THE UNIVERSITY OF MELBOURNE

Responding to children and young people who have experienced DFSV - an intersectoral approach

THE CHRISTIE PROJECT RESEARCH REPORT

November 2025

Acknowledgements, statements and notes

Acknowledgement of Country

The *CHRISTIE 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 *CHRISTIE Project* and on which we live and work each day. We acknowledge and thank elders, 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 families and communities

The *CHRISTIE Project* acknowledges and thanks the traditional owners and Aboriginal custodians of the lands throughout NSW for their wisdom, guidance, and support to work on land where sovereignty was never ceded.

The *CHRISTIE Project* acknowledges the disproportionately high rates of violence experienced by Aboriginal children, women, families and communities in NSW and acknowledge that this is directly connected to policies of child removal, the breakup of families and traditional family structures, dispossession of land, disconnection from culture, genocide, state sanctioned violence and intergenerational trauma. We acknowledge the challenges that Aboriginal and Torres Strait Islander people face when working in violence prevention, early intervention and response in community and the professional and personal impacts of this work. The *CHRISTIE Project* is committed to improving individual and system responses, and recognises the complex relationships between colonisation, trauma and oppression with domestic, family and sexual violence at the intersections.

A note on language and content

This report discusses professional responses to DFSV. While no specific details are given, readers should be aware that case examples refer to the perpetration of DFSV or child sexual assault.

This report uses language that reflects the gender-based nature of domestic, family and sexual violence (DFSV), 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 DFSV, 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.

We refer to those who have experienced violence and abuse as the child or adult victim-survivor. We refer to people choosing to use violence as a person or individual using violence. When citing literature, or providing direct quotations from project participants, terminology is used as it appeared or was spoken.

This report respectfully uses 'Aboriginal', rather than 'Aboriginal and Torres Strait Islander' in the narrative of this document to reflect the NSW context. 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.

CHRISTIE teams

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CHRISTIE Project implementation team

The research team could not have conducted this research without the enthusiasm and hard work of the team who actually made the project happen. Thanks to all the members of the implementation team.

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Executive Summary

The *CHRISTIE Project* (Collaboration to Harness Research Involving Safe & Together: Inquiry and Evidence) extends the evidence about practice in collaborative and holistic service provision for children and families living with domestic family, and sexual violence (DFSV), with a focus on outcomes for children and young people. It is the latest in an ongoing program of research in collaboration with the Safe & Together™ Institute that has simultaneously built research evidence and developed professional and organisational capacity about best practice (Healey et al., 2020; Humphreys et al., 2020,Kertesz et al., 2022; Toivonen et al., 2025).

The *CHRISTIE Project* was funded under the Domestic, Family and Sexual Violence National Partnership Agreement. The NSW Ministry of Health commissioned Domestic Violence NSW (DVNSW), and through them the Safe & Together Institute and a University of Melbourne research team, to conduct the project.

Children at the centre of the service response

Child maltreatment through DFSV is widespread among Australian communities, with 39.6% of Australians having experienced DFSV before the age of 18. Most children who experience multi-type maltreatment are exposed to domestic, family and sexual violence (Haslam et al., 2023). A growing body of evidence demonstrates that children and young people are not silent witnesses or 'secondary victims' in families where there is DFSV, but co-victim-survivors (Callaghan et al., 2015; Family Safety Victoria, 2020; Campo, 2015). The Australian Government's move to recognise 'children in their own right' is an important development in national efforts towards keeping children safe and protected, but it is critical to incorporate in this concept a consideration of the child or young person's living environment, their family, and their support system and structures (Toivonen, 2023).

Experiencing DFSV can have a wide range of detrimental impacts on a child's development, mental and physical health, housing situation and general wellbeing (AIHW 2019; ANROWS 2018; WHO 2016). There is a growing body of literature exploring children's agency, strengths, resistance, and coping strategies (Katz, 2022). However, less attention has been paid to service responses for children – there are fewer studies of child-centric services and approaches, and very limited evidence of effective practice (Smyth et al., 2024). This in turn leads to significant barriers for mothers/carers and their children, as well as for young people themselves when individually trying to access support (Dimopoulos et al., 2025; Fitz-Gibbon, 2025).

The need for more specific interventions to address the needs of children and young people affected by DFSV has been recognised in international studies (Berg et al., 2020; Smyth et al., 2024). Overall, studies continue to stress the need, not just for practitioner capacity-building, but also for complex organisational and systems change if greater attention is to be paid to the safety and well-being of children and young people as victim-survivors of DFSV (Kertesz et al., 2024).

The Safe & Together™ Model

Implementing the Safe & Together™ Model (the Model) into practice and organisational culture within the four participating Local Government Areas was a major goal of the *CHRISTIE Project*. The Model includes a suite of tools (such as the *Perpetrator Pattern Mapping Tool*) 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; Kertesz et al., 2022). The Model highlights the importance of an 'all-of-family' response to domestic violence (Mandel, 2024), and focuses strongly on behaviours – actions and their impacts - going beyond 'incidents of violence' towards a behavioural, pattern-based approach to DFSV. 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.

Project aims and research questions

The CHRISTIE 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's capacity building component aimed to build worker and organisational capacity to enable services to work collaboratively to better partner with child and adult victim-survivors and intervene more effectively with people using violence and coercive control.

The research component of the project aimed to build the evidence base regarding child-focussed practice with families living with DFSV, alcohol and other drugs, and mental health issues; and to evaluate the

effectiveness of the capacity building approach using the Safe & Together™ Model. The research questions were:

- To what extent have the Safe & Together capacity building activities in the CHRISTIE Project led to increased worker focus on, and understanding of, the impacts of domestic and family violence on children and young people, and responsiveness to their safety and wellbeing needs?

- How has the project led to improvement in cross-agency relationships and collaboration and how can these improvements be sustained?

- What do professionals require from their organisations and/or other organisations to support families to experience an effective and collaborative service system that keeps children safe and, where possible, together with non-offending parents?

- How are issues relating to the safety and wellbeing of children and young people, as a result of domestic and family violence, documented in agency records, pre and post Safe & Together capacity building activities?

Project Governance

The CHRISTIE Project was managed by members of the Project Leadership Group, which included DVNSW, ACWA, the Safe & Together Institute, the Ministry of Health, and the University of Melbourne research team. It was guided by an Aboriginal Advisory Group and reported to a Statewide Advisory Committee to ensure robust governance. The governance structure incorporated representation from all project partners, prioritised attention to Cultural safety for Aboriginal stakeholders and considered pathways to action on issues of statewide or national significance.

The diagram shows two main sections: Governance and Research & Capacity Building.

Governance section contains: CHRISTIE Aboriginal Advisory Group, CHRISTIE Statewide Advisory Committee, CHRISTIE Research Team, and CHRISTIE Project Leadership Group.

Research & Capacity Building section contains: Project Action Group 1 and Project Action Group 2, leading to Metro LGA 1, Regional LGA 1, Metro LGA 2, Regional LGA 2, all leading to "Influencing beyond the CoP".
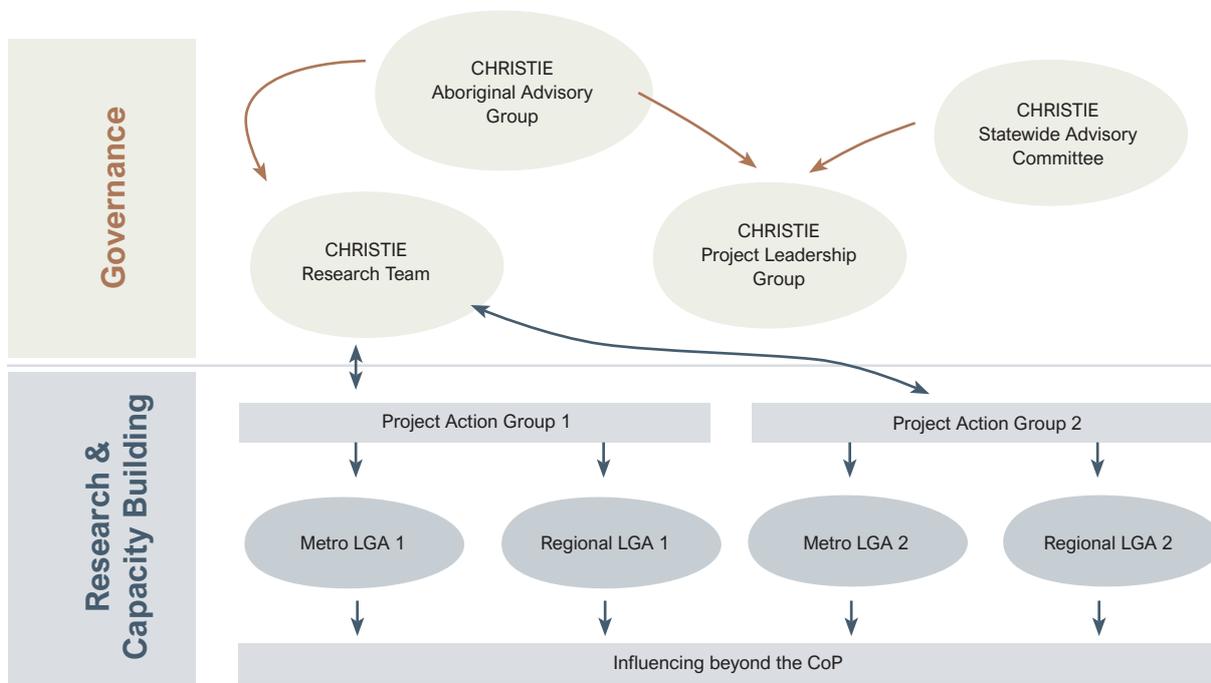
Methodology

Research sites and participants

An Expression of Interest process led by the *CHRISTIE Project* leadership team resulted in the selection of four Local Government Areas (LGAs) in NSW from a pool of 19 applications. The four Local Government Areas selected were in metropolitan Sydney (Inner West and Randwick) and in regional NSW (Port Stephens and Tamworth). There were two key streams of participation:

Project Advisory Groups (PAGs) comprised senior managers from participating services in each site as well as representatives from the Project leadership team. Two PAGs were formed, each with representation from one regional and one metropolitan LGA.

Communities of Practice (CoPs) brought together a core group of professionals from specialist family violence services and non-government child protection services within each LGA, and where possible, a range of other services such as Aboriginal Community Controlled Health Organisations (ACCHOs) Aboriginal Community Controlled Organisations (ACCOs), NSW Health (including Violence, Abuse and Neglect (VAN) services, Mental Health and Alcohol and Other Drug (AOD) services), housing services, child protection (both non-government and statutory), Justice Services, men's behaviour change program providers, and other services working with men who have used violence.

Capacity building component

The first aim of the *CHRISTIE Project* focused on building capacity by applying the Safe & Together approach to DFSV, with a particular focus on children and young people. The project implementation team worked with two LGAs from August 2024 to February 2025, and with the other two LGAs from February to August 2025.

Capacity-building in each LGA involved:

- An engagement phase between the research team and project leaders within each LGA.

- Development of an authorising environment through the PAGs, each of which met twice throughout the project.

- A training phase, where CoP and PAG members were offered four consecutive days of face-to-face training facilitated by Safe & Together Institute Consultants, and access to Safe & Together online modules.

- A capacity-building phase, where CoP meetings were convened to support participants to continue practice change through case discussions, coaching from a Safe & Together Institute Consultant, debriefing and reflection on change agent work. Each CoP met five times throughout the project. According to the preference of CoP members, in two LGAs CoP members met in person and in two LGAs CoP members met via videoconference. All came together in person for the final CoP meeting of their Community of Practice.

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 collected during the research period (Creswell, Klassen, Plano Clark & Smith, 2011).

Data was drawn from several sources, including Community of Practice and Focus Group transcripts, a document audit exercise, and questionnaires for Community of Practice and Project Advisory Group participants. Research ethics approval was granted by the University of Melbourne and from the Aboriginal Health and Medical Research Council of NSW (AH&MRC). Approval for participation of NSW Health employees was obtained through the Research Ethics and Governance Office of relevant Local Health Districts.

Key findings

The following key findings are drawn from the diverse data collected throughout the *CHRISTIE 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. Highlights from the quantitative analysis of the pre- and post-participation CoP questionnaires are incorporated into the main report (volume 1) while the detail can be located in volume 2 of this report – "Analysis of the Pre- and Post-participation Questionnaires to CoP members".

Capacity building

- Overall, the capacity building model was successful in creating a learning environment that provided practitioners rich training in the content of the Safe & Together Model, and ongoing coaching opportunities to practise, reflect and implement new practice approaches.

- CoP participants were enthusiastic about engaging with the *Perpetrator Pattern Mapping Tool* and many reported that it transformed their practice.

- The strength of the *Perpetrator Pattern Mapping Tool* was seen to be its focus on identifying patterns of behaviour, and its function in bringing all relevant information about a family into one place, rather than dispersed and hidden through contact-based notes.

Practice development

- Over the course of the CoP discussions, participants made a significant shift towards a consideration of all members of the family unit, rather than an individual client. Practitioners began to think in more detail about the children and young people in the families they worked with, although most cases discussed in the CoPs did not involve working directly with children and young people.

- CoP members also started seeking information about children more broadly, asking about them in conversations with parents, the broader family network and seeking information from other professionals. Notably, many CoP members recognised the importance of considering the safety and well-being needs of children and young people affected by DFSV, even when the child was neither a client, nor the child of a client.

- Participant reports indicate that *CHRISTIE* helped them change their practice primarily in terms of deeper and more detailed risk assessment, and in recording this assessment in case notes and summaries, and other documentation. These changes were described as transformational, and participants reported to their CoP a number of instances where this new approach had resulted in victim-survivors feeling better supported, and in improved safety outcomes for child and adult victim-survivors.

Cross-agency relationships and collaboration

- Collaborative relationships between CoP participants, and between their services, developed over the timeline of the *CHRISTIE Project*. Foundational to this shift was the development of professional relationships within the CoPs and the participants' eagerness to familiarise themselves with other services and to build collaborative relationships.

- Opportunities for frontline staff from different services to meet each other offered significant advantages in sustaining improved collaboration including when the workforce changed.

- In the current service context, significant barriers exist to collaboration with police, corrective services, and the legal system in general, due to rigid siloing of services and conflicting requirements on service users. It was a frustration to many participants that they were met with a lack of understanding or even with hostility.

- These challenges result in participants spending a large proportion of their workload assisting clients in navigating a way around the barriers set up by the siloed functioning of different sectors.

Shifting the focus for sustainability and better client outcomes

Practitioners and their managers developed a range of strategies to embed and sustain the new knowledge and practices they had gained from *CHRISTIE* and Safe & Together. Some support for sustainability was also forthcoming from peak bodies, including further resources and training opportunities.

However, the Safe & Together Model's broader systems approach requires the coordinated efforts of professionals and organisations across the socio-legal system. Real safety outcomes for child and adult victim-survivors cannot be achieved where other parts of the service system are working from frameworks that do not place a priority on the risks of DFSV.

Sustainability of *CHRISTIE* learnings may be compromised by:

- the difficult emotional labour of work in the DFSV field – along with the tension expressed by practitioners between their wish to feel effective in the work they are doing, and their sense of what they can actually achieve in the context of the current system – leads to worker burnout and workforce turnover.

- hallenges in the NSW workforce, where short-term, insecure and limited program funding (especially in the non-government sector) restricts resources for innovative work outside 'core business' and for inter-agency communication and collaboration.

The evidence from *CHRISTIE* overwhelmingly supports the Safe & Together Model as a valuable tool for understanding what is happening in families living with DFSV, and offering a translatable set of concepts to communicate assessments. However, further socialisation of the Model across a connected NSW service system is necessary to facilitate a coordinated response which can make a difference to children, young people and their families, so that they experience an effective and collaborative service system that keeps children and young people safe, and where possible, together with protective parents or carers.
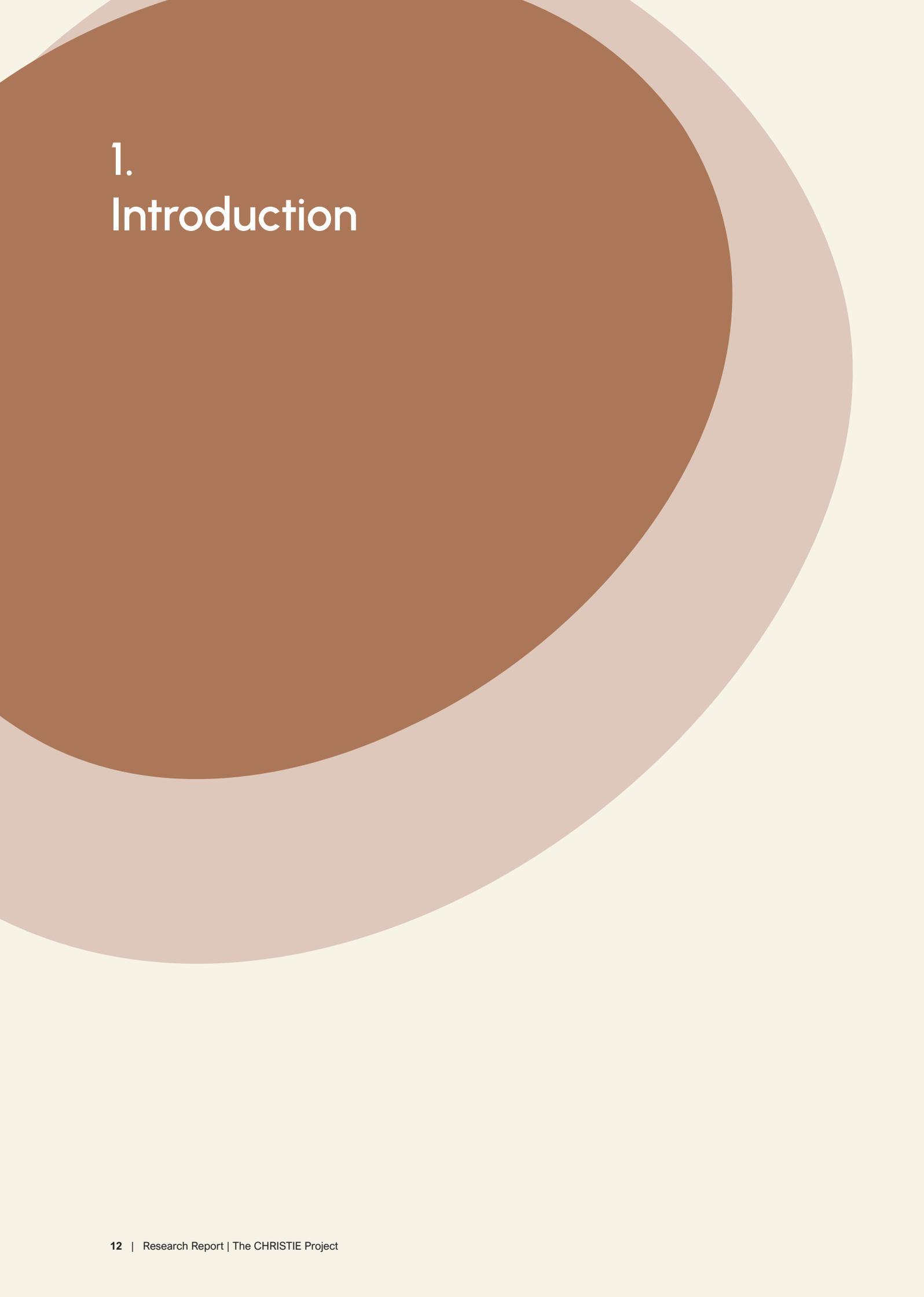
1.
Introduction

1. Background

The *CHRISTIE Project* (Collaboration to Harness Research Involving Safe & Together: Inquiry and Evidence) builds on the foundations of previous projects based on the Safe & TogetherTM Model, including the *STACY* and *STACY for Children* projects (Healey et al., 2020; Humphreys et al., 2020) and the ESTIE project (Kertesz et al., 2022). These were both projects that simultaneously built research evidence and developed professional and organisational capacity about best practice in collaborative and holistic service provision for children and families living with domestic family, and sexual violence (DFSV), where parental issues of mental health and/or alcohol and other drug use co-occurred.

The current project continues this work to extend the evidence base about effective inter-agency work for these families, with a focus on outcomes for children. The project also provides capacity building activities, coordinated by Domestic Violence NSW (DVNSW). These involve training by the Safe & Together Institute[1] followed by a number of coaching sessions with senior practitioners in inter-agency Communities of Practice (CoPs), and discussion of issues arising by senior decision-makers in Project Action Group (PAG) meetings. The overall objective is for children, young people and families impacted by DFSV to experience service systems that work as collaborative partners to keep children safe and together with non-offending parents. *CHRISTIE* has been funded under the Domestic, Family and Sexual Violence National Partnership Agreement. The NSW Ministry of Health commissioned DVNSW, and through them the Safe & Together Institute and a University of Melbourne research team, to conduct the project.

The *CHRISTIE project* brought together a core group of professionals from specialist family violence services and non-government child protection services within four Local Government Areas in New South Wales, and where possible, a range of other services such as Aboriginal Community Controlled Health Organisations (ACCHOs), Aboriginal Community Controlled Organisations (ACCOs), NSW Health (including Violence, Abuse and Neglect (VAN) services, Mental Health services and Alcohol and Other Drug (AOD) services), housing services, child protection (both non-government and statutory), Justice Services, men's behaviour change program providers, and other services working with men who have used violence.

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[1] The Safe & Together Institute has developed a Model which is an internationally respected approach for working with families impacted by domestic violence perpetrator behaviour, focusing on children's safety and wellbeing through identifying perpetrator patterns of behaviour and survivor strengths and partnering with adult survivors to keep children safe and, where possible, together with their protective parent. https://safeandtogetherinstitute.com/

1.1.1. Objectives of the *CHRISTIE Project*

The *CHRISTIE Project* drew on the lessons from previous University of Melbourne and Safe & Together projects to work with practitioners at the intersections of DFSV, alcohol and other drug use, and mental health issues, with a particular focus on children and child protection implications. Building collaboration within each of four Local Government Areas across sectors, services and between practitioners was also a focus. The *CHRISTIE Projec*t combined strategies for inquiry (building the evidence base through research and learning activities) and strategies for development/capacity building (practice and action).

The project's capacity building component, had the following objectives:

* to build worker and organisational capacity to enable services to work collaboratively to better partner with adult victim-survivors and their children, and intervene more effectively with people using violence and coercive control;

* for children, young people and families impacted by DFSV to experience service systems that work as collaborative partners to keep children safe and together with non-offending parents.

The research component of the project aimed to:

* evaluate the effectiveness of the capacity building approach using the Safe & Together™ Model, to improve inter-agency collaboration to enhance safety, health and justice outcomes for children, young people, adults and families;

* build the evidence base regarding child-focussed practice with families living with DFSV, alcohol and other drugs, and mental health issues.

1.2. Children at the centre of the service response

1.2.1. Prevalence of DFSV for children and young people

Child maltreatment through DFSV is widespread among Australian communities. The recent Australian Child Maltreatment Study (Haslam et al., 2023) reports that exposure to domestic violence affects 39.6% of the Australian population who are now aged 16-65 years; physical abuse affects 32%, sexual abuse affects 28.5% and neglect 8.9%. Most children who experience multi-type maltreatment experience exposure to domestic, family and sexual violence (Haslam et al., 2023).

1.2.2. Children as co-victim-survivors of domestic and family violence

The concept of children and young people only 'witnessing' DFSV has been challenged in recent years with a growing body of evidence demonstrating that children are not silent witnesses or 'secondary victims' in families where there is DFSV (Callaghan et al., 2015; Family Safety Victoria, 2020; Campo, 2015). At a national policy level, several policies focus on supporting the safety of children and young people with a recognition that they are impacted by DFSV, including The National Plan to End Violence against Women and Children 2022–2032, The Aboriginal and Torres Strait Islander Action Plan 2023–2025, and Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031 (DSS, 2022a, 2023a, 2021b).

Although the Australian Government's move to recognise 'children in their own right' is an important development in national efforts towards keeping children safe and protected by acknowledging children and young people as co-victim-survivors, this terminology must be used carefully to avoid individual-focused interventions or service responses where children and young people are responded to separately and away from the non-offending parent/caregiver or kinship carers. It is critical to consider the child or young person's living environment, their family, and their support system and structures (Toivonen, 2023).

