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Misunderstandings, misalignments, and motivation for changing systems: Professionals' accounts of working with families experiencing domestic and family violence in the child protection system

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Abstract

The child protection and domestic violence sectors continue to struggle to effectively respond to the complex needs of survivors of domestic violence. This article reports the findings of a study investigating the perceptions and work practices of twenty-five Australian practitioners who work with families to attend to safety concerns of children who experience domestic violence. They reported dissatisfaction with the persistence of systems which hold mothers solely accountable for their children's safety and render violent fathers invisible. Practitioners also expressed motivation to develop better system-wide and collaborative responses to families that are based upon feminist principles that promote gender equity, are person-centred, culturally respectful and violence informed. This however can only be achieved through wide-scale policy and legislative reform.

Keywords

Domestic violence, family violence, child protection, practice issues, sector reform, collaborative practice

Introduction

The last five decades have witnessed increasing calls to develop better responses to survivors of domestic and family violence who are predominantly but not only, women and children (Cox, 2016), particularly when child welfare concerns exist. This article reports the findings of a study of the perceptions and work practices of twenty-five Australian practitioners from DFV, statutory child protection or health services who work with families experiencing DFV and who are engaged with statutory child protection services (CPS). Domestic and Family Violence (DFV) is a complex social issue which can also occur within same-gender relationships and against men perpetrated by women. However, the vast majority of DFV is perpetuated by men towards women and children (World Health Organisation, 2018), and therefore, the majority of people with whom the participants in this study work with are women survivors of male perpetrated DFV (Lovell et al, 2021). Accordingly, this paper will focus on DFV which is perpetrated by men against women and children

The focus of much research with practitioners in this area has been on the contested issue of the effectiveness of services across the CPS and DFV sectors to respond to the multiple and complex needs of both women and children (Douglas & Walsh, 2010) and their ability to hold men who use violence and control to account. Attention has been directed to the misalignment of complex service systems and how they fail to adequately respond to survivors (Hester, 2011). Less attention has been paid to how practitioners experience and navigate misaligned systems in order to improve outcomes for women and children, whilst remaining motivated to work within such systems.

Furthering our understanding in this area is crucial to reform legislation, reduce siloed service provision and improve professional practice in order to develop socially just and gender equitable responses to individuals, families and communities, and to increase common understanding and collaboration across sectors. Connolly, Healey and Humphreys (2017), identify increasing inter-sectorial collaboration of understanding, practices, frameworks and tools, as a key to improving outcomes for women and children subjected to DFV. Statutory CPS, government health services and DFV services have been identified as key institutions that continue to work in colonised and siloed models, and therefore struggle to adequately

address families' multiple and complex needs (Zannettino & McLaren, 2014), and whom often are working with the same families simultaneously but from juxtaposed or contradictory frames. Calls for improvements in these areas have occurred against a backdrop of increasing evidence detailing the multiple ways that perpetrators harm women, children and young people (Bancroft & Silverman & Ritchie, 2012), including ways in which perpetrators use the legal, health and child protection services against women, the inadequacy of cross-sector communication and collaboration, and the diverse ways that survivors resist domestic violence and other forms of oppression.

Misunderstandings, Misdirections and Misalignments

It is well recognised that a multi-disciplinary, multi-service approach is required in order to respond effectively to families experiencing DFV, particularly as family members will have diverse and complex needs (ANROWS, 2019). For example, men who perpetrate DFV may also engage in mental health and/or substance use coercion (Warshaw & Tinnon, 2018); survivors may use alcohol and or other drugs to self-medicate or experience mental distress due to the perpetrator's abusive behaviour towards them. Moreover, families may be adversely affected due to other vulnerabilities directly related to men's use of violence and control – including poverty and housing instability (ANROWS, 2019). Where a collaborative understanding is not shared between services and/or practitioners this can become a barrier to the delivery of a holistic, trauma-informed response to families experiencing DFV. Practitioners from different academic backgrounds who read different professional journals and who work in different fields frequently do not hold the same understanding of DFV or use the same frames of reference to respond. For example, practitioners working in a DFV service frequently have a well-developed understanding of women's experiences of living with DFV and respond from a feminist model which promotes empowerment. Practitioners from statutory CPS guided by policy and legislation directing intervention towards a single victim/survivor will promote the child's needs as paramount and may not see the child's mother as another victim/survivor in need of support. Additionally, health workers, particularly those who are medically trained, may have a lens which at times does not recognise the violence as the underlying case for the presentation, and therefore may inadequately address the issues.

