Evidence to Support Safe & Together Implementation and Evaluation: The ESTIE Project

Research Report

November 2022

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Acknowledgements

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

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

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Acknowledgement of Country

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

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

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

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

The *ESTIE Project* is committed to improving individual and system responses, and recognises the complex relationships between colonisation, trauma and oppression with domestic and family violence, mental health, drug and alcohol use. We have been privileged and honoured to be able to work in this space with our Aboriginal colleagues and build on collaborative learning from their extensive wisdom and expertise. We value their guidance on ways of healing that can be mediated by Aboriginal-led initiatives and culturally appropriate services that nurture the spirit, resilience and cultural identity of Aboriginal families and communities. We also acknowledge that while the Safe & Together™ Model has been developed with consideration of colonisation and racism, it does not consider the specific Australian or NSW experience of colonisation, dispossession and institutional racism, and more work is required to understand how the Safe & Together™ Model intersects with local Aboriginal world views, healing frameworks and principles.

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Disclaimer

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Abbreviations and acronyms

AH&MRC	Aboriginal Health & Medical Research Council of NSW
AOD	Alcohol and Other Drugs
CoP	Community of Practice
CP	Sector code denoting statutory child protection
CPCS	Child Protection Counselling Service
DCJ	Department of Communities and Justice (the statutory child protection agency in NSW)
DFV	Sector code for services focused on domestic and family violence, including men's behaviour change programs
ECAV	Education Centre Against Violence
LHD	Local Health District
MH	Mental Health
MoH	NSW Ministry of Health
NCP	Non-statutory child protection, including Whole Family Teams and CPCS
NGO	Non-government organisation
NSW	New South Wales
OT	Other
PAG	Project Advisory Group
PARVAN	Prevention and Response to Violence, Abuse and Neglect Unit (part of the NSW Ministry of Health)
SA	Sexual Assault Service
S&T	Safe & Together™
VAN	Violence, Abuse and Neglect services
WFT	Whole Family Teams (Integrated MH-AOD teams for families with children at risk of harm)

A note on language

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

The importance of shared and explicit language is noted throughout this report, and in the interests of working towards this, a comprehensive list of key terms and concepts that underpin the *ESTIE Project* is included in the Glossary (Appendix 8.1).

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

Executive summary

The *ESTIE Project* (*Evidence to Support Safe & Together Implementation and Evaluation*) was a research project run by the University of Melbourne in collaboration with the Safe & Together™ Institute and the NSW Ministry of Health. The project employed a Community of Practice (CoP) model to build capacity of workers and generate research evidence about effective practice with families affected by domestic and family violence (DFV). The project focussed on a range of the NSW Health services, including participation from Department of Communities and Justice and local non-government organisations, with a focus on mental health, drugs and alcohol and violence abuse and neglect.

The *ESTIE Project* used action research methodology to simultaneously investigate and develop worker and organisational capacity to drive improvements in collaborative and holistic service provision for children and families living with domestic and family violence (DFV), alcohol and drug use (AOD) and or mental health (MH) issues. A particular interest area included where perpetrators use these issues as part of their coercive control. A key output of the project was development of the *ESTIE Practice Resource: Evidence based guidelines to support the implementation of the Safe & Together approach.*

Research aims and questions

The *ESTIE Project* had three primary aims:

I. Support an influential group of health workers within New South Wales to build capacity within their Local Health District (LHD) following the Safe & Together approach to DFV where there are complex issues of substance use and mental health, who can share their expertise with other workers and senior managers and thereby extend capacity building more widely across Violence, Abuse and Neglect, Alcohol and Other Drug and Mental Health services.

II. Provide research evidence of capacity building through the implementation of the *STACY Practice Guide* and Safe & Together Training.

III. Deliver updated guidance for practice with adult victims/survivors, children and perpetrators (including a section on documentation) where DFV is occurring in the context of AOD and/or MH issues.

The *ESTIE Project* continued the work of a series of projects involving the University of Melbourne research team led by Professor Cathy Humphreys, the Safe & Together Institute, and government departments in NSW. These include the *PATRICIA Project* (Humphreys et al, 2017); *Invisible Practices* (Healey et al, 2018) and *Safe & Together Addressing Complexity* (*the STACY Project)* (Humphreys et al, 2020). Each project sought to develop service capacity and build the evidence base for effective practice with families affected by domestic and family violence.

The *ESTIE Project* focused on the critical components of the Safe & Together™ Model, including how DFV intersects with AOD use and MH concerns. The *ESTIE Project* applied the Model to collaborative work across a range of sectors, with a focus on capacity-building through action research, highlighting the importance of 'practice led knowledge building' (Wagenaar & Cook, 2011). A further focus of attention lay in recognising intersectionalities, the role of structural imbalances in increasing vulnerability for victim-survivors, and perpetrator use of coercive control within the context of other forms of discrimination (Nixon & Humphreys, 2010).

Background

Working at the intersections

The frequency of co-occurrence of DFV with AOD use and MH concerns is well established in the literature (Gilchrist, Hegarty, Chondros, Herman, & Gunn, 2010; Mason & O'Rinn, 2014; Trevillion, Oram, Feder, & Howard, 2012). However, the ways in which perpetrators use AOD and/or MH concerns as a form of coercive control, and the implications for more integrated practice, have received little attention (Isobe, Healey & Humphreys, 2020).

In practice, due to the siloing of service responses, opportunities to respond to the compounding impacts of co-occurring issues is frequently missed (Yates, 2019). This highlights the importance of developing collaborative relationships across sectors (Macy & Goodbourn, 2012). There remains a need to identify appropriate interventions, and rectify the entrenchment of siloed practices that leads to the invisibility of domestically violent fathers, mother-blaming discourses of 'failure to protect' children, and the resultant endless spiralling between services for adult and child victim/survivors (Radcliffe & Gilchrist, 2016; Humphreys, Regan, River & Thiara, 2005; Frederico, Jackson & Dwyer, 2014). Communities of Practice have been highlighted as a promising facilitator of practice change with workers practising with families at the intersections of DFV, MH and AOD use (Heward-Belle et al., 2020).

The Safe & Together™ Model

Implementing the Safe & Together™ Model (the Model) into practice and organisational culture within the four participating LHDs, as part of the NSW Health system more broadly, was a major goal of the *ESTIE Project*. The Model includes a suite of tools that support workers to respond to and document DFV, alongside resources to facilitate broader organisational change and develop a 'shared language' that supports collaboration across organisations (Humphreys & Healey, 2017; Healey et al., 2018). The Model highlights the importance of an 'all-of-family' response to DFV (Mandel, 2009). The three key principles of Safe & Together are:

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

The Model focuses strongly on behaviours – actions and their impacts - going beyond 'incidents of violence' towards a behavioural, pattern-based approach to DFV.

Methodology

Research sites and participants

The academic research team, with Safe & Together consultants and representatives from the Ministry of Health collectively formed the partnership which guided the *ESTIE* research through a Steering Committee. Research sites were then established through an Expression of Interest process in four Local Health Districts in NSW: Northern NSW, Hunter New England, South Western Sydney, and Sydney. There were three key streams of participation:

- **Project Advisory Groups (PAGs)** comprised senior managers from participating services in each site as well as representatives from the Ministry of Health. Two PAGs were formed, one for regional NSW and one for metropolitan Sydney
- **Communities of Practice (CoP)** were established with senior health workers from a range of services within the LHD including Violence Abuse and Neglect Services, mental health, drug and alcohol and social work services. Key interagency partners were also invited to participate including the Department of Communities and Justice and non-government child protection services.

- **Influencees** were nominated by CoP participants as colleagues who could be influenced through sharing learning and championing good practice.

Capacity building component

The first aim of the *ESTIE Project* focused on building capacity by applying the Safe & Together approach to DFV where there are intersecting complex issues of AOD use and poor MH. The research team worked with two LHDs from January to June 2021, and with the other two LHDs from July to December 2021. The July to December round included support from the Aboriginal Cultural Safety Consultant following learning and feedback during the January to June round.

Capacity-building in each site involved:

- An engagement phase between the research team and project leaders within each LHD.
- Development of an authorising environment through the PAGs, each of which met three times throughout the project.
- A training phase, where CoP and PAG members were offered online modules through the Safe & Together Institute, followed by four consecutive half days of virtual training facilitated by Safe & Together Institute Consultants.
- A capacity-building phase, where virtual CoP meetings were convened to support participants to continue practice change through case discussions, coaching from the Safe & Together Institute Consultants, debriefing and reflection on change agent work, influencing and the use of the *STACY Practice Guide*. Each CoP met five times throughout the project.
- 'Socialising' the learning - knowledge translation beyond the *ESTIE Project* (and its predecessor *STACY*) to other stakeholders in NSW Health and the broader service system took the form of information sheets, newsletter articles practice tools and presentations at professional workshops and conference.

Research evidence and evaluation component

Research evidence and evaluation was informed by the broader Integrated Knowledge Management framework developed by Graham and colleagues (2006), and an action research approach that facilitated collaborative and iterative cycles of reflection and review. A mixed methods research methodology was

used to draw together qualitative and quantitative data drawn from several sources, collected during the research period (Creswell, Klassen, Plano Clark & Smith, 2011).

Data was drawn from several sources including Community of Practice and Focus Group notes, a case-file self-assessment exercise, and questionnaires for Community of Practice, Project Advisory Group, and Influencee participants. Research ethics approval was granted by the University of Melbourne (Reference number 2021-20554-13855-3) along with further approval through the Research Ethics and Governance Office within each LHD. AH&MRC ethics approval was not sought as the project did not meet thresholds specified by the AH&MRC.

ESTIE Practice Resource and ESTIE Quick Reference Guide

Two resources have been developed as part of the *ESTIE Project.* The *ESTIE Practice Resource* (the *Practice Resource*) is a comprehensive, evidence-based guide to support practice implementation of a domestic violence-informed approach (in this case, the Safe & Together™ Model). The *Practice Resource* builds on the existing *STACY Guidelines*, incorporating learnings from the *ESTIE Project*, and updating language used throughout the document to reflect the greater focus on the Health context and health workforce which was central to the *ESTIE Project*. The *Practice Resource* was developed through discussions with the Communities of Practice, Project Advisory Groups, Safe & Together Consultants, the Aboriginal Cultural Safety Consultant and researchers, and informed by existing literature and practice principles. The *ESTIE Quick Reference Guide* is a shorter summary document designed for client-facing workers practising at the intersections of DFV, MH and AOD use. It is relevant for those working in the broader health sector and in community organisations, and is applicable to both acute and longer-term therapeutic settings.

Key findings

The following key findings are drawn from the diverse data collected throughout the *ESTIE Project*, including the Community of Practice discussions, case-file self-assessments, participants surveys, and meetings of the Project Advisory Group. Analysis across these sources provided rich, multidimensional perspectives, with each data source informing the interpretation of the others.

Practice development

- Almost all Community of Practice participants (96%) reported that exposure to the Safe & Together™ Model during the *ESTIE Project* improved their practice.
- Practice changes were achieved across all *ESTIE* thematic areas including: identifying the perpetrators' pattern of coercive control and actions taken to harm the children; mapping the perpetrator pattern onto adult survivor's strengths and protective capacities; keeping a focus on children and young people; working safely; and working collaboratively.
- Documentation was the strongest area of practice change, with workers reporting that changing documentation was 'empowering' and a motivator for practice change in the face of complex and systemic barriers. The Safe & Together Perpetrator Mapping Tool in particular was identified as valuable in supporting domestic violence-informed documentation.
- An all-of-family approach involves 'bringing everyone into the room', keeping in mind all family members, particularly children and young people.
- Attention to cultural safety and an awareness of ongoing trauma from racism and colonisation is fundamental in practice with Aboriginal families.
- Dedicated tools, resources and guidelines supported the development of a shared language around DFV and its intersections with AOD use, MH concerns and other complexities.
- Effective practice was underpinned by a shift from focussing on single incidents or presentations, towards pattern-based mapping and understanding the 'fuller picture' and context for a family.

- Systems advocacy, navigation and collaboration were identified as important and integral parts of practice across a range of roles.
- Through practice-focused partnerships, the Safe & Together™ Model was applicable in diverse settings including regional and rural areas, acute care and long-term interventions, services for specific demographic such as younger people, and in policy settings.

Capacity building

- Capacity-building was enhanced when workers participated in training, followed by ongoing coaching, discussion, reflection, peer support and learning through Communities of Practice.
- Collaboration with an Aboriginal consultant and Aboriginal participants during the second stage of the *ESTIE Project* was crucial in responding to concerns about cultural safety and allowed for local cultural knowledge, understanding and voices to be brought into the project.
- Sustainable practice change required all levels of management to champion the change process and provide an authorising environment for workers to prioritise learning and development.
- Client-facing workers across a range of sectors required organisational authorisation to place a priority on DFV and identify broader family functioning as part of their 'core business'.
- Workers called for a 'culture of care' within their organisations, with regard to worker safety, navigating the dangers of holding perpetrators to account, and reducing the risks associated with systems manipulation.
- New practice models require support and 'socialisation' through existing relationships, champions and networks, and appropriate allocation of time and resources.

Conclusion and Next Steps

Among the many learnings and significant impacts from the *ESTIE Project*, a number of issues require attention in the future. These include:

- Effective documentation through organisational reform, specifically in the area of information technology and data management.
- Ongoing exploration of the relevance and applicability of the Safe & Together™ Model to culturally safe work with Aboriginal families.
- Further work at an organisational level to support worker physical, emotional and professional safety and understanding of systems manipulation by perpetrators.
- Increasing communication pathways between client-facing workers and managers
- Consideration of incorporating the *ESTIE Practice Resource* into further socialisation of practice change to maximise its value in informing practice at the intersections of DFV, AOD and MH, alongside the implementation of the Safe & Together™ Model more generally.
- Ongoing development of integrated practices and collaboration across DFV, AOD and MH services

The *ESTIE Project* findings add to the growing body of evidence that identifies a path to systems change that challenges the entrenched history of mother-blaming and promotes more just responses for women and children.

The findings of the *ESTIE Project* indicate that it addressed its aims, with many experienced DFV workers speaking enthusiastically about their learning associated with training and capacity building, supported by senior consultants from the Safe & Together Institute.

1. Introduction, background and research questions

1.1. Project aims

The *Evidence to support Safe & Together Implementation and Evaluation Project* (*ESTIE Project*) has continued the work of a series of projects that have sought to develop service capacity and build the evidence base for effective practice with families affected by domestic and family violence (DFV). These projects, involving the University of Melbourne research team led by Professor Cathy Humphreys, the Safe & Together Institute, and government departments in NSW, include the *PATRICIA Project* (Humphreys et al, 2017); *Invisible Practices* (Healey et al, 2018) and *Safe & Together Addressing Complexity* (the *STACY Project)* (Humphreys et al, 2020). Guidelines and practice tips have also been developed through these research projects (Humphreys & Healey, 2017; Healey et al., 2018; Humphreys, Healey & Mandel, 2018; Heward-Belle et al., 2020).

The *ESTIE Project* applies the Safe & Together™ Model to collaborative work across a range of sectors, with a focus on capacity-building through action research, highlighting the importance of 'practice led knowledge building' (Wagenaar & Cook, 2011). The *ESTIE Project* took an action research approach to simultaneously investigate and develop worker and organisational capacity to drive improvements in collaborative and holistic service provision for children and families living with domestic and family violence (DFV) where parental issues of mental health (MH) and/or alcohol and other drug use (AOD) co-occur. The *ESTIE Project's* primary focus was on services provided by NSW Health, but also included NGO and DCJ workers.

Building directly on the foundations provided by the *STACY* research, the *ESTIE Project* aimed to further the evidence base of this area of work through revising and extending the *STACY Practice Guide* and evaluating the capacity building model used in both the *STACY* and *ESTIE Projects*.

The *ESTIE Project* had three primary aims:

i. Support an influential group of health workers within New South Wales to build capacity within their Local Health District (LHD) following the Safe & Together approach to DFV where there are complex issues of substance use and mental health, who can share their expertise with other workers and senior manager and thereby extend capacity building more widely across Violence, Abuse and Neglect (VAN) services, drug and alcohol services and mental health services.

ii. Provide research evidence of capacity building through the implementation of the *STACY Practice Guide* and Safe & Together Training.

iii. Deliver updated guidance for practice with adult victims/survivors, children and perpetrators (including a section on documentation) where DFV is occurring in the context of AOD and/or mental health issues.

This report will begin by introducing the Safe & Together™ Model and the overarching research context and design. Chapter 2 will focus on the capacity building model used in *ESTIE*, including issues of engagement, cultural safety and the importance of the authorising environment. Chapter 3 will set out the research methodology that was used to evaluate the capacity building model and investigate elements of good collaborative practice at the intersection. Chapter 4 describes findings in relation to capacity building and practice change, while Chapter 5 details the research evidence emerging from the project about collaborative and holistic service provision for children and families at the intersections of DFV, substance use and mental health services. The focus of new evidence drawn from the *ESTIE* research includes documentation and worker safety. The major themes that have emerged from the *ESTIE* research are drawn together in Chapter 6.

1.2. Working at the intersections

The co-occurrence of DFV with other adult problems of substance misuse and mental health problems is well established in the literature (Gilchrist, Hegarty, Chondros, Herman, & Gunn, 2010; Mason & O'Rinn, 2014; Trevillion, Oram, Feder, & Howard, 2012). However, the ways in which perpetrators use drugs and alcohol and/or mental health problems as a form of coercive control, and the implications for more integrated practice, have received little attention (Isobe, Healey & Humphreys, 2020).

While there is considerable evidence about the negative impacts on women's mental health of DFV (Sidebotham & Retzer, 2018; Stewart & Vigod, 2019), engagement from mental health service providers in recognising its role in mental health difficulties, and responding to this issue, is still in its infancy. (Nyame et al., 2013; Trevillion et al., 2016; Humphreys & Thiara, 2003). Similarly, the intersections between substance use and DFV are often overlooked. Police data indicate that alcohol or other drugs are often used before incidents of DFV to which police are called (Yates, 2019). While heavy drinking by men increases the risk of violence (Gilchrist et al., 2019), many women use alcohol and other drugs to numb themselves from the pain caused by the abuse they live with (Devries et al., 2014; Humphreys & Thiara, 2003).

The impacts on children in any of these circumstances may be significant and cumulative. Research evidence confirms that children's distress is linked, not just with women's mental health problems, but also with the DFV they may both be experiencing. Parental substance use is one of the most common reasons for placing children in care (Canfield et al., 2017), and the fear of disclosing domestic and family violence or mental health problems or substance use is compounded by the fear of child removal or of not being believed (Macy et al., 2013), particularly for Aboriginal mothers (Andrews et al., 2021).

Service responses for families living with domestic and family violence, where there are co-occurring problems associated with parental substance use and/or mental health problems, continue to be siloed, with differences in approach and client focus between service sectors. An awareness of the impact of DFV on issues such as substance use and mental health difficulties is not yet integrated into practice in these sectors or into child protection practice (Isobe et al., 2020). Further, children remain relatively unseen in adult mental health (Tchernegovski et al., 2018) and substance use services (Battams & Roche, 2011), as well as in specialist DFV services. In child-focussed services, risks for children are often framed with a focus on mothers' problems, rather than a recognition of the impact on both of DFV (Isobe et al., 2020).

There is a need to identify appropriate interventions, and rectify the entrenchment of practice that leads to the invisibility of domestically violent fathers, mother-blaming discourses for 'failure to protect' children, and endless spiralling between services for adult and child victim/survivors as a result (Radcliffe & Gilchrist, 2016; Humphreys, Regan, River & Thiara, 2005; Frederico, Jackson & Dwyer, 2014).

Siloed service responses miss the opportunity to effectively respond to the compounding impacts of co-occurring issues (Yates, 2019), highlighting the importance of developing collaborative relationships across sectors (Macy & Goodbourn, 2012). However, barriers to collaborative work are created by differences in organizational cultures, practice frameworks, policy guidance and legislation that configure each service (Isobe et al., 2020). Multiple strategies are required to overcome the siloing of service responses and enable collaborative practice, such as interagency events, collaborative case reviews, face-to-face discussion, and informal interactions, protocols, policies and practice guides, and importantly, leadership to create an authorising environment (Macy & Goodbourn, 2012; Isobe et al., 2020).

The *ESTIE Project* has explored best practice at these intersections, and also brought together a number of these strategies, through Communities of Practice involving professionals from multiple service sectors, a management group to inform leaders so that they could support and authorise *ESTIE* activities, and the development of practice guidance. Sustainable practice change has been a focus, with participants encouraged to become change agents, passing on their learning to colleagues. Communities of Practice

were highlighted as a promising facilitator of practice change with workers practising with families at the intersections of domestic and family violence, mental health and substance use (Heward-Belle et al., 2020).

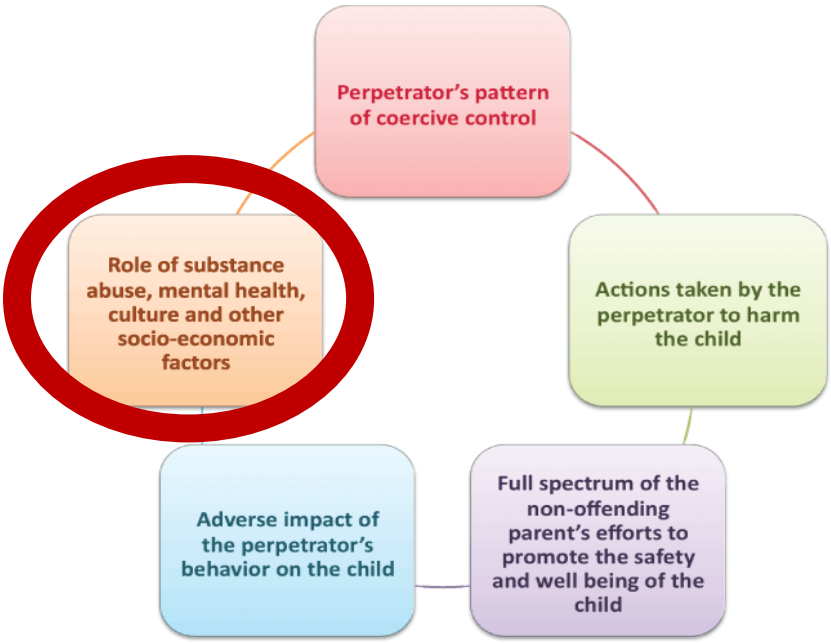
1.3. The Safe & Together™ Model

Implementing the Safe & Together™ Model (the Model) into practice and organisational culture within the four participating LHDs, as part of the NSW Health system more broadly, was a major goal of the *ESTIE Project*. The Model's primary appeal lies in its applicability to working with families where there are complex, intersecting issues, and in the provision of a helpful language, vision and practice tools to support collaborative working across diverse statutory and non-statutory organisations (Humphreys & Healey, 2017; Healey et al., 2018). The Model highlights an 'all-of-family' response which stresses the importance of addressing the needs, support and/or accountability of each family member (Mandel, 2009). The framework promotes the visibility of men as fathers, and focuses attention on supporting children and their mothers. A feminist perspective and Intersectionality are also critical to the conceptualisation and therefore the response to DFV.

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

The Safe & Together™ Model sets out a set of basic principles and critical components creating a framework with a shared language that can support collaboration across different organisations engaged in responding to children living with DFV. The Principles (Figure 1) stress the goals of keeping children safe with their non-abusive parent (usually their mother) as the first principle. This principle leads into the second principle which involves partnering with the non-abusive parent as the foundation from which children are protected. Thirdly, keeping the perpetrator visible as the source of risk and harm to children requires engagement with the person using violence and coercive control where this is safe and practical. Holding perpetrators accountable also involves working within established systems, including details of perpetrator patterns of abusive behaviour in case documentation, collaborative working across programs and services, and the justice system. In practice and philosophy, the Model represents a child-focussed, ethical and complex system intervention which is explicit in situating worker DFV skill enhancement alongside organisational change.

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



While the principles provide the foundations for the conceptual model, the Critical Components (Figure 2) provide more detailed guidance for practices. The first step is always to understand (and document) the pattern of coercive control used by the person using violence. In this sense, the Model is strongly behaviourally based, going beyond 'an incident of violence' to carefully map the range of strategies that are being deployed to establish control by one person over another. In the Model, there is particular emphasis on understanding the range of actions that harm the child. Some of these will be direct abuse or neglect, others will be indirect through undermining the child's relationship with their mother or other family members and community networks.

The first steps focus on the actions of the person using coercive control, while the next critical component focus on the non-offending parent (usually the mother) and the steps they have undertaken to protect both themselves and their children. The Model challenges gender bias in practice by providing a framework for detailing how harms to children are linked back to the behaviours of the perpetrator, usually the father. In addition, by giving mothers credit for a wider range of protective actions; (for example, not just calling the police but also keeping children in school despite the violence) the Model provides guidance for actively moving away from mother-blaming towards a partnership between worker and adult victim/survivor. From this position of partnership, a relationship is developed that is more conducive to exploring the impact of the perpetrator's behaviour on the child.

The Safe & Together Model supports culturally safe work by offering a pathway to value protective efforts that don't engage mainstream services, recognising that that First Nations people often experience these services as unsafe. The Model also values the role of fathers in the functioning of the family, which is important to many collectivist communities, and often ignored by mainstream DFV interventions.

The final critical component, and the one that was the focus of the *ESTIE Project*, recognises that DFV rarely occurs alone, but often co-occurs with mental health and substance use problems, either for the victim/survivor or the perpetrator of abuse. Recent iterations of the Model look beyond a co-occurrence of these problems in families, to actively explore substance use and/or mental health coercion (Heward-Belle et al, 2022). This process pays attention to the ways in which the perpetrator uses their own poor mental health, such as threatening suicide as a tactic of control. Further, the perpetrator's actions may cause issues for the victim/survivor, exacerbate them or interfere with her attempts to address them – for example, abusing her as a bad mother for being depressed, threatening to call child protection about her mental

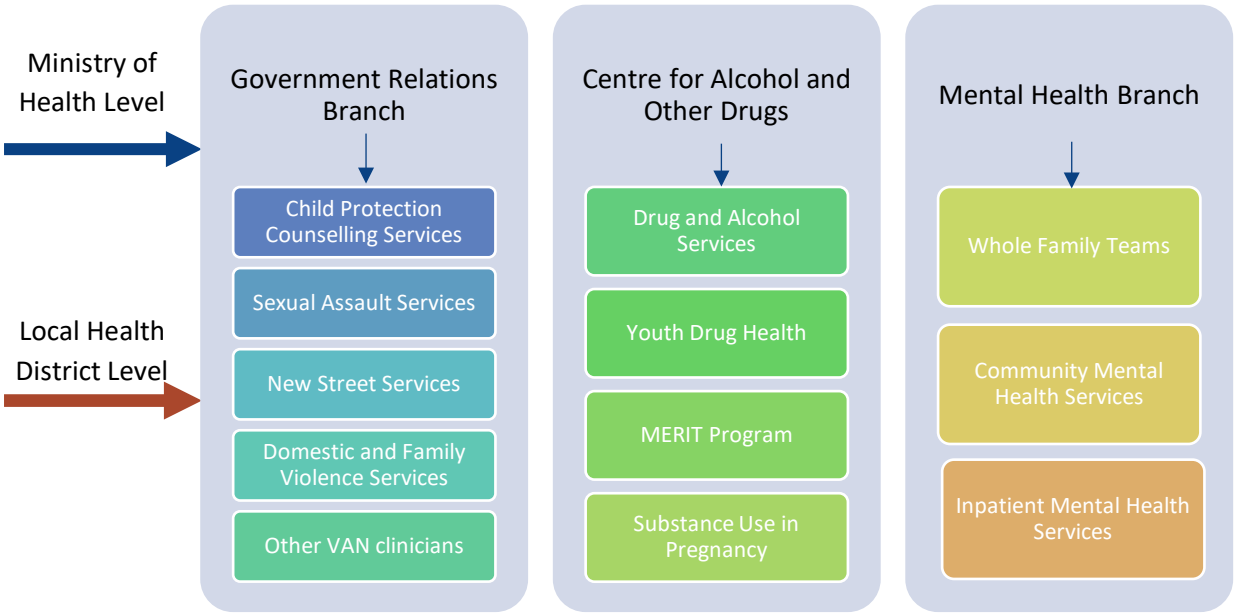
health problems, tampering with her medication, or preventing her from attending appointments. Similar strategies of coercion are also used in relation to alcohol and other drugs (AOD).

Intersectionality and the recognition of the increased vulnerability of both adult and child victim/survivors when structural power imbalances are present, raise further complexities for practice. Examples include the multiple harms caused by the ongoing trauma of colonisation (Andrews, Hamilton & Humphreys, 2021), the tightly circumscribed actions available to women and their children when visas are dependent upon their abusive partner (Segrave, Wickes & Kell, 2021) and the vulnerability of women with disabilities whose partner weaponises her disabilities against her, and there are many more. Poverty may overlay all forms of structural discrimination, circumscribing further the lives of adult and child victim/survivors (Summers, 2022). These examples highlight the importance of understanding intersectionality and the diverse ways in which coercive control can be exercised in the context of other forms of discrimination (Nixon & Humphreys, 2010).

1.4. The NSW Context

The NSW Ministry of Health supports the executive and statutory roles of the Health Cluster and Portfolio Ministers. The NSW Ministry of Health also has the role of 'system manager' in relation to the NSW public health system, which operates public hospitals, as well as providing community health and other public health services through a network of **Local Health Districts (LHDs)**, specialty health networks and affiliated health organisations, known collectively as NSW Health[1]. NSW Health operates as a decentralised system with strategic, clinical, and operational responsibilities cascading from NSW Ministry of Health branches and intersecting differently in each LHD. The ESTIE Project included involvement from both strategically and operationally oriented branches of NSW Health, including the **Government Relations Branch** (PARVAN Unit), and **Mental health Branch** (under the Health System and Strategy Division), and the **Centre for Alcohol and Other Drugs** (under the Population and Public Health Division). These NSW Ministry of Health branches engage and work with each LHD to enable service provision, and in the ESTIE Project, included services as shown in Figure 3:

Figure 3: Ministry of Health branches and LHD level services engaged in the ESTIE Project



[1] For information about NSW Health, visit https://www.health.nsw.gov.au/about/nswhealth/Pages/structure.aspx

The role of the Prevention and Response to Violence Abuse and Neglect (PARVAN) Unit

The funding body, the Prevention and Response to Violence Abuse and Neglect (PARVAN) Unit, Government Relations Branch, NSW Ministry of Health, aims to ensure NSW Health delivers services to children, young people and adults who are victim/survivors of violence, abuse and neglect based on evidence and by providing culturally safe and trauma informed responses. PARVAN supports and drives NSW Health policy and practice priorities in relation to the prevention, identification, response to: domestic and family violence, Aboriginal family violence, adult and child sexual assault, child physical and emotional abuse and neglect, other child wellbeing concerns, working with adult victim/survivors of child sexual assault, children and young people with problematic or harmful sexual behaviours, and medical and forensic examinations relating to sexual assault, child protection or domestic and family violence.

PARVAN Redesign

Currently, PARVAN are undertaking the Violence, Abuse and Neglect (VAN) Redesign Program which aims to enhance the capacity of the public health system to provide 24-hour, trauma-informed and trauma-specific, integrated psychosocial, medical and forensic responses to sexual assault, child physical abuse and neglect, and domestic and family violence presentations. A key component of the redesign is *the Integrated Prevention and Response to Violence, Abuse and Neglect Framework.* The framework focuses on the system, service, practice and workforce to support responses for victim/survivors and families. The framework's four key objectives are to:

- strengthen leadership, governance and accountability;
- enhance the skills, capabilities and confidence of the Health workforce;
- expand violence, abuse and neglect services to ensure they are coordinated, integrated and comprehensive;
- extend the foundations for integration across the whole NSW Health system.

The *ESTIE Project* aligns with the framework's four key objectives as it aims to support and enhance leadership through building stronger authorising environments, build capacity and enhance skills of workers through training and communities of practice, and it supports collaborative and integrative practices across the service sectors responding to domestic and family violence.

