University Library

MINERVA ACCESS

A gateway to Melbourne's research publications

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:
Heward-Belle, S;Kertesz, M;Humphreys, C;Tsantefski, M;Isobe, J

Title:
Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use

Date:
2022

Citation:
Heward-Belle, S., Kertesz, M., Humphreys, C., Tsantefski, M. & Isobe, J. (2022). Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use. Advances in Dual Diagnosis, 15 (1), pp.51-65. https://doi.org/10.1108/ADD-12-2021-0017.

Persistent Link:
https://hdl.handle.net/11343/297200

Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use

Authors:
Susan Lynn Heward-Belle, Margaret Kertesz, Cathy Humphreys, Menka Tsantefski and Jasmin Isobe

AUTHOR ACCEPTED MANUSCRIPT

Journal:	*Advances in Dual Diagnosis*
Manuscript ID	ADD-12-2021-0017.R1
Manuscript Type:	Discussions Paper
Keywords:	children and families, domestic and family violence, practice guidelines, dual diagnosis

Heward-Belle, S. L., Kertesz, M., Humphreys, C., Tsantefski, M., & Isobe, J. (2022). Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use. *Advances in Dual Diagnosis.*

DOI: 10.1108/ADD-12-2021-0017

This Manuscript is deposited under the Creative Commons Attribution Non-commercial International Licence 4.0 (CC BY-NC 4.0). Ay reuse is allowed in accordance with the terms outlined by the licence. To reuse the AAM for commercial purposes, permission should be sought by contacting permissions@emeraldinsight.com.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Abstract

Participatory practice guideline development at the intersections of DFV, mental distress and/or parental substance use

Purpose – It is well established that the service system has a poor history of responding holistically to address the needs of children and families living with co-occurring complexities such as domestic violence, parental mental health and/or substance use. The purpose of this conceptual paper is to describe the developmental process and content of guidelines created to inform practice at the intersections of domestic violence, mental health and alcohol and other drug services, ensuring that the tactics of coercive control are visible in contexts of complexity.

The approach – The guidelines were developed through undertaking a literature review, followed by a practice-led research approach with practitioners from 33 organisations across three Australian states. Communities of practice comprised of practitioners providing interventions to children and families were central to the approach. Data that informed the development of the guidelines included a literature review, ethnographic notes, qualitative interviews, quantitative surveys, and reflections.

Findings – Practice-led research engaged practitioners in the development of guidelines to promote an integrated response to working with families experiencing domestic violence, substance use and mental health issues. The integrated approach drew from the Safe & Together Model, emphasising partnering with women survivors, pivoting to the perpetrator, focusing on children's safety and wellbeing, promoting worker safety, collaborating across agencies, and influencing organisational change. The process demonstrated the usefulness of this integrated approach, using practitioner-based examples.

Originality/value – Successful iterative processes to develop the guidelines were undertaken to support cultural change towards holistic and collaborative work across multiple sectors and organisations.

Keywords: children and families; domestic and family violence, mental health, substance use, practice guidelines

Advances in Dual Diagnosis

Introduction

> Siobahn has sporadically worked with mental health practitioners and alcohol and other drug (AOD) support workers for over a decade. She has received multiple mental health diagnoses, been prescribed various medications and been involuntarily hospitalized on occasions over this time. After the birth of her last child, Siobahn was diagnosed with severe postnatal depression and substance dependence. Concerns about the development of both of her children were reported to child protection services. Six months ago, Siobahn separated from the children's father after he sexually assaulted and attempted to strangle her. His long history of violence and coercive control toward Siobahn and her children rarely featured as the focal point of professional interventions by mental health and AOD workers. Recently, Siobahn began working with a domestic violence counsellor and participating in a survivor's group where she was supported to safely share aspects of her life story. Recently, Siobahn has been feeling confident, well and has been stable on an opioid treatment program. On reflection, she wishes that she had been supported to disclose her experiences earlier, as she sees her ex-partner's violence and control as central factors contributing to her mental distress, AOD usage, insecure housing and children's developmental concerns.

Siobahn's reflections[1] on professional practice are illustrative of many common pitfalls of contemporary service delivery at the intersection of domestic and family violence (DFV), mental health (MH) and use of alcohol and other drugs (AOD). Her observations reflect a siloed, fragmented, and under-developed approach to working with families experiencing DFV and associated complexities, including, but not limited to, MH, AOD, social disadvantage and child welfare concerns (Macy, Renz, and Pelino, 2013). Characteristically, this approach results in 'blinkered' practice whereby professionals see and attend to those aspects of a client's life that align with their area of specialization (Blythe, Heffernan, Walters, 2010), but do not sufficiently consider other issues such as the social and material conditions that underpin distress or the complex relationships between AOD, mental health and DFV. Notwithstanding the many initiatives including training, guideline development and novel service delivery

[1] This fictitious case study is based upon a composite of case studies shared by mental health, AOD and DFV practitioners involved in an Australian research project titled, Safe & Together Addressing ComplexitY (STACY Project).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

models that have been established to create integrated policy and practice responses, the service system remains stubbornly fragmented (Hester, 2011).

This paper contributes to the dual diagnosis knowledge base and informs policy and practice when working with people living with DFV particularly when MH and/or AOD are used in the tactics of coercive control. The paper is both conceptual and research based. It begins with foundational knowledge to inform practice before describing common pitfalls and approaches to service improvement. A participatory, practice-led approach to conceptualizing and developing practice guidelines influenced by Wagenaar's and Cook's epistemology of practice is then presented (Wagenaar and Cook, 2011; Cook and Wagenaar 2012). This approach critiques modernist notions that privilege knowledge as objective and something that must be gained before practice can occur. It was central to the development of practice guidelines titled, "*Working at the intersections of DFV, parental substance use and/or mental health issues*" (Heward-Belle *et al*., 2020). The *Practice Guidelines* were an outcome of the STACY (Safe & Together Addressing ComplexitY) Project, an Australian action research project that investigated and enhanced workforce capacity in responding to DFV, parental substance use and/or mental health issues within families (Healey *et al.*, 2020).

Domestic and family violence

Violence against women is a global public health epidemic and human rights violation with devastating individual and social consequences. Globally, one in three women are subjected to physical and/or sexual violence perpetrated mainly by an intimate partner (WHO, 2020). In Australia, on average one woman a week is killed by her intimate partner (Bryant and Bricknell, 2017) and twelve women a day are hospitalized (AIHW, 2019).The terminology to describe this form of violence against women differs across countries and between jurisdictions, domestic and family violence was the term used in the STACY Project and hence is used in this paper to refer to:

> "an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children and can be both criminal and noncriminal. Domestic violence includes physical, sexual, emotional and psychological abuse." (COAG, 2011)

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

'Family violence' is the term commonly used in Australia to represent the experiences of Aboriginal and Torres Strait Islander people, as it encompasses a broader range of marital and kinship relationships within which abuse may occur.

Empirical evidence consistently shows that women are disproportionately victims-survivors of violence and coercive control perpetrated mainly, but not only, by men (Cox, 2015). Other patterns do exist. Women, men, trans and non-binary people in straight, gay or lesbian relationships can perpetrate and/or be victims-survivors of DFV (Ali, Rogers and Heward-Belle, 2021). It is a form of abuse experienced by many children even though their lived experiences are often overlooked (Donagh, 2020).

Our understanding of perpetrator behaviour is growing. It now actively includes coercive control, defined as a pattern of behaviours within intimate relationships that results in the micro-regulation of the lives of victim-survivors (Stark and Hester, 2019). Compared with physical violence, coercive control is associated with more frequent abuse, more severe injuries, and death, and is more likely to leave victims feeling afraid (Cox, 2015).

Substance abuse and mental health coercion

Coercive control may be perpetrated by leveraging AOD usage or by tactics designed to destabilize a victim-survivors' mental health. Warshaw and colleagues (2014) named these tactics, "substance abuse coercion" and "mental health coercion" based on data collected from nearly 6000 victims-survivors. In both forms of coercive control, the abusive tactics are part of a broader pattern of abuse and control.

In the case of mental health coercion, perpetrators commonly deploy tactics which can include: "using force, threats, or manipulation to deliberately undermine a survivor's sanity, preventing a survivor from accessing treatment, controlling a survivor's medication, using a survivor's mental health to discredit them with sources of protection and support, leveraging a survivor's mental health to manipulate police, influence child custody decisions, and/or engaging mental health stigma to make a survivor think no one will believe them, among many other tactics." (Warshaw & Tinnon*,* 2018, p.5). Nearly 90% of 2741 survivors indicated that their abusers had called them 'crazy' or accused them of being 'crazy' and 74% had purposefully done things to make them feel they were going 'crazy' or 'losing their mind', a tactic sometimes referred to as 'gaslighting'. Of the 54% of victims-survivors who sought help from health/welfare professionals, almost all were discouraged from getting help and/or taking medication. Half the respondents reported that their abusers had threatened to report them to

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

authorities for being 'crazy' in order to gain advantages in relation to child custody or in other contexts including legal or police matters.

Mental health coercion also arises through the behaviour of the person using violence. In particular, threats of suicide in this context are common and flagged in all domestic violence risk assessment tools (Lamb et al, 2021). They point to heightened risk due to the proportion of domestic violence homicides where prior threats of suicide have been recorded (Bryant & Bricknell, 2017).

In the Substance-Abuse Coercion Study (Warshaw et al., 2014), 3248 victims-survivors described common perpetrator tactics of substance abuse coercion. This was defined as "coercing or forcing a survivor to use substances or to use more than they want, using a survivor's substance use to undermine and discredit them with sources of protection and support, leveraging a survivor's substances use to manipulate police or influence child custody decisions, deliberately sabotaging a survivor's recovery efforts or access to treatment, and/or engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal, among many other tactics." (Warshaw & Tinnon, 2018, p.5) A quarter of respondents indicated that they used substances to reduce physical pain caused by abuse. Of the 15% who indicated that they had sought help for their substance usage, 60% indicated that their (ex)partners actively discouraged them from seeking help.

Perpetrators of violence also frequently use alcohol and other drugs (AOD) in the context of violence and coercive control. Police data (Yates, 2019) and domestic homicide data (Bryant & Bricknell, 2015) point to the use of substances as part of the domestic and family violence used as a precursor to violence or in the context of an abusive incident (Humphreys et a, 2005).

