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Title:
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Date:
2022-05-01

Citation:
Humphreys, C., Heward-Belle, S., Tsantefski, M., Isobe, J. & Healey, L. (2022). Beyond co-occurrence: Addressing the intersections of domestic violence, mental health and substance misuse. Child and Family Social Work, 27 (2), pp.299-310. https://doi.org/10.1111/cfs.12885.

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Beyond co-occurrence: Addressing the intersections of domestic violence, mental health and substance misuse

Abstract

This paper reports an Australian project designed to simultaneously explore and capacity build professional practice when working at the intersection of parental mental health and/or problematic substance use and domestic violence (DV). Data from this paper is derived from two main sources: observations and ethnographic notes obtained during 28 Community of Practice (CoP) meetings; and semi-structured interviews with 28 CoP participants. Participants were front-line workers from a range of government and non-government organisations providing services to families experiencing DV across three Australian states who participated in *The STACY Project: Safe and Together Addressing ComplexitY*. Thematic analysis was employed to examine the research questions: *How do professionals and organisations understand and respond to families experiencing DV, parental mental health difficulties and problematic substance use issues? How did practitioners report participation in the STACY Project reorienting professional practice with families experiencing DV, parental mental health difficulties, and substance misuse issues?*

This paper reports workers' exploration of practice implications. The research found that 'domestic violence blind' practice has become entrenched at the intersections of child protection, substance misuse and mental health problems, but a shared framework could bring practitioners from diverse sectors together to generate new ways of working with these complex problems.

Key words: domestic violence; alcohol and other drugs; mental health; intersections; coercive control; holistic practice

Beyond co-occurrence: Professionals' accounts of reorienting practice with families experiencing domestic violence, substance misuse and mental health difficulties.

The co-occurrence of domestic violence (DV) with other adult problems of substance misuse and mental health difficulties is well recognised (Gilchrist et al., 2010; Mason & O'Rinn, 2014; Trevillion et al., 2012). However, while a lack of routine inquiry across sectors into these co-occurring issues for clients has been identified (Holly & Horvath, 2012), the ways in which these problems intersect, the barriers, and the implications for more integrated practice have received far less attention. This paper explores the ways in which practitioners attempted to re-orientate their practice with families experiencing the complex, intersecting issues of domestic violence, mental health difficulties, and substance misuse.

Our interest lies in the problems and directions for extending practice beyond the identification of co-occurrence. Building from previous work engaging fathers who use violence and coercive control (Heward-Belle et al., 2019), this extension focuses on how domestically violent men use alcohol and other drugs, and/or mental health problems, as an integral part of their coercive tactics and how practitioners can integrate this knowledge into their practice. For example, a woman who has been assaulted by an intoxicated partner will experience fear (and therefore be controlled) when her partner next reaches for the bottle. A partner's threats of suicide if the woman leaves an abusive relationship may be real, but they are also a means of controlling her sense of agency and choices. The current silos in practice tend to ignore these intersections.

The *STACY Project: Safe & Together Addressing ComplexitY* (the *STACY Project*) brought practitioners together in Communities of Practice (CoPs) to explore these complex intersections between domestic violence, mental health and substance misuse, with a particular emphasis on keeping the domestic violence in view, especially when children were involved.

Literature Review

Male violence against women and children is the primary focus of this study and aligns with the majority of domestic violence services in Australia and elsewhere. It is well established that this is the dominant pattern of domestic violence (Cox, 2015; Heise et al., 2002), and that gender intersects with other aspects of women's and children's identities to increase the likelihood and severity of domestic violence, and poor practice and service responses. Feminist theorising in relation to intersectionality and the compounding

impacts on women and their children from underserviced communities are significant in informing this understanding (McKibbin et al., 2015; Crenshaw, 1991).

The intersections of domestic violence, mental health difficulties and/or substance misuse are consistently identified for both adult victim/survivors and perpetrators (Isobe et al., 2020). The research evidence is clear that the mental health of women is adversely affected by domestic violence (Sidebotham & Retzer, 2018; Stewart & Vigod, 2019). The rates for women experiencing depression (Trevillion et al., 2012), posttraumatic stress disorder (PTSD), anxiety, suicide attempts and suicide are significantly elevated for women experiencing domestic violence when compared to women unaffected by domestic violence (Dillon et al., 2013; Howard et al., 2010). In spite of the evidence of co-occurrence, there is not widespread engagement from mental health service providers in identifying or responding to domestic violence (Nyame et al., 2013; Trevillion et al., 2016), or with treating mental health difficulties as a 'symptom of abuse' (Humphreys & Thiara, 2003). The focus of intervention can become fixated on treating 'the depression' separated from the experience of domestic violence. Accounts from women survivors of mental health services are generally negative (Marsden et al., 2021) and often reported as re-traumatising (Sweeney et al., 2018).