NSW Health priorities

In addition to being aligned with the IPARVAN framework, the *ESTIE Project* aligns with the values and priorities of NSW Health including:

- The NSW Premier's Priorities: 'Reducing domestic violence reoffending' and 'Protecting our kids'
- The National Plan to Reduce Violence against Women and their Children 2010-2022
- The NSW Domestic and Family Violence Blueprint for Reform 2016-2021
- NSW Health Domestic and Family Violence Strategy 2020-2025

Interagency Partners

Alongside workers from NSW Health services, participants in the *ESTIE Project* included representatives from the Department of Communities and Justice, Non-Government Child Protection services, and other Non-Government Organisations including services supporting Aboriginal communities.

1.5. Research Design and questions

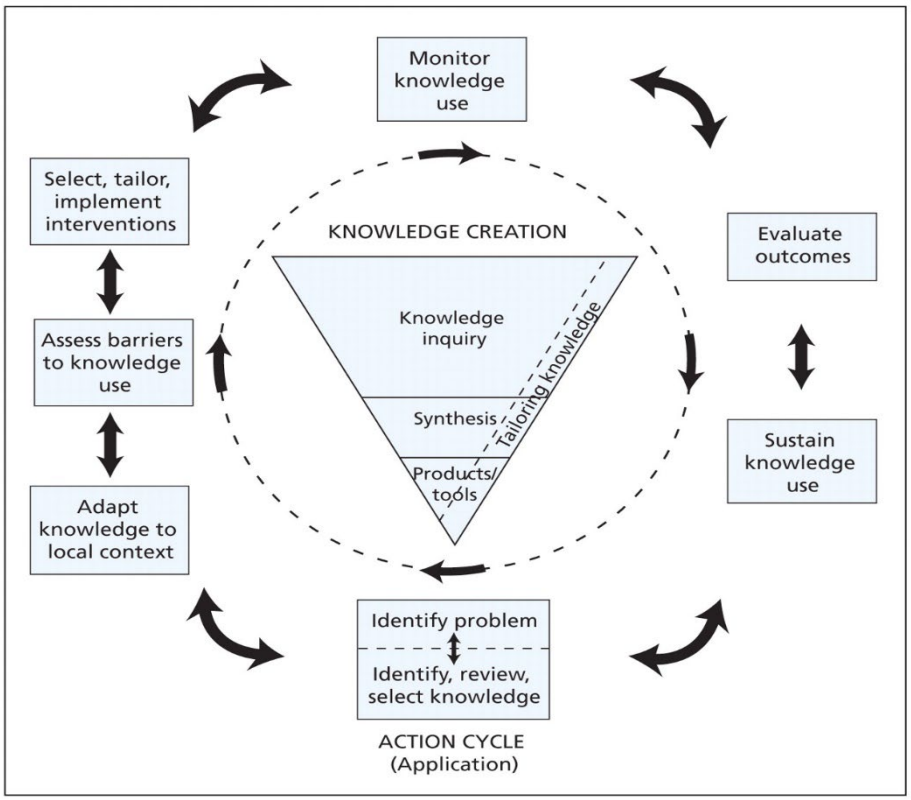
The *ESTIE Project* research questions were as follows:

1. What evidence is there that capacity building through the Community of Practice Model, supported by coaching and supervision from Safe & Together Institute consultants:
    - enables workers and organisations to embed the *STACY Guide* into policy and practice?
    - enables case and other documentation which maps perpetrator patterns, and records the strengths and needs of the non-offending parent and children?
    - increases worker skills and confidence in working effectively at the intersections of DFV, AOD and MH?
2. What do workers require from their organisations and/or other organisations to support them in practising effectively at the intersections of DFV, AOD and MH?

The *ESTIE Project* combined strategies for inquiry (building the evidence base through research and learning activities) and strategies for development/capacity building (practice and action). The project design is grounded in several frameworks.

In developing practice capacity in a workforce drawn from diverse professional backgrounds and roles, the research team drew on Wagenaar's and Cook's (2011) assertion that 'practice is prior to and generative of knowledge' (p.208). Within the complex context of NSW, with multiple legislative, policy and practice frameworks, a range of factors influence how organisations (and therefore health workers) respond to service users and other organisations. These include formal guidance, legislation, documentation conventions, practice protocols, norms and cultures. Improving practice was therefore a complex process that required participation from multiple actors, including client-facing workers, managers, policy workers and research academics.

Figure 4: The knowledge-to-action framework



In addition to capacity building, the research team aimed to further understand and build evidence for the *ESTIE* capacity building model, with particular reference to the use and implementation of practice guidelines and to DFV-informed casework and other documentation. The Integrated Knowledge Management framework (Figure 4) developed by Graham and colleagues (Graham & Tetroe, 2006; Straus et al, 2009) is an approach which highlights the complementary expertise – knowledge and skills - of academic researchers and 'knowledge users'. In this project this refers to stakeholders at all levels of the NSW health service system, from client-facing workers to senior management. This type of worker-led research involves participants being actively engaged in the planning, governance and the conduct of the research (Graham, Kothari & McCutcheon, 2018).

The action research and capacity building model for workers and their organisations implemented for this project was grounded in these approaches, and refined following its trial in the *Invisible Practices Project: Interventions with fathers who use violence*, and the *STACY Project*: *Safe and Together Addressing ComplexitY*. In this model, collaborative and iterative cycles of reflection and review enabled simultaneous contribution to evidence gathering and practice change (Ison, 2008). Further details of the research and capacity-building methodologies can be found later in this report.

1.6. The Research Partnership

Consistent with the approach of a research partnership between the academic research team, the funding body, and other participants and 'knowledge users', the identity and role of these groups are summarised here.

1.6.1. ESTIE Research Team

The *ESTIE Project* was carried out by an interdisciplinary team of researchers based in Sydney, NSW and the University of Melbourne, VIC. The research team also included David Mandel, Director of the Safe & Together Institute, enabling strong collaboration and planning with the Institute based in the US. The *ESTIE* research team met every fortnight via Zoom for the duration of the project, at a minimum, and more often when necessary.

Master of Social Work placement students

In 2020 and 2021, the *ESTIE Project* was supported by four Master of Social Work students who undertook their field placements with the *ESTIE* research team through the University of Melbourne. Two students completed placement between October and December, 2020, and two between June and August, 2021.

The 2020 students were supported to conduct a small follow up study with participants from the *STACY Project*, 12 months following their participation in the Communities of Practice in 2019. This study focused on collecting insights on the sustainability of practice change occurring as a result of participation in the *STACY Project*, and contributed to informing the *ESTIE Project*. A briefing paper (Isobe, Watson, So, Links & Kertesz, 2021) was published by the University of Melbourne based on this study, and supported the development and initial engagement for the *ESTIE Project*.

The 2021 students were generously supported by NSW Health to participate in the Safe & Together virtual training in July. The value in training the students in the Safe & Together™ Model as part of their placement has been recognised as contributing towards their future as domestic violence-informed workers.

1.6.2. ESTIE Steering Committee

The *ESTIE* Steering Committee consisted of the *ESTIE* research team and senior PARVAN representatives. Initial project planning meetings were held in the final months of 2020, with formal Steering Committee meetings scheduled regularly throughout 2021 and 2022. In addition, informal discussions were held when necessary to support communication with the LHDs, fine-tuning of project issues, and facilitate publicity for the project. Meeting dates can be found in Table 1.

Table 1: ESTIE Steering Committee meeting dates, 2020 - 2022

Meeting type	Dates	
Project planning meeting, UoM and MoH, 2020	September 2, 2020	September 30, 2020
ESTIE Steering Committee meetings, 2020	October 27, 2020	December 2, 2020
ESTIE Steering Committee meetings, 2021	February 24, 2021 April 27, 2021 May 25, 2021	August 12, 2021 September 24, 2021 November 26, 2021
ESTIE Steering Committee meetings, 2022	February 15, 2022 May 13, 2022	June 22, 2022 August 4, 2022

1.6.3. Practice partners and research sites

Practice and research partners in the *ESTIE Project* included senior health workers and their managers, working in a range of services within four Local Health Districts in NSW. In October 2020, the NSW Ministry of Health (Prevention and Response to Violence, Abuse and Neglect (PARVAN) Unit, Government Relations Branch), in conjunction with the University of Melbourne, called for Expressions of Interest (EOI) from Local Health Districts to participate in the *ESTIE Project*.

Applicants were asked to identify a key violence, abuse and neglect (VAN) service or site within the LHD, which was engaging with families experiencing DFV where there were additional complexities relating to MH and/or AOD issues and was interested in building practice change in this area. Applicants were also asked to identify other services within the LHD where there were established working relationships, or a commitment to developing strong working relationships. It was required that one of the services should be either a Mental Health or an Alcohol and Other Drug Service, but other participating services could include other VAN, MH services, AOD services, other parts of NSW Health, community-controlled health services, non-government organisations and other government agencies such as the Department of Communities and Justice (child protection). Strong representation from Aboriginal services in the LHD was stated as desirable.

Applications from seven LHDs were received in December 2020 – four from metropolitan areas, and two from regional NSW. In addition to assessing applications on the published selection criteria, the selection committee aimed to support involvement from LHDs both in metropolitan Sydney and in regional NSW. The four LHDS who participated in *ESTIE* are listed in Table 2.

Table 2: LHD participation in ESTIE

Round 1: February to June 2021	Round 2: July to November 2021
Hunter New England	South Western Sydney
Northern New South Wales	Sydney

Northern NSW Local Health District (NNSWLHD) is a regional LHD and covers a large area in north-eastern NSW extending from Tweed Heads in the north to Tabulam and Urbenville in the west and to Nymboida and Grafton in the south, an area of 20,732 square kilometres. The estimated population within NNSWLHD is 288,241. Traditional custodians of the land include Bundjalung, Yaegl, Gumbaynggirr and Githabul peoples, and people of Aboriginal and Torres Strait Islander heritage make up 4.5 per cent of the population in Northern NSW compared to 2.9 per cent for all NSW.

Hunter New England Local Health District (HNELHD), also a regional LHD, covers a region of 131,785 square kilometres. It encompasses a major metropolitan centre, regional communities, with a small percentage of people located in remote communities. The estimated resident population in 2021 was 920,370 people. Overall, the population is experiencing rapid growth and ageing, although several local areas are experiencing depopulation. Kamilaroi, Gomilaroi, Geawegal, Bahtabah, Thungutti, Awabakal, Aniawan, Biripi, Worimi, Nganyaywana, Wonnarua, Banbai, Ngoorabul, Bundjalung, Yallaroi and Darkinung peoples are the traditional custodians of the land in HNE, and Aboriginal and Torres Strait Islander people make up 5.9 per cent of the population.

South Western Sydney Local Health District (SWSLHD) looks after all public hospitals and healthcare facilities in south western Sydney from Bankstown to Bowral. SWSLHD covers seven local government areas from Bankstown to Wingecarribee and has a population of approximately 966,450 people. The District also operates 14 major community health centres providing prevention, early intervention and community-based treatment, palliative care and rehabilitation services. The traditional custodians are the Cabrogal clan of the Darug Nation and peoples of the Dharawal and Gundungurra Nations.

Sydney Local Health District (SLHD) is responsible for providing health care services to more than 700,000 people living in the centre and inner west of Sydney and beyond. The District is home to large hospitals including Royal Price Alfred, Concord, Canterbury, Balmain hospitals, and the Sydney Dental Hospital as well as a range of integrated healthcare services including community health, mental health, drug and alcohol and aged care services. The traditional custodians of the lands in SLHD are the Gadigal, Bediagal and Wangal peoples of the Eora Nation.

Figure 5: ESTIE Project structure

Figure 5 illustrates how participation in the *ESTIE* capacity building and action research was structured. The academic research team, with Safe & Together consultants and representatives from the Ministry of Health collectively formed the partnership which guided the *ESTIE* research. Two Project Advisory Groups were convened, one in regional NSW and one in metropolitan Sydney, comprising senior managers from services and organisations participating in the *ESTIE Project* as well as representatives from the Ministry of Health. These health workers (senior client-facing workers or practice leaders) from each participating service in each LHD participated in a Community of Practice (CoP), and then individually selected a further group of health workers (influencees) whom they 'influenced' through sharing their learning.

1.7. Limitations

There were a number of limitations of the *ESTIE Project*, and its two main components of capacity building and generating research evidence, that are worth noting. While the Community of Practice methodology and associated capacity building and research activities were appropriate to the broad aims of the project, the approach has limitations in managing the needs of specific individuals within the Communities of Practice, and in collecting detailed information about certain groups unless discussion is specifically focused and guided.

Engagement with the first two LHDs at the end of 2020 and beginning of 2021 was time pressured, and the relationships between the research team and participating PAG and CoP members would have benefitted from longer initial engagement periods. This was taken into consideration in the second half of 2021 with the two metropolitan LHDs.

While cultural safety considerations were built into the *ESTIE Project* design from the outset, the initial six months of CoP sessions were limited by the lack of cultural consultancy and supervision provided by Marlene Lauw in the second half of 2021.

The research evidence component of the *ESTIE Project* is limited in that sample sizes are small. This was primarily due to the disruptions, pressures and impacts of the COVID-19 pandemic. Participants faced iterative waves of COVID-19 infection and lockdowns, staff redeployments and high workloads throughout the duration of the project, impacting on their ability to engage with the research activities. In addition, the NSW Health context was further pressured due to natural disasters in 2021, including significant flooding and access issues, particularly in regional areas, resulting in further strain on staff as the health system responded to these crises. It is a testament to participants' dedication to practice improvement and capacity building that the Safe & Together training and CoP sessions were well attended, and participants highly engaged when able to attend.

The *ESTIE Project* was also limited in that it did not directly include voices of victim/survivors and clients of the participating services within each LHD. The initial design of the project aimed to achieve this, however due to the COVID-19 pandemic, natural disasters and strain on the workforce, it was agreed between the research team and the Project Advisory Group not to pursue this aspect of the project.

2. Capacity-building component

2.1. Overview

The first aim of the *ESTIE Project* focused on building capacity by applying the Safe & Together approach to DFV where there are complex issues of AOD and mental health. This section of the report describes the activities conducted by the project team to build capacity across VAN, AOD and MH services within participating LHDs.

The research team worked with two LHDs from January to June, and with the other two LHDs from July to December 2021. Each of these two stages of the project involved an engagement phase, a training phase, and a capacity building phase, in which the Communities of Practice met five times, influencing work commenced, and the Project Advisory Group met three times.

In accordance with the action research cycle of the knowledge-to-action framework discussed in Chapter 1, the capacity building activities were developed and adapted by the research team over the duration of the project, in response to discussions with ESTIE Project participants and with the project steering committee.

The *ESTIE Project* coincided with the considerable disruption to work and personal lives caused by the COVID-19 pandemic and by local crises such as major flooding in the Lismore area. Heavy workloads and emergency secondments had a significant impact on the ability of many health workers to attend and complete project activities, regardless of their position and seniority. However, the project team encountered considerable enthusiasm about the opportunities offered by *ESTIE* from those who were able to participate, including client-facing health workers, managers within LHDS, and several Ministry of Health representatives.

2.2. Engagement

Following the selection of participating LHDs in December 2020, the research team met with project leaders within the two regional LHDs in late December and several times during January 2021, to introduce and discuss the research. The research team supported LHD representatives to engage with the range of services identified in their Expression of Interest, with the aim of building collaborative partnerships through participation in *ESTIE*. The constellation of services varied between LHDs, but aimed to include VAN services, drug and alcohol services, mental health services and child protection services. Once services were engaged, individuals were identified by the LHD project leaders who were able to make the necessary time commitment to participate.

During this engagement period, the research team sought permission to conduct the research component of *ESTIE* within each LHD. This process was separate from the application for ethics approval (see section 3.2) and was different for each LHD particularly given the diversity in cross-sector involvement. It included, for example, completing access requests and/or site permissions, and acknowledgement from the LHDs of the University of Melbourne Research Ethics approval. The project team also supported individual participants to register with the Safe & Together Institute in order to be eligible for the initial training provided.

Experience demonstrated that these engagement activities added up to a complex and time-consuming set of tasks for LHD participants. For professionals more familiar with conventional research methods, the project's approach of combining capacity building with knowledge translation and practice-led research was initially difficult to grasp. The restrictions imposed by state governments due to the COVID pandemic resulted in all meetings and project activities being conducted via videoconference.

Due to research timeline imperatives, the engagement phase for the first stage was restricted to a short period from late December 2020 to early February 2021, coinciding with summer leave being taken at

different times by research team members and LHD representatives, and resulting in limited opportunities for the research team to meet and support LHD project leaders.

Following reflection on the difficulties of the engagement phase, the research team made a number of adaptations in order to better support and prepare representatives of the LHDs participating in the second stage of the project, from July to December 2021. Introductory meetings commenced in April, to allow LHD project leaders more time to understand the project and engage services and workers. This longer period leading into the professional learning phase also facilitated the development of constructive relationships between the research team and the LHD leaders.

Further, a preliminary Project Advisory Group meeting was scheduled in June 2021, prior to the training phase, to introduce the project to the broader group of managers who were responsible for supporting the project and enabling client-facing health workers to participate. In addition, the research team revised its documentation, creating several guidance documents which separately explained the professional learning activities and the research activities (see Appendix 8.2 for *ESTIE Project* Activities outline document).

2.3. Cultural safety and representation of Aboriginal People

The Safe & Together™ Model was developed in the United States, incorporating discussion of colonisation and anti-racism at a universal level into training, tools and resource materials. Due to the broad and diverse NSW Health workforce, project design for the *ESTIE Project* took a generalist approach in the first instance, with a view to including but not specifically focussing on the experience and input of First Nations health workers.

Given the research aims and that the *ESTIE Project* focused on professional development of staff and services, the project was deemed not to meet the criteria above for submission to the AH&MRC (see Section 3.2 for further detail on ethics permissions). This decision was informed through consultation with senior NSW Health leadership across PARVAN and the Centre for Aboriginal Health.

The research team aimed to engage Aboriginal health workers in the project at all levels through:

- preliminary discussions with Aboriginal managers in each LHD during the engagement phase,
- ensuring that cultural issues were visible and discussed in the CoP and PAG meetings,
- conscious support of Aboriginal participants.

However, during the first professional learning stage of the project (February to June 2021), concerns around cultural safety were identified, particularly relating to the format of the CoP sessions.

As with all participants in the project, Aboriginal participants were able to withdraw both their participation and data from the project. Participants who did not wish to continue their participation due to cultural safety concerns were supported to withdraw from the project. Any data from participants who chose to withdraw from the capacity building and/or research component of the project were deleted, including notes taken during participation in the CoP discussions, completed self-assessment case files and influencee lists.

The withdrawal of Aboriginal participants from the first professional learning stage of the project may have limited the ability of the project to consider the Safe & Together™ Model in the context of Aboriginal people's experiences and cultures.

The concerns raised in relation to cultural safety were discussed and reflected on at length by the research team in collaboration with the Steering Committee. Cultural supervision was also sought by the research team, with participation from the Safe & Together Institute. To improve cultural safety, the following adaptations were made to the implementation of *ESTIE* in the second stage from July to December 2021.

- Greater efforts were made to communicate to all participants that Aboriginal participants were not expected to fill the gaps in understanding about how the Safe & Together™ Model intersects with Aboriginal frameworks and principles. It was made explicit in meetings and written communications to all *ESTIE* participants that establishing cultural safety and creating an

environment where trust can be developed is the responsibility of all health workers, researchers and participants, not the responsibility of Aboriginal people.

- An Aboriginal consultant was appointed to the research team to provide ongoing cultural advice in the implementation of the project and the production of project outputs, such as practice guidelines. Marlene Lauw, the Aboriginal consultant engaged, is a Wiradjuri and Ngunnawal woman with specialised skills and knowledge in competency-based training, supervision, and workforce development. She has extensive experience in the NSW Health system, and expertise in work addressing domestic and family violence and abuse.
- The Aboriginal consultant co-facilitated CoP meetings and attended PAG meetings, supporting a more culturally safe space and providing insight into relevant key issues for Aboriginal families and communities. Marlene Lauw's presence and expertise not only supported collaboration and safety, but better promoted active participation from non-Aboriginal participants to reflect on their engagement and behaviours in order to prioritise establishing trust and strong relationships with First Nations colleagues.
- The Aboriginal consultant was instrumental in engaging and supporting Aboriginal workers through the second stage of *ESTIE*. In line with the importance of relationship-based work in Aboriginal cultures, she provided support to Aboriginal participants before, during and after all *ESTIE* activities.

These adjustments to the design and implementation of the *ESTIE Project*, and particularly the collaboration with Marlene Lauw, have informed the whole approach of the project following her engagement. For example:

- The tone and atmosphere of CoP meetings differed significantly.
- First Nation's voices were embedded in all of the work: documentation, programs, and practice with families.
- Learnings relating to cultural safety were fed directly back to both the research team and the Safe & Together Institute.
- Respect for participants' cultures was further highlighted and prioritised through a spirit of reflection, learning and feedback.
- Non-Aboriginal CoP members from the first stage of the project actively sought feedback about how they could improve their own practice following cultural safety concerns being raised.

Collaboration with Aboriginal participants allowed for local cultural knowledge, understanding and voices to be brought into the Community of Practice and led to the development of shared learning and connection. The concerns and reflective learning process undertaken throughout the *ESTIE Project* have been documented and will inform future collaboration, engagement, implementation, and practical work.

As a direct outcome of these processes and learnings, the Ministry of Health has funded Aboriginal-co-led research to explore how the Safe & Together™ Model, as an all of family approach, intersects with local Aboriginal healing frameworks and principles.

2.4. Developing an authorising environment: Project Advisory Group

Evidence from earlier research (Healey et al., 2020;) indicates the importance of promoting practice change not just with client-facing workers but also at leadership levels – a top down and bottom-up approach. An authorising environment provided by leadership within and across services can take the form of organisational policies and procedures, adequate and sustainable program resourcing, system level policy and legislation, management expertise and support, attention to culturally safe practices, and to the safety needs of the workforce, DFV-informed theoretical practice frameworks, and workplace cultures that encourage collaboration and information-sharing with regard to all members of families affected by DFV (Kertesz et al., 2022).

In the context of the NSW Health system, the *ESTIE Project* team considered several layers of authorising environment. First, the Steering Committee included both senior executives of PARVAN and the research team, and met regularly to guide the project. Secondly, the Project Advisory Group (PAG) included senior managers from each LHD, senior executives from PARVAN and members of the research team. It was established to create an authorising environment for practice change emerging from the *ESTIE Project*. PAG members were responsible for: providing an authorising environment in which Community of Practice (CoP) participants were able to fully participate in the research; supporting the work of CoP members as change agents within the organisation and across the relevant multi-agency networks; providing information and advice on the development of the workshop themes; reflecting and advising on implications of practice and policy issues arising from the research project; providing potential networking links relevant to the project's progress; acting as a problem-solving forum to address issues arising from the research project; and promoting the work of the project and its outcomes.

Table 3: Project Advisory Group meeting dates 2021

Regional Project Advisory Group Meetings	Metropolitan Project Advisory Group Meetings
11 March 2021 4 May 2021 8 June 2021	24 June 2021 (Information session) 25 August 2021 13 October 2021 9 December 2021

2.5. Safe & Together virtual training

In order to provide a foundational shared knowledge base for *ESTIE* professional learning activities, CoP and PAG members were encouraged to complete three online e-learning modules offered by the Safe & Together Institute: 1) *Safe & Together:* An *Introduction to the Model,* 2) *Multiple Pathways to Harm: A Comprehensive Assessment Framework;* and 3) *Intersections: When Domestic Violence Perpetration, Substance Abuse, and Mental Health Meet.* These modules were made available to all *ESTIE* participants, including the CoP and PAG members and influencees.

CoP members were then required to attend four consecutive half days of training, conducted via videoconference. While the training was compulsory for Community of Practice members, Project Advisory Group members were also encouraged to attend to strengthen their understanding of domestic and family violence-informed practice and support the development of an authorising environment for the Safe & Together™ Model that their CoP members would be working with. In addition, a small number of 'training only participants' were supported by the NSW Ministry of Health to attend.

Two rounds of Safe & Together training were conducted in 2021, with one training group for each LHD. Each training group was facilitated by a Safe & Together consultant supported by members of the research team who would be working with each LHD respectively. Virtual training for the regional LHDs was conducted in February 2021, and for the metropolitan LHDs in July 2021. The mix of attendees consisted of Community of Practice, Project Advisory Group and training only participants.

Each group was facilitated and supported in a similar manner. However, the metropolitan training sessions incorporated adaptations based on feedback from the first *ESTIE* stage. These included elements of facilitation regarding cultural safety, discussion formats and practical exercises. Marlene Lauw co-facilitated sections focused on cultural issues and provided additional support to Aboriginal participants taking part.

Table 4: Round 1 Safe & Together virtual training attendees

Participants	Round 1 Feb 2 – 5	Round 1 Feb 9 – 12	Round 2 July 13 – 16	Round 2 July 20 – 23
Community of Practice members	22	13	23	26
Project Advisory Group members	8	2	4	11
Training only participants	3	4	1	6*
Total participants for training group	33	19	28	43
Average attendance across training days	30	18	24	39

*Training only participants for the July 20 – 23 training group included three Community of Practice members that following the training participated in the LHD that trained between July 13 – 16, 2021.

Table 5: Cross-sector attendance at the Safe & Together virtual training Rounds 1 and 2

Training rounds 2021	R1 Feb 2 – 5	R1 Feb 9 – 12	R2 July 13 - 16	R2 July 20 - 23	Totals
Drug and Alcohol Services	3	1	5	11	**20**
Statutory Child Protection	2		1		**3**
Health Violence, Abuse and Neglect, and Social Work Services	6	2	9	8	**25**
Mental Health Services	3	1	1	5	**10**
NSW Health Child Protection Services *	5	6	6		**17**
Non-government Child Protection Services		2	3		**8**
Other Services	3		1	2	**6**
Totals	**22**	**12**	**26**	**26**	**86**

* This included the Child Protection Counselling Service & Whole Family Teams.

2.6. Communities of Practice

Following the training, five Community of Practice (CoP) meetings were convened via videoconference in each LHD. Communities of Practice have been found to be an effective way to share knowledge and acquire skills (Healey et al., 2020; Wenger, 1998).

The CoP meetings were structured in similar ways across the sites. This involved a discussion with participants, facilitated by the research team, about examples of practice with families where there were parental mental health issues or substance use in the context of DFV in relation to the meeting's topic and use of the *STACY Guide* (listed below in Table 6). Up to three CoP members presented a de-identified case example and question(s) to a Safe & Together consultant, followed by a cycle of questions, discussion, coaching, and reflection led by the consultant. Debriefing and sharing of examples of attempts to influence practice through participant change agent work within their respective services and partnerships were also discussed. This was followed by a final debrief, a reflection on the meeting's key issues and heralding of the next meeting's topic of discussion.

Table 6: Community of Practice meetings and topics across LHDs

CoP meetings		HNE LHD	NNSW LHD	SWS LHD	S LHD
CoP 1	**Partnering with women**	24 Feb 2021	4 March 2021	Weds Aug 11	Tues Aug 10
CoP 2	**Working with men**	25 March 2021	1 April 2021	Thurs Sept 16	Tues Sept 14
CoP 3	**Focusing on children and young people**	15 April 2021	29 April 2021	Weds Oct 6	Tues Oct 5
CoP 4	**Working safely**	13 May 2021	20 May 2021	Weds Nov 3	Tues Nov 2
CoP 5	**Working collaboratively**	10 June 2021	17 June 2021	Weds Dec 1	Tues Nov 30

Table 7: Community of Practice participants across LHDs

CoP participants	HNE LHD	NNSW LHD	SWS LHD	S LHD
Total CoP members at beginning of phase	22	12	23	23
Total CoP members at end of phase	10	9	25[1]	22
CoP member average attendance out of 5 sessions[2]	3	4	3	3
Average number of participants in CoP sessions[3]	10	9	16	14

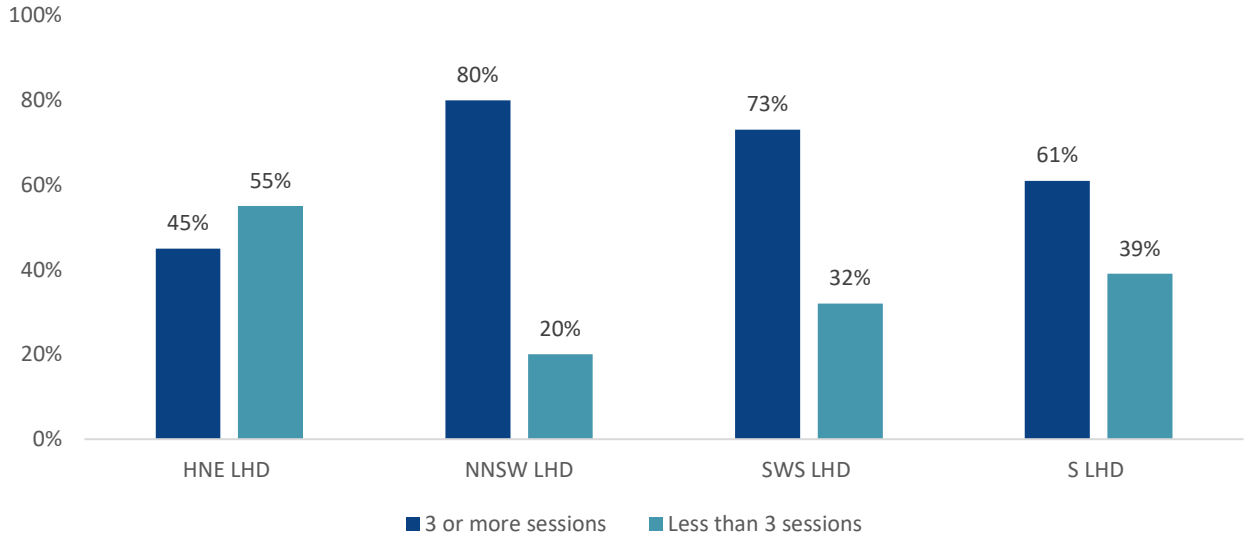
[1] In SWSLHD, one member joined the Community of Practice after Session 3, and one member joined the Community of Practice after Session 4. These changes were due to internal restructures in the participating services, leading to staffing changes during the project.

[2] Calculated based on participants who did not formally withdraw, therefore had the opportunity to attend all 5 sessions.

[3] Calculated based on attendance totals for each session regardless of withdrawals over time.

As mentioned earlier, the year of 2021 was a difficult year for health workers and services in NSW due to natural disasters coupled with pressure placed on services and individual health workers by COVID-19 and associated restrictions. In light of this, attendance at CoP sessions was remarkably steady: on average participants attended three out of five meetings. In each LHD there was a core group who engaged strongly and consistently. A number of health workers who were unable to attend contacted the research team to emphasise their interest in the project, staying in contact and receiving materials following each session to support their continued learning and development. See Figure 6 for a snapshot of CoP session attendance by LHD.

Figure 6: CoP member session attendance by LHD



Community of Practice members were asked to complete activities that contributed to building both the capacity of workers and the evidence base for the project. The activities were designed to be practical exercises that provided opportunities for learning and embedding of the Safe & Together™ Model while simultaneously generating research data.

2.7. Change agent 'influencing' work

During the CoP phase, participants were asked to act as agents of practice change within their service and their LHD. They were asked to act as Safe & Together champions, and identify 3-10 colleagues (influencees), with whom they could discuss what they were learning through *ESTIE*. These influencees were also given access to the Safe & Together online learning modules. CoP participants' change agent work could be wide-ranging, or focus on small numbers of colleagues. Each individual health worker was asked to tailor this work to their own particular role and context.