1.2.3 The impact of DFSV on children and young people

Experiencing DFSV can have a wide range of detrimental impacts on a child's development, mental and physical health, housing situation and general wellbeing (AIHW 2019; ANROWS 2018; WHO 2016). More specifically, research has found that for child victim-survivors there are other associated outcomes, including; diminished educational attainment, reduced social participation in early adulthood, physical and psychological disorders, suicidal ideation, behavioural difficulties, homelessness, and future victimisation and/or violent offending (AIHW 2018; Bland & Shallcross 2015; Campo 2015; De Maio et al., 2013; Holt et al., 2008; Jaffe et al., 2012; Knight, 2015 as cited in AIHW, 2020). The participants in the *CHRISTIE Project* also identified a long list of situations and actions causing harm to children. In recent years, these impacts have been increasingly understood through the lens of complex trauma. Extended exposure to DFSV and other adverse child experiences can lead to 'cumulative harm' (Price-Robertson et al., 2013; Jaffe, Wolfe, & Campbell, 2012).

However, children and young people are affected differently by the impacts of domestic, family and sexual violence – each child has

their own unique experience and survives or manages their situation in their own way (Toivonen et. al, 2022). Children have their own agency, strengths, resistance, and coping strategies and there is a growing body of literature exploring the complex range of strategies that children and young people use to cope with the violence they are experiencing (Katz, 2022).

1.2.4. Seeking support

Children and young people are on the "periphery of domestic violence policy and practice" (Noble-Carr et al., 2021, p.935). While studies have highlighted the impacts of DFSV on children and young people, increasingly focusing on and capturing lived experience, there remain fewer studies of child-centric services and approaches, and very limited evidence of effective practice (Smyth et al., 2024). This in turn leads to significant barriers for mothers/carers and their children, as well as for young people themselves when individually trying to access support. For children and young people, an adult-centric system which treats them as inherently vulnerable, dependent on adults, and having the same needs as their parent or carer, or alternatively leaves them invisible in the service response, is problematic.

In their study examining effective supports for children and preadolescents as victim-survivors Dimopoulos and colleagues (2025) found multiple systemic barriers. These included:

- an insufficiently resourced DFSV service system (long wait times, staff shortages, high staff turnover, and a lack of specialised programs for children);

- Family court orders requiring children to spend time with the person using violence;

- the need for consent from both parents for children to engage with services, which can be used to prevent children's access to support as a form of control and ongoing abuse;

- poor service collaboration and communication, resulting in a lack of action on important risk information about children;

- a lack of practitioner skills, training and confidence, with practitioners indicating that they felt ill-equipped to support children because they lacked the skills, experience or confidence (Dimopoulos et al., 2025).

A further study that aimed to understand how young people experiencing and escaping DFSV in Victoria accessed support at the point of crisis (Fitz-Gibbon, 2025), identified the following key barriers for young people seeking help:

- information gaps and delayed attempts at seeking help (that is, young victim-survivors described growing up without a clear understanding of what DFSV is and looks like);

- navigation of adult-centric services being overwhelming and isolating for young victim-survivors;

- a sense of invisibility and mistrust characterising young people's experiences of seeking help at the point of crisis;

- crisis-driven response systems leaving young people unsupported until the point of crisis;

- out-of-home care placements often compounding trauma (Fitz-Gibbon, 2025).

1.2.5. How can the service system better respond to support children and young people who have experienced DFSV?

The need for more specific interventions to address the needs of children and young people affected by DFSV has been recognised in international studies (Berg et al., 2020; Smyth et al., 2024). Professionals working within the sector have identified targeted initiatives across all child-serving systems to address children and young people's needs through trauma-informed care frameworks, culturally sensitive practices, and collaborative approaches (Berg et al., 2020). Morris and Humphreys (2023) highlight that international models and evidence have been influential in Australian DFSV reform, and that the Safe & Together Model in particular is expanding in Australia, as a practice approach for working with children and families who live with DFSV.

Key service responses to children and young people who have experienced DFSV have been identified in a range of studies, summarised in the list below (Campo, 2015; Humphreys & Absler 2011; Hooker, Kaspiew & Taft 2016; Australian Domestic and Family Violence Clearinghouse, 2011; Urquhart & Doyle, 2022).

- Collaborative or integrated practices between DFSV, child protection, and other sectors such as health, social support and education have been called for by victim-survivors to promote healthy child development and develop positive child-parent relationships (Letourneau et al., 2013 as cited in Hooker, Kaspiew, & Taft 2016);

- Child-aware and all-of-family early intervention and prevention approaches, that are strengths based, consider intersectionality and are culturally appropriate;

- Community, welfare-based responses that validate and partner with victim-survivors (child and adult) rather than a mandatory reporting approach (Davies & Krane, 2006; Holt et al., 2008; Humphreys & Absler, 2011 as cited in Hooker, Kaspiew & Taft 2016);

- Trauma-informed service responses;

- Continuing, coordinated contact for families with a service to avoid brief and often unhelpful service responses (Urquhart & Doyle, 2022);

- Therapeutic responses offering a range of options, including individual counselling, group work and mother/carer–child interventions, with the aim of strengthening parent–child relationships (Humphreys, Thiara, Sharp, & Jones, 2015);

- Programs and policies that prevent homelessness and promote economic security for families;

- Services appropriate for adolescent and young adults who may be seeking help individually rather than in the context of their families (Fitz-Gibbon, 2025);

Overall, studies continue to stress the need, not just for practitioner capacity-building, but also for complex organisational and systems change to ensure greater attention to the safety and well-being of children and young people as victim-survivors of DFSV (Kertesz et al., 2024).

1.3. The Safe & Together™ model

Implementing the Safe & Together™ Model (the Model) into practice and organisational culture within the four participating LGAs, as place-based systems development, was a major goal of the *CHRISTIE Project*. The Model provides a practice framework which promotes the safety and well-being of children in the context of their protective relationships by keeping children safely together with a protective parent and making visible the behaviour of people using violence (usually men) as parenting choices. The Model's strength is its ability to flexibly inform work 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 and traditionally siloed practices (Humphreys & Healey, 2017; Healey et al., 2018, Kertesz et al., 2022). The Model highlights an 'all-of-family' response which stresses the importance of addressing the needs, support and/or accountability of each family member, enabling a focus on the impact of DFSV on children and their needs (Mandel, 2024).

The Safe & Together Model's principles and critical components create a framework with a shared language that can support collaboration across different organisations engaged in responding to children living with DFSV. The Principles (Figure 1) start with the goal of keeping children safe with their non-offending parent (usually their mother). The second principle situates the protection of children in the practice of partnering with the non-offending parent as the expert in family safety.

The third principle advocates keeping the person using violence and control visible as the source of risk and harm to children, and engaging with them where this is safe and

practical. Holding the person using violence accountable also involves working within established systems, including details of perpetrator patterns of abusive behaviour in case documentation, collaborative working across programs and services, and the justice system. The Model challenges gender bias in practice by providing a framework for detailing how harms to children are linked back to the behaviours of the person using violence, usually the father. In practice and philosophy, the Model represents a child-focussed, ethical and complex system intervention which is explicit in situating the DFSV skill enhancement of frontline workers, alongside organisational change.

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

1   **Keeping child Safe and TogetherTM with non-offending parent**
• Safety   • Healing from Trauma   • Stability and nuturance

2   **Partnering with non-offending parent as default parent**
• Efficient   • Effective   • Child-centered

3   **Intervening with perpetrator to reduce risk and harm to child**
• Engagement   • Accountibility   • Courts

While the principles provide the foundations for the conceptual model, the Critical Components (Figure 2) provide more detailed guidance for practice. The paramount component (red) 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-based approach to carefully map the range of strategies that are being deployed to establish control by one person over others. In the Model, there is particular emphasis on understanding the range of actions that harm the child. Some of these may be direct abuse or neglect, others may be indirect through undermining the child's relationship with the non-offending parent (usually their mother) or other family members and community networks.

Figure 2: Safe & Together Critical Components (reproduced with permission)
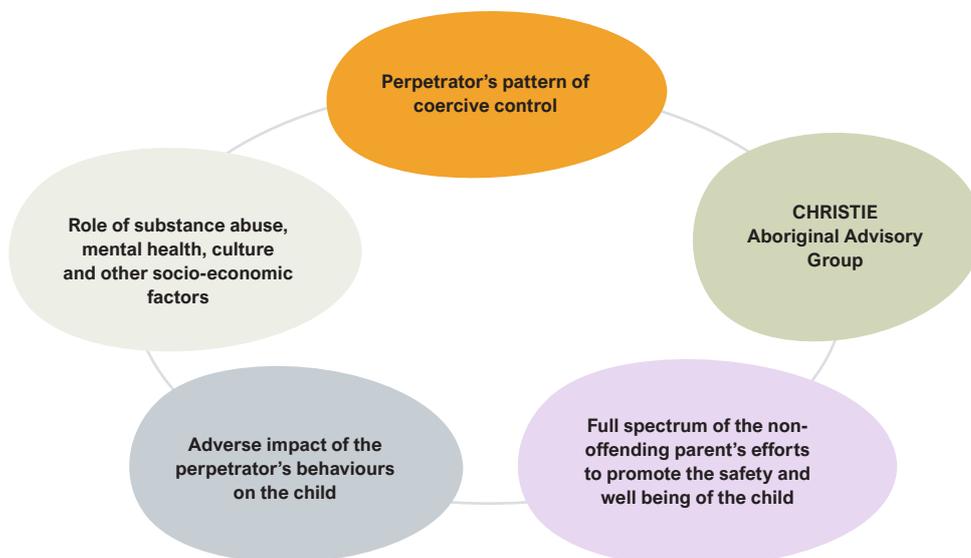
The first step (green) in understanding the perpetrator's pattern of coercive control is to identify the actions of the person using violence and control and their impact on the child – whether the impact is harmful or the actions are protective. The next critical component (purple) focuses on the non-offending parent (usually the mother) and describes what she does to protect both her children and herself. 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 context of abuse and control), 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 impacts of the person using violence's behaviour on each child in a family - physical, emotional and developmental (blue).

The Safe & Together Model supports culturally safe work by offering a pathway that values protective efforts outside mainstream services, recognising that First Nations people often experience mainstream services as culturally unsafe. The Model also values the role of fathers in the functioning of the family, which is important in Aboriginal communities, and often ignored by mainstream DFSV interventions.
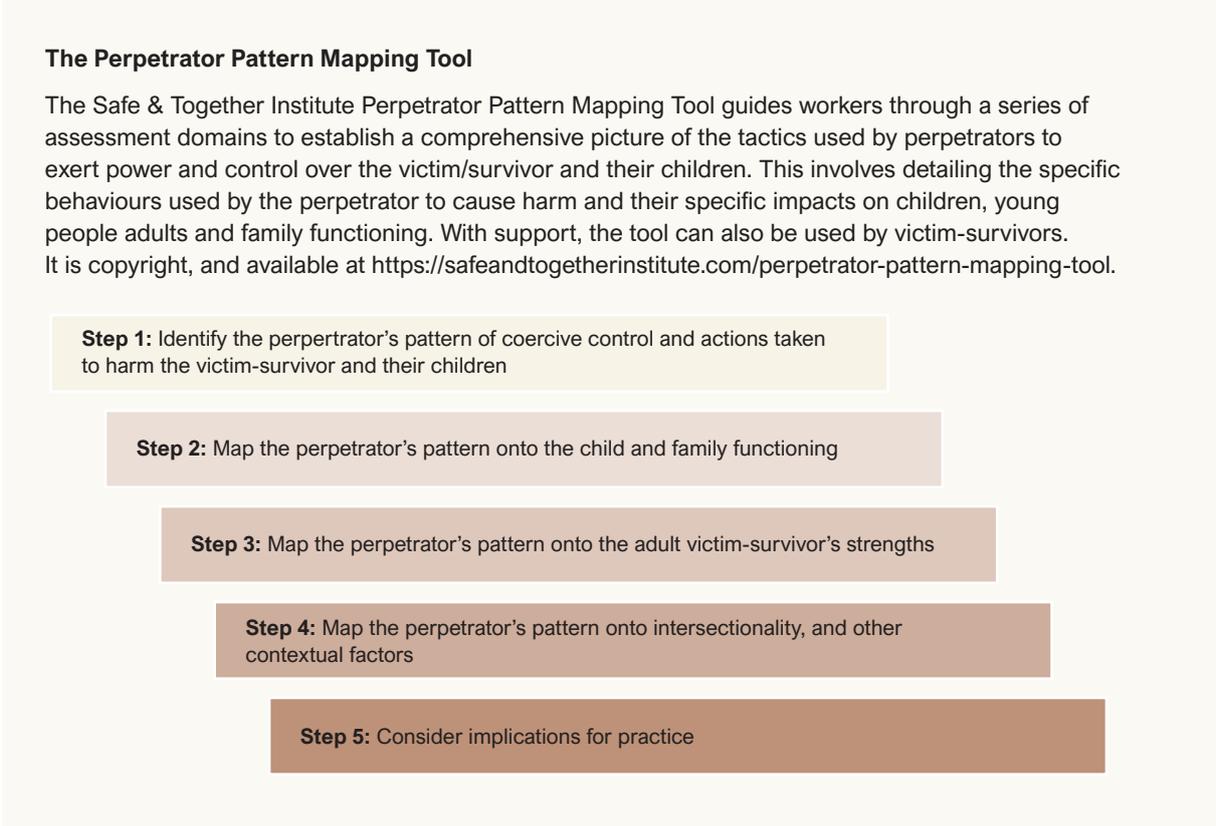
Figure 3. Safe & Together Perpetrator Pattern Mapping Tool

The Perpetrator Pattern Mapping Tool

The Safe & Together Institute Perpetrator Pattern Mapping Tool guides workers through a series of assessment domains to establish a comprehensive picture of the tactics used by perpetrators to exert power and control over the victim/survivor and their children. This involves detailing the specific behaviours used by the perpetrator to cause harm and their specific impacts on children, young people adults and family functioning. With support, the tool can also be used by victim-survivors. It is copyright, and available at https://safeandtogetherinstitute.com/perpetrator-pattern-mapping-tool.

Step 1: Identify the perpertrator's pattern of coercive control and actions taken to harm the victim-survivor and their children

Step 2: Map the perpetrator's pattern onto the child and family functioning

Step 3: Map the perpetrator's pattern onto the adult victim-survivor's strengths

Step 4: Map the perpetrator's pattern onto intersectionality, and other contextual factors

Step 5: Consider implications for practice

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 & Keel, 2021) the vulnerability of women with disabilities and their children when a partner weaponises her disabilities against her, and there are many more. Poverty may overlay all forms of structural discrimination, circumscribing further the lives of child and adult 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).

Safe & Together has developed the Safe & Together *Perpetrator Pattern Mapping Tool* to enable practitioners to apply the Safe & Together Model's Principles and critical concepts to their assessment and intervention. This behavioural- and fact-based tool helps to identify the individual who using violence and their pattern of coercive control, assess the harm to children, and document protective parenting efforts. Safe & Together consultants framed their training and coaching in the *CHRISTIE Project* around its use (see Figure 3).

1.4. The NSW context

The NSW Ministry of Health has the role of 'system manager' in relation to the NSW public health system. It operates more than 220 public hospitals, as well as providing community health and other public health services for the NSW community through a network of local health districts, specialty networks and non-government affiliated health organisations, known collectively as NSW Health. The Ministry of Health guides the development of services and investments in the NSW public health system to ensure that the health priorities of the NSW Government are achieved for the community of NSW.

The leadership role of NSW Health in supporting the implementation of the Safe & Together Model across the NSW service system is demonstrated in its funding of three projects focussing simultaneously on capacity-building services through Safe & Together training and coaching, and on building the evidence base for effective DFSV-informed practice and service systems. These projects are:

1. The *ESTIE Project* - Evidence to Support Safe & Together Implementation and Evaluation;

2. The *ALFies Project* - All/Whole of family approaches for addressing domestic and family violence: An Aboriginal lens on the Safe & Together Framework; and

3. The *CHRISTIE Project* - Collaboration to Harness Research Involving Safe & Together: Inquiry and Evidence.

In funding the *CHRISTIE Project* through the Domestic, Family and Sexual Violence National Partnership Agreement, NSW Health recognised the need to explore systems collaboration between specialist DFSV services, and statutory (DCJ) and non-government child protection organisations. Domestic Violence NSW (DVNSW), as

an independent, non-government peak organisation providing representation and advocacy for specialist DFSV services was therefore commissioned to implement the capacity building model originally trialled in the ESTIE Project. DVNSW have done this in partnership with the Association of Children's Welfare Agencies (ACWA)[2], the Safe & Together™ Institute as the training provider, and the University of Melbourne conducting the research component of the project.

Inter-agency partners

The CHRISTIE Project aimed to draw partners from various service sectors in four different NSW Local Government Areas (LGAs), to enhance local collaboration between the following key intersecting sectors:

- DFSV organisations;

- Non-government child protection organisations (early intervention, targeted early intervention and/or family preservation);

- Aboriginal Community Controlled Organisations (ACCOs);

- Local NSW Health services in the areas of Mental Health, and Alcohol and Other Drugs (AOD), Aboriginal Community Controlled Health Organisations (ACCHOs) and Violence, Abuse and Neglect (VAN);

- Men's behaviour change program providers and other services working with men who have used violence;

- Department of Communities and Justice local services such as child protection services and corrective services;

- NSW Police Force.

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[2] ACWA is the NSW peak body representing the voices of non-government community organisations that deliver services to vulnerable children, young people and their families

Representatives from most of these sectors took part in the training and in the Communities of Practice. For service capacity reasons, representatives from child protection services, corrective services and the police did not attend Communities of Practice, although these organisations were represented on the Statewide Advisory Committee (see below).

1.5. The CHRISTIE Project partnership and project structure

The *CHRISTIE Project* was managed by members of the Project Leadership Group, which included DVNSW, ACWA, the Safe & Together Institute, the Ministry of Health, and the University of Melbourne research team. It was guided by several advisory groups, which together created a robust governance structure for the project. The governance structure incorporated representation from all project partners, prioritised attention to Cultural safety for Aboriginal stakeholders and considered pathways to action on issues of statewide or national significance (Figure 4). The membership and roles of each of the governing groups are set out below.

1.5.1. CHRISTIE Statewide Advisory Committee

The Statewide Advisory Committee offers strategic advice, recommendations, and feedback to steer the Project's direction so that the objectives and projected outcomes are achieved. The Committee facilitates collaborative inter-agency relationships and enables the members' expertise and experience to influence the project. In addition, committee members disseminate project findings throughout their networks, with the aim of promoting NSW statewide (and where appropriate national) level action to

ameliorate blockages and problems identified in the research discussions.

Advisory Committee Meetings were held quarterly, with representatives from the following organisations:

- DVNSW;

- Aboriginal Consultant for DVNSW on the *CHRISTIE project*;

- The Association of Children's Welfare Agencies (ACWA);

- Safe & Together Institute;

- University of Melbourne Research team;

- NSW Ministry of Health - Program Delivery Office;

- NSW Ministry of Health – Mental Health;

- NSW Ministry of Health – Centre for Alcohol and Other Drugs;

- Department of Communities and Justice - Child Protection;

- Department of Communities and Justice - Women, Family and Community Safety;

- Department of Communities and Justice - transforming Aboriginal Outcomes project;

- Department of Communities and Justice Corrective services - Strategy Planning and Policy, DFSV Framework project;

- AbSec (NSW Child, Family and Community Peak Aboriginal Corporation);

- Women's Domestic Violence Court Advocacy Program;

- No To Violence (Australia's largest peak body for organizations and individuals working to end men's family violence);

- DV West;

- ANROWS (Australia's National Research Organisation for Women's Safety);

- NSW Children's Guardian.

1.5.2. CHRISTIE Aboriginal Advisory Committee

The Aboriginal Advisory Committee provided cultural expertise, directions, advice and support to the *CHRISTIE Project* team regarding culturally appropriate and safe management of the project, based on the needs of Aboriginal, children, families and communities. Committee members provided recommendations throughout the project on engagement and best practice.

The Aboriginal Advisory Committee members included Aboriginal professionals representing DVNSW (the Aboriginal CoP co-facilitators), the Safe & Together Institute and the University of Melbourne research team. Aboriginal professionals in the four participating LGAs were invited to join the

Figure 4: CHRISTIE project governance and implementation structure
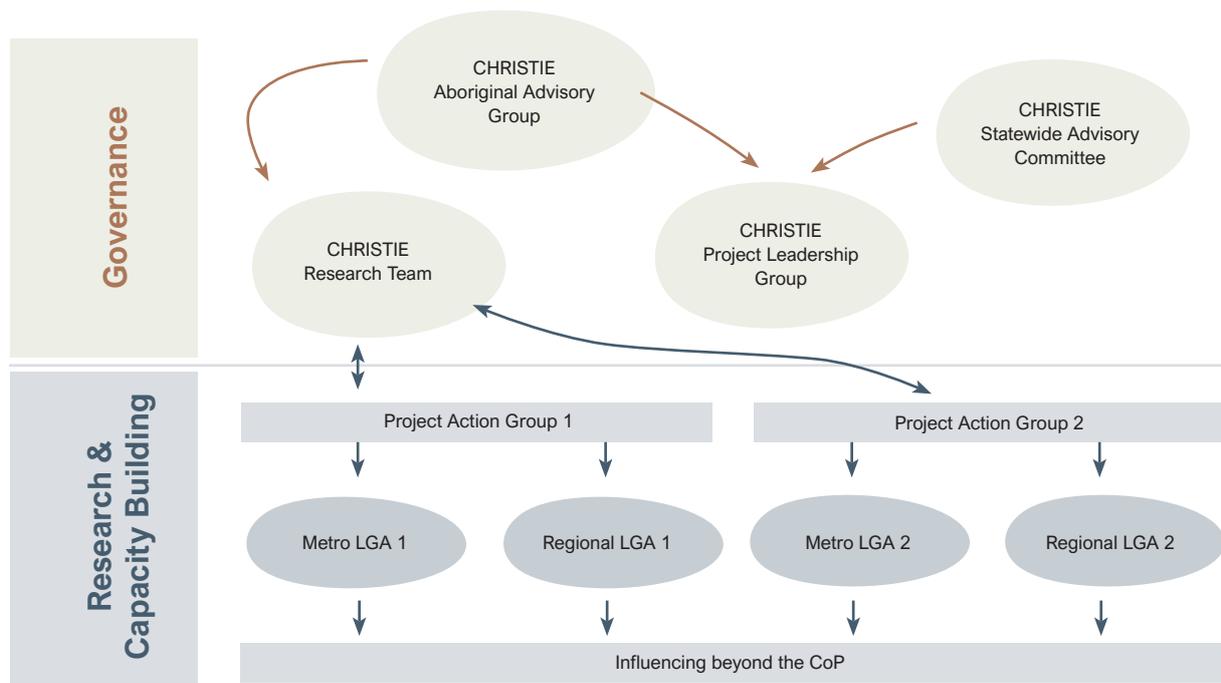
Advisory Committee but declined due to large caseloads and the significant cultural loads they already carry within their own organisations.

The Aboriginal Advisory Committee first met in June 2024, and then in August 2024 to facilitate a change of Aboriginal co-facilitator, necessitated by workload management issues. A meeting scheduled for late 2024 was postponed twice due to sorry business. A project reflection session was held in November 2025 to understand learnings from the Advisory Community throughout the project.

1.5.3. CHRISTIE Project Leadership Group

The Project Leadership Group managed the day-to-day implementation of the *CHRISTIE Project*. Members included representatives from DVNSW and ACWA, the CEO and Asia Pacific Regional Manager of the Safe & Together Institute, the Ministry of Health, and members of the University of Melbourne research team. The group met fortnightly from the inception of the project, moving to monthly meetings in 2025 until the Communities of Practice were completed.

1.5.4. CHRISTIE Research Team

The University of Melbourne *CHRISTIE* research team was responsible for facilitating the Community of Practice sessions and the Project Action Group meetings, and for data collection and analysis to build the evidence base. The team met weekly throughout the project.

1.5.5. Research sites and participants

An Expression of Interest process led by DVNSW and the Ministry of Health resulted in the selection of four LGAs from a pool of 19 applications. The four LGAs selected were Inner West, Port Stephens, Randwick and Tamworth.

A **Project Action Group** (PAG) was convened in phase one of the project and included representatives from a regional NSW LGA (LGA 1) and a metropolitan Sydney LGA (LGA 2). In phase two of the project, a second PAG was convened, with representatives from a second regional NSW LGA (LGA 3) and a second metropolitan Sydney LGA (LGA 4). Both PAGs consisted of senior managers from participating organisations in each LGA, as well as representatives from the Project Leadership Group and the Ministry of Health. Each PAG met twice during their phase of the project.