In particular, fear of disclosing mental health problems is compounded by the fear of child removal (Macy et al., 2013), and particularly for Aboriginal mothers (Andrews, Humphreys & Hamilton, 2021). Further, there is growing evidence that demonstrates the links between women's mental health problems, domestic violence, and the distress experienced by children (Hegarty et al., 2013; Howarth et al., 2016; Howell et al., 2015). Few studies make the point that the intervening variable accounting for the link between women's and children's mental health may be that both are living with the same violent man. Too often children's mental health is framed as being causally linked to the mother's mental health, irrespective of the violence they both experience (Sullivan, 2007).

A similar picture emerges in relation to the co-occurrence of domestic violence with substance misuse. It is clear from police data that alcohol and other drugs have frequently been consumed prior to police attending incidents of domestic violence (Yates, 2019). However, the gendered dimensions of the patterns of substance use and domestic violence are frequently overlooked (Radcliffe & Gilchrist, 2016; Taft et al., 2019). Men experience more public violence from other men when they have been drinking, whereas women experience greater severity of violence from men under the influence of substances in the privacy of the home (Graham et al., 2011). Women living with domestic violence are over-represented with substance misuse problems when compared with women who are not experiencing domestic violence (AIHW, 2014), and their

vulnerability or risks increase when drinking heavily or using drugs (Yates, 2019). It has been pointed out that women frequently use alcohol and other drugs to anesthetise the pain of the violence they are experiencing (Devries et al., 2014; Humphreys & Thiara, 2003), whereas men who are heavy drinkers increase their use of violence towards women in this context (Gilchrist et al., 2019).

Again, the impacts on children where either parent is misusing substances may be substantial. The vulnerability of infants is particularly pertinent in this context and, when combined with domestic violence, is a prime reason for entry of children into care (Canfield et al., 2017;) with a significant over-representation of Aboriginal infants (Andrews et al, 2021). The research literature has highlighted the problems of adult mental health (Tchernegovski et al., 2018) and substance misuse services (Battams & Roche, 2011) keeping children in view. However, the cumulative risks to children, and the particular focus of keeping domestic violence in the foreground of practice where there are co-occurring problems associated with parental substance misuse and/or mental health problems, have been given less attention (Frederico et al., 2014; Isobe et al., 2020).

In the face of these issues, the promotion of collaborative relationships across sectors is important but remains challenging (Macy & Goodbourn, 2012). The siloing of service responses misses the opportunity to treat the compounding intersections of co-occurrence and often obfuscates a significant aspect of a problem (Breckenridge et al., 2012; Yates, 2019). The differences in organisational cultures, practice frameworks, policy guidance and legislation that configure each service create barriers to collaboration that need to be overcome if the response to the family, and the individuals within it, is not to be fragmented and siloed (Isobe et al., 2020).

There are nevertheless examples both within Australia (Foster et al., 2016) and internationally (Copello et al., 2005), of services working within integrated responses to mental health problems, substance misuse, and domestic violence. The complexity of problems in families is not new. Clearly, the significant developments associated with dual diagnosis provide an example of the extensive work required to bring practice frameworks and organisations together; although, a recent meta-analysis showed that, in spite of years of work, this practice remains contentious (Fantuzzi & Mezzina, 2020). Similar extensive work has not yet occurred with domestic violence.

This paper draws on data from the *STACY Project* that specifically focused on the 'intersections' component of the Safe & Together™ Model (see Figure 1) and utilised the shared language and resources provided by the Model to support collaborative working and research. The *STACY Project* was conducted in three Australian states, with statutory and non-statutory organisations working with families where child

protection issues were paramount. The project was undertaken with an explicit understanding that domestic violence, substance misuse and mental health difficulties are significantly intertwined for many families. The subject of this paper is not an evaluation of the Safe & Together Model but, rather practice-led research (Joubert & Webber, 2020) to explore the questions: *How do professionals and organisations understand and respond to families experiencing DV, parental mental health difficulties and substance misuse issues? How did practitioners report participation in the STACY Project reorienting professional practice with families experiencing DV, parental mental health difficulties, and substance misuse issues?*

Research design and methodology

The researchers drew heavily from the Safe & Together Model to create a shared vision, or agreement, about the dynamics and conceptualisation of domestic violence across services and organisations (Humphreys et al., 2019) (See Figure 1). This shared understanding provided an important starting point for the establishment of Communities of Practice (CoPs) from which the research which underpinned this paper is drawn.

Figure 1 here

Methodology

The *STACY Project* was underpinned by an action research methodology which provided a combined strategy for inquiry (research and learning) and development (practice and action). Iterative cycles of reflection and review enable simultaneous contributions to evidence gathering and practice change (Ison, 2008), that work towards improving an identified problem or situation. In this project, the assessment and management of the complex intersections of parental mental health and/or substance misuse with domestic violence were explored. The project involved the establishment of an active Project Advisory Group (PAG) of senior managers and Communities of Practice (CoP) in three Australian states (see Figure 2) to explore knowledge and practice at the intersections of the service system.

Figure 2 here

Data collection

The project utilised mixed methods data collection (Royce et al., 2010) across its three sites, including: case study interviews; observations and ethnographic note taking of CoP meetings; focus groups; an online questionnaire; and participant assessments of domestic violence-informed practice. This paper draws on two

of these data sources described below: the ethnographic notes from CoPs and focus groups; and the interviews with participating practitioners. Ethical clearance was provided by committees in each research site (University of Melbourne, Sydney University, Griffith University).