Hester (2012) argues that women survivors and practitioners often need to learn how to navigate life on disparate planets, which includes understanding how the inhabitants/practitioners on each 'planet' understand and respond to DFV.

Compounding these challenges for both victim/survivors and workforce are the harmful ideologies upon which much of the social and human service system were built upon. Whilst some improvements have been made over time, (De Simone & Heward-Belle, 2020) argue that sexist patterns remain pervasive across the social and human service system that include: 1) representing women survivors as 'bad mothers' and holding them responsible for men's domestic violence, 2) rendering men who use violence invisible, and 3) decontextualizing parental mental health issues and/or problematic substance use that occur within the context of domestic violence. Strega et al (2013) argue that such patterns are common across colonised systems. These patterned and predictable responses result in misdirection – or responses that direct the gaze on survivors whilst men who use violence fade into the background.

Misdirected and sexist institutional practices are buoyed through patriarchal, cultural norms that ascribe gendered societal roles. Legislation and institutional policies establish a robust framework that reinforces and perpetuates gendered social norms. For example, women survivors frequently become the subject of child protection interventions that pivot on whether or not mothers can protect children from men's violence. Women's responses to victimisation are centred; men's use of violence and coercive control is side-lined. Hunnicutt (2009) argues that in the case of DFV, oppressive gender-based power relations in the domestic sphere are often replicated in the public arena when families are reported to child protection services or other social service agencies. The exercise of misdirection constitutes a secondary level of risk for women survivors who are mothering in the context of DFV.

In response to the myriad challenges faced by both workers and clients (women and children) when working in the intersections of DFV and child protection the current research was initiated by practitioners working across 'the planets.' The purpose of which was to explore the nuances of multi-disciplinary practice in this complex area, and to identify the barriers to developing shared understandings and client-centred trauma-informed collaboration. Knowledge gained from research, which suggests that practitioners and service users are

variously engaged in a struggle to navigate multiple misaligned and complex systems (Hester, 2012), was considered alongside an analysis of the meaning practitioners make of their practice. Particular attention was paid to practitioners' descriptions of power relations in order to better understand how professional practice is produced and reproduced. The overall research aim was to explore professionals' perceptions of working across the complex service system in order to identify challenges and opportunities for sustainable collaboration between the multiple services intervening in the lives of individuals and families when children have been reported to the statutory CPS due to allegations that they are experiencing DFV.

Method

This qualitative study was underpinned by the principles of trauma-informed practice – safety, trust, empowerment, collaboration, mindfulness, and acknowledgement of cultural, historical and gender issues (Brown et al 2020) and informed by feminist research principles as described by Reinhartz (1992), in that the researchers aimed to establish a collaborative environment to share ideas freely. As such, a combination of one-on-one interviews and service specific focus groups were determined the most appropriate methodology. Focus groups were chosen as they are proven to be useful in obtaining detailed information about personal and group feelings, perceptions and opinions and can provide a broader range of information as participants generate new ideas and opinions based on the discussion that is taking place (Busetto, 2020). One-to-one interviews were also considered appropriate, as they offer participants an additional level of anonymity, as well as providing flexibility where time constraints restrict an individual's participation (Busetto, 2020). Interviews and focus groups were loosely guided by anchor points, which were used to guide, rather than control the direction of the discussion. Participants' observations were invited in relation to their perceptions of:

- how the system operates when children experiencing DFV are reported to CPS.
- key challenges faced by families involved in the CPS due to concerns about childhood exposure to DFV.
- the barriers and enablers of multi-disciplinary collaboration.
- how practitioners remain motivated in their work.

Recruitment

To be eligible to participate in the study, workers had to be currently employed by a child protection, DFV or health service that provided services to individuals, couples or families involved with both the CPS and DFV sectors simultaneously. It was determined by the research team that recruitment via domestic violence and child protection inter-agency meetings would provide the best opportunity for attracting a representative sample of the sector. As such, a scoping activity was undertaken to identify the relevant domestic violence and child protection inter-agency meetings. Eight multidisciplinary DFV and child protection interagency committees where identified from within a metropolitan area of Sydney, Australia. These committees comprised of a range of practitioners from multiple agencies involved in responding to families experiencing DFV including CPS, women's refuge workers, health care practitioners, legal practitioners, and family support services. The scoping activity was informed by the practice experience and localized knowledge of the research team who were senior/front-line managers in the child protection and/or domestic violence government, non-government and health sectors. Research team members visited each inter-agency meeting to introduce the project using a standardised PowerPoint presentation which outlined the aims and methodologies of the project. In order to ensure that there were no conflicts of interest, committee recruitment at DFV interagencies was undertaken by one of the three research team members working in the child protection sector and recruitment at child protection interagencies was undertaken by one of the three research team members working in the DFV sector. Potential research participants were given contact details for various recruitment sites/interviewers and asked to indicate by email, or phone their interest in participating in the research project directly to the interviewer of their choice. Several recruitment sites were utilised in order to ensure interested participants could choose a site and interviewer with whom they did not have a professional or personal relationship. Interagency members also received one follow-up email via the Interagency Chair and were asked that they pass the email onto their team members (with the permission of their manager). The recruitment email contained a copy of the presentation and a participant information sheet.