A **Community of Practice** (CoP) was established in each LGA, consisting of practitioners nominated by PAG members from their organisations. The CoP in each LGA therefore included professionals with varying roles and from a range of services within the LGA. Each CoP met five times following their Safe & Together training.
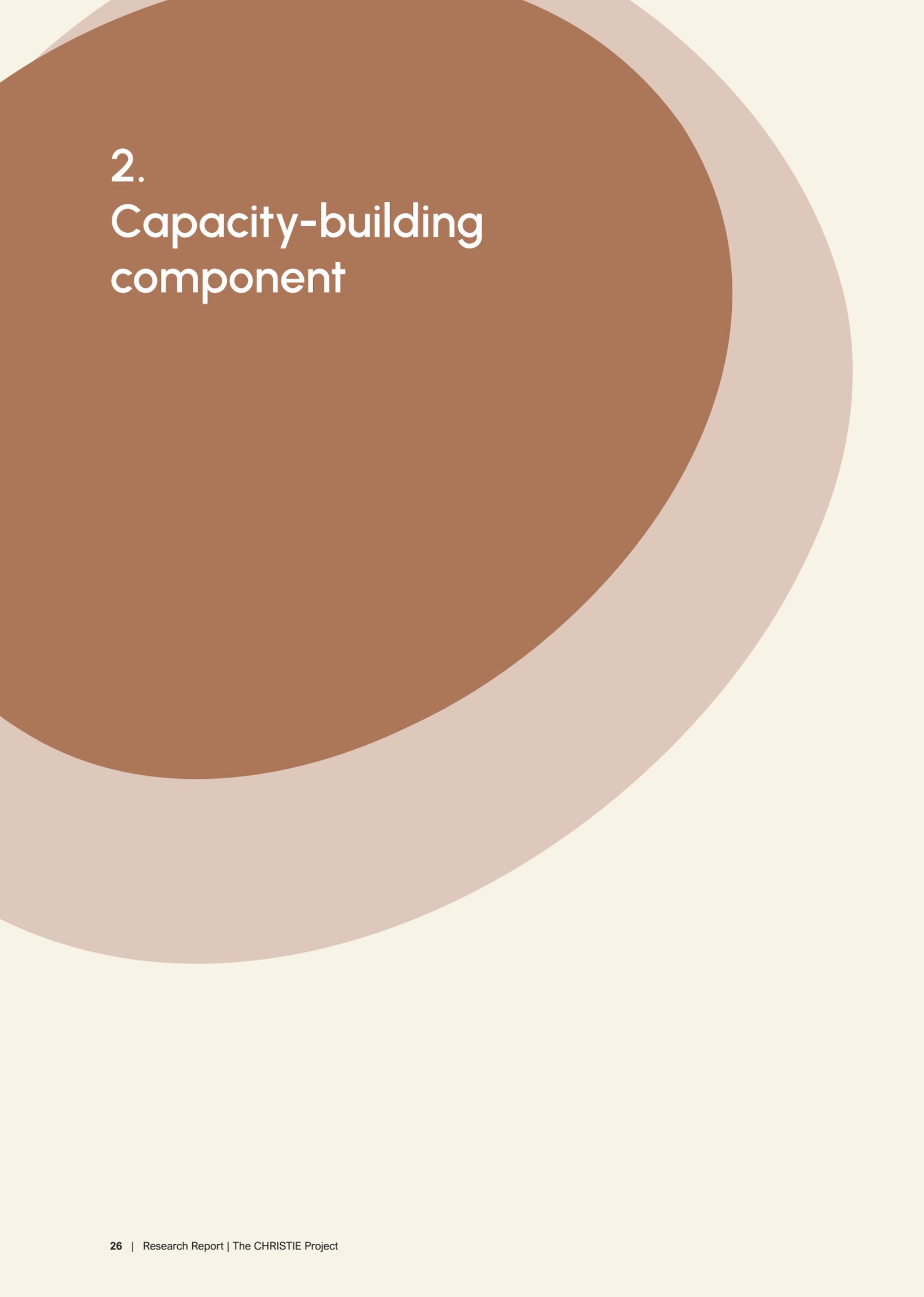
2.
Capacity-building component

In developing practice capacity in a workforce drawn from diverse professional backgrounds and roles, the project team has drawn 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 frontline practitioners 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,

2.1. Overview of capacity-building

The *CHRISTIE Project* encompassed a combined focus on building capacity among the professionals and organisations in selected LGAs and developing the evidence base on strategies that improve outcomes for children and young people affected by DFSV. DVNSW delivered the capacity building component of the project, in partnership with the research team, who supported DVNSW using their expertise developed through previous projects with the same methodology. This section summarises this activity.

The capacity-building model was based on that used in the *ESTIE Project* (Kertesz et al., 2022). Following the selection of the four participating LGAs through an Expression of Interest process, Port Stephens and Tamworth were selected as regional LGAs, and Randwick and Inner West as Sydney metropolitan LGAs.

Capacity-building in each LGA involved the following steps.

- An engagement phase between DVNSW, the research team and project leaders within each LGA;

- Development of an authorising environment through meetings of the Project Action Group for each capacity-building round, as well as quarterly meetings of the Statewide Advisory Committee;

- Building in Cultural safety in each LGA;

- A training phase, where the Safe & Together Institute's Core Training package was delivered by Safe & Together Institute Consultants over four days at a venue in each LGA;

- A capacity-building phase, where CoP meetings were facilitated by the research team to support participants to continue practice change through case discussions, coaching from the Safe & Together Institute Consultants, debriefing and reflection on collaboration, sustainability and disseminating the learning;

- 'Socialising' and sustaining the learning - knowledge translation beyond the *CHRISTIE Project* to other stakeholders in the broader NSW service system.

2.2. Cultural safety

Attention to Cultural safety in the *CHRISTIE Project* primarily focussed on Cultural safety for participants from Aboriginal backgrounds. The Safe & Together Model was developed in the United States but has operated in Australia since approximately 2013. During this time, it has incorporated discussions of colonisation and anti-racism at a universal level into training, tools and resource materials, and has engaged in consultations regarding the alignment of the Model with Aboriginal ways of knowing, being, and doing, in particular through the ALFies Project (Toivonen, C. et al., 2025).

The *CHRISTIE Project* was designed to involve professionals from all cultural backgrounds, with no particular focus on any cultural group. Nevertheless, it was deemed important that Aboriginal professionals and organisations should be encouraged to participate due to the overrepresentation of Aboriginal women and children experiencing DFSV and involved with the child protection system. Measures were taken to create a Culturally safe environment in all *CHRISTIE* activities, with guidance from the Aboriginal Health and Medical Research Council of NSW.

An Aboriginal Advisory Committee was established by DVNSW, to advise on the needs of Aboriginal participants in training, capacity-building, and research activities (see section 1.5.2). The Aboriginal co-facilitators attended all training sessions, and all meetings of CoPs, PAGs and governance groups. In addition, the Aboriginal co-facilitators engaged with Aboriginal CoP members before and between training and CoP sessions to support their attendance and to ensure they felt safe. In particular, the fact that Jackie Wruck - the Safe & Together consultant who co-facilitated the Communities of Practice – is Aboriginal, created a strong sense of cultural safety in these groups.

Based on feedback from CoP participants, this approach was successful in supporting attendance by Aboriginal participants, promoting Culturally safe discussions, and enabling the development of professional relationships between Aboriginal and non-Aboriginal professionals. It also supported building trust and connection between workers in each local LGA.

2.3. The authorising environment: Project Action Groups and Statewide Advisory Committee

Evidence from earlier research (Healey et al., 2020; Kertesz et al., 2022) 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, the safety needs of the workforce, DFSV-informed theoretical practice frameworks, and workplace cultures that encourage collaboration and information-sharing with regard to all members of families affected by DFSV (Kertesz et al., 2022).

The *CHRISTIE Project* team considered several layers of the authorising environment. First, the Project Leadership Group met regularly to oversee and guide the project. Secondly, the Project Action Groups (comprising key representatives from organisations in each LGA at a senior or management level) formed a problem-solving forum to address issues arising from the

research project, support the work of CoP participants as change agents within their organisation and across the relevant multi-agency networks, and reflect and advise on the implications of practice and policy issues arising from the project.

Thirdly, the *CHRISTIE* Statewide Advisory Committee was established to reflect and advise on implications and actions relating to issues raised by participants and CoP and PAG level, particularly in relation to system-wide issues, service silos and blockages in collaboration that have statewide or national applicability. Table 1 indicates the meeting dates for PAGs and the Statewide Advisory Committee.

Table 1: Meeting dates

Statewide Advisory Committee	Project Action Group (Phase 1)	Project Action Group (Phase 2)
24 April 2024 6 August 2024 22 January 2025 5 June 2025 14 November 2025	29 October 2024 13 March 2025	12 June 2025 11 September 2025

2.4. Safe & Together training

In order to provide a foundational shared knowledge base for *CHRISTIE* professional learning activities, CoP members were required to attend the four-day Safe & Together Core Training. While this was a significant commitment on the part of participating organisations and professionals, Safe & Together advised that participants had not been satisfied in the past with abbreviated training offerings, and the full four days provided a solid common body of understanding about the Safe & Together Model.

While the training was compulsory for Community of Practice members, Project Advisory Group members were also encouraged to attend, to strengthen their understanding of DFSV-informed practice and

support the development of an authorising environment for the Safe & Together Model that their CoP members would be working with. Both groups were also provided with the online Safe & Together modules and e-learning pack.

Training for each LGA was held in person at a convenient location within the LGA and was facilitated by a Safe & Together consultant and an Aboriginal co-facilitator, supported by members of the project team. The mix of attendees consisted of Community of Practice members, Project Action Group members and a small number of other stakeholders. Table 2 sets out Training attendance figures.

Table 2: Training attendees

Participants	LGA 1	LGA 2	LGA 3	LGA 4
Training dates 2024 & 2025	8-9 Aug 15-16 Aug	22-23 July 12-13 Aug	10-11 Feb 17-18 Feb	13-14 Feb 20-21 Feb
Community of Practice members	31	27	22	34
Project Action Group members who did not attend the CoP	2	2	5	2
Training only attendees	7	10	13	7
Total participants for training group	40	39	36	41
Average attendance across training days*	37	37.5	33.75	38.75

Calculated as the sum of total attendance on each day divided by 4 training days
NB. LGA1 – three people from the corrective services team discontinued after attending the first 2 days of training and are therefore not included in numbers.

Figure 5: Communities of practice - roles and opportunities (Toivonen, 2022)

2.5. Communities of Practice

Following the training, five Community of Practice (CoP) meetings were held in each LGA. Communities of Practice are a form of collective learning, a concept derived from learning theory where a specific community or group of people act as a "living curriculum" for participants (Wenger 2007). As shown in Figure 55, they have been found to be an effective way to share knowledge, acquire skills and build relationships across silos (Healey et al., 2020; Wenger, 1998).

Communities of Practice may take many different forms, ranging from informal and self-organised to more formally organised with some form of leadership or authorising environment. They can take place in person or through a range of online modalities. Following Wenger's model (1998), there are three key characteristics which together constitute a Community of Practice, which is not just about learning but also about innovating and solving problems.

1. The domain: CoPs are defined by a shared domain of interest in which members are committed and skilled. For *CHRISTIE* participants, the domain is the service response to DFSV, with a particular focus on children at the centre of practice.

2. The community: In following this area of interest, CoP members engage in joint discussions where they help each other and share information. The CoP is member led, with a collective responsibility for managing the knowledge members all need.

3. The practice: CoP participants are practitioners and use the CoP meetings to develop a shared repertoire of practice, tools, techniques and strategies to address recurring problems. These are not only derived from the Safe & Together Model, but also from the expertise brought by CoP members themselves, whether it is professional skill and knowledge, lived experience, insights about clients' needs or an understanding about how the service system works in a local area.

As in previous projects, the *CHRISTIE Project* designed Communities of Practice to be supported by organisational leadership, and to involve facilitation by the research team, and expert input by a Safe & Together consultant in addition to the expertise brought by participants. The CoP meetings had a common structure and agenda in all four LGAs. Each CoP session had a specific theme, which was connected with use of the Safe & Together *Perpetrator Pattern Mapping Tool* (see Figure 3), thus creating a cross-cutting theme focussing on documentation as a form of intervention throughout the series of CoPs (see Table 3 for topics and dates).

Each CoP agenda started with a discussion among participants, facilitated by the research team, about examples of practice which had arisen in the weeks preceding the CoP session, followed by small group discussions about practice relevant to the theme of the CoP session. One or more de-identified case examples and questions were presented to a Safe & Together consultant, followed by a cycle of questions, discussion, coaching, and reflection led by the consultant. Each session finished with group reflection on what participants could do as 'agents of change' to share their CHRISTIE learning beyond

the CHRISTIE Project, and on strategies for ensuring the sustainability of the practice changes they were reporting.

2.5.1. Community of Practice participation

Participants were located in four Local Government Areas (LGAs), with numbers relatively evenly distributed in each Community of Practice (Table 4). The pattern of organisational representation from the non-government sector differed between regional and metropolitan LGAs. Regional CoP membership was dominated by practitioners from a range of services within one larger local organisation, while metropolitan CoPs included staff from a number of small community organisations.

Table 4 sets out participation in the Communities of Practice. While the initial project design anticipated separate membership of CoP and PAG groups, several PAG members also attended CoP meetings. The nature of work in small community-based organisations means that managers may often be also involved in client-facing work in addition to their leadership roles.

Table 3: Community of Practice meetings and topics across LGAs

Meeting topics	LGA 1	LGA 2	LGA 3	LGA 4
CoP 1: The perpetrator pattern-based approach can help with collaboration between systems	26 Sep 2024	24 Sep 2024	25 Mar 2025	1 Apr 2025
CoP 2: Using the Mapping Tool to document harm to child, partner, and family functioning	24 Oct 2024	15 Oct 2024	29 Apr 2025	6 May 2025
CoP 3: Using the Mapping Tool to identify protective efforts from children and adults	14 Nov 2024	12 Nov 2024	27 May 2025	3 June 2025
CoP 4: Assessing and documenting intersections and intersectionalities	5 Dec 2024	3 Dec 2024	24 June 2025	1 July 2025
CoP 5: Using the Mapping Tool to document worker safety issues	6 Feb 2025	4 Feb 2025	29 July 2025	5 Aug 2025

Table 4: Community of Practice participants across LGAs

Meeting topics	LGA 1	LGA 2	LGA 3	LGA 4
Total CoP members (incl. some PAG members)	33	28	22	31
CoP member average number of sessions attended (out of 5 sessions)	2.3	2.8	3.2	3.9
Average number of participants in CoP sessions*	15 (45%)	16 (57%)	14 (64%)	17 (55%)

* Calculated based on attendance totals for each session regardless of withdrawals over time.

Their expertise proved of great value in CoP discussions, and their participation in the training and CoPs enabled them to better support their practitioners in implementing Safe & Together practices in the workplace.

A core group of 15-16 participants attended most CoP meetings. Almost no one was able to attend all five sessions, for a range of reasons including leave, illness and the demands of their work. CoP 4 in December 2024 was very poorly attended in LGA 1, due to a combination of '16 days of activism' events[3] and mandatory organisational training that prevented a significant number of participants from attending. If this particular session is omitted, the average attendance at LGA 1 CoP meetings was 18, or 55%.

2.6. Characteristics of CoP participants

Almost all participants identified themselves as women (92.8%, n=116), and 90% of the sample reported having post-secondary qualifications, a quarter at diploma or certificate level, a third at degree level and slightly less than a third at postgraduate level. Approximately one in five participants were from Aboriginal or Torres Strait Islander backgrounds (22%, n=27). A fifth (20.7%, n=25) were born overseas, coming from Europe, the Asia-Pacific including New Zealand, South American countries and the Middle East. Almost all those born overseas had lived in Australia for more than five years. Statistical information can be found in the Analysis in Volume 2 of this report.

Over half the CoP participants worked in DFSV services (Figure 6), including men's services, specialist women's family services, women's refuges, and WDVCAS (56.3%, n=71). However, there were very few (4) representatives from services for men across the board, and no representation in one LGA. A smaller proportion (14.2%, n=18) worked in child and family services, either statutory or non-statutory, and 7.1% (n=9) belonged to the housing sector (including housing services, motels and crisis housing providers). A similar number represented a range of other services such as alcohol and other drugs, mental health, disability, community paediatrics, and sexual assault (5.6%, n=7). Very few CoP members worked in justice services (2.4%, n=3). This was defined as Family and Magistrates Courts, legal services, solicitors and juvenile justice.

Three-quarters of participants had a frontline role (Figure 7), working directly with service-users (76%, n=95). An additional thirteen participants (10.4%) were team leaders and a further sixteen (10.8%) identified as managers in the CoP. Several managers attended both

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[3] 5 November - 10 December: https://www.unwomen.org/en/get-involved/16-days-of-activism

Figure 6. Organisation type %

n=125

Organisation type

Organisation type	Value
DFV	56.3
Non-statutory child & family services	7.9
SW Health - Violence, Abuse & Neglect	7.9
Housing services	7.1
DCJ - SCP	6.3
AOD, MH, Disability, CP, CSA, & HS	5.6
ACCO & ACCHO.	4.8
Justice services	2.4
Generalist service	0.8
Other / non-specified	0.8
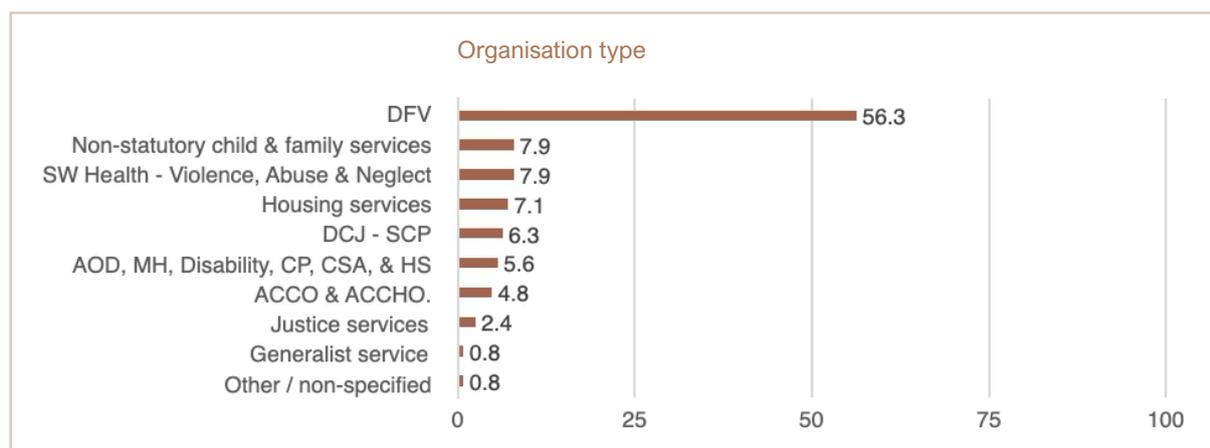
CoP and PAG meetings, as the role of the manager in community organisations appears to be broad, including client-related work as well as management duties.
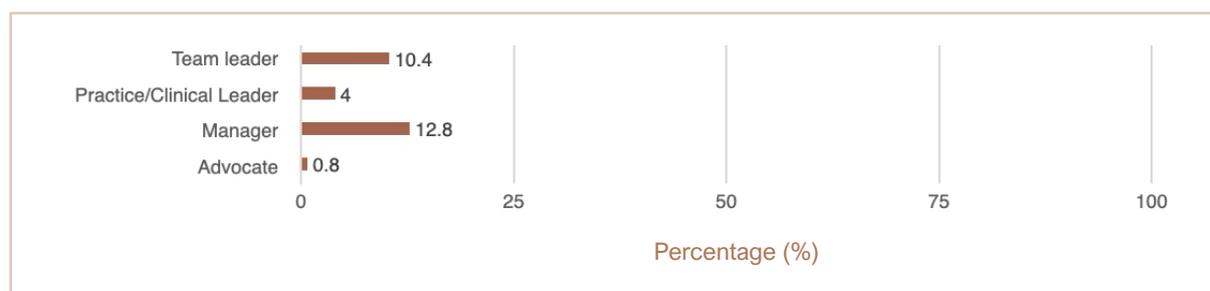
Adult victim-survivors (women) were identified by 49 participants (39.2%) as the primary client of their service (Figure 8), with a further 17 (13.6%) identifying child or young person victim-survivors as the primary client. A significant group of participants (28%, n=35) defined their client group more broadly,

as all family members of a nuclear family or extended family network. Relatively few participants worked directly with people using violence (8.8%, n=11).

Data regarding the characteristics of CoP participants was drawn from the pre-participation questionnaire, as there was a very high response rate (see Table 55). The questionnaire was completed by CoP participants during, or shortly after, the four-day training.

Figure 7. Participants' professional role %

n=125

Professional role	Value
Team leader	10.4
Practice/Clinical Leader	4
Manager	12.8
Advocate	0.8

Percentage (%)

Figure 8. Primary Client of service %

n=125

Primary Client of service

Primary Client of service	Value
Person using violence	8.8
Adult victim-survivor	39.2
Child/young person who is a victim-survivor	13.6
All family members in the nuclear family	24
Other family members and kinship networks	4
Other (Please specify)	10.4
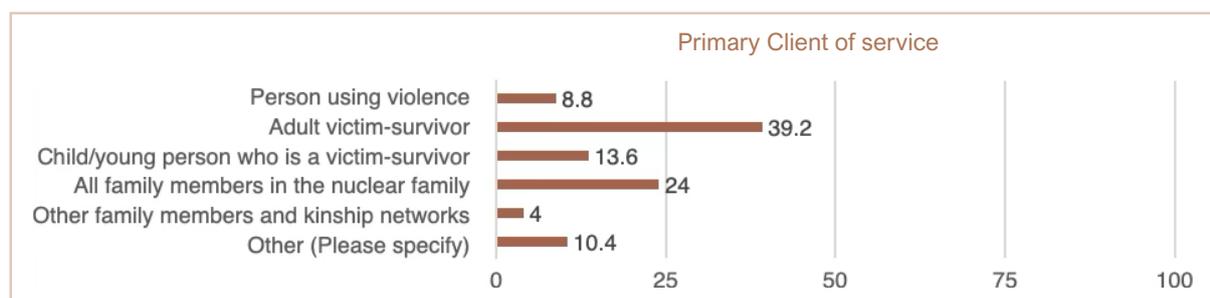
3.
Research evidence and evaluation

In addition to capacity building, the research team aimed to further understand and build evidence for the capacity building model used in the *CHRISTIE Project*, with particular reference to inter-agency collaboration, and to DFSV-informed, child-centred casework and documentation. The Integrated Knowledge Management framework (Figure 9) developed by Graham and colleagues (Graham et al., 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, the term 'knowledge users' refers to participating stakeholders at all levels of the NSW 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).