STACY Communities of Practice

The *STACY* CoPs were established in each state to provide the foundations for the action research project. Senior practitioners from participating organisations attended three days of intensive training on the Safe & Together Model, facilitated by a Safe & Together trainer in each site. The training draws from evidence-informed practice developed by the Safe & Together Institute (Mandel, 2014) provided the foundations for working at the intersection of DV with issues of substance misuse and mental health. Increasing attention to the Australian context informed by Aboriginal participants is dynamic and a work in progress as more Aboriginal workers are currently becoming trainers in the model. Following the training, practitioners participated in CoPs supported by a Safe & Together consultant on a monthly basis between 2018 and 2019. A total of 28 CoP sessions were held across the three sites. Participants across the three sites involved 88 senior practitioners working in the following service areas: child protection (CP), family support (FS), specialist domestic violence (DV), mental health (MH), substance misuse (AOD), and other services that included police, probation and parole (justice services), health services and recognised entities (OS) (see Figure 3). Each CoP practitioner committed themselves to becoming a practice 'influencer' which involved using strategies to influence a chosen group of secondary participants (N=278) in their organisation. Practitioners reported back to the CoP on their progress in relation to influencing practice improvements. This framework created a ripple effect through the organisation that went beyond the CoP and involved a greater number of participants in the research.

Figure 3: Participant backgrounds

Communities of Practice were developed as an effective way to share knowledge and acquire skills (Wenger, 1998), and to support change processes in complex systems (Blackmore, 2010). The *STACY Project* CoPs addressed themes relevant to the project's overall inquiry. Each session involved discussion and reflection on practitioners' de-identified case examples, with consultation via videoconference from a Safe & Together consultant; and discussion of complex practice at the intersections of mental health, substance misuse and domestic violence. The CoP began with identifying relevant cases in small groups, with a view to finding a consensus from the small group about a relevant and rich practice example that could be bought for

further consultation and coaching from the Safe & Together consultant and the full CoP. Case examples discussed were not necessarily of 'good practice', but rather where a theme such as 'worker safety' or 'pivoting to the perpetrator' could be unpacked and explored in greater depth to make visible the micro-practices and principles that lay behind the implementation of a domestically violence informed framework at the intersection of a complex problem. The sessions were audio-recorded with consent from participants. Detailed ethnographic notes were taken by a research team member in each session, documenting the case examples, discussions and participant perspectives on complex practice.

Semi-structured interviews were conducted with twenty-eight practitioners who provided interventions to clients living with domestic violence, substance misuse and/or mental health difficulties, across the sites. Similar to the CoPs, interviews were audio-recorded with participant consent, transcribed and coded.

Data Analysis

Themes were identified inductively in the analysis of both the interviews and CoP ethnographic notes and transcripts. Drawing on the multi-site methodology of Stake (2013), a common coding template was developed and used across sites to code data supported by QSR NVivo 12 software. An iterative process of thematic development and coding was used across sites (Thomas & Harden, 2008).

The interview transcripts were initially managed separately from the CoP ethnographic data. Primary codes were identified after each line of the qualitative data was read and re-read. Researchers met regularly to share their primary codes and to identify the existence of recurrent themes. Secondary codes were established through the identification of recurrent themes, which summarized the core ideas repeatedly expressed by multiple interview participants. Key codes were established for both the CoP ethnographic notes and the interview data. Using Stake's (2013) multi-site guidance for analysis, it was agreed by the researchers that the richness of the complex practice examples bought to the CoPs was best illustrated through case studies complemented by the interview data.

Findings

The findings are presented through three case summaries. Drawn from examples presented by practitioners to a CoP, they illustrate particular themes that recurred across CoP sites, highlight important practice issues, and contribute to answering the research questions. The questions focus on both practice and the changes

that occurred through engagement with the Safe & Together model and CoPs. The questions are interrelated and make it difficult to report findings against each question. Further quotes from interviews or discussions within the CoPs are provided to support the themes, with examples of how the practice issue was addressed.

Partnering with the non-offending parent/adult survivor

Working with women to keep them safe and together with their children is a core area for practice change and sits in contrast to approaches that consistently focus on mothers' problems and their 'failure to protect' their children. While child removal to a greater place of safety may still occur, the strength-based approach to women's resistance and protective strategies allows for more opportunities to explore safety and well-being for all family members.

Case Study 1: Lara

The alcohol and other drugs practitioner brought to the CoP dilemmas faced in working with Lara who had a history of significant mental health difficulties and problematic alcohol use. She had been diagnosed with PTSD, depression, anxiety and possible borderline personality disorder. Her partner Jez, like Lara, had grown up in a family where there were intersecting problems of domestic violence, substance misuse and mental health problems. He has a history of violent perpetration of DV towards previous partners with whom he has several children, as well as to Lara and her children. He has a history of cannabis, opiate, alcohol, and methamphetamine use leading to several hospitalisations for drug-induced psychoses.