There were twenty-five people who elected to participate in the study from across the child protection, DFV (government and non-government) and health sectors (Table 1). Of those participating from health, around half worked within a DFV lens (with the mother as the client), and the remaining half work with a child protection lens (with the child as the client).

Table 1. Service of participants

Service Group		Participants n (%)
Child protection (CP)		8 (32)
CP Non-Gov	5 (20)	
CP Gov	3 (12)	
Domestic and Family Violence (DFV)		8 (32)
DFV non-gov	4 (16)	
DFV gov	4 (16)	
Health		9 (36)
Health (CP)	5 (20)	
Health (DFV)	4 (16)	
Total		**25 (100)**

Additional demographic data collected indicated that the average age of practitioners was 42.75 years with an age range of between 29 – 62 years. There were no significant differences in age when the practitioners' field of practice was taken into consideration. Twenty-four participants identified as women and one as a man. Twenty-one of twenty-five participants were born in Australia, three in European countries and one in an Asian country. Only one participant identified as Aboriginal. English was identified as the primary language spoken at home for all but two participants.

Participants consented to participating in the study, which was approved by and complied with

all requirements of the (Area Withheld) Human Research and Ethics Committee. Participants were given a choice about whether to participate in a face-to-face interview or a focus group. Face-to-face interviews were conducted with sixteen participants and three focus groups were conducted with nine participants in total. Interviews and focus groups were led by one of six interviewers who had extensive experience working in the intersections of DFV and child protection. Two of the six also had experience working within a health service context.

Data Collection

A primarily qualitative method using semi-structured, in-depth interviews was utilised. Interviews and focus groups were audio-taped with the permission of the participants and audio-files were transcribed. Interview transcripts were de-identified prior to review by the research group to ensure anonymity between participants and non-interviewing members of the research team. At the conclusion of the interview or focus group, participants were asked to complete a demographic questionnaire that contained questions about their age, gender, country of birth, Aboriginal and/or Torres Strait Islander status, language spoken at home, field of practice and participation in recent training opportunities.

Data Analysis

Data analysis was conducted by a three-member team – comprised of a doctoral level qualified social worker, a Research Assistant and senior health practitioner. Qualitative data was organised into themes, following thematic analysis techniques described by Braun & Clarke (2006). Coding was used as a way to link data to ideas and ideas back to supporting data and involved reading and re-reading each interview or focus group transcript and categorising the text into emergent categories and subcategories. Initially, each member individually read all interview and focus group transcripts and made notes about their initial impressions of themes identified in the data. After this first round of analysis, the team met together to collectively discuss and refine themes which were contained as nodes within NVivo12, a data management software. After codes were collectively developed, each member re-read each interview and focus group transcript and coded them according to the themes collectively established.

Initially four broad themes were identified which included: 1. Accounts of Professional Practice and Markers of Success 2. Barriers to collaborative practice 3. Enablers for collaboration 4. Professionals' motivations for this work. Subcategories within each code were also developed. In relation to the first broad theme, subcategories included: "safety for woman and child", and "collaborative support". In relation to the second broad theme, subcategories included: "mother-blaming policies and practices", "invisible fathers", and "double standards". Subcategories that related to the third broad theme included: "constructions of power relations" "shared understandings", and "all-of-family based approaches". In relation to the last theme, subcategories included: "desire for social justice", "redressing sexism", and "contributing to safer families and communities."

Findings

Theme One: Accounts of Professional Practice and Markers of Success

All participants described working with mothers and children experiencing DFV who were involved with statutory CPS, and most practitioners worked with families that were experiencing multiple oppressions arising in the context of DFV. The most identified were problematic substance use and mental health issues. All participants engaged enthusiastically in discussions about aspects of their practice, of which a particular focus was their perception of success.

