to understand them, but trying to understand their context, and the context the violence has created. — CoP participant.

Key to effective work with victim/survivors is an examination of power dynamics. Although not intentional, at times therapeutic relationships may mirror the victim/survivor's relationship with the perpetrator. Thinking about the inherent power dynamics in the service provider-client relationship is a good way to improve your practice in working collaboratively in partnership with victim/survivors. Feminist-based approaches strive to empower survivors to regain the sense of personal agency and control that perpetrators of domestic and family violence attempt to take away.

A critical reflection on power

Workers can add to victim/survivors' resources through active listening and collaborative planning. It is important to explore what has and hasn't worked and what the victim/survivor thinks may make things better. It is crucial to reflect on how you use your professional power to decrease the potential for secondary victimisation of DFV victim/survivors and amplify their voice and agency when engaging with other services.

Reflective questions to support working collaboratively with victim/survivors

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

- Do we critically reflect on how we use our professional power when engaging with victim/survivors of DFV? Do our actions close or open help-seeking possibilities?
- Are we being led and taking instruction from the victim/survivor? Are we respecting their agency?
- Are we listening to how they define 'better' or 'safer?'
- Do we consider what they would like their and their children's relationship with the perpetrator to look like?
- Do we seek to support their connection to culture and to safety?
- How do we use our resources to help them achieve their vision of safety and a better life for themselves and their children?
- How are we advocating for them with other systems that they are involved with?
- If we are DFV providers, are we sharing information, with her permission, with the victim/survivor's mental health or alcohol and other drug use service providers about the perpetrator's patterns and the victim/survivor's strengths as parent?
- If we are mental health or drug and alcohol workers, how are we developing plans that account for the potential for the perpetrator to sabotage the victim/survivor's recovery and treatment efforts?

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- Do we aim to build strong alliances with victim/survivors and their children that honour their expertise gained through lived experiences? Do we use 'power over' or 'power with' approaches in our work with victim/survivors?
- Are we aware of the ways in which our agency or the wider service system might be replicating the dynamics of power and control used by perpetrators? Do we seek to counteract these dynamics?
- Are we considering intersectionality and focusing on working with victim/survivor's strengths?

Practice Tip: Considerations for collaborating with victim/survivors

Take every opportunity to work collaboratively with victim/survivors. Some questions that you may find useful 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 or alcohol?'*
- *'Since part of my job is to work with the whole family, what would you like me to talk to your partner about?'*

Some examples of collaborative case planning may include:

- Contacting the victim/survivor's alcohol and other drug program or service after they have been excluded due to absences caused by their partner, and advocating for them to return to the program. Alternatively, engaging with the program before the victim/survivor is excluded. Advocating for the victim/survivor to stay with the service, acknowledging the impact of the perpetrator on their attendance.
- Working with the victim/survivor to address housing issues created by the perpetrator's drug and alcohol use.
- Having an understanding and knowledge of the diversity of Aboriginal peoples, communities and cultures, and the skills and attitudes to collaborate with First Nation victim/survivors.

Case practice example: Engaging with Aboriginal families

A family was referred to an Aboriginal-specific service as statutory child protection were not able to engage with the parents. Aboriginal workers took a respectful approach with the family and did not 'jump into' developing a case plan or safety plan without engaging with the family first.

The Aboriginal caseworker let the family talk and ask questions, shared information about services transparently, and focused on the positive support that services could provide. The victim/survivor was able to share more information about her situation with services after hearing that being honest would help her get the support she needed.

"There's a mutual understanding, they aren't afraid to tell me if I said something wrong, they're not scared to approach me because I have an appropriate approach... be learning, be open minded, and expect the unexpected in a good way."

— CoP participant.

Theme 2: Increasing the visibility of perpetrators

Understanding the context: how do we keep the perpetrator in view?

A note on Safe & Together

Pivoting to the perpetrator or keeping the perpetrator 'in view' is one of the three cornerstone principles of the Safe & Together™ Model and a child-focussed, DFV-informed, all-of-family approach.

Keeping the perpetrator in view is about keeping the cause of the harm at the centre of practice, whether or not the perpetrator is present. This concept requires a perpetrator-pattern based approach, as opposed to a 'single DFV incident' focus and requires careful documentation and attention to context. While this aspect of practice can involve direct contact and engagement with perpetrators, this is not necessary and often not the case. The critical element is that the perpetrator's harmful actions and the impacts of those actions on the victim/survivor and family functioning is 'brought into the room' and made visible in collaborative conversations with victim/survivors and other services.

A critical practice point

Always bring the perpetrator 'into view' by centring their harmful behaviours, actions, and use of coercive control into the discussion with survivors. The impacts of these behaviours on the victim/survivor's mental health, alcohol and other drug use and broader family functioning should also be documented.

Even though service provision to perpetrators of domestic and family violence exist, and many workplace policies do not exclude working with perpetrators, in practice, the focus of workers and organisations is usually on supporting victim/survivors and their non-offending family members. This may be interpreted by workers as requiring the exclusion of perpetrators from practice, and there may be an established culture of this approach in the workplace. Workers may be limited in the type of contact they have with perpetrators, embedding further the belief that they can't undertake any significant or impactful work with them.

There are multiple scenarios for keeping perpetrators in view, depending on the focus of services, types of programs and organisational culture. The following list is not exhaustive, and everyday practice will not always fit neatly into one of these scenarios.

1. Keeping the perpetrator in view while working with victim/survivors and children and young people even when perpetrators are not directly involved or present (e.g., therapeutic services, mental health or drug and alcohol services for victim/survivors).
2. Working directly with perpetrators as part of a service provided to their adult victim/survivors, their children, and children and young people (e.g., youth services, housing services, VAN services).
3. Working directly with perpetrators in a capacity not specifically related to their perpetration of abusive behaviours, but perhaps at the intersections with mental health and alcohol and other drug use (e.g., drug rehabilitation programs or mental health services).
4. Working directly with perpetrators and providing a service to them in relation to their abusive behaviours (e.g., perpetrator-focussed services and men's behaviour change programs)

In settings where a worker has **limited or no contact** with the perpetrator, keeping the perpetrator 'in view', means that we consistently keep them in the picture when assessing, planning and intervening in cases where there is domestic and family violence. When working **directly** with perpetrators at the intersections of domestic and family violence, alcohol and other drug use, and mental health issues, the work also involves 'pivoting to the perpetrator'. Techniques of this approach are outlined in more detail below. Approaches include developing practices that hold perpetrators accountable for their use of violence and control, irrespective of factors that increase the complexity of their lives, and engaging those who use violence and control within a context of complexity using the Safe & Together approach.

Case practice example: Keeping the perpetrator visible in case notes and other records

Workers from a mental health service engaged with a victim/survivor in relation to a range of mental health challenges and observed that her ex-partner was significantly impacting her mental health. Conversations with the victim/survivor and observations during home visits enabled them to map his patterns of behaviour. Workers identified that 'relapses' in her mental health occurred when he forced his way back into her life. Workers discovered that he was selling her medications and intimidating workers who tried to visit. Some of the victim/survivor's mental health challenges also made sense in the context of his violence, for example her fears of being watched. Even though they never worked with the ex-partner directly, workers documented these observations, and his behaviours became visible in her health record, case notes, and care planning.

Practice Tip: Attention to culture when keeping the perpetrator in view

It is important to prioritise culturally responsive practice when perpetrators of violence are Aboriginal men and racism embedded in mainstream services and systems must be considered. This includes how communities often balance perpetrator accountability and a wish to protect men from victimisation by these systems.

Whether or not perpetrators are Aboriginal, racism, fear of systems, and perceived power can be used as tactics to oppress and discourage victim/survivors to seek help as part of perpetrator patterns of behaviour. Using fear of colonial systems and child removal can be particularly salient tactics, as well as leveraging entrenched attitudes and harmful stereotypes against victim/survivors and their children.

Advice from the ESTIE Aboriginal Cultural Consultant - How do we hold perpetrators accountable in a way that is culturally safe for Aboriginal people?

It may be important to contextualise a perpetrator's level of grief, displacement, and the impacts of colonisation and ongoing racism and discrimination.

Non-Aboriginal workers should discuss with cultural brokers how to address individuals, families and community members in a culturally safe way. The approach will depend on your existing relationships with the relevant Aboriginal community. First steps could include asking community elders or cultural brokers for assistance in engaging with Aboriginal men or asking to attend Aboriginal Men's programs to understand what is important when working with Aboriginal men in a culturally safe way.

This can assist in gaining knowledge and skills to work with Aboriginal men and how to ask the following key questions, which Aboriginal male workers may use in their work towards creating

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safety for a man's partner and children along with him taking responsibility for all of his behaviour and choices.[6]

- Do you feel safe to talk with me about the role of culture and identity in your life? Have you lost aspects of your culture? If so, how is this impacting your life?
- How do you see yourself as a partner, and how does this behaviour impact and harm your partner?
- How do you see yourself as an Aboriginal father raising Aboriginal children and how does your behaviour impact and harm them?
- How do you want your children to see you or remember you?
- What would you need to help support you to address your behaviour, the DFV, alcohol and other drug use and mental health issues?
- What would recovery and healing mean to you as an Aboriginal man and what cultural considerations need to be factored in?

Key questions for consideration when increasing the visibility of perpetrators

To guide practice when 'pivoting to the perpetrator' at the intersections, the following reflective questions can be kept in mind.

- What role does the offending parent's alcohol and other drug use and/or mental health issues play in exacerbating the risk to the victim/survivor, the family, or harm to the children?
- Are we integrating risk and safety considerations into the treatment of the perpetrator's alcohol and other drug use and/or mental health issues for adult and child victim/survivors?
- Are we working collaboratively with services working with victim-survivors to continuously assess and respond to risk?
- Are we exploring how the perpetrator may interfere with or undermine the adult victim/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 alcohol and other drug use and/or mental health issues of the perpetrator or victim/survivor?

Techniques for 'pivoting' at the intersections

The three practical strategies below highlight how practitioners can 'pivot to the perpetrator' within a context of complexity.

1. Increasing the visibility of perpetrators who use violence and control

It can be difficult for services who do not work directly with perpetrators to feel they can hold the perpetrator at the centre of their work and keep them accountable for their use of violence and control. This feeling can be exacerbated for those working in an acute setting where contact with victim/survivors is time limited and often requires responding to a crisis.

Those services who do come into contact with perpetrators such as mental health and alcohol and other drug services may not be able to identify the ways in which the drug and alcohol use or mental health needs may intersect with the perpetrator's use of violence. They may also feel ill-equipped to respond to the tactics of the perpetrator. This allows perpetrators to remain invisible as behaviour is minimised or ignored in the context of siloed service delivery.

A note on Safe & Together

The Safe & Together approach aims to build confidence both in working with men generally, and specifically with men who use DFV and who have alcohol and other drug use issues and/or mental health issues. It also emphasises the importance of keeping perpetrators in view in work with any family members and responsible for harm caused by their behaviour. It is critical to consider how to increase the visibility and accountability of perpetrators of domestic and family violence and their impact on women and children within your service setting.

"The foundation is to change the way you think about domestic and family violence and assess it in all interactions." – Safe & Together Consultant.