> *Loved the idea and support of the influencing. It is a way of making the training live past the training days and think about and do application. The CoP really helped with this.*
>
> – CoP participant

The idea of this influencing work caused some anxiety in each CoP group, with some participants critical of the lack of specific guidance and finding the task difficult to prioritise within their workplace. However, it was taken on enthusiastically by many CoP participants, who enjoyed sharing learning with others in their own way, without time pressure in the form of deadlines. While influencing work provided a chance for CoP members to reach colleagues not able to attend the CoPs, or without opportunities for supervision or clinical review meetings, participants also reached beyond their own services to develop collaborative relationships with professionals from other services working alongside their own, both within the health system and outside. By the end of the CoP phase, over 300 influencees had been identified across the four LHDs, reaching into DCJ, as well as Health, and into NGOs and other agencies.

Table 8: Influencees identified across LHDs

Change agent work	HNE LHD	NNSW LHD	SWS LHD	S LHD	Total
Number of influencees identified	90	114	50	80	334

2.7.1. Actioning change agent work

The following information is drawn from CoP discussions and questionnaire responses (information about data collection can be found in Chapter 3).

CoP discussions highlighted the many options for influencing work that avoided time-consuming tasks, supporting participants' motivation for continuing their role as change agent. It was empowering for individual workers to see they could make changes within a challenging system, bringing others along with them, and this was a driver for purposeful practice going forward. In addition, health workers found that the impetus to communicate the Safe & Together™ Model to others helped consolidate their own learning and increased their sense of accountability to continue sharing their learning.

Asked about the influencing approaches used, responses from CoP members and influencees cited strategies ranging from formal training and information sharing in formal settings through to role modelling Safe & Together informed individual reflective practice.

Using the shared language based on the Safe & Together™ Model in communication with workers from different sectors, extended an understanding to them about domestic and family violence and how it operates, and assisted those unfamiliar with domestic and family violence to question their assumptions. In this way shared language was also a powerful advocacy tool, both in case discussions and through case file notes, reports, and other documentation.

> *The case manager joked to me that previous to using Safe & Together language, it would be 'oh there are some red flags here'. Rather than, this is what's going on and this is how the children are being affected.*
>
> - S2_CoP, CoP 4

Sharing practice tools, in particular the *Mapping Perpetrators' Patterns Practice Tool* and the *STACY Practice Guide,* was a popular strategy for reflecting on the application of Safe & Together principles to work with shared clients. This was perceived to be of great practical benefit for all involved.

Case-based discussion emerged for participant responses as a cornerstone of influencing, whether it was in training situations, formal clinical review meetings, in supervision or in debriefing sessions. Prompt questions based on *ESTIE* learning became routine for many workers to filter into case consultations and discussions.

Formal presentations of *ESTIE* concepts were prepared by some CoP participants for colleagues within their own teams, workers from other sectors, onboarding of new employees and other groups, such as medical students. However, where managers were not supportive, it was found to be more difficult to bring colleagues together for influencing work.

Informal discussions with colleagues created a 'really positive ripple effect sort of thing'. CoP members reported that corridor conversations did not create a huge workload but were effective in influencing colleagues' perspectives and practice.

> *I found the most effective strategy I employed in influencing was actually incidental conversations within the workplace… I found colleagues more responsive when there was less added pressure from being in a formal environment.*
>
> - S3_CoP_MH-4_Q

Role modelling the incorporation of Safe & Together principles into everyday practice and documentation also created influencing opportunities.

> *…sometimes the biggest change we can make is by role modelling, by saying well this is what good practice does look like.*
>
> - S4_CoP, CoP 5

The common theme for most of these strategies was that they provided opportunities for reflective discussion about client-facing practice. Responses were negative where free training modules were emailed to influencees without introduction or context, or long information emails were circulated. Many CoP participants took on board the idea of practice change through micro-practices as more empowering and achievable than structured activities.

2.8. Beyond the ESTIE sites – 'socialising' the learning

To be effective, knowledge translation, or embedding knowledge into practice, needs to commence from the outset of any project, and be built into the process of learning. In *ESTIE*, discussions at PAG level, CoP level and with influencees, all played a role in this process.

In addition, the research team presented at workshops and conferences throughout the period of the *ESTIE Project*. The learnings from *ESTIE* and its predecessor *STACY* were taken further than the four LHDs involved, to other stakeholders within the NSW Health service system and beyond. A list of publications and workshop and conference presentations completed at time of writing can be found in Table 9.

Table 9: List of knowledge translation activities

'Socialising' the learning beyond ESTIE
Conference presentations
Humphreys, C., Kertesz, M. & Isobe, J. (2021, May) *Changing the language: Shifting the organisation/s*. Presentation to the 4th Asia Pacific Safe & Together Model Conference, virtual event.
Kertesz, M. Isobe, J. & Humphreys, C. (2021, September) *Making children exposed to domestic violence visible in adult services*. Presentation to the European Domestic Violence Conference, virtual event.
Kertesz, M. Isobe, J. & Humphreys, C. (2021, October) *Keeping children in view through the Safe & Together™ Model*. Presentation to the OPEN Sector Research Symposium, Melbourne Australia
Kertesz, M., Lauw, M. & Humphreys, C. (2022, May) *Safe & Together at the intersections of DFV with AOD and MH: Crossing silos, sharing practices.* Presentation with panel discussion to the 5th Asia Pacific Safe & Together Model Conference, virtual event.
Workshop Presentations
Kertesz, M. & Curtis, D. (2021, March) *Building capacity across services to manage the intersecting complexities of DFV, AOD and MH.* Presentation to the Senior Executive Workshop sponsored by Prevention and Response to Violence, Abuse and Neglect (PARVAN) in the NSW Ministry of Health.
Humphreys, C. & Kertesz, M. (2021, July) S*afe & Together Addressing ComplexitY for Children* (STACY for Children). QDCJMA Research Seminar
Humphreys, C. & Kertesz, M. (2021, October) *Implications of the Safe & Together Model for initial responses*. Presentation to the ECAV Domestic Violence Routine Screening (DVRS) Forum (NSW Health), virtual event.
Kertesz, M. (2022, March) *Child- focussed Work when addressing domestic and family violence.* Presentation to the Collaborative Sectors Network Meeting, Melbourne Victoria.
Kertesz, M. (2022, July) *Child- focussed Work when addressing family violence.* Presentation to the Bayside Peninsula Joint Practice Forum, Melbourne Victoria.
Publications
Kertesz M, Humphreys C, MacMillan H, Brown S, Giallo R, Hooker L, Alisic E, Hegarty K, (2022) *All-of-family responses to children, mothers and fathers accessing services for domestic and family violence in Victoria, Australia: Policy and Practice Brief*. Safer Families Centre. University of Melbourne.
ESTIE Intake/Assessment Tool - brief and crisis responses (2021, October)[2]
The Evidence to Support Safe & Together Implementation and Evaluation (ESTIE) Project – informational article published in *adVANsing: News from Prevention and Response to Violence, Abuse and Neglect (PARVAN) and Program Delivery Office (PDO) Units*. December 2021
Good documentation – supporting women and children experiencing domestic and family violence (DFV) - Royal Australian College of General Practitioners Information Sheet on Documentation (Information provided February 2022).

[2] See Appendix 8.3 for this tool.

3. Research evidence and evaluation

3.1. Methodology, Sample and Response Rates

As stated earlier in this report, this research has been informed by the broader Integrated Knowledge Management framework developed by Graham and colleagues (2006), and an action research approach that facilitated collaborative and iterative cycles of reflection and review.

A mixed methods research methodology has been used to draw together qualitative and quantitative data drawn from several sources, collected during the research period (Creswell, Klassen, Plano Clark & Smith, 2011). This methodology has been found to be useful when researching the area of domestic and family violence from worker perspectives (Healey, Humphreys, Tsantefski, Heward-Belle & Mandel, 2018; Healey et al., 2020).

The *ESTIE Project* Research Questions were explored using the following methods.

3.1.1. Communities of Practice note-taking

Research team members acted as participant-observers in the Communities of Practice, taking detailed notes about the de-identified case examples presented for discussion, and about the participants' change agent work. De-identified case studies created from these examples are used illustratively in the findings section of this report, as well as embedded into the accompanying *ESTIE Practice Resource*. Information about participation in the CoPs can be found in Section 2.6.

Focus Groups: Following the final session of the Community of Practice in each LHD, a focus group with workers was held to record their reflections on elements of change that participants could identify in their practice or in inter-organisational practice, as a result of their involvement with *ESTIE*, the impact of shared language, changes in documentation, and the strengths and limitations of the *ESTIE* learning model.

3.1.2. Case File self-assessment exercise

This exercise involved CoP participants assessing a case file or other relevant documentation for content consistent with the Safe & Together framework, using the *Case Reading Tool (Domestic Violence in Current Allegation)*, developed by the Safe & Together Institute. The *Case Reading Tool* asks users to rate the quality of domestic violence-related practice, and the level of documented evidence in a case note, report, or other piece of documentation they have produced. The exercise does not ask for specific details or examples, but users are able to provide comments relating to their reading and assessment of their documentation for each of the following themes:

A) Connection of the perpetrator pattern with child harm
B) High standards for fathers
C) Connection of Protective efforts and child safety and wellbeing
D) Integration of other issues
E) Partnership with adult survivor
F) Intervention with the perpetrator
G) Interventions with children

Respondents assessed documentation using the *Case Reading Tool* at two time points: 1) once for documentation written before *ESTIE*, with the exercise completed between the Safe & Together virtual training and the first CoP (pre-CoP), and then 2) assessed documentation written at some time during the CoP phase, with the exercise completed following the final CoP session (post-CoP). This pair of exercises aimed to ascertain the impact of *ESTIE* on documentation practices, based on self-reports.

To supplement self-reports, and in the spirit of mutual learning, PAG members were asked to complete a post-CoP case file assessment exercise, using the same *Case Reading Tool*, for documentation completed by a CoP member under their supervision. However, only three PAG members submitted such a case file assessment. Response rates for this exercise were relatively low (see Table 10). Despite encouragement

from the research team to choose a manageable portion of documentation to assess (a small file, or section of a file, or a specific report), CoP members were both pressured for time and somewhat anxious about what was expected of them. Many of the health workers who were able to complete the exercise reported gaining an enlightening insight into their former documentation practice and what they could change.

Table 10: Case-file self-assessment response rates

Case File Assessment Response Rates	Eligible sample	Responses	Return rate
CoP Case-file self-assessment (post training, pre CoP)	65	30	46%
CoP Case-file self-assessment (post CoP phase)	66	14	21%
PAG Case-file assessment (post CoP phase)	9	3	33%

3.1.3. Questionnaires

Post Cop Questionnaire to CoP members and their influencees: Drawing on the preceding *STACY Project* questionnaire, and developed in consultation with the research team, Ministry of Health representatives and the Safe & Together Institute, this questionnaire included multiple choice, open-ended and ranking questions to obtain quantitative and qualitative data. The questionnaires sought to assess the impacts of the Safe & Together training, and both capacity building and research activities, to understand how involvement in the *ESTIE Project* may have impacted professional and organisational practice. The surveys also provided participants with an opportunity to reflect on their overall experience and to provide feedback to the research team.

A return rate of 38% (N=26: see Table 11)) for the CoP respondents to the questionnaire is worth noting, particularly in the context of COVID-19 interruptions, redeployments, and extenuating circumstances. This return rate speaks to the commitment from CoP members to not only attend sessions during 2021 and respond to the survey, but to the project and advancement of domestic violence-informed practice change overall.

Post Cop Questionnaire to PAG members: A similar questionnaire was distributed to PAG members, which included questions focussing on capacity building, implementation, impact, sustainability and championing. Responses to the PAG survey were received from both regional and metropolitan PAG members, and one response was received from a state-wide NSW Health representative.

Both questionnaires were administered through Qualtrics, a secure online survey platform used by the University of Melbourne. The full text of both CoP and influencee survey and PAG survey can be found in Appendix 8.5 and 8.6. Relevant findings from the survey questions are included in subsequent sections, integrated with findings from other data sources.

A demographic profile of questionnaire respondents was compiled, although it should be noted that this profile is not necessarily the same as for the entire *ESTIE* participant group. Not all respondents completed every question. Brief detail is included here and details can be found in Appendix 8.7.

Questionnaire responses were received from all LHDs, and several from state-wide Ministry of Health representatives. There was a significantly higher return rate from regional LHDs, reflective of the significant difficulties caused by the COVID pandemic in Sydney in the second half of 2021, which prevented many health workers from participating as they would have liked.

Table 11: Survey response rates

Survey Response Rates	Eligible sample	Responses	Return rate
CoP survey responses	67	26	38%
Influencee survey responses	277	36	13%
PAG survey responses	39	9*	23%

Most respondents to the survey identified themselves as women, and non-Aboriginal. While 15% of those who responded spoke a language other than English, none of these used these languages regularly with their clients. More than a third of the responses to all questionnaires came from non-statutory child protection workers (i.e., Whole Family Teams, and CPCS). A quarter of respondents worked in 'other service areas' included early childhood and counselling, sexual assault, and social work services. Mental health workers (14%), VAN workers (13%) and AOD workers (10%) were also represented in the responses. Respondents to each of the questionnaires had a minimum of a degree level education, with approximately half having Masters degree level qualifications.

The majority of both CoP and influencee respondents described themselves as caseworkers, clinicians, counsellors or client-facing workers (50%, n=11 for CoP, 91% n=11 for influencees). A third were experienced in this role, holding practice lead or team leader positions. PAG respondents were primarily in service, program or clinical manager positions.

3.1.4. Data analysis

Each aspect of the research was analysed separately in the first instance, and the data from each research method (the Communities of Practice, the focus groups, the questionnaires, participants' assessments of documentation, and the process of evaluation) was used to triangulate the data collection and analysis processes before a final synthesis was developed.

3.2. Ethics permissions

Research ethics approval was granted by the University of Melbourne in late January 2021 (Reference number 2021-20554-13855-3). This was followed by an amendment to the research design, approved in early June 2021. The amendment included questionnaires to CoP members, PAG members and influencees, that were developed in the first six months of 2021. Research approval was also sought separately from the Research Ethics and Governance Office in each participating LHD, and was granted prior to data collection commencing in each LHD.

The need for approval by the Aboriginal Health and Medical Research Council (AH&MRC) was considered early in the project following discussions with research partners, as detailed in Section 2.3. The Steering Committee discussed at length the focus of the *ESTIE Project* and whether it would be appropriate to submit to the AH&MRC. The Ethical and Scientific Review of Human Research in NSW Public Health Organisations (NSW Health Ministry, 2010, Section 5.2, p.7) states that approval from the AH&MRC is required where any one of the following applies:

- The experience of Aboriginal people is an explicit focus of all or part of the research;
- Data collection is explicitly directed at Aboriginal people;
- Aboriginal peoples, as a group, are to be examined in the results;
- The information has an impact on one or more Aboriginal communities; or
- Aboriginal health funds are a source of funding.

The *ESTIE Project* was deemed not to meet these criteria given its stated research aims and methods, and considered inappropriate for submission to the AH&MRC. As stated earlier, this decision was informed through consultation with senior NSW leadership across PARVAN and the Centre for Aboriginal Health.

3.3. Development of the ESTIE Practice Resource

Development of an *ESTIE Practice Resource* to be more responsive and targeted to health workers across all settings (acute, long-term, AOD, MH and VAN) was a key output for the research. Building on the work of the *STACY Project* and *Practice Guide*, the aim was to produce a resource and reference 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 approach aimed to drive and embed practice improvements within a complex context that centred both victim/survivors' lived experiences and worker's practice experience.

The Community of Practice was used as a site of knowledge production. To elicit data to inform the development of the *ESTIE Practice Resource*, CoP participants were provided with the *STACY Practice Guide* as part of their resource collection. They were encouraged to review the section of the guidelines that corresponded to the monthly theme of the CoP (for example, partnering with victim/survivors) and bring their ideas and feedback to the relevant CoP meeting. The researchers used time during each CoP meeting to explore the usefulness of the *STACY Practice Guide* and how (or if) they supported worker's current practice.

The research questions were investigated through a collaborative process which included participation from CoP participants, the researchers, and the Safe & Together Institute consultant. Questions that were explored in each CoP included:

- How has the *STACY Practice Guide* supported workers when engaging with families at the intersections?
- How have workers used the resource in the last month in their work (for example: had they used it as an influencing tool, or at an interagency meeting)?
- How could the *STACY Practice Guide* work better to support daily practice - what other information would be useful to include, were there things that needed to be removed or changed, and was there a format that would work better (for example: more practice tips, advice on documentation, techniques for working across the intersections)?

The feedback was recorded and transcribed, and notes from PAG discussions about the *STACY Guide* were incorporated into the data. The data was analysed using NVIVO and the findings were directly fed into the development of the new *ESTIE Practice Resource*.

Following the completion of the *ESTIE Practice Resource*, a much briefer *ESTIE Quick Reference Guide* was produced, to be an accessible desktop document for health workers. These documents provide guidance on implementation of domestic violence-informed practice at the intersections of DFV, AOD, and MH, informed by the Safe & Together framework as an example of an all-of-family approach.

4. Findings – Capacity Building and Practice Change

This chapter presents findings regarding capacity building and practice change from the *ESTIE Project*, including authorising environments, participant views of the *ESTIE* model for capacity building, use of the *STACY Practice Guide* and evidence of change in documentation practices. The following information speaks to key enabling and sustaining factors for practice development, and to the importance of holistic, evidence-based approaches for individual and systemic change.

4.1. The Authorising Environment

4.1.1. Findings from the Communities of Practice

In CoP discussions, participants spoke about the importance of an authorising environment in terms of: enabling participation in the *ESTIE Project*; creating space for operational remits to include more domestic violence-informed practice; creating a culture of care that supported rather than restricted workers; and encouraging collaboration and communication between operational and strategic-level contexts for practice.

Authorising participation in the ESTIE Project and practice change activities

Workers described varying experiences in terms of management support and development of an authorising environment for their participation in the *ESTIE Project*, and particularly for their influencing activities. Some workers reported feeling very supported, encouraged, and trusted by their managers to take the work forward, with commitments to allow staff time to take part and dedicate reflective practice or case discussion time to *ESTIE* topics.

> *Management are on the same page as myself and the one other counsellor we have, in making sure we are clearly documenting behaviours of the perpetrator and using that wrap around approach, and that's been clearly articulated not so much in supervision but in conversations around practice. I feel like management are on the same page and supportive of the model.*
>
> - S4_CoP_DFV-4, CoP 4

Some workers found negotiating time release for themselves relatively straight forward when speaking about the CoPs, but others described having had no support or even some resistance from management levels. This was particularly the case where resourcing and release of time concerned influencing work, and even more so if workers were trying to create influence and collaboration across teams or services (as opposed to within their own local team).

Some workers spoke about the support they had received from PAG members, but not their direct line managers towards their participation in the *ESTIE* CoPs and influencing activities. The importance of that approval from higher levels and across accountability streams, was emphasised by workers, as this different level of commitment and authorisation enabled the worker to make the case for putting time towards these activities even when line managers were not fully on board.

Top down and bottom up: Supporting safe practice change

Workers articulated an incongruence between workers, and manager and higher levels, that would need to be addressed if practice change was to be sustained. One worker articulated this as 'we're talking clinical, but the PAG are dealing with systems. Cross over of feedback when going forward would be really interesting.' This speaks to the importance of both bottom up (clinical) and top down (systems) practice change, working together. While awareness and recognition of the need for practice innovation and change might be present at senior levels, workers emphasised the need for this to be followed through with concrete changes at operational levels, such as creating space in workloads or dedicating additional resources to support sustainable initiatives and embed practice change.

One CoP participant who worked in a team leader role, reflected on their experience of trying to support and create an authorising environment for their staff to practice in a more domestic violence-informed way in their everyday work. Another team leader described thinking through how to sustain practice change in their team following the *ESTIE Project*, saying that their goal was to embed domestic violence-informed practice into the team culture.

> *For me, as a worker in a sort of management role, it's made me more reflective about how I support workers and talk to them, whether we be debriefing, talking about cases, in that more informal way, there has been a… not a huge shift, because I think I did lots of those aspects already, but a clearer way I'm engaging in that space from this perspective.*
>
> – NCP Team leader, S2_FG

CoP participants also discussed a desire for greater connection between managers and client-facing workers, in this case the CoP and PAG *ESTIE* participation groups, to support embedding of domestic violence-informed practice across services and levels of practice. Workers expressed eagerness to hear PAG discussing fundamental issues such as safety and wellbeing, saying that at times it felt like all responsibility rested with them, in a system that was not ready for practice change to occur safely.

One example of this that was raised multiple times, was the risk of psychological or reputational safety being threatened by perpetrators adept at manipulating systems. Without a supportive, authorising environment to practice through a domestic violence-informed lens, workers felt unsafe and personally at risk in their work with families. Workers felt restricted in their ability to meaningfully address or intervene with perpetrators for fear of retribution in the form of strategic complaints, in particular, when management support was not explicitly behind them, and systems were not agile enough to respond to complex cases and perpetrator patterns of behaviour.

In relation to documentation, workers emphasised a need for consistent guidance and support around how to navigate legal and statutory systems, in particular. This was described as a 'minefield' by one worker, and a part of practice that many felt was left to individuals rather than authorised more widely at senior level of the organisation.

Supporting domestic violence-informed practice as core work

For workers from AOD, MH, and child protective services, reframing their operational remit to include attention to domestic and family violence and abuse was a key shift that could only occur with senior leadership support, if it were to be sustainable. For those specialising in domestic and family violence work or related trauma fields, having the authorisation to explore presenting issues of AOD and MH, and how they might be being used by perpetrators, was also a crucial shift requiring strong support from management. Similarly, and as already mentioned, there were varying experiences of support for participation in the *ESTIE Project* itself. Workers described a broad range of experiences when discussing how domestic violence-informed practice was considered as core work or not, depending on how management and services as a whole viewed their operational remits.

One worker described how in their mental health service, they were only told to screen for domestic and family violence, described as an 'ask and hope they say no' situation. No guidance was provided about completing the form, and what to do next if someone did disclose being a victim/survivor of abuse. Prior to *ESTIE*, there had been no training or support for exploring how mental health issues were being used as tactics of power and control, or how the perpetrator might be sabotaging the substance use recovery work with the client.

Workers described significant challenges to integrated practice that would support them to be curious and address multiple intersecting issues with clients, but also gave examples where explicit support for a domestic violence-informed approach could make a significant impact in advancing practice. High level,

explicit endorsement of domestic violence-informed work with greater resourcing, was raised as a mechanism for alleviating some of the systems pressure around work with complex clients.

Support for greater flexibility and exploration of presenting issues was required, rather than immediately referring to other services. This was discussed as being able to 'work with the consumers or clients that were in front of you'. Where a service's *core focus* was not domestic and family violence (for example substance use), exploring clients' situations in full even when they included experience of domestic or family violence was essential for a more holistic practice. One CoP member described recognising that their comfort zone lay with AOD. However, without attending to domestic violence when working with AOD, a whole area of response was at risk of being ignored and families left to deal with the ramifications alone.

> *With this family we could go down the AOD route and leave the DFV out and we'd miss a whole piece of work you know what I mean? If you're not experienced to work more across the issues in a family and you're just going to go down the path that you know well, then you're just going to miss out a lot of stuff, aren't you?*
>
> - S2_CoP_HCP-3, CoP 1

Time pressure and lack of resourcing were often cited as the main barriers, with CoP participants calling on management support to address them.

> *Management needs to be better informed and give us more support to support the client.*
>
> - S3_CoP_MH-5, S3_FG

On a service level, this was discussed in terms of service criteria that were often not in line with clients' lived experiences or needs. Workers described trying to find creative ways to stay engaged with clients who might not fit their operational remit well, because of the impacts of domestic and family violence, or because of AOD or MH issues. Having management support to explore issues that might not exactly fit service criteria was invaluable; its absence was described as damaging to clients in their recovery journey. One worker presented a case of working with a woman with a significant past and ongoing trauma history relating to sexual assault. The worker's service had a limit of six months to engage with clients, which the worker described as a timeframe 'that was never ever ever going to barely scratch the surface for her' (S2_CoP_NCP-5, CoP 5). The worker successfully advocated for extensions on financial and other support, but the client was eventually discharged after being in the service for too long when the worker moved to another role.

Creating a culture of care

The importance of organisational culture, and the role that management and leadership play in creating this, was discussed at length in CoP sessions, particularly in relation to worker safety and wellbeing. While many workers described a trauma-informed, person-centred approach to clients, and great care taken in practice to validate and provide empathic responses to disclosures, this did not always extend to health workers themselves.

Creating a culture where workers could appropriately address personal challenges brought up for them by their work within supervision, and being able to trust that this would not be constructed as a management issue or issue with their capacity to do their job, was a priority for many of the CoP participants.

> *When workers have bad management experience, it means they won't trust in the future. Just like DV disclosures, same in this situation.*
>
> – S3_CoP_DFV-2, S2_CoP 4

> *Sometimes the response to critical incidents where workers are assaulted or something, we can be blamed for not preventing it somehow, or not looking after ourselves, and a similar approach to vicarious trauma as well.*
>
> – S3_CoP_DFV-2, S3_FG

The Safe & Together consultant provided a case example from previous work that illustrated this point. A young male worker was assigned to interview a male client known to have been violent to his partner. The worker disclosed to the Safe & Together consultant that his own father had been violent, and that this client work was triggering memories and difficult associated feelings. The worker described feeling 'afraid I'm gonna go over the table at him, or I'm gonna freeze'. Being able to provide a supportive environment for that worker to disclose this, process it, and have support to conduct the interview, was a clear use of authority that supported responsible help-seeking on the part of the worker, and a safer outcome for all involved in the case. Workers described the need for management and health contexts in general to be more open to challenges and complex conversations like this, and the necessity of 'leaning into' those conversations rather than shutting them down.

4.1.2. Findings from PAG discussions

The Project Advisory Group (PAG) played a unique role that allowed for the discussion of policy and practice issues that arose in the CoPs. A wide range of issues were identified that often relate generally to the implementation of the Safe & Together™ Model. The location of these discussions in the PAG amongst senior managers highlights that they form part of the authorising environment, not only for the project, but for the implementation of policy and practice change. The following issues were among those discussed in PAG meetings for consideration by leaders in each LHD, in service streams, and by the NSW Ministry of Health.

CoP members' reflections on the importance of support and communication between managers and client-facing workers in creating an authorising environment for DFV-informed work and practice change were discussed in PAG meetings. In particular, the variability in the quality of communication between sectors and services was noted.

Client-facing staff emphasised the need for management support for collaboration to work. However, the example set by workers in Aboriginal communities over decades, where collaboration has been a necessity for effective practice and organisational survival, suggests that barriers also exist in mainstream conceptions of workforce functioning. Aboriginal cultural safety consultant Marlene Lauw provided examples of Aboriginal Community Controlled Health Services, and many Aboriginal health workers in mainstream settings, approaching their work with a markedly different mindset that non-Aboriginal services and systems could benefit from. This included an established conceptualisation of operational remit that covered any presenting issues a family might present with, and a principle of being on a journey towards recovery with those families rather than a system based on referrals and siloed service provision.

While PAG members were familiar with the range of policies and information established by NSW Health to support worker safety, not all client-facing workers were similarly aware, and there was discussion in the PAG about how to communicate effectively the message of support for worker safety in all workplaces. The separation of clinical supervision from line management was suggested as a strategy to allow workers (and especially those with lived experience of violence and abuse) to safely seek support to professionally manage risks, without their professionalism being questioned. Workplace safety issues are raised more fully in Section 5.4 of this report.

Documentation and record-keeping were major themes throughout the *ESTIE Project*. With recent moves in parts of the health system towards more abbreviated records, it was noted that contact-based record-keeping (e.g., records of phone calls, visits, interviews) works against pattern-based mapping of perpetrator behaviour, unless there is also a case summary or other opportunity for a narrative. PAG members discussed the power of the shared language offered by the Safe & Together™ Model, and the use of tools such as the Perpetrator Mapping tool and the *Safe & Together Intersections Meeting (STIM) Guide*, as clearly demonstrated in Communities of Practice and in influencing activities. The importance of developing consistent documentation practices and forms, including transparency and information sharing across all

areas of the health system was recognised, and is a long-term project for NSW Health. Similarly, it was recognised that service provision structures and models of care may act as barriers to information sharing.

4.2. Participant view of the ESTIE capacity building model

This section presents findings from the participant surveys and CoP member focus groups relating to their perception of the *ESTIE* capacity building model. This feedback informs the research process and methodology, and contributes to a growing body of evidence around action research, organisational change models and strategies for sustained impact on practice at the intersection of DFV, AOD and MH.

The majority of PAG survey respondents (n=9) were positive about the *ESTIE Project* and capacity building in participating LHDs and services. Eight of the nine PAG survey respondents (89%) strongly or somewhat agreed with the statements:

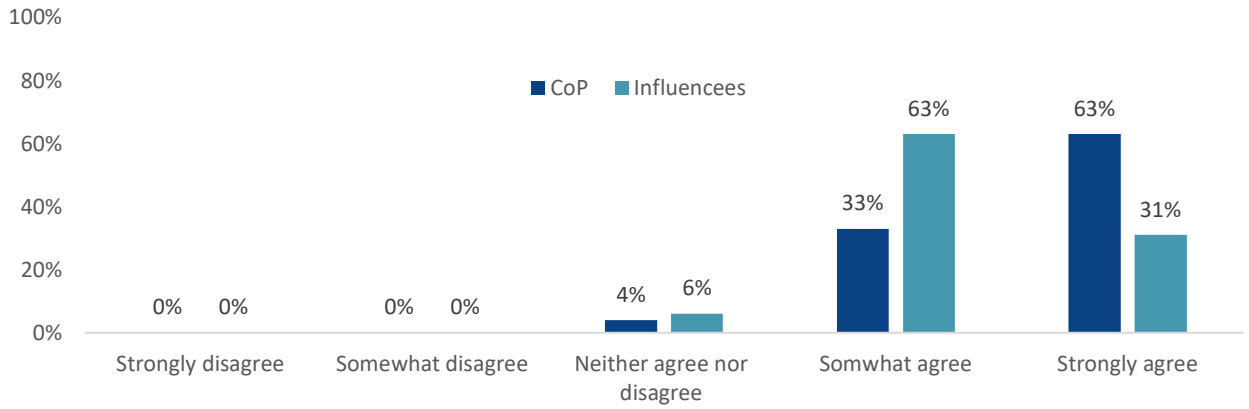
> *'The ESTIE Project has contributed to capacity building within the participating LHDs in relation to the Safe & Together approach and the focus of ESTIE*', and
>
> '*The ESTIE Project represents an efficient way of capacity building practitioners and services*'.

Two thirds of PAG respondents strongly or somewhat agreed with the statement '*the ESTIE Project has had an impact on the safety of victim/survivors of domestic and family violence'*, with two (22%) saying they neither agreed for disagreed, and 11% saying they did not know.

4.2.1. Impact on practice

Almost all CoP participants (96%) reported that exposure to the Safe & Together™ Model during the *ESTIE Project* improved their practice, and Influencee participants overall similarly agreed (94%), but less strongly (Figure 7).

Figure 7: CoP and Influencee view of exposure to Safe & Together through ESTIE



Exposure to the Safe & Together Model during the ESTIE Project has improved my practice and/or my management of staff when their clients experience intersecting issues of DFV/AOD/MH

CoP survey respondents were asked to rank *ESTIE Project* components in order of impact on practice change for them (see Table 12). Mean rankings indicate the following evaluation on a scale of 1-9. The Safe & Together virtual training was ranked as the most impactful component (mean = 1.5) by respondents (n=22), followed by the Community of Practice sessions (mean = 3.18). The PAG authorising environment was ranked as the least impactful component by CoP respondents (mean = 8.45).

PAG survey respondents (n=9) were asked to rank the same components (excepting support from the research team, which was listed as an 'other' option), from most to least valuable in building capacity within their services to implement the Safe & Together™ Model (see Table 12). The Safe & Together training was similarly ranked most valuable (mean = 1.33), followed by the Safe & Together online training modules. The least valuable aspect ranked by PAG members was the 'other option (mean = 7.56), though no responses included a specification. The next ranked least impactful by PAG respondents was the case-file self-assessment exercise (mean = 7.22).