Advances in Dual Diagnosis

Common pitfalls in service delivery

As Siobahn's story illustrates, services and practitioners in a variety of fields, including child protection, DFV, mental health and/or AOD, frequently work with individuals experiencing intersecting complexities (Oram *et al*., 2013). Yet, theoretically and practically, the service system response to children and their families who live with these complexities is at a relatively early stage (Isobe *et al.*, 2019). The adult MH, substance use, and dual diagnosis service system has not been designed to attend to the complex needs of children and their families experiencing this 'trifecta' (Gilchrist, 2010) of problems. Common areas identified for improvement include building the capacity of the service system and professionals working

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

within it to: 1) recognise and detect the presence of DFV, MH and/or AOD: 2) understand the complex ways in which these problems intersect and contribute to coercive control; and 3) collaborate and deliver all-of-family based responses that centre the safety and wellbeing needs of survivors and promote the accountability of perpetrators.

Recognition and detection

Despite the high number of individuals who experience DFV and access mental health and/or AOD services, numerous studies point to the persistent failure of practitioners within such services to recognize, detect and ask about DFV. (Oram *et al*., 2013;). The failure to recognise and detect DFV can have a damaging impact on individuals and families, leading to situations in which imminent threat and/or longer-term risks to women and children are not assessed. Practitioners are rarely trained to adequately engage people who use violence and control in discussions that would enable them to assess and respond to risk, and many do not believe that it is their responsibility to assess or address DFV in their work with men (Heward-Belle *et al.,* 2019).

Multiple validated risk assessment tools (Lamb *et al.*, 2021) provide empirical evidence that offenders who use substances and/or have mental health issues are more likely to reoffend and pose a high level of danger towards victim-survivors. This is especially the case when DFV, mental health issues and substance use intersect with other behaviours and contexts (Toivonen and Backhouse, 2018).

Addressing complexity

The emergence of the dual diagnosis field has led to new service delivery models and practices that have increased our understanding of the interconnections between substance use and mental health and have resulted in many innovative practices (Rettie et al, 2021; Wamel, Lempens & Neven, 2021). Yet, DFV has been largely constructed as ‘co-existing’ rather than as a central issue of concern and often part of the tactics of coercive control. The way these problems intersect is gendered, complex and multi-directional. Yates (2019) argues that AOD is linked to DFV in three ways: increased frequency and severity of perpetration; increased severity of victimization; and as a coping strategy for victim-survivors.

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

PRACTICE LED GUIDELINE DEVELOPMENT

As illustrated by Siobhan's story, the failure to make the connections between these complex social problems has left many DFV survivors in damaging and sometimes lethal situations, and frequently leads to practices that decontextualize survivors' mental distress and/or substance use, ignoring the abuse they have experienced (Humphreys *et al*., 2005). Yates (2019) argues that professionals within the DFV, AOD and mental health sectors understand these connections differently and these differences influence service delivery and treatment philosophies.

Advancements in collaborative practice to address complexity are hindered by the lack of a common theoretical approach to practice that centres the safety and wellbeing of women and children and promotes perpetrator accountability in the context of significant complexity. Training for many MH and AOD professionals frequently focuses upon the medical model for understanding mental health problems and substance use, resulting in a gender-neutral or individualistic approach that, in the case of AOD for example, leads to professionals making an inappropriate causal link between AOD usage and DFV. This over-simplified approach fails to address complexity and the need to look to more holistic approaches to a family, its problems and the role of coercive control (Isobe et al, 2020).

A siloed service system

Most mainstream services are established to respond to a singular issue (for example, substance use or mental health problems) and/or a 'primary client' (Humphreys *et al*., 2005), with separate services for adults and for children and young people. Few services deliver an all-of-family service, conceptualising the family itself as their primary client. The narrow focus on treating adult clients has led to practices where children's interests, including their right to live free from all forms of violence, are rendered invisible, hence opportunities to prevent and address inter-generational trauma are often missed.

For women mothering in a context of complexity, services frequently focus on coercing their compliance with undertakings to address their supposed "failure to protect" children from DFV, rather than offering support and intervening directly with perpetrators to identify their abusive behaviour as the central issue. A scoping review summarised the systemic problems thus:

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

> "(w)omen who experience co-occurring problems are required to parse out the complexities to identify a single priority issue in order to access services. Should intimate partner violence first be addressed, or depression and low self-esteem? Should dependence on pain killers or alcohol be the primary focus or the violence and abuse?" (Mason and O'Rinn, 2014, p.13)

Concerns about poor service system responses are compounded for families from underserviced communities. For example, many women and children who live in Australia's poorest postcodes are Aboriginal and Torres Strait Islander, from culturally and linguistically diverse communities, reside in Australia on precarious visas, have (dis)abilities and/or live in rural and remote locations. They are not only at increased risk of experiencing co-occurring DFV, MH and AOD problems, but they are also more likely to experience poor service responses.

Attempts to redress pitfalls in service delivery

Attempts to address complexity within families have been many and varied. Isobe and colleagues' review of the literature (2020) points to areas in which promising practices are emerging in response to the co-occurrence of DFV, AOD and MH. These include: the development of programs that address more than one issue (for example, Stover, Carlson & Patel, 2017); mandating of multi-agency risk assessment and management frameworks across the service system (Family Safety Victoria, 2018); and multi-agency training (Notko *et al.*, 2021). Other strategies include the development of guidelines to create clear directions for practitioners.

Guideline development has burgeoned as a solution to the inconsistencies of practice across multiple domains, particularly within the health sector. Guidelines have now even been produced for the development of guidelines! These steps include attention to the evidence-base, the process of creation, and the process of implementation (Bhaumik *et al.*, 2017; Woolf *et al.,* 2012). While attention to process is important, there is debate about the usefulness of guidelines in changing practice. Based on a systematic review, Feder and colleagues (1999) highlighted purpose and implementation as central issues in guideline development, rather than 'passive' guidelines dissemination through, for example, professional journal publications and mailouts to targeted professionals. These points are pertinent when addressing the specific issue of collaboration in the area of DFV. Notko and colleagues' research (2021) indicated that

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

guidelines can be too focused on practitioners, with little engagement with organisational issues to overcome structural barriers to practice change.

A different approach to guideline development

The STACY Project's approach to guideline development stemmed from our desire to redress some of the problems previously identified in the service system's response to individuals experiencing complexity, whilst avoiding some of the common capacity-building pitfalls. Specifically, the approach aimed to drive and embed practice improvements within a complex practice context to deliver violence and trauma-informed services that centred survivors' lived experiences and foregrounded the behaviours and influence of perpetrators.

Our approach was influenced by Cook and Wagenaar's epistemology of practice. (2012). They contend that many contemporary approaches to research, design, consultancy work, education, and training, and the development, implementation and review of public policies, remain rooted in modernist assumptions that knowledge begets practice (p.26). This belies the complex and multi-directional relationships between knowledge, practice and context. As they argue:

> "The standard model for training in corporations and public agencies, for example, rests firmly on the Received View: work stops, a period of training ensues (frequently offsite), after which employees return to the workplace to put new knowledge into practice (not always with sterling success). Billions are spent annually on training following this model. What might corporate and public agency training look like (and what might its costs be) if work and workplaces were designed to foster learning as part of work practice rather than as an interruption in it?" (p.27)

Our approach to developing the capacity of a practitioner workforce from diverse professional backgrounds and roles built on Wagenaar's and Cook's (2011) assertion that "practice is prior to and generative of knowledge" (p.208). All practice occurs within a given context, which in this case was a complex legal, health and social service system underpinned by multiple legislative, policy and practice imperatives. Practice configured through formal guidance, legislation, documentation conventions, practice protocols, norms and cultures, enforce and reinforce how organisations respond to service users and other organisations. Improving practice was therefore a complex process that required participation from multiple actors, including frontline practitioners, managers, policy actors and research academics.

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Communities of practice as sites of knowledge production

Practice-led research drawing on the Integrated Knowledge Management framework developed by Graham and colleagues (2006) complemented the theoretical approach described above. The framework provided a useful approach to undertaking research in practice settings for the purpose of generating new knowledge and ensuring that knowledge produced is utilized for the benefit of service users. Together, the two frames provided a roadmap for a collaborative and iterative research process which culminated in amongst other outcomes, the development of the *Practice Guidelines*.

Knowledge gained from practice generated through communities of practice (CoPs) informed the *Practice Guidelines*. Four CoPs constituted by 87 practitioners explored experiences of working with families who were experiencing DFV, substance use and mental distress. Specifically, the following questions informed the action research undertaken within the CoPs:

1. How do workers as part of case management, assess and manage the complexity of the intersections of mental health, AOD and DFV whilst maintaining the DFV focus?
2. What guidance would support practitioners working at the intersection of DFV with AOD and or MH?

The research questions were investigated through a collaborative process which included participation from frontline practitioners from government and non-government organisations, academics and researchers, managers, members of Project Advisory teams and Safe & Together Institute consultants. Figure 1 illustrates the project structure that existed across the three research sites located in Victoria, Queensland and New South Wales, and the tiered levels of participants and participant numbers. Primary participants were practitioners who were directly involved in the CoPs, whereas secondary participants were practitioners nominated by primary participants as people with whom they chose to 'influence' or share their emerging practices and knowledge.

[Insert Figure 1]

An iterative process was used to simultaneously explore the research questions, improve practice, and develop the *Practice Guidelines*. The process commenced with the Safe & Together Institute providing two days of face-to-face training with CoP participants in each research site. The Safe & Together Model (https://safeandtogetherinstitute.com/) originated to

Advances in Dual Diagnosis

guide practitioners and their organisations (where child protection issues are paramount) toward policies and practices that are 'DFV-informed'.

The Safe & Together Model prioritises the safety and wellbeing of children and young people. The work aims to keep children 'safe and together' with the non-offending parent (the adult survivor who is usually the mother); partnering with her and being involved with the perpetrator in ways that strengthen the safety and wellbeing of children whilst holding him to account for his abusive behaviours. The Safe & Together (S&T) Model's Critical Components of practice underpinned the STACY project, which focused on one particular aspect, namely, the intersection of mental health issues and/or substance use and DFV (Figure 2). The STACY Project aimed to shift practice from merely focusing on co-occurrence to exploring the ways the perpetrator's use of violence and coercive control can be kept in view when considering the relationship of DFV with substance use and/or mental health issues.

[Insert Figure 2]

A Program Advisory Group was established in each state site comprised of senior managers to create the authorising environment to support practice change in each of their organisations. Training with S&T followed and was further supported by participants meeting six times on a monthly basis. These CoP meetings were facilitated by an S&T consultant and a member of the research team. Practitioners were invited to present or share their experiences of working with a family experiencing DFV, AOD use, and/or mental health problems. Practitioners presented situations in which they applied elements of the S&T model and had the opportunity to discuss challenges or enablers to effective practice. Participants also discussed how they were sharing their learning with 'secondary participants.' The CoPs were established as safe learning environments where practitioners could share their work in order to develop new knowledge, collaborate and deconstruct complex matters and develop new perspectives on how to approach this work. S&T consultants provided coaching and support to participants and facilitated generative discussions about the challenges, complexities, benefits and experiences of applying a new practice model.