Practice Tip: Three key ways to ensure perpetrator visibility if you aren't working with them directly

1. Understand patterns of behaviour.
2. Understand the multiple pathways to harm for children and young people and the impact on them.
3. Contextualise factors such as alcohol and other drug use and mental health.

The following practice tips are useful to consider when increasing the visibility of perpetrators in your practice and agency' processes if you do not have direct contact with them:

- Ask victim/survivors how the perpetrator's behaviours and choices affect the family on a daily basis, particularly in relation to the use of alcohol and other drugs, and violence and abuse. Be sure to document the impacts on the family, keeping the perpetrator's acts of harm at the centre.
- Continue to use language that holds the perpetrator responsible for the violence and control.
- Engage victim/survivors in conversations about their partner's or ex-partners' contributions to the family as parents. Think about keeping the standards for both parents equal when asking about: parenting skills - alcohol and other drug use - mental health - relationship choices - meeting children's basic needs (food, medical, safe shelter, education) - Kin network - employment choices - childcare choices - co-parenting – criminal history.

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- Where it is safe and appropriate to do so, identify opportunities for workers involved with children and young people to allow children to express their thoughts, feelings and views about their father's parenting, behaviour toward the other parent, their impact on the family as a whole, and the child or young person's needs and priorities. The worker must ensure open communication about what will or may happen as the result of the child or young person sharing their views and experiences is in place prior to engaging children and young people, to ensure their safety and respect their agency. It is important to understand children and young people living with a perpetrator's use of violence as actively managing complex and shifting circumstances and relationships, which may include complex feelings and reactions towards the perpetrator and the protective parent/carers.

Case practice example: Understanding a victim/survivors's choices in the context of the perpetrator's behaviour

Presenting issue: A victim/survivor reports ongoing financial abuse after separating from her husband and fears he will 'hunt' her through the different systems (e.g., legal, child custody) if she doesn't engage with his demands around property settlement.

Practice advice: It is important that services understand that continuing to engage with her husband around property settlements is a safety strategy for the victim/survivor. Explore threats that influence her decision-making, such as threats to take the children or attempts to paint her as an 'incapable' parent. Document perpetrator behaviours and victim/survivor strengths. Support the victim/survivor to understand her choices and collaborate with legal services as needed.

2. Holding perpetrators accountable for their use of violence and control in the context of complexity

The response that perpetrators who use violence and control receive from workers can significantly influence the safety and wellbeing outcomes for victim/survivors and their children. A response to perpetrators that encourages them to take responsibility for their violence, irrespective of their mental health and/or alcohol and other drug use, can increase safety for victim/survivors and promote positive behaviour change. On the other hand, professional responses that ignore, excuse or justify perpetrator's use of violence and control can place a victim/survivor and their children at significant risk of harm.

Reflective questions to support holding perpetrators accountable

Irrespective of whether the perpetrator is your direct client or not, the following reflective questions are useful to consider in relation to your practice and your agency's processes. They are applicable in both acute and non-acute settings.

- Do we map the perpetrator's patterns of coercive control separate to their use of violence and control from their alcohol and other drug use and/or mental health issues?
- Do we send a consistent message that those who use violence and control are 100% responsible for their use of abusive behaviours?
- Do our alcohol and other drug 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 victim/survivor about the safest and best way to approach and engage the perpetrator?

Practice Tip: How can we hold perpetrators accountable for their behaviours?

The following strategies can be useful when holding those who use violence and control responsible.

- Avoid practices that inhibit perpetrators from leaning towards accountability for abusive and controlling behaviour.
- Avoid colluding with the perpetrator.
- Critically reflect on explanations that are provided by perpetrators, family members and professionals to explain abuse and coercive control – focus on behaviour and its impacts.
- Be careful to avoid practising in a manner that holds victim/survivors responsible for perpetrators' abusive behaviours.
- Be careful not to assume causal connections between domestic violence and the perpetrator's mental health issues and/or alcohol and other drug use.

Instead of labelling victim/survivors 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.

3. Engaging perpetrators in a context of complexity

Perpetrators who use violence and control in the context of complexity often deny, minimise and justify their abusive behaviours by blaming their partners, mental health issues, alcohol and other drug use, trauma histories, and/or life circumstances. Those who use violence and 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 workers to understand the gendered nature of domestic and family violence, the drivers of violence,[7] perpetrator tactics and victim/survivors' acts of resistance in order to avoid colluding with perpetrators. Workers from all sectors and types of services that engage with perpetrators can benefit from adopting a perpetrator patterned based mapping tool to guide their work.[8] Such a tool allows practitioners to focus on patterns of behaviour and avoid being misled by perpetrator grooming tactics.

Practice Tip: Key ways to pivot to the perpetrator if you have direct contact with them

- Ask perpetrators about how they can act to strengthen the functioning of the family and their relationship with their children.
- When working in alcohol and other drug use services or mental health services, explore men's role as fathers and the intersection of their issues with fathering behaviour.
- Explore the offending parent's concerns for their children and their identity as a father/Kinship/other as a potential motivator for change.
- Be prepared to step out of personal comfort zones to understand concerns about the forms of violence encountered by male perpetrators under colonial structures, without excusing domestic and family violence.

A note on prioritising safety: strategies for engaging with the perpetrator should be consistent with practitioner's confidence, experience and expertise, and the role and capacity of the service. Further advice or secondary consultation on working with perpetrators may be obtained from specialist services such as the Men's Referral Service.

Practice Tip: How to avoid colluding with a perpetrator

Perpetrators are often highly skilled at grooming and manipulating those around them. There is a fine line between engagement and collusion.

- Engage, but never validate the perpetrator's statements that blame others or 'the system'.
- Redirect your line of questioning to focus on the perpetrator's pattern of abusive behaviour instead of colluding with his explanations for violence or labelling victim/survivors as mutually responsible.
- Use a mapping tool to focus on patterns of behaviour without being misled by perpetrator grooming tactics.

Case practice example: Addressing DFV in complex situations

A drug and alcohol worker who did short-term work with men seeking support for their drug and alcohol use, noticed that many of these men also reported using violence against their partners. He started to talk with men about being a father and partner, metaphorically bringing 'all the family into the room' when he spoke with his clients. He identified this important role as 'planting the seeds' of behaviour change.

"As workers we can 'plant the seeds' even in brief interventions, by starting conversations with men about being a father and a partner, rather than just focusing on mental health and alcohol and other drug use." – CoP participant.

Build confidence in engaging with perpetrators who use violence and who are seeking your assistance to address their drug and alcohol use and/or mental health issues. Providing therapeutic assistance does not preclude gathering information about perpetration patterns and/or engaging them in a project to address their use of violence and control. However, keep in mind that all engagements and interventions with perpetrators must keep victim/survivors and their children's safety as the highest priority. If the perpetrator stops drinking but doesn't stop their violence, we have not been successful.

Reflective questions to support engaging perpetrators in a context of complexity

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

- Do we use a mapping tool to enable us to assess and engage perpetrators in conversations about their perpetration patterns, mental health and/or alcohol and other drug use?
- Do we balance our therapeutic role with perpetrators who use violence and control with our ethical obligations to ensure the safety of victim/survivors?
- Are we assessing for danger to others when someone presents as depressed or suicidal, particularly when they have a history of violence?
- Are we assessing for patterns of manipulation around mental health issues, e.g., clients using a mental health diagnosis as an excuse for violence or 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 alcohol and other drug use or mental health challenges?
- Are we exploring the issues in relation to their fathering and attitudes to fathering when they are using violence, alcohol and other drugs or when they are struggling with their mental health issues?

Key advice from your NSW Health colleagues

'Think about how to become skilled in initial engagement with perpetrators. It is often not about the violence straight away. You can start to talk about their use of alcohol and other drugs and what they are not happy about as a way in to address use of violence'.

'Have an awareness that accountability conversations can move too quickly to blame and shame, rather than focusing on behaviours that can be a way to work through and engage the client with (often in a short amount of time)'.

'Referrals of perpetrators to counselling can often be difficult to engage (particularly with a female dominated workforce). Think about different pathways, linking with positive peers/ mentors/role models that can help reduce risk and harm'.

Practice Tip: Focusing on perpetrators as fathers as a 'way in'

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 alcohol and other drug use 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. Ask the father:

- 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 do you do to provide for your children?
- What do you do to support your partner or ex-partner as a mother?

Theme 3: Keeping the focus on children and young people

There is a large body of evidence demonstrating that children are not silent witnesses or 'secondary victims' in families were there is domestic and family violence. Children are affected by domestic and family violence differently – each child has their own unique experience and responds to survive or manage their situation in their own way. There is, however, more work to be done from all services to hear from children and young people. This is particularly true for Aboriginal and Torres Strait Islander children and young people who have to date been largely silenced in the literature.[9]

When working with children, young people and families where there is domestic and family violence and intersecting issues, a key focus for practitioners should be:

- Keeping children and young people visible and heard.
- Connecting the dots between the perpetrator's pattern, including alcohol and other drug use and/or mental health issues and the impact on children.
- Avoiding blaming children for the trauma impacts (and how they may impact their behaviours).
- Validating and supporting children and young people.

The ways in which workers achieve this is dependent on their role and scope of practice, subject to clinical judgement and always with consideration of the child's safety and wellbeing at the forefront. All workers in NSW have legal and professional responsibilities in relation to child protection, including reporting suspected risk of significant harm. However, workers with appropriate training and who work with children and young people as part of their scope of practice should also identify safe and appropriate opportunities to talk with a child or young person about their experiences of DFV.

1. Keeping children and young people visible and heard: through the eyes of the child

Practitioners must maintain a strong focus on the safety and wellbeing needs of children and young people living in families where there is DFV. The perpetrator pattern-based approach, which assesses for coercive control toward the adult victim/survivor, abuse and control toward children, and the tactics that undermine the mother-child relationship can help keep children and young people visible and heard. A focus on a family functioning approach, which considers how the perpetrator's actions change the way the family functions day to day, can make visible how the perpetrator is harming children and impacting normal developmental activities. The approach is more comprehensive that the traditional 'witnessing' framework that is applied to children by including multiple other pathways to identifying and understanding harm.

Case practice example: Attending to all family members

While attending counselling, a young person requested that his mother attend appointments with him. After several months, the young person and his mother disclosed ongoing domestic violence perpetrated by his father, including an attempted abduction while he was an infant. The counsellor identified that the father's violence was interfering with the young person's mental health and recovery from trauma.

Over time, the counsellor built trust with the young person and was able to help him explore his relationship with both parents, his experiences of violence, and his hopes for the future. The young person was able to bring specific issues into his sessions for support, for example when his father changed contact arrangements. The mother was able to attend some sessions at her son's request and was validated around her parenting choices and connection with her children.

Practice Tip: Keeping children and young people visible

- Workers with appropriate training and who work with children and young people as part of their scope of practice should talk with a child or young person about their experiences when it is safe to do so. Engage children in developmentally appropriate conversations about their experiences of living with DFV, parental drug and alcohol use and/or parental mental health issues.
- 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.
- Ensure you are up to date with the research about how children can be impacted by DFV, parental drug and alcohol use and/or parental mental health issues.
- Ensure you are assessing and documenting the full range of risk factors, protective factors and strengths that exist in children's and young people's lives.
- Think about additional barriers and support needs for Aboriginal children and young people and considerations of cultural safety, connection and healing in your approach.
- Think about your service setting and how that may impact children and young people (for example, how would a child or young person feel discussing their experiences of violence in an acute busy hospital setting?). Consider what you can put in place to make this easier for children and young people.