Table 12: ESTIE Project components impact ranking by participant type

CoP member responses	PAG member responses
1. Safe & Together 4 half days of virtual training	1. Safe & Together 4 half days of virtual training
2. Community of Practice sessions	2. Safe & Together online training modules
3. Access to Safe & Together resources (e.g., Perpetrator Mapping Tool)	3. STACY Practice Guides
4. Safe & Together online training modules	4. Community of Practice sessions
5. STACY Practice Guides	5. Access to Safe & Together resources (e.g., Perpetrator Mapping Tool)
6. Influencing work	6. Influencing work
7. Support from the research team	7. PAG authorising environment
8. Case-file self-assessment exercise	8. Case-file self-assessment exercise
9. PAG authorising environment	9. Other

Despite many comments about the difficult timing and six-month timelines of the project, with services dealing with staff redeployments, illness, leave and intense pressure on the health system, a number of CoP participants observed that the Community of Practice sessions gave them valuable opportunities for reflection. They described the sessions as a space where they could allow themselves to be vulnerable in considering challenging areas of practice through diverse and mutual learning with professionals from a range of sectors and disciplines.

> *Actually having those Communities of Practice is a little moment, a little pause, to go 'okay what am I actually doing'. And I'm going to have to talk about this, to listen to what other people are saying, it was just like a little hey [waves hand], remember to actually think.*
>
> - S4_CoP_SA-4, S4 FG

For some, the Communities of Practice modelled group supervision, embedding the training into practice by systematically working through the *STACY Practice Guide*, and by combining conceptual learning as well as a grounding into practice. Respondents to the survey commented on how they applied what they learned in CoP discussions immediately into their daily practice, such as to the next referral received or next case discussion. There was value not just in discussions between workers from different sectors, but also in group attendance from the same team or service, as colleagues could support each other in practice change.

> *This process really embeds the training… It's also great for me, seeing faces of all the people we work with and having those conversations. It becomes a much more collaborative process, you get so many other bits from that, hearing how other people are working. We often don't have that kind of contact, don't get to hear case studies from other services, and have conversations about our clients. All of those extra processes really go a long way to embed a change of thinking and practice.*
>
> – S2_CoP_HCP-3, S2 FG

The *ESTIE Project's* active research and practice change process helped participants at all levels to model culture change and open up collaboration. Some CoP members were disappointed in the level of communication between CoP and PAG members, and expressed their hopes for ongoing and better communication between client-facing workers and managers, with greater clarity about ongoing expectations and how to sustain the advances made during the *ESTIE Project*.

> *It feels like, the format has been useful, the continuing practice discussions, but I would be really really interested in more of that supported communication and planning between COP and the PAG and whoever else might be involved in moving things forwards a bit more.*
>
> - S2_CoP_HCP-6, S2_FG

4.2.2. Key enablers and challenges to sustaining change

PAG survey respondents provided feedback on what they perceived to be key challenges for their services, LHDs and the NSW Health system following the conclusion of the *ESTIE Project*. While the sample for this question was small (n=8), the suggestions for how to address the challenges raised are worth noting. These included:

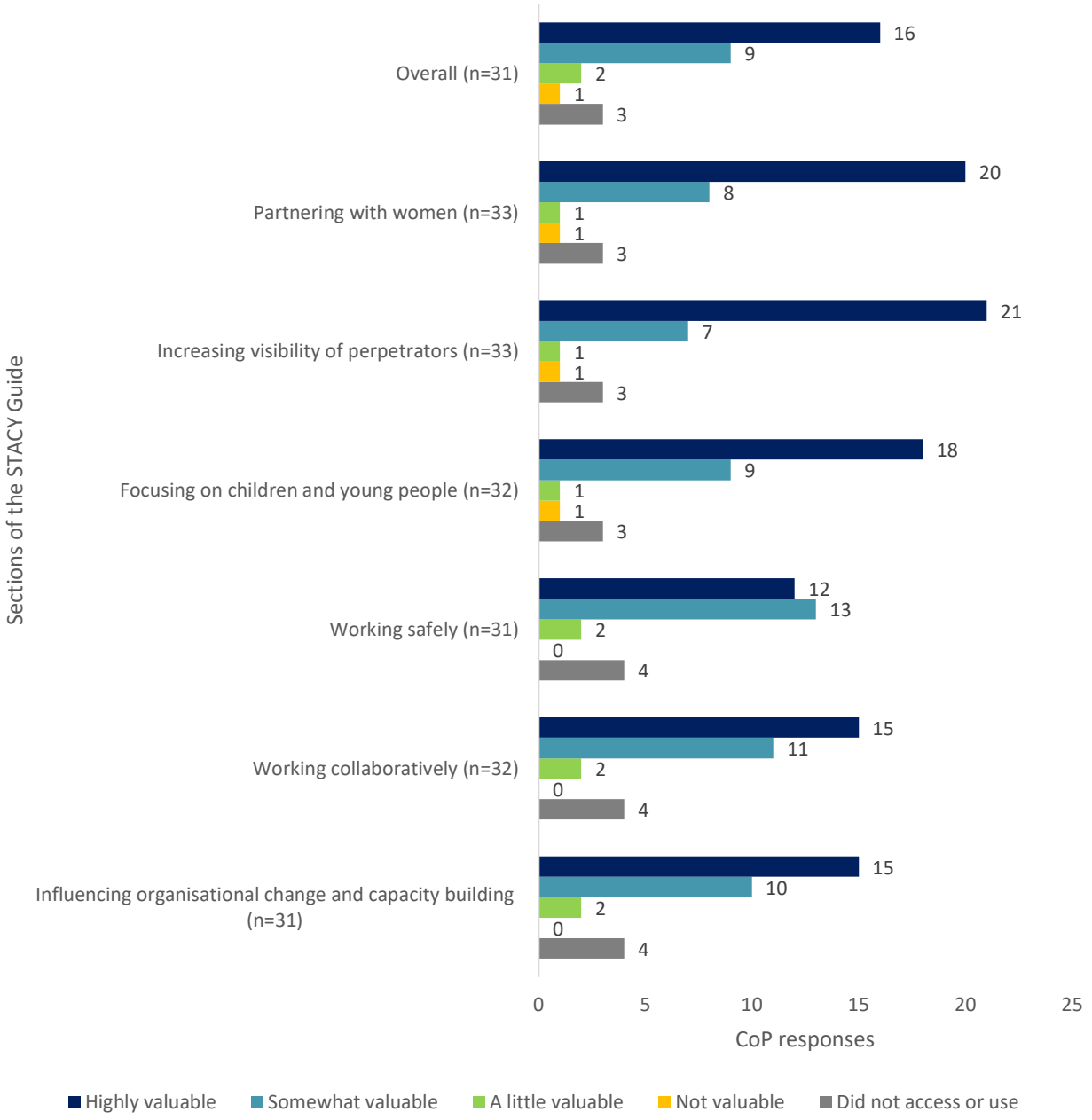
- Explore and address concerns raised about how the Safe & Together™ Model may be relevant and how it can be applied in a culturally safe way for Aboriginal families.
- Incorporate Safe & Together into NSW Health policies as an example of evidence-informed practice, in order to support momentum and mitigate the risks of domestic and family violence not being prioritised due to a lack of working groups dedicated to sustaining learning, and the impacts of COVID-19 and the VAN redesign processes. This would include legislation that enables proactive information sharing to support safety planning and risk mitigation strategies (for both clients and workers).
- Further capacity building initiatives focussing on introducing domestic violence-informed frameworks into LHDs who have not participated in the *ESTIE/STACY* projects and into non-specialist domestic and family violence services/sectors (AOD, MH, community health, nursing, medical disciplines).

4.3. Use of the STACY Practice Guide

The *STACY Practice Guide* was rated as somewhat or highly valuable by 81% of CoP survey respondents (Figure 8). Feedback during the Communities of Practice indicates that it was seen as a useful reference, particularly the reflective questions and the case examples. They were most useful for those workers who had taken part in training – without training several CoP participants in non-DFV services commented that they did not see the relevance of the *Guide* to their work until the training. Use of the *STACY Practice Guide* was not universal among participants, but most had referred to it. The *Guide* was seen as a valuable resource for reflection on practice – 'to hold myself accountable while I was thinking about the case' - and was used by several workers to help them prepare case presentations for group supervisions and other discussions. Tools such as the *Safe & Together Perpetrator Mapping Tool* were preferred when trying to understand the complexity of a family situation.

> *That's the best thing, rather than embedding in progress notes or EMR [Electronic Medical Records], sitting down and reflecting on practice and planning. I'm seeing the benefit of this so far.*
>
> - S2_CoP_MH-1, CoP 4

Figure 8: Value of the STACY Practice Guide (overall and by section), CoP responses



4.4. Evidence of change in documentation practices

Documentation practices were a key focus for the *ESTIE Project*. In this section, findings are presented based on the case-file self-assessments, online participant surveys, and drawing on the CoP member focus groups. Further findings related more closely to practice are presented through Chapter 5.

4.4.1. Areas of impact on documentation practices

The case file self-assessment exercise aimed to ascertain the impact of *ESTIE* on documentation practices, based on self-reports by CoP participants. Given the small sample of case-file self-assessments, trends for the whole sample were examined along with paired sample tests for the sub-sample where both pre- and post-CoP self-assessments were available. Trends for the whole sample (30 pre-CoP self-assessments and 14 post-CoP) were consistent with the paired sample trends (12 paired pre- and post CoP self-assessments).

In general, CoP members reported stronger documentation of a range of DFV assessment and practice in the files written during the *ESTIE* CoP phase than in those files recorded before *ESTIE* commenced. While the sample size was small, the following trends were identified through the self-ratings and associated comments about the following themes from the case-file self-assessment tool: Limited information and lack of detail about the **perpetrator's pattern of behaviour, and especially about its impact on children**, were noted for the pre-*ESTIE* assessments. All self-assessments post-CoP noted some or strong evidence in this area. A similar improvement was noted in relation to **holding fathers to high standards of parenting**, moving from 'a lost opportunity to explore role as father' to reports that post-*ESTIE* files contained details of parenting and co-parenting behaviours. The *Safe & Together Perpetrator Pattern Mapping Tool* was mentioned by several participants as useful in this regard.

Survey respondents reported that **engaging with perpetrators** was generally unsupported in their workplace and that there were few, if any, perpetrator interventions available to refer men to. For this reason, most respondents found that there was little change in evidence of engaging perpetrators or identifying suitable interventions.

Some or strong evidence about the **protective activities of adult victim/survivors** was reported in the post-CoP assessments, with about half showing stronger evidence. This appeared to be an area of documenting strength both before and after *ESTIE*, and evidence about partnering with the adult victim/survivor was also reportedly stronger (some or strong evidence) in case files compiled following *ESTIE* training.

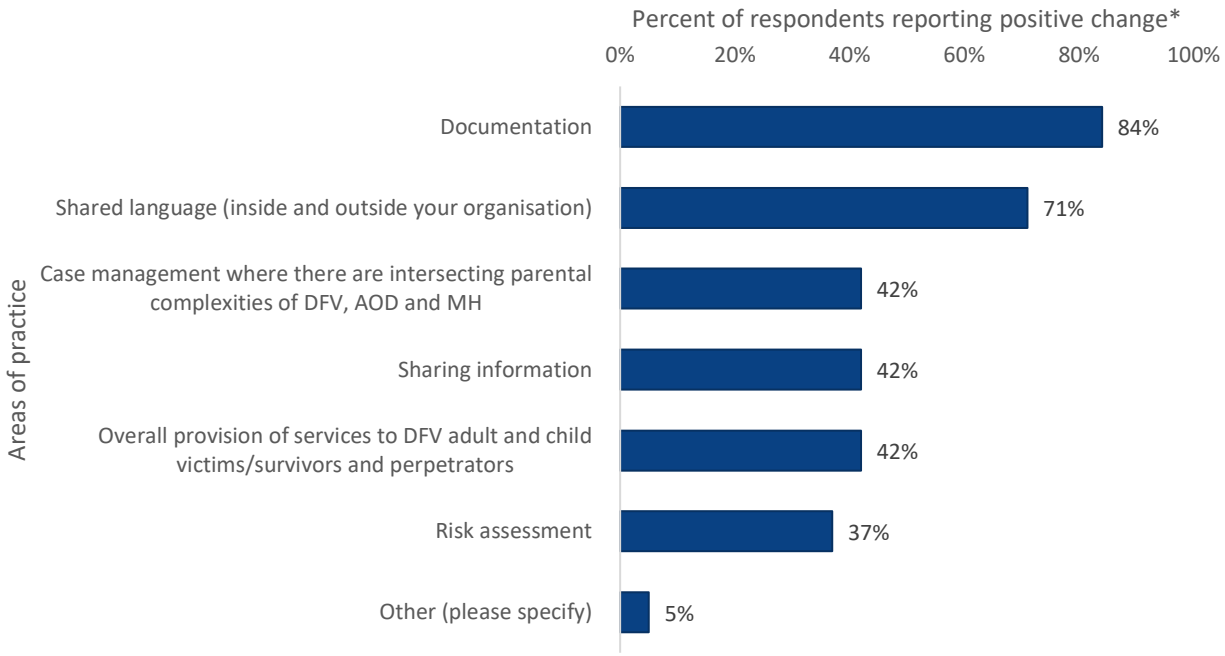
While links between **protective efforts and children's safety and well-being** were noted by few respondents, the number of respondents reporting some or strong evidence of engagement with children and planning for an appropriate service plan for them, increased from pre- to post-CoP.

Evidence of the **integration of other issues** into assessments was mixed, both before and after *ESTIE*. Improvements may relate to workers including more detail in their assessments. Several comments were made about substance issue not being an issue in the case under review. In the case files reviewed post-CoP, evidence was generally stronger about an assessment of the intersection of DFV with substance abuse than with mental health issues. Evidence of integrating other Issues into the assessment, such as ethnicity, culture, religion, or financial inequity, was generally stronger after *ESTIE*.

In summary, self-reporting indicates that workers improved their documentation practice most strongly in detailing the perpetrator's pattern of behaviour and its impact on children, and on partnering with adult victim/survivors and recording their protective efforts.

Documentation was also the area of practice where CoP and influence respondents to the post-CoP survey reported most improvement, followed by shared language, information sharing, overall provision of services and case management for clients with intersecting issues of DFV, AOD and MH were all equally reported to have seen improvement through participation in the *ESTIE Project* (see Figure 9).

Figure 9: CoP and influencee areas of positive practice change (n=38)



*Respondents were able to select more than one area of practice

When asked specifically about documentation and information sharing practices, CoP and influencee participants reported the most change in their practice around identifying the perpetrators' pattern of coercive control and actions taken to harm children, and mapping the perpetrator pattern onto adult victim/survivor's strengths and protective capacities. The area identified as having seen the least improvement was mapping the perpetrator pattern onto worker safety concerns. PAG survey respondents also indicated that since the start of the *ESTIE Project*, the area of documentation and information sharing where they had observed most change was identifying the perpetrators' pattern of coercive control and actions taken to harm the children, and the least was also worker safety. These findings from the surveys are consistent with the self-reported changes from the case-file self-assessments.

> *It sounds silly, but is it almost like once you know, you cannot unsee it. I think the language and documentation have become embedded into my philosophical approach to clinical work.*
> – *S4*_CoP_NCP_Q

4.4.2. Sustaining practice change in documentation and information sharing

The following quotation illustrates how workers articulated the connection between the changes in their individual documentation practice shifts and the impact on a much broader scale.

> *The lived experience of the difference this makes for survivors and their children. The alignment with my own values around promoting dignity of survivors and their children.*
> – S1_CoP_HCP-4_Q

In addition to their individual commitment to practice change, as articulated by the above quotation, CoP and influencee participants suggested the following strategies for sustaining these practice changes in documentation and information sharing.

- Set up assessment and case noting templates that incorporate questions and prompts consistent with the Safe & Together™ Model, including in the Electronic Medical Records system and clinical audit tools.
- Institute standards and training on documentation and information sharing, informed by Safe & Together, across the NSW Health system, including refresher training and induction training for new staff.
- Continue contact with the *ESTIE* CoP participants and influencees, both informally and through projects emerging from the *ESTIE Project*.
- Continue engagement with the *STACY Practice Guide* and the *ESTIE Practice Resource*.
- Incorporate concepts and tools into team and peer consultations, supervision and reflective practice, such as use of the *Perpetrator Mapping Tool*.
- Ongoing working groups to sustain practice change following *ESTIE*.
- Effectively communicate updated information about policy changes at district and state level, to all partner services working across NSW Health.
- Continue efforts to engage child protection services and non-government agencies in Safe & Together work.
- Explore the Safe & Together™ Model with Aboriginal communities.

These suggestions were all echoed in PAG survey responses, confirming the emphasis CoP and influencee participants placed on the need for Ministry and management levels to provide support and commitment sustainable positive change.

> *Realistically, nothing will change unless the service and systems change, which is led by management, and then this will only change if there is support and resources allocated to drive and implement the changes*.
> – S3_CoP_AOD-11_Q

5. Practice Findings

This chapter presents findings based on the discussions in Community of Practice (CoP) sessions conducted in collaboration with the Safe & Together Institute in 2021, and focus groups conducted with CoP members following their participation in these meetings. These findings provide grounding in the direct practice of health workers across the broad range of disciplines and sectors involved in the *ESTIE Project,* and are structured around the main themes from the project. Illustrative, de-identified case examples are used throughout this section, reflecting the challenging and uplifting aspects of practice with families living at the intersection of domestic and family violence, alcohol and other drug and mental health issues, and the service systems that workers operate within.

While there is a discrete section regarding documentation, given the focus of the project, insights and examples particularly relevant to each other section and theme have been provided to illustrate the cross-cutting and foundational nature of documentation practice.

Particularly in the second round of CoP sessions (June to December 2021), Marlene Lauw's cultural safety consultancy added an additional depth to discussions about the cultural aspects of cases and practice, and supported all CoP participants to consider culture and in particular work with Aboriginal families in a new way. A discrete section is included in this chapter to reflect these discussions and the learnings that can be taken forward from them.

5.1. Pattern-based thinking and systems advocacy

5.1.1. Pattern-based thinking

Discussions in the CoP sessions often started with a focus on how much each presenter had tackled moving away from an incident focus and explored a pattern-based approach to practice in their case. As this is the basis for the Safe & Together™ Model, many points of discussion were not new, and echoed findings from the *STACY Project* (Healey et al., 2020). This shift towards pattern-based thinking is both a more effective way to explore use of violence and control, and a stronger foundation for informed safety assessments across disciplines and contexts of practice.

However, particular ways in which workers explored this approach through the *ESTIE Project* brought out high-level insights worth noting about the connections between a pattern-based approach to individual case work and broader shifts in practice and service delivery. While no single worker or service may ever know the full, complex picture of what clients deal with, or have all the answers to questions around safety and risk, each worker and service can contribute their piece of the puzzle towards informing proactive and collaborative responses to keep people safe and accountable.

Pattern-based thinking goes beyond a focus on perpetrators' actions within their families to an essential awareness of how perpetrators manipulate systems, for example by grooming workers, presenting themselves as charming, functional and responsible, all while setting up their partners to appear 'crazy', addicted or otherwise as poor and neglectful parents. In addition to manipulation of this kind, perpetrators may use threats and intimidation against professionals and their families. Workers targeted in this way, especially when unsupported, are less likely to feel able to intervene with perpetrators, either directly or through making their behaviour patterns visible. In these ways, poor practice in the areas of alcohol or other drug use and mental health, that is not DFV-informed, can lead to detrimental decisions in systems such as child protection or the Family Court and putting adult and child victim/survivors at ongoing risk.

Engaging from a position of respectful curiosity and purpose

As workers explored shifting from an incident focus to a pattern-based approach, much discussion during the *ESTIE* CoPs concerned starting from a place of respectful curiosity – both in terms of their approach to practice, and how they implemented it when engaging with families and other services. Keeping safety,

recovery, and accountability front of mind as primary purposes for engaging with clients supports this active curiosity.

Curiosity about patterns in their clients' lives, as well as about the interactions between past experiences and history, allowed workers to better understand abusive behaviour and tactics of coercive control from perpetrators, and acts of strength and resilience from victim/survivors. Using respectful inquiry to unpack assumptions about family dynamics and contact was a key part of shifting to a pattern-based approach. This could take the form of clarifying whether children still had contact with fathers despite a no-contact order, asking questions about how perpetrators acted as parents and how issues of AOD or MH might interact with this, or opening up conversational space for victim/survivors to describe how individual incidents fitted into their overall experiences.

Complexity and connections

CoP participants developed a deepening awareness of how a single incident can be used as a catalyst to explore and address a range of complex underlying issues. Supporting workers to unpick patterns that 'thread through' this complexity at the intersections of DFV, AOD and MH for families was a key focus for the *ESTIE* CoPs. For example, perpetrators' abusive behaviours or tactics of coercive control might span across multiple partners, and involve using AOD or MH issues (their own or their partners/children's) to exercise power and control.

For victim/survivors who might not be presenting in an 'expected' or 'traditional' way, finding threads of connection between their past experiences and the current situation was discussed as particularly valuable, and often the entry point for productive and safer discussion between workers and the client. One example case focused on a woman who had grown up in a family where the use of violence and control was the norm. In discussing this with Safe & Together consultants, CoP members were asked to acknowledge that this woman might not have any other strategies to draw on, but also to consider the other side of the story where multiple people had chosen to use violence against her. And yet again, that another side of her story includes the people who perhaps suspected or knew about this violence and did nothing to intervene. These connections are possible even when working in practice frameworks like the addiction disciplines, which traditionally have a primary focus on responsibility for one's own use of substance and associated behaviours. When working with domestic and family violence, responsibility for behaviour is foundational, but requires nuanced contextual grounding and exploration of how issues can become tangled and intersect.

Refocusing on facts towards a fuller picture

Safe & Together consultants highlighted the value of taking a step back from complex and high-tension cases, particularly where higher risk factors and emotionally charged incidents are prominent, and refocusing on the facts that were available to them. Individual incidents that involve heightened emotions and require intense intellectual and professional responses can detract from an accurate understanding of patterns and context if workers do not have the space for processing and development of perspective. Implementing practices such as listing behaviours (protective and abusive), without judgement or justification, helps to ground workers in facts and identify gaps in knowledge, and can then be documented and acted on. Safe & Together consultants emphasised that noticing the gaps and unclear areas of a story provide a stronger view of the situation, and allow for better prioritisation and future focused work.

Such gaps in understanding could also relate to case files or notes that do not mention domestic and family violence. Bringing wider knowledge and research data into their practice can enable workers to push practice standards to be more responsive, proactive and respectful of complexity in families' lives. An example of this is holding awareness that research evidence indicates that one in three women will experience abuse in their lifetime. Taking this into screening practices, workers can adopt a 'rule out'

framework of exploration and curiosity, gathering evidence that an individual is safe, rather than working from a 'rule in' framework where the catalyst for action is heightened risk or evidence of harm.

5.1.2. Systems advocacy as part of practice

During discussions about acting as change agents (see Section 2.7), the role of individual practice in systems advocacy emerged as a common practice component. Both large and small actions may shift the practice environment to a more ethical, safe, and caring one for workers and the families they engage with. One worker articulated this as a commitment on an individual level to promoting child safety, even in adult focused work.

> *Yes, we have all these challenges and our scope of practice, our roles, our tools, our forms, our whatever, but we also have an individual practice. If we can make a commitment to our individual practice as a social worker or whatever to do this, and accept yes this is difficult, [then] to be promoting child safety in the context of adult mental health, to be using language that invites people into those considerations, that's what I can realistically do.*
>
> – S1_CoP_HCP-1, CoP 5

CoP participants reported that while these individual efforts towards practice change act as advocacy and impact towards broader systems change, they must be supported by structural changes if they are to be sustainable. Workers discussed individual attempts, strategies, and efforts that were not effective, reporting that this can be the hardest part of working in a large and sometimes unwieldy service system.

> *Clinicians, intentions, and goodwill can do a lot, but systems have no memory in some ways. It's hard to build sustained change that is situated only in individuals. You need both*.
>
> – S1_CoP_SA-2, CoP 5

Addressing issues from multiple perspectives

A range of strategies for incorporating systems advocacy into practice were discussed during the CoPs, ranging from practical strategies such as team leadership and organisational management to influence the immediate systems they worked in, to broader and less tangible approaches that require nuanced attention and collaboration.

Attending to existing evidence, and highlighting the learnings emerging from established ways of working such as those in Aboriginal community work, can support advocacy for systems change and challenge assumptions that change is 'too hard' and not worth attempting.

Building alliances and networks was perceived as a powerful (and individually safe) means of influencing systemic change, and workers were eloquent about the challenges facing individuals advocating for practice change without collegial support. Networks of likeminded workers were seen as providing crucial support to these workers and the families they serve. Collaborative efforts from multiple services better support families to access essential services (e.g., Centrelink, housing, financial support), and address presentations of underlying and intersecting issues.

Discussions about the interaction between legal, welfare and health systems highlighted the dangers of families being further harmed by these systems. An awareness of the power of these systems, and the opportunity they also represent for positive advocacy for families, emerged as a focus for CoP members. For example, a supportive child protection case worker willing to support and partner with a mother through her court process may open doors that are otherwise shut. The mother's credibility was perceived to be greater due to the presence and support of the case worker.

Actively using expertise to address gaps

An important aspect of systems advocacy and the practice that supports it, is a focus on proactively offering knowledge and expertise about cases and systems to other professionals, where workers saw connections

being missed in case formulations. This is particularly powerful when done as part of partnering with victim/survivors. Having conversations about who knows what about their journey and service engagement, and asking permission to actively share and develop collaborative practice around them, fills many of the knowledge gaps often identified by workers and highlights perpetrator patterns and their potential exploitation of systems blind to siloed practices. Providing clear information that contributes a counter-narrative to the perpetrator's story and details of mitigating actions can influence the direction of cases significantly.

> *So we then advocated hard to DCJ because they didn't look favourably on the last DV incident but again because mum made some choices following that incident that didn't reflect well for her…We did advocate quite hard to sort of say, yes those weren't good choices but we felt they were quite responsive following that DV incident…They were quite reactive to that incident as opposed to it being a reflection of her parenting over all. So, we did advocate quite hard and used a lot of language, I would say from the Safe & Together space.*
>
> – S2_CoP S2_NCP-1, CoP 3

5.2. Documentation

Documentation was a major theme throughout the *ESTIE Project*, with a focus on exploring enablers to domestic violence-informed case and other documentation. The following section presents the themes, key concepts and discussion points relating to documentation that emerged from the *ESTIE* Communities of Practice and focus groups.

Discussions focused predominantly on the power of documentation, for both health workers and their clients. The impact of documentation on systemic levels was also explored, with workers increasingly discussing barriers to good documentation practices at the intersection of DFV, AOD and MH, and the impact that domestic violence-informed documentation could have on cross-sector collaboration and outcomes for clients engaged with multiple services.

Documentation as a theme was woven through all other major focus areas, and was a key focus for *ESTIE* participants in their influencing work, and a 'site' for improvement and sustainable change towards domestic violence-informed practice. Insights into domestic violence-informed documentation are included in the following sections on each of these areas where they are particularly relevant or illustrative.

Interrelated themes emerged in discussion of documentation and its impact as part of domestic violence-informed practice:

- Bringing everyone into the room
- Focusing on patterns rather than incidents

5.2.1. Bringing everyone into the room

> *I can say my documentation is more well-rounded, in terms of discussing a client and their family context. It's something, I haven't done a lot in the past, I used to be more client focused, I've expanded to include the whole family context. They also say write with an audience in mind. I used to just write the notes, for whoever might be interested. Now I write for other services who will be reading the notes, to give them a context of what I know and what I have learnt in the time the client is with us. It might be mental health, it might be [service name], whoever, I know they might read those notes. And I want them to be informative.*
>
> – S2_CoP_AOD-1, S2_FG

The idea of 'bringing everyone into the room' was explored in depth across the *ESTIE* Communities of Practice. As part of an all-of-family approach, this involves considering, and wherever possible,

documenting the actions and their impacts of each family member, along with their needs and efforts towards safety or recovery. Within a pattern-based approach, this emphasises the need to consider the 'absent presence' (Thiara & Humphreys, 2017) of perpetrators, even if they are not physically there. Where services are adult-focused, this crucially involves bringing the perspectives and where possible the voices of children into the room, considering and documenting their needs as individuals.

One worker spoke of using documentation to ground a client who had perpetrated violence, as part of behavioural change work. The worker described how documenting the impacts of the perpetrator's action on his children was a powerful awareness raising activity, that opened up a new perspective for the client to consider their behaviours. This in turn provided a platform for further engagement with the client, who was more motivated to address harmful behaviours and work towards safety for their children. 'Bringing everyone into the room' also applied to workers' inter-service practice and the use of case documentation and collaborative mechanisms to work towards coordinated service responses for clients.

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

Shifting from an incident-based focus to a pattern-based approach was a major theme in discussions of documentation. Given the focus of the Safe & Together™ Model, this is not surprising, and much discussion included examples and exploration of how to increase perpetrator visibility by mapping their behaviours and clearly documenting their patterns of abuse.

Each piece of documentation that a worker creates becomes part of a client's history, within and across services. Holding perpetrators accountable starts with language - how we describe the problem, who is responsible for creating the problem, the impact of their behaviours on others and the expectation that they have responsibility to change behaviour and repair the harm. Language is also important in contributing to recognition of a victim/survivor's circumstances and the safety risks they face. Observing, noting, and creating informed narratives of how perpetrator actions, as well as victim/survivor efforts, impact children and their wellbeing and development helps to set up opportunities for intervention and restorative justice, particularly where children have been used by perpetrators to control non-offending parents.

This power of documentation to create narratives of victim/survivor strengths and resilience was a strong theme in the Communities of Practice. The importance of clearly articulating harmful behaviours and use of coercive control cannot be understated, but equally, workers and the Safe & Together consultants explored the importance of documenting context and 'her pieces of strength' as a strong, counter-narrative.

> *How are we making decisions about the safety and wellbeing of kids if we're all only looking at the deficits? You can't possibly. I mean if we only look at the perpetrators behaviours, we'd probably be taking all the kids. Right? Cause what else have we got. We just know that these things are happening and the perpetrators responsible and the kids are being impacted. So, without that other conversation we can't be really looking at how is she mitigating the risk…thinking about how survivors are supporting kids in all those ways and often in the context of what the perpetrator's doing to disrupt that. So, it can really give you that bigger picture.*
>
> – Safe & Together Consultant, Site 2_CoP 2

When workers discussed the impact of domestic violence-informed documentation for their clients, an emergent focus was on the power of good documentation in the present moment, regardless of past practices or framings. By creating a new piece of documentation written through a domestic violence-informed lens, the trajectory or pattern of previous documentation can be shifted, and the dial moved towards a more contextual and accurate picture of cases, supporting re-framed service responses.

One mental health clinician provided an example of how they were working to increase perpetrator visibility and reframe their client's current circumstances through documentation. The client was suffering from serious mental health concerns, including schizophrenia, and was also presenting with concerns around problematic use of AOD. The mental health clinician described how the client's file included many references over the years to domestic and family violence, noting the client as the victim of her partner's abuse, but sometimes insinuating that he was the victim. The mental health clinician described how the partner was clearly in a position of power and control – he was financially stable, had no reported mental health concerns, and was always 'in control'. The mental health clinician described his pattern of behaviour including actions such as pretending to have an affair with the client's previous care coordinator, in order to make her jealous and sabotage that relationship, and when the client lashed out and assaulted someone, he used this as evidence of her being 'crazy'.

The mental health clinician, applying a domestic violence-informed lens to the documentation, went back and wrote a mental health review as an update to provide current details and recontextualise past documentation. This included naming the perpetrator's behaviours and activities that had sabotaged the client's efforts towards recovery, and detailing the serious repercussions of that behaviour that the client had faced. Reflecting on the exercise, the mental health clinician spoke about how the main change that stood out was using language that clearly articulated and drew visibility to the perpetrator's choice to use coercive control, shedding new light on the pattern of behaviour and its impact on the victim/survivor.