Figure 9: The knowledge-to-action framework (Graham et al., 2006)
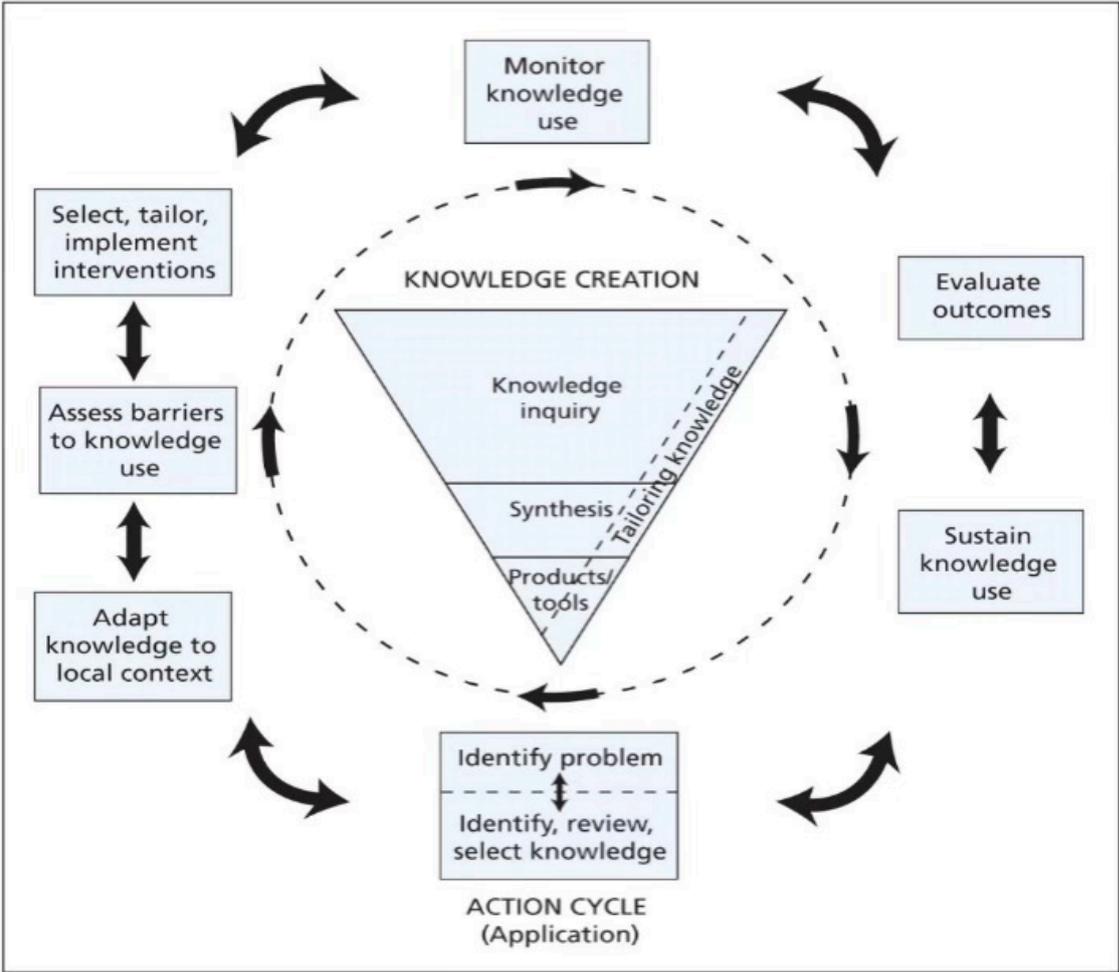
3.1. Ethics and research governance permissions

Research ethics approval was granted by the University of Melbourne in August 2024 (Project ID: 29467). As participants from Aboriginal backgrounds were invited to participate in the *CHRISTIE Project* along with professionals from other backgrounds, ethics approval was also sought from the Aboriginal Health and Medical Research Council of NSW (AH&MRC), and received in September 2024 (ID: 2278/24) on condition that a final draft report and any associated presentation are approved as complying with ethical and cultural criteria prior to any submission for publication and any dissemination of the report.

Research approval was also sought separately from the Research Ethics and Governance Office in each Local Health District whose staff participated in *CHRISTIE*, prior to research activities commencing in each LGA. These included Hunter New England, Sydney and South Eastern Sydney Local Health Districts.

3.2. Research design

The action research and capacity building model for workers and their organisations implemented for this project was grounded in the Integrated Knowledge Management framework discussed above. In this action research model, collaborative and iterative cycles of reflection and review enabled simultaneous contribution to evidence gathering and practice change (Ison, 2008).

3.2.1.Research aims and questions

- To what extent have the Safe & Together capacity building activities in the *CHRISTIE Project* led to increased worker focus on, and understanding of, the impacts of domestic and family violence on children and young people, and responsiveness to their safety and wellbeing needs?

- How has the project led to improvement in cross-agency relationships and collaboration and how can these improvements be sustained?

- What do professionals require from their organisations and/or other organisations to support families to experience an effective and collaborative service system that keeps children safe and, where possible, together with non-offending parents?

- How are issues relating to the safety and wellbeing of children and young people as a result of domestic and family violence documented in agency records, pre and post Safe & Together capacity building activities?

3.3 Methodology, sample and response rates

A mixed methods research methodology was used to draw together qualitative and quantitative data 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 DFSV from worker perspectives (Healey, Humphreys, Tsantefski, Heward-Belle & Mandel, 2018; Healey et al., 2020, Kertesz et al., 2022). The following data collection methods were used to explore the *CHRISTIE Project* research questions.

3.3.1. 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. These discussions were also recorded and transcribed for analysis.

3.3.2. Focus group consultations

Following the final session of the Community of Practice in each LGA, 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 *CHRISTIE*, the impact of shared language, changes in documentation, strategies to place children at the centre of assessment and service provision, and participants' reflections on the learning model and the sustainability of the *CHRISTIE*-related practice change.

3.3.3. Documentation audit exercise

This exercise involved CoP participants assessing a case file or other relevant documentation for content consistent with the Safe & Together framework, using a brief Audit Tool. The exercise did not ask for specific details or examples, but users were able to provide comments relating to their reading and assessment of their documentation for each of the following themes:

1. the actions and patterns of behaviour of the adult using violence.

2. the needs of children/young people in the context of the DFSV and intersecting issues.

3. the impact on the child/young person/ family functioning, of the actions and patterns of behaviour of the adult using violence.

4. protective factors and capacity / acts of resistance from the non-offending parent.

Respondents were asked to assess documentation using the Audit Tool at two time points: 1) once (retrospectively) for documentation written before the *CHRISTIE* training, and then 2) documentation written after CoP 3, with the exercise completed following the final CoP session (post-CoP). This pair of exercises aimed to ascertain the impact of *CHRISTIE* on documentation practices, based on self-reports, as well as to provide a tool for participant self-reflection.

As shown in Table 5, there was a disappointingly small response rate to the Documentation Audit exercise, despite considerable encouragement from the research team. This is consistent with a similar exercise implemented in the *ESTIE Project*.

3.3.4. Questionnaires

CoP members were invited to complete a questionnaire during or shortly after the Safe & Together training, and then after participation in the five CoPs.

Pre- and Post-participation Questionnaire to CoP members: Drawing on questionnaires used in both the preceding *STACY* and *ESTIE Projects*, but with particular reference to child-centred practice, this questionnaire included multiple choice, open-ended and ranking questions to obtain quantitative and qualitative data. The questionnaires were designed to evaluate the impacts of the Safe & Together training, and both capacity building and research activities, to understand how involvement in the *CHRISTIE Project* may have impacted professional and organisational practice. Both instruments were designed to enable pre–post comparison and contained parallel sections assessing participants' understanding of DFSV, their current practice at both the service and individual levels, and perceptions of inter-agency collaboration. The surveys also provided participants with an opportunity to reflect on their overall experience and to provide feedback to the research team. There were high return rates for the pre-participation questionnaire, as time was allocated during training for participants to complete this. Return rates for the post-participation CoP survey were lower, but still very good compared with the general rate of return reported in other studies (Wu et al., 2022).

Post Participation Questionnaire to PAG members: A similar questionnaire was distributed to PAG members, which included questions focussing on capacity building, impact on children and young people affected by DFSV, collaboration, implementation, and sustainability.

Table 5: Survey response rates

Survey Response Rates	Eligible sample	Responses	Return rate
CoP pre-participation survey responses	156	131	84.0%
CoP post-participation survey responses	69	51	73.9%
CoP Documentation Audit	69	7	10.1%
PAG post-participation survey responses	32	10	31.3%

3.4. Data analysis

Ethnographic notes and transcripts from Community of Practice sessions and Project Action Group meetings, as well as textual answers from the questionnaires to CoP and PAG members, were analysed thematically (Braun & Clarke, 2006) by a member of the research team. Identified themes were discussed by research team members and consensus reached regarding the themes and sub-themes.

Quantitative data collected through the CoP questionnaires were analysed statistically, using IBM SPSS Statistics (Version 29.0). First, descriptive statistics (frequencies and valid percentages) were generated for all pre- and post-participation responses by period. This approach allowed interpretation of overall response patterns even when paired data were unavailable. Secondly, pre–post comparisons were performed on the subset of 28 paired responses to examine changes in participants' perceptions of DFSV practice and inter-agency collaboration. Further details about the analysis can be found in the supplementary file: "Analysis of the Pre- and Post-participation Questionnaires to CoP members".

4.
Findings

Information from all sources is drawn together to present the findings of the *CHRISTIE* research in this section of the report. This includes Community of Practice discussions, CoP focus group consultations, Project Action Group meeting notes, the documentation audit exercise, pre- and post-participation questionnaires to CoP members and the post-participation questionnaire to PAG members. While the key findings from the quantitative analysis of the pre- and post-participation CoP questionnaires are included here, detailed reporting of these findings - "Analysis of the Pre- and Post-participation Questionnaires to CoP members" – can be located in volume 2 of this report. All case examples included in the report have been de-identified and, where necessary disguised.

4.1 The capacity-building model

The capacity-building model implemented in the *CHRISTIE project* draws on the principle that knowledge and practice are intertwined, and that new ways of understanding and doing practice involves trying things out within an ongoing coaching setting. In *CHRISTIE*, practitioners from a diverse range of disciplines and sectors were brought together in the Safe & Together training, and then entered the coaching environment of the Communities of Practice (CoP) with a common body of knowledge.

4.1.1. The Community of Practice at the core of the capacity building model

In the CoP sessions, discussions were informed by the expertise from a range of groups – the Safe & Together consultant's knowledge of the Model, worker expertise about direct practice and the service system as it operated in their LGA, worker testimony about the experiences of their clients, and finally expertise from the researchers who provided academic evidence to inform the discussions. The CoPs were central to the capacity building model in all four LGAs, and included a mix of senior practitioners and less experienced workers. This mix of experience enriched discussions and enhanced the learning of more junior practitioners. PAG members reported that these CoP discussions were significant in keeping the momentum of practice development that the Safe & Together training had generated.The CoPs provided an opportunity to apply the Model in practice in the context of each LGA and the broader NSW service. The value of bringing together professionals from a range of services within each LGA is evidenced by the significant shift in participant understanding of 'the roles and responsibilities of other agencies who work with clients experiencing DFSV' (p=0.0018). Agreement and strong agreement with this statement increased from 70.3% pre-CoP to 100% following the CoPs (Figure 10).

Figure 10. Pre–post change in personal practice: understanding other agencies' roles

n=125

I understand the roles and responsibilities of other agencies who work with clients experiencing DFV.
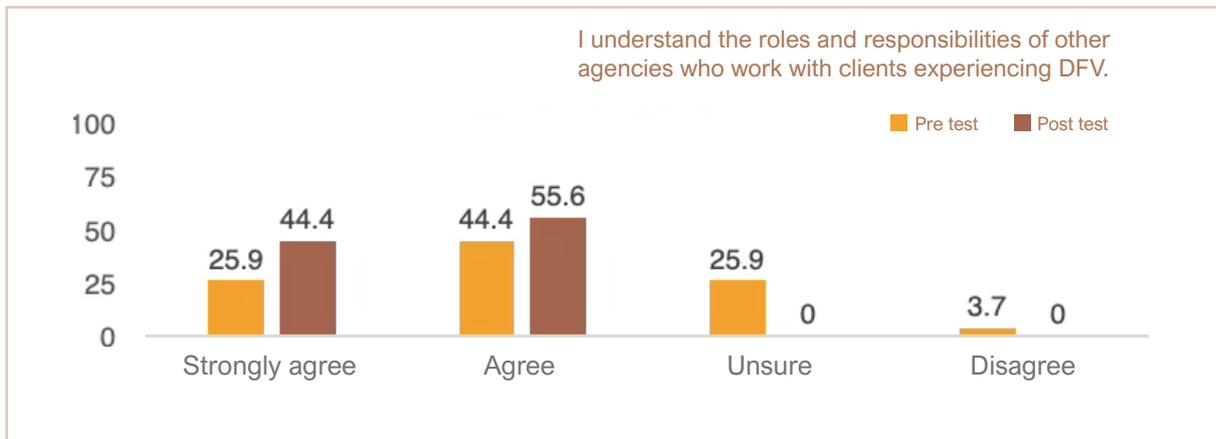
The CoP was seen by participants as a reflective space to develop a shared understanding of how each service sector responded to women and children experiencing DFSV. Importantly, CoP participants developed a shared understanding of "the literacy of each other's services" – LGA 4, CoP 1, the limitations of each service (e.g. eligibility criteria, long waiting lists, staff shortages) as well as what they could provide in terms of support for families.

One of the interesting outcomes of the collaboration with the group is having a better understanding of the challenges our colleagues have in getting certain work done or certain approaches. – LGA 2, Focus Group

The CoP provided an opportunity to discuss new and innovative ways to approach cases, including complex cases with a number of services involved, who were responding to intersecting issues for a family.

Perhaps it's down to the community aspect, because it's such hard work, and it's human services work, and so

I think to be with other people that get that and to learn from each other … Like, I know the thing I find most helpful is being able to talk about it, and there's a sense of that check-in so you get some other strategies… It's just that being able to have some support, I guess, in what is a tricky area. I think that's why the Community of Practice has been particularly good, because there's been such a focus on real situations and people bringing those situations. You can flesh out a lot more because you're constantly discussing situations going, "What do I do here?" – LGA 4, CoP 1

According to one participant, the Community of Practice was "really awesome in terms of collaboration" – LGA 4, CoP 2. The CoP was viewed as a forum to break down barriers, to connect and engage in a more personal way as workers, and for workers to start to develop trust with each other. This had a positive impact on developing inter-agency collaborative relationships for practitioners who were working in silos and who mostly did not know each other at the start of the

project. The CoP provided an opportunity for professionals, hungry to collaborate, to get to know other professionals and services in their local area.

For Aboriginal workers, the CoP provided a safe space where trust was developed. This supported the development of working relationships and deeper understandings of working with Aboriginal families.

Well, it's definitely a bit of insight on how you work with Aboriginal people. And confidence that goes with that. As you are aware, I find in many places and many organisations that just the word Aboriginal is very scary for the people. Not everyone is confident to work with Aboriginal people and you know you can have the best intentions, you know what I mean? So it's really important to know how that looks and that cultural understanding for the people working with Aboriginal people. It just gives me a bit more confidence and trust and knowing you as services that are culturally safe. – LGA , CoP 5

The place-based nature of the CoPs added an extra dimension to discussions which were sometimes very practical about services in each LGA. In the metropolitan LGAs, where a number of small NGOs were participating, participants were particularly proactive in taking advantage of the opportunity to visit each other's services. In regional areas, with fewer separate organisations, there was greater familiarity with the local service system, but relationships nevertheless developed. The CoPs also provided an opportunity for discussion and collaboration between Aboriginal and non-Aboriginal workers, due to the level of Cultural safety and trust developed in the CoP environment.

So we have come to this, we did the training together, we are quite intimate

already. But in terms of, I don't know, a little catchup about each service, what you do. Like a directory of who is who, and I want to reach out to everybody in services around. I think that might be a good introduction if we go forward in this community of practice, so after the community of practice we can touch base. And I think it's great. – LGA 4, CoP 1

The CoP provided time for reflection about current practices. Workers felt safe enough to bring case examples from their current workloads to the monthly sessions, where an opportunity was provided for peer feedback in real time. Workers spoke of appreciating this as a safe space with a culture of care that supported their own practice development.

The way it's been delivered… You know, normally, you'd go and do your training, and then that's sort of it, whereas this way, you've done the training, and then each time we've come back… Because you can't take it all in anyway, and you lose some stuff, and I think continually having a lot of that… some of that information discussed again, you've had the opportunity to reflect, to try it out. It just helps embed some of those things a lot more than if you just went and did the two-day training and that's it. – LGA 4, CoP 5

*In two LGAs. CoP sessions were he*ld in person, while participants opted for online meetings in the other two LGAS, due to time needed for travel. In all LGAS, the training, the final CoP meeting and the focus group were held in person. Participants did not provide feedback about how they valued the modality in their respective LGAs, or whether it affected their learning. While face-to-*face meetings may provide better opportunities for relationship building, significant partnerships*

also developed in LGAS that met online, and CoP members unable to travel were able to attend online.

4.1.2. The impact of Safe & Together

The training and the subsequent coaching from Safe & Together during the CoPs was impactful for participants. Workers, as well as their managers in the PAG, described how the use of the Safe & Together tools fundamentally changed practices, through assisting them to understand the source of the risk to families. Developing a shared language in documentation for improved client outcomes was important for practice change.

4.1.2.1. Professional support needs and learning development

There was a high level of facilitated teaching and coaching in the CoPs from the Safe & Together Institute as practitioners worked through their cases. The Safe & Together CoP consultant and facilitator provided clear guidance on the use of the Mapping Tool, how documentation could be used for advocacy and changing outcomes for families and role modelling what is appropriate language to use when working with families. She also drew on personal experiences in frontline work to give very specific 'nitty gritty' practice examples, and challenging workers, with the anticipated outcome of shifting practice to become more DFSV proficient.

We've changed a lot of our intake process as well, by focusing also on the mum and dad relationship, not just the mum, which was something that was in the initial training that we've never done. – LGA 4, CoP 5

4.1.2.2. The use of the Safe & Together tools

Participants described the use of both mapping tools – the *Perpetrator Mapping Tool* as well as mapping the mother/carer/non-offending parent's strengths and resilience – as helpful in both training and coaching, and believed it had improved their practice with families.

And so I think it's trying to find something really practical that – or maybe extracting parts of what Jackie has said about documentation, summarising patterns, things like that, that we can use within such a broader system to help us actually then ensure that we're keeping obviously – you know, we're keeping that victim-survivor in mind and that documentation is obviously so powerful, but I think it's hard to know how to address it in such a big system like Health with the time poor barrier, you know, being time poor and resources and whatever else. But absolutely I think the value of what Jackie has said has kept the Mapping Tool – has brought it back into my mind. – LGA 4, CoP 4

This included bringing people using violence into consideration and holding them accountable for the impacts on women and children.

I feel like I've just had a bit of a penny drop [laughs] around, you know, a lot of the time we don't have the opportunity to work directly with the fathers, so how we map that, like you were just saying, mapping it out and the impacts on the children and what we can do with that evidence across multiple areas with the other services and supports that can be offered to the families that we work with. So yeah, it's given me lots… – LGA 1, CoP 2

The training and capacity building that shifted documentation practices in alignment with Safe & Together principles were seen as game-changing by both CoP and PAG participants. The area of documentation as a significant tool for practice change will be explored further in section 4.4.

I just notice more and more at the start of assessments I have a statement about the role of intersections… this client is experiencing intersecting injustices. – LGA 2, CoP 5

4.1.2.3. Developing a shared language

Although this did not emerge as significant from the questionnaire data, practitioners in the CoPs described how the development of a shared language for behaviours, drivers and impacts of violence, across service sectors, was critical to keeping women and children safe. Using language that was specific about behaviours (e.g. "strangled her on three occasions to the point she lost consciousness"), rather than the broad descriptor "domestic violence", provided essential context for understanding many aspects of a family's life.

If we knew, for instance, that he got a message to her through the daughter, that: "If you don't come back to me, I'm going to kill your entire family. I know where they live. If we don't reconcile, it's going to be on your head that they're dead." If we got that piece of information, would it change the way we looked at her choices? Would we start thinking it's trauma bonding, or managing safety? – Safe & Together facilitator, CoP 3

The specificity of language around behaviours was also relevant to engaging with clients. For example: a woman who denied being 'raped' or 'sexually assaulted' may respond with a yes if asked whether 'he has done something sexual that made her feel uncomfortable'. Similarly, women may say no to screening questions about strangulation, but yes to hands around throat. Partnering with women allowed an exploration and unpacking of the language used to talk about them by others, including other service providers – e.g. "I'm just a druggie" – which could be addressed in the moment. Language was seen as important for a victim-survivor's sense of self and narrative that workers created for and about them.

The importance of challenging deficit based and blaming language was discussed by participants, such as: mother-blaming rhetoric, neutralising or mutualising language (e.g. "children exposed to DV"), culturally blind assessment, and unconsidered use of diagnoses and labels such as post-traumatic stress disorder which creates an artificial binary between past and currently occurring trauma.

4.2. Practice development

4.2.1. The complexities of the cases discussed

It was clear from the data that practitioners in NSW are working with families who face a range of difficult issues. Participants came to the *CHRISTIE Project* with significant experience of complexity in their casework. Most cases discussed in the CoPs involved child sexual assault alongside the DFSV experienced by the family. In supporting children and young people with their experiences of sexual harm, practitioners played an important role in understanding indirect disclosures and identifying warning signs. An intersectional approach was critical, especially when working with children and young people with disabilities, experiencing mental health concerns and/or with other complex needs. The majority of children and young people identified through the case discussions had engaged in some kind of verbal/physical aggression towards the non-offending parent and were typically engaged with multiple services such as specific service responses for children and young people, schools, and NDIS. Children and young people in families had complex support needs as they tried to manage high levels of violence and control from the person using violence.
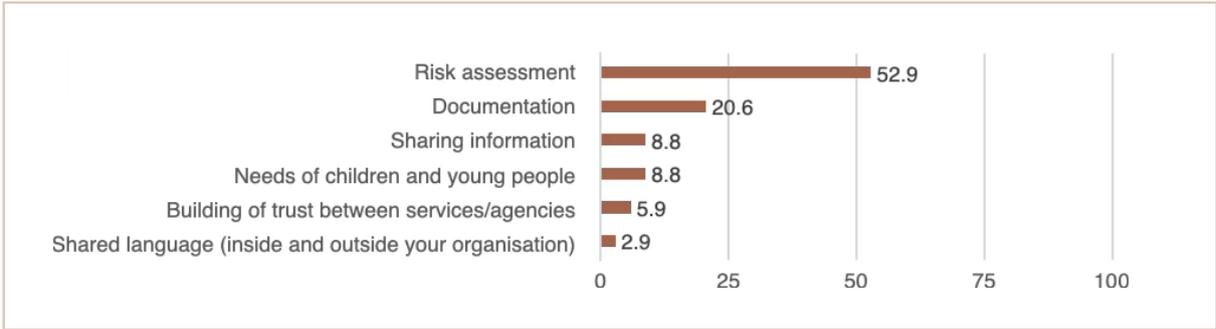
4.2.2. Participant self-assessment of practice development

Based on the sample of participants who completed both pre-and post CoP questionnaires, analysis shows a modest strengthening of holistic, reflective, and collaborative approaches in practice. Participants were slightly more likely to view DFSV as affecting the whole family, to recognise child safety as interconnected with the safety and well-being of the adult survivor, to acknowledge fathers' roles more actively, and consider behavioural patterns rather than isolated incidents in their practice.

Exposure to the Safe & Together Model was widely experienced as helpful. A large majority (88.6% of n=35) reported that their practice and/or staff management had improved when cases involved DFSV, mental health and AOD with children present. Positive change in risk assessment was reported by more than half the respondents, and in documentation practice by one fifth of the respondents (see Figure 11).

Figure 11. Practice areas with reported positive change

n=35

Practice area	Value
Risk assessment	52.9
Documentation	20.6
Sharing information	8.8
Needs of children and young people	8.8
Building of trust between services/agencies	5.9
Shared language (inside and outside your organisation)	2.9

4.2.3. Embedding the Safe & Together Principles: Practice changes

4.2.3.1. Partnering with the non-offending parent/mother

Practitioners described how they used the Safe & Together principle of partnering with the victim-survivor to support their clients with the intention of improving safety and wellbeing for non-offending parents and their children. They did this through strong validating engagement, identifying strengths and resistance work and identifying how the person using violence should be held accountable for the impacts of violence on the family.

> When we were doing the DVSAT [assessment tool], she got emotional and I just said, "I believe you." And she was like, that made her more - a little bit more upset because she was like, "the police officer when I was telling him things said he doesn't believe me". – LGA 4, CoP 1

The work shifted into more DFSV-informed practices across the areas of assessment, engagement and documentation, as participants sought to understand and record in more detail the impacts of violence and abuse in the lives of women and their children. A number of CoP members spoke about receiving feedback about the impact of this partnering on the women they were working with – the women felt heard and believed.

> I've done support letters before, but lately I'm getting emails and texts saying, "Thank you so much," or "That's my life," and it's so sad, but it's so..." they don't use the word impactful, but it almost feels like through the trauma, you're taking the fragmented trauma, you know, and putting it back together, integrating it into that piece. They're seen as that trauma and they're like oh you know, so that's very, very, very powerful. – LGA 1, Focus Group

> [The Mapping Tool] actually has shaped how we have conversations with the women, in identifying that it is a parenting behaviour, a parenting choice, and that the mapping helps show the mums… Because it's not always why the kids are behaving the way they are, but why they could be behaving the way they are, and that actually supports them to get the right support in place, rather than going all around, trying… "Oh, well, it's not this. It's not this." They can literally go down the one pathway, pretty much straight away, because they identified that it's behaviours of the perpetrator that are causing these behaviours. – LGA 3, CoP 3

4.2.3.2. Holding the person using violence accountable for harm to the family and impact on family functioning

Most practitioners participating in *CHRISTIE* did not work directly with the person using violence. However, the Safe & Together Model gave them a mechanism for acting on this Principle by bringing the person using violence 'into the room' through the use of the Mapping Tool and a suite of practice questions that could be used when engaging with non-offending parents. This was particularly evident in the case of intake and assessment processes. For example:

Case study 1

A 'whole of family' non-statutory child protection service received a referral for a family from statutory child protection services, due to concerns about domestic violence perpetrated by the father towards the mother and the four children, aged between one and ten years old.