Children living in the context of domestic and family violence may face a wide range of negative experiences that can have long-term detrimental effects on their development and wellbeing. This can include being present when property and belongings are physically damaged or threatened, when a parent is injured or distressed, experiencing ongoing tension between family members, and anxiety, fear and trauma associated with any of these experiences. They may be asked to keep secrets from family members, may be used as a weapon or mechanisms for control by a perpetrator, and may experience divided loyalties that are exploited and manipulated by offending parents. They may also be the target of child abuse by the perpetrator and/or neglect by either parent, particularly when the impacts of violence intersect with mental health issues or alcohol and other drug use. The ripple effects of domestic and family violence are pervasive and can adversely affect many aspects of children's health and development, as well as the family's ecology.

Workers should listen to and assess the full spectrum of experiences of children and young people and document these – highlighting patterns of harm and acts of resistance and creating safety. Advocating for a child or young person is a critical component of a domestic and family violence-informed response.

Practice Tip: Working with children and young people

Workers with appropriate training and who work with children and young people as part of their scope of practice should talk with a child or young person about their experiences, when it is safe to do so.

When engaging with the child or young person, it is important to talk about what has been happening in a developmentally appropriate way and in words that they can understand:

- Ask the child or young person how they're feeling.
- Ask the child or young person what is most important to them to talk about.
- Explore with the child or young person whether there are things they do when things are hard at home.
- Talk with them about protective and trusted adults in their lives (e.g. non-offending parent, aunt, teacher, GP).
- Tell the child or young person it's not their fault. Say: 'Lots of the children and young people that I meet blame themselves for the troubles in their family, but I am very clear that it's never the child or young person's fault'.
- Allow them to be angry, sad, or have any other feelings about the perpetrator and the non-offending parent.
- Encourage the child or young person to find ways to share their feelings including through play or art.
- Ask: 'How do you work out which people in your friends and family would be likely to understand and help you?'.
- Make appropriate referrals to family support services or child protection services.
- Use language that does not make them feel responsible e.g., not 'what did you do when dad was yelling at mum?' but 'how did you keep yourself safe when…'

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 control, and other risk factors such as parental mental health issues and alcohol and other drug use when considering outcomes for children and young people. This is important even when the child or young person is not your direct client or patient. Some key areas to consider include:

- Has the perpetrator injured the child through physical abuse targeting the child or as a result of proximity to the intended target of the violence (e.g. a child intervening to protect the non-offending parent) or whilst in the process of running away from/evading the violence?
- Has the perpetrator psychologically abused the child as part of coercive control and other violence perpetrated against the victim/survivor?
- Has there been violence or threats of violence towards the victim/survivor that create child trauma concerns? For example: driving dangerously leading children to being afraid of being in the car with the perpetrator.
- Has the child experienced trauma as a result of living with the domestic and family violence? Is this impacting on the way they feel, see the world, behave and/or interact with others?
- Is there neglect that creates safety issues? For example, has the perpetrator's behaviour led to the children being placed in unsafe situations, such as being left alone for developmentally inappropriate periods of time without supervision?
- Has the perpetrator's coercive control interfered with the victim/survivor's ability to discipline, guide and/or care for the children? Has this led to behavioural concerns, impacts on the child's health, developmental delays, mental health issues, use of drugs or alcohol, or attachment concerns?
- Has the perpetrator targeted or undermined the child's bond with their non-offending parent as part of their pattern of abuse?
- Has the perpetrator's behaviour impacted on the child's ability to interact with extended family or kin, or understand and participate in their culture?

Case practice example: Connecting the dots

A young person in out-of-home care was initially referred to health services for emotion dysregulation and aggressive behaviours. Health workers started engaging with her family of origin as well as her foster family and identified ongoing domestic and family violence within her family of origin perpetrated by her father. His pattern of behaviour extended beyond the family home and was still having a significant impact on his child and her behaviour in out-of-home care. The young person had learned to mirror her father's mistrust in services and her 'aggressive' behaviours were reframed as survival strategies. The father's pattern of behaviour was seen as the underlying factor in over twenty different placement breakdowns for this young person, even though he wasn't living with her.

"So it became rather than, this girl is hard to like, she is violent to everyone, to actually here is dad's behaviour, and how she responds, mirrors and survives, and is fearful." – CoP participant.

Practice Tip: Using the Perpetrator Mapping Tool to determine the impact of violence and control on children

Step 2 of the perpetrator mapping tool asks practitioners to document the perpetrator's pattern of behaviour on the child, victim/survivor and family functioning. The key questions for practitioners to consider in this section are:

- How has the perpetrator's behaviour pattern caused trauma-related effects on the children?
- How has the perpetrator's behaviour pattern disrupted the family's ecology (and in what ways)?
- How did the perpetrator's behaviour pattern affect the victim/survivor's parenting (and in what ways)?
- How else did the perpetrator's behaviour pattern weaken family functioning?
- How is the child/children's daily life different because of the perpetrator's behaviours?

Case practice example: Determining the impact of DFV on children

A non-government child protection service started working with a couple and their four children. The children were referred due to significant developmental delays, limited speech and behavioural challenges. Workers used the 'pathways to harm' resources to understand how the children's development was linked back to the perpetrator. For example, speech delays could be linked to the children learning to be quiet around their father when he was violent. Once risk assessment and safety planning had been carried out, a plan was developed to build protective factors, including partnering with the mother, parenting interventions with the father, and referrals to the National Disability Insurance Scheme and childcare services.

3. Placing the responsibility with the perpetrator: Not blaming 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 violence. Workers must be mindful to assess children's behaviours by paying attention to the wider traumatic context that the perpetrator established. Inter-generational trauma must be considered particularly for Aboriginal children and young people, families from refugee backgrounds and children and young people in out-of-home care.

Practice Tip: Using the Perpetrator Mapping Tool to determine the impact of DFV and control on children

Be aware of the impacts of domestic and family violence on children and young people and how these may be visible in day to day life. DFV can impact a child's sense of safety, trust and self-worth, with a loss of sense of self and disrupted connection with their mother. The ways these impacts are exhibited will differ across developmental stages and ages, and for each child or young person.

DFV impacts may look like:

- The child or young person demonstrating disorganised or agitated behaviour.
- Aggressive and harmful behaviour towards peers or themselves.
- The child not attending school or medical appointments. This may be due to trauma impacts on the child or family members or other factors for example, homelessness, or fear of the child protection system.
- Difficulties learning, focussing at school or following instructions.
- Unusual parent/carer and child interactions. For example, what the parent or carer says about the child or how they respond to them.
- Not meeting developmental milestones.
- Behaviours common to younger children for example thumb sucking or wetting the bed in an older child.
- For First Nations children and young people – experiencing shame due to racism and racist past responses.

Note: Questions from workers can trigger emotional distress, shame and grief. It is important to be sensitive to this and frame questions or discussions in a way that is non-stigmatising, non-judgemental, culturally safe and which does not blame children for the impacts of trauma.

Reflective questions to understand children and young people's responses to DFV

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 alcohol and other drug use and/or mental health problems?
- Do we consider how children's behaviours may serve to protect them and/or their non-offending parent and siblings from further violence or abuse from the perpetrator?
- Do we help children and young people make sense of abuses of power occurring within their families in ways that are developmentally appropriate and safe, in the context of safety planning or healing work?
- Do we help children understand neither they, nor their non-offending parent, are responsible for DFV?
- Do we identify the child's strengths and adaptive responses in partnership with the child or young person, and affirm these?
- Do we ensure we are supporting the child or young person to identify and discuss what is most important to them, and communicate their needs and priorities?
- Do we communicate with children and young people in developmentally appropriate ways and using words that they can understand?
- 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?
- Are we assessing the possible connections between children's behaviours, 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?
- Are we mindful of the impacts of intergenerational trauma, colonisation and racism?

Where children are engaging in violence themselves, avoid using terms like 'child-initiated violence' or 'adolescent perpetrator' as these can serve to blame children and fail to account for the reasons that they may use abusive behaviours, including protecting themselves or others from parental violence.

We need to assess safety strategies of children and young people as much as we assess the strategies of an adult victim/survivor. Be aware that mental health frameworks that emphasise 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 using protective strategy and behaviour mapping.
- Assess how a child works with a parent and/or other siblings to increase the safety for all family members.
- Assess whether a child may be being co-opted by the perpetrator onto their 'side' or be the target of manipulation.

Practice Tip: Asking about children's strategies for keeping themselves safe

Below are examples of respectful questions aimed to elicit information about the strategies children might use to keep themselves and their families safe. Workers should consider their service setting and whether they have the level of skill and training needed to work with children/young people in this context, and seek advice where necessary.

- *'I can see you care a lot about your family, and both of your parents. You've managed to keep yourself safe even when you might be scared of what is happening in your family. Can you tell me a little bit about how you do that?'*
- *'Sometimes adults can't see all the ways you're helping them or trying to keep them safe. Can we talk a bit about what you do to help your family be safe?'*
- *When you see your parents drinking or getting sad or afraid, do you do anything in particular to look after yourself? Can you tell us about that?'*
- *'You are the one who knows best what you need to feel safe and supported. Can you tell us what that looks like and how we can help you feel safe?'*
- *'What are some of the things you are most afraid of when you come to see us? Is there anything we can do to make it less scary?'*

4. The importance of providing a validating and supportive response

Children and young people who experience domestic and family violence and other trauma associated with parental mental health issues and/or parental alcohol and other drug use have their own needs for protection, understanding and support that are separate to the needs of the adults in their lives.

Reflective questions to validate children and provide a supportive response

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 child victim/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 practitioner efforts to build relationships based upon trust and validation, even though this takes time given the multiple complexities involved?

Practice Tip: Children's agency and role in their families

It is important to remember that 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. Workers must be mindful to gather information about the child's role within the family and be sensitive to their sense of agency.

Case practice example: Children's agency and its limits

Children's behaviours may make sense as a survival strategy or a way to manage living with domestic and family violence.

- One domestic and family violence worker described how a child threw 'screaming fits' so her family would not go out, in order to prevent violence.
- A Health child protection service was asked to provide advice about contact between a child and his abusive parent. The referral requested strategies for the child to use, for example speaking to supervising workers if they felt unsafe. The service responded that this presenting the child with these kinds of strategies actually placed further responsibility on the child to manage violence from adults.

Helping children understand that they are not responsible for DFV, parental alcohol and other drug use and/or mental health issues is imperative. A staged approach to support children feeling less responsible for the family may be necessary to avoid compounding children's feelings of loss of control that come with experiencing DFV.

Practice Tip: Considering children and young people in context

- If there is any history of DFV in a family, ensure that in making any diagnosis of a child this history is considered.
- Consider how to safely include 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 victim/survivor, not on themselves and their behaviour.
- Consider the range of threats that children have heard which involve them (e.g., threats to kill, harm, report to child protection and have them taken away, threats to their belongings or pets).

Theme 4: Working Safely

"We heard from several agencies that they couldn't intervene as it was too unsafe to do so. The perpetrator was in the centre – controlling everything – the woman and her children, staff in agencies and government departments. The other agencies were manipulated by the perpetrator who was minimising everything." – CoP participant.