In contrast, the danger of records perpetuating harmful stereotypes and embedded practices, particularly around child removal, was raised as an issue for many families, and particularly for Aboriginal women. In one example, 'red flags' in the records system relating to a past pregnancy triggered scrutiny by child protective services at each subsequent pregnancy and service engagement, even when there were no present issues.

Discussions about culturally safe documentation focussed on the use of the appropriate language style. While reports and professional referrals between services often require the use of clinical language, case plans or letters of engagement that are client-facing were discussed as needing to be always written in accessible, plain language. Employing language that clients are not likely to have come across before or easily understand, for example the use of clinical terms or conventions without explanations, is ineffective and may hinder engagement. Particularly for people from marginalised communities where mainstream services have historically (and in some cases currently) used documentation in manipulative, punitive or dishonest ways (e.g., to support inappropriate removal of children from families), clinically worded documents such as case plans may feel unsafe if they are not given the opportunity to work through their understanding and clarify meanings.

5.3. Working with culturally diverse families

Throughout the *ESTIE* Communities of Practice, participants were encouraged to consider and explore the cultural context for their cases in more nuanced ways. Attention to culture was framed as everyone's business. This was supported by Marlene Lauw in the second half of 2021, who acted as a cultural consultant and facilitator in the CoP discussions and supported reflection about working with Aboriginal families.

Attending to culture in practice, from engagement onwards, is an area needing improvement for many professionals particularly in mainstream services. For example, experiences of violence and abuse, and perception around the perpetration of these behaviours, might be interpreted differently across cultures; specific cultural contexts may influence responses to violent behaviours; or, 'symptoms' of abuse may be considered differently in relation to individuals and communities. Culturally competent practice in this

space involves being able to respond to these differences with respect, while continuing to implement ethical and violence-informed practice that holds perpetrators to account and supports victim/survivors.

To be effective, this must be underpinned by a sound understanding and cognisance of the historical and ongoing contexts of violence, oppression and trauma which disproportionately impact families from diverse cultural backgrounds, and particularly Australia's First Nations peoples. This underpinning is separate to, but crucially informative of, culturally competent practice across areas such as domestic and family violence, alcohol and other drug, and mental health.

In many CoP case discussions, the cultural background of clients was initially invisible, with cultural elements emerging through prompting by Safe & Together consultants or the research team.

Drawing on the practice experience of the diverse CoP membership, including Marlene Lauw and the research team, the following insights and points for consideration proved valuable for professionals working towards more positive, competent practice with families from diverse cultural backgrounds:

- Acknowledge dynamics of privilege and power, historical and current harmful practices.
- Make an individual commitment as a worker to strive towards practising deep listening for different experiences and perspectives, and how they intersect with more familiar aspects of practice.
- Be prepared to step out of personal comfort zones to understand concerns about the forms of violence encountered by male perpetrators under colonial structures, without excusing domestic and family violence.
- Take responsibility to actively develop and implement professional and personal practice changes that increase safety for clients while decreasing the perpetuation of cultural patterns of oppression and control.

> *We work with vulnerable families, so simple, straight to the point, rather than beat around the bush, is what we like for myself and clients […] I just think moving forward for indigenous and non-indigenous workers, more training on how understanding our culture can improve working relationships between indigenous and non-indigenous workers. It can improve just by understanding. We don't expect a non-indigenous worker to understand our culture but to be learning, just be open minded, and expect the unexpected in a good way.*
>
> – S4_CoP_NCP-8, CoP 5

Other aspects of culturally competent practice relating specifically to themes of pivoting to the perpetrator, partnering with victim/survivors and focusing on children and young people, are included in later sections of this report.

5.4. Worker safety

Throughout the *ESTIE* CoP discussions, Safe & Together consultants continually emphasised worker safety as a foundational driver of the Model. If workers are unaware of how perpetrators are willing to use abusive behaviours, violence and threats, they cannot work safely with families. If they are unaware of the actions that victim/survivors take to keep themselves and their children safe every day, they cannot properly support them towards living free from violence. If workers are unaware of how domestic and family violence, AOD and MH intersect in the personal lives of their clients, or how they interact in terms of service provision, they cannot effectively support families living with complexity. And if workers lack organisational support to attend to these issues, they are more likely to be personally at risk, physically and psychologically, and their practice is less likely to be domestic violence-informed. This section presents the findings from discussions focused on working safely, including the challenges and best practices reported by *ESTIE Project* participants and explored with the research team and consultants.

5.4.1. Finding ways to practice safely through violence, intimidation, manipulation, and threat

Addressing safety concerns, however they present, enables workers to more effectively weave together knowledge of violence, use of AOD or MH issues, and connect the dots between risks and mitigating actions, between safety issues and case formulation, and work towards safer practice with families and services.

> *For me as a worker, I want to know if he's acted out on a previous worker or someone else in a position of power because that's what I need to think about to navigate what I'm willing to do physically, or how I feel emotionally, or how we need to be shifting how I work with this perpetrator. That preparation and documentation.*
>
> – Safe & Together consultant, S2 CoP 4

Workers who have not been supported to examine perpetrator patterns of behaviour nor effectively partner with victim/survivors to do so, are more likely to step into collusive or victim blaming practices, and to be at risk of compromised safety (physical and psychological). CoP members explored with the Safe & Together consultants how feelings of being unsafe or under threat significantly impacts workers' ability to conduct ethical work with families. This may be based on a direct physical threats or other forms of intimidation from a perpetrator, or a perceived threat to safety based on contextual factors and lack of support to address them. Addressing these feelings improves assessments, practical inquiry and documentation, and collaboration with other services.

Partnering with victim/survivors was discussed as a central aspect of practice that. When safety risks are heightened as a result of perpetrator threat, or perceived to be heightened with no support to address it, the 'path of least resistance' to working with families is often to engage *only* with the victim/survivor. Although this is a central aspect of practice and supports effective risk assessment for families, workers and services, CoP members explored how this practice puts all the onus and responsibility for safety onto victim/survivors, without addressing that the perpetrator is the *source* of risk.

This approach may be particularly detrimental for victim/survivors with limited socioeconomic resources and people from culturally and linguistically diverse backgrounds, as it interacts with and compounds existing pressures and oppressive systems of power. Workers discussed with Safe & Together and cultural consultants how to approach practice in ways that do not further increase the burden on victim/survivors, and victim/survivors from minority groups, in particular. This includes being cognisant of how worker practices and characteristics might impact victim/survivors' sense of safety, even if they have arisen out of concern for worker safety. For example, a practice of requiring male workers to accompany female workers to conduct home assessments, due to perpetrator presence and potential for harm to workers, sets a particular tone. While this practice may have become routine in an effort to support female workers out in the field, victim/survivors may have concerns the perpetrator could perceive this as threatening, or they themselves may prefer to interact only with female workers.

Finding ways to practice as individuals with unique constellations of safety concerns was a particularly salient topic throughout all the *ESTIE* Communities of Practice. Individual worker characteristics and circumstances are connected to broader discussions of gender, parenthood, discipline-specific challenges, and contextual settings (e.g., rural/regional versus metropolitan). CoP members described doing their best to navigate these individualised challenges – female workers felt more vulnerable to physicality from perpetrator, but reflected they were more likely to face challenges around invitations to collude through use of charm and grooming behaviours from perpetrators alongside physical intimidation. Male workers, while they felt less threatened by physicality, reflected they might be more at risk of perpetrators using aggression, as well as invitations into misogynistic or patriarchal conversations when discussing violence against women. Workers who were parents, male and female, felt that this aspect of their personal identity was both a vulnerability and a point of strength when working with families experiencing DFV, AOD and MH. On the one hand, threats from perpetrators to harm children were heightened, and on the other,

engaging perpetrators through their role as parent and father was a 'way in' to discussions (though workers reflected they often did not disclose whether they were parents). When working with victim/survivors, being able to relate to experiences and perspectives on child safety was valuable, but if partnering efforts were challenging, workers reflected that some victim/survivors used the worker's inexperience of parenthood as a point of resistance.

5.4.2. Attending to physical safety

Most CoP participants reported feeling physically safe in contexts such as health headquarters, office buildings, community centres, clinics and other organisationally run workplaces. Eestablished protocols, with good assessment, understanding and attention to risks all contributed to this sense of physical safety, and were for the most part already in place for them.

Outside of these organisationally run workplaces, workers did not feel protected by their organisations in settings such as external consultations, home visits to clients and in their personal lives outside of work hours. In regional areas and small communities, where the boundary between personal community and client groups they provided services to was more likely to overlap, this was reported to be a ever-present concern. Regional workers gave examples of feeling particularly vulnerable when working with perpetrators, who they then encountered in their community outside work, even if no overt threats had been made towards their safety. Home visits in regional areas pose a range of risks, including workers visiting on their own due to the lack of co-worker availability, large remote properties, lack of access, and uncertainty about who was on the property during their visits.

Home visits where perpetrators were physically present were described as less worrying than those where perpetrators might be present but unseen, concealing themselves on the property. Workers described more fear for their own and their clients' safety in these situations.

> *It's really, it is scary. I've lost count of the amount of times the perpetrator is under the house, in the garage, in the bedroom, on the roof. And the client talking, the woman, speaking softly. That experience there, it can be scarier that they aren't seen, rather than if they are sitting in the lounge room. You think, who is in that room. We have ice users, dealers under houses in our home visits. You can just see the pressure the client is under.*
>
> – S2_CoP_NCP-5, CoP 4

In some cases where organisations did not appear to take threats from perpetrators seriously, workers did not feel physically safe at work. Workers emphasised the need for management and organisational leadership to pay attention to worker concerns regarding clients, consider the impact on them as individuals, and hold the person using violence accountable, rather expecting workers as professionals to be able to individually keep themselves safe.

> *One worker described a deeply disappointing response from management following an experience with a male client known to have a history of using violence. The worker was not supported to pursue legal avenues to mitigate risks to their safety when the client used stalking behaviours against them and was instead directed to alter their own behaviour. Following a physical attack on the worker by the client, in an organisationally run workplace, the worker's line management response focused on deficits in how the worker had handled the situation. The worker was required to repeat safety training, amendments were made to their workplan, and restrictions on the types of clients they engaged with were put in place by management.*

5.4.3. Promoting emotional and psychological wellbeing

ESTIE participants consistently advocated for increased attention to emotional and psychological wellbeing, going beyond a focus on physical safety alone. Workers described shared experiences of stress, frustration, exhaustion, fear, isolation and overwhelm as a result of navigating complex patterns of risk and harm caused by perpetrators. Specific examples of challenges to worker wellbeing included grooming and fear of collusion with perpetrators, concerns that service involvement could increase risks to adult and child victim/survivors, pressure to manage significant workloads with limited resources, and navigating complex systems not aligned with DFV-informed principles.

> *One of the pathways I think for vicarious trauma for a lot of people is that bumping up against the challenges, especially when there are ethical or moral kinds of challenges you have to hold, and you are fighting against the system…. you're doing the best you can absolutely, but you're seeing that not necessarily impacting the system right now. And having to hold that I think is a really big impact.*
>
> – S4_CoP_SA-1, CoP 4

Participants highlighted the risks to both workers and families when workers were left to navigate these experiences without support. Potential implications for job satisfaction and sustainability were discussed, including a sense that workers felt unable to support families in the way they would like to, or were forced to work with 'blinkers on' and avoid more difficult conversations. Many participants described working in organisations with a dominant culture of expecting individual workers to keep themselves psychologically and emotionally healthy when responding to DFV, with the only alternative to exit the workforce. This led to workers feeling unable to discuss the impacts of the work and downplaying their own needs.

> *Our skin gets so tough that we can't actually be responsive to the people we are supposed to be caring for.*
>
> – S2_CoP_MH-1, CoP 4

Participants were motivated to discuss their own support needs within the project. Recurring throughout CoP discussions was the notion of developing a 'culture of care', aligned with reducing workers' feelings of individual responsibility and instead fostering organisational responsibility, collaboration and mutual support. The CoP members identified with this concept, and the *ESTIE* CoPs were commonly referenced as a model to develop this approach and reduce workers' feelings of isolation.

> *It makes such a difference communicating with other workers who communicate…. After every visit we contact each other, there is so much going on, need to know the plan each week. And if I need help or they need help with something, we do rely on each other. It's fantastic to have that working relationship for services but also for the clients.*
>
> – S2_CoP_HCP-4, CoP 4

> *I loved hearing you talk about your mutual support, taking time outs, breathing together, laughing or crying. All those pieces and how we survive in those settings.*
>
> – Safe & Together Consultant, S2 CoP 4

Meaningful, DFV-informed supervision and line management were both identified as crucial but separate elements of a culture of care. The need for high-quality, violence-informed, external supervision was a recurring topic of discussion in CoP sessions, but the extent of satisfaction with existing supervision arrangements varied greatly across roles and services. Similarly, workers called for a greater focus on structural support through management, policies, training and systemic change, particularly for workers navigating complex legal issues and systems, such as being required to attend court, understanding legislation around information-sharing, and preparation of documentation for use in a legal setting.

Another emerging area of discussion was the need to build awareness and structural support for the significant proportion of health workers with their own lived experiences of violence (McLindon, Humphreys & Hegarty, 2018), as well as other professionals working with families experiencing DFV, MH and/or AOD issues. CoP participants emphasised the importance of acknowledging the expertise of lived experience and a worker's potential to translate this into professional skills and a meaningful understanding of these issues and client experiences and the issues confronting them (McLindon, Humphreys & Hegarty, 2019). Ethical considerations around impacts of current and past experiences on workers was also considered, with participants emphasising this as an often-unaddressed support need.

Overall, participants believed in the potential for empowering and sustaining experiences if they could work within a culture that supported care at both an organisational and individual level. This included the ability to be vulnerable, being allowed to have and discuss emotional needs, having time to plan, reflect and debrief, being trusted to utilise professional judgment, and being more understanding of other services' limitations as opposed to blaming or attacking. A culture of care was also identified as crucial for workers to feel able to achieve practice change at the intersections of DFV, AOD and MH, such as within the *ESTIE Project*.

5.4.4. Threats to professional identity

Threats to professional identity emerged as a key theme throughout the *ESTIE* CoP discussions on worker safety. Perpetrators' threats to make complaints or actual complaints lodged against professionals were experienced by professionals as a major concern. Workers reported that the impact of these complaints extended beyond their own wellbeing and safety, to that of their families and the clients they were working with. In one instance discussed during a CoP meeting, a perpetrator was reported to have threatened to accuse a health worker's husband of child sexual abuse, and the impact of this threat was felt by professionals who subsequently worked with the family.

In contrast to issues of physical safety and risk assessment, workers described feeling underprepared and less supported in relation to threats to their professional identity. Although protocols exist for physical and obvious threats to psychological wellbeing, workers described a lack of rigorous mechanisms to determine the credibility of repeated complaints made by a perpetrator, potentially reinforcing his tactics of coercive control.

> *I feel more of a threat to my professional reputation and standing, because the way psychology works as a profession, psychologists are registered. It's a big deal to be registered, and complaints are taken seriously, with a lot of processes. … I feel less supported by my organisation to deal with it, than a physical threat. Workplaces are set up, training etc, for physical threats. Trouble-making complaints are dealt with in the same way as real ones. It's a threat to worker safety, I find it quite significant.*
>
> – S1_CoP_SA-1, CoP 4

Obligatory investigation when a perpetrator makes (perhaps false) allegations against a partner or ex-partner as part of their tactics of control, often undermines the safety of the relationship between workers and victim/survivors and increases victim/survivors' perception of the control that perpetrators have over systems and service providers. Clear pattern-based protocols were called for, which assessed and documented the credibility of each complaint in the context of the complainant's pattern of behaviour and control tactics.

Using research and other evidence to develop appropriate responses was also discussed as an important way to support domestic violence-informed practice in this area. Safe & Together consultants also recommended that protocols are informed by research evidence about general patterns of complaints in the context of DFV.

5.4.5. Documentation to support working safely

Participants spoke of using documentation to support their safety as workers, through creating counter-narratives that supported workers and their practice decisions, in the face of spurious or egregious complaints made by perpetrators who sought to intimidate or threaten workers. Workers described keeping notes of conversations with supervisors, phone calls with clients, and other elements of their practice at the intersection of DFV, AOD and MH, in order to be prepared if a complaint or threat was made against them. However, this constant need to be documenting takes its toll on sense of safety and wellbeing.

> *I guess, my approach has been about making sure I documented an alternative narrative, notes, conversations with supervisors, managers. It's preparing for a fight right, when actually, it would be nice to feel safer than that.*
> – S1_CoP_SA-2, CoP 4

The link between workers' sense of safety and the way documentation is used in risk assessment and evaluations for families was discussed in the context of boundaries and outcomes. When perpetrator actions indicated a willingness to threaten or harm workers as well as their family members, this affected what workers were willing to document. Fear of physical as well as litigious reprisal can influence the way workers document cases, as well as impacting personal wellbeing and sense of safety. This in turn affects the possible outcomes for families and their engagement with services. Advice from Safe & Together consultants particularly touched on the role of documentation in signposting possible risk, through recording where investigations have not led to clear assessments, resisting potentially dangerous case closures, and highlighting to future workers that 'more work needs to be done'.

However, documentation of perpetrator patterns, including any apparent willingness to use complaints or service system mechanisms against professionals, can function to support workers and provide an effective counter-narrative. In the absence of management or supervisory support, workers emphasised that positive documented attention to coercive control, such as including reflections, planning and expectations in assessments and case notes and summaries, was particularly important for safety.

For client safety, family information and contact details need to be updated as information is obtained, using a domestic violence-informed lens. One CoP member noted that the medical records of a client without extended family or community or service connections, included the man who had been abusing them as next of kin and therefore the only contact for professionals wanting to support the client, despite documented evidence of this risk.

5.4.6. Attending to cultural safety for clients and workers

Cultural safety is a critical component across all work, and applies not just to the culturally and linguistically diverse, and particularly Aboriginal families, involved in health services, but also to those diverse professionals working in, or interacting with, a mainstream health system. Creating cultural safety for families engaging with mainstream services was a key area of discussion throughout the *ESTIE* CoPs, particularly in the second stage CoPs. The practice of individual workers as a driver towards more culturally safe services and systems included explicitly addressing past systemic abuse and demonstrating an awareness of the impacts of intergenerational trauma that many Aboriginal families live with in Australia today. Culturally safe practice starts with engaging in open-minded collaboration and active learning from culturally competent workers and services. A number of approaches were discussed:

- Build authentic rapport and relationships.
- Demonstrate an awareness of the concerns that culturally and linguistically diverse, and Aboriginal families, have about the service system. For example, a worker explains the purpose of their services as supporting the client as a victim/survivor, rather than investigating neglect or parenting deficits.

- Be vigilant about whether a service upholds its own principles of culturally safe practice. Have Kinship networks been contacted to support children and victim/survivors? Has an out-of-home placement for a child been explored within Kinship, community, or cultural networks? Do care plans explicitly support connections to culture?
- Be creative and flexible in engaging with clients on their terms. One worker described working with an Aboriginal woman who reported feeling closed in and trapped when visiting a service's consulting rooms based on negative past experiences, and impressions of the functioning of mainstream services as colonial institutions. While it was not standard protocol, the worker enlisted management and colleagues' support to meet with this victim/survivor in the service's courtyard, with careful scheduling to ensure privacy and confidentiality. This resulted in an approach tailored to the individual client, based on their unique concerns and needs, and supported engagement with the client to include consideration of cultural context and connection to country by changing the physical space.

The CoP discussions explored how these ways of working can increase safety for everyone, and with support particularly from Marlene Lauw, discussed strategies and ways forward to support both Aboriginal clients and workers, and non-Aboriginal clients and workers. Discussion considered reports that Aboriginal clients often felt culturally safer when Aboriginal Health Liaison workers accompanied non-Aboriginal workers on visits. Anecdotes from workers and Marlene Lauw highlighted the difference observed when culturally competent workers were able to support clients to feel culturally safe. This was particularly true for identified Aboriginal workers engaging with community where the ongoing impacts of entrenched colonisation, oppression ad intergenerational trauma are particularly salient. Examples were given of how workers could see clients become visibly less tense, more willing to engage with health services, and less agitated when discussing their circumstances and concerns.

> *I could settle mum quite quickly when I was around… I was there to support the family, let them know I was an indigenous caseworker, and then her mood would go from slamming the door, it changed completely, she was completely calm.*
> – S4_CoP_NCP-8, Aboriginal worker, CoP 5

Mainstream and non-Aboriginal workers actively prioritising the development of their own cultural competency and learning in this area also increases the safety of organisations for culturally and linguistically diverse and Aboriginal workers. Discussion and anecdotes from workers and Marlene Lauw included reports of how Aboriginal workers described the constant feeling of being pulled in a multitude of directions through requests for case consultations, home visit collaborations, and training and supervision. By creating an expectation that cultural competence is the responsibility of every health worker, workers and clients become safer both physically and psychologically and Aboriginal workers and those with high cultural competency are less burdened.

5.5. Partnering with the adult victim/survivor

Substantial evidence from earlier research about partnering with adult victim/survivors has previously been published (Healey et al, 2020). This material is not repeated in this report; rather, a summary of new insights from *ESTIE* discussions is presented.

5.5.1. Documentation as part of partnering with adult victim/survivors

The documentation of victim/survivors' strengths and insights into their circumstances and capacity, regardless of what this looks like, is an activity that contributes to building stronger worker-client relationships and often functions to boost clients' capacity as well. While partnering with a client *about* perpetrator behaviour, a worker reported that mapping previously unexplored perpetrator patterns, and

carefully documenting this information, had opened up new opportunities to discuss contextual issues and explore impacts on children and family. Through updating documentation templates to include sections and prompt questions about the impact and context of abuse, with a focus on perpetrator actions, partnering practices are now reflected in the actual language of records.

Conversations around partnering explored how documenting victim/survivor strengths and actions taken to protect and support children or family, must *always* include detail of perpetrator's behaviours, as a core component of practice. This approach significantly shift case trajectories and outcomes, particularly when children are involved. Without this contextual information however, documentation may inadvertently collude with perpetrators' aims, and be extremely damaging for both workers and victim/survivors.

5.5.2. Bringing cultural competence to partnering with victim/survivors

Partnering with victim/survivors in the context of cultural safety included key approaches to practice, such as bringing awareness and understanding of historical and ongoing impacts of colonialisation, systems abuse, oppression and damage of and impact on connection to culture; , respectful curiosity to dig deeper beyond assumptions and stereotypes; and attention to unique tensions that come with community protection and engagement of perpetrators.

Historical and current child removal practices present a critical challenge to creating a sense of safety for victim/survivors of violence, particularly when AOD and mental health challenges are present. CoP members emphasised the need to recognise the fears that this history has engendered, particularly when engaging with Aboriginal victim/survivors, as well as fear of a perpetrator. Engagement is strengthened by explicit acknowledgement of these dynamics and past harmful practices, and clear articulation of a strengths-based approach that focuses on supporting the wellbeing of each family member. This includes acknowledging the importance of the relationship with a perpetrator that many victim/survivors feel, but upholding the need to hold them accountable for their choices to use violence and control. Where possible to do safely, this also includes supporting perpetrators of violence and abuse to address their own trauma, AOD or MH concerns in a parallel process, without framing these concerns as excuses for violence. Practice tensions in this area include understanding victim/survivors' sense of loyalty and protectiveness of their communities, even when it comes at the cost of their safety and wellbeing; but also acknowledging that victim/survivors may feel silenced or ignored by communities who focus only on protecting perpetrators from systems victimisation.

The multiplicity of truths and fears that these dynamics create are important to acknowledge when working with Aboriginal victim/survivors, and validating feelings of loyalty, actions taken to protect children and themselves amongst these tensions is always crucial. The historical and current context for mistrust in systems and motivations behind victim/survivor behaviours and fears must underpin engagement, and workers emphasised the need to open conversations in a way that allows the client to feel safe in talking about their experiences and those of their children. Reticence to speak about violence, or other behaviours that victim/survivors display that workers find confusing or contradictory, can be explored respectfully when bringing awareness that victim/survivors may be fearful of consequences both from perpetrators and service systems. Fear of child removal and placement in the child protection system is a particularly critical point for workers to reflect on and address with their clients safely, if they hope to effectively partner with her and uphold child safety and wellbeing.

5.6. Pivoting to the perpetrator

While pivoting to and working with perpetrators at the intersections was one of the most prominent areas of interest for CoP members, substantial evidence from earlier research has previously been published (Healey et al, 2018; Healey et al, 2020). This material is not repeated in this report; rather, a summary of new insights from *ESTIE* discussions is presented.

5.6.1. Using documentation to increase visibility of perpetrators and their patterns

Shifts in language were seen as central to holding perpetrators accountable through case notes and emails through to formal court reports. Jargon and short-hand phrases that do not articulate perpetrators' specific behaviour patterns, let alone their impacts, and can obscure actual harm and render perpetrators invisible. Recording perpetrators' refusal to engage, response, or support partners and children act is just as important. CoP members reflected that workers hold substantial amounts of detailed information in their heads, but when this information, particularly in relation to patterns of coercive control, is not explicitly present in their documentation, visibility of perpetrators and their patterns is easily lost.

> *I noticed over and over again in psychiatrist notes, collateral information from housing, over and over again, all it said was 'victim of domestic violence, has been physical in the past'. No actual... because what I heard in clinical reviews was coercive control patterns. I can't come to appointments because I don't have a car anymore for example. Heaps of stuff that wasn't documented.*
>
> –S2_CoP_MH-1, CoP 4

Further, documentation can also build evidence about how perpetrators sabotage the efforts of partners and children to seek help by including contextual detail about why they 'did not present', 'missed appointment' or 'failed to attend'. Clearly documenting these pieces of information again increases perpetrator accountability and visibility, and provides context for other services who may be engaged with the client as well. With this information available, proactive steps can be taken by workers to provide support to non-offending parents so they can access services effectively.

5.6.2. Attention to culture in pivoting practices

CoP discussions about culturally competent practice when perpetrators of violence are Aboriginal men included reflections on the racism embedded in mainstream services and systems. This included how communities often balance perpetrator accountability and a wish to protect men from victimisation by these systems.

CoP members also discussed the importance of attending to how racism, fear of systems, and perceived power all might be used to oppress and discourage victim/survivors seeking help as part of perpetrator patterns of behaviour, whether or not perpetrators are Aboriginal. Using fear of colonial systems and child removal were particularly salient tactics, as well as leveraging entrenched attitudes and harmful stereotypes against victim/survivors and their children.

5.7. Focusing on children and young people

In exploring the Safe & Together model through the *ESTIE Project*, CoP members described a significant shift in the way they conceptualised working with a focus on children and young people, particularly when they were based in adult-focused services. While earlier research in conjunction with the Safe & Together Institute has been published (Humphreys et al., 2020), the following section relates to new insights from *ESTIE* discussions.

As a foundational point, workers explored the conceptualisation of children as individuals in their own right, with their own vulnerabilities and strengths separate from their parents, their siblings, and their extended family or caregivers. While different implementation options and tensions may present, this foundational point applies whether or not the child is the client of the service, or they are engaged as part of working with a parent. Speaking directly with children involves focusing on each child's experience of their family and relationships, and of themselves as an individual in that family unit. When direct work with children was not possible or practical, CoP participants explored how to 'bring children into the room' through mapping the impacts of parental issues onto their experiences and life trajectories. Some key points in these conversations included the following areas for consideration:

- Engaging with adult clients as parents and discussing their relationships with their children.
- Exploring how parental actions may cause, exacerbate, or interfere with children's journey towards recovery and safety (e.g., undermining therapeutic engagement)
- Exploring why children might be presenting with concerning behaviours but not disclosing (past or present) experiences of trauma (e.g., have perpetrating parents threatened consequences if they disclose, how are past dynamics impacting current presentations)
- Considering the context for children's actions, that is, the perpetrator's use of violence, and moving away from labelling children as perpetrators where they use violence themselves by considering how their use of behaviours may be a mirroring act and survival strategy

> *Dad would say, 'oh yes she can have counselling, that's fine'. And then he was actively telling his daughter do not engage with that counsellor, they're pigs, they're dogs, just like police, you need to go out when she comes here or kick off or do whatever. So ultimately, I was never able to get her to a place where she wanted to engage because of that undermining.*
>
> – S4_CoP_HCP, CoP 3

5.7.1. Documentation to increase a focus on children and young people

As in the *STACY Project*, the precursor to *ESTIE*, children and their needs were notably less visible in documentation even when the impacts on their health and wellbeing were significant. This was particularly the case when higher risk AOD and MH concerns were present for adults engaged with services and family support programs, Children were a focus for documentation mainly in the context of cases involving Family Court proceedings. Workers saw case outcomes shift positively when they recorded observations of children with their parents, detailed the impacts of parental issues on children and included children's perspectives in case formulations and reports. Safe & Together consultants highlighted the need to situate children's mental health concerns in family functioning, including perpetrator actions taken to harm children, in order to effectively build understanding of children's needs and possibilities for intervention. This is particularly important given historical and ongoing patterns where children's mental health and wellbeing are considered only in the context of their mother's health.

Diligent domestic violence-informed documentation of the impacts of perpetrator actions on children, family functioning, the mother-child relationship, and the mother's protective efforts and commitment to their child's safety and wellbeing, was seen as an important practice that could provide narratives and perspectives that children may engage with later in life. This was emphasised particularly where perpetrators had attempted to or succeeded in drawing children into their narratives to use them as part of their pattern of abuse against their mothers.

ESTIE also brought a new perspective for many health workers about how services and workers often put the onus of responsibility onto children for monitoring safety, raising concerns and managing parental behaviours – in supervised contact visits, for example, asking a child to signal distress through and action like making a hand signal. Records that took this approach were identified as problematic, and a reformulation discussed which documented the actions of adults in the room aimed at managing parental behaviour and keeping children safe.

5.7.2. Promoting cultural safety for children and young people

Wherever possible, exploring with children and young people their connection to culture and how this contributes to their wellbeing was discussed as an important focus for working with culturally and linguistically diverse families. Health workers should be aware of perpetrator tactics that undermine children's connection to culture, and the dynamics of structural racism and power that may be involved, particularly for children with one Aboriginal parent and one non-Aboriginal parent in the Australian context. Conversely, exploring, validating, and documenting parental efforts to maintain cultural

connections may be crucial to making visible the importance of culture for Aboriginal children and their families, and the way continued connection supports children's health and wellbeing.

5.8. Collaborative working

This report details evidence that all *ESTIE* participants recognised the benefits of collaborative practice for better family outcomes and made great efforts to put it into practice. However, CoP participants also reported barriers to collaboration based on current siloed practices. Waiting lists and pressures to discharge from service result in clients being passed from service to service rather than professionals working together. Siloed services working separately with different family members may take positions which pull the family in different directions. In the current system, there are few services who assume a responsibility for engaging perpetrators.

> *If all those services aligned, you would end up with that focus on supporting her, you would end up probably with a client supported enough to manage, and keep her kids in her care. But when everyone is kind of siloed and all going 'we don't have capacity, its great you're there but we won't come in because you're there', you end up with this fragmented service where needs don't get met. And it's more likely kids will go into care.*
>
> – S2_CoP_HCP-3, S2 FG

The shared language provided by the Safe & Together Model frames DFV as relevant and impactful to holistic work in all sectors, and was seen as strongly supporting collaborative work in that it provided common ground for workers, even when they came from different clinical or practice frameworks.

> *When we have inter-agency meetings with anyone who has been on this ESTIE Project, we are going to go into those meetings or client discussions, and we're all going to be going 'oh, you're going to know what I'm talking about and we are all going to reflect in a similar way'. Its fantastic.*
>
> - S2_CoP_HCP-3, FG

Many health workers expressed concern about the time and resources required to work holistically with families in collaboration with a range of services. However, CoP discussions highlighted the many ways that, over the past few decades, Aboriginal workers based in community programs have developed family-focussed practice that promotes collaborative sharing of expertise and resources and creates sustainable networks to draw on. While individual workers may not have expertise across all disciplines that families require support in (e.g., addictions, mental health or violence and abuse), they have *experience* in a wide range of areas that allows them to accompany families on their journey and support them to access support from other services. This includes working with all family members and the wider community surrounding them, in a way that promotes accountability and increasing support.