The mother was very willing to engage with the case manager and accepted home visits, but the father refused to engage but remained present during home visits. As the case managers described the initial engagement: "It's very clear he wants us gone, but also very clear that she wants us around".

In the community of practice, the Safe & Together facilitator guided discussion about creative ways to engage with the perpetrator and partner with the mother without increasing risk. She also advised documenting details of what was observed during home visits, such as the father's pattern of behaviour on home visits and his refusal to engage, as well as the barriers making it difficult for the mother to leave the relationship and her protective actions towards the children.

The case managers continued visiting the family, despite the father's presence, and were able to map how other child protection concerns identified in the referral connected back to his use of violence. This included concerns about school attendance, use of drugs and alcohol by both parents, and medical neglect due to the children missing specialist health appointments.

The Safe & Together facilitator again guided discussion about how these issues could be explored to create accountability for the perpetrator and 'pivot' to discussing the children's safety. The case managers were then able to clarify that the perpetrator was strategically using services to position himself as the 'better' parent - for example taking the children to school and blaming the mother for previous issues with attendance.
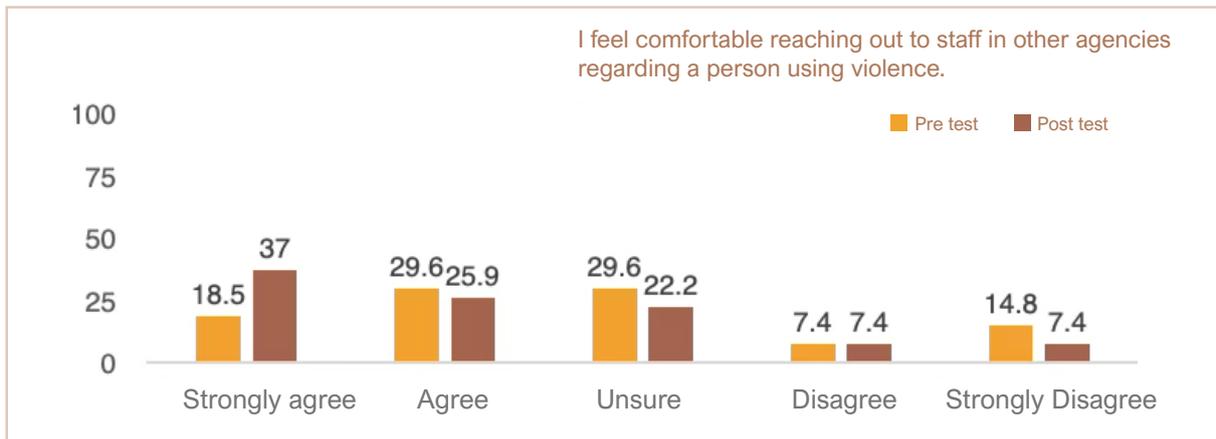
By using the Safe & Together Model, the case managers were also able to map other relevant information about the family, such as how the perpetrator exploited the mother's isolation and own child protection history, how the perpetrator prevented the mother from attending appointments leading to her being exited from a number of support services, and preventing the mother from getting a driver's license so that he could control her ability to leave the house.

On one home visit, when the father was away from the house attending a court hearing, the mother was able to speak more frankly to the case managers, disclosing the extent of his violence, and her goal of escaping the abuse with her children when it was safe to do so.

The case managers used the community of practice to help them think creatively about how to proceed with working with the family in collaboration with other services. Ideas that were raised by the group included meeting the mother at playgroups or child health appointments, working collaboratively with men's behaviour change programs to engage the father, navigating joint home visits, and using the Mapping Tool to document their observations.

Figure 12. Pre–post change in personal practice - reaching out about a person using violence

n=15

The chart title reads: "I feel comfortable reaching out to staff in other agencies regarding a person using violence."

Legend: Pre test, Post test

	Strongly agree	Agree	Unsure	Disagree	Strongly Disagree
Pre test	18.5	29.6	29.6	7.4	14.8
Post test	37	25.9	22.2	7.4	7.4

So, for us, we don't work with the perpetrators, but it has been a good tool to be able to open conversation with the mums, and it takes a lot of blame away from them, because they have a lot of guilt. So, to be able to say, "Actually, this was his parenting choice, not your parenting choice," has made a difference. – LGA 3, CoP 3

The concept of harmful actions being a parenting choice was also highlighted as a valuable message by practitioners working with either all family members or specifically the person using violence. In addition, the Safe & Together training diagram showing Pathways to Harm illustrated for them the many impacts that an individual's pattern of behaviour can have, on all members of the family, including children, and on family functioning. This was also described as having significantly supported practice change.

We have amended the way we do intake, but also asking more questions around the fathers, the user of violence, and the dad's role in the family, but also asking about his strengths… I guess it's

questions that we wouldn't have asked previously. But since doing the Safe & Together we've kind of brought it in on our intake questions so we have seen a bigger picture of the family unit as a whole. – LGA 4, CoP 2

The pre / post questionnaire findings confirm this shift from indecision to greater confidence in focussing on the people who use violence, regardless of the identity of a practitioner's client. The proportion of questionnaire respondents who strongly agreed that 'they felt comfortable reaching out to staff in other agencies regarding a person using violence' (figure 12) increased over the capacity-building phase from 18.5% to 37%, and the percentage of those reporting uncertainty or disagreement declined (p=0.005).

This improved confidence in considering the harmful actions of individuals who use violence also manifested in a significant shift in agreement with the pre/post questionnaire statement: 'I am informed as often as I should be about the person who uses violence and their involvement with other agencies', despite most participants continuing to

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[4] https://www.youtube.com/watch?v=MQ_CI4w6FPU

Figure 13. Pre–post change in personal practice – information about the person using violence

n=17

I am informed as often as I should be about the person who uses violence and their involvement with other agencies.
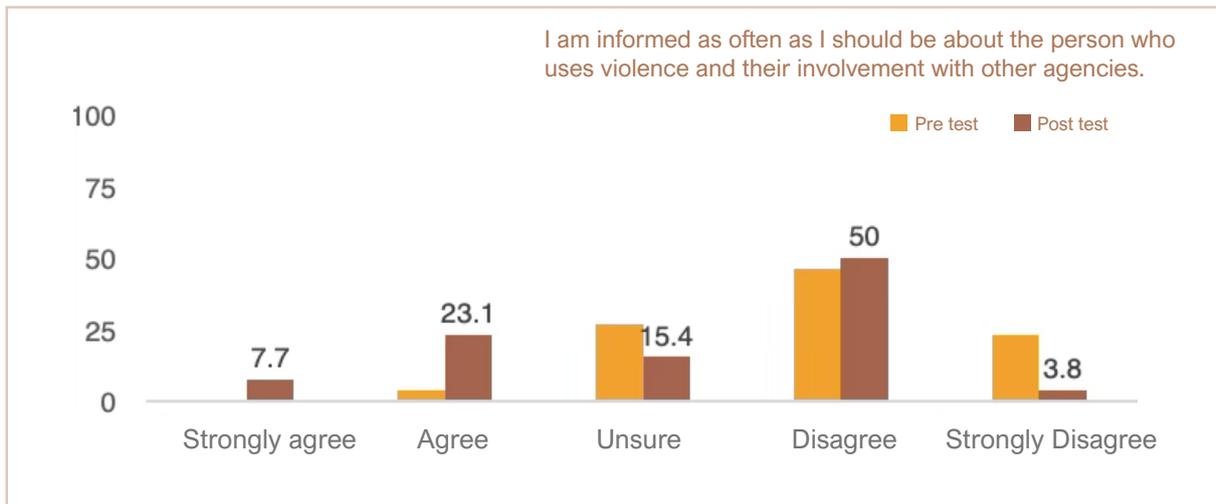
disagree (p=0.003). Only 3.8% of participants agreed that they were adequately informed before the *CHRISTIE* CoPs, compared with 30.8% afterwards, while those who strongly disagreed dropped from 23.1% to 3.8% (Figure 13).

The *Mapping Tool* and a more detailed way of documenting harms and impacts of DFSV were seen as valuable in rendering the person using violence visible and accountable in inter-agency meetings and other advocacy work for families.

We had that conversation as well, where we had that meeting, holding him accountable, because with DCJ [statutory child protection], it was all about her. You know, "She needs to do this, she needs to do that", and we actually brought up: "okay, but what about him? What about his actions?" Actually, the response wasn't great. It was like, "well, we can only offer doing – you know, see if he wants to do some

parenting courses". It's like, "But he's the perpetrator, he's done this, he's done that", you know. But we'll work on it. – LGA 1, Focus Group

4.2.3.3. Keeping children in focus

Consistent with the Safe & Together primary Principle, the *CHRISTIE Project* supported practice change to ensure that children and young people become central to service responses and are kept at the forefront of assessment, mapping and engagement – moving from the framing that DFSV experienced by children is solely a child protection issue to a recognition that all services have a responsibility for the safety of children and young people in the context of their protective relationships. The following section focuses on positioning children and young people at the centre of service provision.

4.3. Children at the centre of the service response

4.3.1. Repositioning children and young people in the service response: how to think differently about children experiencing DFSV

If we're adult-facing services and we're working with adults, so - mums and dads - we're often not thinking about the children and young people, but it doesn't mean that they're not there… So, it's almost like this deep dive into thinking about children and where are they in the space, because they are definitely around. – LGA 3, CoP2

The *CHRISTIE project* shifted the focus of specialist DFSV and other adult-facing services, towards a greater consideration of children and young people in their practice approaches. Practitioners described an increased awareness of children and young people in their engagement with parents - asking about children in the household or children and young people in general, including questions about children they did not have contact with or did not physically see. PAG members also reported that they had observed more detailed analysis by practitioners of the impacts of violence on children and young people. While few questionnaire respondents reported seeing positive change in focussing on the needs of children and young people (see analysis in Volume 2), the qualitative CoP data clearly evidences extensive consideration of how to place children and young people at the centre of practice.

The CoP discussions about children encouraged practitioners to move to a practice approach that recognised the needs of children and young people as core business, even in adult-facing services,

moving away from seeing children as powerless, passive or secondary victims. Practitioners reported that they started to see children and young people as individuals with differing experiences (according to their age, gender, relationship with the person using violence such as being a favourite or a target). This repositioning of children and young people also allowed practitioners to see the child in their own right, but in the context of the 'whole family' around the child or young person, with child specialists engaging parents, extended family members or other significant connections to build a network of safety around a child.

4.3.2. Impacts of DFSV: what the pathways to harm look like for children and young people.

Violence and control inflicted on families may result in a number of harms for children and young people. As the CoP sessions progressed, practitioners started to connect the dots and see the direct impacts of the harm caused. In the cases that were discussed in the CoPs, children typically had at least one diagnosis of a health or behavioural concern (e.g. post-traumatic stress disorder or its complex version CPTSD, developmental delay, intellectual disability, externalising or internalising behaviours, self-harm, etc). The following pathways to harm due to the actions of a person using violence were identified:

- Preventing children's access to mental health/disability/health and developmental support, or if children were attending, the person using violence did not engage in care or attend appointments;

- Creating housing instability (e.g., refusal to pay rent, rentals registered in the non-

offending parent's name, creating a risk of homelessness, family is forced to move frequently, etc);

- Inappropriate use of alcohol or other drugs in front of the children;

- Creating rifts between siblings through favouritism (splitting);

- Isolating children from grandparents, aunties, uncles, extended family and friends;

- Suicide attempts in front of the children;

- Financial insecurity (e.g. Lack of food, draining non-offending parent's finances through legal processes, refusing to pay for basic expenses such as child support);

- Disrupting children's education (e.g. children having problems at school due to inability to regulate their response to trauma, school absences, moving schools, preventing access to daycare, disrupting extra-curricular activities);

- Preventing children's contact with their family culture;

- Abducting children;

- Undermining the children's relationship with the non-offending parent (e.g. disrupting attachment, destroying trust, undermining authority, encouraging directly harmful behaviours to mum);

- Weaponising contact arrangements post-separation (e.g. denying the non-offending parent contact visits, making unachievable demands for visits, using the child or young person as a weapon to continue the abuse, and denying children medications during contact or interrupting routines so they return to the non-offending parent unwell or dysregulated);

- Harm caused by service system interventions (e.g. separating siblings in out-of-home care placements).

Case example: the impact on children of housing decisions

A housing worker was working with a family who was being evicted from their public housing. The worker found that the normal process of requiring families to move to a different area for housing in these situations would cause considerable disruption to the children in the family – they would be forced to change schools or manage a long daily commute on a school bus. The worker successfully advocated for a housing solution that enabled the children to stay at the same school.

4.3.3. What participants learned from Safe & Together: approaches to centering children

Not being afraid of exposing the children to too much through asking questions or exploring their experiences – "the dad brought the child into the world of violence already". – Safe & Together facilitator LGA 3, CoP3

As discussed in section 4.2 on Practice Development and evidenced in the data, a number of key insights from the Safe & Together Model supported shifts in understanding for practitioners about how to keep children at the centre of service responses for families experiencing DFSV. These shifts included:

• Understanding the use of violence as a parenting choice;

• Identifying the specific impacts of the pattern of harmful behaviour by the person using violence on children and young people, as partially listed above, and understanding that children and young people experience this in individual ways;

• Identifying and acknowledging specific non-offending parenting strengths, given the difficulties they face providing basic needs and maintaining routines, while subject to violence and control;

• Identifying and assessing children and young people's survival strategies, agency, and acts of resistance.

I can see how my lens has changed a little bit, how I'm remembering the importance of considering the whole family unit, children being in focus, children not ever forgotten. And the way I document is a lot different as well. – LGA 1, Focus Group

4.3.4. Changes in practice to centre children and young people in the DFSV response

Embedding the learning from Safe & Together was a continuing experience for practitioners, from the training and throughout the CoPs. Reported changes in practice included asking their clients about children in the household and encouraging non-offending parents to feel comfortable talking about their children and young people. Practical examples of how children became visible in participants' work included:

• Changing referral forms to capture patterns of behaviour and their impact on child and family functioning;

• Changing language in ROSH (risk of significant harm) reports and written reports for statutory child protection to include more specific detail on the pattern of harm;

• Identifying and including children in more concrete ways in assessments;

• Working with kinship networks – talking with grandparents, carers, extended family, and siblings to explore the context of a child's life;

• Increased case conferencing with children and young people as clients;

• Focusing more on children and young people in professional supervision;

• Information sharing through chapter 16A of the NSW Children and Young Persons (Care and Protection) Act 1998;

• Using information captured in assessment and other documentation to advocate more strongly for children, young people

and their families to statutory child protection (DCJ), Safety Action Meetings (SAM) and the Family Court;

- Supporting and engaging non-offending parents with parenting support needs and strategies;

- Running education sessions about the impacts of DFSV on children for local GPs who treat children.

Case example: Pathways to harm

A practitioner working with a family found that the children were not attending school – identifying this as a child protection concern. Using the Mapping Tool as a guide for understanding what was happening in the family, the practitioners discovered that the reason for this was not maternal neglect, but a past experience when their father had picked the children up, forced them into the car, and driven dangerously while speaking to their mother on the phone, threatening that he would hurt the children. The real source of harm to the children, and why they weren't attending school, was rightly attributed to the actions of the person using violence.

4.3.5. Links to Safe & Together: embedding the Model into practice

Alongside the very practical application of the Safe & Together Model, practitioners described a shift in their overarching approach to engaging with clients when there were children and young people in the family. Pre / post questionnaire respondents indicated a statistically significant improvement in their level of comfort in 'reaching out to staff in other agencies regarding a child client or child of a client experiencing DFSV' ($p=0.002$). Before *CHRISTIE*, 76.9% agreed or strongly agreed that they felt comfortable, while one in five were unsure. Following the CoPs, all participants (100%) agreed or strongly agreed, with strongly agree responses increasing from 34.6% to 61.5%, and none reported uncertainty or disagreement (Figure 14).

Figure 14. Pre–post change in personal practice - reaching out about a child experiencing DFSV

n=10
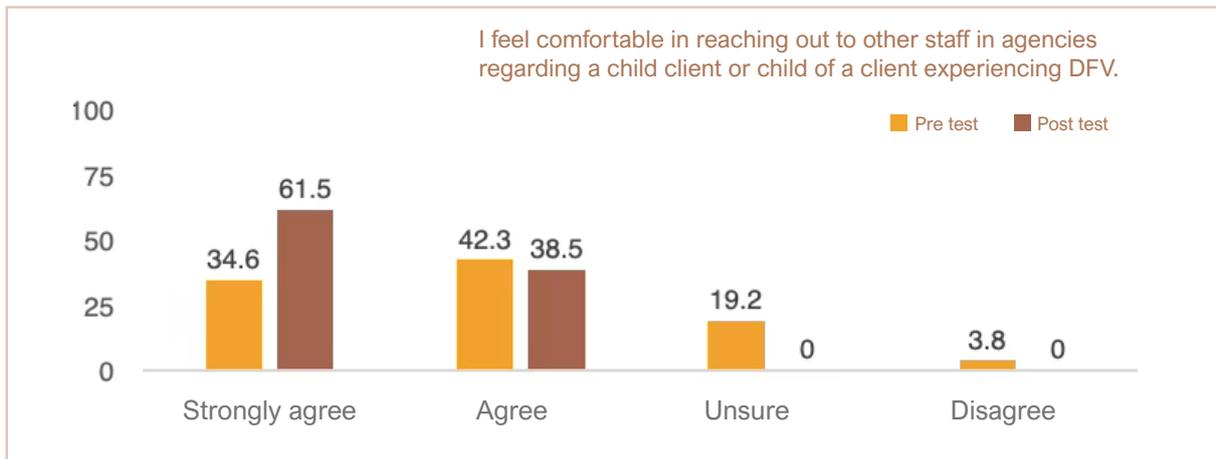
The observed shifts in approach included practitioners exploring the experiences of children and young people even when they were not in the care of the parent who was a client. For example, when a person using violence disclosed they had children but reported they had no contact with them, workers were able to explore what had happened in the past (such as DFSV incidents) to reach this situation. In this way, professionals were able to disrupt the strategic use of systems by individuals using violence and control, such as false reports to statutory child protection, allegations of neglect, and poor parenting while sabotaging the mother's parenting, and other pathways to harm as detailed above.

Magistrates are another story, they'll run their own… they have, I suppose, that discretion. Or they're also guided by, like, what happens in the day. Sometimes the perpetrator will present a really good case... Or they will say, I won't, I will. I've had a situation at court where the perpetrator would only agree or consent to the AVO if the children were taken off [it], and the magistrate went with it. So that court space is very

different and final sometimes. – LGA 1, CoP 2

Working with parents to situate children as the central focus was important. Participants reported beginning to partner with non-offending parents around parenting, using the Mapping Tool to identify the needs driving the children's behaviours, helping mothers recognise how children use resistance behaviour, and helping mothers identify pathways to harm ("he is not just a naughty kid").

Those practitioners who worked with people choosing to use violence found that engaging them as parents provided the opportunity to further engage about their own harmful actions. Questions to do this included: What are you doing to help your kids around that issue? How are you supporting mum with that issue? How can you role-model this behaviour for your kids?

Importantly, workers recognised and identified children's acts of resistance – faking anger when services speak to them, defending the user of violence, connecting with peers to find connection and care, acting out behaviours to diffuse an unsafe situation, reaching out

to services through externally observable behaviours, and staying home to protect mum. A key concern for practitioners was to avoid unnecessary pressure on children and young people by working with the adult victim-survivor to understand what was happening in the home.

The *Mapping Tool* was critical in supporting this shift towards child-focused practice, with the following examples of its use being offered during CoP sessions.

- Recognising that the *Mapping Tool* could be used either directly with children and young people themselves, or with their significant adults, to understand children's lives, regardless of whether a service was adult or child focused;

- Using the *Mapping Tool* directly with children and young people so they could develop an understanding of DFSV and its impacts on their mum, create a narrative of their experience, and develop a sense of self;

- Incorporating the assessment domains from the *Mapping Tool* into organisational documentation templates, including electronic records, to bring together information about individual children;

- Sharing the *Mapping Tool* documentation with other professionals, with police (e.g., as contextual information for an Apprehended Violence Order application) or with the Family Court, to provide information and context for decision-making;

- Developing genograms to map behaviours of, and impacts on, extended family members;

- Sharing the *Mapping Tool* documentation with the non-offending parent for them to use when advocating for themselves.

Practice example: Impact of the *Mapping Tool*

When I completed the perpetrator Mapping Tool with a client it gave her – I think she started feeling really good because there were certain things they we were talking about, especially about the impact of the perpetrator's behaviour onto the children, and a lot of times she'd be like, "Oh, my child done this because of him." Like you know, what he'd done. And it sort of opened her eyes to it as well, because before it was like, "my child's just naughty." And now it's, you know, she's been able to really think about her child's behaviour and where that stems from. – LGA 1, Focus Group

Case example: Adult focused services are well placed to identify pathways to harm for children

The practitioner used the *Mapping Tool* with the children's mum to identify specific pathways to harm. They identified that dad was not providing mental health medications to the kids during their visits with him, so they were dysregulated and escalated when they returned to mum's care. The visits were frequent enough to destabilise the kids' routines and their mental health through the week, creating considerable disruption for the whole family. Using the *Mapping Tool* to direct the conversation enabled the practitioner to understand that dad's pattern of behaviour and highlight to mum and in her notes how mum was trying to maintain stability for the children. – LGA 4, CoP2

4.3.6. Direct work with children and young people

Children that don't sort of have a voice or have any agency will often either consciously or mostly unconsciously find a symptom, a big symptom, that will bring them to the hospital or to mental health or to the eating disorders unit, to

the principal's office… that is then kind of asking or showing how they're feeling when they don't actually sort of really have that voice. – LGA 2, CoP 3

Practitioners who worked directly with children and young people were able to apply in their work what they had learned through the *CHRISTIE* training and CoPs. They spoke about engaging with children and young people at an age-appropriate level, using the language children themselves used, while also seeking to understand their lives in the context of their families and the complex issues they faced (e.g., siblings, blended family dynamics, coparenting). Engagement strategies included: getting to know infants through work with their non-offending parent, meeting children at school, and providing outreach to engage adolescents. Other strategies reported by CoP members included the following:

- Using art-based activities and other interventions that children and young people find appealing;

- Asking children curious questions – e.g., What happens if you refuse to do an activity with dad? What happens if you aren't smiling and happy when you see dad? What happens if you don't swear at mum like dad tells you to?;

- Recognising children's indirect communications about their experiences and needs through non-verbal behaviour, as well as listening to children's voices directly;

- Supporting children who have ongoing contact with a person who uses violence to focus on articulating their experiences, expressing what they want, and communicating their needs;

- Discussing the *Mapping Tool* and other Safe & Together concepts with young

people to help them understand and make sense of their experiences, (e.g. why does mum drink when dad is shouting?);

- Supporting significant relationships that may protect the long-term well-being of children and young people, such as friendships, sibling contact and access to pets;

- Introducing the *Mapping Tool* domains into co-case management meetings between case managers for the non-offending parent and the child's worker, to enable detailed discussions of the needs of all family members;

- Child-focused intake at a refuge alongside an adult-focused intake through conversations with the child, using age-appropriate explanations and the child's own language for DFSV.

With our interactions even with young children, [we have] just been blown away by how they've really been able to engage in that conversation. Even like a four year old saying, you know, "daddy's strong and mummy's weak". Like you know, children are just so aware of power dynamics even at a young age… it's been a really interesting space for us to step into as a service. – LGA 2, CoP 3

4.3.7. Child-focused documentation

Good documentation which concretely demonstrates the causes of harm for children and young people, can provide a platform for advocating to other services, and reduce mother-blaming practices. This is a critical form of intervention when collaborating with child protection services.

Case example: Embedding direct engagement with children

A refuge for women and children initiated a child-focused intake process alongside their adult-focused intake procedures. This involved direct conversations with children to explain domestic violence and the functions of a refuge in an age-appropriate way.