1.1 Safety for Woman and Child

Workers from both the DFV and child protection sectors consistently defined success as obtaining safety for the woman and child, with one child protection worker remarking that "Success looks like where the child is actually in a safe environment". One aspect of increasing safety that was only discussed by participants working in DFV services was the perpetrator being removed from the woman or the family. Workers from both sectors identified the woman keeping her child as a successful outcome, however, this was discussed more commonly by DFV workers, with one DFV worker stating that: "The ultimate success is when you know, restoration orders are completed or the child is not removed." Some Child Protection workers

identified safety as a change in the perpetrator's behaviour and equated this to success. This, however, was not expressed as a marker of success by DFV workers.

1.2 Receiving Collaborative Support

Workers across sectors commonly defined success as the client having received "the support that they needed". With many describing effective support as being empowering and collaborative. This was expressed by one DFV worker as follows: "what we see as successful is the woman's got the support, woman move out, they are not in danger everyone is safe."

Similarly, a child protection worker highlighted the success produced by collaborative client focussed support, stating that:

[they had been] able to work in a multidisciplinary way with the police, with FACS, with social workers, and allied Health, as part of a multidisciplinary team, to keep the woman safe, and in her home with her children.

Theme Two: Barriers to Collaborative Practice

2.1 Mother blaming policies and practices

Notwithstanding their field of practice, most participants indicated that in cases in which there were reports of DFV, mothers were overwhelmingly the target of interventions and they were categorised within official statutory CPS documents as "people associated with causing harm" to children, rather than as people directly harmed by violent and controlling men. Interventions failed to target men's violence and coercive control as the paramount issue requiring attention and instead women's lives and particularly their mothering experiences and practices were scrutinised. This gendered pattern of working did not sit comfortably with many participants. A child protection worker from an NGO explained that despite ongoing work, there continues to be a "blind spot in the sector and society" that blames women survivors of DFV for their circumstances and holds them responsible for creating safety for herself and her children. Oftentimes, this results in workers expecting women to leave domestically violent men, without "remembering that her family is at greatest risk when they separate." Some

participants offered a socio-political analysis to explain this gendered response, citing patriarchy as the operating system that embedded sexist and misdirected institutional practices that produced unequal expectations of men as fathers and women as mothers, as the following quote from a statutory child protection illustrates:

Participant: I'm really aware there is a lot of mother blaming, I'm not just, I'm not saying only within the organisation but I'm saying in Australia, in, in the broader scheme of things, there is a lot of focus on what mothers are or are not doing to keep their children safe or to look after their kids whatever.

2.2 Invisible fathers

At the same time, many participants indicated that practice largely continues to ignore fathers who perpetrate DFV and renders them invisible. Participants employed by the state government health service discussed how their perceptions of agency policy regarding working with men who perpetrate DFV produced gendered practice. Most health participants interpreted their agency policy as precluding them from working with male perpetrators of violence entirely or working on issues associated with their abusive attitudes or behaviours. This interpretation commonly produced practices that involved creating boundaries around the work with fathers who use DFV. A health worker described how she would "never meet with a dad by himself" and if she worked with a dad it would only be in relation to issues like his mental health or drug use but never in relation to his abusive attitudes and behaviours.

Some workers identified how the system results in the fragmentation of men who use DFV as two discrete and disconnected binary categories: fathers or perpetrators. This binary denies that a man's use of violence and coercive control is central his fathering practices and establishes an unsafe and unhealthy environment for women and children to live within, as the following quote from a health practitioner illustrates:

Participant: I guess we're not getting involved in any sort of discussion with the perpetrator,

that's not our role at all, um we would just be generally looking at the whole parenting as a whole, how the parenting is going. Um, so yes, we wouldn't have any involvement directly with the perpetrator in, in, that capacity.

Interviewer: About his use of violence?

Participant: About his use of violence, absolutely, no we would only be looking at his role as a father.

This was particularly prevalent in child focussed health services where most participants reported that conversations with fathers were appropriate when the issues discussed related to "child development, looking after baby, parenting, growth and development, play, safety, nutrition." Amongst health services participants, it was universally agreed that DFV was a topic outside of the remit of the child focussed health worker. However, the idea that men's fathering can be disconnected from their use of violence and coercive control within families was problematised by specialist child protection workers who deliver an all-of-family based approach to their work.

2.3 Double standards (working with violent men considered too complex)

Some participants identified sexist institutional practices explaining that workers often justify their failure to engage men who use DFV on the basis of the complexity of this work or because workers lack confidence. A child protection worker questioned the assertion that practice with women who use force is less complex, explaining that work with men who use violence and control is "very challenging but no more than working with women." Similarly, DFV workers discussed how they frequently work with women who have used force and seemed to be engaged in a struggle to make meaning out of how this work might be similar or different to working with men who have used violence. A number of reasons were given to account for practitioners' failure to engage men who use violence which were predicated on the belief that workers could "trigger" men's "unpredictable" use of violence and make things worse for women and children.