Lara and Jez have recently begun living together again, with Child Protection approval, after a period of separation owing to his violence and breaches of protection orders, escalated by his substance misuse. Lara is now pregnant with their second child. A health practitioner has concerns about Lara's safety and the risks to Lara's baby in utero, given that Lara's explanations of physical injuries do not appear to match the evidence. With encouragement from the health services, Lara disclosed her pregnancy to Child Protection who created a new plan that included referral to family services to work with both parents, albeit separately.

The practitioner used the Safe & Together resources to present information specifically about Jez's patterns of coercive control to harm children and Lara's efforts to promote child safety. In terms of the latter, it included: reframing her history of 'disengaging' from services as a protective mechanism for herself and her child when she sensed Jez's escalating DV; Lara 'reading' Jez's behaviours and responding carefully in order to

keep herself and the child safe; and having 'difficult' conversations with Jez by going for a walk to limit eye contact with him so they can go their separate ways if conversations become heated.

Through the practitioners' partnering work, they contextualised Lara's struggles with mental health and substance misuse issues, highlighting Jez's interference with Lara's life; for example, causing her to miss mental health appointments and interfering with her treatment by providing 'take away' methadone. Through establishing a partnership with Lara and not making the perpetrator of violence invisible, the door to further protective work has remained open and she is able to disclose abuse that had previously been hidden. (CoP2B-#2-AOD)

Practitioners found the issue of 'mothers' disengagement' from services or their 'disappearance' from contact with services troubling, if not challenging. Through CoP discussion, practitioners who might frequently use the language of maternal 'disengagement' began to re-cast their language by thinking about what the mother might need to hear to reduce the risk of her 'disengaging' with them. As the case of Lara demonstrates, shifting their approach enabled practitioners to understand that what was negatively communicated as 'disengagement' might be a protective strategy for the mother, and thus of her care for her children, allowing the opportunity for greater care and safety planning. Furthermore, as the following participant's words suggest, this re-framing gives a degree of agency to, and respect for, a mother's difficult circumstance:

> "*…maybe we need to frame this as 'she's not ready' rather than 'non-engaging'. Giving control back to her [to] reflect her perspectives and reasons…"* (CoP#1-S3-CP)

Practitioners also spoke about the need to be more transparent in their expectations of mothers and fathers. This could include explaining more clearly why the court requires drug screening to be conducted. It might involve communicating to a mother that that there could be setbacks in her progress to reduce her drug use, and ensuring that there is exploration of any attempts by (ex)partners to sabotage her help-seeking efforts. As a Child Protection practitioner said:

> *If you partner with mums, mums will give you a pattern of the [perpetrator's] drug use, and then the impacts, and how that intersects with the violence that he is perpetrating against her. We had a mum that would say, 'he would get money on a Saturday, buy drugs, and then when he would come down on Wednesday that is when he would attack, rape me.' … you need more than a drug screen test, you*

need to see how the behaviours are interacting with that and his pattern [of violence and control]. (CoP#5-S1-CP4)

Addressing the intersection of domestic violence with mental health and/or substance misuse

A further consistent theme drawn from the CoP examples lay with the 'blindness' of the service system in addressing domestic violence when mental health or substance misuse issues were present.

Case Study 2

Jenny was referred to a mental health service and had been seeing a counsellor for five months. She was given an ultimatum by her partner to stop opiate replacement even though she was stable when taking this. Jenny had made several suicide attempts since adolescence, one of which was a pact where her mother died but she did not. She was well engaged with the service system.

There had been a serious incident of domestic violence where her partner placed his hands around her neck and attempted to strangle her. While the mental health team noted that attempted strangulation is a significant risk factor for domestic homicide, it was described as an isolated incident, which the counsellor did not return to discuss in further detail. The presence of historical and ongoing emotional and psychological abuse was constantly noted. The couple had two sons aged three and five-years-old. The partner was described as very academic and articulate. He was involved in and was very controlling of Jenny's mental health treatment, frequently contacting her workers. His controlling behaviours and problematic parenting were noted, but frequently avoided by professionals as the father constantly averted attention from his behaviour and shifted the focus of intervention to the mother's suicidality, focusing on her mental health problems, deficits, and alleged inability to function as both a mother and a partner. (CoP#1-S3-AOD)

The inability of the mental health team to disentangle and integrate the intersections between domestic violence and the mental distress that Jenny was experiencing, and the team's vulnerability to being manipulated by Jenny's partner, enabled him to dictate the terms of Jenny's treatment. This case study illustrated the high risks posed to women and children by perpetrators who are skilled at manipulating professionals, particularly in a situation where the risks of homicide and suicide are heightened. The focus on Jenny's problems reified from the violence and control she experienced, and the failure to attend to the

perpetrator's patterns of violence and coercive control, were continuous themes that ran through all Communities of Practice.