The components of the practice model have been detailed elsewhere (Humphreys *et al.*, 2021). Within the CoPs, practitioners discussed aspects of the model's application including how practice could pivot to the perpetrator, enabling practitioners the opportunity to assess and

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

manage the perpetrator's violence and coercively controlling behaviours. Practitioners also discussed and developed new knowledge about partnering with survivors in order to centre women's and children's safety whilst simultaneously ensuring that perpetrators were accountable for abusive behaviours that impacted all family members. Opportunities to develop new ways of working were imagined, that enabled an all-of-family approach, which attended to the needs of each family member. Rich discussions also ensued about practitioners' experiences of work processes and outcomes, and, on deeper levels, about the embodied experience of working amidst suffering, complexity, danger and uncertainty, often within complex and misaligned systems (Hester, 2011).

Researchers took in-depth ethnographic notes of each CoP session, containing rich qualitative data that was analyzed within and across all research sites. After all CoP sessions were complete, focus groups were held at each site, alongside a full day workshop to bring the learning together to inform the *Practice Guidelines*. These were attended by primary participants, secondary participants, managers, policy actors, members of the Project Advisory Group, researchers and academics. Preliminary data was presented about the themes identified within and across the CoP, and a collaborative process based on the seven integrated design principles of the World Café methodology (http://www.theworldcafe.com) was used to facilitate a reimagining of practice. Thus, the rich, qualitative data produced through this collaborative process and provided the knowledge contained within the *Practice Guidelines,* emerged from practice.

Ethical clearance was provided at each research site: at the University of Melbourne (HREC ID: 1852605.2, CoPs component; HREC ID: 1954087.2, interviews component), University of Sydney (HREC ID: 29019/189) and the Queensland Government's Hospital and Health Service (Metro North) (HREC/18/QPCH/46628).

Building knowledge from direct practice experience

In order to foster this approach to practice-led knowledge, the *Practice Guidelines* contain numerous composite case studies of de-identified situations, such as Siobhan's, that were deconstructed and reconstructed within the learning environment of the CoP. Although guidelines frequently contain case studies to illustrate a point, they are included in the *Practice Guidelines* for a further purpose - to elicit a critically reflective process that may occur individually or within teams. In this way, the case studies themselves promote a process of

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

practice-led knowledge development that exists beyond the research project itself and into the "eternally unfolding present" (Cook and Wagenaar, 2012).

During the CoPs and the final planning day (using the World Café method), participants identified six key themes they considered to be fundamental to redress common practice pitfalls. These themes became the central practice areas of the *Practice Guidelines*:

1. Partnering with women survivors
2. Pivoting to the perpetrator
3. Focusing on children's safety and wellbeing
4. Promoting worker safety
5. Working collaboratively across agencies

The best approach to presenting the *Practice Guidelines*, consistent with their theoretical underpinnings of collaborative and practice-led knowledge pedagogy, was discussed. The aim was to produce a document that would facilitate ongoing practice-led knowledge development through critical reflection, rather than conventional practice guidelines that prescribe a rigid approach to practice. The latter approach often reifies practitioners' lived experiences of working with complexity. With this consideration in mind, each theme contained within the guidelines includes practice strategies generated from the CoPs, questions to inspire individual, dyadic or team reflection, composite case studies and practitioner insights.

Discussion

The STACY project worked through both process and content issues to explore the two research questions. The development of practice at the intersection of DFV with AOD and/or MH created the content focus for the project (Q1). Informed by training and the Safe & Together Model, practitioners in Communities of Practice worked with the researchers and the Safe & Together consultants to explore their current practice, the enhancements derived from the Model and the adaptions tailored to their work. The guidelines to support complex practice contexts grew from the practice examples bought to the CoPs, and were designed to promote the critical reflection processes that characterised CoP discussions (Q2).

Throughout the action research project, knowledge was developed through dialogue about direct case work practice. In developing the guidelines, practitioners clearly recommended

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

that practice-based scenarios, like that of Siobahn, should be included in the *Practice Guidelines* to anchor practitioners' and agencies' examinations of their practice and foster an environment for critical reflection. In the tradition of Fook (2012), the process of critical reflection pivots on the in-depth analysis or interrogation of practice which involves deconstruction, resistance, challenge and reconstruction. Fook's approach uses contextual practice as the starting point for unsettling hegemonic assumptions or 'dominant discourses' in order to disrupt assumptions about practice. This approach was aligned with Cook's and Wagenaar's interrogation of micro-practices to understand the context in which practice occurs. The value of this approach lies in the relevance and adaption of guidelines as a resource to support practice, one which had senior management or organisational support through an active Program Advisory Group (see Figure 1) which oversaw and participated in the guideline development.

The CoP model and research frameworks also challenged standardised and siloed current models of practice. For example, the medical model offers little to illuminate the complex and multi-directional relationships between gender, MH, AOD and DFV. It falls short in theorizing and offering solutions to prevent and address violence against women. In particular, feminist scholars and practitioners have critiqued the model for failing to centre patriarchy and other oppressive social structures that embed unequal power relations - the key drivers of DFV (WHO, 2020; Our Watch, 2015).

In recent years, trauma-informed practice has increasingly gained traction in the mental health, AOD and dual diagnosis fields. Harris and Fallot (2001) argue that "to be trauma informed in any context is to understand the ways in which violence, victimization, and other traumatic experiences may have impacted the lives of the individuals involved and to apply that understanding to the design of systems and provision of services so they accommodate trauma survivors' needs and are consonant with healing and recovery." (p. 264) Yet, in this article we argue that many services and practitioners are not sufficiently DFV-informed (Mandel, 2014), and thus the service system's capacity to provide trauma-informed services is significantly reduced.

Where DFV is present, a trauma informed approach needs to go beyond individual, siloed services to understand and respond to the context in which the AOD and/or MH problems are occurring. An all-of-family approach (Humphreys *et al*., 2021) requires that each member of the family is provided with a service, or at least an assessment that explores the context and the consequences of AOD and MH where DFV is present. The potential highly damaging impacts of failing to address substance abuse and/or mental health coercion have

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

undermined the effectiveness of the current service system for women and their children living with DFV (Warshaw *et al*., 2014). The development of guidelines to inform a different practice approach represents a small, but important step in countering the dominant service system cultures and frameworks.

Conclusion

DFV, mental health problems and substance use commonly co-occur within families. The DFV-informed approach, six practice themes, composite case studies, and practitioner insights discussed in this conceptual paper illustrate how practitioner wisdom and experience can be democratically harnessed to drive practice improvements. The *Practice Guidelines* were built upon the extensive experience of practitioners, researchers, policy makers, and senior managers. This shared approach to working at the intersection of DFV, mental health and substance use advanced in the *Practice Guidelines* will serve to redress common pitfalls in practice and advance collaborative approaches to intervention and prevention across a complex service sector.

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

Ali, P., Rogers, M. and Heward-Belle, S., 2021. COVID-19 and domestic violence: impact to mental health. *Journal of Criminal Psychology*. DOI 10.1108/JCP-12-2020-0050.

Australian Institute of Health and Welfare, 2019. Family, domestic and sexual violence in Australia: Continuing the national story 2019. Canberra: AIHW.

Bhaumik, S., 2017. Use of evidence for clinical practice guideline development. *Tropical parasitology*, 7(2), p.65.

Blythe, B., Heffernan, K. and Walters, B., 2010. Best practices for developing child protection workers' skills: Domestic violence, substance abuse, and mental health training. *Revista De Asistenta Sociala*, (2), pp.51-64.

Bryant W and Bricknell S., 2017. *Homicide in Australia 2012–13 to 2013–14: National Homicide Monitoring Program report.* Statistical Report no. 2. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/sr/sr2

Cook, S.N. and Wagenaar, H., 2012. Navigating the eternally unfolding present: Toward an epistemology of practice. *The American Review of Public Administration*, 42(1), pp.3-38. DOI: 10.1177/0275074011407404

Council of Australian Governments (2011), National Plan to Reduce Violence against Women and their Children.

Cox, P., 2015. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey. (Horizons. Research Paper No. 1), Sydney: Australia's National Research Organisation for Women's Safety Limited (ANROWS). Retrieved from www.anrows.org.au/publications/horizons/PSS .

Donagh, B., 2020. From unnoticed to invisible: the impact of CoViD-19 on children and young people experiencing domestic violence and abuse. *Child abuse review*, 29(4), pp.387-391. https://doi.org/10.1002/car.2649.

Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne: Victorian Government. https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

Feder, G., Eccles, M., Grol, R., Griffiths, C. and Grimshaw, J., 1999. Using clinical guidelines. *BMJ*, 318(7185), pp.728-730. https://doi.org/10.1136/bmj.318.7185.728

Fook, J. and Gardner, F. eds., 2012. *Critical reflection in context: Applications in health and social care*. Routledge.

Gilchrist, G., Hegarty, K., Chondros, P., Herrman, H. and Gunn, J., 2010. The association between intimate partner violence, alcohol and depression in family practice. *BMC Family Practice*, 11(1), pp.1-10. https://doi.org/10.1186/1471-2296-11-72

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L.M. and Gadd, D., 2019. The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy*, 65, pp.8-23. https://doi.org/10.1016/j.drugpo.2018.12.009

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., Caswell, W. and Robinson, N., 2006. Lost in knowledge translation: time for a map?. *Journal of continuing education in the health professions*, 26(1), pp.13-24. https://doi.org/10.1002/chp.47

Harris, M. and Fallot, R.D., 2001. "Envisioning a trauma-informed service system: a vital paradigm shift", Harris, M., and Fallot, R. D (Eds.) *Using trauma theory to design service systems,* Jossey-Bass/Wiley, pp.3-22.