Workers' fears for their own and the victim/survivor's safety are among the most significant barriers to implementing domestic and family violence-informed work, including partnering with victim/survivors and intervening with perpetrators. When safety risks are heightened as a result of perpetrator threat or perceived to be heightened with no support to address it, the 'path of least resistance' to working with families is often to engage only with the victim/survivor.

Critical point

Considerations about a worker's safety cannot be separated from considerations about the safety of the victim/survivor and their children. Threats to worker safety are serious and need to be planned for and responded to in all agency policy and procedures coupled with crucial management support. Addressing this is central to addressing perpetrators' attempts at manipulating systems as threats sit alongside, manipulation/charm, and mis/disinformation.

Workers attending to domestic and family violence across the intersections can often face challenges to their physical, psychological, cultural, and emotional safety at work. Threats to worker's safety can include; technology facilitated abuse, meeting a perpetrator if you live and work in a small community, travelling long distances to see clients, psychological threats and manipulation, invitations to collude and perpetuate harmful patterns and behaviours, threats to professional reputation, threats to physical safety, and ongoing psychological impacts through vicarious trauma.

Some workers also fear making the situation worse through intervention with the perpetrator and worry about their own safety when directly engaging the perpetrator. This lack of safety is often used by the perpetrator to continue to their coercive control and violence. Improving worker safety and helping workers feel safe is crucial to ensuring victim/survivors receive the services they need to improve their own safety.

What do workers in NSW say?

Workers in NSW who participated in the *ESTIE Projec*t highlighted the following factors that contribute to workers feeling unsafe:

- Working across different service sectors with different understandings of risk and safety and use of different terminology and language.
- Workers being made to feel responsible for dealing with safety issues themselves.
- The high rate of domestic and family violence lived experience in workers and workers with lived experience being triggered by their work and not receiving adequate support.
- Supervision and care of staff responded to through Employment Assistance Programs (EAPS) and direct workload management, creating the response as a human resource issue, rather than supervision and workplace support concern.
- Lack of cultural safety.
- Unfair systemic practices such as child removal and family court responses.
- Differences in expectations and approaches to the client/worker relationship and the related practice assumptions between different types of workers (for example: privileging a victim/survivor's expertise and voice compared to privileging the medical model and associated responses).

Considering and responding to worker safety in your organisation

Key practice point

It is not the responsibility of the individual practitioner to instigate, develop, and uphold their own safety when working across the intersections. It is the agency and management's responsibility to foster a culture of care, supporting their workers employed in the system.

Building confidence, skills and knowledge related to working with perpetrators is a basic support for worker physical and emotional safety. When this is missing workers are more likely to over or underestimate risk to themselves and the family.

Practice Tip: Keeping staff safe

Some key components when planning for worker safety in your agency and its practice include:

- Develop steps for your organisation and management to mitigate risks to workers resulting from abuse (including technology facilitated abuse), threats, harassment, vexatious complaints and intimidation from perpetrators.
- Prior to meeting with those who use violence, ensure that we have gathered information about their perpetration patterns, alcohol and other drug use patterns, and mental health status.
- When making arrangements to meet with those who use violence and/or other family members, meet with managers and colleagues to plan how to best approach the meeting, including the development of worker safety plans. Consider the practical aspects of keeping practitioners safe (for example: workers attending in pairs, having time to travel long distances in rural areas, de-briefing and management support after the meeting).
- Hold meetings in locations that are deemed to be safe.
- Provide staff with opportunities to participate in training that focuses on enhancing worker safety.
- Have 'worker safety' as a regular agenda item at team/staff meetings.
- Have your agency consider intersectionalities when assessing worker safety, e.g., how perpetrators may target workers based on race, ethnicity, gender or other factors.
- Create a safe environment where workers can talk about how their experiences of violence (personal and professional) which may be shaping their practice.
- Work towards shared understandings of violence, harm, risk and safety with partner agencies.
- Ensure supervisors/team leaders regularly include discussions of worker physical and →

emotional safety in their supervisory meetings with their workers.

- Ensure professionals who are targeted by the perpetrator (stalking, threats etc) are moved from the case and that there are consequences for perpetrators who threaten the safety of workers. Such decisions should be informed by risk assessment that considers the nature of the threat, ongoing risk and the worker's views.
- Ensure that you provide workers with consistent guidance and support around how to navigate legal and statutory systems including reporting to Police.

Reflective questions for managers to consider when planning for worker safety

- How do we assess and manage perpetrator risks to workers engaging with families where there is DFV, mental health issues or alcohol and other drug use?
- Are we mapping the perpetrator pattern onto worker safety concerns?
- How do we share information and collaborate with other professionals to ensure worker safety when multiple agencies are engaging with the family? Do we have a shared understanding of risk and safety?
- How are workers and organisations considering psychological, emotional, and cultural safety to promote worker and client wellbeing?
- How do we support those workers who have lived experience of domestic and family violence?
- Are we aware of the tactics perpetrators use to manipulate the system, other professionals, or your organisation leading to workers becoming unsafe?
- What sorts of conversations are we having with victim/survivors that can assist with planning for safety?

Promoting emotional and psychological wellbeing through a culture of care

"The major challenge is the systemic support and the interagency relationships... sometimes just being that lone voice, its very draining, very tiring, and very repetitive. I think the way we can support each other in the work is something that we can build from this." — CoP participant.

Working with families at the intersections in difficult and often unjust service systems, bearing witness to trauma, facing the violent and controlling tactics of perpetrators, and at times, not being supported in the workplace, can have deleterious effects on workers. For many workers, the emotional impact of this work is compounded by working within a risk averse culture prone to blaming workers when things go wrong. This further undermines workers' sense of safety.

For workers with their own experience of domestic and family violence (and other forms of violence), we need to consider how these processes might intersect with their practice, including acknowledging that this can mirror violence or abuse previously experienced and/or relationships with perpetrators. A domestic and family violence-informed agency creates opportunities for workers to safely explore how their own experiences impact their practice, including their sense of safety.

Critical supports: Supervision

Workers require high quality professional supervision and organisational mandates that aim to establish a safe working environment. Think about the following:

- 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 ensure there are external supervision opportunities rather than 'in-house' or group sessions?
- Do we ensure that supervision is separate from Human Resources or Employee Assistance Program mechanisms?
- Do we ensure that we have cultural supervision to support work with Aboriginal families and communities?

Culture of Care =

An authorising environment which demonstrates to workers that their safety is important to the organisation and understands the concept of perpetrator patterns of abuse and coercive control.	Flexible responses to workers' concerns by managers and organisations.	Clinical and cultural supervision and supportive de-briefing to sustain worker well-being.

Case practice example: Organisational support

Limited support	Appropriate support
A home visit risk assessment that has a yes/no box next to a question about whether the client you are visiting is a 'perpetrator of violence'.	A home visit risk assessment which allows for the assessment of the nature and pattern of violence, including a history of whom the violence was towards and in what context, and how the person has previously responded to service involvement.
Debriefing is offered to the staff members who were in the room when a perpetrator threatened to assault workers of the service.	Debriefing is offered to all staff of the service following the incident, including people who were not in the room but were still impacted.
Worker safety is occasionally discussed in case conferences and interagency meetings, when advocated by an individual worker.	Worker safety is a part of all meetings and information is shared consistently and in a timely manner about any concerns.

Practice Tip: Enhancing worker safety

The following strategies were highlighted by workers who participated in *ESTIE* Communities of Practice and are illustrative of workers' perceptions of their needs in relation to worker safety:

- Worker safety should be seen as a managerial priority and embedded in practice and policy.
- Risk needs to be held collectively as a team, and even between agencies, not just as the responsibility of individual clinicians.
- There is a need for a caring, considered and validating response to issues arising from breaches of worker safety.
- There must be 'top down' support for practitioners, with managers understanding issues of DFV.
- A culture of care rather than a self-care model needs to be embedded. Solutions such as a referral to an EAP or HR and discussion of self-care places the responsibility on the worker rather than the organisation and broader structure. Supervision should be available to a range of workers (not just those in social work roles).
- Ideally supervision should be separate from line management.
- Valuing the agency of workers and their capacity to know when they are triggered or struggling, and providing support needs to happen without the staff member being overwhelmed by bureaucratic processes and requirements.
- Understanding that many staff in this sector have their own lived expertise of domestic and family violence and for an organisation to respond appropriately.
- Perpetrator-proof your service and system using techniques outlined by the Safe and Together™ Institute.[10]

Case practice example: Safety for workers and service users

"What we needed to ensure our safety was a shared understanding between workers."
— CoP participant.

Health child protection and mental health services were working in partnership with a young person and her family. No worker safety concerns were identified in the initial referral from the statutory child protection body, but when health workers started to visit the home, they experienced physical and verbal aggression from the young person's father. Workers described feeling 'on edge' and needing to manage their presence around him during visits and on phone calls. Workers also had to manage frustrations around ongoing service failures for the young person.

Strategies that supported worker safety for the team included: working in a co-clinician model, opportunities for informal debriefing and reflection, experiencing validation around frustrations and fears, and mapping perpetrator behaviours. Health workers also communicated with the other services involved to try and develop a shared understanding of safety concerns. It became clear that the father was manipulating services by presenting as the 'ideal parent' to statutory services, but intimidating workers from voluntary services. Information-sharing, documentation and using a shared language were key to supporting safety for workers and for the young person.

Theme 5: Working collaboratively

"When everyone is on the same page, the outcomes are better in a shorter time." — CoP participant.

There has been a long history of siloed service provision across the domestic and family violence, child protection, alcohol and other drug, and mental health sectors, despite these sectors working with the same clients and families. Holistic and integrated service provision across the sectors is necessary to improve outcomes; however, there are significant challenges to achieving this. **Developing holistic integrated service provision is challenging and takes time.**

When we think about keeping collaboration at the centre of our practice, we need to think of the following partners and the focus of the collaboration:

- ***With the victim/survivor*** – who is pivotal in any multi-disciplinary approach and with whom workers need to collaborate throughout all phases of their work.
- ***With family members*** – who can provide supports, information, and expertise.
- ***Between service types*** – acute care and long-term therapeutic within our service sectors.
- ***Between service sectors*** – through developing a shared language, sharing documentation, keeping the perpetrator visible and accountable in all approaches, partnering with the victim/survivor in all approaches and keeping the children safe and with the non-offending parent at the centre. When services collaborate around interventions with perpetrators, using shared information and a common framework around accountability and change, outcomes can improve for families.
- ***With Aboriginal workers, families and communities*** – to ensure we are all working with the family in a trauma-informed and culturally safe and appropriate way.
- ***With those facing additional barriers to seeking help*** (priority populations) including rural and regional expertise/voices, members of the LGBTIQ+ community and those from a culturally and linguistically diverse or refugee backgrounds.

Practice Advice from the ESTIE Aboriginal Cultural Consultant

Collaborative partnerships with Aboriginal clients and communities

Many Aboriginal clients and workers can be experiencing trauma, such as mental health, alcohol and other drugs, and child protection, have extensive trauma histories, and consequently, have complex service needs that cannot be responded to without a trauma-informed lens which provides a common framework for understanding the various manifestations of trauma responses.