Several practitioners indicated that addressing the perpetrator's pattern of abuse and coercive control, rather than focusing on a single incident, helped them reduce the risk of manipulation by the perpetrator. Collusion with the perpetrator's world view was minimised through continuous reflection on how his behaviours paved a pathway of harm for his (ex)partners and children. Some practitioners indicated that they noticed a significant shift in how their colleagues and teams practiced with women survivors, once a broader perspective on abuse was integrated into practice:

> *"The [mental health practitioner] who previously had a conversation with me about making sure I wasn't damaging the "loving relationship" between husband and wife – that [practitioner] has done a full shift, and has been very supportive and patient. We are not discharging her (mum who was scared to return home) ... I have the treating team behind me now and the conversations are entirely different. The clinical notes are different, the wording is different. The reviews are different, so we are making progress.*" (CoP#1-S1-MH)

The pressures, practices and culture of the mental health system and teams within it created and compounded particular risks for victim survivors.

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

The siloed service system, and the lack of information sharing across organisations working with different family members created particular vulnerabilities where there were intersecting issues.

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

Sharing information was also supported by understanding the purpose or key elements of information that needed to be shared in relation to substance misuse, domestic violence, mental health problems, and children, to keep the perpetrator in view:

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

Pivot to the perpetrator

A common theme identified by many practitioners across CoP sites was the siloed service system which resulted in perpetrators being intermittently seen by multiple practitioners who worked within a limited purview of their particular organisation, rendering invisible the intersections between domestic violence, substance misuse and mental health problems. A case study is presented which promoted a different way of working.

Case Study 2: Kwielle and Leon

The Child Protection worker received a report about an unborn baby due to concerns about Leon, the father's, DV and MH issues. Kwielle, the mother, wanted to remain in the relationship. She had support from her family, a DV worker and the maternal health service; she also had a protection order in place. Leon was receptive to receiving help from Aboriginal services (as an Aboriginal man). After the baby's birth, Leon began working with a psychologist, and a DV worker. Despite tensions which sometimes occurred between professionals particularly in relation to risk and rehabilitation, they were guided by the principle that the safety of Sharelle (the baby) and Kwielle was paramount. When differences of opinion existed within the care team, separate meetings and discussions between practitioners were used to tease this out, instead of 'splitting' in front of the family. The practitioner reported using Safe & Together language around parental choices, perpetrator patterns and how this had brought the case to where it was. The DV worker engaged both parents in sessions together and apart, and the protection order was altered to allow unsupervised contact. This approach changed the direction of practice to be about supporting and strengthening Kwielle as a mother, whilst engaging Leon in his role as a father. Kwielle decided through this process that she actually did not want to

stay in a relationship with Leon, that they had very different views around parenting. Leon remained engaged with his care team working towards being a consistent and caring father. (CoP#3-S3-CP)

The pressure for more holistic practice when working with Aboriginal families may have been a factor that, along with the training and support of the Safe & Together Model, pushed a care team to a shared approach with a family experiencing complex intersecting issues (Davy, Kite, Sivak, et al, 2017). The cultural connections inscribed through family relationships are clearly seen in the Leon's perseverance to stay engaged with the care team to work with them on strengthening his fathering. While this practice example emerged for discussion, *The STACY project* also consistently raised the difficulties of working with different approaches across the service system, as discussed below.

Differing frameworks across services

In the CoP sessions, a theme emerged about a tendency to polarise and disconnect perpetrator healing from perpetrator accountability. This resulted in some practitioners, particularly those who worked in the substance misuse area or mental health fields, to express the view that it was not their remit to work with men to address their use of violence and control, principally because they delivered a therapeutic service. This approach was most strongly expressed by practitioners in substance misuse services, as the following example attests:

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

Practitioners described engaging men differently according to their beliefs about the drivers of domestic violence. Illustrative of this was a substance misuse worker who described how the focus of her work with perpetrators of domestic violence is on unearthing their trauma history, rather than mapping their patterns of abuse:

> *"I think there is some trauma history there … to me, that is more significant in my work with him than his DV in working with his substance use." (CoP#1-S1-AOD)*

A recurring theme across practitioner interviews and discussions within the CoPs lay with the difficulties of working with MH and DV, given the different language, concepts and philosophies of services:

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

> *"I think [MH organisation] needs to change the culture around working with DV. For example, the perpetrator using attempted suicide as a form of control with women. MH workers do not understand what that behaviour means. They are not seeing the patient in the context of DV, just looking at the presenting issue." (CoP#4-S2-OS)*

It was pointed out that shifting the framework involved moving to a shared language which could enable the perpetration of violence and its effects to be kept in view:

> *"I went to a (AOD) conference and there was a presentation on family violence, mental health and alcohol and other drugs and all of the differences in language between the sectors. The alcohol and other drug sector comes from the psychological model, the mental health sector uses the medical model, the family violence draws on the feminist model. My practice is 15 years in alcohol and other drugs ... Our use of language needs to change." (CoP#3-S3-AOD)*