Healey, L., Heward-Belle, S., Humphreys, C., Isobe, J., Tsantefski, M. and Young, A., 2020. *Working at the intersections of domestic and family violence, parental substance use and/or mental health issues.* Research report of the STACY Project: Safe & Together Addressing ComplexitY. https://www.anrows.org.au/project/stacy-for-children/

Hester, M., 2011. The three-planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. *British journal of social work*, 41(5), pp.837-853. doi:10.1093/bjsw/bcr095

Heward-Belle, S., Healey, L., Isobe, J., Roumeliotis, A., Links, Erin, Mandel, D., Tsantefski, M., Young, A., and Humphreys, C., 2020. *Working at the intersections of domestic and family violence, parental substance use and/or mental health issues. Practice Guide from the STACY Project: Safe & Together Addressing ComplexitY.* https://www.anrows.org.au/project/stacy-for-children/

Heward-Belle, S., Humphreys, C., Healey, L., Toivonen, C. and Tsantefski, M., 2019. Invisible practices: Interventions with men who use violence and control. Affilia, 34(3), pp.369-382. doi:10.1177/0886109919848750

Humphreys, C., Heward-Belle, S., Tsantefski, M. and Isobe, J. (2021) Beyond co-occurrence: Addressing the intersections of domestic violence, mental health and substance use. *Child and Family Social Work* DOI:10.1111/cfs.12885

Humphreys, C., Regan, L., River, D. and Thiara, R.K., 2005. Domestic violence and substance use: Tackling complexity. *British journal of social work*, 35(8), pp.1303-1320. https://doi.org/10.1093/bjsw/bch212

Isobe, J., Healey, L. and Humphreys, C., 2020. A critical interpretive synthesis of the intersection of domestic violence with parental issues of mental health and substance use. *Health and social care in the community*, 28(5), pp.1394-1407. https://doi.org/10.1111/hsc.12978

Lamb, K., Humphreys, C., Forsdike, K. and Hegarty, K., 2021. Drawing upon the evidence to develop a multi-agency risk assessment and risk management framework for domestic violence *Journal of Gender Based Violence*

Macy, R.J., Renz, C. and Pelino, E., 2013. Partner violence and substance abuse are intertwined: Women's perceptions of violence–substance connections. *Violence Against Women*, 19(7), pp.881-902. DOI: 10.1177/1077801213498208

Mandel, D. "Beyond domestic violence perpetrator accountability in child welfare systems." *The No to Violence Journal* 1 (2014): 50-85.

Martin, S.L., Moracco, K.E., Chang, J.C., Council, C.L. and Dulli, L.S., 2008. Substance abuse issues among women in domestic violence programs: Findings from North Carolina. *Violence Against Women*, 14(9), pp.985-997. https://doi.org/10.1177/1077801208322103

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Mason, R. and O'Rinn, S.E., 2014. Co-occurring intimate partner violence, mental health, and substance use problems: a scoping review. *Global health action*, 7(1), p.24815. https://doi.org/10.3402/gha.v7.24815

Notko, M., Husso, M., Piippo, S., Fagerlund, M. and Houtsonen, J., 2021. Intervening in domestic violence: interprofessional collaboration among social and health care professionals and the police. Journal of interprofessional care, pp.1-9. https://doi.org/10.1080/13561820.2021.1876645

Oram, S., Trevillion, K., Feder, G. and Howard, L.M., 2013. Prevalence of experiences of domestic violence among psychiatric patients: systematic review. *The British Journal of Psychiatry*, 202(2), pp.94-99. doi:10.1192/bjp.bp.112.109934

Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth., 2015. *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, Melbourne, Australia.

Rettie, H., Georgewill, J., Stacey, S. and Griffith, E. (2021), "An evaluation of the psychosocial group programme at an inpatient detoxification and stabilisation unit: a service improvement project", *Advances in Dual Diagnosis*, Vol. 14, pp. 217-230. https://doi.org/10.1108/ADD-09-2021-0011

Stanley, N. and Humphreys, C., 2017. Identifying the key components of a'whole family'intervention for families experiencing domestic violence and abuse. *Journal of gender-based violence*, 1(1), pp.99-115. https://doi.org/10.1332/239868017X14913081639164

Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81-104. https://doi.org/10.1177/1077801218816191

Stover, C.S., Carlson, M., & Patel, S. (2017). Integrating intimate partner violence and parenting intervention into residential substance use disorder treatment for fathers. *Journal of Substance Abuse Treatment,* 81, 35-43. https://doi.org/10.1016/j.jsat.2017.07.013

Toivonen, C., and Backhouse, C., 2018. National Risk Assessment Principles for domestic and family violence (ANROWS Insights 07/2018). Sydney, NSW: ANROWS.

Tsantefski, M., Jackson, A.C. and Humphreys, C., 2015. A delicate balance: intervention with mothers with dual diagnosis and their infants, *Advances in Dual Diagnosis*, 8(2), pp.78-89. https://doi.org/10.1108/ADD-09-2014-0027

Wagenaar, H. and Cook, S.D., 2011. The push and pull of the world: How experience animates practice. *Evidence and Policy: A journal of research, debate and practice,* 7(2), pp.193-212.
Wamel, A., Lempens, A. and Neven, A. (2021), "Integrated treatment of dual disorders in The Netherlands: a qualitative study of client experiences", Advances in Dual Diagnosis, Vol. 14, pp. 183-197. https://doi.org/10.1108/ADD-12-2020-0029

Warshaw, C., Lyon, E., Bland, P., Phillips, H. and Hooper, M., 2014. Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline.

Warshaw, C. & Tinnon, E. 2018. Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings. National Center on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline.

Woolf, S., Schünemann, H.J., Eccles, M.P., Grimshaw, J.M. and Shekelle, P., 2012. Developing clinical practice guidelines: types of evidence and outcomes; values and

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

economics, synthesis, grading, and presentation and deriving recommendations. *Implementation Science*, 7(1), pp.1-12. https://doi.org/10.1186/1748-5908-7-61

World Health Organisation (2020) Retrieved on 19/12/2021 at: https://www.who.int/news-room/fact-sheets/detail/violence-against-children

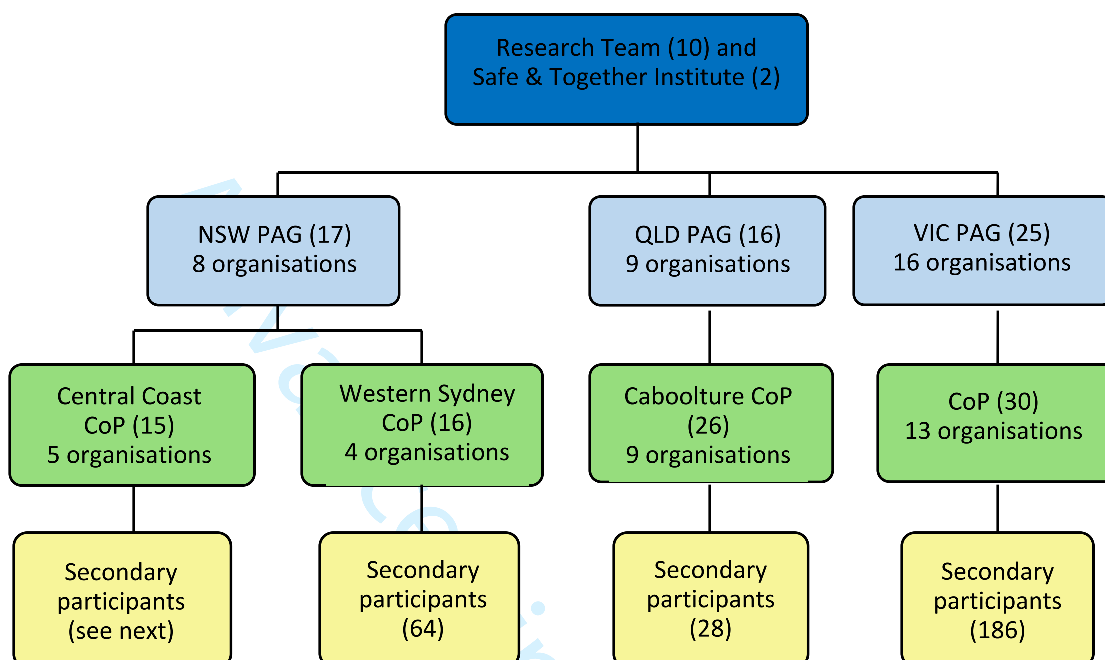
World Health Organization, 2013. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. World Health Organization. Retrieved on 15/11/2021 at https://www.who.int/health-topics/violence-against-women#tab=tab_1

Yates, S., 2019. "An exercise in careful diplomacy": talking about alcohol, drugs and family violence. *Policy Design and Practice,* 2(3), pp.258-274. https://doi.org/10.1080/25741292.2019.1638697