For Aboriginal clients with complex intergenerational trauma histories, the barriers to receiving help are compounded by current and past experiences of racism. Effective assistance needs not only to be trauma-informed but also culturally safe.

Reflective questions for working collaboratively

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

- Do we consider victim/survivors' voices and expertise to be central in relation to the safety and wellbeing needs of their children and families?
- Do we identify where and how the service system is fragmented and advocate for more collaboration and integration?
- Are services coordinating interventions with perpetrators?
- Where do we rate our agency on the Safe & Together continuum of domestic and family violence-informed practice? How often do we review this?
- What can we do to move our agency towards domestic violence proficient practice?
- How do we work with adult focussed services to ensure that they enquire about children, or the adult as a mother or father?

Techniques for working collaboratively

The following techniques can support the developing collaborative work between key stakeholders.

1. Identifying and breaking down silos

Perpetrators who have mental health and/or alcohol and other drug issues may be connecting to the service system at multiple points. There can be little or no communication between these services and each sector will be focusing on the predominate presenting issue. The siloing can lead to negative impacts on the safety of victim/survivors and their children. Identifying the silos and associated issues can be a starting point to developing techniques which can be used to start breaking down barriers.

Reflective questions to identify barriers and opportunities for collaborative work

The following reflective questions can be used as a starting point to identify barriers and opportunities for collaborative work:

- When those who use violence and 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, alcohol and other drug use and/or mental health issues?
- Do practitioners working in mental health and alcohol and other drug services understand the intersection of DFV perpetration, alcohol and other drug use and mental health issues?
- If you work in a mental health or alcohol and other drug service, does your agency routinely undertake formal, universal screening for DFV for all clients? I.e., do we routinely integrate and ask specific questions related to DFV within our assessment/diagnostic procedures?
- How do we promote the idea that engaging with fathers who use violence is the responsibility of all agencies working with men? Do we see it as our role to engage in a perpetrator patterned based response to our practice?

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- Do agencies that only work with perpetrators proactively seek to partner with agencies working with the perpetrator's partner/ex-partner in order to gain information regarding their perceptions of safe engagement, safety and evidence of change?

Practice Tip: Working collaboratively across the sectors

Responding appropriately to those who use violence, and adult and child victim/survivors is the responsibility of all services. It is important for workers across all sectors to be tuned into perpetration patterns throughout their diagnostic or assessment processes. Make it your business to consider the perpetrator's patterns of behaviours as well as victim/survivor's acts of resistance in context. Some practical examples include:

- Draw from the Safe & Together principles and critical components (see figure 1) and use in your sector. Undertake assessments that keep the violence, abuse and control at the centre and hold the perpetrator accountable.
- Include information from perpetrator mapping and documenting victim/survivor's strengths in referrals to other services and ensure it is included in documents such as court reports.
- Refer clients with indicators of coercive control and abuse to specialised DFV or men's behaviour services.
- Consult with specialised DFV or men's behaviour services when necessary to guide your practice.
- 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.
- In any meetings where cases are discussed, ask questions to understand the details of any DFV in terms of abusive behaviours and their impacts.
- Dedicate time for reflection, discussion and exploration of the Safe & Together™ Model.
- Establish a community of support for practitioners implementing practice change (e.g., Community of Practice).
- Have key contact teams, rather than individual practitioners, between collaborating organisations.
- Co-locate services which helps to build relationships and collaboration.
- Establish local connections and use proximity of work locations which are powerful enablers of collaborative and sustained relationships between practitioners.

2. Leadership and formalisation of protocols

It takes time to build trusting relationships within and between agencies who have historically engaged in siloed practices backed by fragmented policies and legislation. Strong leadership and an authorising environment are both required to support organisational cultures to become more domestic and family violence-informed.

Case practice example: Formalising collaboration

A Health child protection service primarily receives referrals from the statutory child protection body. Health workers identify the need to share more information about DFV at the intake stage and create a shared approach to the family. They review their handover process and documentation to include Safe & Together language such as perpetrator patterns, victim/survivor strengths, and pathways to harm for children.

Formalised protocols, particularly those that guide information sharing, can enhance communication within and between agencies. Sharing relevant information that enhances a worker's ability to make informed professional judgements about safety and risk is vital. Key to this approach is the importance of developing a **shared language** that resonates across the various sectors. This language can be embedded in documentation highlighting the perpetrator's pattern of harm as well as the victim/survivor's strengths and protective efforts.

Reflective questions 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 and family violence-informed practice related to the intersection of DFV and alcohol and other drug use and/or mental health issues?
- Are we aware of all relevant domestic and family violence legislation, policies and protocols that exist to guide practice, and particularly to guide information sharing and collaboration within and between agencies?
- Are we drawing on the expertise of Aboriginal workers, researchers and policy makers to develop cross-sector practices that support Aboriginal women, children and their families?

3. The role of the service navigator

Service navigator[11] is a term used to describe a worker who practises across the service sectors to provide wrap-around support for a victim/survivor of domestic and family violence and their children. Service navigators are victim/survivor-led in their approach, taking advice and direction from women and their children. They support the victim/survivor through their contact with the varied sectors (DFV, VAN, MH, AOD, NGO, justice) by providing an understanding of the language and practicalities of engaging in those spaces. The navigator then uses a solution-focused approach to work with the victim/survivor and their children, bringing the system around them through co-work and referrals.

Health workers from the CoPs described working in this way across the Health sector and broader system. This type of approach aligns with new frameworks such as the implementation of the IPARVAN in NSW Health. Safe & Together approaches and frameworks are particularly useful when working in this collaborative way across the sectors, particularly given the core focus on documentation in this way of working.

Practice Tip: Advice from NSW Health workers on how to develop collaborative practice

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

- Understand that inter-agency and collaborative work is a broader systems issue, but there are many ways that workers can individually collaborate in practice. Examples of this type of work include: the language you choose to use, the way you document your notes, reaching out to other individuals and information sharing.
- Identifying opportunities or areas of change, and seeking authorisation from management to have the leadership, capacity, and ability for workers to action the change.
- Use respectful clarifying questions across teams/services/sectors to remind workers of the importance of perpetrator patterns and partnering with the victim/survivor.
- Review alcohol and other drug use and mental health programs intake and assessment forms and ensure they include appropriate questions regarding DFV.
- Consider multi-disciplinary meetings focused on cases involving DFV and mental health and/or alcohol and other drug use. Safety Action Meetings in NSW are an example of this type of practice. Using the STIM Protocol (as described below) could support the process.

Safe & Together Practice tip: Use of the Safe & Together Intersections Meeting (STIM) Guide

"Collaboration can be limited when it is reliant on individual worker relationships and positive changes can be lost when that worker is not available. Using tools, such as the Safe & Together Perpetrator Mapping Tool and STIM Protocol, can help institutionalise practice change."
— CoP participant.

The STIM Protocol was developed by Safe & Together to guide workers from distinct service sectors to come together in a case conference style meeting to discuss a case using a DFV-informed approach. The STIM protocol has three major steps:

- Initial presentation of the case by the caseworker.
- A behavioural discussion of the key components of the case.
- Development of action steps.

The guide highlights how to discuss the perpetrator's pattern of behaviour and intersection with other issues, ensuring that domestic and family violence is considered as the context for the discussion of mental health and/or alcohol and other drug use. Either the perpetrator mapping tool is used, or the following issues are covered in the discussion:

Risk and safety concerns for children from the perpetrator's behaviours:	Describe the perpetrator's pattern of coercive control and actions taken to harm the children and their impact on child, parent and family functioning.
Protective efforts by the non-offending (survivor) parent:	Describe the full spectrum of the survivor's efforts to promote the safety and wellbeing of the children.
The intersections of domestic and family violence, alcohol and other drug use and mental health concerns:	Describe how the perpetrator's behaviour intersects with alcohol and other drug use use and/or mental health issues.
How culture, privilege and marginalisation factor into the case:	Describe factors related to privilege, oppression and vulnerability that have an impact.
Worker safety issues:	Describe any worker safety concerns in this case.
Interventions and Partnering:	Describe the interventions attempted with the perpetrator and the steps taken to partner with the adult survivor.
Next steps in the case:	Describe what happens next in the case.

Case practice example: Using the Safe & Together framework in an interagency context

Case Example 1:

We had a meeting with DCJ [Child Protection] who had written a family action plan solely around mum's drinking, mum's poor parenting, mum's mental health. We used the information gathered with the knowledge of the mapping tool to shape that meeting from a point where a statement was made at the beginning where mum was the biggest risk in this family, there were lots of concerns about her and the neglect, to actually seeing mum as the biggest strength in this family. And that the concerns were actually about the wider system including us, including DCJ, seeing her and supporting her. And really kind of mobilising to get her lots of practical support. And placing people where they rightly belonged, as perpetrators, and survivors, doing many incredible things to keep herself and her kids safe.
- (CoP participant).

Case example 2:

Safety Action Meetings were identified as an opportunity to enhance collaboration. A child protection worker from an NGO shared information collected from the perpetrator mapping tool at a Safety Action Meeting for the family. The worker was able to challenge descriptions of the mother as 'difficult to engage', highlighting her strengths and previous work with services. The worker aimed to build a shared understanding that if the mother didn't engage, it would be because of the perpetrator's interference (Community of Practice example).

Theme 6: Documenting effectively

Documentation is a powerful tool in any service response to domestic and family violence and is a form of practice in itself. Documentation will stay with the victim/survivor, perpetrator and their children throughout their journey with the service system. Documentation can be used for identification of interventions and treatment options, or as evidence in child protection or criminal matters, or with family law cases. Documentation is captured in all parts of the work - assessment, case notes, referral notes, and reporting. Using documentation as an advocacy tool is a way to provide an alternative narrative to service systems that are not DFV-informed. It is a strategy to improve responses to families both immediately and in the longer term.

The welfare sector has traditionally used a 'failure to protect' narrative for victim/survivors of domestic violence and simultaneously made perpetrators invisible in formal documentation. This is particularly evident in child protection settings. This is compounded when systems, structures and agency procedural guidance make it difficult to record descriptions of pattern-based violence and its cumulative impact. Systems often allow only single, incident-based information to be recorded or only information about the presenting issue to the service which may be alcohol and other drug or mental health issues. This often works against a pattern-based approach to documentation. The alternative to 'case based' documenting is the Safe & Together™ Model's perpetrator pattern approach. Using this approach alongside your normal recording system to synthesise a pattern is useful.

Critical supports: Documentation and language

The language you use and how you document the case will stay with the client on their journey across services. Your initial recording will colour responses from other collaborating services. Partnering with the victim/survivor and holding the perpetrator accountable for their actions and the impacts of those actions is critical and includes your practices in documentation. Being culturally appropriate is key. Your documentation may also be viewed by the victim/survivor, or their children, later down the track. Depending on how documentation is drafted, it has potential to help or hinder the victim/survivor's safety and healing.

Practice Tip: How to document effectively

Perpetrators are skilled at manipulating the service system. Ensure that information related to DFV or child protection concerns is appropriately secured. This is particularly important when documentation is held in a child's file which may be accessed by the perpetrator.

Documentation may need to be clearly marked as containing child protection sensitive information in order to be removed from the record if requested by either parent.

Always ensure that addresses and contact details are kept secure, so as not to put women and children at risk.