Overwhelmingly, practitioners perceived that the Safe & Together resources, and particularly a tool (the perpetrator mapping tool) that carefully guided the practitioner in how to map the perpetrator's wide range of coercive controlling behaviours, and the impact on children, were of great value. The tool was identified as a vehicle that aids in rendering visible the complex connections between multiple factors. It enabled practitioners to conceptualise and attend to substance abuse coercion and mental health coercion. They described holding this type of analysis in their mind when engaging in understanding the perpetrator's pattern of abuse, as the following account from a Child Protection team leader illustrates:

> *"I'm working to figure out what is just the alcohol, the drugs, the diagnosis and what is the combination of this with choosing to be violent. We are working on getting the conversations right … it's about having the tools in the model to use in group supervision where hopefully it's helping our guys to understand the 'how' of the work, more than just being told what to do, helping them make sense of what we are doing. We are running through the perpetrator's patterns of harm, how we can structure our practice, developing questions for our assessments for our engagement with mum and dad about what's going on.*" (CoP-S2A-CP)

In short, whilst practitioners faced many barriers at the intersection of substance misuse and/or mental health issues with domestic violence, collaborative and respectful discussions in the relatively safe setting of a CoP enabled practitioners space for critical reflection on such intersections, particularly in relation to how practice can make the perpetrator visible and accountable, and partnerships can be created with the non-offending parent, usually mothers, to also keep the children's needs in view.

Discussion

An action research model underpinned the work of the *STACY Project*. The inter-related processes of inquiry through learning/research and the simultaneous development of practice and action (Ison, 2008) are encapsulated in the two research questions. These focus on identifying practice challenges and the processes used to engage and explore these issues through CoPs and the implementation of the Safe & Together model. A number of different themes arose to address the interconnected research questions. Communities of Practice were the vehicles that enabled practitioners to look beyond co-occurrence of domestic violence, problematic substance use and mental health problems, to the ways in which these issues intersect in practice. A key issue lay with keeping women and children's safety in focus while holding the perpetrator and his pattern of violence and coercive control in view, when other issues of complexity emerged for attention.

The multi-disciplinary Communities of Practice provided a different focus to the relatively few bespoke programs that have worked at the intersection of these complex issues (Stover et al., 2017). Many of these programs are specialised women's domestic violence services that recognise the mental health issues that arise for women subjected to domestic violence (Humphreys & Thiara, 2003), or programs where there is attention to dual diagnosis with MH and substance misuse issues, but which do not tackle the issue of DV (Holly & Horvath, 2012). Others are family focused interventions that traverse MH and its intersection with other issues, specifically for children whose parents have MH problems (Foster et al., 2016), or systems of care models which are family focused for children with severe emotional disturbance (Mayberry & Helflinger, 2012). While taking a broader brief than the individual, and often creating a multi-disciplinary or multi-organisational service that address the intersections of different problems within a family, they are not designed to specifically address these issues where domestic violence is present.

By contrast, The *STACY Project* worked with practitioners in mainstream child protection, justice, domestic and family violence, mental health and substance misuse services to integrate understanding of the dynamics of domestic violence into these services recognising that many (though of course not all) of their

clients experience co-occurring problems (Howard et al., 2010; Gilchrist et al., 2019). Many of the men who are engaged with these services are voluntary and will be on a continuum, from highly involved in the change process, to denial that they have any issues to address (Trevillion et al., 2016; Heward-Belle et al., 2019). *STACY* practitioners engaged with particular themes presented by the model, but tended to bring their most difficult cases to the CoP; hence, case examples portrayed most men employing blame and denial. However, the Safe & Together Model emphasises engagement and accountability rather than the invisibility of men, particularly in their role as fathers.

The Safe & Together Model provided a cohesive framework through which a diverse group of practitioners were provided with multi-disciplinary training, coaching and mentoring through the CoPs (https://safeandtogetherinstitute.com/). The model originated in the United States with David Mandel, but has gained traction in the UK, Europe, Canada, as well as Australia. Its attention to addressing power and control through lifting the focus of domestic violence to the perpetrators of violence, and specifically to their fathering (Heward-Belle et al., 2019), provided a contrast to 'mother-blaming' narratives which are not uncommon in the child protection arena (Lapierre, 2016). The focus on the complexity of intersecting issues is highlighted as an integral part of the model (see Figure 1).

The *STACY* practitioners often highlighted the contrasting approaches to practice from different sectors, an issue consistently raised elsewhere (Isobe et al., 2020). The emphasis in substance misuse services ranges from addiction issues as illness, through to individuals voluntarily engaging with workers to take responsibility for their problematic use of substances (Humphreys et al., 2005). Within many parts of the mental health sector, the medical model still holds sway, although psycho-social approaches based around group work, and individual and family counselling are often integrated into treatment models (Trevillion et al., 2012). In holding men to account, the approach in the DV sector is more challenging of men's perspectives than standard counselling models (Heward-Belle et al., 2019). Such diversity in approaches is not easily resolved when practitioners come together. The Safe & Together model assisted STACY practitioners to find common ground and a shared understanding (Heward-Belle et al., 2020) through: an emphasis on behaviours and the impact on others when working with men who use violence; the constant attention to safety; and identifying the strength and resilience in relationships between children and their mothers.