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

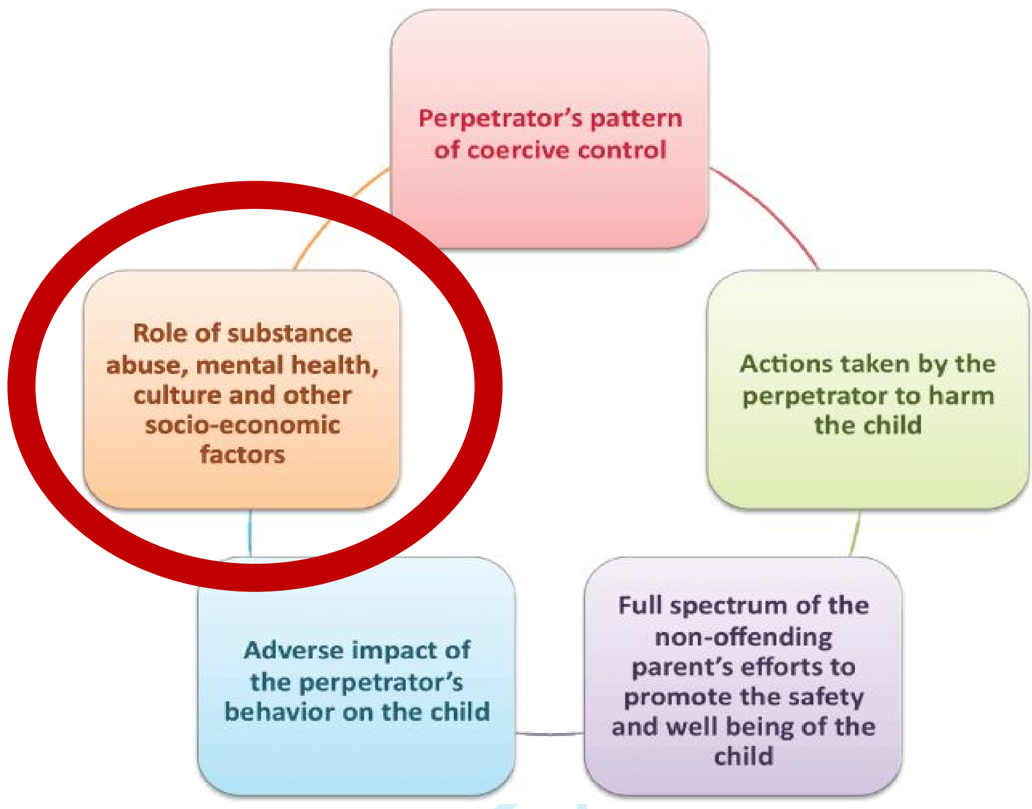
Figure 1. STACY project structure



Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

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



Advances in Dual Diagnosis

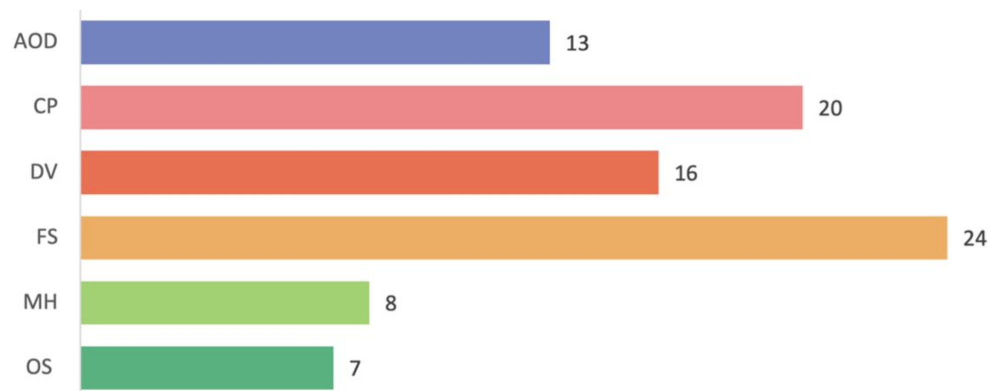
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 1: STACY CoP participant numbers and attrition

Research site	Number of CoP members registered at beginning of CoP phase	Number of CoP participants at end of CoP phase	CoP participant attrition
Site 1	25	23	2
Site 2	38	37	1
Site 3	30	28	2
Total across sites	93	88	5

Advances in D

Figure 3: STACY CoP participant backgrounds



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Abstract

Participatory practice guideline development at the intersections of domestic and family violence, mental distress and/or parental substance use

Purpose – It is well established that the service system has a poor history of responding holistically to address the needs of children and families living with co-occurring complexities such as domestic violence, parental mental health and/or substance use. The purpose of this conceptual paper is to primarily to describe the developmental process used to created to create guidelines to inform practice at the intersections of domestic violence, mental health and alcohol and other drug services, ensuring that the tactics of coercive control are visible in contexts of complexity.

The approach – The guidelines were developed through undertaking a literature review, followed by a practice-led research approach with practitioners from 33 organisations across three Australian states, Safe & Together consultants and researchers. Communities of practice comprised of practitioners providing interventions to children and families were central to the approach. Data that informed the development of the guidelines included a literature review, ethnographic notes, qualitative interviews, quantitative surveys, and reflections.

Findings – Practice-led research engaged practitioners in the development of guidelines to promote an integrated response to working with families experiencing domestic violence, substance use and mental health issues. The integrated approach drew from the Safe & Together Model, emphasising partnering with women survivors, pivoting to the perpetrator, focusing on children's safety and wellbeing, promoting worker safety, collaborating across agencies, and influencing organisational change. The process demonstrated the usefulness of this integrated approach, using practitioner-based examples.

Originality/value – Successful iterative processes to develop the guidelines were undertaken to support cultural change towards holistic and collaborative work across multiple sectors and organisations.

Keywords: children and families; domestic and family violence, dual diagnosis, practice guidelines

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Introduction

Siobhan has sporadically worked with mental health practitioners and alcohol and other drug (AOD) support workers for over a decade. She has received multiple mental health diagnoses, been prescribed various medications and been involuntarily hospitalized on occasions over this time. After the birth of her last child, Siobhan was diagnosed with severe postnatal depression and substance dependence. Concerns about the development of both of her children were reported to child protection services. Six months ago, Siobhan separated from the children's father after he sexually assaulted and attempted to strangle her. His long history of violence and coercive control toward Siobhan and her children rarely featured as the focal point of professional interventions by mental health and AOD workers. Recently, Siobhan began working with a domestic violence counsellor and participating in a survivor's group where she was supported to safely share aspects of her life story. Recently, Siobhan has been feeling confident, well and has been stable on an opioid treatment program. On reflection, she wishes that she had been supported to disclose her experiences earlier, as she sees her ex-partner's violence and control as central factors contributing to her mental distress, AOD usage, insecure housing and children's developmental concerns.

Siobhan's reflections[1] on professional practice are illustrative of many common pitfalls of contemporary service delivery at the intersection of domestic and family violence (DFV), mental health (MH) and use of alcohol and other drugs (AOD). Her observations reflect a siloed, fragmented, and under-developed approach to working with families experiencing DFV and associated complexities, including, but not limited to, MH, AOD, social disadvantage and child welfare concerns (Macy, Renz, and Pelino, 2013). Characteristically, this approach results in 'blinkered' practice whereby professionals see and attend to those aspects of a client's life that align with their area of specialization (Blythe, Heffernan, Walters, 2010), but do not sufficiently consider other issues such as the social and material conditions that underpin distress or the complex relationships between AOD, mental health and DFV. Notwithstanding the many initiatives including training, guideline development and novel service delivery

[1] This fictitious case study is based upon a composite of case studies shared by mental health, AOD and DFV practitioners involved in an Australian research project titled, Safe & Together Addressing ComplexitY (STACY Project).

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

models that have been established to create integrated policy and practice responses, the service system remains stubbornly fragmented (Hester, 2011). The service system in the context of domestic and family violence includes all areas of services including government and non-government funded that play a role in preventing and addressing family violence. In the context of this research, relevant services include drug and alcohol services, mental health services, primary health care, family violence teams, police, and child protection services to name a few.

This paper contributes to the dual diagnosis knowledge base and informs policy and practice when working with people living with DFV particularly when MH and/or AOD are used in the tactics of coercive control. The paper is both conceptual and research based. It begins with foundational knowledge to inform practice before describing common pitfalls and approaches to service improvement. A participatory, practice-led approach to conceptualizing and developing practice guidelines influenced by Wagenaar's and Cook's epistemology of practice is then presented (Wagenaar and Cook, 2011; Cook and Wagenaar 2012). This approach critiques modernist notions that privilege knowledge as objective and something that must be gained before practice can occur. It was central to the development of practice guidelines titled, "*Working at the intersections of DFV, parental substance use and/or mental health issues*[2]" (Heward-Belle *et al*., 2020). The *Practice Guidelines* were an outcome of the STACY (Safe & Together Addressing ComplexitY) Project, an Australian action research project that investigated and enhanced workforce capacity in responding to DFV, parental substance use and/or mental health issues within families (Healey *et al.*, 2020).

Domestic and family violence

Violence against women is a global public health epidemic and human rights violation with devastating individual and social consequences. Globally, one in three women are subjected to physical and/or sexual violence perpetrated mainly by an intimate partner (WHO, 2020). In Australia, on average one woman a week is killed by her intimate partner (Bryant and Bricknell, 2017) and twelve women a day are hospitalized (AIHW, 2019).The terminology to describe this form of violence against women differs across countries and between jurisdictions, domestic and family violence was the term used in the STACY Project and hence is used in this paper to refer to:

[2] For brevity, '*The working at the intersections of DFV, parental substance use and/or mental health issues Practice Guidelines'* are referred to as *'The Practice Guidelines'* in this paper.

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

> "an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children and can be both criminal and noncriminal. Domestic violence includes physical, sexual, emotional and psychological abuse." (COAG, 2011)

'Family violence' is the term commonly used in Australia to represent the experiences of Aboriginal and Torres Strait Islander people, as it encompasses a broader range of marital and kinship relationships within which abuse may occur.

Empirical evidence consistently shows that women are disproportionately victims-survivors of violence and coercive control perpetrated mainly, but not only, by men (Cox, 2015). Other patterns do exist. Women, men, trans and non-binary people in straight, gay or lesbian relationships can perpetrate and/or be victims-survivors of DFV (Ali, Rogers and Heward-Belle, 2021). It is a form of abuse experienced by many children even though their lived experiences are often overlooked (Donagh, 2020).

Our understanding of perpetrator behaviour is growing. It now actively includes coercive control, defined as a pattern of behaviours within intimate relationships that results in the micro-regulation of the lives of victim-survivors (Stark and Hester, 2019). Compared with physical violence, coercive control is associated with more frequent abuse, more severe injuries, and death, and is more likely to leave victims feeling afraid (Cox, 2015).

Substance abuse and mental health coercion

Coercive control may be perpetrated by leveraging AOD usage or by tactics designed to destabilize a victim-survivors' mental health. Warshaw and colleagues (2014) named these tactics, "substance abuse coercion" and "mental health coercion" based on data collected from nearly 6000 victims-survivors. In both forms of coercive control, the abusive tactics are part of a broader pattern of abuse and control.

In the case of mental health coercion, perpetrators commonly deploy tactics which can include: "using force, threats, or manipulation to deliberately undermine a survivor's sanity, preventing a survivor from accessing treatment, controlling a survivor's medication, using a survivor's mental health to discredit them with sources of protection and support, leveraging a survivor's mental health to manipulate police, influence child custody decisions, and/or engaging mental health stigma to make a survivor think no one will believe them, among many other tactics." (Warshaw & Tinnon*,* 2018, p.5). Nearly 90% of 2741 survivors indicated that their abusers had called them 'crazy' or accused them of being 'crazy' and 74% had

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

purposefully done things to make them feel they were going 'crazy' or 'losing their mind', a tactic sometimes referred to as 'gaslighting'. Of the 54% of victims-survivors who sought help from health/welfare professionals, almost all were discouraged from getting help and/or taking medication. Half the respondents reported that their abusers had threatened to report them to authorities for being 'crazy' in order to gain advantages in relation to child custody or in other contexts including legal or police matters.

Mental health coercion also arises through the behaviour of the person using violence. In particular, threats of suicide in this context are common and flagged in all domestic violence risk assessment tools (Lamb et al, 2021). They point to heightened risk due to the proportion of domestic violence homicides where prior threats of suicide have been recorded (Bryant & Bricknell, 2017).