> *Because with our families sometimes it's about hand holding […] And then they start getting to know us, feeling safe, and connected and supported, and then we're holding their hand and walking together. And down the track, after a good 6 months or we could work with families for 12 months, they're ready to go out on their own. . . . A little bit of dragging at the start, moving forward, hand holding, then letting go.*
>
> – S4_CoP_NCP-10, CoP 5

Strategies for collaborative practice discussed in the Communities of Practice included:

- sharing information and exchanging expertise;
- using routine activities such as car-sharing for home visits to build rapport and strengthen relationships between workers;

- ‘leaning in’ to workers across sectors and service disciplines while supporting clients throughout their experience of multidisciplinary response – through meetings, letter-writing, or testifying in court, to provide context to those who have other expertise;
- using tools, templates, and protocols (such as the *Safe & Together Intersections Meeting (STIM) Guide*) to keep DFV and its intersections with AOD and mental health in focus. This moves beyond a reliance on individual staff expertise, embedding good practice in organisational procedure and mitigating the effects of staff churn.

5.8.1. Documentation to support effective collaboration

Workers reflected on opportunities to integrate domestic violence-informed documentation into systems change at different levels. Small, iterative changes, such as the following, were proposed to encourage a more pattern-based, integrative approach:

- amending intake and assessment forms to include headings or prompts around ‘cause, exacerbate, interfere’ lines of inquiry, to promote holistic practice across issues of DFV, AOD and MH;
- developing new sections in templates to provide space to explore multiple pathways to harm and capturing impacts on children;
- adding new headings or key questions;
- reframing existing language within documents to encourage a more domestic violence-informed, collaborative response;
- being conscious of the audience for record-keeping and stakeholders for information-sharing, both at the time of writing or in the future; and
- consciously including details about behaviour in documentation regarding perpetrator patterns and behaviours, protective actions, impacts on children, and service responses.

Going beyond direct work with clients to focus on inter-service collaboration may involve recording which services have been engaged with clients or their families, who was present at collaborative meetings and case discussions, and what information has been, or is able to be, shared between relevant services. Documenting service engagement as well as client engagement brings more visibility and transparency into cases, and enables better coordinated responses, particularly where multiple pathways to harm might be present. These types of practices provide strong foundations for, and should be considered part of, effective client work. However, varying documentation practices across service settings and varied terminology about types of documentation was reported to lead in some cases to collaborative work being challenged by a lack of sufficiently informative documentation.

In contrast, templates and tools need to be customised for specific services. Acute health settings allowing limited time and engagement with clients, and requiring rapid assessments, presented particular challenges for workers. CoP members engaged with these challenges in different ways depending on their roles, and were creative in the possibilities they identified for further work that could provide opportunities for preliminary evidence of DFV to be gathered towards informing subsequent documentation. For example, a psychosocial assessment tool for acute settings, enhanced through the inclusion of domestic violence-informed language and brief questions, could lay positive foundations for more holistic work with families further engaged with the service system.

What information should be recorded, and how much detail to include, was the focus of much CoP discussion, particularly when content could be the subject of subpoenas and have significant impact on the outcomes of court cases (within a system that has a long way to go to being domestic violence-informed). This aspect of record-keeping felt like a particular ‘minefield’, with workers looking for training and

organisational support. Grappling with the tensions inherent in documenting complexity across DFV, AOD and MH, the highly contextual nature of documentation for different services, disciplines and sectors remained an unresolved challenge throughout the *ESTIE* CoPs. Domestic violence-informed documentation, in itself, was reported as a positive aspect of practice change for CoP members and an empowering outcome of participation in the project, but could only be taken so far without organisational and structural change and commitment.

Documentation platforms within the NSW Health system itself (such as the Electronic Medical Record system), which prioritise privacy and confidentiality, can be barriers to effective sharing of information through documentation, both within programs or services and between sectors. Health workers reported partnering with victim/survivors to proactively share information with their consent, and making formal requests for information that were documented and that could be referred back to.

Most record-keeping systems used in health services across the world rely on contact-based modalities of practice (e.g., noting dates and times, modes of contact, visits etc.) and in this way work against pattern-based mapping of behaviours and development of domestic violence-informed context and narrative. Highlighting this pattern, Safe & Together consultants advocate making a deliberate, conscious effort to map and document patterns and gaps in information, particularly where multiple services are involved with a client or family, and engagement with them is dispersed or uncoordinated. Collating, and documenting in one location, information from multiple sources and sections of discrete available systems can be challenging, but builds a solid foundation for collaboration and safer, more informed assessment and planning for clients.

5.9. Practice settings

ESTIE CoP discussions were enriched by the diversity of expertise, roles and workplace contexts represented by participants. The participant group included workers from acute care settings such as emergency departments, in short-term treatment programs across addictions and mental health disciplines, and longer-term therapeutic workers who engaged with clients for extended periods of time. Participants also worked in client-facing roles, some in team leader positions, and policy development. The diversity of experience allowed for rich discussion of practice development and implementation across a wide range of contexts.

5.9.1. Rural and regional settings

Challenges included increased worker vulnerability in terms of geographically isolated workplaces, lack of client transport and housing options, poor access to service programs in remote areas, and limited resourcing resulting in workers operating alone. Workers described increased risks when conducting home visits alone to isolated properties, in some cases when they knew safety was a concern, but the family would otherwise not receive services. The nature of presenting issues featured acute and chronic mental ill-health with notably high risks, including concerns for worker wellbeing and risk of vicarious trauma when engaging with clients experiencing high levels of abuse and neglect. Psychological safety and wellbeing were also discussed as particularly complex for rural and regional workers, as their smaller communities meant that their personal and professional lives were more likely to overlap.

However, rural and regional practice settings provided positive opportunities for collaborative workplace relationships and living in tighter knit communities. Health professionals encountered a diversity of issues in their practice, giving them broad experience, and the likelihood of more stable workplace teams supported ongoing collegial relationships and warm referrals between workers.

5.9.2. Acute care settings

Practice in acute care settings focuses on a brief crisis response to emergencies, leaving little room for considering the complex interactions of DFV, AOD and MH for presenting patients, particularly coercive control. Existing documentation templates do not support assessment of issues such as patterns of violence and their impacts, beyond the minimum. CoP discussions considered the possibility of mitigating the often highly intrusive service response necessary in acute care settings through acute care professionals using their engagement with patients as groundwork for future service engagement and therapeutic work. Proposed strategies included: asking about parental relationships, even when contact with children was limited; upskilling medical staff in domestic violence-informed child and parent observations; and revising policies and procedures to support partnering, pivoting and sensitive responses in the crisis setting.

5.9.3. Short-term versus longer-term therapeutic settings

Short-term therapeutic programs presented similar tensions between immediate harm reduction and responses addressing underlying issues that would benefit clients in the long run. CoP members working in these settings reported that a mix of resourcing and time constraints limited their opportunities for building the rapport with clients necessary for exploring the impacts of violence on family members, and children in particular. However, through discussion in the *ESTIE* CoPs, many short-term therapeutic workers embraced a shift in perspective, recognising the opportunity to plant the seeds of engagement and healing that would support clients in their journeys towards recovery. CoP members also recognised the value of documenting single assessments and meetings, to provide preliminary evidence of safety risks, flag issues for future work, and act as a catalyst for further referrals to other long-term services.

> *From an acute care perspective, longer term therapeutic questions you want to ask but are constrained by the [program] is a 4-week window. What I've noticed works well, is saying to people, 'look I want to explore all of this stuff, connections to children, relationships between kids, I want to explore but this is not the time and place. But should we write some of it down so when you do get to that ongoing therapeutic stage, you have somewhere to start, some questions you've started to explore.*
>
> – S2_CoP_MH-1, CoP 2

CoP members from longer-term therapeutic settings were extremely encouraging of the contribution made by short-term therapeutic workers, across AOD, MH and DFV sectors. They described the positive impact of these preliminary conversations on clients' readiness to engage and their understanding of service systems and pathways.

5.9.4. Policy development settings

ESTIE discussions encompassed the role of policies, protocols, and overarching guidance in creating an environment that supports client-facing workers to shift towards domestic violence-informed practice. CoP members working in policy development areas described the opportunities they had to embed Safe & Together principles into organisational culture. They discussed using a domestic violence-informed lens to draft policy, which included considerations of the unique dynamics, risks, and enablers for work at the intersections of AOD, MH and DFV. CoP members not engaged directly in this work highlighted the following areas of policy which, when properly communicated and socialised to the client-facing workforce, could have significant impact towards safe, ethical practice with families. Some workers felt that while these points may be implemented (or in the process of being implemented at time of writing) in some areas, or information regarding them available through government websites, increased communication and awareness-raising through the client-facing workforce is needed.

- Explicitly considering the needs of employees in policy and legislation relating to safety practices and information sharing.

- Using research to inform the development and interpretation of policies and protocols. For example, guidance for physical or sexual assault assessments should be informed by evidence about the association with coercive control.
- Guidance on interpreting key legislature and policy, such as the NSW Crimes Act, to support staff in navigating work at the intersections of DFV, AOD and MH, and to challenge interpretations based on narratives that render perpetrators invisible and blame mothers.
- Policy direction relating to documentation of assessments and program outcomes, and regulation the use made of these records by other institutions.
- Embedded internal review processes that support workers to explore client and case histories already available within health documentation systems, alongside crisis management and documentation. This supports pattern-based thinking and understanding of how incidents might be connected, and as well as increasing in-depth understanding of the complexity that might be driving presentation at any one time point.

5.9.5. The role of resourcing and infrastructure

CoP discussions included a range of reflections about the impacts on practice of resourcing and infrastructure issues. Local issues such as service level contracting, staff capacity and lengthy wait lists hinder effective early intervention service delivery, despite the emphasis in health policy and communication on early intervention. Short-term staff contracts for staff also impact continuity for programs, the clients looking to access programs, and capacity to build relationships between services.

CoP participants reported the following high-level issues of concern:

- The need for specialist roles harnessing expertise in work with families at the intersection of DFV, AOD and MH.
- The dearth of male staffing in health and mental health services (particularly across a range of marginalised groups) was perceived to result in male clients being reluctant to engage with services, due to perceived stereotypes, gender norms or assumptions about who attends therapy and why.
- Lack of services to refer clients to, particularly male clients. This issue was particularly salient in rural and regional LHDs, with workers describing a scarcity of services, and prohibitive costs for those available.

CoP members reflected that issues such as these lead to professionals feeling unable to pursue domestic violence-informed work, and reported that time pressures and heavy caseloads significantly impeded their ability to map families' presenting issues, conduct thorough safety assessments, build rapport with clients, and maintain detailed records. This lack of capacity for profound practice with clients was seen to result in frustration, burnout and cynicism.

> *My cynical guess is if we look too closely, we would go 'I don't have the capacity to put that into place with the staffing we've got'.*
>
> – S2_CoP_HCP-6, CoP 4

However, workers who felt they did have adequate resourcing available to them, described high levels of satisfaction in the work they were able to do. When they had manageable caseloads, workers described being able to do active outreach to clients, explore client issues beyond crisis management, and build relationships and collaborative networks that supported effective and safe domestic violence-informed practice. Workers also described being better able to actively pursue learning and development opportunities, including creative forms of casework, such as the use of technology, with a consequent positive impact on clients.

6. Discussion and next steps

The *ESTIE Project* used an action research model to engage with health workers and senior managers. This enabled the research team and project participants to share, generate and embed new knowledge (research and learning activities) and to build capacity in organisations (practice and action) (Ison, 2008).

The *ESTIE Project* therefore focused on health workers in the context of their organisations to strengthen their practice at the intersections of DFV with AOD and MH. The research team was interested in several research questions which explored: capacity building workers to implement the Safe & Together™ Model using guidelines, training, and communities of practice; strengthening the documentation of DFV; and increasing professional skills and confidence in working at the intersections of DFV, AOD and MH. We were also interested to question what client-facing workers required from their organisations to work with safety and efficacy in the sensitive area of DFV when it intersects with other complexities. These two questions are closely entwined and will be explored together in the Discussion.

Central to the Discussion is the increasingly clear evidence that changing DFV practice, particularly where children are involved, requires complex systems change. Short-term training for front-line workers, while popular, shows little impact in terms of implementing practice change (Wagenaar & Cook, 2011). The series of projects undertaken with Safe & Together by members of the research team have sought to develop a different approach to practice change, and the *ESTIE Project* provides a further example, with the focus on DFV at the intersection of AOD and MH, strengthening attention to documentation, and using *the STACY Practice Guide* as a resource to support practice (Heward-Belle et al, 2022).

Both client-facing workers and managers had much to say about their experience of working with a complex intervention involving senior managers to provide an authorising environment; training with the Safe & Together Institute; Communities of Practice facilitated and supported by Safe & Together consultants; and engagement by Community of Practice participants in strategies to influence a specific group of other workers. Clearly, it is a project design that goes beyond training (Humphreys, Healey & Heward-Belle, 2020) and seeks to achieve a stronger possibility of practice change. A significant disrupter in the action research design was the COVID-19 pandemic which placed increased time and emotional pressures on workers and managers (McKibbin et al, 2022). Nevertheless, the response to the questionnaire by both CoP and PAG members endorsed both the content and tools of the Safe & Together™ Model as well as the mode of implementation through the *ESTIE Project*.

6.1.1. Practice development

Workers who participated in the *ESTIE Project*, either directly through participation in the virtual training and Communities of Practice, or as 'influencees', reported that their domestic violence practice had improved, that is, had become more domestic violence-informed. Both groups of workers stated that documentation was the area in which they saw the greatest practice change, indicating that the project successfully met its aim of building worker capacity to produce documentation which maps perpetrator patterns and records the strengths and needs of non-offending parents and children.

These new documentation practices were applied across all the Safe and Together thematic areas of identifying the perpetrators' pattern of coercive control and actions taken to harm the children, mapping the perpetrator pattern onto adult victim/survivor's strengths and protective capacities, keeping a focus on children and young people, working safely and working collaboratively. They were applied to a range of contexts, from emails and case notes to formal court reports.

Participants reported new understandings of the power of domestic violence-informed documentation, both for clients and for systemic advocacy. For example, for victim/survivors, it can provide an alternative to deficit-focused, victim blaming narratives that may follow women across organisations, including legal

systems (De Simone & Heward-Belle, 2020). Children's safety is directly supported through reports for child protection and family court proceedings, and domestic violence-informed documentation can also provide them with the future legacy of a different perspective about protection, accountability and connection to culture.

ESTIE participants reported that documentation reflecting behavioural, contextualized and pattern-based understandings was a powerful tool for advocacy and collaboration across health sectors and with a range of external organisations that need to be mobilized to support the victim/survivors' protective efforts and to hold perpetrators accountable. Collaboration was also enhanced through building and promoting a shared language, the second most frequently nominated area of practice improvement.

The strong emphasis by CoP members on the importance of 'bringing everyone into the room' reflects the uptake of the Safe and Together all-of-family approach which proved a powerful tool in working at the intersections, where AOD and MH services traditionally have an adult focus, rather than a focus that includes keeping children in mind. Also 'brought into the room' were other services involved with clients, using pattern-based documentation and the development of a shared, domestic violence-informed language (Humphreys et al., 2022).

An important area of practice development was recognising the crucial importance of attention to the cultural aspects of practice. Many participants learned that the context of colonial violence, including child removals and ongoing systemic racism, needs to be acknowledged when working with Aboriginal families (Herring, Spangaro, Lauw & McNamara, 2012). This understanding of socially generated risks is essential for engaging with Aboriginal victim/survivors, and for implementing an all-of-family and community approach. Without this acknowledgement, for example, partnering with an Aboriginal victim/survivor cannot incorporate a full understanding of her protective actions, including maintaining children's connection to culture and community.

In understanding the enablers of practice change, CoP members ranked the Safe & Together virtual training as the most impactful, followed by the Community of Practice sessions (Table 12). The difference in the level of practice improvement reported by direct *ESTIE* participants compared to those less directly involved ('influencees'), indicates that capacity building is enhanced when professionals can participate in both training and ongoing coaching and peer support through a Community of Practice as they apply the learning from the training in their practice. Nevertheless, the model of supporting senior workers to promote practice change within and between organisations, adds to the critical mass of professionals who are developing domestic violence-informed practice. Workers also found the Safe and Together tools, particularly the *Perpetrator Pattern Mapping Tool*, of great assistance in the ongoing development of their practice and in sharing their learning with colleagues in health and other services.

One important finding of the *ESTIE* research was that, in the face of complex cases and systemic barriers, CoP members experienced the practice changes in documentation as empowering and reported that this was a strong motivator to continue developing and sharing domestic violence-informed practice.

When identifying the elements necessary to sustain these changes, *ESTIE* participants suggested practice-focussed processes, such as incorporating use of concepts and tools into team and peer consultations, supervision and reflective practice. However, they primarily identified broader organisational and system changes as vital to sustaining practice change, to which this discussion now turns.

6.1.2. Organisational challenges

Evidence from Communities of Practice highlighted the significance of the authorising environment provided by senior management to: support team leaders and front line workers to prioritise the time for training, learning and coaching; and to support the directions for practice change. The CoP highlighted a number of issues that were of importance. First, *all levels of management need to be involved* in

championing the change process, including both direct line managers and senior managers at the highest levels of the organisation. This is an issue raised in other areas of organisational change which highlight the requirement for 'an all of organisational' approach when complex systems and cultural change is being developed (Esaki, Benamati & Yanosy, 2013). Every level within an organisation, and particularly senior manager, needs to be involved in authorising practice changes if these are to become embedded in that organisation. The complex levels of hierarchy, particularly in government organisations, require a strategic approach to management at different levels (Andrews, Pritchett & Woolcock, 2016). This was an issue raised during the *ESTIE* Communities of Practice, with senior workers sharing both positive and negative examples from their experiences of management across their different workplaces.

Second, managers in the Program Advisory Group, as well as CoP workers, pointed to the challenges of *bringing together siloed systems* (e.g., AOD and MH and DFV) and the facilitative worker necessary to enable services to engage in multi-disciplinary and multiagency work. It was evident that intra-organisational silos were easier to bridge than inter-organisational silos (Humphreys et al, 2020). Furthermore, the experience from the *ESTIE Project* was that preliminary work to 'socialise' a new practice model required time and multiple conversations between senior manager champions who already had pre-existing relationships across the silos. These factors facilitated the development of an authorising environment for multi-agency and multi-disciplinary work. In the second stage of the *ESTIE Project*, the research team was able to spend significantly more time discussing the project vision with senior managers than in the first stage, and the impact on CoP participation and engagement across MH and AOD sectors in the second stage is evident in the *ESTIE Project* data.

Third, authorising AOD and MH professionals to *place a priority on DFV* and surface this issue in their practice was essential to changing DFV practice in these services. Traditionally, DFV has not been considered core AOD or MH business, although workers were discovering the significance of the experiences of violence and abuse in understanding the response of their clients once they began to proactively explore the issue (Heward-Belle et al, 2022; Humphreys et al, 2020). CoP participants regularly highlighted that senior management support is required to authorize this shift in practice from referral to active engagement with DFV, and to provide the *time and resources to realistically manage the change*. Creative ways to engage clients who also did not see DFV as relevant to their involvement with these services were explored in the Communities of Practice to share new practices in this area. It is an ongoing issue for both MH and AOD services, when narrowly defined therapeutic models focus only on the problem that a client seeks to identify and address (Isobe et al, 2020), rather than understanding and responding to a broader range of problems which impact family functioning. This broader holistic practice includes understanding adults as parents and exploring the needs of their children when DFV is present (Humphreys, Healey & Heward-Belle, 2020).

6.1.3. Creating a culture of care for workers

A central feature of the Safe & Together™ Model is the importance of paying attention to the person using violence and coercive control, usually the child's father or father figure (Mandel, 2009). However, these acts of violence and coercive control are characterised by secrecy and isolating victim/survivors. Shining a light in this area, making the tactics of coercive control visible, and holding perpetrators to account for the impact and consequences of this abuse will not occur without backlash and escalation of abuse (Hill, 2019). It is not only victim/survivors who will be threatened with punishing consequences for breaking the silence, but also professionals who dare to expose the patterns of coercive control (Mandel, 2019). Interestingly, there is surprisingly little research on this issue in the context of domestic and family violence – for example, in the recently published *International Handbook of Domestic Violence and Abuse,* worker safety is not the subject of any of the fifty chapters, nor is it indexed as part of another chapter (Devaney, Bradbury-Jones, Macy, Overlien & Holt, 2021). An exception lies in developing research on DFV in rural

areas which highlights the vulnerability associated with isolation for both victim/survivors and workers. A challenge which organisations need to address, the experience of violence from clients more generally draws attention to this as a cause of workforce attrition (Natalier et al, 2021).

CoP participants made constant reference to this issue of worker safety. It is one which is highlighted through previous projects with Safe & Together, and is a significant element in the development of DFV guidelines (Heward-Belle et al, 2022). It is clear from *ESTIE Project* findings that client-facing workers need to feel safe if they are to address the harm created by the person using violence or indeed, engage with that person. In the first instance, client-facing workers looked for reassurance that the health and safety measures in place in the workplace were sound, and expressed the need to experience that in action. CoP participants generally reported experiencing a sense of physical safety in their office workplaces. However, they raised issues of emotional and psychological safety that require addressing at organisational level for client-facing workers to feel sufficiently safe to develop partnerships with victim/survivors and to avoid inadvertent collusion with perpetrators of violence and abuse. This is an issue raised previously by Littlechild and Burke (2006), whose research about child protection workers highlighted the strategies of intimidation that workers were subjected to, rather than many incidents of direct physical abuse.

CoP participants also spoke of their *fear of reputational damage* as perpetrators sought to discredit them professionally through raising unsupported complaints and threatening their livelihoods. Examples were provided of their management not 'having their back', and where perpetrators were able to use the system against workers who were striving to expose their tactics of abuse. Perpetrators' honed skills in manipulation were deployed against workers in similar ways to their use against victim/survivors. Some workers noted the ways in which their managers and Human Resources staff were naïve, ill-prepared or otherwise unprotective of their reputations. In this often disappointing context, workers communicated that they expected the same trauma-informed and DFV-informed support in their roles, as they were expected to provide in their work with clients,. Workers also expected an organisational approach that took into account the unique challenges of working at the intersections of DFV, AOD and MH.

A further issue, raised particularly by rural and regional workers, lay in their lack of *safety outside the office*, not only on home visits, but more generally in small communities where they lived 'side by side' in the same towns and neighbourhoods as perpetrators of DFV. 'I never order home delivery pizza' stood out as a general reminder of the vigilance required by these client-facing workers as they negotiate the porous boundaries between their work and personal lives.

As discussed elsewhere in the report, workers recognised the importance of *cultural safety* and suggested that proactive action at higher organisational levels towards an 'all of organisation' response may ensure the cultural safety of Aboriginal colleagues in their workplaces and wider organisations, with all workers (both non-Aboriginal and Aboriginal) taking responsibility for cultural safety (De Zilva, Walker, Palermo, & Brimblecombe, 2022). These discussions took place at a time when large mainstream government and non-government organisations across Australia are striving to develop stronger, culturally safe organisations. Health services are also engaged in this process (De Zilva, Walker, Palermo & Brimblecombe, 2022; Ministry of Health, 2022), and this project demonstrates the significant work still to be undertaken.

6.2. Next Steps

The *ESTIE Project* was a complex and exciting project which involved four Local Health Districts in New South Wales, 80 senior health workers, 334 workers whom CoP members sought to influence, and a committed group of senior managers involved in the Steering Committee and two Program Advisory Groups. As outlined, there were many learnings and significant impacts from the project, and a number of issues highlighted that require attention in the future.

a) The *attention to documentation* by *ESTIE* participants demonstrated, that with support and training, workers were able to make measurable progress towards more detailed, comprehensive, and accurate reporting of domestic and family violence. Institutionalising tools like the *Perpetrator Mapping Tool* and the *Safe & Together Intersections Meeting (STIM) Guide* will help to embed this progress.

   However, at the organisational level, client-facing workers were hampered by expectations that curtailed the amount of detail that could be easily written in electronic forms. Workers also faced hurdles when data platforms in different parts of the service system were not aligned, leading to significant repetition of data entry. It is an area where organisational reform is needed if workers are to actively work with documentation as a core practice component, rather than a peripheral administrative requirement.

b) The ongoing development of *culturally safe practice* is a major commitment of the NSW Ministry of Health, and also one which was highlighted as a key priority area in this project. In particular, further attention is required, in partnership with Aboriginal Community Controlled Health Services, to the utility of and potential alignment between the all-of-family responses advocated by the Safe & Together Model and holistic services working with Aboriginal families and their communities.

c) Worker safety was highlighted as an area in which further work was required by the organisation to ensure that workers experienced physical, emotional and professional safety. This was a particular issue in rural and regional areas. It was also an area where organisational managers require greater understanding of the manipulative strategies of perpetrators who target workers using similar strategies to those deployed against victim/survivors.

d) Practice leaders in Communities of Practice recommended that they be able to share the issues raised in practice directly shared with their senior managers. While there were boundaries between the Program Advisory Group senior managers and CoP participants, the *ESTIE* team encouraged communication between the groups. In the absence of 'brokering' by the research team between these operational and strategic layers, workers called for regular discussions between themselves and senior managers about issues relating to embedding DFV reform into their work practices.

e) One of the goals of the *ESTIE Project* was the revision and expansion of the *STACY Practice Guide*. It was clear that this *Guide* was generally valued by those that used it, but that the *Guide* was less often accessed by health workers where it was not 'socialised' as a central part of practice development (Heward-Belle et al, 2022). The new *ESTIE Practice Resource* will require this attention if it is to fulfil its role in advancing domestic violence-informed practice at the intersections of DFV, AOD and MH, alongside the implementation of the Safe & Together™ Model more generally.

f) The *ESTIE Project* explored directions for working at the intersections of AOD and MH services with DFV. Research findings show this to be a fruitful and enriching area of multi-agency work. However, sustained attention by senior managers, and their championing and commitment to ongoing practice development, is required if 'working at the intersections' is to be maintained and developed as good practice for families with complex needs.

6.3. Conclusion

The findings of the *ESTIE Project* indicate that it addressed its aims. The findings add to the growing body of evidence that identifies a path to systems change that challenges the entrenched history of mother-blaming, promotes more just responses for women and children and holds perpetrators to account for their choice to use violence.

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8. Appendices

The following Appendices provide further detail to that in previous chapters. The Appendices are:

8.1: Glossary

8.2: *ESTIE* Project Activities Outline for CoP and PAG members, June 2021

8.2: Consent and data management process

8.3: CoP & Influencee questionnaire

8.4: PAG questionnaire

8.5: Survey respondent demographics

8.1. Glossary

Acute settings

An acute care setting is any setting in which care is provided in response to an urgent need or crisis. This includes emergency departments, ambulances, mental health emergency services, and crisis accommodation.

All-of-family approach

The all-of-family approach is a holistic approach to working with each family member in the context of their family, extended family, community, and Kinship groups, as well as collaboratively across services and sectors. It is underpinned by feminist theories that attend to the intersections of drivers of domestic and family violence (DFV) including sexism, racism, colonisation, ableism, homophobia, and other forms of oppression. All-of-family approaches recognise the potential safety risks in working with the family as a unit allow for separate work with each family member where this is more appropriate.

Authorising environment

The authorising environment is the management, policies, and service system structures that support organisations to function. The authorising environment can either help or hinder workers to engage effectively with clients experiencing domestic and family violence using the Safe & Together™ Model, and embrace domestic violence-informed practice. Different authorising environments may act at a number of different levels and may support or contradict each other.

Behavioural focus

In the Safe & Together™ Model, behaviours are the focal point for assessment and intervention. Mapping the behaviours of both the perpetrator and the victim/survivor, gives workers a starting point for all their practice with the family. In parallel process, the behaviour of the worker and the system become a focus by exploring the 'how' not just the 'what'.

Child-focus

Within this document, this phrase refers to inclusive practices that keep a focus on the impact of violence on children, and their individual experiences of perpetrator patterns of coercive control and parents' substance misuse and/or mental health issues.

Child safety

Child safety refers both to the physical safety of the child and also to their emotional safety and well-being - keeping the child or children safe in their own homes and in the community, and living without violence and abuse.

Coercive control

AA pattern of physical and/or non-physical actions taken by perpetrators that are intended to intimidate and manipulate both adult and child victim/survivors, through tactics such as threatened or actual violence, isolation, emotional and/or financial abuse, suicide or suicidal threats, and micromanagement (such as constant surveillance). Coercive control instils significant levels of fear that constrain the behaviour of victim/survivors, undermining their liberty, self-determination, and choices.

Collaboration

Collaboration involves work and practices that simultaneously build shared respect, learning and knowledge, and actively contribute to shared outcomes, goals and/or decision-making. Collaborative practices create safe environments for workers and clients when based on foundational elements of integrity and cultural competence, and genuine reciprocal partnerships involving deep listening and engagement with organisational and personal values. Collaborative partners acknowledge and uphold each

other's identities, skills, and contributions, while being aware of biases and their impacts, and actively address each other's needs and priorities.

Cultural safety

'Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.' (PARVAN, 2022, p.14).

In the context of engaging participants throughout the professional development and research activities of the project, this document refers to efforts to support cultural safety. In the context of outcomes of these activities towards improved practice with families from diverse cultural backgrounds, this document refers to cultural competence and culturally safe practice.

Domestic and family violence (DFV)

Domestic and family violence is defined as any behaviour in an intimate or family relationship that is violent, threatening, coercive or controlling, and causes a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour. An intimate relationship refers to people who are (or have been) in an intimate partnership, whether or not the relationship involves or has involved a sexual relationship: i.e., married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, and couples who are dating.

A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, or sibling and extended family relationships. It includes the full range of Kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships. It also includes family within communities of people with diverse sexualities, gender identities or intersex variations. People living in the same house, people living in the same residential care facility and people reliant on care may also experience domestic or family violence if their relationship exhibits dynamics of coercive and abusive behaviours.

Domestic violence-informed

This term refers to practices, policies and systems that incorporate knowledge and attention to the unique dynamics, challenges and manifestations of domestic and family violence and abuse, particularly coercive control. Domestic violence-informed practice attends to power imbalances and assumptions in relationships between people engaging with services, workers and their clients, and the service system, its workers and its clients. This approach upholds the resilience and strengths of victim/survivors, accountability for perpetrators and the rights and experiences of children as individuals, while attending to family functioning and wider social influences on people's lives. The Safe & Together™ Model is one example of a framework for domestic violence-informed practice.

Drivers of violence

The drivers of violence are associated with gender inequality and are the most consistent predictors of violence against women. These drivers include: condoning violence against women; men's control of decision-making and limits to women's independence; rigid gender roles and identities; and male peer relations that emphasise aggression and disrespect towards women.

A public health model is prevention focused, targeting key risk and social factors including the drivers of violence at a population level through a cross-disciplinary and multi-agency approach.

Expectations of men as fathers

This is highlighted as a way of counteracting gender double standards in parenting. Fathers should be held equally accountable as mothers in their capacity for parenting, particularly in exploring the impact on the children and on family functioning of fathers' parenting choice to use domestic and family violence.

Gender and Gender inequality

Although people with diverse sexualities, gender identities and intersex variations experience domestic and family violence, international and Australian research consistently identifies gender as the biggest risk factor for intimate partner violence.

Gender inequality is the social condition that underpins gender as the most common risk factor where women are predominantly the victims and men the perpetrators of domestic and family violence. It is a social condition characterised by unequal value afforded to men and women and an unequal distribution of power, resources and opportunity. It often results from, or has historical roots in, laws or policies formally constraining the rights and opportunities of women and is reinforced and maintained through more informal mechanisms. These include, for example, social norms such as the belief that women are best suited to care for children, practices such as differences in childrearing practices for boys and girls, and structures such as pay differences between men and women.

This project recognises that domestic and family violence is a gendered crime. The project uses the terms 'woman'/'survivor'/'victim/survivor'/'non-offending parent' to reflect those who have experienced harm from domestic and family violence and perpetrator/offending parent as the person who chose to use harm.