'Bringing everyone into the room'

This involves considering, and wherever possible, documenting the actions and their impacts of each family member, along with their needs and efforts towards safety or recovery. Within a pattern-based approach, this emphasises the need to consider the 'absent presence'[12] of perpetrators, even if they are not physically present. Where services are adult-focused, this crucially involves bringing the perspectives, and where possible, the voices of children into the room, considering and documenting their needs as individuals. 'Bringing everyone into the room' is part of an all-of-family approach.

Focusing on patterns rather than incidents: Creating domestic and family violence-informed narratives and context

Shifting from an incident-based focus to a pattern-based approach is key to increasing perpetrator visibility by mapping their behaviours and clearly documenting their patterns of abuse. Holding perpetrators accountable starts with language - how we describe the problem, who is responsible for creating the problem, the impact of their behaviours on others and the expectation that they have responsibility to change behaviour and repair the harm. Language is also important in recognising a victim/survivor's circumstances and the safety risks they face. Observing, noting, and creating informed narratives of how perpetrator actions, as well as victim/survivor efforts, impact children and their wellbeing and development helps to set up opportunities for intervention and restorative justice, particularly where children have been used by perpetrators to control non-offending parents.

Reflective questions to guide effective documentation

Some key questions that may be helpful for your agency to think about in relation to documentation for cases where there is domestic and family violence:

- What are the current limitations of your agency's recording systems in relation to identifying patterns of coercive control which may make the perpetrator invisible or blame the victim/survivor?
- How would you re-imagine your current assessment and intake tools so that they include recording perpetrator patterns of harm and victim/survivor's resistance rather than single, incident-based events?
- What information would you want to collect from someone who might be a domestic violence perpetrator (particularly one who is in parenting role) as part of an AOD or MH intake?
- How do your intake and assessment forms help guide making connections between the issues of mental health and alcohol and other drug use and domestic violence?
- What sections and questions would you add to your current intake and assessment forms to make them more domestic and family violence-informed?
- How do we pull all of the important information together: patterns, harm, impact on children, protective capacities? How do we keep the lens of coercive control whilst responding to issues around mental health and alcohol and other drug use?
- What avenues exist for you to influence changes to these forms and systems?
- What work arounds are available if these systems and forms cannot be changed in the short term?

Case practice example: The power of documentation

When workers discussed the impact of domestic and family violence-informed documentation for their clients, an emergent focus was on the power of good documentation in the present moment, regardless of past practices or framings.

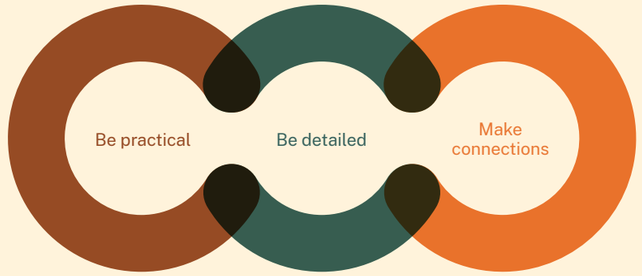
By creating a new piece of documentation written through a domestic and family violence-informed lens, the trajectory or pattern of previous documentation can be shifted, and the dial moved towards a more contextual and accurate picture of cases, supporting re-framed service responses.

Practice Tip: Key components of effective documentation

Be mindful to always include in your documentation:

- The pattern of harm caused by the perpetrator through their pattern of behaviour.
- Evidence of the impact of the perpetrator's actions on family functioning, family ecology, the victim/survivor, and the children. This will include: trauma impacts, impacts on the victim/survivor's and children's health, mental health and development, education, housing and broader socio-economic factors.
- Evidence of the effects of the perpetrator's actions on the victim/survivor's parenting.
- How the intersections are part of the multiple pathways to harm.
- Ensure your documentation is practical, detailed, behaviour based and makes the connections.

An example of a brief assessment tool can be found in the Appendix.



The following section provides practice examples of how a scenario can be effectively documented. Examples are provided for: an acute hospital setting, partnering with victim/survivors, increasing the visibility of perpetrators, and keeping the focus on children and young people.

Case practice example: Effective documentation across acute/hospital settings

Creating a 'whole of service' approach to documentation was identified as important by workers in an antenatal clinic setting. Social workers, doctors, midwives and other clinical staff identified key areas where they could improve documentation of DFV. This included documenting the context for any missed appointments, for example:

Previous documentation	DFV-informed documentation
'Mother did not present to clinic.'	'Mother did not present for appointment. Social worker rang mother who reported she wanted to attend but her partner and father of baby refused to transport'.

The team noted that this shifted negative perceptions of the mother, allowed workers to problem-solve, changed how information was shared with statutory child protection and had potential to interrupt perpetrator patterns. If the mother requested a copy of her records, she would also see that the health service did not blame her for having missed the appointment, but more appropriately held the perpetrator responsible.

Case practice example: Partnering with victim/survivors

Previous documentation	DFV-informed documentation
'Mother returned to DFV relationship.'	'Mother reports that she left her partner 6 months ago. She reports he continued to threaten to take the children away from her to force her to return to live with him. Concerned that he would take the children and they would be at risk from him without her, she returned to live with him.'
'History of non-compliance with medication.'	'Sam is experiencing ongoing domestic and family violence perpetrated by her partner. She reports he often steals and sells her prescribed medications. This means she is often unable to take the medication for several days. Sam reports that her anxiety gets worse when she can't access her medications.'
'Mother met with social workers on home visits.'	'Mother consistently met with social workers and engaged in home visits, despite ongoing violence and threats from her ex-partner. Services observed her ex-partner calling her phone multiple times during appointments and on one occasion he was seen leaving the house when workers arrived.'
'Presenting issues.'	'Current pattern of domestic and family violence, impacts on victim/survivor and family ecology.'

Case practice example: Keeping the focus on children and young people

Previous documentation	DFV-informed documentation
'Children witnessed DFV incident.'	'The children have been exposed to domestic and family violence perpetrated by their mother's current partner over the past 3 years. Because of his violence they have been homeless, had to change schools, and been isolated from their peers. Their mother reports that this has led to changes in the children's behaviour and difficulties at school.'
'The young person was referred for counselling for emotion dysregulation, aggression, verbal outbursts and PTSD.'	'The young person was referred for counselling for emotion dysregulation, aggression, verbal outbursts and PTSD. The young person continues to experience manipulation and verbal abuse from her biological father. Workers observed that her father encourages her to be aggressive, including towards workers.'

Case practice example: Increasing the visibility of perpetrators

Previous documentation	DFV-informed documentation
'Father not included in referral.'	'Workers made consistent attempts to engage the father, Chris, over 12 months. Chris would not answer worker calls although his partner reports he has a working phone.'
'Children from previous relationship, minimal contact.'	'Kody has four children with his ex-partner and reports he sees them approximately 1-2 times a year on holidays. On their last visit Kody physically assaulted his ex-partner and threatened to kill her in front of the children. When asked about the incident, Kody confirmed that he had assaulted his ex-partner but minimised his behaviours, reporting that the children 'didn't see that much of it.'
'Completed program, recommended long-term counselling when discharged.'	'Over the 12 weeks of counselling, we discussed Kody's current relationship with his partner and children. When asked how his drug use and violence impacted on them, the father struggled to identify any impacts. We recommend that services continue to address his use of violence and monitor behaviour change.'

Practice Tip: The challenge of documentation

Although broader systems change may be outside the control of the individual worker, there are ways that workers can use documentation to promote more DFV-informed practice.

- Think about how you document at both the individual and systems levels – what can you do to create the space for effective documentation?
- Some organisations have limited space for documenting behaviour mapping and the detail of the coercive control. Even where space is limited it may be possible to attach documents such as the perpetrator pattern mapping tool.
- To avoid information getting lost in long term documentation or incomplete records, write up-to-date, short summaries. This can be done at critical junctures in treatment, for example at discharge or at clinical handover.
- Include 'recommendations' in reports and key information in this section as this is often all that people have time to read.
- Use existing forms creatively to insert DFV information – consult with other staff in your service, so that there is a consistent way of doing this.
- If intake or assessment forms do not provide the opportunity to note DFV issues, workers should look for opportunities to suggest amendments and revise forms to allow for more DFV-informed documentation.

Case practice example: Using a domestic and family violence lens in documentation

A mental health clinician provided an example of how the mental health team were working to increase perpetrator visibility and reframe their client's current circumstances through documentation.

The client was suffering from serious mental health concerns, including schizophrenia, and there were also concerns around problematic use of AOD. The mental health clinician reported that the client's file included many references over the years to domestic and family violence, noting the client as the victim of her partner's abuse, but sometimes implying that he was the victim. They described the partner as clearly in a position of power and control – he was financially stable, had no reported mental health concerns, and was always 'in control'. The mental health clinician noted that his pattern of behaviour included pretending to have an affair with the client's previous care coordinator in order to make her jealous and sabotage that relationship, and when the client lashed out and assaulted someone, he used this as evidence of her being 'crazy'.

Applying a domestic and family violence-informed lens to the documentation, the mental health clinician went back to the client record and wrote a mental health review as an update to provide current details and recontextualise past documentation. This included naming the perpetrator's behaviours and activities that had sabotaged the client's efforts towards recovery and detailing the serious repercussions for the client of that behaviour.

Reflecting on the exercise, the mental health clinician spoke about how the main change that stood out was using language that clearly articulated and drew visibility to the perpetrator's choice to use coercive control, shedding new light on the pattern of behaviour and its impact on the victim/survivor.

Theme 7: Influencing organisational change and capacity building

Influencing organisational practice change and capacity building is complex and requires both a 'top down' and 'bottom up' approach involving individual workers, senior management and governance structures. The authorising environment is crucial to this work.

Practice Tip: Influencing organisational change

"Start small, embrace the work with supportive colleagues and work together to achieve change." — CoP participant.

- To gain traction 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 towards improved practices.
- Engaging and influencing smaller groups of workers more intensely can stimulate wider agency change as you impact your peers and demonstrate value and practicality of implementation of the Model to the agency leadership.

Reflective questions for enhancing organisational change and capacity building

The following questions are useful to consider when influencing organisational practice change and capacity building:

- Where is our practice (organisationally) in implementing a child-focussed, DFV-informed, all-of-family approach to working at the intersections?
- Do we support domestic and family violence-informed practice as core work?
- What are the key areas that need to be addressed in our organisation to implement 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 will contribute cumulatively to complex systems change?
- Do we have the capacity to be transparent with victim/survivors about the notes that we are writing about them? Can our notes and documentation have therapeutic value in the ways in which they are written?

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- How can we garner the support of senior management and leadership in moving towards DFV-informed practice?
- How can we influence the authorising environment to better allow for this influencing work?

Useful techniques for influencing organisational change and building capacity

1. Explore key areas for practice change and capacity building

It is useful to think about the key areas on which to focus within your organisation where you can develop collaborative partnerships. This can have a ripple effect leading to practice change and capacity building in the service system. Some initial ideas include:

Start by improving internal systems and processes.

- Does our organisation have clear and understandable processes to guide information sharing in complex family matters?
- Are we developing short and long-term goals and plans to develop and sustain practice improvements?
- Do our agency supervisors have the authorisation, skills and experience to guide workers in new practice?

Implement targeted training and coaching toward new practice.