In the Substance-Abuse Coercion Study (Warshaw et al., 2014), 3248 victims-survivors described common perpetrator tactics of substance abuse coercion. This was defined as "coercing or forcing a survivor to use substances or to use more than they want, using a survivor's substance use to undermine and discredit them with sources of protection and support, leveraging a survivor's substances use to manipulate police or influence child custody decisions, deliberately sabotaging a survivor's recovery efforts or access to treatment, and/or engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal, among many other tactics." (Warshaw & Tinnon, 2018, p.5) A quarter of respondents indicated that they used substances to reduce physical pain caused by abuse. Of the 15% who indicated that they had sought help for their substance usage, 60% indicated that their (ex)partners actively discouraged them from seeking help.

Perpetrators of violence also frequently use alcohol and other drugs (AOD) in the context of violence and coercive control. Police data (Yates, 2019) and domestic homicide data (Bryant & Bricknell, 2015) point to the use of substances as part of the domestic and family violence used as a precursor to violence or in the context of an abusive incident (Humphreys et a, 2005).

Common pitfalls in service delivery

As Siobhan's story illustrates, services and practitioners in a variety of fields, including child protection, DFV, mental health and/or AOD, frequently work with individuals experiencing intersecting complexities (Oram *et al*., 2013). Yet, theoretically and practically, the service system response to children and their families who live with these complexities is

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

at a relatively early stage (Isobe *et al.*, 2019). The adult MH, substance use, and dual diagnosis service system has not been designed to attend to the complex needs of children and their families experiencing this 'trifecta' (Gilchrist, 2010) of problems. Common areas identified for improvement include building the capacity of the service system and professionals working within it to: 1) recognise and detect the presence of DFV, MH and/or AOD: 2) understand the complex ways in which these problems intersect and contribute to coercive control; and 3) collaborate and deliver all-of-family based responses that centre the safety and wellbeing needs of survivors and promote the accountability of perpetrators. Common pitfalls are briefly described to provide relevant background to contextualize the research and *Practice Guidelines*.

Recognition and detection

Despite the high number of individuals who experience DFV and access mental health and/or AOD services, numerous studies point to the persistent failure of practitioners within such services to recognize, detect and ask about DFV. (Oram *et al*., 2013;). The failure to recognise and detect DFV can have a damaging impact on individuals and families, leading to situations in which imminent threat and/or longer-term risks to women and children are not assessed. Practitioners are rarely trained to adequately engage people who use violence and control in discussions that would enable them to assess and respond to risk, and many do not believe that it is their responsibility to assess or address DFV in their work with men (Heward-Belle *et al.,* 2019).

Multiple validated risk assessment tools (Lamb *et al.*, 2021) provide empirical evidence that offenders who use substances and/or have mental health issues are more likely to reoffend and pose a high level of danger towards victim-survivors. This is especially the case when DFV, mental health issues and substance use intersect with other behaviours and contexts (Toivonen and Backhouse, 2018).

Addressing complexity

The emergence of the dual diagnosis field has led to new service delivery models and practices that have increased our understanding of the interconnections between substance use and mental health and have resulted in many innovative practices (Rettie et al, 2021; Wamel, Lempens & Neven, 2021). Yet, DFV has been largely constructed as 'co-existing' rather than

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

as a central issue of concern and often part of the tactics of coercive control. The way these problems intersect is gendered, complex and multi-directional. Yates (2019) argues that AOD is linked to DFV in three ways: increased frequency and severity of perpetration; increased severity of victimization; and as a coping strategy for victim-survivors.

As illustrated by Siobahn's story, the failure to make the connections between these complex social problems has left many DFV survivors in damaging and sometimes lethal situations, and frequently leads to practices that decontextualize survivors' mental distress and/or substance use, ignoring the abuse they have experienced (Humphreys *et al*., 2005). Yates (2019) argues that professionals within the DFV, AOD and mental health sectors understand these connections differently and these differences influence service delivery and treatment philosophies.

Advancements in collaborative practice to address complexity are hindered by the lack of a common theoretical approach to practice that centres the safety and wellbeing of women and children and promotes perpetrator accountability in the context of significant complexity. Clearly, effective approaches must address complexity and look towards more holistic approaches to addressing domestic and family violence, predicated on a thorough understanding of the perpetrator's use of violence and coercive control (Isobe et al, 2020).

A siloed service system

Most mainstream services are established to respond to a singular issue (for example, substance use or mental health problems) and/or a 'primary client' (Humphreys *et al*., 2005), with separate services for adults and for children and young people. Few services deliver an all-of-family service, conceptualising the family itself as their primary client. The narrow focus on treating adult clients has led to practices where children's interests, including their right to live free from all forms of violence, are rendered invisible, hence opportunities to prevent and address inter-generational trauma are often missed.

For women mothering in a context of complexity, services frequently focus on coercing their compliance with undertakings to address their supposed "failure to protect" children from DFV, rather than offering support and intervening directly with perpetrators to identify their abusive behaviour as the central issue. Qualitative data gathered from interviews with 54 Australian professionals working in child protection, family law, domestic violence or broad

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

health services informed the development of a model to understand the myriad ways that professionals coerce women survivors and compound the trauma caused by experiencing domestic and family violence (Heward-Belle et al, 2018). Mason and O'Rinn's scoping review summarises some of the systemic problems that particularly exist at the intersection of domestic violence, mental health and substance misuse thus:

> "(w)omen who experience co-occurring problems are required to parse out the complexities to identify a single priority issue in order to access services. Should intimate partner violence first be addressed, or depression and low self-esteem? Should dependence on pain killers or alcohol be the primary focus or the violence and abuse?" (Mason and O'Rinn, 2014, p.13)

Concerns about poor service system responses are compounded for families from underserviced communities. For example, many women and children who live in Australia's poorest postcodes are Aboriginal and Torres Strait Islander, from culturally and linguistically diverse communities, reside in Australia on precarious visas, have (dis)abilities and/or live in rural and remote locations. They are not only at increased risk of experiencing co-occurring DFV, MH and AOD problems, but they are also more likely to experience poor service responses.

Attempts to redress pitfalls in service delivery

Attempts to address complexity within families have been many and varied. Isobe and colleagues' review of the literature (2020) points to areas in which promising practices are emerging in response to the co-occurrence of DFV, AOD and MH. These include: the development of programs that address more than one issue (for example, Stover, Carlson & Patel, 2017); mandating of multi-agency risk assessment and management frameworks across the service system (Family Safety Victoria, 2018); and multi-agency training (Notko *et al.*, 2021). Other strategies include the development of guidelines to create clear directions for practitioners.

Guideline development has burgeoned as a solution to the inconsistencies of practice across multiple domains, particularly within the health sector. Guidelines have now even been produced for the development of guidelines! These steps include attention to the evidence-base, the process of creation, and the process of implementation (Bhaumik *et al.*, 2017; Woolf *et al.,* 2012). While attention to process is important, there is debate about the usefulness of

Advances in Dual Diagnosis

guidelines in changing practice. Based on a systematic review, Feder and colleagues (1999) highlighted purpose and implementation as central issues in guideline development, rather than 'passive' guidelines dissemination through, for example, professional journal publications and mailouts to targeted professionals. These points are pertinent when addressing the specific issue of collaboration in the area of DFV. Notko and colleagues' research (2021) indicated that guidelines can be too focused on practitioners, with little engagement with organisational issues to overcome structural barriers to practice change.

Advances in Dual Diagnosis

A different approach to guideline development

The STACY Project's approach to guideline development stemmed from our desire to redress some of the problems previously identified in the service system's response to individuals experiencing complexity, whilst avoiding some of the common capacity-building pitfalls. Specifically, the approach aimed to drive and embed practice improvements within a complex practice context to deliver violence and trauma-informed services that centred survivors' lived experiences and foregrounded the behaviours and influence of perpetrators.

Our approach was influenced by Cook and Wagenaar's epistemology of practice. (2012). They contend that many contemporary approaches to research, design, consultancy work, education, and training, and the development, implementation and review of public policies, remain rooted in modernist assumptions that knowledge begets practice (p.26). This belies the complex and multi-directional relationships between knowledge, practice and context. As they argue:

> "The standard model for training in corporations and public agencies, for example, rests firmly on the Received View: work stops, a period of training ensues (frequently offsite), after which employees return to the workplace to put new knowledge into practice (not always with sterling success). Billions are spent annually on training following this model. What might corporate and public agency training look like (and what might its costs be) if work and workplaces were designed to foster learning as part of work practice rather than as an interruption in it?" (p.27)

Our approach to developing the capacity of a practitioner workforce from diverse professional backgrounds and roles built on Wagenaar's and Cook's (2011) assertion that "practice is prior to and generative of knowledge" (p.208). All practice occurs within a given context, which in this case was a complex legal, health and social service system underpinned by multiple

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

legislative, policy and practice imperatives. Practice configured through formal guidance, legislation, documentation conventions, practice protocols, norms and cultures, enforce and reinforce how organisations respond to service users and other organisations. Improving practice was therefore a complex process that required participation from multiple actors, including frontline practitioners, managers, policy actors and research academics.

Communities of practice as sites of knowledge production

Practice-led research drawing on the Integrated Knowledge Management framework developed by Graham and colleagues (2006) complemented the theoretical approach described above. The framework is premised upon the idea that "knowledge translation is about turning knowledge into action and encompasses the processes of both knowledge creation and knowledge application." (p. 22) The framework provided a useful approach to undertaking research in practice settings for the purpose of generating new knowledge and ensuring that knowledge produced is utilized for the benefit of service users. Together, the two frames provided a roadmap for a collaborative and iterative research process which culminated in amongst other outcomes, the development of the *Practice Guidelines*.

Knowledge gained from practice generated through communities of practice (CoPs) informed the *Practice Guidelines*. Four CoPs constituted by 87 practitioners explored experiences of working with families who were experiencing DFV, substance use and mental distress. Specifically, the following questions informed the action research undertaken within the CoPs:

1. How do workers assess and manage the complexity of the intersections of mental health, AOD and DFV whilst maintaining the DFV focus as part of case management?
2. What guidance would support practitioners working at the intersection of DFV with AOD and or MH?

The research questions were investigated through a collaborative process which included participation from frontline practitioners from government and non-government organisations, academics and researchers, managers, members of Project Advisory teams and Safe & Together Institute consultants. Figure 1 illustrates the project structure that existed across the three research sites located in Victoria, Queensland and New South Wales, and the tiered levels of participants and participant numbers. Primary participants were practitioners who were directly involved in the CoPs, whereas secondary participants were practitioners nominated by primary participants as people with whom they chose to 'influence' or share their emerging practices and knowledge.