Intersectionality

Intersectionality refers in this report to people's differential experiences of domestic and family violence and how they are influenced by different forms of oppression including sexism, racism, ableism, homophobia, and other aspects of identity. Taking an intersectional approach means recognising that the barriers to seeking support, and the particular forms of violence that victim/survivors from some groups experience, are not only driven by sexism and gender inequality, but also by other forms of discrimination. This extends to recognising that men who perpetrate violence experience different responses from service providers and structural systems based on different constellations of identity.

Intersections

Intersections refers to the complex relationship between domestic and family violence and parental issues of mental health and/or substance use, as experienced by families (often in the context of child protection concerns). This relationship may take different forms, including where one issue shapes or exacerbates the other or, where an issue is used or exploited by the perpetrator for the purposes of coercive control. It can also refer to the complex relationship between the perpetrator's own pattern of abusive behaviour and their own substance use and/or mental health issues.

Life generated risks, external context, social context risks

Life generated risks are the challenges that women face (in addition to those posed by the perpetrator's behaviours) because of their social location, such as poverty, racial discrimination and disability. Life generated risks create extra challenges in women's efforts to protect their children, and understanding them is essential to partnering with her. The perpetrator often uses these circumstances to extend his control over family members.

Model/framework/approach

Rather than being a manualised, step-by-step implementation guide as often associated with implementation of models for practice, the Safe & Together™ Model is a framework for practice and action, applicable to high-level systems change and individualised practice. Throughout this document, the Safe & Together™ Model is referred to variously as a 'Model', a 'framework', and an 'approach'. Reference is also

made to other domestic violence-informed frameworks, models and approaches, with the same interpretation. These terms are used interchangeably. **Pattern-based harm and pivoting to the perpetrator** This phrase refers to the pattern of behaviour chosen by perpetrators to harm and control both adult and child members of his family. Rather than focussing on a single incident or many incidents that have occurred separately, mapping the perpetrator's pattern of behaviour contextualises his violence and captures its cumulative impacts on child, partner, and family functioning. In practice, this pattern-based approach requires 'pivoting to the perpetrator', a phrased used by the Safe & Together Institute to capture the practices that occur in a multitude of ways. Pivoting does not always involve direct contact or engagement with the perpetrators themselves. It involves keeping a focus on the perpetrator patterns of behaviour throughout discussion and questioning of cases, working within established systems, in documentation, and in collaborative working across programs and services. Pivoting should never be undertaken without keeping children's safety and wellbeing in view and thus without 'partnering' with the child's mother (or non-offending carer).

Perpetrator – those who choose to use violence
The term 'perpetrator' is used consistently in research literature and in Australia's domestic and family violence policy and legislative environment. The term is used to reinforce the serious nature of violence in intimate or familial relationships. This project uses the term to refer to men, fathers or those who use violence and coercive control toward their family and community. We recognise that it is preferable to separate 'the offending person' from their 'behaviours', however, at times the use of the phrase 'fathers who use violence and coercive control' or 'person using violence' can be unwieldy. We use 'perpetrator' as a shorthand term and a term which has broad usage across systems e.g., criminal justice and child protection, with a focus on the dominant gendered pattern of men's violence against women and children.

Priority Population
The term 'priority populations' refers to diverse groups for whom there is significant evidence of heightened vulnerability to violence, both in frequency and severity, and who may encounter a range of specific barriers to seeking support and securing safety, related to intersecting identity-based and situational factors, and experiences of discrimination.

Safe & Together™ Model
A high-level, transferable framework for conducting holistic and collaborative work across services and sectors. The Model involves a focus on keeping children safe and together with the non-offending parent, partnering with the non-offending parent and recognising their strengths and protective capacities for their children, and finally intervening with the perpetrating parent and holding him accountable for his violence and coercive control. Developed by David Mandel and the US-based Safe & Together Institute, further details can be found at https://safeandtogetherinstitute.com/.

Victim/survivor
The term 'victim' is most commonly used in public, legal and criminological discourse to describe people who have experienced violence, while 'victim/survivor' and 'survivor' are used to reflect the process of victimisation and the work survivors do to rebuild their lives after violence. Current literature also increasingly recognises and refers to children as 'victim/survivors' or 'survivors' of violence, rather than as 'witnesses'.

Worker
The term worker includes all people working with women, children and families experiencing domestic and family violence, alcohol and other drug and/or mental health issues and child protection concerns. It includes practitioners, clinicians and other health professionals who engage with families towards safety, recovery and wellbeing.

8.2. ESTIE Project Activities outline

The ESTIE Project
Activities outline for Project Advisory Group and Community of Practice members

INTRODUCTION

The *ESTIE Project* (*Evidence to Support Safe & Together Implementation and Evaluation*) is an action research project run by the University of Melbourne in collaboration with the US-based Safe & Together Institute. The project is being conducted with New South Wales (NSW) Health and uses a Community of Practice (CoP) model to capacity build practice and generate research evidence.

This document provides information on the activities that Project Advisory Group (PAG) and Community of Practice (CoP) members are asked to engage with as part of their participation in the *ESTIE Project*. These activities are framed by the project goals and research questions.

The research team is keenly aware that PAG and CoP members have very full schedules and workloads. The activities have been designed to be practical exercises that contribute to the capacity building goal of the project, as well as generate research data and provide opportunity for further learning and embedding of the Safe & Together™ Model.

Contents of this document

ESTIE PROJECT GOALS

iv. Deliver updated guidance for practice with adult victims/survivors, children and perpetrators (including a section on documentation) where DFV is occurring in the context of AOD and/or mental health issues.

v. Support an influential group of Health workers to build capacity within their LHD in relation to the Safe & Together approach to DFV where there are complex issues of AOD and mental health, who can share their expertise with other practitioners and senior manager and thereby extend capacity building more widely across VAN, AOD and MH services.

vi. Provide research evidence of capacity building through the implementation of the STACY Practice Guide and Safe & Together Training.

ESTIE RESEARCH QUESTIONS

3. What evidence is there that capacity building through the Community of Practice Model, supported by coaching and supervision from Safe & Together Institute consultants:
    - effectively enables practitioners and organisations to embed the STACY Practice Guide into policy and practice?
    - enables case and other documentation which maps perpetrator patterns, and records the strengths and needs of the non-offending parent and children?
    - increases practitioner skills and confidence in working effectively at the intersections of DFV, AOD and MH?

4. What do practitioners require from their organisations and/or other organisations to support them in working effectively at the intersections of DFV, AOD and MH?

Version 3, June 2021

PROJECT ADVISORY GROUP AND COMMUNITY OF PRACTICE MEMBER ROLE SUMMARY

Project Advisory Group membership

The Project Advisory Group comprises key representatives from organisations whose practitioners are participating in the Communities of Practice. In addition, representatives of other key organisations within the LHD with expertise in domestic and family violence. Project Advisory Group (PAG) members will be senior managers of services involved in the *ESTIE Project* in your LHD and will have an advisory and participatory role involving the following aspects. PAG members are responsible for championing the ESTIE Project within their service sectors and promoting intersectoral collaboration according to the needs of your LHD. The activities we ask you to engage in are listed below.

Preparation phase

1. Work with the research team to identify cross-sector PAG members
2. Identify appropriate CoP members in your LHD and services

You are invited to take part in the following activities:

i. Register for online Safe & Together pre-learning modules
ii. Safe & Together pre-learning modules
iii. Safe & Together 4 half days of training

PAG role during the CoP phase

3. Ensure that CoP members' work commitments allow them to attend training, participate in CoP sessions and research activities
4. Support and work with CoP members as agents of practice change
5. Attend three PAG meetings to reflect on and problem-solve issues arising from the CoPs

PAG role during the post-CoP phase

6. Case-file assessment of a CoP member file
7. Post-CoP survey
8. Feedback on ESTIE Project findings

Community of Practice membership

Community of Practice (CoP) membership is for senior clinicians, team and practice leaders. As a CoP member in the *ESTIE Project*, we ask you to take part in the research aspect of the project. This overlaps with the project's aim of capacity building practice in NSW Health, and involves the following activities. There are three main phases to your involvement in the *ESTIE Project* as a CoP member, and the activities we ask you to engage in are listed below.

Preparation phase

1. Register for online Safe & Together pre-learning modules
2. Safe & Together pre-learning modules
3. Safe & Together 4 half days of training
4. Case-file self-assessment (1)
5. Identify influencees

CoP phase

6. Five CoP meetings
7. Acting as agents of change, influencee work

Post-CoP phase

8. Post-CoP focus group
9. Case-file self-assessment (2)
10. Post-CoP survey

PROJECT ADVISORY GROUP MEMBERSHIP DETAIL

The activities we ask you to engage with as a PAG member are detailed below. This information is in addition to the Project Advisory Group Member Information Sheet. If you have any questions or would like to discuss the activities or information included here or in the Information Sheet, please contact the *ESTIE Project* research team.

ESTIE Research task	Description of what we are asking you to do	How long will it take?	When we will ask you to do this
PREPARATION PHASE – Project Advisory Group activities			
1. Work with the research team to identify cross-sector PAG members	Work with the research team to identify other potential PAG members who can contribute to championing practice change and enabling an authorising environment across sectors for the *ESTIE Project* and CoP members. This could include other NSW Health services, interagency partners such as DCJ, and local NGOs working across DFV, mental health and substance use.	Between one and five hours (April-July), depending on your role and LHD involvement	At the beginning of your LHD's involvement in the *ESTIE Project*, before the CoP phase.
2. Identify appropriate CoP members in your services	Work to identify appropriate practitioners in your services to become CoP members. There should be approximately 25 participants in the CoP across all participating services in your LHD. These should be practitioners who are interested in championing practice change and who welcome the opportunity for training and supervision with the Safe & Together Institute's team.	Between two and five hours (April-July) depending on your role and management of/access to practitioners	At the beginning of your LHD's involvement in the *ESTIE Project*, before the CoP phase.
i. Register for online Safe & Together pre-learning modules	You are invited to register yourself as a Project Advisory Group member at the link below to gain access to the Safe & Together online learning. This is not compulsory, but highly encouraged to deepen your understanding of the project and Safe & Together. Registration link: https://share.hsforms.com/1TD4I7PPZQZSauXYyRVjsJA3a1w1	A few minutes	At the beginning of your involvement in the project, before the Safe & Together training days (see 3 below)
ii. Safe & Together pre-learning tasks	You are invited to undertake pre-learning tasks in advance of the Safe & Together training. This is not compulsory, but highly encouraged to deepen your understanding of the project and Safe & Together. This will be online learning through the Safe & Together Institute, covering modules on: • Introduction to the Safe & Together Model • Multiple Pathways to Harm • Intersections: where domestic violence, substance misuse and mental health meet	Approximately five hours of online learning.	At the beginning of your involvement in the *ESTIE Project*, before the 4 half days of training (see next)
iii. Safe & Together training	You are invited to attend 4 half days of training, either face-to-face or through videoconferencing, with a consultant from the Safe and Together Institute in 2021, facilitated by one of the project's experienced Chief Investigators. This is not compulsory, but highly encouraged to deepen your understanding of the project and Safe & Together.	Four hours each day, for four days.	At the beginning of your involvement in the *ESTIE Project*
COMMUNITIES OF PRACTICE PHASE – Project Advisory Group activities			

ESTIE Research task	Description of what we are asking you to do	How long will it take?	When we will ask you to do this
3. Ensure that CoP members' work commitments allow them to attend training, participate in CoP sessions and research activities	We ask you to provide an authorising environment to CoP members to support their completion of pre-training materials and attendance at the four half-days of training, attendance at CoP meetings and final focus group, and completion of case-file self-assessments, and response to post-CoP survey. This could involve approval of time allocation, access to key contacts or resources, and general support for CoP participants under your supervision and in collaboration with other PAG members.	The time you put into this work is up to you and should not be onerous.	Throughout the CoP phase.
4. Support and work with CoP members as agents of practice change	Support your CoP members to act as agents of practice change in relation to colleagues and teams you are responsible for in your area of working with families experiencing co-occurring issues of DFV, MH and AOD. This could involve approval of time allocation, access to key contacts or resources, and general support for CoP participants under your supervision and in collaboration with other PAG members.	The time you put into this work is up to you and should not be onerous. We will provide examples and tips on how you and your CoP members could approach this work.	Throughout the CoP phase.
5. Attend three PAG meetings to reflect on and problem-solve issues arising from the CoPs	Attend three 2hr PAG meetings held via videoconferencing, throughout the *ESTIE Project*.	Three 2hr meetings (total of 6hrs).	Depending on your LHD, these meetings will occur from February to June, or July to December, in 2021.
POST-COMMUNITIES OF PRACTICE PHASE – Project Advisory Group activities			
6. Case-file assessment of a CoP member file	Undertake a case-file assessment following the CoP meetings, of one of your CoP members' case notes. This will be supported by template documentation and instructions.	1 -2 hours	At the end of the CoP phase.
7. Post-CoP survey for PAG members	Respond to an online post-CoP survey at the conclusion of the CoP series.	20 – 30 minutes	Following the CoP phase.
8. Provide feedback on ESTIE Project findings	Provide feedback on project findings and reports generated by the research team.	1 – 2 hours.	Following the CoP phase, as they become available.

COMMUNITY OF PRACTICE MEMBERSHIP DETAIL

The activities we ask you to engage with as a CoP member are detailed below. This information is in addition to the Community of Practice Member Information Sheet. If you have any questions or would like to discuss any of the activities or information included here or in the Information Sheet, please contact the *ESTIE Project* research team.

ESTIE Research task	Description of what we are asking you to do	How long will it take?	When we will ask you to do this
PREPARATION PHASE – Community of Practice activities			
1. Register for online Safe & Together pre-learning modules	You will need to register yourself as a Community of Practice member at the link below to gain access to the Safe & Together online learning. Registration link: https://share.hsforms.com/1TD4I7PPZQZSauXYyRVjsJA3a1w1	A few minutes	At the beginning of your involvement in the project, before the Safe & Together training days (see 3 below)
2. Safe & Together pre-learning tasks	Undertake pre-learning tasks in advance of the Safe & Together training. This will be online learning through the Safe & Together Institute, covering modules on: • Introduction to the Safe & Together Model • Multiple Pathways to Harm • Intersections: where domestic violence, substance misuse and mental health meet	Approximately five hours of online learning.	At the beginning of your involvement in the ESTIE Project, before the 4 half days of training (see next)
3. Safe & Together training	Attend 4 half days of training, either face-to-face or through videoconferencing, with a consultant from the Safe and Together Institute in 2021, facilitated by one of the project's experienced Chief Investigators.	Four hours each day, for four days.	At the beginning of your involvement in the *ESTIE Project*
4. Case-file self-assessment (1)	Undertake an initial case-file self-assessment exercise, before the workshop series. You will be provided with instructions and template documents.	1-2 hours	1. Once at the beginning of your involvement, after the training but before the Communities of Practice begin 2. Once at the end of your involvement, after the last Community of Practice (see below).
5. Identify influencees	Nominate 3 – 10 colleagues or staff you will seek to 'influence' during the course of your engagement with the project. These will be your 'influencees', who you will work with in a way that suits your role and practice, around the Safe & Together Principles towards positive practice change and development Your influencees will be given access to online learning modules, and asked to register through the same link as above, and asked to respond to a feedback survey at the end of the workshop series.	This will depend on your role and team structure, and who you would like to work with as influencees. We will provide advice for this work and who could be involved.	At the beginning of the CoP phase.
COMMUNITIES OF PRACTICE PHASE – Community of Practice activities			
6. Five Community of Practice meetings	Engage in a 2.5 hour Community of Practice meeting, online, once a month for 5 months. This is the main task we are asking you to be involved in, to share your practice, expertise, insights and ideas for domestic-informed	2.5 hours each, once a month for 5 months	Depending on your location, workshops will occur once a month from February-June or July-October 2021.

ESTIE Research task	Description of what we are asking you to do	How long will it take?	When we will ask you to do this
	practice at the intersections of domestic and family violence, substance misuse and mental health.		
	Identify and offer de-identified examples of practice with families (where there is DFV and co-occurring issues of parental MH and/or AOD) or examples of attempts to effect practice change for discussion in the Community of Practice sessions.	15 minutes of preparation	Prior to each CoP session.
7. Act as agents of practice change	Act as agents of practice change in relation to colleagues and teams you are responsible for in your area of working with families experiencing co-occurring issues of DFV, MH and AOD.	The time you put into your influencing work is up to you and should not be onerous. We will provide examples and tips on how you could approach this work.	Throughout the CoP phase.
POST-COMMUNITIES OF PRACTICE PHASE – Community of Practice activities			
8. Post-CoP focus group	Engage in a reflective focus group at the end of CoP 5	1 hour	Following CoP 5 (with a break in between the CoP session and the focus group)
9. Case-file self-assessment (2)	This is the same exercise we ask you to complete at the beginning of the CoP phase.	1 – 2 hours	Following the final CoP and focus group.
10. Post-CoP survey	Respond to an online post-CoP survey at the conclusion of the CoP series.	20 – 30 minutes	Following the final CoP and focus group.

ESTIE Project Research Team contact details

If you have any questions about the information in this document, or in the Information Sheets provided to you that detail the *ESTIE Project*, you can contact the Research Team at any time.

Principal researcher	Professor Cathy Humphreys T: 03 8344 9427 | E: cathy.humphreys@unimelb.edu.au
Chief Investigator	Dr Margaret Kertesz T: 03 9035 8508 | E: mkertesz@unimelb.edu.au
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8.3. ESTIE Intake/Assessment Tool: Brief and crisis responses (Version 1, October 2021)

ESTIE Intake/Assessment Tool
Brief and crisis responses

(Informed by Safe & Together™)

This tool was developed initially for a triage team which included practitioners from: domestic violence, family services and child protection.* These practitioners had all been trained in working with the Safe & Together Model, but requested a tool to guide referrals and implementation of the Model in practice. The tool can also be used for initial work with people with lived experience, or referral into a single service. Individual services should tailor the tool to their circumstances.

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

*This Intake/Assessment Tool was adapted from a practice tool used in the Multi-Agency Triage Project funded by NE Region of the Victorian Department of Human Services (2015-2017).

The original tool was developed by Dr Lucy Healey, Deb Nicholson (University of Melbourne) & Lyn Turner (Berry Street), with input from Professor Cathy Humphreys (University of Melbourne) and David Mandel (Safe & Together Institute).

ESTIE Intake/Assessment Tool: Brief and crisis responses

(Informed by Safe & Together™)

1 Brief history from all possible sources

- Have the adult or child victims/survivors been seen by professionals in the past in relation to DFV?
- Does the person using violence and/or coercive control have a history with police or any service?

2 What behaviours by the person using violence and/or coercive control have led to this presentation or referral?

3 How is the adult victim/survivor supporting the safety and wellbeing of the child/ren? (protective factors)

4 (a) What are the risks to the ADULT VICTIM/SURVIVOR, posed by the person using violence and/or coercive control?

- Risks as identified in the DVSAT, screening tool, or other information from other services or police

(b) What are the risks to the CHILD/REN, posed by the person using violence and/or coercive control?

- Risks as identified in the DVSAT (section on children), screening tool, or other from other services or police

5 What are the risks to FAMILY FUNCTIONING posed by the person using violence and/or coercive control?

- threats to mother-child relationship
- homelessness
- cultural safety
- health
- family finances

7 What is the level of fear shown by the adult victim/survivor?

◯ Not afraid ◯ Afraid ◯ Terrified ◯ Unable/ unwilling to answer (from DVSAT)

8 What <u>don't</u> we know?

9 <u>Individual</u> risk assessment of a) adult and b) child victims/survivors?

Requires immediate protection	→	Highest risk
Elevated risk	→	Medium / moderate risk
At risk	→	Lowest Risk

10 <u>Collaborative</u> risk assessment of a) adult and b) child victims/survivors?

(for team / multi-service intake processes)

Requires immediate protection	→	Highest risk
Elevated risk	→	Medium / moderate risk
At risk	→	Lowest Risk

11 What is the referral pathway and rationale for:

- **the person using violence and/or coercive control?**
- **the adult victim / survivor?**
- **the children?**

- Which service/s will be involved with the different family members?

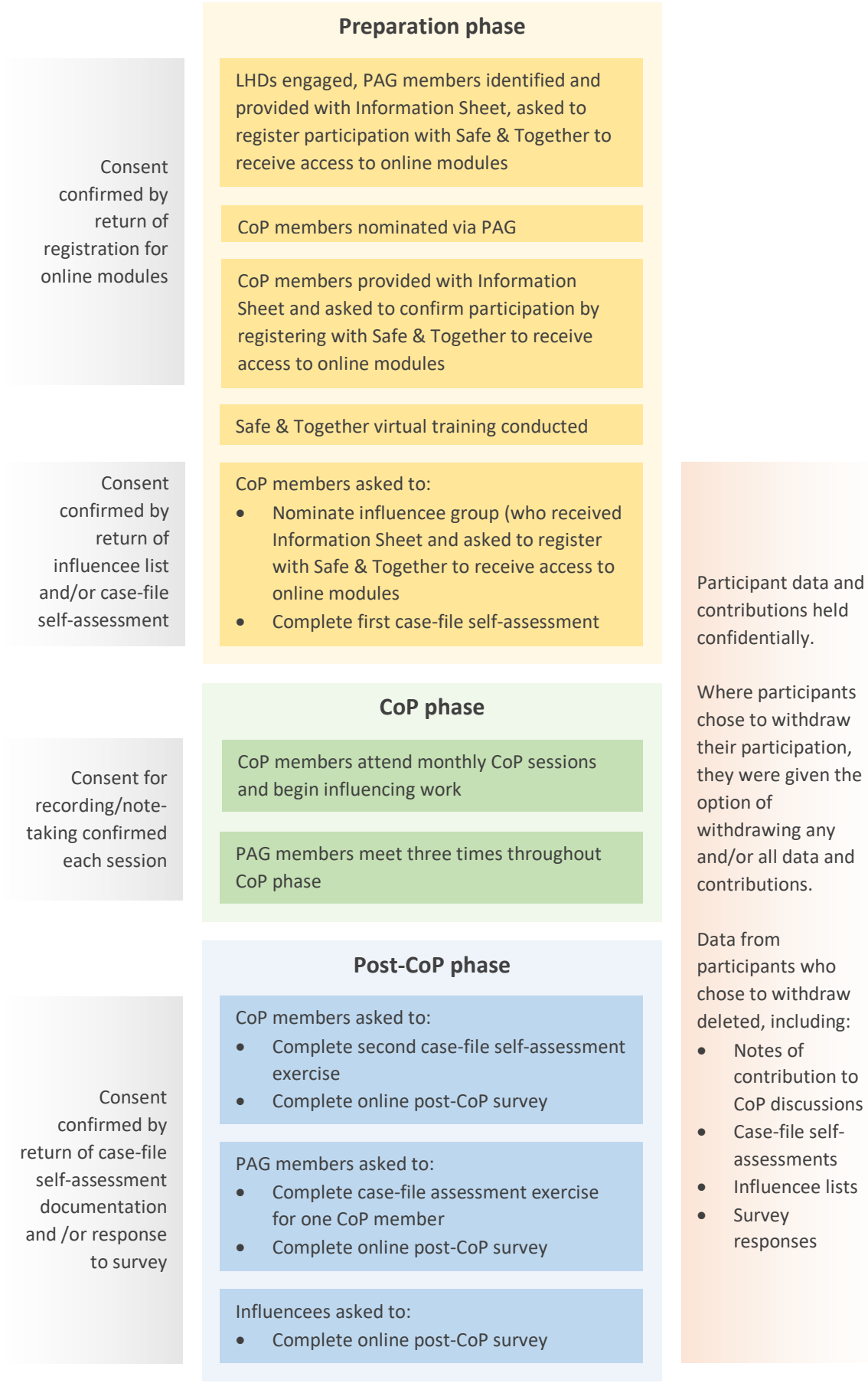
ESTIE Intake/Assessment Tool: Brief and crisis responses *Version 1, 19 October 2021*

8.4. Consent and data management processes

Consent to participate in the *ESTIE Project* activities was managed through a rolling, iterative process, shown in Figure 10. Participants were able to confirm their consent to participate at each of the preparation, CoP and post-CoP phases. Each research activity involved a discrete consent process (i.e., the case-file self-assessments, influence work and online surveys), and consent for data recording during discussions was reconfirmed at the beginning of each CoP session.

Where participants chose to end or withdraw their participation in the ESTIE Project, they were given the option to also withdraw any data they had contributed. Where participants chose to do this, their data and contributions to discussions were deleted.

Figure 10: Consent and data management process



8.5. CoP & influencee questionnaire

Survey Flow

Block: 1. Introduction (3 Questions)
Standard: 2. Demographics A (3 Questions)
Standard: 3. ESTIE participation (23 Questions)
Standard: 4. Safe & Together engagement (5 Questions)
Standard: 5. Feedback on STACY Practice Guides (10 Questions)
Standard: 6. Comments and feedback (4 Questions)
Standard: 7. Demographics B (9 Questions)

Start of Block: 1. Introduction

Intro **The ESTIE Project: Community of Practice and influencee participants**

This questionnaire is designed to be undertaken because (a) you attended the *ESTIE Project's* Communities of Practice (CoPs) or (b) you are an 'influencee' (that is, a colleague or supervisor of someone who attended the CoPs).

We will be using questionnaire data to help us assess the impact of the Safe & Together™ Model on your work and professional practice.

The questionnaire will take approximately 20 minutes to complete (depending on how much you wish to write in the open-ended questions). You can skip or write N/A in any question you do not feel comfortable responding to.

Your participation is entirely voluntary. If you choose to participate, we would be grateful for your contribution by **December 22, 2021**.

A high response rate increases the validity of the information we report on, which will be invaluable in providing evidence of the impact of your experience of the *ESTIE Project*.

The information we collect from you will be confidential. We will not be sharing any of your individual information with anyone. Whilst we ask for your name, it is only so we can send reminders to those who have not yet submitted a questionnaire and to confirm your participation as either a CoP or influencee participant. **Once we have closed the questionnaire and checked answers, we will delete your name and be unable to find your individual questionnaire response.**

We ask for your sector identifier to help us look across the sectors involved. We ask for demographic information because we want to know about the diversity of participants engaged in this project. We will present and report the data from the questionnaires by sector or type of agency when appropriate, while ensuring anonymity.

We appreciate you taking the time to complete this questionnaire.

The *ESTIE* Research Team

Professor Cathy Humphreys | Dr Margaret Kertesz | Cherie Toivonen | Associate Professor Lesley Laing | Jasmin Isobe | Erin Links | David Mandel

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Q1.1 Please indicate if you consent to participating in this survey by selecting one of the options below.

- ○ By completing this questionnaire, I give my consent to participate (1)
- ○ I don't want to participate (2)

Skip To: End of Survey If Q1.1 = I don't want to participate

End of Block: 1. Introduction

Start of Block: 2. Demographics A

Q2.1 **What is your name?**

We only ask for your name so we can send reminders to those who have not yet submitted a response to this questionnaire and to confirm your participation as either a CoP or influencee participant. **Once we have closed the questionnaire and checked responses, we will delete your name and be unable to find your individual questionnaire response.**

- ○ First name (1) _____
- ○ Last (family) name (2) _____

Q2.2 **Please select your LHD/affiliation**

- ○ Hunter New England Local Health District (1)
- ○ Northern New South Wales Local Health District (2)
- ○ Sydney Local Health District (3)
- ○ South Western Sydney Local Health District (4)
- ○ Ministry of Health (5)
- ○ Education Centre Against Violence (6)
- ○ Department of Communities and Justice (7)
- ○ Non-government organisation (8)
- ○ Other (9)

Q2.3 **Please select your service area that best applies to your position.**

- ☐ AOD - Alcohol and other drugs (1)
- ☐ CP - Statutory child protection (includes specialist MH, AOD, Indigenous and legal) (2)
- ☐ NCP - Non-statutory child and family services (including Child Protection Counselling Services and Whole of Family Teams) (3)
- ☐ DFV - Domestic and family violence (includes men's services, specialist women's family violence services) (4)
- ☐ JS - Justice services (includes police, corrective services/probation and parole) (5)
- ☐ MH - Mental health (6)
- ☐ Other (Please specify. If you would like to include a secondary service area, please indicate this here). (7) _____

End of Block: 2. Demographics A

Start of Block: 3. ESTIE participation

***ESTIE Project* participation**

The following questions ask about your participation in the *ESTIE Project* as either a Community of Practice or influencee participant.

Q3.1 Were you a Community of Practice or influencee participant in the *ESTIE Project*?

- Community of Practice participant (1)
- Influencee (2)

Display This Question:

If Q3.1 = Community of Practice participant

Q3.2a How many CoP sessions were you able to attend?

- 1 CoP (1)
- 2 CoPs (2)
- 3 CoPs (3)
- 4 CoPs (4)
- 5 CoPs (5)
- None (6)

Display This Question:

If Q3.1 = Influencee

Q3.2b **As an influencee participant, how frequently were you engaged in activities related to the *ESTIE Project*?**

(Think about how often the CoP member working with you might have engaged you in activities or practice change discussions, e.g., supervision sessions, case discussions or meetings incorporating Safe & Together principles).

- One single session or conversation (1)
- Once or twice a month (2)
- Once or twice a week (3)
- Every couple of days (4)
- Not at all (5)

Influencing practice change

The following questions ask you to identify influencing strategies that either a) you used as a CoP member with your influencees; or b) that a CoP member used with you as an influencee.

Q3.3 **Could you give an example of an *effective* influencing strategy that you used as a CoP member/was used with you as an influencee?**

_____

_____

Q3.4 **Please explain why it was an <u>effective</u> influencing strategy.**

_____

Q3.5 **Could you give an example of a <u>less than effective</u> influencing strategy that you used as a CoP member/was used with you as an influencee?**

_____
_____

Q3.6 **Please explain why it was a <u>less than effective</u> influencing strategy.**

_____
_____

Assessment of practice change

We are interested to hear how you feel your practice, and that of your organisation or team, has or has not changed since being exposed to the Safe & Together™ Model and being involved in the *ESTIE Project*.

Q3.7 Exposure to the Safe & Together™ Model during the *ESTIE Project* has improved my practice and/or my management of staff when their clients experience intersecting issues of DFV/AOD/MH.

- ○ Strongly disagree (1)
- ○ Somewhat disagree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat agree (4)
- ○ Strongly agree (5)

Continuum intro

The next few questions ask you to think about your service's and your own personal practice, and how it takes into account DFV and complex intersecting issues. We are interested in your perceptions of any change in practice, and ask you to think about and reflect on certain aspects of practice at two time points:

- Before you and your service became involved in the *ESTIE Project*
- After your involvement in the *ESTIE Project* (now, when you are completing this questionnaire)

These questions use a rating scale from 1 to 5, with statements about aspects of practice at either end. We ask you first about your service's practice, and then about your personal practice. Please select a rating for each statement. Your responses and ratings of practice will be kept confidential, and only reported as part of aggregate results. There is a space for your reflections on your ratings at the end of the section.

Q3.8 **My service's current practice**

Thinking about policy, practice, training, services and collaboration, please rate the **current performance of your service** (not your own personal practice) against the following statements about practice that **takes domestic and family violence into account and addresses complexity.**

	1	2	3	4	5	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	
DFV is only about the adult relationship	○	○	○	○	○	Explores impact of perpetrator's pattern on child and family functioning
The safety interests of the child are perceived in opposition to the adult survivor's safety	○	○	○	○	○	Child safety and wellbeing tied to adult survivor safety and wellbeing
"Failure to protect" as the dominant paradigm	○	○	○	○	○	Partnering with adult survivor is the dominant paradigm
Fathers' roles invisible	○	○	○	○	○	High standards for fathers
Incident-based approach	○	○	○	○	○	Perpetrator pattern-based approach
Intersectionality, structural disadvantage and diversity neglected/dismissed	○	○	○	○	○	Active attention to intersectionality, structural disadvantage and diversity
Siloed practice focus (for example, AOD issues only)	○	○	○	○	○	Intersections of issues actively explored and documented
Isolated, non-collaborative practice	○	○	○	○	○	Active collaboration across services and sectors
Worker safety and wellbeing neglected/dismissed	○	○	○	○	○	Attention to/integrated assessment of worker safety and wellbeing

This exercise is adapted from the Safe & Together *Continuum of Domestic Violence-Informed Practice*, and the *STACY Project Domestic Violence-Informed Continuum*.