In responding to the question of the ways in which substance use and mental health are implicated in the perpetrators' patterns of abusive behaviour and coercive control, the CoP discussions bought compelling evidence through case-based examples of the intersection of mental health or substance misuse problems

with DV. The case-based examples demonstrated the many ways in which services avoided or struggled to address domestic abuse perpetration and its impact on partners and children. The invisibility of the perpetrator of domestic violence was aided by lack of initial and on-going assessments of DV within most of the mental health and substance misuse organisations. In this sense, the experience of the STACY practitioners aligns with the evidence that, in spite of known high rates of co-occurrence of DV that practice does not reflect this intersection of problems (Mason & O'Rinn, 2014; Nyame et al., 2013; Trevillion et al., 2014; Trevillion et al., 2016). This is a primary way in which the perpetration of violence becomes invisible (Choo et al., 2010; Howard et al., 2010), with a major research review indicating that, unless clients are asked about DV, they do not disclose (Trevillion et al., 2016).

Even less attention was directed at the ways in which either mental health or substance misuse issues were employed as part of the suite of tactics of coercive control used by perpetrators of DV. For example, the use of suicide threats or attempts in the context of DV is considered such a high-risk indicator for homicide or serious assault that it is included in the majority of DV risk assessment tools (Forsdike et al., 2017). This is not new knowledge. Many of these tools have been in use for decades (Campbell, 1986; Campbell et al., 2009; Dutton & Kropp, 2000). Similarly, the knowledge that the severity and frequency of violence towards women partners increases when perpetrators of domestic violence use alcohol and/or other drugs has been evidenced for more than 30 years (Berman et al., 1989), with study after study showing the same pattern (Taft et al., 2019). Yet, with the exception of two substance misuse organisations in the *STACY Project*, the ways in which alcohol or other drugs are used as tactics to create fear in, and control of women and children in the family remained marginalised or non-existent in practice.

STACY participants found that few services that they worked with acknowledged and addressed parenting issues with their clients. Concerns are frequently raised by child protection workers about children living with the so called 'toxic trio' of DV, mental health, and substance misuse (Radcliffe & Gilchrist, 2016). However, the *STACY Project* indicated that there remains a strong tendency to focus all work on the woman and her problems, with the focus on the father as the perpetrator of violence disappearing from view (Sidebotham & Retzer, 2018).

Nevertheless, practitioners who participated in training and coaching from the Safe & Together Institute were pointing towards the directions for practice change more aligned to keeping a focus on the perpetrator of violence when issues of complexity were present, and strengthening the collaboration between

different parts of the service system through the use of shared language and frameworks that go beyond co-occurrence.

Conclusion

Disentangling and integrating the intersections of DV with substance misuse and/or mental health issues, particularly when children are involved, is a challenging area of practice which has been slow to develop. The co-occurrence of these issues is not disputed. The *STACY Project* sought to go beyond co-occurrence to explore the practice implication of the intersection of these issues and, specifically, the way in which perpetrators of abuse used their own, or their partner's substance misuse or mental health issues in their tactics of coercive control.

The project drew attention to the difficulties of making progress where 'domestic violence blind' practice has become entrenched at the intersections of child protection, substance misuse and mental health problems. However, it also demonstrated the ways in which a shared framework could provide a practice model to bring practitioners from diverse sectors together to generate new ways of working at the intersection of these complex problems.

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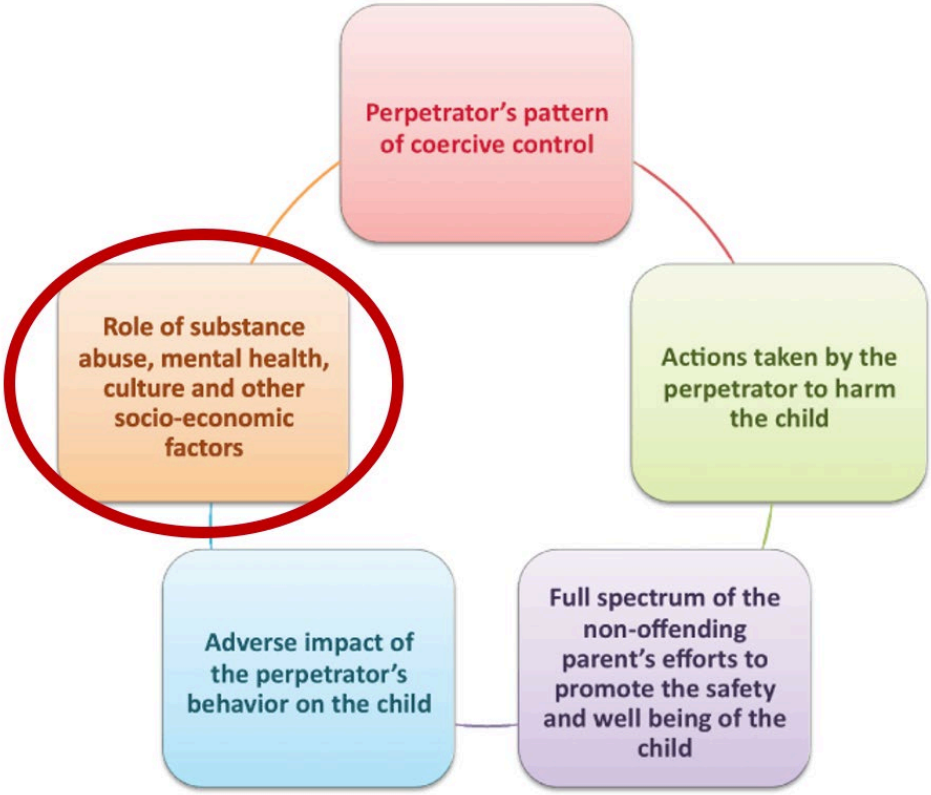
Figure 1: Safe & Together Critical Components (reproduced with permission)