Advances in Dual Diagnosis

PRACTICE LED GUIDELINE DEVELOPMENT

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

[Insert Figures 1]

An iterative process was used to simultaneously explore the research questions, improve practice, and develop the *Practice Guidelines*. The process commenced with the Safe & Together Institute providing two days of face-to-face training with CoP participants in each research site. The Safe & Together Model (https://safeandtogetherinstitute.com/) originated to guide practitioners and their organisations (where child protection issues are paramount) toward policies and practices that are 'DFV-informed'.

The Safe & Together Model prioritises the safety and wellbeing of children and young people. The work aims to keep children 'safe and together' with the non-offending parent (the adult survivor who is usually the mother); partnering with her and being involved with the perpetrator in ways that strengthen the safety and wellbeing of children whilst holding him to account for his abusive behaviours. The Safe & Together (S&T) Model's Critical Components of practice underpinned the STACY project, which focused on one particular aspect, namely, the intersection of mental health issues and/or substance use and DFV (Figure 2). The STACY Project aimed to shift practice from merely focusing on co-occurrence to exploring the ways the perpetrator's use of violence and coercive control can be kept in view when considering the relationship of DFV with substance use and/or mental health issues.

[Insert Figure 2]

A Program Advisory Group was established in each state site comprised of senior managers to create the authorising environment to support practice change in each of their organisations. CoP members were identified by senior managers in their services as influential practitioners with the capacity to positively contribute to practice change and embedding of the Safe & Together Model. They included clinicians, practitioners and practice leaders working in child protection, domestic and family violence, family services, alcohol and other drug, mental health, and other health services in each research site. Of fifty out of a possible 87 CoP participants who completed a final questionnaire that contained demographic details, 45 identified their gender as female and five as male. Figure 3 illustrates the participants' professional practice backgrounds.

Advances in Dual Diagnosis

[Insert Figure 3: STACY CoP Participant Backgrounds]

Training with S&T followed and was further supported by participants meeting six times on a monthly basis. Participants were highly dedicated to the project and there was a low attrition rate across the life of the project. For example, a total of 91 participants across 3 sites commenced the project and with 87 completing the project. These CoP meetings were facilitated by an S&T consultant and a member of the research team. Practitioners were invited to present or share their experiences of working with a family experiencing DFV, AOD use, and/or mental health problems. Practitioners presented situations in which they applied elements of the S&T model and had the opportunity to discuss challenges or enablers to effective practice. Participants also discussed how they were sharing their learning with 'secondary participants.' Table 1 illustrates the number of participants at each site at the beginning and end of the project.

[Insert Table 1: STACY CoP Participant Numbers and Attrition]

The CoPs were established as safe learning environments where practitioners could share their work in order to develop new knowledge, collaborate and deconstruct complex matters and develop new perspectives on how to approach this work. Blackmore (2010) describes that CoPs are established to share knowledge and acquire skills by working collectively and regularly on a shared problem or challenge. In the STACY Project CoPs were the engines for developing *The Guidelines*.

Safe & Together consultants provided coaching and support to participants and facilitated generative discussions about the challenges, complexities, benefits and experiences of applying a new practice model. The components of the practice model have been detailed elsewhere (Humphreys *et al.*, 2021). Within the CoPs, practitioners discussed aspects of the model's application including how practice could pivot to the perpetrator, enabling practitioners the opportunity to assess and manage the perpetrator's violence and coercively controlling behaviours. Practitioners also discussed and developed new knowledge about partnering with survivors in order to centre women's and children's safety whilst simultaneously ensuring that perpetrators were accountable for abusive behaviours that impacted all family members. Opportunities to develop new ways of working were imagined, that enabled an all-of-family approach, which attended to the needs of each family member. Rich discussions also ensued about practitioners' experiences of work processes and outcomes,

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

and, on deeper levels, about the embodied experience of working amidst suffering, complexity, danger and uncertainty, often within complex and misaligned systems (Hester, 2011).

Members of the research team audio-recorded and took detailed ethnographic notes of each CoP session, including de-identified notes of practitioner cases presented for discussion. This data (as with all qualitative data collected) was identified and coded into themes, facilitated by using NViv12 software. Themes were developed inductively by the research team, and a common coding template drawn up to reflect the themes and sub-themes for the team to use across all research sites. Data was extracted and analysed for similarities and differences across, for example, research sites, or programmatic identifiers (e.g. participant from an AOD, MH or another program).

After all CoP sessions were complete, focus groups were held at each site, alongside a full day workshop to bring the learning together to inform the *Practice Guidelines*. These were attended by primary participants, secondary participants, managers, policy actors, members of the Project Advisory Group, researchers and academics. Preliminary data was presented about the themes identified within and across the CoPs, and a collaborative process based on the seven integrated design principles of the World Café methodology was used to facilitate a reimagining of practice. Unfortunately, it is beyond the scope of this paper to outline the methodology and we urge interested readers to seek further information at the World Café page: http://www.theworldcafe.com/key-concepts-resources/design-principles/

Thus, the rich qualitative data produced through this collaborative process and provided the knowledge contained within the *Practice Guidelines,* emerged from practice. Quantitative data was also collected via an online questionnaire that included participant demographic data, and perceptions about participation in the STACY project, assessment of the coaching model, Safe & Together training modules, and multi-agency working. The results of this data are beyond the scope of this paper but are available in the STACY Final Report (Healey, Heward-Belle, Humphreys, Isobe, Tsantefski, & Young, 2020).

Ethical clearance was provided at each research site: at the University of Melbourne (HREC ID: 1852605.2, CoPs component; HREC ID: 1954087.2, interviews component), University of Sydney (HREC ID: 29019/189) and the Queensland Government's Hospital and Health Service (Metro North) (HREC/18/QPCH/46628).

Building knowledge from direct practice experience

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

In order to foster this approach to practice-led knowledge, the *Practice Guidelines* contain numerous composite case studies of de-identified situations, such as Siobhan's, that were deconstructed and reconstructed within the learning environment of the CoP. Although guidelines frequently contain case studies to illustrate a point, they are included in the *Practice Guidelines* for a further purpose - to elicit a critically reflective process that may occur individually or within teams. In this way, the case studies themselves promote a process of practice-led knowledge development that exists beyond the research project itself and into the "eternally unfolding present" (Cook and Wagenaar, 2012).

During the CoPs and the final planning day (using the World Café method), participants identified six key themes they considered to be fundamental to redress common practice pitfalls. These themes became the central practice areas of the *Practice Guidelines*:

1. Partnering with women survivors
2. Pivoting to the perpetrator
3. Focusing on children's safety and wellbeing
4. Promoting worker safety
5. Working collaboratively across agencies

The best approach to presenting the *Practice Guidelines*, consistent with their theoretical underpinnings of collaborative and practice-led knowledge pedagogy, was discussed. The aim was to produce a document that would facilitate ongoing practice-led knowledge development through critical reflection, rather than conventional practice guidelines that prescribe a rigid approach to practice. The latter approach often reifies practitioners' lived experiences of working with complexity. With this consideration in mind, each theme contained within the guidelines includes practice strategies generated from the CoPs, questions to inspire individual, dyadic or team reflection, composite case studies and practitioner insights.

Discussion

The STACY project worked through both process and content issues to explore the two research questions. The development of practice at the intersection of DFV with AOD and/or MH created the content focus for the project (Q1). Informed by training and the Safe & Together Model, practitioners in Communities of Practice worked with the researchers and the Safe & Together consultants to explore their current practice, the enhancements derived from

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

the Model and the adaptions tailored to their work. The guidelines to support complex practice contexts grew from the practice examples bought to the CoPs, and were designed to promote the critical reflection processes that characterised CoP discussions (Q2).

A strength of this action research project is that knowledge was developed through dialogue about direct case work practice. In developing the guidelines, practitioners led the process - articulating what gaps existed in current knowledge and policy and co-created tools to address these gaps. They clearly recommended that practice-based scenarios, like that of Siobahn, should be included in the *Practice Guidelines* to anchor practitioners' and agencies' examinations of their practice and foster an environment for critical reflection. In the tradition of Fook (2012), the process of critical reflection pivots on the in-depth analysis or interrogation of practice which involves deconstruction, resistance, challenge and reconstruction. Fook's approach uses contextual practice as the starting point for unsettling hegemonic assumptions or 'dominant discourses' in order to disrupt assumptions about practice. This approach was aligned with Cook's and Wagenaar's interrogation of micro-practices to understand the context in which practice occurs. The value of this approach lies in the relevance and adaption of guidelines as a resource to support practice, one which had senior management or organisational support through an active Program Advisory Group (see Figure 1) which oversaw and participated in the guideline development. The process utilised to develop *The Practice Guidelines* could be applied to other practice settings where multi-agency responses are required and democratic, participatory practices are promoted. This approach is limited for use within practice settings that are extremely hierarchal, non-democratic and non-reflexive.

The CoP model and research frameworks also challenged standardised and siloed current models of practice. For example, the medical model offers little to illuminate the complex and multi-directional relationships between gender, MH, AOD and DFV. It falls short in theorizing and offering solutions to prevent and address violence against women. In particular, feminist scholars and practitioners have critiqued the model for failing to centre patriarchy and other oppressive social structures that embed unequal power relations - the key drivers of DFV (WHO, 2020; Our Watch, 2015).

In recent years, trauma-informed practice has increasingly gained traction in the mental health, AOD and dual diagnosis fields. Harris and Fallot (2001) argue that "to be trauma-informed in any context is to understand the ways in which violence, victimization, and other traumatic experiences may have impacted the lives of the individuals involved and to apply that understanding to the design of systems and provision of services so they accommodate

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

trauma survivors' needs and are consonant with healing and recovery." (p. 264) Yet, in this article we argue that many services and practitioners are not sufficiently DFV-informed (Mandel, 2014), and thus the service system's capacity to provide trauma-informed services is significantly reduced.

Where DFV is present, a trauma-informed approach needs to go beyond individual, siloed services to understand and respond to the context in which the AOD and/or MH problems are occurring. An all-of-family approach (Humphreys *et al*., 2021) requires that each member of the family is provided with a service, or at least an assessment that explores the context and the consequences of AOD and MH where DFV is present. The potential highly damaging impacts of failing to address substance abuse and/or mental health coercion have undermined the effectiveness of the current service system for women and their children living with DFV (Warshaw *et al*., 2014). The development of guidelines to inform a different practice approach represents a small, but important step in countering the dominant service system cultures and frameworks.

Conclusion

DFV, mental health problems and substance use commonly co-occur within families. The DFV-informed approach, six practice themes, composite case studies, and practitioner insights discussed in this conceptual paper illustrate how practitioner wisdom and experience can be democratically harnessed to drive practice improvements. The *Practice Guidelines* were built upon the extensive experience of practitioners, researchers, policy makers, and senior managers. This shared approach to working at the intersection of DFV, mental health and substance use advanced in the *Practice Guidelines* will serve to redress common pitfalls in practice and advance collaborative approaches to intervention and prevention across a complex service sector.