Practitioners reflected on having meaningful conversations with children and which helped interrupt the manipulations of the person using violence who often spoke negatively about refuges. – LGA 4, CoP 3

Nearly all *CHRISTIE* CoP questionnaire respondents (87.9%) reported that they had made some or a lot of change to their documentation practices in relation to mapping patterns of violence and abuse onto child, young person, adult victim-survivor and family functioning. During the CoP sessions, participants began to 'connect the dots' between the harmful actions of the person using violence and a child or young person's presentation, looking further for the causes of issues such as unsettled infants, poor nutrition, developmental delays, medical

Case study 2

A domestic violence service had worked with the mother of a 13-year-old child over a decade, due to ongoing violence from her ex-partner. The mother and child were "terrified" of him but had been told they could not extend the latest of several ADVOs (keeping the child as a 'protected person') as there were "no new offenses". The case manager used the *Perpetrator Mapping Tool* to understand that each time an ADVO expired, the ex-partner would initiate contact and escalate his abuse again, and to inform the letters she wrote to support the extension of the ADVO.

Description of support letter, shared with the CHRISTIE Project

Document and purpose: The document was a statement of position letter, written to the court to advocate for the extension of an ADVO for a client, which was due to expire. The person using violence was also due to come off his parole period.

Actions and patterns of behaviour of the adult using violence: Part of the purpose of this document was to really articulate to the court the patterns of behaviour and how over a period of approximately 10 years the pattern of behaviour had not changed, resulting in multiple ADVOs, criminal charges and time in custody.

There had been multiple attempts to engage the person using violence in behaviour change or to support safe, quality time with his daughter. He was unable to do without resorting to continued violent behaviours.

Needs of young person: The impacts and needs of the young person were articulated in the letter to demonstrate that these patterns of behaviour had existed throughout her life. The young person felt unable to have a relationship with her father because it was too unsafe. The focus of this letter was on the young person's need to feel safe and protected. It spoke about her feelings and about what she wished for.

Impact on the young person & on family functioning: The letter spoke about how the young person was impacted by her father's behaviour and how it made her feel unsafe and anxious to leave her home due to a pattern of behaviour where the person using violence would confront his family in public places.

Protective behaviour of the non-offending parent: The letter outlined all the steps that the young person's mother had taken to protect and keep her daughter safe, and the support the mother needed from the court to continue to act in a safe and protective manner.

Through support letters, such as the one described above, the mother was successful in obtaining a five-year extension of the ADVO, without a court hearing, and with strong conditions specifically relating to the ex-partner's pattern of behaviour towards the mother and child. The case manager reflected on the process:

I think for that child, who is 13 years old now, that will take her into her late teens, where she will then be old enough to sort of make her own decisions about what her relationship with her dad looks like and how to do that safely. But I think that writing that letter was very impactful for me because I was able to make sure that she was also part of the focus… getting that extension and getting it so quickly was such a good outcome.

neglect, disordered eating, or mental health concerns. Practitioners asked practical and concrete questions to identify and document day to day impacts, as well as to recognise cumulative harm due to long-term patterns of abuse – for example, a twelve-year-old may have experienced over twelve years of violence.

When you use the whole *Mapping Tool,* it allows the voice of the child, and it was specifically important in a recent conversation that I had with a family where a child had voiced that he understood why mum was smoking pot so much that morning, because of how dad was hounding her… he said, "It's no wonder mum was smoking, with the way dad was acting. – LGA 3, CoP3

Use of the *Mapping Tool* as a guide for assessment and documentation of these impacts on children and young people was central to making these connections. In addition, the *Mapping Tool* helped workers move from general statements about adult victim-survivors, to recognising and highlighting their parenting strengths and protective actions, such as maintaining family routines or getting children to school regularly. Further detail about documentation practices is explored further in section 4.4.

Practice tip: Documenting with a focus on children and young people

- Highlight patterns in a child or young person's life through using a document such as the *Mapping Tool*, rather than recording isolated incidents of harm single-contact-based notes.

- Focus on specifics rather than general descriptions of impact.

- Document children's opinion and perspectives, where possible using their own words in direct quotation, especially when major decisions are being made, such as the Family Court determining contact arrangements with a father the children do not want to see.

- Keep in mind when writing case notes and reports that children and young people may access their records as adults to understand their experiences and decisions made about their lives.

- Professionals in adult-focused services should also record information about the needs of children and young people, which may arise when discussing parenting with adults (who use violence or are subjected to it).

- Be specific in documenting the parenting strengths and protective actions of a parent or carer.

4.4. Documentation

Contact-based note taking works against pattern-based thinking. And so the Mapping Tool is meant to fix that.
– Safe & Together Consultant LGA 2, CoP2

The *CHRISTIE Project* promoted a key component of the Safe & Together framework, emphasising the critical importance of documenting detailed risk and safety assessments, for the purposes of establishing evidence of patterns of violence and abuse, patterns of protective actions and advocacy for child and adult victim-survivors (Kertesz et al., 2022; Isobe et al., 2025).

In the *CHRISTIE* discussions, the term documentation was used to describe any written or electronic record that accurately contributed to a family's story, including but not limited to referral and intake forms, risk assessments, safety plans, case notes, handover notes, formal reports and support letters or other inter-agency communication.

4.4.1. Practitioner views on the value of effective documentation

Practitioners involved in the *CHRISTIE* CoPs discussed the value of documenting patterns of behaviour and their impacts, noting that good records provide a basis for effective risk assessments, safety planning and long-term healing. Many CoP discussions focused on how records could promote accountability on the part of service providers, with each service contributing a 'piece of the puzzle' towards understanding a family's story. CoP members were particularly concerned with ways in which their recording could be effective in decisions for families in the context of the recent introduction of coercive control legislation in NSW. The implications for allowing information to be transferred across service sectors and enabling interaction with different parts of the service system is discussed later in the report. Several practitioners also reported that they had started documenting their intersectional service approach by highlighting in their records the compounding structural issues faced by their clients.

We have definitely felt we are better able to name the impact of the perpetrator's behaviour in documentation and support letters, and better validate the victim-survivor's experience. So that's both sides of it. – LGA 1, CoP1

The *Perpetrator Mapping Tool* was seen by *CHRISTIE* participants as transformative in providing a template for a pattern-based approach to assessing DFSV historical and current risk. Safe & Together consultants, as well as *CHRISTIE* participants, identified the following benefits to creating high quality DFSV-informed records, including documentation based on *Mapping Tool* exercises.

- Mapping the underlying causes of children's behaviour to inform assessments and obtain access to appropriate supports, as well as the impacts of DFSV on family functioning;

- When there are claims of mutual violence or mum is misidentified as the primary aggressor, mapping the actions of each partner separately may clarify who has power and control, who is fearful, and whether intersecting issues play a role (e.g., alcohol or other drug use, mental health, disability, immigration status, etc.);

- Challenging false reports and allegations, to counteract the strategic manipulation of systems by individuals using violence;

I did [the Mapping Tool], and we submitted it to Family Law, and so at the time dad was trying to twist the narrative to say that he was the victim in it and that's where we gave the perpetrator map to the lawyer. And now I've got to put it in an affidavit, and they were able to straight away chuck out his affidavit because that was completely against everything that the whole trial, the whole Family Court, all the evidence before it. And the other positive thing is the kids were – he took the kids off her and she hadn't seen the kids since November last year – and as of today the kids are going to get returned back to mum. Yeah, so it's been a really great positive experience. It's been a long hard slope but, yeah, finally some success. – LGA 1, CoP 5

- Recording the perspectives of child and adult victim-survivors can help open conversations about violence as a parenting choice and create a narrative sense of self experiences that is positive and meaningful;

- Mapping the protective efforts and parenting strengths of adult victim-survivors, in the context of a pattern of violence and control;

- Reducing victim-blaming by contextualising survivor decisions as evidence to support 'professional opinions', rather than relying on untested assumptions;

- Recording information relevant to concerns about worker safety;

- Ensuring the effective handover of important information between workers and services;

- Capturing the patterns of harmful behaviour by those who use violence over

time to maintain a focus on the person causing harm, particularly alterations in tactics of control in response to, or following, statutory decision-making, or uneven patterns of mental health or issues with alcohol or other drugs;

I did talk about using a perpetrator Mapping Tool and then using it to write a statement and position to apply for an extension of an AVO. We did get a five-year extension on that AVO, so we got the outcome we were after. We got strong conditions on it. The client was very pleased. We were able to avoid taking it to a hearing, which was also a fantastic outcome for them. And I think for that child who is 11 years old now, that will take him into his late teens. – LGA 1, Focus Group

- Recording the context of past injustices that continue to have an impact on survivors – e.g., racist responses from police, or lack of belief from professionals;

- Becoming part of a 'funnel of information' about a family, starting from individual workers documenting effectively at their level, with all records coming together to funnel up to statutory decision-making systems determining the lives of families;

The documentation stuff - he talked about the documentation as being like a funnel. So it's like if everyone is doing that at that level, then that funnels out. And when it comes to the Family Court and a judge or the AVO, the magistrate – that's what they see. And so if you kind of flood that and saturate the space with that, there's no choice but to look at that. – LGA 4, CoP 1

- Preventing reactive decision making, reversing unsafe decisions or shift system responses, and reducing the risk of systems abuse. In particular, unnecessary

removal of children into out-of-home care can be avoided.

… if I think of like, my counselling notes that are not going into a Perpetrator Mapping Tool, I just feel really confident and really strong in them, and I feel quite confident if they are to get subpoenaed I wouldn't stress… It just comes [a lot easier]. I think that is really important. I think language is power. You can go to training, and do the training, and then that's it, really. Unless you practise it… – LGA 4, CoP 5

4.4.2. Embedding a different approach to documentation

Let's not make all of our documentation around how well we've worked with her, she's not the person using violence and causing harm to the children. – Safe & Together Consultant LGA 1, CoP 2

Practitioners described their documentation practices developing throughout the time they were involved in the *CHRISTIE Project*, with a shift in their approach to documenting. The following developments were reported by CoP members.

- Documenting details of behaviour patterns by people using violence rather than general statements such as "the children were exposed to DFSV";

- Using professional judgment to ensure these important details are recorded, rather than rigidly following organisational templates and forms;

- Considering children and young people as clients in their own right, even when documenting context for their adult clients;

- Writing from the perspective of survivors rather than about survivors – "this is how it affected me";

- Keeping within one's own professional expertise and primary service scope.

For example, not interpreting, and using appropriate reliable specialist information resources rather than attempting to interpret medical information as non-medical professionals;

- Documenting systems issues for clients – such as refused referrals, ineffective conversations, or attempts by non-offending parents to obtain assistance – that challenge stereotypes of deserving victims or neglectful mothers in the context DFSV;

She escaped him by admitting herself into hospital under mental health. So still actively going through all that trauma, daily experiencing PTSD symptoms. And so I've been able to sort of piece all of that together and now funnel it into the context, what she's doing really well. – LGA 4, CoP1

- Documenting systems issues regarding professional actions, to promote systems accountability and support practitioners' sense of efficacy. (e.g., lack of response when an issue is escalated appropriately to management, recording whose role it is to address a specific issue or which service is accountable for managing risk).

"Better documentation leads to reduced professional frustration." – Safe & Together Consultant

Case example: Shifting documentation

A mother with a history of drug use suffered a health collapse, leading to child protection involvement. This incident was documented with a lack of context, which led child protection workers to focus on whether the woman had started using again. However, the woman and her NGO case manager mapped the patterns of violence and abuse she had suffered, including non-fatal strangulation. Using specialist health resources about this issue, the practitioner was able to link her health symptoms with these experiences, and advocate for a DFSV-focused assessment and response – LGA 4, CoP1

4.4.2.1. The practicalities of documenting differently

The documentation practices described are new, innovative and challenging. The comprehensiveness of the *Perpetrator Mapping Tool* as an assessment and intervention tool proved quite intimidating for some CoP participants. This tool offers guidance in the form of several main assessment domains (see Figure 3) accompanied by notes and questions to prompt inquiry. The format requires practitioners to use professional judgement

in how to engage with clients and gather information, usually over a number of sessions. This was a challenge for many practitioners with extensive workloads. Some workers were concerned about not being able to complete all sections of the *Mapping Tool*, particularly practitioners in adult-focussed services who did not think they could record the perspectives or experience of children and young people.

Integrated into practice, rather than being implemented as an add-on form, the *Mapping Tool* has the potential to promote more effective, time-efficient practice. However, a considerable time allocation is needed for practitioners as they learn to make the best use of it.

There was extensive discussion in the CoPs about how to integrate the *Mapping Tool* into existing case management and records management systems. Some workers created 'live' documents, that could be updated and added to over time, as in the practice example. However, this was reported to be more difficult in organisations that used restrictive internal case management systems, or that did not allow for storing extra documentation, and in offices where storage of files was not perceived as secure.

It is clear that organisational support is necessary for frontline workers integrating these new ways of documenting into their normal practice. In several organisations, referral and intake forms as well as case note templates were restructured to introduce headings and prompts adapted from the *Mapping Tool* domains and the Safe & Together Critical Components (see Figure 2). Taking this idea further, some CoP members advocated the adaptation of the Domestic Violence Safety Assessment Tool (DVSAT)[5] in the same way, to promote documentation of

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[5] https://dcj.nsw.gov.au/service-providers/supporting-family-domestic-sexual-violence-services/dfsv-tools-and-resources/domestic-violence-safety-assessment-tool.html

privilege and vulnerability, and intersectional factors such as culture, religion, disability and sexuality.

Security of information recorded in the *Mapping Tool* and other shared documentation was a recurring concern in the CoPs, despite the strong advantages detailed above of sharing and accumulating information about patterns of abuse and control across service sectors and over time. Clear guidance about victim-survivor consent to information-sharing was called for, amid concerns about the ethics of acting on an 'implied consent' basis. Once information was shared with another professional, practitioners reported feeling powerless about further sharing of their records to others, and fearful that their documentation could be used against a victim-survivor, causing further harm.

4.4.2.2. Changes to documentation practice among CoP members

Re-thinking their record-keeping practice was pivotal for many *CHRISTIE* participants. After risk assessment at 50.6%, documentation was rated the most positive change taken from *CHRISTIE* by one in five questionnaire respondents (20.6%). When asked specifically about changes in their documentation practice after *CHRISTIE* participation, approximately 80% of respondents reported some or a lot of change in their documentation relating to the person using violence and their pattern of coercive control, mapping these onto child and family functioning, onto the adult

victim-survivor's strengths and protective capacities, and onto intersectional issues. Fewer participants (57.6%) indicated some or a lot of change in documenting worker safety concerns.

> *But just the way I'm structuring my case notes has really changed. So with this one in particular, especially now I'm doing handover notes with [my co-worker], I've done a big context of how he's affecting her and the children's lives. So I'm looking at he's not attending medical appointments, so it's blocking the child to get the intervention that he needs and the ways that mum's trying to counteract that. And then I've done a big section on all of the strengths, so all the stuff that she's been able to implement to bypass all the barriers that he's been putting in place. Yeah, so really going into that and the stuff that she's doing to help herself as well through the trauma. – LGA 4, CoP 1*

As a self-reflective exercise and a self-reported assessment of change in documentation practice, CoP members were invited at the end of the CoP phase to review their progress in documenting: 1) the actions and patterns of behaviour of the adult using violence; 2) the needs of children/young people; 3) the impact on the child/young person/family functioning, of the actions and patterns of behaviour of the adult using violence; and 4) the protective factors and capacity / acts of resistance from the non-offending parent. Details are in section 3.3.3.

Unfortunately, only six CoP members completed the comparative exercise. Results are therefore not generalisable, as it must be assumed that those who responded were more interested and motivated than others

in documentation. However, even in this very small sample, the findings reflect the value of the exercise.

All those who responded worked in domestic violence services and with families or victim-survivors, with five from non-government organisations and two from Violence Abuse and Neglect services within NSW Health. All were in direct contact with clients. The documents they assessed were either case notes or progress notes, or case summaries. The responses were reflective but quite brief - for example, "*some level of impact on the children documented - could improve*".

Using a scoring system where 0=no evidence of the issue and 3= strong evidence, the research team scored the responses. While there was little difference in scoring between the four issues assessed at each time point, mapping the impact of the abuse onto family functioning scored slightly lower than the others. However, the documentation ratings considerably improved between the first and the second documents assessed, from an average of 4 points to an average of 10 points out of a possible 12 points. All respondents reported a stronger Safe & Together orientation in their documentation, although one commented:

> *There are still gaps in the documentation when looking from a S&T lens. I am noticing it is not in my documentation but it is in my thoughts and it will be put into file notes. – Questionnaire Response*

4.4.2.3. Training and support needs for effective documentation: enablers for good practice

Appropriate training and capacity building is necessary for practitioners to feel knowledgeable and confident to undertake these documentation practices. Practically, it is important for workers to be granted the time and supportive work structures to learn the new approach of using the *Mapping Tool* for a period of several months. In addition, an authorising organisational environment, with management support, is crucial to introduce new practices, reduce the pressure on individual workers and integrate new practices into organisational procedures. Both CoP and PAG members called for Safe & Together training for all staff, or the development of a culture of shared language and concepts consistent with the Safe & Together Model.

Participants reported that effective DFSV documentation practice will not occur without efficient case or client electronic management systems with the functionality to offer flexible formats for contact-based case notes, as well as distinct and easily accessible locations for pattern-based or narrative case summaries (such as the *Perpetrator Mapping Tool*).

CoP members were inspired by the idea that the documentation that they create would have an impact on families experiencing DFSV into the future, through contributing a small 'piece of the puzzle' that makes up the comprehensive body of information about a family. However, clear systems and policies were required for keeping files secure or ensuring that information is safely shared without placing victim-survivors at risk.

Practice tip: Effective documentation

- Use headings in your notes that support specific documentation on issues such as pathways to harm for children and young people, housing, economic security or well-being. If necessary, create a template or another method to remind you to keep children at the centre of your practice.

- Revise referral and intake forms to capture harmful patterns of behaviour and their impacts on child and family functioning.

- Create a *Mapping Tool* template for each family member in your electronic records to bring together information about each child.

- Include notes in your case file about family members other than your client. To support more holistic assessment, include extended family members who are supporting child and adult victim-survivors.

- Use the victim-survivor's own words wherever possible.

- Highlight children's voices and perspectives on their relationships with professionals and non-professionals, and significant decisions such as family contact plans.

- Imagine children returning as adults to read their case files and understand their life story – write for this audience as well as for professional readers.

- Document worker safety issues, detailing harmful actions of people using violence towards services and professionals, programs or organisations to inform current risk assessments and decision-making.

- Be clear, or seek clear guidance, about ethically accessing files of other family members – for example, can you access the mother's records to support a risk assessment of your child client?

4.5. The safety of professionals working with DFSV

I was just thinking when she was talking about those things, as a service we could do better. I don't know, for me personally I feel like we're always thinking about the safety of our clients but we don't think about safety for ourselves. – LGA 1, CoP 52

Throughout the *CHRISTIE* CoPs, worker safety was a common theme. Without knowledge of the ways in which individuals used the tactics of violence and control, an understanding of the daily actions adult victim-survivors take to protect themselves and their children from violence, and an awareness of how DFSV intersects with alcohol/drug issues and mental health challenges in their clients' lives, workers cannot effectively assist families dealing with such complexities.

Many of the themes reported in past Safe & Together research (Kertesz et al., 2022; Isobe et al., 2025: Humphreys et al., 2024) were raised in the *CHRISTIE* discussions, including: the management of physical safety, promoting practitioner emotional and psychological wellbeing, documenting risks to promote safe practice and attending to cultural safety for clients and workers. These issues will not be repeated in detail in this report. Instead, the following discussion will raise several themes arising in CoP discussions that have not been raised in the past.

4.5.1. Safety outside the office and outside the work environment

The majority of CoP members reported that organisational protocols resulted in physical safety within their workplace – environments such as feeling physically secure in physical environments like health department buildings,

office spaces, community centres, or clinics. Well-implemented procedures, thorough risk assessments, and vigilance regarding possible danger, all played a role. Management support in cases where a worker feels under threat, physically, psychologically or professionally is important, but in the degree and nature of support was reported to vary. In one NGO, a manager stepped in by taking a phone call from a person using violence on behalf of the practitioner working with the child and adult victim-survivors, and prohibited him from phoning again.

He's quite [sic], this perpetrator. He's different from what I'm used to. I call him a 'perpetrator in a suit'. Very clever, very charming. He was able to charm his way into finding out who I was, where I work, trying to keep calling. So we actually got the assistant manager involved. – LGA 1, CoP 4

In other situations, practitioners felt that organisational responses showed little recognition of the risk to workers extending beyond the period of the immediate crisis. For example:

When I was in Child Protection, I was at a dispute resolution conference for a family where there'd been a child removal and the father in that situation… threatened to come [to the office]. He said he has a gun and he's going to kill everybody. So they went into lockdown, police got called, all of those sorts of things, I got told to wait until it was safe… I was really concerned because I'd been sitting in the room with him, he knew my face, he knew my name, I was obviously this child's case worker, so everything he had received up until now like he knew who I was. When I got back – … management obviously spoke to me

and I parked my car underneath in the carpark for a little while… but I think after a few weeks it sort of just blew over and it was "Oh, it'll be fine", and there was a little bit of a communication strategy but it sort of broke down and I was again being the contact person… – LGA 1,CoP 5

Outside the physical workplace, risks to safety were less well recognized by organisations. In the example above, the practitioner lived and worked in a small town, where the person using violence could discover where she lived – she stayed with her grandmother for a time. 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. Where they could, practitioners conducted home visits in pairs, and their agencies operated check-in plans following home visits, and provided distress beacons. Small NGOs with limited funding do not always have the resources to provide these protections, leaving employees in rural and remote areas to travel long distances alone to see clients, often without phone reception.

In Aboriginal communities, the distrust and fear engendered by historical child removal policies, intergenerational trauma and ongoing racism, may put Aboriginal professionals at further risk if they are identified with decisions made by statutory authorities. A CoP member recounted a situation they had been involved in, when a small child had been removed from a family they were working with in an Aboriginal-led service. The worker was later identified due to their name not being removed from case documentation shared with the family. This worker was Aboriginal, while all other professionals involved with the family were not. The worker reported being very fearful of the child's father who was a dangerous man. While feeling well supported by their organisation, they found community

attitudes less supportive. As another CoP member commented:

The Aboriginal community would only remember her, not anyone else that was involved, and it makes it harder because community talk and they're going to be targeting the Aboriginal person, where there could have been ten other non-Aboriginal people in it, they won't see it like that. They will see that there was an Aboriginal person involved and they're the ones to blame – LGA 1, CoP 5

4.5.2. Working and living in the same community

In addition to the risk of being identified and subject to threats and harassment, CoP members described the challenges of meeting clients outside the work environment and out of office hours, both in metropolitan and in regional areas. At times clients would approach them outside work hours in shopping centres or at the football field. Workers had to be creative about how they could manage professional and personal boundaries, as well as keeping themselves safe from those in the community who used violence. Aboriginal CoP participants indicated that this is a particular issue for them, where personal and professional boundaries are often differently interpreted, and it is easy for professionals to feel that they are never off duty.

If I go to the food court [in my local shopping centre] and I want to have a meal with my family and then I've got like one, two, three families that are right there. And they will see me and I'm trying to disguise myself, not because I want to be rude, but because of the fact that that's my time. And that's me looking after my own emotional safety

as well... so I go to [another shopping centre] sometimes because I just don't want to deal with that. – LGA 2, CoP 5

4.5.3. The impacts of holding the responsibility for risk

I think, is what people are really sort of raising as well, as well as the burnout. You were talking about the worker in a rural health service, doing all those things, seeing all those clients, in a limited amount of time, and just sort of expected to do that work. – LGA 4, CoP 5

As described above, CoP discussions reflected the acceptance by practitioners that their work is emotionally difficult and sometimes dangerous. The physical, emotional and Cultural threats to safety faced by workers were central to many discussions, with practitioners articulating a contrast between what they viewed as safe, and the policy of their service or organisation. However, professionals were aware of the cost to themselves and expressed a sense that their commitment to their clients and the risks they took were taken for granted by employers and other parts of the service system.

I was affected by [the incident] for a while and then I was just kind of told "Get supervision, get EAP", but then I think the responsibility was all on me to follow that up…, we get people like that it's like "oh, well we'll just sort of deal with it because that's what happens". – LGA 1, CoP 5

Holding risk in under-resourced agencies exacerbated the impact for workers. For those working in rural and regional areas, the lack of services, long distances and physical threats

with guns and remoteness made the threats to safety very high risk.