- Are workers across the MH, AOD and VAN sectors engaged in DFV-informed practice training?
- Develop opportunities for collaboration around DFV informed practice.
- Are we adapting our organisation's practices to work towards providing DFV-informed, child-focussed, all of family approaches that are based on evidence?
- Are we engaging in a true partnership with locally led Aboriginal services, privileging and remunerating Aboriginal expertise?

Improve processes to share information and collaboratively assess risk, using consistent language and documentation processes.

- Are we using a common language within our organisation?
- Do we have a shared language with our partner agencies built on principles such as partnering with the non-offending parent, maintaining the focus on children and holding perpetrators accountable?
- Develop strong leaders who can establish the authorising environment to sustain improvements and build capacity.
- Is our senior leadership supportive of organisational practice change and capacity building at the intersections?

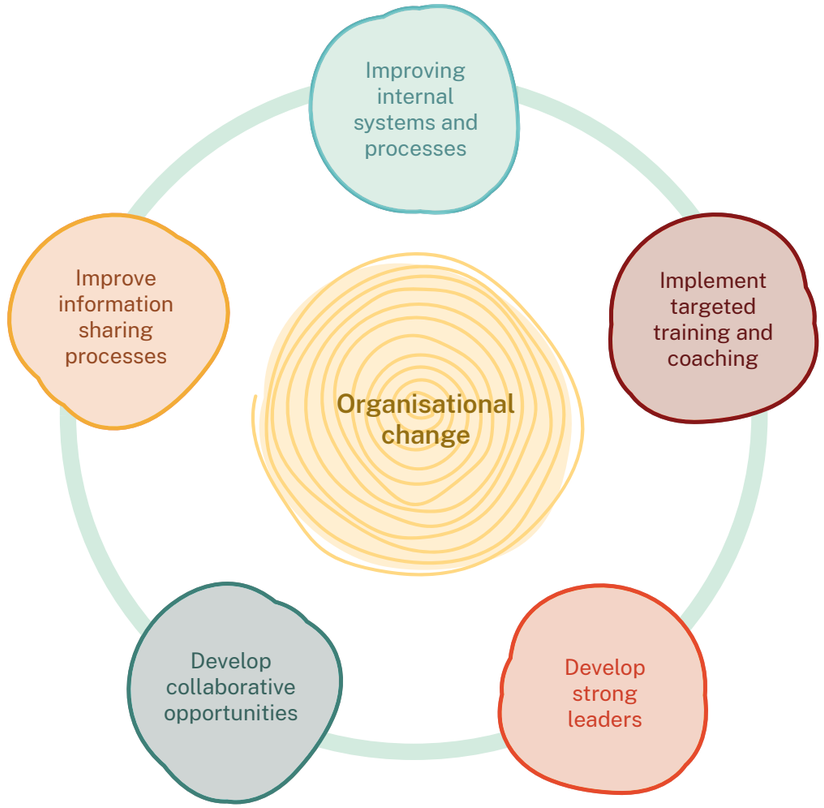

Figure 4: Creating organisational change

Case practice example: Influencing and supporting organisational change

Case Example 1: Influencing to build collaboration with NGOs

Representatives from a Health Drug and Alcohol Service aimed to influence practice in a local NGO they commonly partner with, that provides support to people experiencing mental health and drug use concerns in the community. Workers they sought to influence within the service included NGO workers, nursing staff, social workers and a range of allied health roles. Influencing activities included exploration of the Safe & Together modules, regular meetings modelled on a CoP structure and reflective discussions. The CoP members reported positive feedback and great engagement with their "influences"[13] to build a shared approach to their clients

Case example 2: Influencing to create connections with other Local Health Districts (LHDs)[14]

Representatives from a participating LHD wished to influence practice across their state-wide network and connect with services in other LHDs who were also interested in using Safe & Together. Key representatives were identified across five LHDs and a dedicated meeting was coordinated to discuss embedding Safe & Together and practice guidance in their service model. This included engagement at a clinician, coordinator and clinical advisor level. An ongoing interest group was established following the first meeting.

2. Explore acknowledge and understand the key barriers and facilitators

Through your ongoing work you will develop an understanding of the things that build capacity and improve practice, as well as the barriers. Understanding these will be critical to implementing a DFV-informed approach.

Reflective questions regarding barriers and facilitators to promoting organisational practice change and capacity building

Reflective questions for thinking about the barriers and facilitators to your efforts to promote 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 workers to reflect, discuss and develop their learnings and collaborative relationships?
- Have we examined how we are assessing all clients who are fathers for the positive and negative impact of their behaviours, especially DFV, alcohol and other drug use 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 alcohol and other drug use and/or mental health issues?
- Are we working together to effect change on broader social issues that perpetuate violence against women and children?
- Are we harnessing worker and organisation excitement and interest in changing their practice and building their capacity?

Practice Tip: Using tools and examples

Tools and examples which demonstrate DFV-informed approaches can help connect theory and everyday practice and can be powerful when advocating for practice change. Tools like the Safe & Together Perpetrator Mapping tool are particularly useful to highlight the impact of shifting from an incident focus to a pattern-based approach. Cases can be used in reflective discussions, allowing workers to further develop their work and a deeper understanding of the intersections of DFV, MH and AOD use.

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

3. Identify key strategies to influence practice change and build capacity

As a worker, you are the expert in your service system and will be able to identify effective strategies to influence practice change. Explore key strategies that you could use to influence practice change within your agency and wider service system.

Influencing and championing ideas from the ESTIE Communities of Practice

- Presentations to colleagues and interagency partners.
- Introducing ideas in group supervision, case reviews and consultations.
- Training colleagues to use specific tools, such as the Perpetrator Mapping Tool.
- Advocacy around specific cases/families.
- Undertaking and promoting online Safe & Together modules.
- Creating a Dropbox or shared folder with DFV-informed resources.
- Informal 'corridor conversations' about key concepts.
- Modelling DFV-informed practice.
- Creating a discussion group, working group or local Community of Practice.
- Developing a targeted quality improvement project.
- Documenting using Safe & Together language in Health records.
- Using Safe & Together frameworks when sharing at Safety Action Meetings.
- Using Safe & Together language in reports shared with other services.
- Introducing Safe & Together in other training settings, for example DV routine screening training, staff induction and student placements.
- Changing policies and procedures to align with Safe & Together principles.
- Creating medium and long-term action plans to implement changes.
- Engaging team leaders and senior managers.
- Connecting with other services and geographic areas with strong use of the Safe & Together model.

Reflective questions for championing change

- Have my fellow workers 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 alcohol and other drug use 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 alcohol and other drug use?
- 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? How can we influence this?

Practice Tip: Cross agency training and the use of language

Developing or organising cross-agency tailored training is a great way to 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 withstand personnel changes.

Experiment with the STIM Protocol from Safe & Together to explore whether it makes a difference to multi-agency case meetings.

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 perpetrators who use violence and control have established fear and danger in their homes. Pay attention to how adult and child victim/survivors are constructed in our documentation and conversations. Consider whether the ways that they resist the perpetrator's behaviours are 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'.

"It's really powerful to ask someone something like 'I just want to understand this better. When you say domestic and family violence, can you describe to me what you mean when you say that?'. It gives you a great opportunity when you have a conversation around coercive control, specific behaviours you might not otherwise have." — CoP participant.

Glossary

Acute settings	An acute care setting is any setting in which care is provided in response to an urgent need or crisis. This includes emergency departments, ambulances, mental health emergency services, and crisis accommodation.
All-of-family approach	The all-of-family approach is a holistic approach to working with each family member in the context of their family, extended family, community, and Kinship groups, as well as collaboratively across services and sectors. It is underpinned by feminist theories that attend to the intersections of drivers of domestic and family violence (DFV) including sexism, racism, colonisation, ableism, homophobia, and other forms of oppression. All-of-family approaches recognise the potential safety risks in working with the family as a unit and allow for separate work with each family member where this is more appropriate.
Authorising environment	The authorising environment is the management, policies, and service system structures that support organisations to function. The authorising environment can either help or hinder workers to engage effectively with clients experiencing domestic and family violence using the Safe & Together™ Model, and embrace domestic and family violence-informed practice. Different authorising environments may act at a number of different levels and may support or contradict each other.
Behavioural focus	In the Safe & Together™ Model, behaviours are the focal point for assessment and intervention. Mapping the behaviours of both the perpetrator and the victim/survivor, gives workers a starting point for all their practice with the family. In parallel process, the behaviour of the worker and the system become a focus by exploring the 'how' not just the 'what'.
Child-focus	Within this document, this phrase refers to inclusive practices that keep a focus on the impact of violence on children, and their individual experiences of perpetrator patterns of coercive control and parents' alcohol and other drug use and/or mental health issues.
Child safety	Child safety refers both to the physical safety of the child and also to their emotional safety and well-being - keeping the child or children safe in their own homes and in the community and living without violence and abuse.
Coercive control	A pattern of physical and/or non-physical actions taken by perpetrators that are intended to intimidate and manipulate both adult and child victim/survivors, through tactics such as threatened or actual violence, isolation, emotional and/or financial abuse, suicide or suicidal threats, and micromanagement (such as constant surveillance). Coercive control instils significant levels of fear that constrain the behaviour of victim/survivors, undermining their liberty, self-determination, and choices.
Collaboration	Collaboration involves work and practices that simultaneously build shared respect, learning and knowledge, and actively contribute to shared outcomes, goals and/or decision-making. Collaborative practices create safe environments for workers and clients when based on foundational elements of integrity and cultural competence, and genuine reciprocal partnerships involving deep listening and engagement with organisational and personal values. Collaborative partners acknowledge and uphold each other's identities, skills, and contributions, while being aware of biases and their impacts, and actively address each other's needs and priorities.