Advances in Dual Diagnosis

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

References

Ali, P., Rogers, M. and Heward-Belle, S., 2021. COVID-19 and domestic violence: impact to mental health. *Journal of Criminal Psychology*. DOI 10.1108/JCP-12-2020-0050.

Australian Institute of Health and Welfare, 2019. Family, domestic and sexual violence in Australia: Continuing the national story 2019. Canberra: AIHW.

Bhaumik, S., 2017. Use of evidence for clinical practice guideline development. *Tropical parasitology*, 7(2), p.65.

Blackmore, C. (2010). Social learning systems and communities of practice. London: Springer.

Blythe, B., Heffernan, K. and Walters, B., 2010. Best practices for developing child protection workers' skills: Domestic violence, substance abuse, and mental health training. *Revista De Asistenta Sociala*, (2), pp.51-64.

Bryant W and Bricknell S., 2017. *Homicide in Australia 2012–13 to 2013–14: National Homicide Monitoring Program report*. Statistical Report no. 2. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/sr/sr2

Cook, S.N. and Wagenaar, H., 2012. Navigating the eternally unfolding present: Toward an epistemology of practice. *The American Review of Public Administration*, 42(1), pp.3-38. DOI: 10.1177/0275074011407404

Council of Australian Governments (2011), National Plan to Reduce Violence against Women and their Children.

Cox, P., 2015. Violence against women: Additional analysis of the Australian Bureau of Statistics' Personal Safety Survey. (Horizons. Research Paper No. 1), Sydney: Australia's National Research Organisation for Women's Safety Limited (ANROWS). Retrieved from www.anrows.org.au/publications/horizons/PSS .

Donagh, B., 2020. From unnoticed to invisible: the impact of CoViD-19 on children and young people experiencing domestic violence and abuse. *Child abuse review*, 29(4), pp.387-391. https://doi.org/10.1002/car.2649.

Family Safety Victoria, 2018. Family Violence Multi-Agency Risk Assessment and Management Framework. Melbourne: Victorian Government. https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

Feder, G., Eccles, M., Grol, R., Griffiths, C. and Grimshaw, J., 1999. Using clinical guidelines. *BMJ*, 318(7185), pp.728-730. https://doi.org/10.1136/bmj.318.7185.728

Fook, J. and Gardner, F. eds., 2012. *Critical reflection in context: Applications in health and social care*. Routledge.

Gilchrist, G., Hegarty, K., Chondros, P., Herrman, H. and Gunn, J., 2010. The association between intimate partner violence, alcohol and depression in family practice. *BMC Family Practice*, 11(1), pp.1-10. https://doi.org/10.1186/1471-2296-11-72

Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L.M. and Gadd, D., 2019. The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy*, 65, pp.8-23. https://doi.org/10.1016/j.drugpo.2018.12.009

Advances in Dual Diagnosis

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

Graham, I.D., Logan, J., Harrison, M.B., Straus, S.E., Tetroe, J., Caswell, W. and Robinson, N., 2006. Lost in knowledge translation: time for a map?. *Journal of continuing education in the health professions*, 26(1), pp.13-24. https://doi.org/10.1002/chp.47

Harris, M. and Fallot, R.D., 2001. "Envisioning a trauma-informed service system: a vital paradigm shift", Harris, M., and Fallot, R. D (Eds.) *Using trauma theory to design service systems,* Jossey-Bass/Wiley, pp.3-22.

Healey, L., Heward-Belle, S., Humphreys, C., Isobe, J., Tsantefski, M. and Young, A., 2020. *Working at the intersections of domestic and family violence, parental substance use and/or mental health issues.* Research report of the STACY Project: Safe & Together Addressing ComplexitY. https://www.anrows.org.au/project/stacy-for-children/

Hester, M., 2011. The three-planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence. *British journal of social work*, 41(5), pp.837-853. doi:10.1093/bjsw/bcr095

Heward-Belle, S., Healey, L., Isobe, J., Roumeliotis, A., Links, Erin, Mandel, D., Tsantefski, M., Young, A., and Humphreys, C., 2020. *Working at the intersections of domestic and family violence, parental substance use and/or mental health issues. Practice Guide from the STACY Project: Safe & Together Addressing ComplexitY.* https://www.anrows.org.au/project/stacy-for-children/

Heward-Belle, S., Laing, L., Humphreys, C. & Toivenon (2018). Intervening with Children Living with Domestic Violence: Is the System Safe? *Australian Social Work*, 71(2), pp. 135-147.

Heward-Belle, S., Humphreys, C., Healey, L., Toivonen, C. and Tsantefski, M., 2019. Invisible practices: Interventions with men who use violence and control. *Affilia*, 34(3), pp.369-382. doi:10.1177/0886109919848750

Humphreys, C., Heward-Belle, S., Tsantefski, M. and Isobe, J. (2021) Beyond co-occurrence: Addressing the intersections of domestic violence, mental health and substance use. *Child and Family Social Work* DOI:10.1111/cfs.12885

Humphreys, C., Regan, L., River, D. and Thiara, R.K., 2005. Domestic violence and substance use: Tackling complexity. *British journal of social work*, 35(8), pp.1303-1320. https://doi.org/10.1093/bjsw/bch212

Isobe, J., Healey, L. and Humphreys, C., 2020. A critical interpretive synthesis of the intersection of domestic violence with parental issues of mental health and substance use. *Health and social care in the community*, 28(5), pp.1394-1407. https://doi.org/10.1111/hsc.12978

Lamb, K., Humphreys, C., Forsdike, K. and Hegarty, K., 2021. Drawing upon the evidence to develop a multi-agency risk assessment and risk management framework for domestic violence *Journal of Gender Based Violence*

Macy, R.J., Renz, C. and Pelino, E., 2013. Partner violence and substance abuse are intertwined: Women's perceptions of violence–substance connections. *Violence Against Women*, 19(7), pp.881-902. DOI: 10.1177/1077801213498208

Mandel, D. "Beyond domestic violence perpetrator accountability in child welfare systems." *The No to Violence Journal* 1 (2014): 50-85.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Martin, S.L., Moracco, K.E., Chang, J.C., Council, C.L. and Dulli, L.S., 2008. Substance abuse issues among women in domestic violence programs: Findings from North Carolina. *Violence Against Women*, 14(9), pp.985-997. https://doi.org/10.1177/1077801208322103

Mason, R. and O'Rinn, S.E., 2014. Co-occurring intimate partner violence, mental health, and substance use problems: a scoping review. *Global health action*, 7(1), p.24815. https://doi.org/10.3402/gha.v7.24815

Notko, M., Husso, M., Piippo, S., Fagerlund, M. and Houtsonen, J., 2021. Intervening in domestic violence: interprofessional collaboration among social and health care professionals and the police. Journal of interprofessional care, pp.1-9. https://doi.org/10.1080/13561820.2021.1876645

Oram, S., Trevillion, K., Feder, G. and Howard, L.M., 2013. Prevalence of experiences of domestic violence among psychiatric patients: systematic review. *The British Journal of Psychiatry*, 202(2), pp.94-99. doi:10.1192/bjp.bp.112.109934

Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth., 2015. *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*, Our Watch, Melbourne, Australia.

Rettie, H., Georgewill, J., Stacey, S. and Griffith, E. (2021), "An evaluation of the psychosocial group programme at an inpatient detoxification and stabilisation unit: a service improvement project", *Advances in Dual Diagnosis*, Vol. 14, pp. 217-230. https://doi.org/10.1108/ADD-09-2021-0011

Stanley, N. and Humphreys, C., 2017. Identifying the key components of a'whole family'intervention for families experiencing domestic violence and abuse. *Journal of gender-based violence*, 1(1), pp.99-115. https://doi.org/10.1332/239868017X14913081639164

Stark, E. and Hester, M., 2019. Coercive control: Update and review. *Violence against women*, 25(1), pp.81-104. https://doi.org/10.1177/1077801218816191

Stover, C.S., Carlson, M., & Patel, S. (2017). Integrating intimate partner violence and parenting intervention into residential substance use disorder treatment for fathers. *Journal of Substance Abuse Treatment,* 81, 35-43. https://doi.org/10.1016/j.jsat.2017.07.013

Toivonen, C., and Backhouse, C., 2018. National Risk Assessment Principles for domestic and family violence (ANROWS Insights 07/2018). Sydney, NSW: ANROWS.

Tsantefski, M., Jackson, A.C. and Humphreys, C., 2015. A delicate balance: intervention with mothers with dual diagnosis and their infants, *Advances in Dual Diagnosis*, 8(2), pp.78-89. https://doi.org/10.1108/ADD-09-2014-0027

Wagenaar, H. and Cook, S.D., 2011. The push and pull of the world: How experience animates practice. *Evidence and Policy: A journal of research, debate and practice,* 7(2), pp.193-212.
Wamel, A., Lempens, A. and Neven, A. (2021), "Integrated treatment of dual disorders in The Netherlands: a qualitative study of client experiences", Advances in Dual Diagnosis, Vol. 14, pp. 183-197. https://doi.org/10.1108/ADD-12-2020-0029

Warshaw, C., Lyon, E., Bland, P., Phillips, H. and Hooper, M., 2014. Mental Health and Substance Use Coercion Surveys: Report from the National Center on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline.

Warshaw, C. & Tinnon, E. 2018. Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief

Counseling in Primary Care and Behavioral Health Settings. National Center on Domestic Violence, Trauma and Mental Health and the National Domestic Violence Hotline.

Woolf, S., Schünemann, H.J., Eccles, M.P., Grimshaw, J.M. and Shekelle, P., 2012. Developing clinical practice guidelines: types of evidence and outcomes; values and economics, synthesis, grading, and presentation and deriving recommendations. *Implementation Science*, 7(1), pp.1-12. https://doi.org/10.1186/1748-5908-7-61

World Health Organisation (2020) Retrieved on 19/12/2021 at: https://www.who.int/news-room/fact-sheets/detail/violence-against-children

World Health Organization, 2013. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. World Health Organization. Retrieved on 15/11/2021 at https://www.who.int/health-topics/violence-against-women#tab=tab_1

Yates, S., 2019. "An exercise in careful diplomacy": talking about alcohol, drugs and family violence. *Policy Design and Practice,* 2(3), pp.258-274. https://doi.org/10.1080/25741292.2019.1638697

Advances in Dual Diagnosis