While the *Mapping Tool* assisted practitioners to identify the risks confronting child and adult victim-survivors, their new skills in encouraging their clients to share these with them on occasion left them overwhelmed at the level of risk they uncovered, and at their responsibility to assist these families. For Aboriginal workers, systems abuse, Cultural load, and encountering racist systems while living and working in community amplified their distress. Many stories were shared, in which practitioners identified patterns of abuse and serious risks to both children and adults, only to be faced with a lack of action by statutory authorities. Here is one example.

…and I feel like that's where we can't really work collaboratively because – and sometimes we organise a welfare check on the family and we're thinking like maybe the police go out and Child Protection will go out because there's a DV incident. And then the police never showed up and then just left us caseworkers there trying to de-escalate the situation to work with families… Sometimes as caseworkers we're just left in that situation because we're a mandatory service, but we're just left hopeless because we don't have anything else but our mouth basically just to do our best to de-escalate. – LGA 1, CoP 3

Situations such as this, leaving practitioners with a sense of hopelessness, distress or vicarious trauma which is often cumulative in nature, may result in burnout. In addition, the crossover of lived experience and professional practice is felt by many practitioners in the DFV sector. A lack of recognition and appropriate support for these workers is an ongoing issue, particularly if workers are

asked to engage with people using violence as part of the service response. The impact of these issues on the workforce and therefore sustainability of practice change itself is

further discussed in section 4.7.

Practice tip for Supervisors: supporting practitioners to work safely (Safe & Together Consultant)

Supervisors are often… good at looking at workers' physical safety and wellbeing, but they may miss details of practitioners' psychological or cultural safety. We as supervisors are not prepared for when a worker may feel emotionally, culturally, or psychologically unsafe. We're all good for the physical: "Yes, this is what we're going to do." But when someone comes in with that, we generally… You know, it might take us aback a bit.

We need to address workers' fears and don't just fob it off as them being resistant or not being able to perform their duties. If we do, then what we see is that we won't have a worker coming in and saying, "Hey, I'm feeling unsafe." Instead, we might see that they say, "Hey, I can't find the user of violence", or "hey, we can't find him. Even if I found him, he probably wouldn't change anyway". You know, there would be a sort of level of resistance from workers. So, we need to address this to put it in our standard sort of supervisions, as a question, or so it's part of your supervision. "Hey, how are you travelling with your cases on domestic and family violence?"

Worker safety concerns can be clustered into three main areas. One is their personal and professional experiences of domestic and family violence. With that,

we could either over or underestimate dangers, not only for the survivors and the children, but also for ourselves. "Hey, I've been through DV myself. I can handle myself." … With these kind of things and not checking ourselves and… where our strength comes from in regards to working with people affected by DV, our personal biases and experiences can sort of cloud our vision.

The [second] thing is that fear for family safety due to our actions or our inactions. Workers may go home feeling: "What if I ask this question? Will I cause more repercussions? What if I don't ask it? Am I missing something?" So, workers actually look at it from that level as well.

[Thirdly], fear for your own safety. You may be working in a small community. Say if you're First Nations, working in a small community, or if not First Nations, you're in a rural area, and people know what your role is. So, there's safety [concerns] due to my involvement with working with this family who has got domestic and family violence. "Will I get retaliation from the user of violence myself?" This is always a big one, and we should be planning for that. – LGA 4, CoP 5.

4.5.4. Creating a culture of care – professional supervision and teamwork

There is a reinforcement and an encouragement when you're not standing alone against the system and I think it's empowering, it's empowering. – LGA 1, CoP 1

When workers were left to navigate difficult and dangerous professional challenges without support, they sometimes felt unable to support families to the degree that they wished. Discussions in the *CHRISTIE* CoPs echoed a concept identified in the *ESTIE* project - the notion of developing a 'culture of care', reducing workers' feelings of individual responsibility through a focus on organisational responsibility, collaboration and mutual support.

The CoPs were commonly noted as a way of developing this approach and reducing workers' feelings of isolation. It was evident that the CoPs provided a shared, collective opportunity for reflection for many of the practitioners involved. The space offered them the chance to be vulnerable, to discuss emotional needs, to plan, reflect and debrief, and to gain an understanding of the frameworks and operational constraints faced by practitioners in other services, rather than allocating blame.

Workers saw continuing and ongoing professional development, preferably in a supportive group context with other practitioners as something to be prioritised for their own self- care. Further, their experiences in the CoPs made them more sensitive to the difficulties of collaborations with professionals operating from different frameworks.

I think it would be helpful if everybody had the same training. – LGA 4, Focus Group

Overall, CoP members valued the CoPs as a structure that allowed for sharing of responsibility, knowledge and creating new initiatives and an opportunity to create a culture of care and embed new practices.

I think meeting each other, just hearing each other talk and tell about the work, and the hard times, the good times, I think that's really been invaluable. I don't think we're siloed in our way of being. I think we get siloed because we're so busy. The demand…I think we're actually quite relational and want to learn from each other. It's just the busyness of the work. – LGA 1, CoP 3

4.6. Place based cross-agency work and collaboration

One of the aims of the *CHRISTIE* project was to promote cross-agency work and intersectoral collaboration, to increase safety for child and adult victim-survivors of DFSV and hold users of violence accountable for their harmful actions. All project participants were very aware that their work with family members constituted only a small part of the range of responses required across sectors to achieve this aim. A significant proportion of the CoP discussions focussed on these issues.

When asked about changes in their information sharing practices, most post-participation questionnaire respondents indicated they had made at least some change. Reported change was most prevalent regarding adult survivors' strengths, the behaviour patterns of people using violence and children and family functioning. Far fewer respondents reported any change in their information sharing practice where it affected worker safety. As noted in the previous section on documentation, concerns were raised about ensuring that information sharing did not escalate the risk for victim-survivors.

4.6.1. Intra-service practice collaboration

Practitioners' descriptions of their work on an individual practice level involved seeking and sharing information, requesting or writing letters of support and making referrals in order to provide a wraparound service for their clients. Within organisations or services, collaborative work occurred both between individuals within the same team or the same service.

Collaborative innovations reported by participants included sharing critical contextual information about a client among team members within one service and working together within a service to support shared

clients - working collaboratively with children and young people as a focus.

Developing a shared language and a mutual understanding of the Safe & Together Model, using the tools for guidance and as a foundation for practice, supported this collaborative way of working. CoP members reported acting as Safe & Together champions within their team: organising and facilitating group reflective supervision sessions within their team; supporting team members in the development of their case notes; and working with team members to mutually improve their own practice. Some PAG members also reported supporting the introduction of the Safe & Together Model as managers, by mentoring staff.

> *We also are trialling a new process where we're having regular co-case management meetings with the case managers, the refuge case managers, and the child and young people caseworkers. So, I think that there's a space, again, for this focus and this language to be used in these types of meetings that will then I think filter through. – LGA 4, CoP 3*

4.6.2. Inter-agency collaboration at a practice level

Practice level collaborative work also occurred between individual workers in different agencies. Descriptive analysis of the pre/post questionnaire data points to small but consistent positive movements in respondents' own practice, documenting multiple client issues across service boundaries and in cross-sector collaboration (though changes were not statistically significant). Similar trends were observed for perceived inter-agency collaboration and

openness of communication at the service level. From a management perspective, PAG members reported that the connections made through learning and training together had brought noticeable benefits, in terms of building relationships between professionals and between organisations. They highlighted the faster pathways for clients that were the result of practitioners becoming familiar and comfortable enough to contact other professionals regarding client needs.

The CoP discussions also highlighted that collaboration is smoothest when individuals know each other. Developing personal relationships at the CHRISTIE training and then building on that relationship through CoP sessions were seen as key to the process. Discussions with CoP members from other services and sectors helped workers view their own role as 'part of the puzzle' of the broader service response. In some cases, this worked well, but there were also extensive systemic barriers hindering effective collaboration and positive client outcomes (to be explored later in this section).

Participants shared a number of examples of collaborative practice that had developed through relationships developed in the CoP context.

- Practitioners improved their understanding of other services and sectors through CoP discussions and better communication between agencies;

As a housing provider, people often see us as a black-and-white service. You know, this is our policy, this is our procedure, that is how you get housing, this is right, wrong, NCAT, all that stuff. But there are so many grey areas, and… we try to work in those grey areas as much as possible and advocate in that space for what needs to happen to keep families safe as well.

So I think in terms of collaboration, don't be scared to reach out to us either. Like even if it does seem like, "oh, there's no way housing providers would do that", it doesn't hurt to actually ask the questions and advocate in that space as well. – LGA 1, CoP 5

- Inter-agency visits were organised, as well as some 'meet and greet' events, so that professionals could familiarise themselves with other services operating in their LGA;

- Professionals from different services discussed the needs of their clients using Safe & Together concepts and reflected that the development of a 'shared language' supported collaboration;

I think it's probably given us a shared language, … we know each other a bit better now we've got more common language. But actually this area's good for helping each other. – LGA 2, Focus Group

- Workers from different organisations within the LGA working together more closely, including jointly completing the Mapping Tool, to better assist their clients;

- New professional connections made at the Safe & Together training generated referrals in both directions between two services;

- Two organisations combined staff resources to provide another cycle of a group program for victim-survivors, with each organisation providing a worker.

4.6.3. Cross-sector collaboration

Findings for the state of cross-sector collaboration at both practice and service levels differed between the pre/post questionnaire data and the analysis of CoP discussions. CoP participants often focussed on case-related experiences of working with other sectors that caused their clients difficulties and the practitioners themselves distress – these consultations were a primary purpose of *CHRISTIE*, to provide coaching for practitioners. The pre/post questionnaire data, however, provides a more positive picture, although these findings should be treated as indicative as sample sizes were very small. Positive findings may be skewed due to a self-selecting sample being more positive about *CHRISTIE* outcomes and their own practice.

Questionnaire respondents were asked to nominate up to five services in their LGA, with whom they or their service did business, and then to rate these cross-agency relationships. Practitioner relationships with professionals in other services were assessed on the following scale: *no contact – communication - information sharing – collaboration - coordination.*

Cross-sector relationships at service level were rated as: *no relationship – minimal – complex– growing – effective – highly collaborative.*

Numbers in each category were quite small, and services were aggregated by sector, hiding differences within sectors. However, the findings provide an indication of perceived changes to cross-sector collaboration during the CHRISTIE project.

Relationships with DFSV services (including men's services, specialist women's family services, women's refuges, and WDVCAS) remained strongly collaborative at both data collection timepoints. For housing services,

practice level relationships showed an upward trend in collaboration from 30.0% to 42.9%. While relationships at service level were less developed, the number rated growing increased from10.0% to 50.0%.

Perceived relationships with DCJ statutory child protection services also improved, particularly for practitioners. At practice level, the proportion of collaboration responses rose from 14.3% to 44.4%, while information sharing declined slightly, suggesting a more integrated form of engagement. At service level, effective relationships remained stable at 28.6%, while the share of growing responses increased (from 42.9% to 50.0%), suggesting continued improvement.

Relationships with justice services (such as police, including DV liaison officers, the Magistrates and Family Courts) exhibited a marked improvement. The proportion of respondents who rated how they worked with professionals in the justice sector as collaborative increased from 7.1% to 30.0%. At the service level, improvements were even more notable, with growing and effective relationships increasing from 41.1% to 73.3% and ratings of highly collaborative rising slightly from 5.9% to 6.7%.

It was nevertheless clear from the CoP discussion data that cross-agency work at practitioner level usually depended on individual working styles, with some professionals interested in collaboration, and others whose perspectives did not reach beyond the remit of their organisation. Unless they sought the support of a senior staff member, practitioners felt it was up to them to make collaboration work. As one practitioner put it in their pre-participation questionnaire response:

> *Silos are in place. Time is pressured and inter-agency collaboration is an extra, a bonus, rather than structured in as core business.*

Case study 3

A mother and children with complex needs relating to disability and mental health issues, were referred to a child sexual assault counsellor for support around alleged sexual abuse towards the younger children by their father. The younger children were living primarily with their mother, while the young adult son was living with the father.

As part of ongoing Family Law court proceedings, the father had recently obtained orders for unsupervised contact, including overnights, with the younger children. The children told their independent lawyer they felt uncomfortable and unsafe with seeing their father and increasing contact.

The counsellor used the Perpetrator Mapping Tool to document pathways to harm. The father undermined the mother's parenting, disrupted home life (for example by phoning during bedtime routines) and refused to pay child support. He also coerced their son to move back in with his mother and the younger children, forcing him to encourage the younger children to see their father and share information about the family with him. The father extended the family court matter, costing the mother hundreds of thousands of dollars in legal fees despite her financial reliance on Centrelink payments. He also obtained orders preventing the children from seeing counsellors other than private therapists which the mother could not afford. During the Mapping Tool conversations, the mother also disclosed that the father was stalking her and trying to find her address as the ADVO [Apprehended Domestic Violence Order] protecting her and the children had expired.

The counsellor reported the sexual abuse concerns to statutory authorities. While initial responses sympathised with the concerns, no action was taken by police, child protection or the Family Court. Both police and Family Court deemed the matter outside their scope, describing the abuse as "historical" and subject to a "past" assessment that could not be reopened". Unsure about applying the new coercive control legislation, police were also reluctant to investigate the other abuse reported.

With advice and support from *CHRISTIE* Community of Practice members, the counsellor made referrals for the mother for court support, domestic violence services and legal advice, and extended the Mapping Tool into a timeline detailing domestic violence and child sexual assault, systems failures, and harm to the children over a 20-year period. On the advice of Safe & Together facilitators, she included the children's un-coerced perspectives and challenged the concept of "historical abuse" when impacts are current. In the light of this systematic documentation, along with evidence of escalating abusive behaviour by the father, and advocacy from her organisational management, police granted the mother an ADVO.

In the Family Court, the police submitted the Mapping Tool as full evidence that was accessible to the father and his lawyer, assuming that the mother had given consent by sharing it with them. The father's abusive behaviours altered and escalated in retaliation. The counsellor and her service have continued to advocate with police for a more considered approach to consent for sharing confidential documentation.

The counsellor has kept updating the *Mapping Tool* to document the ongoing harm to the children. She has made referrals to multiple services including other Community of Practice participants, and reported feeling supported by the group to manage the challenges of the work. The mother feels more confident and supported to continue advocating for her children.

"I think mum has felt really supported… by services, and I think that's providing her with a lot of the strength to keep going and keep kind of tackling these system barriers… The takeaway is that collaboration is really valuable and really important and for women to have a team around them… being able to kind of witness what she's going through and… walk alongside her, I'm just visualising the hands lifting her up."

A prominent example of cross-sector collaboration work discussed in the CoPs was the Safety Action Meeting (SAM). Led by police, these fortnightly meetings bring together police, health, housing, child protection, education, and support services to protect those at serious risk of DFSV. SAMs were seen as an opportunity for bringing Safe & Together informed assessment, mapping and documentation to an intersectoral group to inform decision-making.

They really take notice because they know that we're working with the woman within the home so we're actually seeing those emotions, you know, we're sharing her fears for her safety. – LGA 3, CoP 5

And the whole purpose of SAMS is around that inter-agency response… I think it really is a developing space in [this LGA] and I think that our participation in [CHRISTIE] has helped that along a little bit. – LGA 1, Focus Group

Feedback about the role of liaison positions in facilitating service responses across sectors was also generally positive. Roles such as police domestic violence liaison officers (DVLO) and the Women's Domestic Violence Court Advocacy Service (WDVCAS) are skilled in understanding the frameworks of both DFSV services and the legal system and assist in 'translating' and explaining DFSV risks to professionals who do not have that expertise.

I am very, very fortunate that I sort of have their ear and I can express in a very respectful way but in a very forward way what my concerns are for some of my clients... So I've learned a lot about how I articulate that, how I encourage police to review things and look back at things. My DVLOs are great. They will feed that back to officers and try and educate them a little

bit as well. – LGA 1, Focus Group

WDVCAS, we're the filter. We're the filter between the client and the police, because we know how they use that in court, especially when the perpetrator's solicitor has access to evidence. So, we have to present information that's going to support the client… we filter it to the police, where they can see the risks and dangers and safety, and all the rest of it, but we don't give them the full picture. It's filtered information [to protect client safety]. – LGA 4, CoP 5

The role of statutory child protection (DCJ) is integral to any child-centred service response, and while practitioners expressed frustration at times with DCJ professionals who did not share vital information or were not collaborative, there were also favourable reports of collaborative work with them from CoP members, most positive when professionals were able to make use of their expertise.

Our CEO… was actually working closely with DCJ with this family to make sure that she was handing over all the correct information. – LGA 4, CoP 5

DCJ are involved. So, we're working collaboratively with them… We tend to reach out to them I guess, to do some of that work with the perpetrator of violence. – LGA 4, CoP 3

With the majority of *CHRISTIE* participants from non-government organisations (NGOs), it was the relationships with statutory governmental organisations that they were most focussed on, feeling more relaxed about navigating relationships within the NGO sector. CoP discussions highlighted a barrier between community-based services and government services such as Health, with practitioners from both sides expressing a wish for closer communication and collaboration. As some of the comments above indicate, NGOs' funding

and governance arrangements enable them to be nimble in their service response and in adapting to changing client needs and allow their staff to reach collaboratively outside their sector, in ways that are harder for government employees.

As an NGO we get to be more – well I think, it's my belief, that we get to be a bit more engaged and pushy as opposed to workers that work within, you know, government organisations like DCJ and Health and Corrections. There's very much a party line that they have to tow. And I understand that... So that's what I love about being an NGO. – LGA 1, Focus Group

4.6.4. Challenges for collaboration

Police, statutory child protection (DCJ) and the court system were discussed extensively in the CoPs. Apart from the examples listed above, participants described their interactions with the justice sector as almost entirely negative, particularly the family court and police. Examples provided showed workers feeling ineffectual to change the outcomes of decisions which had detrimental impacts on their clients. Examples included:

- misidentification of women as primary aggressor;

- systems abuse;

- a culture of mother blaming;

- inadequate or negative police responses;

- inappropriate practices by independent children's lawyers; and

- risks to the safety of women and children through inconsistent confidentiality procedures.

Considerable frustration was also expressed about interactions with statutory child protection workers (DCJ), but practitioners were more tolerant of individual practitioners, recognising the difficulties created by heavy workloads, lack of a shared framework, and systems barriers to achieving the work.

It's one of the hardest things in our roles… I've worked alongside some really, really good, positive and supportive workers. And then you've got others that, you know, you're against… That's not just with DCJ; that's with other agencies that you work with, as well. I think it's changing the mindset of workers as well, and they've got protocols they've got to go with, but see the bigger picture, as well, and get out there and be involved… A lot of the DCJ workers would never have met the families that they've worked with. It's all through another agency, and they're only getting feedback... All the hard work that we've put in, or another agency's put in, but DCJ at the end of the day has got the last say, and this is why there's not a lot of trust… – LGA 3, CoP 3

These issues arose time and time again for *CHRISTIE* participants – the degree to which the siloed nature of the broader service system, creating distinct frameworks, procedures and priorities, has resulted in broad sections of the workforce with an inadequate understanding of the dynamics of DFSV, and with lack of time, encouragement or interest in understanding beyond their own area of responsibility. Managers in the PAG meetings highlighted the need to work around obstructive systems in a reactive and practical way, to circumvent the barriers created by siloed systems. However, this added responsibility on top of already busy workloads felt overwhelming to many workers.

I feel like the Mapping Tool's so important but we don't have sometimes like the time to sit with DCJ and help them see what's going on, and the lack of curiosity from DCJ, the lack of curiosity from other services. – LGA 4, CoP 4

When things went wrong, such as differing interpretations of confidentiality procedures leading to the person using violence obtaining a copy of a *Mapping Tool* completed by the woman he was abusing, practitioners were able to escalate the issue, and discussions took place at a more senior level to prevent a repetition. However, these overtures are not always received responsively, and do little to alleviate a practitioner's distress at the danger their client was placed in.

Local coordination of service responses to DFSV was reported by CoP and PAG members to be missing on an organised level in all four LGAs where *CHRISTIE* was implemented. Challenges raised by participants involved systems that were seen to create barriers to collaboration, despite the efforts of a number of exceptional individuals within those services

I think the biggest problem we're having is all the people who are not in the room such as police, yeah, because I feel like that's a really big barrier to our job and, yeah, as much as the Mapping Tool would be great I think it's just the barrier of just having communication with them. – LGA 1, CoP 1

A consistent message from CoP and PAG participants was their disappointment that statutory child protection services (DCJ), police and corrective services were poorly represented or not at all in CHRISTIE, especially at CoP level, despite the engagement efforts of DVNSW and local leaders. NGO participants were eager

to engage with professionals from these services, to share learning and collaborate for better client outcomes.

I would like to stay that it was incredibly disappointing that we didn't have buy in from Child Protection Services on this one, and I get that they're busy and I get they're short-staffed but so are we, … for better lives for these guys, they should have been at the table with us. – LGA 3, Focus Group

4.7. Embedding and sustaining practice change

Practitioners in the CoPs expressed their enthusiasm for the Safe & Together Model, describing how it helped them seek detailed information about the tactics of power of control used by people who use violence, the pathways to harm, and resistive and protective strategies used by child and adult victim-survivors. For many practitioners at the frontline of work with families, the Model offered them a practice approach that aligned more closely with their own professional values than their perception of the broader service system in NSW. Those managers who understood the Model also expressed enthusiasm, especially those who had attended the Safe & Together training. Several also attended CoP sessions, in order to better support and mentor their staff.

4.7.1. Sustaining new practices informed by Safe & Together

Invited to reflect on embedding into personal and organisational practice the lessons from *CHRISTIE* in terms of Safe & Together, child-centred service responses, documentation and collaboration with the wider service system, a key theme raised by many *CHRISTIE* participants concerned the value of conversations with other professionals, within the same service and in other sectors.

… facilitate more conversations with others who would use this [Safe & Together] in practice so that it actually becomes a lot more present in the way that we think about how we approach our work. And I think that's been really valuable for me as well because I don't directly work and obviously the day-to-day is not always DV, and so [I am] trying … to keep it on the forefront of my agenda and ensure my practice remains current. – LGA 4, CoP 4

As noted in the above quotation from a CoP participant, conversations were perceived as keeping the lessons alive and reminding professionals to continue implementing them in their practice. As noted in section 4.5.1, the language and concepts of Safe & Together create shared language that facilitates communication between professionals and service systems functioning under very different frameworks, supporting collaborative practice and through this, creating a cycle of sustainability.

I attended a coercive control training about a month ago, facilitated by DCJ [statutory child protection], and even the facilitator was using very similar language and like encouraging everybody to take notes in a different way.... So, it was really great to see that within the community, we've started to use that language and be more aware of the Safe & Together framework. – LGA 2, CoP1

The Communities of Practice were cited as a good model for facilitating conversations, with participants in all LGAs expressing an interest in continuing to meet beyond the project's timeline. It was clear that support would be required to make this happen, as participants would need organisational permission to attend, resources and leadership would be needed to coordinate and convene meetings involving professionals from a range of sectors.

We had a community health forum last week and that was with people who work in the community health within Health, … one of the workers actually said that it would be great to actually create our own CoP because I said, you know, we obviously meet together and this is what we do, and she said it would be great to actually kind of keep that going and look at how we actually practise in our different

settings and using the knowledge that we've obviously got across the different settings. – LGA 4, CoP 4

While the project aimed to recruit at least two participants per organisation into the CoPs, this was not always possible. Practitioners attempting to implement the Safe & Together Model as the only professional in their team, or as a sole practitioner, described the difficulties of learning on their own. It was easier to learn and sustain new practice in a mutually supportive group; reporting on lessons learned from training and explaining the Model to others, or initiating questions and case discussions informed by Safe & Together concepts.

… we're just trying to, in our team meeting, sprinkle a little bit of it in. So, our last team meeting last week, I put it up and gave everybody a copy of the prepared Mapping Tool, and also just an example of some of the de-identified support letters just for people to keep for their resources. Next time, we'll just take something else and have a little bit of a chat… – LGA 1,CoP 3

Sustainability was a theme re-visited in each *CHRISTIE* CoP session and a range of approaches to embedding Safe & Together practice into direct practice within teams were reported or proposed, including the following strategies by Safe & Together champions.