Q3.9 **My service's practice pre-ESTIE** Now think about where your service's practice was before involvement with the *ESTIE Project*, and rate it in the same way as the previous question.

	1	2	3	4	5	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	
DFV is only about the adult relationship	○	○	○	○	○	Explores impact of perpetrator's pattern on child and family functioning
The safety interests of the child are perceived in opposition to the adult survivor's safety	○	○	○	○	○	Child safety and wellbeing tied to adult survivor safety and wellbeing
"Failure to protect" as the dominant paradigm	○	○	○	○	○	Partnering with adult survivor is the dominant paradigm
Fathers' roles invisible	○	○	○	○	○	High standards for fathers
Incident-based approach	○	○	○	○	○	Perpetrator pattern-based approach
Intersectionality, structural disadvantage and diversity neglected/dismissed	○	○	○	○	○	Active attention to intersectionality, structural disadvantage and diversity
Siloed practice focus (for example, AOD issues only)	○	○	○	○	○	Intersections of issues actively explored and documented
Isolated, non-collaborative practice	○	○	○	○	○	Active collaboration across services and sectors
Worker safety and wellbeing neglected/dismissed	○	○	○	○	○	Attention to/integrated assessment of worker safety and wellbeing

Q3.10 **My own current practice** Thinking about policy, practice, training, services and collaboration, please rate **your own current practice**, separate to your service, against the following statements about practice that **takes domestic and family violence into account and addresses complexity.**

	1	2	3	4	5	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	
DFV is only about the adult relationship	○	○	○	○	○	Explores impact of perpetrator's pattern on child and family functioning
The safety interests of the child are perceived in opposition to the adult survivor's safety	○	○	○	○	○	Child safety and wellbeing tied to adult survivor safety and wellbeing
"Failure to protect" as the dominant paradigm	○	○	○	○	○	Partnering with adult survivor is the dominant paradigm
Fathers' roles invisible	○	○	○	○	○	High standards for fathers
Incident-based approach	○	○	○	○	○	Perpetrator pattern-based approach
Intersectionality, structural disadvantage and diversity neglected/dismissed	○	○	○	○	○	Active attention to intersectionality, structural disadvantage and diversity
Siloed practice focus (for example, AOD issues only)	○	○	○	○	○	Intersections of issues actively explored and documented
Isolated, non-collaborative practice	○	○	○	○	○	Active collaboration across services and sectors
Worker safety and wellbeing neglected/dismissed	○	○	○	○	○	Attention to/integrated assessment of worker safety and wellbeing

Q3.11 **My own practice pre-ESTIE** Now think about where your own practice was before involvement with the *ESTIE Project*, and rate it in the same way as the previous question.

	1	2	3	4	5	
	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	
DFV is only about the adult relationship	○	○	○	○	○	Explores impact of perpetrator's pattern on child and family functioning
The safety interests of the child are perceived in opposition to the adult survivor's safety	○	○	○	○	○	Child safety and wellbeing tied to adult survivor safety and wellbeing
"Failure to protect" as the dominant paradigm	○	○	○	○	○	Partnering with adult survivor is the dominant paradigm
Fathers' roles invisible	○	○	○	○	○	High standards for fathers
Incident-based approach	○	○	○	○	○	Perpetrator pattern-based approach
Intersectionality, structural disadvantage and diversity neglected/dismissed	○	○	○	○	○	Active attention to intersectionality, structural disadvantage and diversity
Siloed practice focus (for example, AOD issues only)	○	○	○	○	○	Intersections of issues actively explored and documented
Isolated, non-collaborative practice	○	○	○	○	○	Active collaboration across services and sectors
Worker safety and wellbeing neglected/dismissed	○	○	○	○	○	Attention to/integrated assessment of worker safety and wellbeing

Q3.12 If you have any thoughts or reflections on the questions in this section, please feel free to include them here.

_____

_____

Display This Question:
If Q3.1 = Community of Practice participant

Q3.13 **What aspect of the *ESTIE Project* had the greatest impact on practice change for you?**
Please rank the below aspects of the project, with 1 being the most impactful and 9 being the least impactful.

_____ Safe & Together Online training modules (1)

_____ Safe & Together 4 half days of virtual training (2)

_____ STACY Practice Guides (3)

_____ Access to Safe & Together resources (e.g., Perpetrator Mapping Tool, Safe & Together Intersections Meeting (STIM) Protocol) (4)

_____ Community of Practice sessions (5)

_____ Influencing work (6)

_____ PAG authorising environment (7)

_____ Case-file self-assessment exercise (8)

_____ Support from the research team (9)

Q3.14
Which areas of practice have you seen positive change in (if any) since being involved in the ESTIE Project? (You may tick more than one)

- ☐ Risk assessment (1)
- ☐ Case management where there are intersecting parental complexities of DFV, MH and AOD (2)
- ☐ Sharing information (3)
- ☐ Documentation (4)
- ☐ Shared language (inside and outside your organisation) (5)
- ☐ Overall provision of services to DFV adult and child victims/survivors and perpetrators (6)
- ☐ Other (please specify) (7) _____

Q3.15 **Thinking specifically about <u>documentation</u> and <u>information sharing,</u> what changes (if any) have you made to your practice through being part of the *ESTIE Project*?** You could think about changes to the way you are documenting, wording, or reporting these things in your work on cases, and how you are sharing information regarding them.

	No change (1)	A little change (2)	Some change (3)	A lot of change (4)	Not applicable (5)
Identifying the perpetrator's pattern of coercive control and actions taken to harm the children (1)	○	○	○	○	○
Mapping the perpetrator's pattern onto the child, survivor and family functioning (2)	○	○	○	○	○
Mapping the perpetrator pattern onto adult survivor's strengths and protective capacities (3)	○	○	○	○	○
Mapping the perpetrator pattern onto substance abuse (4)	○	○	○	○	○
Mapping the perpetrator pattern onto mental health (5)	○	○	○	○	○
Mapping the perpetrator pattern onto intersectionalities (6)	○	○	○	○	○
Mapping the perpetrator pattern onto worker safety concerns (7)	○	○	○	○	○

Q3.16 **What do you think will help you sustain those practice changes in documentation and information sharing into the future?**

_____
_____

Q3.17 **Thinking about work at the intersection of domestic violence, substance misuse and mental health, what does your team, organisation or sector need to improve most in its practice?**

_____
_____

End of Block: 3. ESTIE participation

Start of Block: 4. Safe & Together engagement

Engagement with Safe & Together resources

We are interested in the way you engaged with the Safe & Together resources throughout the *ESTIE Project*, and how these were or were not valuable to you.

Q4.1 **Did you find the Safe & Together online training and resources valuable, and if so, to what extent.**

	Not valuable (1)	A little valuable (2)	Somewhat valuable (3)	Highly valuable (4)	N/A - did not access or use (5)
Safe & Together Online Module: An Introduction to the Model (1)	○	○	○	○	○
Safe & Together Online Module: Multiple Pathways to Harm (2)	○	○	○	○	○
Safe & Together Online Module: Intersections (3)	○	○	○	○	○
Safe & Together Perpetrator Mapping Tool (4)	○	○	○	○	○
Safe & Together Intersections Meeting (STIM) Protocol (5)	○	○	○	○	○

Display This Question:
If Q3.1 = Community of Practice participant

Q4.2 Did you find the Safe & Together four half-days of virtual training valuable, and if so, to what extent.

	Not valuable (1)	A little valuable (2)	Somewhat valuable (3)	Highly valuable (4)
4 half days of virtual training (1)	○	○	○	○

Q4.3 Do you have any feedback on the Safe & Together training, either virtual or modules?

_____

_____

Q4.4 **Please indicate which of the following Safe & Together learning activities you have completed, in addition to the 4 half-days and online modules of training provided to you as a CoP or influencee participant in the *ESTIE Project*.**

If you have started but not completed any of these activities, please describe in the 'Other' text box provided. If you have not accessed or started any, please select 'None of the above'.

- ☐ Online Safe & Together e-learning (i.e., not related to the ESTIE or STACY Projects) (1)
- ☐ Attended a Safe & Together Conference (2)
- ☐ Safe & Together™ Model Overview Training (one-day training) (3)
- ☐ Safe & Together™ Model CORE Training (4-day training) (4)
- ☐ Safe & Together™ Model Supervisor/Manager Training (5)
- ☐ Safe & Together™ Model Train the Trainer (6)
- ☐ Additional in-person training, webinar or specialist workshop (7)
- ☐ Engaged with the Safe & Together Blog (8)
- ☐ Engaged with the Safe & Together Podcasts (9)
- ☐ None of the above (10)
- ☐ Other (please explain) (11) _____

End of Block: 4. Safe & Together engagement

Start of Block: 5. Feedback on STACY Practice Guides

Guides into The *ESTIE Project* aims to assess and improve the *STACY Practice Guides*. We are very interested in your assessment of the *Guides*, and any feedback you may have on how they can be improved.

Q5.1 Did you find the *STACY Practice Guides* valuable, and if so, to what extent.

	Not valuable (1)	A little valuable (2)	Somewhat valuable (3)	Highly valuable (4)	N/A - did not access or use (5)
STACY Practice Guides overall (1)	○	○	○	○	○
Section 1: Partnering with women (2)	○	○	○	○	○
Section 2: Increasing visibility of perpetrators (3)	○	○	○	○	○
Section 3: Focusing on children and young people (4)	○	○	○	○	○
section 4: Working safely (5)	○	○	○	○	○
Section 5: Working collaboratively (6)	○	○	○	○	○
Section 6: Influencing organisational change and capacity building (7)	○	○	○	○	○

Q5.2 We are very interested in your feedback about any ways we can improve, update or change the *STACY Practice Guides* to be more useful, insightful or accessible. Please feel free to comment on the *Guides* overall, or on specific sections.

Q5.2a *STACY Guides* overall

_____

_____

Q5.2b Section 1: Partnering with women

_____
_____

Q5.2c Section 2: Increasing the visibility of perpetrators

_____
_____

Q5.2d Section 3: Focusing on children and young people

_____
_____

Q5.2e Section 4: Working safely

_____
_____

Q5.2f Section 5: Working collaboratively

_____
_____

Q5.2g Section 6: Influencing organisational change and capacity building

_____
_____

End of Block: 5. Feedback on STACY Practice Guides

Start of Block: 6. Comments and feedback

Q6.1 **Do you have any final comments or feedback about your experience of being involved in this project?**

_____
_____

Display This Question:
If Q3.1 = Community of Practice participant

contact intro The research team would like to follow up with CoP participants after the *ESTIE Project* has concluded to reflect on practice change and your experience of being part of the project. This would involve a short interview, and you will have the opportunity to decline if you are no longer interested.

Display This Question:
If Q3.1 = Community of Practice participant

Q6.2 **Do you consent to being contacted 6-12 months down the track?**

- ○ Yes (1)
- ○ No (2)

Display This Question:
If Q6.2 = Yes

Q6.2b **Thank you. Please provide the best contact details we can reach you on in 6-12months.**

- Email (1) _____
- Phone (2) _____

End of Block: 6. Comments and feedback

Start of Block: 7. Demographics B

Demo B intro **Some final details about you.**

Q7.1 **How do you identify your gender?**

- Man (1)
- Woman (2)
- Non-binary (3)
- Gender queer (4)
- Prefer not to say (5)
- Another identity (please specify) (6) _____

Q7.2 **What is your highest educational qualification?**

- Below Year 12 (1)
- Year 12 or equivalent (2)
- Diploma or certificate level (3)
- Degree level qualification (4)
- Masters degree, postgraduate degree or postgraduate diploma/certificate (5)
- Doctorate (6)
- Other (please specify - please avoid acronyms and abbreviations) (7)

  _____

Q7.3 **What is your primary role?**

If you have more than one role or a specialist role, please select 'Other; and write in the text box provided.

- Senior manager (1)
- Team leader (2)
- Practice/clinical leader (3)
- Caseworker/clinician/counsellor/frontline worker (4)
- Other (please specify) (5) _____

Q7.4 **Are you of Aboriginal or Torres Strait Islander origin?**

- Yes, Aboriginal (1)
- Yes, Torres Strait Islander (2)
- Yes, both Aboriginal and Torres Strait Islander (3)
- No (4)
- Prefer not to say (5)

Q7.5 **Were you born in Australia or overseas?**

If you were born overseas, please specify in which country.

- ○ Australia (1)
- ○ Overseas (2) _____

Display This Question:
If Q7.5 = Overseas

Q2.8a How many years have you lived in Australia?

- ○ Less than 5 years (1)
- ○ More than 5 years)2)

Q2.9 Do you speak any languages other than English?

- ○ Yes (please specify) (1) _____
- ○ No (2)

Display This Question:
If Q2.9 = Yes (please specify)

Q2.9a Do you use this language on a regular basis in your role with clients?

- ○ Yes, verbal only (1)
- ○ Yes, written (e.g., texts, emails or messages with clients) (2)
- ○ Yes, written (e.g., case notes, reports, formal documentation) (3)
- ○ No (4)

End of Block: 7. Demographics B

8.6. PAG questionnaire

Survey flow

Block: 1. Introduction and consent (3 Questions)
Standard: 2. Demographics A (3 Questions)
Standard: 3. Main questions (14 Questions)
Standard: 4. Demographics B (7 Questions)

Start of Block: 1. Introduction and consent

Intro

THE ESTIE Project: Project Advisory Group Survey

As a member of the *ESTIE Project's* Project Advisory Group, we invite you to complete the following questionnaire. We will be using the data collected to help us assess the impact of the Safe & Together™ Model on professional practice and collaboration between services in your LHD or area of influence. For further information, please see the *ESTIE Information Sheet*.

Your participation is entirely voluntary. If you choose to participate, we would be grateful for your contribution by **December 22, 2021**.

A high response rate increases the validity of the information we report on, which will be invaluable in providing evidence of the impact of your experience of the *ESTIE Project*. If you change your mind about participating, you can ask the research team to withdraw your data. This will in no way affect your position within NSW Health.

The information we collect from you will be confidential. We will not be sharing any of your individual information with anyone. Whilst we ask for your name, it is only so we can send reminders to those who have not yet submitted a questionnaire. **Once we have closed the questionnaire and checked answers, we will delete your name and be unable to find your individual questionnaire response.**

The questionnaire will take approximately 20 minutes to complete. You can skip or write N/A for any question you do not feel comfortable responding to.

We ask for your sector identifier to help us look across the sectors involved. We ask for demographic information because we want to know about the diversity of participants engaged in this project. We will present and report the data from the questionnaires by sector or type of agency when appropriate, while ensuring anonymity.

We appreciate you taking the time to complete this questionnaire.

The *ESTIE* Research Team

Professor Cathy Humphreys | Dr Margaret Kertesz | Cherie Toivonen | Associate Professor Lesley Laing | Jasmin Isobe | Erin Links | David Mandel

Q1.1 Please indicate if you consent to participating in this questionnaire by selecting one of the options below.

- ○ By completing this questionnaire, I give my consent to participate (1)
- ○ I don't want to participate (2)

Skip To: End of Survey If Q1.1 = I don't want to participate

End of Block: 1. Introduction and consent

Start of Block: 2. Demographics A

Q2.1 **What is your name?**

We only ask for your name so we can send reminders to those who have not yet submitted a response to this questionnaire and to confirm your participation as either a CoP or influencee participant. **Once we have closed the questionnaire and checked responses, we will delete your name and be unable to find your individual questionnaire response.**

- ○ First name (1) _____
- ○ Last (family) name (2) _____

Q2.2 **Please select your LHD/affiliation**

- ○ Hunter New England Local Health District (1)
- ○ Northern New South Wales Local Health District (2)
- ○ Sydney Local Health District (3)
- ○ South Western Sydney Local Health District (4)
- ○ Ministry of Health (5)
- ○ Education Centre Against Violence (6)
- ○ Department of Communities and Justice (7)
- ○ Non-government organisation (8)
- ○ Other (9)

Q2.3 **Please select your primary service area that best applies to your position.**

- ☐ AOD - Alcohol and other drugs (1)
- ☐ CP - Statutory child protection (includes specialist MH, AOD, Indigenous and legal) (2)
- ☐ NCP - Non-statutory child and family services (including Child Protection Counselling Services and Whole of Family Teams) (3)
- ☐ DFV - Domestic and family violence (includes men's services, specialist women's family violence services) (4)
- ☐ JS - Justice services (includes police, corrective services/probation and parole) (5)
- ☐ MH - Mental health (6)
- ☐ MoH – Ministry of Health (7)
- ☐ NSWH – New South Wales Health worker in external organisation (please also specify your focus through the 'other' option below) (8)
- ☐ Other (Please specify. If you would like to include a secondary service area, please indicate this here). (9) _____

End of Block: 2. Demographics A

○ Start of Block: 3. Main questions

3 intro The *ESTIE Project* focusses on individual and organisational responses at the intersection of domestic and family violence with parental mental health and alcohol and other drug issues, where there are children involved. The *ESTIE Project* model, involving initial training, and ongoing Project Advisory Groups and Communities of Practice, is more intensive than a simple training model.

Q3 **Please consider the following statements about the ESTIE Project, and indicate to what extent you agree or disagree with them.**

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)	Don't know (6)
The ESTIE Project has contributed to capacity building within the participating LHDs in relation to the Safe & Together approach and the focus of ESTIE. (1)	○	○	○	○	○	○
The ESTIE Project model represents an efficient way of capacity building practitioners and services. (2)	○	○	○	○	○	○
The ESTIE project has had an impact on the safety of victims/survivors of domestic and family violence. (3)	○	○	○	○	○	○
Implementation of the ESTIE Project by the research team has been consistent with principles of respect and justice for ESTIE participants and their clients. (4)	○	○	○	○	○	○

Display This Question:
If Q2.3 != MoH – Ministry of Health
Or Q2.3 != NSWH – New South Wales Health worker in external organisation (please also specify your focus through the 'other' option below)

Q3.5

What elements of the *ESTIE Project* do you believe have been most valuable in building capacity within your service to implement the Safe & Together approach to DFV intervention where there are complex issues of AOD and mental health?

Please rank the following elements, with 1 being the most valuable and 8 being the least valuable. (If you have not been involved directly enough to comment on these elements, please select 'Other' and leave a comment if you wish).

_____ Safe & Together Online training modules (1)
_____ Safe & Together 4 half days of virtual training (2)
_____ STACY Practice Guides (3)
_____ Access to Safe & Together resources (e.g., Perpetrator Mapping Tool, Safe & Together Intersections Meeting (STIM) Protocol) (4)
_____ Community of Practice sessions (5)
_____ Influencing work (6)
_____ PAG authorising environment (7)
_____ Case-file self-assessment exercise (8)
_____ Other (please specify) (9)

Q3.6 **In your view, what strategies have been effective in championing the *ESTIE Project* within your service or participating LHD? I.e., championing implementation of the Safe & Together approach to DFV where there are complex issues of AOD and mental health.**

	Not at all effective (1)	Somewhat effective (2)	Effective (3)	Very effective (4)	Don't know/Not applicable (5)
Leadership group (PAG) in place to progress DFV-informed practice, including senior representatives from all relevant service areas (1)	○	○	○	○	○
A designated person within your service who has lead responsibility for coordinating work within this area (2)	○	○	○	○	○
The inclusion of DFV-informed content in practice and policy protocols across all services within your LHD - using a common language around risk and perpetrator accountability (3)	○	○	○	○	○
Expectations of collaboration across services within the LHD are clearly authorised (e.g., in job descriptions) (4)	○	○	○	○	○
Clear statements in all relevant policies and processes that recognise the importance of the Safe & Together principles (holding the perpetrator to account, partnering with the non-offending parent, keeping the child together with the non-offending person wherever possible) (5)	○	○	○	○	○
Other, please specify (6)	○	○	○	○	○

Q3.7 **In your view what strategies have been effective in addressing barriers to implementing the Safe & Together approach to DFV where there are complex issues of AOD and mental health.**

	Not at all effective (1)	Somewhat effective (2)	Effective (3)	Very effective (4)	Don't know/Not applicable (5)
Differences in organisational priorities, goals and tasks are being addressed between services and sectors (1)	○	○	○	○	○
There has been a consistent core group of skilled and committed staff throughout the ESTIE project (2)	○	○	○	○	○
Establishment of teams of skilled and committed staff, rather than isolated individual champions (3)	○	○	○	○	○
There are formal structures for safe sharing of information and resolving demarcation disputes (4)	○	○	○	○	○
Use of 'warm referrals' between services and across sectors (5)	○	○	○	○	○
Opportunities for relationship-building between staff in different services through co-location or working in close proximity (6)	○	○	○	○	○
Dedicated time for influencing work and other forms of reflective practice (7)	○	○	○	○	○
Organisational culture supporting revision or adaptation of established frameworks (procedures and systems) rather than replacement of ways of working (8)	○	○	○	○	○
Senior authorisation of the Safe & Together approach at LHD and Ministry of Health level (9)	○	○	○	○	○
Other (please specify) (10)	○	○	○	○	○

Display This Question:
If Q2.3 != MoH – Ministry of Health

Q3.8 **Thinking specifically about documentation and information sharing, what changes (if any) have you observed in your service since the start of the *ESTIE Project*?**

You could think about changes to the way practitioners are documenting, wording, or reporting on these things in their work on cases, and how they are sharing information regarding them. If you have not been in a position to observe practice change, please select 'Not applicable' in the following table.

	No change (1)	A little change (2)	Some change (3)	A lot of change (4)	Not applicable (5)
Identifying the perpetrator's pattern of coercive control and actions taken to harm the children (1)	○	○	○	○	○
Mapping the perpetrator's pattern onto the child, survivor and family functioning (2)	○	○	○	○	○
Mapping the perpetrator pattern onto adult survivor's strengths and protective capacities (3)	○	○	○	○	○
Mapping the perpetrator pattern onto substance abuse (4)	○	○	○	○	○
Mapping the perpetrator pattern onto mental health (5)	○	○	○	○	○
Mapping the perpetrator pattern onto intersectionalities (6)	○	○	○	○	○
Mapping the perpetrator pattern onto worker safety concerns (7)	○	○	○	○	○

Q3.9 **What do you think will help you sustain practice changes in documentation and information sharing into the future?**

_____

_____

Q3.10 **Thinking specifically about <u>policy</u> and related work, what changes (if any) have you observed since the start of the *ESTIE Project*?**

You could think about broader integration of VAN, MH and AOD, changes in language used in policy documents or correspondence, or use of Safe & Together principles in your work. If you have not been in a position to observe policy or practice change, please select 'Not applicable' in the following table.

	No change (1)	A little change (2)	Some change (3)	A lot of change (4)	Not applicable (5)
Incorporating a focus on perpetrators and their patterns of violence and coercive control (1)	○	○	○	○	○
Incorporating a focus on partnering with survivors and mapping their strengths and protective capacities (2)	○	○	○	○	○
Incorporating a focus on children's safety and wellbeing in the context of whole family functioning (3)	○	○	○	○	○
Understanding of the intersections of DFV, AOD and MH, and the need for exploration and integration of issues (4)	○	○	○	○	○
Attention to how perpetrator patterns and safety concerns interact with intersectional issues (5)	○	○	○	○	○
Incorporating a focus on worker safety and wellbeing in the context of perpetrator patterns and systemic issues (6)	○	○	○	○	○
Use of Safe & Together language, concepts and tools in my work (7)	○	○	○	○	○
Understanding of the enablers and barriers to changing practice to be more DFV-informed (8)	○	○	○	○	○

Q3.11 **What do you think will help you sustain practice changes in <u>policy and related work</u> into the future?**

_____
_____

Q3.12 Thinking about work at the intersections of domestic violence, substance misuse and mental health, **what do you see as the key challenges for your service, or more broadly, your LHD and NSW Health, once the *ESTIE project* is completed?** If you do not feel you can comment on this, please feel free to leave this question blank**.**

_____
_____

Q3.13 **Please comment on any ways that you believe *ESTIE* has successfully contributed to capacity building for practitioners and services, and has had an impact on practice and client safety.**

_____

follow up intro The research team would like to follow up with PAG participants after the *ESTIE Project* has concluded to reflect on changes in practice and collaboration, as well as your experience of being part of the project. This would involve a short interview, and you will have the opportunity to decline if you are no longer interested.

Q3.14 **Would you be comfortable being contacted 6-12 months down the track?**

- ○ Yes (1)
- ○ No (2)

Display This Question:
If Q3.14 = Yes

Q3.14b **Thank you. Please provide the best contact details we can reach you on in 6-12months.**

- ○ Email (1) _____
- ○ Phone (2) _____

End of Block: 3. Main questions

Start of Block: 4. Demographics B

B intro **Finally, a few details about yourself.**

Q4.1 **How do you identify your gender?**

- ○ Man (1)
- ○ Woman (2)
- ○ Non-binary (3)
- ○ Gender queer (4)
- ○ Prefer not to say (5)
- ○ Another identity (please specify) (6) _____

Q4.2 **What is your highest educational qualification?**

- ○ Below Year 12 (1)
- ○ Year 12 or equivalent (2)
- ○ Diploma or certificate (3)
- ○ Degree level qualification (4)
- ○ Masters degree, postgraduate degree or postgraduate diploma/certificate (5)
- ○ Doctorate (6)
- ○ Other (please specify - please avoid acronyms and abbreviations) (7)

_____

Q4.3 **What is your primary role? If you have more than one role or a specialist role, please select 'Other; and write in the text box provided.**

- ☐ Team or clinical leader (1)
- ☐ Service, program or clinical coordinator (2)
- ☐ Service, program or clinical manager (3)
- ☐ Director (4)
- ☐ Principal or senior policy officer (5)
- ☐ Educator (6)
- ☐ Other (Please specify. If you would like to include a secondary role, please do so here). (7)

_____

Q4.4 **Are you of Aboriginal or Torres Strait Islander origin?**

- ○ Yes, Aboriginal (1)
- ○ Yes, Torres Strait Islander (2)
- ○ Yes, both Aboriginal and Torres Strait Islander (3)
- ○ No (4)
- ○ Prefer not to say (5)

Q4.5 **Were you born in Australia or overseas? If you were born overseas, please specify in which country.**

- ○ Australia (1)
- ○ Overseas (please specify) (2) _____

Display This Question:
If Q4.5 = Overseas (please specify)

Q4.5b **How many years have you lived in Australia?**

- ○ Less than 5 years (1)
- ○ More than 5 years (2)

End of Block: 4. Demographics B

8.7. Survey respondent demographics

Table 13: Online post-CoP and PAG questionnaire data collection

	Distributed	Ineligible	Eligible sample	Responses	Return rate
CoPs	71	4	67	26	38%
Influencees	288	11	277	36	13%
Regional PAG	11	1	10	5	50%
Metro PAG	21	0	21	3	14%
State PAG	8	0	8	1	13%
Total PAG	40	1	39	9	23%

Return rates were calculated taking into account the following:

- Initial distribution as the total number of participants emailed
- Ineligible participants as those whose email addresses returned an out of office for the entire duration the survey was open; a notification of the practitioner having moved on from their role; an email bounce notification that could not be resolved through checking and resending.
- Eligible sample used to calculate the return rate consisted of the initial distribution number minus the ineligible participant number
- Return rate calculated as percentage of the final sample (to the nearest whole number)
- Responses received that either only provided consent to participate and no other responses, or a response that the participant did not want to move further than the information page, were not counted in the final response count. This included 6 responses indicating unwillingness to participate, and 5 responses that provided no details beyond clicking consent to participate.
- Where participants were unable to finish a response in one sitting, or submitted two responses, the research team combined qualitative comments, and took the last response submitted as final for all quantitative items. Only two instances of this were identified in data cleaning.

Responses to the online surveys were received from all participating LHDs, and from CoP, influencee and PAG participants.

LHD affiliations: Respondent LHD affiliations are given in Table 14.

Table 14: Survey respondent LHD affiliations

LHD	CoP responses	Influencee responses	PAG responses	Total responses to this question	%
Hunter New England (Site 1)	5	19	2	26	37%
Northern New South Wales (Site)2)	7	5	3	15	21%
Sydney (Site 3)	6	4	2	12	17%
South Western Sydney (Site 4)	8	4	1	13	19%
State-wide representatives and other*	0	3	1	4	6%
Total responses by participant type	26	35	9	70	

*Other included Ministry of Health, Department of Communities and Justice, Non-government

Service areas: Respondents were asked to indicate the most appropriate service area, and given the option of specifying a secondary service area (the total therefore does not add to 100%). Respondent service areas across all sites by respondent types are provided in Table 15. Non-statutory child protection had the largest

representation across the sites and participant types, with notable participation from alcohol and other drug, specialist domestic and family violence, and mental health services. Responses specifying 'other service areas' included early childhood and counselling, sexual assault, and social work services.

Table 15: Survey respondent service areas by participant type

Service area (as displayed in the survey)	CoP responses	Influencee responses	PAG responses	Total
AOD (Alcohol and other drugs)	4	2	1	7
CP (Statutory child protection including specialist MH, AOD, Indigenous and legal)	0	1	0	1
NCP (Non-statutory child and family services including Child Protection Counselling Services and whole Family Teams)	10	12	4	26
DFV (Domestic and family violence (include men's services, specialist women's family violence services)	3	4	2	9
JS (Justice services including police, corrective services/probation and parole)	0	0	0	0
MH (Mental health)	1	7	2	10
OT (Other health)	8	9	0	17
Total	26	35	9	70

Gender: The vast majority of participants across all types provided a response of 'woman' when asked about their gender. This proportion is not surprising, and will be picked up in discussions of gendered dynamics in the workforce. The proportion of participants who selected a response other than 'woman' (including 'man', 'non-binary', 'gender queer', 'another identity'), or who chose not to specify, is not reported to protect confidentiality for those participants given the small response rate.

Education: Respondents to both the CoP and influencee and PAG surveys had a minimum of a degree level education, with approximately half having Masters degree level qualifications (see Table 16).

Table 16: Survey respondent education level by participant type

Education level	CoP	Influencee	PAG	Total
Year 12 equivalent or below	0	0	0	0
Diploma, certificate or degree level qualification	9	7	4	20
Masters degree, postgraduate degree or postgraduate diploma/certificate	11	6	4	21
Doctorate/PhD	2	0	0	2
Total	22	13	8	43

Primary roles: The majority of both CoP and influencee participants who responded to this item were caseworkers/clinicians/counsellors/frontline workers (50%, n=12 for CoP, 91% n=11 for influencees). CoP participants also held team/practice/clinical lead positions (45%, n=10) (see Table 17). PAG respondents were primarily in service, program or clinical manager positions (78%, n=7), with one service, program or clinical coordinator and one psychology clinician.

Table 17: Survey respondent primary roles by participant type

CoP/influencee primary roles	CoP	Influencees	Total
Senior manager	0	0	0
Team/Practice/Clinical leader	10	1	11
Caseworker/clinician/counsellor/frontline worker/other	12	11	23
Total	22	12	34

Aboriginal or Torres Strait Islander background: The *ESTIE Project* survey received a very small number of responses across all participant types specifying Aboriginal and/or Torres Strait Islander background. The exact response rate is not reported here in the interests of confidentiality for those participants. Section 2.3 discusses participation from Aboriginal participants and the steps taken to enhance the cultural safety of the *ESTIE Project.*

Languages other than English: CoP and influencee respondents were asked if they spoke any languages other than English, and if they used these languages in their everyday work with clients. While 15% (n=5) of CoP and influencee respondents who answered this item indicated they did speak a language other than English, they all indicated they did not use these languages on a regular basis in their work with clients.

Table 18: CoP and influencee survey respondent language other than English

Do you speak any languages other than English?	CoP	Influencees	Total
Yes	3	2	5
No	19	10	29
Total	22	12	34


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