Cultural safety	‘Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.’ (PARVAN, 2022, p.14). In the context of engaging participants throughout the professional development and research activities of the project, this document refers to efforts to support cultural safety. In the context of outcomes of these activities towards improved practice with families from diverse cultural backgrounds, this document refers to cultural competence and culturally safe practice.
Domestic and family violence (DFV)	Domestic and family violence is defined as any behaviour in an intimate or family relationship that is violent, threatening, coercive or controlling, and causes a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour. An intimate relationship refers to people who are (or have been) in an intimate partnership, whether or not the relationship involves or has involved a sexual relationship: i.e., married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, and couples who are dating. A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, or sibling and extended family relationships. It includes the full range of Kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships. It also includes family within communities of people with diverse sexualities, gender identities or intersex variations. People living in the same house, people living in the same residential care facility and people reliant on care may also experience domestic or family violence if their relationship exhibits dynamics of coercive and abusive behaviours.
Domestic and family violence-informed	This term refers to practices, policies and systems that incorporate knowledge and attention to the unique dynamics, challenges and manifestations of domestic and family violence and abuse, particularly coercive control. Domestic and family violence-informed practice attends to power imbalances and assumptions in relationships between people engaging with services, workers and their clients, and the service system, its workers and its clients. This approach upholds the resilience and strengths of victim/survivors, accountability for perpetrators and the rights and experiences of children as individuals, while attending to family functioning and wider social influences on people’s lives. The Safe & Together™ Model is one example of a framework for domestic and family violence-informed practice.
Drivers of violence	The drivers of violence are associated with gender inequality and are the most consistent predictors of violence against women. These drivers include: condoning violence against women; men’s control of decision-making and limits to women’s independence; rigid gender roles and identities; and male peer relations that emphasise aggression and disrespect towards women. A public health model is prevention focused, targeting key risk and social factors including the drivers of violence at a population level through a cross-disciplinary and multi-agency approach.
Expectations of men as fathers	This is highlighted as a way of counteracting gender double standards in parenting. Fathers should be held equally accountable as mothers in their capacity for parenting, particularly in exploring the impact on the children and on family functioning of fathers’ parenting choice to use domestic and family violence.
Gender and Gender inequality	Although people with diverse sexualities, gender identities and intersex variations experience domestic and family violence, international and Australian research consistently identifies gender as the biggest risk factor for intimate partner violence. Gender inequality is the social condition that underpins gender as the most common risk factor where women are predominantly the victims and men the perpetrators of domestic and family violence. It is a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity. It often results from, or has historical roots in, laws or policies formally constraining the rights and opportunities of women and is reinforced and maintained through more informal mechanisms. These include, for example, social norms such as the belief that women are best suited to care for children, practices such as differences in childrearing practices for boys and girls, and structures such as pay differences between men and women. This project recognises that domestic and family violence is a gendered crime. The project uses the terms ‘woman’/’survivor’/’victim/survivor’/’non-offending parent’ to reflect those who have experienced harm from domestic and family violence and perpetrator/offending parent as the person who chose to use harm.
Intersectionality	Intersectionality refers in this report to people’s differential experiences of domestic and family violence and how they are influenced by different forms of oppression including sexism, racism, ableism, homophobia, and other aspects of identity. Taking an intersectional approach means recognising that the barriers to seeking support, and the particular forms of violence that victim/survivors from some groups experience, are not only driven by sexism and gender inequality, but also by other forms of discrimination. This extends to recognising that men who perpetrate violence experience different responses from service providers and structural systems based on different constellations of identity.
Intersections	Intersections refers to the complex relationship between domestic and family violence and parental issues of mental health and/or alcohol and other drug use, as experienced by families (often in the context of child protection concerns). This relationship may take different forms, including where one issue shapes or exacerbates the other or, where an issue is used or exploited by the perpetrator for the purposes of coercive control. It can also refer to the complex relationship between the perpetrator’s own pattern of abusive behaviour and their own alcohol and other drug use and/or mental health issues.
Model/framework/ approach	Rather than being a manualised, step-by-step implementation guide as often associated with implementation of models for practice, the Safe & Together™ Model is a framework for practice and action, applicable to high-level systems change and individualised practice. Throughout this document, the Safe & Together™ Model is referred to variously as a ‘Model’, a ‘framework’, and an ‘approach’. Reference is also made to other domestic and family violence-informed frameworks, models and approaches, with the same interpretation. These terms are used interchangeably.

Pattern-based harm and pivoting to the perpetrator	This phrase refers to the pattern of behaviour chosen by perpetrators to harm and control both adult and child members of his family. Rather than focussing on a single incident or many incidents that have occurred separately, mapping the perpetrator's pattern of behaviour contextualises his violence and captures its cumulative impacts on child, partner, and family functioning. In practice, this pattern-based approach requires 'pivoting to the perpetrator', a phrased used by the Safe & Together Institute to capture the practices that occur in a multitude of ways. Pivoting does not always involve direct contact or engagement with the perpetrators themselves. It involves keeping a focus on the perpetrator patterns of behaviour throughout discussion and questioning of cases, working within established systems, in documentation, and in collaborative working across programs and services. Pivoting should never be undertaken without keeping children's safety and wellbeing in view and thus without 'partnering' with the child's mother (or non-offending carer).
Perpetrator – those who choose to use violence	The term 'perpetrator' is used consistently in research literature and in Australia's domestic and family violence policy and legislative environment. The term is used to reinforce the serious nature of violence in intimate or familial relationships. This project uses the term to refer to men, fathers or those who use violence and coercive control toward their family and community. We recognise that it is preferable to separate 'the offending person' from their 'behaviours', however, at times the use of the phrase 'fathers who use violence and coercive control' or 'person using violence' can be unwieldy. We use 'perpetrator' as a shorthand term and a term which has broad usage across systems e.g., criminal justice, with a focus on the dominant gendered pattern of men's violence against women and children.
Priority Population	The term 'priority populations' refers to diverse groups for whom there is significant evidence of heightened vulnerability to violence, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors, and experiences of discrimination.
Safe & Together™ Model	A high-level, transferable framework for conducting holistic and collaborative work across services and sectors. The Model involves a focus on keeping children safe and together with the non-offending parent, partnering with the non-offending parent and recognising their strengths and protective capacities for their children, and finally intervening with the perpetrating parent and holding him accountable for his violence and coercive control. Developed by David Mandel and the US-based Safe & Together Institute, further details can be found at https://safeandtogetherinstitute.com/.
Victim/survivor	The term 'victim' is most commonly used in public, legal and criminological discourse to describe people who have experienced violence, while 'victim/survivor' and 'survivor' are used to reflect the process of victimisation and the work survivors do to rebuild their lives after violence. Current literature also increasingly recognises and refers to children as 'victim/survivors' or 'survivors' of violence, rather than as 'witnesses'. The Safe & Together Institute use the term 'survivor' in their model. When direct reference is made to the work of Safe & Together, 'survivor' is the term used.
Worker	The term worker includes all people working with women, children and families experiencing domestic and family violence, alcohol and other drug and/or mental health issues and child protection concerns. It includes practitioners, clinicians and other health professionals who engage with families towards safety, recovery and wellbeing.

Useful resources

1. Useful sites within the Safe & Together website.

- https://safeandtogetherinstitute.com/evidence-resources/free-resources-for-professionals/
- https://safeandtogetherinstitute.com/safe-together/safe-together-overview/assumptions-principles-critical-components/
- https://academy.safeandtogetherinstitute.com/course/intersections
- https://safeandtogetherinstitute.com/blog/podcast/

2. Example of a Brief Assessment Tool (informed by Safe & Together™)

The tool on the following page was developed initially for a triage team which included Safe & Together trained practitioners from domestic violence, family services and child protection.

The tool can be used for:

- guiding referrals
- initial work with people with lived experience

Individual services should tailor the tool to their circumstances and, where relevant, in line with NSW Health policy.

This Intake/Assessment Tool was adapted from a practice tool used in the Multi-Agency Triage Project funded by NE Region of the Victorian Department of Human Services (2015-2017). The original tool was developed by Dr Lucy Healey, Deb Nicholson (University of Melbourne) & Lyn Turner (Berry Street), with input from Professor Cathy Humphreys (University of Melbourne) and David Mandel (Safe & Together Institute).

Please contact Dr Margaret Kertesz (mkertesz@unimelb.edu.au) or Professor Cathy Humphreys cathy.humphreys@unimelb.edu.au for enquiries and further information about the ESTIE tool below.

ESTIE Intake/Assessment Tool - brief and crisis responses

(Informed by Safe & Together™)

1.	**Brief history from all possible sources** ● Have the adult or child victims/survivors been seen by professionals in the past in relation to DFV? ● Does the person using violence and/or coercive control have a history with police or any service?
2.	**What behaviours by the person using violence and/or coercive control have led to this presentation or referral?**
3.	**How is the adult victim/survivor supporting the safety and wellbeing of the child/ren? (protective factors)**
4.	**a. What are the risks to the ADULT VICTIM/SURVIVOR, posed by the person using violence and/or coercive control?** ● Risks as identified in the DVSAT, screening tool, or other information from other services or police **b. What are the risks to the CHILDREN, posed by the person using violence and/or coercive control?** ● Risks as identified in the DVSAT (section on children), screening tool, or other from other services or police
5.	**What are the risks to FAMILY FUNCTIONING posed by the person using violence and/or coercive control?** ● threats to mother-child relationship ● homelessness ● cultural safety ● health ● family finances
6.	**What are the risks to FAMILY FUNCTIONING posed by the person using violence and/or coercive control?** ☐ Not afraid ☐ Afraid ☐ Terrified ☐ Unable/ unwilling to answer (from DVSAT)
7.	**What don't we know?**
8.	**Individual risk assessment of a) adult and b) child victims/survivors?** Requires immediate protection → Highest risk Elevated risk → Medium / moderate risk At risk → Lowest Risk
9.	**Collaborative risk assessment of a) adult and b) child victims/survivors?** *(for team / multi-service intake processes)* Requires immediate protection → Highest risk Elevated risk → Medium / moderate risk At risk → Lowest Risk
10.	**What is the referral pathway and rationale for:** – the person using violence and/or coercive control? – the adult victim / survivor? – the children? ● Which service/s will be involved with the different family members?

Endnotes

1. https://safeandtogetherinstitute.com/ This website offers a large range of useful and accessible resources.

2. For a definition of priority population cohorts please see Glossary.

3. The *Perpetrator Mapping Tool* is copyright and available to those who have completed the Safe & Together training.

4. Backhouse, C., & Toivonen, C. (2018). *National Risk Assessment Principles for domestic and family violence: Companion resource. A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence* (ANROWS Insights 09/2018). Sydney, NSW: ANROWS.

5. The *Mapping Survivor's Protective Capacities Tool* is copyright and available to those who have completed the Safe & Together training.

6. The questions below are drawn from the Strong Aboriginal Men Program run by the NSW Health Education Centre Against Violence.

7. Our Watch (2021) *Change the story. A shared framework for the primary prevention of violence against women in Australia (second edition)* https://www.ourwatch.org.au/change-the-story/ .

8. An outline of the *Perpetrator Mapping Tool* is on page 21.

9. Morgan, G., Butler, C., French, R., Creamer, T., Hillan, L., Ruggiero, E., Parsons, J., Prior, G., Idagi, L., Bruce, R., Gray, T., Jia, T., Hostalek, M., Gibson, J., Mitchell, B., Lea, T., Clancy, K., Barber, U., Higgins, D., … Trew, S. (2022) *New Ways for Our Families: Designing an Aboriginal and Torres Strait Islander cultural practice framework and system responses to address the impacts of domestic and family violence on children and young people* (Research report, 06/2022). ANROWS.

10. Mandel, D., Mitchell, A., Stearns-Mandel, R. (2020) *How Domestic Violence Perpetrators Manipulate Systems: Why Systems & Professionals Are So Vulnerable & 5 Steps to Perpetrator-Proof Your System*. Safe & Together Institute. https://f.hubspotusercontent00.net/hubfs/5507857/Free%20Downloads/PerpManipulation_4721.pdf

11. McKibbin, G. & Humphreys, C. (2020) Service navigation in the context of domestic violence. In J Donovan, R. Hampson & M. Connolly (eds) *Service Navigation*. Macmillan Education, UK. pp 147-166.

12. Thiara, R.K. and Humphreys, C. (2017) Absent presence: the on-going impact of men's violence on the mother-child relationship. *Child and Family Social Work*, 22, 137-145. http://doi.org/10.1111/cfs.12210

13. 'Influencees' in the ESTIE Project were those practitioners nominated by CoP participants as colleagues who could be influenced through sharing learning and championing good practice.

14. Local Health Districts (LHDs) provide health services to specific geographical areas in NSW.


ESTIE
Evidence to Support Safe & Together
Implementation and Evaluation