• Facilitating group supervision sessions;

• Supporting team members to develop case notes informed by the Mapping Tool;

• Mentoring of staff by managers and practice leads;

• Providing organisational support for practitioners to attend a Community of Practice (a specific PAG proposal from Health managers to sustain lessons from both *ESTIE* and *CHRISTIE* projects among health practitioners);

• Structuring meeting agendas and records templates to align with Safe & Together;

• Having a 'buddy system' within agencies to support new workers to learn the S&T approach;

• Holding Safe & Together staff development days;

• Integrating Safe & Together practices into staff induction and training;

In the PAG meetings, there was a recognition that sustaining the outcomes of *CHRISTIE* depends on action at different levels of governance. There was considerable enthusiasm for the Model, and a wish to see it expanded across a wider range of services including the police and court systems. However, ideas for sustainability initiatives such as running CoPs and developing practice guides, tended to be limited to one service stream, rather than ambitions for cross-sectoral work. The discussions also focussed on the challenges of staff turnover with the consequent loss of trained practitioners, and the investment needed for further training, and for embedding the knowledge into the daily flow of work.

To build directly on the *CHRISTIE* project, DNVSW have provided further access to Safe & Together training to professionals in the four participating LGAs, including additional access for each participating organisation to the Safe & Together Foundations e-learning bundle, and a webinar with Jackie Wruck, the *CHRISTIE* Safe & Together Consultant. In addition, DNVSW is developing resources to support organisations in participating LGAs to facilitate their own communities of practice and embed key themes from the training such as the Perpetrator Mapping Tool, worker safety and intersectionality.

> **Practice example: Integrating Safe & Together into team meetings**
>
> *We do refuge accommodation and case management, and then we do a bit of outreach, but we normally have a Monday morning meeting where we go through whatever handover from the weekend, and the clients that we feel are at risk. But we've really tried to focus on the pattern of behaviour during that meeting, and obviously think about what is this person doing to keep themselves safe, but what is it that we can anticipate happening from the pattern that we know. So, yeah, that's a small thing that we've changed, but I think it just kind of sets the tone for the week ahead… Even though it's a slight shift, it makes a lot of difference. – LGA 4, CoP 4*

4.7.2. Sector-wide initiatives for sustainability

In addition to a number of initiatives described in earlier sections of this report that enhance inter-agency and cross-sector collaboration through embedding the Safe & Together Model, the following strategies were proposed by *CHRISTIE* participants.

- Working in partnership with other agencies to complete the *Mapping Tool*;

- Bringing Safe & Together informed documentation into Safety Action Meetings by trained workers;

- Ensuring that all participants of DFSV-related case conferences have an understanding of the Model;

- Structuring case conferences relating to families living with DFSV and other issues through the Safe & Together Intersections Meeting Guide (https://safeandtogetherinstitute.com/stim-guide);

- Facilitating cross-sector communities of practice;

- Providing professional development in Safe & Together across the service system.

Taking a wider systems approach, *CHRISTIE* project partners DVNSW and ACWA, as peak bodies for the specialist domestic violence services and child and family services respectively, are concerned to support the sustainability of practice and collaborative change, and to further implement Safe & Together across NSW. ACWA has funded Safe & Together training and a Community of Practice in Dubbo, Bathurst and Walgett through their place-based work in western NSW. Under the auspices of DVNSW, two documentation masterclass webinars have been held for DVNSW members in 2025 with David Mandel (CEO of the Safe & Together Institute). David Mandel was also interviewed for DVNSW's *Coercive Control - conversations that count* [6] podcast series. This conversation which had over 1,500 downloads in the two months following its release.

DVSNW and ACWA are also looking at further opportunities to grow the reach of the Safe & Together model through place-based collaboration in NSW.

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[6] https://dvnsw.podbean.com/

4.7.3. Challenges for sustainability

4.7.3.1. Resourcing

I've been really lucky in that my manager really supported these training sessions because it was part of the CHRISTIE project… I'm taking time away from my role and my team and our clients. Although I can see the value in it, I'd wonder how [continuing this community of practice] would be implemented and supported. – LGA 4, Focus Group

In some organisations in *CHRISTIE*, service managers attended the training so that they could support their staff and understand how they were putting Safe & Together into practice. In these situations, the whole service was pulling together. For many CoP participants, especially those working in small non-government organisations, time-release for *CHRISTIE* was practically difficult, in the context of small teams covering the work, and the time-release entailing a significant in-kind cost to these services.

A large proportion of the services participating in *CHRISTIE* were based in the community sector and operating on small and insecure funding grants. Lack of resourcing, piecemeal contractual funding, and competitive funding mechanisms were cited as barriers to services working effectively both as stand-alone services as well as collaboratively together. This included lack of access to men's behaviour programs (no service available or long waiting lists for those LGAs who did have a program available in their area), closing down services funded specifically to support children and young people, cutting positions in rural and regional areas and limited funding for frontline DFSV services. During the project period itself, Family Preservation

services went through a tender process and did not know whether future funding would ensue for their service. In these conditions, sustaining the practice change achieved during *CHRISTIE*, and continuing to develop innovative practice, will prove a challenge in these low resourced environments.

What we need, is reliable, decent, ongoing funding, particularly in men's behaviour change work… It's hard to get sufficiently well trained, available staff, when the offering of the job is so piecemeal. It's funded… and [then] it's gone. It's gone, and people have moved on. Two years later, "here's a piece of funding back". We've got to start all the way back up from scratch. – LGA 4, Focus Group

A consistent and clear message from participants in the CoPs and PAGS was for services to be fully funded in a secure and non-competitive way. Workers believed that this would decrease the pressure put on them to fill the gaps of service provision and sustain the workforce more effectively, allowing for creativity and innovation in service provision.

You know, you've got a certain amount of training and skill, and you know what would be a good intervention, but you're not able to do that, and you have to compromise that because of resourcing. – LGA 4, CoP 5

4.7.3.2. Sustaining practice change in the context of the wider service system

Practitioners greatly valued and improved their assessment and documentation skills through the Safe & Together training and coaching activities offered by *CHRISTIE*. However, it was clear from the *CHRISTIE* data that developing an understanding of the harmful actions taken by people using violence and

the impacts on child and adult victim-survivors does not in itself create positive outcomes for families. Developing a service system which is experienced differently by families living with DFSV is only possible with the involvement of all parts of the service sector, and *CHRISTIE* participants offered many examples situations where different parts of the service system counteracted each other's efforts due to competing considerations in the in the interests of client safety. This is an example of the complexities within just one organisation.

I did a lot of work with the mother and my documentation was obviously very reflective of [Safe & Together]… But then I think when there was a bit of a flavour of the dad maybe going through Family Court and obviously using the court process as a way of his use of abuse. Legal team - as soon as there's like a flavour of something that might hint, you know, of legal kind of involvement… they seek legal advice, and so the legal team will actually inform what we do as opposed to what is needed. And so it's really hard because then we've got extra layers where we're guided by the legalities of what Health need to protect. – LGA 4, CoP 1

CHRISTIE participants provided examples of effective collaborative work informed by Safe & Together concepts and principles that made a difference in promoting safety for child and adult victim-survivors. The Safety Action Meetings are an outstanding example of a sustained collaborative initiative which will continue to provide opportunities for collaboration.

However, CoP members shared many stories about how their efforts to safely seek or share information, and work in a coordinated way

with other services – to hold a person using violence accountable or keep victim-survivors safe – were ineffective (see section 4.5.4), because frontline workers in other sectors did not listen, or their managers overrode risk assessments for procedural reasons. As expressed by one practitioner, sustaining practice change is a challenge in these circumstances, and requires attitudinal and procedural adjustment throughout all sectors and all layers of the service system.

It's like come on, like what are we doing, let's just get in there and support one another… We need our university, we need like other executives, like-minded people to be pushing in those spaces. Like I said before, like they're thinking it's hunky dory out there, but does it go right down to the officer that takes the details or even Centrelink or whatever service, is it filtering down?, Because it's not, hasn't been for years. – LGA 4, CoP 2

4.7.3.3. Moral distress and burnout

A great amount of time was spent in the CoPs discussing situations described by practitioners a causing a sense of moral injury or distress[7]. Practitioners provided examples of being forced to engage with a person using violence in the community and outside work (e.g. a restaurant waiter). Some workers described having their professional identity attacked or being spoken to "like you are an idiot". In a sector stretched for resources, practitioners reported that they knew of DFSV services seeking non-government funding in order to keep the service operating, who had to choose whether to accept funding from a community identity identified as a user of violence.

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[7] Moral injury is defined as "the psychological disequilibrium that emerges when agency policies and/or practices conflict with an individual's professional values and ethics". (Voth Schrag et al., 2024)

Because we also know that the people we report to like in a fundraiser… are perpetrators as well. So we have to think if we are going to go to this person for money… Because what's that like for a client knowing that that guy standing up saying "I gave all this money" is a perpetrator. And that happens a lot, which is why it's so disappointing that we have to go to private funds… No one ever talks about that. – RW CoP 5

Other examples of moral injury or distress that were raised in the CoPs (and are cited throughout this report) concerned situations where workers felt let down by service responses from other sectors, in their efforts to practice in alignment with their professional ethics, as well as letting down the families they were supporting.

For me just really reflecting on every moment about moral injury, it sits so deeply with me just hearing stories and trying to kind of like – I'm getting upset. Just trying to navigate that can be really hard sometimes… but I know we all get kind of really bowed down by the systems that keep failing us. – LGA 4, CoP 2

This combination of challenges – scarce resources for service provision in the community sector, the complexity of competing considerations in relation to client interests, and the moral distress experienced by many frontline workers – was noted by *CHRISTIE* participants as possibly leading to burnout for practitioners and exacerbating the turnover of skilled professionals that services are already experiencing. As noted above, a significant number of CoP participants did not complete the *CHRISTIE* project due to moving on to other jobs. This represents a serious drain on service resources, who have committed to providing staff with the training and coaching opportunity. While

these workers may take their learning to new workplaces, they will not necessarily be supported there by managers who know and value what the Safe & Together Model offers. Asking practitioners and their services to sustain the skills, understanding and improved practices initiated during the *CHRISTIE* project is in doubt while these forces are in operation.

5.
Discussion: Shifting the service approach for a skilled and stable workforce

The *CHRISTIE Project* used an action research model to engage with practitioners, from DFSV services for both victim-survivors and people who use violence, non-government child protection organisations, Aboriginal Community Controlled Organisations (ACCOs and ACCHOs) local NSW Health services, housing services and DCJ child protection services. This enabled the research team and project participants to share, develop and embed new knowledge in the form of research and the *CHRISTIE* learning activities, and to build capacity in organisations (Ison, 2008).

The research team was interested in the effectiveness of capacity building activities for professionals and their services to implement the Safe & Together™ Model, through preliminary training, followed by five months of coaching and reflective practice in communities of practice. The aim was to increase practitioner skills and confidence in understanding the impacts of DFSV on children, young people and their families, and responding to their needs, strengthening DFSV documentation practices and building local collaborative partnerships in the four NSW local government areas where the project was run. Finally, the research team sought to understand what professionals need from their organisations and the service system, to support families in experiencing an effective and collaborative service system.

The reflections of CoP participants about the *CHRISTIE* capacity building activities provides clear evidence that changing DFSV practice requires complex systems change. The common approach of providing one-off training courses for practitioners, without ongoing coaching or organisational support, has little impact on sustained practice change (Wagenaar & Cook, 2011). In this respect, the *CHRISTIE* findings confirm the evidence developed through the series of projects undertaken by the University of Melbourne

with Safe & Together, with the *CHRISTIE Project* the latest example of this capacity building model.

5.1. Practice development

Through the practical focus of the communities of practice, with all discussion themes linked to the *Perpetrator Pattern Mapping Tool* (see Figure 3), CoP members were guided through each of the *Mapping Tool*'s assessment domains, and were able to trial new aspects of practice, and return to the group for further discussion and guidance. This approach allowed participants to reflect over time on how they could put Safe & Together principles into practice, and promoted several significant changes in practice, particularly in terms of engagement and risk assessment.

1. Over the course of the CoP discussions, participants moved towards a consideration of all members of the family unit, rather than an individual client. This was assisted by the all-of-family perspective of many services involved in *CHRISTIE* but was nevertheless a significant shift.

2. Practitioners began to think in more detail about the children and young people in the families they worked with, although most cases discussed in the CoPs did not involve working directly with this group. They started to see children and young people as individuals with differing experiences (according to their age, gender, and their relationship with the person using violence), and as having 'agency', rather than being only 'witnesses' or victims. They gained a greater understanding of the many ways a person using violence could harm them directly or disrupt family functioning. CoP members also started seeking information about children more broadly, asking about them in conversations with parents, the broader family network and seeking information from other professionals.

Notably, many CoP members recognised the importance of considering the safety and well-being needs of children and young people affected by DFSV, even when they were neither a client nor the child of a client. This included helping mothers understand, accept and articulate the impacts on their children of the violence and abuse they themselves had experienced, and recognise that the source of harm was not themselves. For professionals working with individuals who use violence, it also involved focusing on their role and responsibility as a parent.

3. CoP participants were enthusiastic about engaging with the *Perpetrator Pattern Mapping Tool* and many reported that it transformed their practice. The strength of the Tool was seen to be its focus on identifying patterns of behaviour, and its function in bringing all relevant information about a family into one place, rather than dispersed and hidden through contact-based notes.
The focus on the *Mapping Tool* enabled a continuing conversation about the role of various forms of documentation in holding people who use violence accountable and advocating for the safety of victim-survivors. The *Mapping Tool* was instrumental in providing a common language about the impacts of DFSV, and a language that can be used to communicate this detail to other professionals.
Evidence from both discussions and questionnaires was clear that the guidance in the *Mapping Tool* made a significant difference to how practitioners approached engagement and assessment with clients, and enabled them to document differently, including more detail about an individual's pattern of abusive behaviour and its impacts on their family

members. Many participants initially found the full *Mapping Tool* to be overwhelming in length and detail, particularly those who saw it as a form to be filled out, rather than as a guide to understanding violence and control in a family. Over time, familiarisation with the Tool eased this concern, highlighting the importance of ongoing coaching and supervision in its implementation.

4. After risk assessment skills, the most significant change in practice noted by *CHRISTIE* participants concerned how these assessments were recorded – in case and clinical notes, case summaries, referrals and letters of advocacy. A number of examples were provided at CoP meetings of situations where a detailed case summary, or the *Mapping Tool* itself, was shown to have influence with other sectors in decision-making for families. Implementing this into routine recordkeeping effectively, and for the long term, involves three factors. Firstly, the practitioner prioritises reflective time and effort while they are learning the new skill and developing their own habits. Secondly, support and guidance in the workplace creates a context which encourages the new practice. Finally, adapting or creating templates for case notes, referral forms and other records to reflect the *Mapping Tool* domains can be helpful. The challenge for many practitioners was to ensure that their more detailed assessments were moved out of their head, and into tangible record form.

Overall, the capacity building model was successful in creating a learning environment that provided practitioners rich training in the content of the Safe & Together Model, and ongoing coaching opportunities to practise, reflect and implement new practice approaches.

5.2. Cross-agency relationships and collaboration

The Communities of Practice provided an opportunity for professionals, hungry to collaborate, and to get to know other professionals and services in their local area. The place-based nature of the CoPs added an extra dimension to discussions which could be very practical about what services could offer in each LGA. In the metropolitan LGAs, where a number of small NGOs were participating, participants were particularly proactive in taking advantage of the opportunity to visit each other's services. In regional areas, with fewer separate organisations, there was greater familiarity with the local service system from the outset.

The development of professional relationships within the CoPs created an environment which encouraged workers to discuss cases, share information and collaborate. In some cases, these relationships spanned Aboriginal and non-Aboriginal services, where Cultural safety and trust is of the utmost importance. In addition, CoP members also gained a greater familiarity with the work of other organisations and other sectors, their professional approaches, the assistance they offered, and the limitations they were bound by. These two factors were foundational in participants' perception that collaborative relationships improved over the period of the *CHRISTIE Project*. The common language provided by the Safe & Together Model also created an ease of communication.

Research findings regarding collaboration between agencies and sectors were in some places apparently contradictory. Questionnaire data suggesting positive moves towards collaboration with Justice services refer primarily to inter-agency level collaboration with police, rather than collaboration at the practitioner level (see section 4.6.3). These data are very small, only indicative and generalisations cannot be made. In contrast,

conversations in the Communities of Practice highlighted many examples of problems with communication and collaboration between the services represented in the CoPs and police, corrective services, parole or Court decision-making (see section 4.6.4). It is possible that CoP members felt more confident in how to deal with these services as a result of CoP discussions.

It was clear that meeting and getting to know each other was essential to the process for CoP participants, and continued opportunities for frontline services from different services to meet each other would appear to offer significant advantages, in sustaining improved collaboration and providing similar opportunities as the workforce changes. Without clear messaging from organisational leadership to prioritise relationship-building activities, however, it is unlikely that these improvements will be sustained, particularly in the face of multiple barriers.

CHRISTIE participants identified challenges that involved systems seen to create barriers to collaboration, despite the efforts of a number of exceptional individuals within those services. It proved difficult to engage some key workforces in the *CHRISTIE Project* – namely the police, corrective services, statutory child protection from DCJ and health services focussing on issues such as mental health and alcohol and other drug use. CoP participants described continuing challenges in promoting the safety of child and adult victim-survivors when working with police, corrective services, and the legal system in general, due to rigid siloing of services and conflicting requirements on service users.

Finally, it was a frustration to many participants that they were met with a lack of understanding or even with hostility, when communicating or attempting to collaborate

with professionals who were unaware of the Safe & Together Model or whose work context created barriers to reaching across sector boundaries in the best interest of the client. These challenges are perceived to result in a situation where a large proportion of practitioner workloads entails assisting clients in navigating a way around the barriers set up by the siloed functioning of different sectors.

5.3. Shifting the focus for sustainability and better client outcomes

This report details strategies proposed and undertaken by practitioners and their service managers to embed new practices developed during the *CHRISTIE Project*. Unfortunately, the voices of the children, young people and adults who are living with or have experienced DFSV and its impacts are not heard directly as this was outside the scope of the research. Further research is recommended that specifically focuses on understanding how the Safe & Together Model can improve the assistance they are provided and promote their safety and well-being.

The Safe & Together Model clearly offers skills, tools and knowledge to practitioners in the areas of engagement, risk assessment and individual work with clients and professionals. While these skills are essential for DFSV-related work, and some practitioner-mediated feedback from victim-survivors supports the value of this work, real safety outcomes cannot be achieved where other parts of the service system are working from different frameworks, which do not place a priority on the risks of DFSV.

However, it should be emphasised that the Safe & Together Model also offers a broader systems approach, advocating that improving outcomes for child and adult victim-survivors and holding those who use violence visible and accountable, requires the coordinated efforts of professionals and organisations across the socio-legal system in a context such as NSW. While the research report has focused on the collaborative work of individual practitioners, and to some extent their managers, it is important that this focus does not obscure the role of institutional and structural factors (the authorising environment) in sanctioning or impeding these coordinated efforts (Notko et al., 2021; Powell et al., 2025).

A number of barriers to the socio-legal system pulling together, which are directly relevant to issues of sustaining the lessons of Safe & Together and collaborative work, were raised during CHRISTIE. At the frontline, these include 'core business'-focussed organisational demands, such as case closure pressures, lack of time for record-keeping / documentation, or lack of resourcing for inter-agency communication and collaboration.

The availability of a skilled and stable workforce is undermined by issues such as the tension expressed by practitioners between their wish to feel effective in the work they are doing, and their sense of what they can actually achieve in the context of the current system. In addition, the difficult emotional labour of work in the DFSV field including exposure to risk and trauma – expressed eloquently by *CHRISTIE* participants along with their moral distress – exacerbates levels of burnout and workforce turnover (Wendt et al., 2020).

At an organisational or service level, particularly in the NGO sector, limited resourcing, short-term funding cycles, and project-based innovation funding, create challenges in embedding new practice, providing the necessary leadership and supervision, and retaining a skilled workforce that sustains the practice. These pressures may also be responsible for the *CHRISTIE* team's partial success in engaging organisational senior management in understanding Safe & Together through attending training, so that they can fully support practitioners in a new service practice approach.

Beyond individual organisations, structural factors also play a role. Gaps in the service system, such as the scarcity of specialist professionals working directly with children

and young people, and a lack of services targeting people who use violence, create barriers to sustaining effective practice. This is a particular issue outside metropolitan areas.

It was noted that local coordination of DFSV responses receives little support unless individual organisations take the initiative. Peak bodies such as DVNSW and ACWA are able to assist in selected local areas, but do not have the resources to cover the whole state. At a cross-sectoral level, sustaining the coordinated and effective responses promoted by Safe & Together and the *CHRISTIE* participants is impeded by service sectors operating in siloed ways, an issue also identified in earlier research (Healey et al., 2020; Kertesz et al., 2022). For NGO professionals involved in CHRISTIE, an extra element existed, relating to a power imbalance compared with the statutory bureaucracies, such as statutory child protection (DCJ), corrective services, police and the court systems. This manifested in a number of ways: at the frontline, practitioners were reliant on colleagues being willing to collaborate and improvements based on personal relationships; at a systems level, each bureaucracy functions separately with few visible formal bridges over the divide between these sectors. Thus, the authorising environment for embedding and sustaining the Safe & Together Model and cross-agency collaboration is multilayered and complex (Kertesz et al., 2024), as illustrated in Figure 15).

Research over decades has consistently pointed to the importance of political will, or an authorising environment, to impel vertical

Figure 15. Unpacking the authorising environment - complex and multi-layered (Kertesz et al., 2024)
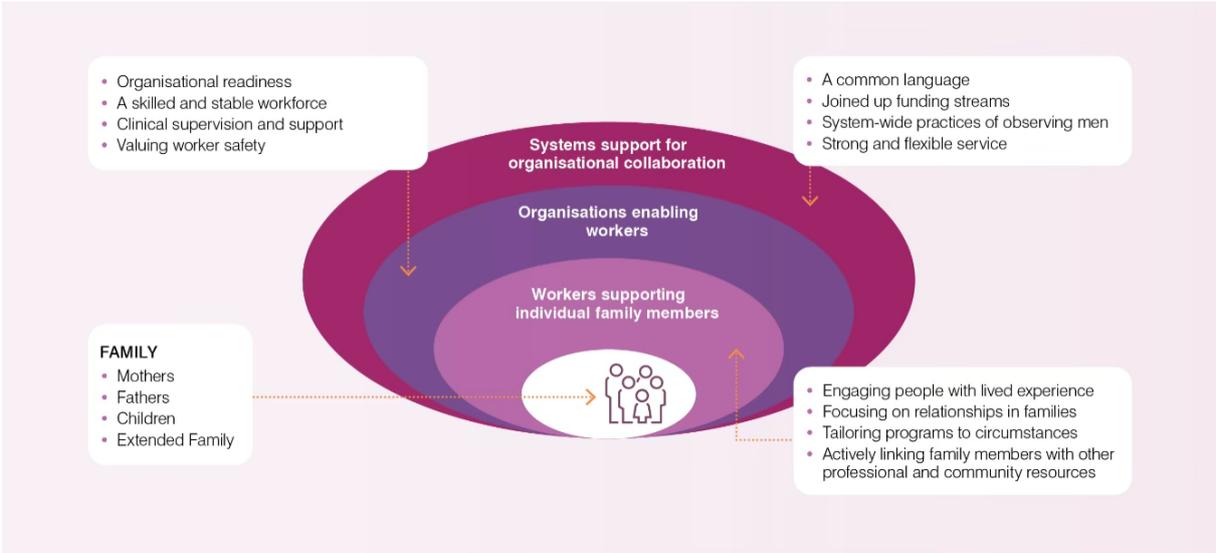
bureaucratic hierarchies to coordinate horizontally across these silos. Political directives for collaboration or coordination need to be monitored at implementation level to encourage informal coordination, or ensure that more formally established collaborative mechanisms are acted upon (Bundred, 2006; Scott and Gong, 2021). The Statewide Advisory Group established by the *CHRISTIE Project* has been considering these issues, and it is important to recognise that some advances have been made. These advances include Safe & Together training being provided to Family Court of Australia staff, and the Safety Action Meetings, which provide opportunities to coordinate the service response for high risk cases in each local area. However, a systematic focus on collaboration across sectors continues to be a gap in NSW.

While the evidence from *CHRISTIE* overwhelmingly supports the Safe & Together Model as a valuable tool for understanding what is happening in families living with DFSV, and offering a translatable set of concepts to communicate assessments, further socialisation of the Model across a connected NSW service system is necessary. This socialisation could facilitate a coordinated response and make a difference to children, young people and their families, so that they experience an effective and collaborative service system that keeps children and young people safe, and where possible, together with protective parents or carers.

6.
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