Source: https://safeandtogetherinstitute.com/safe-together/safe-together-overview/assumptions-principles-critical-components/

Figure 2: STACY Project participants

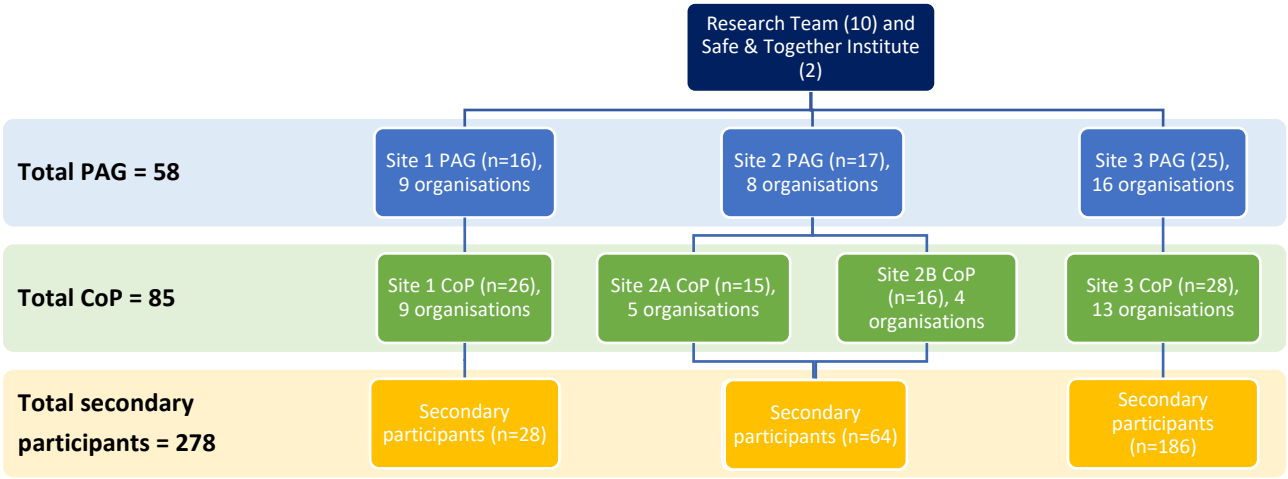
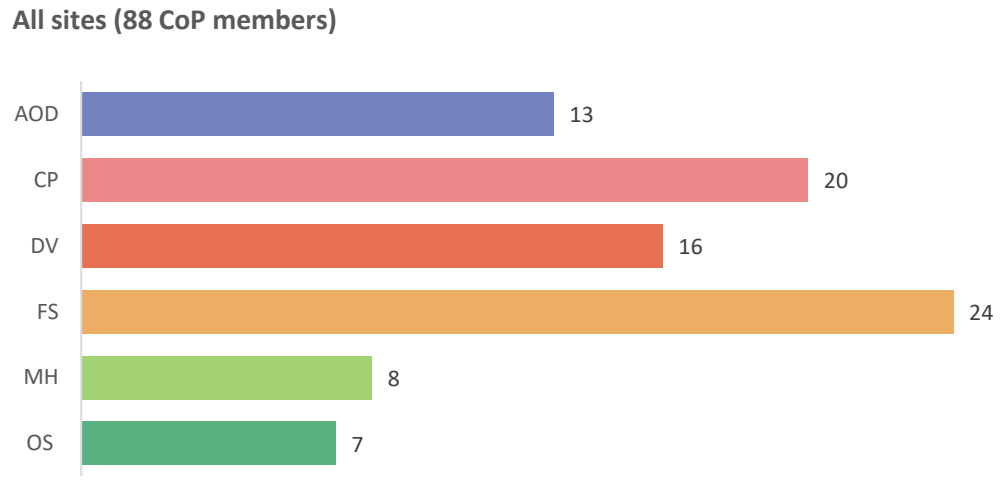


Figure-3: STACY CoP participants backgrounds



AOD - alcohol and other drugs | **CP -** child protection (includes specialist MH, AOD, Indigenous, legal and WWD) | **DV** – domestic violence (includes men's services, specialist women's DV) | **FS -** child and family services | **MH** - mental health | **OS -** other services (includes other health services, justice and corrective services such as police, probation