A statutory child protection worker from a service that adopted an all-of-family based approach believed that rendering men who use violence invisible resulted in practices that were contrary to social justice principles. She commented on how her agency's practice had developed out of years of listening to women and child survivors of domestic violence who wanted perpetrators to not only be held accountable, but also to be offered support and services to change abusive behaviours. She described aspects of the agency's practice thus:

Participant: [i]f I'm asking the mother certain questions I'm asking the father the same, like I'm going to be finding out what the role is of both parents and what they are doing. Although you can ask the mums about what they are doing to keep the children safe we are saying what do you (dad) do when this happens? You know if he comes home and he's angry what, how do you keep the kids safe? I would be saying to the dad, you know these are the concerns that we are worried about this is why we are here if it's about domestic violence, you know what happens when you come home? How do you deal with your anger? What was your childhood like? How do you keep the kids safe? Like how do you know that you're feeling angry and that this is going to happen? So I think we are holding perpetrators accountable in that sense, we are asking hard questions.

However, many health workers opined that working with men who use violence was occurring without robust evidence of its effectiveness and could potentially increase the risks to women and children. A woman-focused health worker cautioned that an optimistic reliance on men's behaviour change programs to change all men was dangerous. She provided an example of a situation whereby a woman that she was working with, who had survived being strangled in pregnancy, may have been placed at increased risk due to professionals' desire to include the perpetrator in family-based interventions despite the high level of risk to the woman's and her unborn child's safety and wellbeing.

Theme Three: Enablers for collaboration

3.1 Constructions of power that facilitate collaborative all-of-family based practice

Some participants highlighted their ongoing struggle to ensure that their practice did not replicate the unequal power relations established by the perpetrator in the domestic sphere through his use of violence and coercive control. Participants from DFV services and the statutory non-government agency that provided an all-of-family based approach described how they were conscious of the power they held as a result of their professional status and how they tried to share this power in a constructive way with survivors. A social worker working with statutory CPS described some of the complexities around this approach, describing how it is not always possible to directly intervene with fathers who use violence because they may not live in the home and won't accept calls. In these circumstances, the participant stated it is easy for men to "disappear from us and be much more evasive" leaving the mother to remain involved with the service. The focus of the work then becomes enhancing the mother's knowledge and resilience to ensure that his violence and control remains central to the intervention. She cautioned against using professional power to tell mothers what they should do, stating that many practitioners commonly direct mothers to leave abusive partners. Further, she explained that this was a complex decision that only women could make and that her agency's role was to educate and build resilience to help women make the best decision possible for their families.

Domestic violence participants described how they approach their work from a relational, woman-centred, trauma informed perspective that aims to share power with clients. As a participant described "we focus on working with families, not flinging things onto them, we try to be really understanding and patient, our philosophy is that we just plant seeds" (NGO child protection worker). She described how they are conscious of the fact that leaving may not always be the only or best option for survivors. She further described how multi-agency working provides the opportunity to use the statutory power of the child protection agency constructively, particularly in dealings with men who use DFV. In some circumstances, she felt that using the coercive power of the state was productive because it created the opportunity to hold fathers who use violence and control accountable for the harm they cause to family members. Whilst there was agreement amongst participants about using the power of state to

hold men who use violence accountable for their actions, the use of power over women survivors was contested. Many practitioners from the domestic violence and health services commented that they believed that statutory CPS routinely misused their powers to coerce women survivors and frequently misunderstood the context within which survivors were mothering.

Theme Four: Professional Motivations (and working towards systemic change)

Many participants described being motivated to improve practice based upon their desire to bring about social justice, to redress sexism and to contribute to creating safer families and safer communities. Their motivation to continue their work with families pivoted on contributing to systemic changes that would result in reorienting the system towards holding men who use violence – rather than survivors – accountable for abusive behaviour and its impact on family members.

Participants identified that they remained motivated in their work to bring about specific changes within their workplaces and across the service system that could support an all-of-family based approach to practice in this area. For example: clear policies and governance protocols supporting work with fathers who use violence and coercive control; capacity building and training opportunities; joined multi-agency responses and; increased funding and additional services to support survivors. These were the most frequently cited components that may improve the response to families. Many domestic violence participants and women-focussed health workers indicated that they were motivated by the fact that many of their services were considering working collaboratively with men's behaviour change program providers, to bring their expertise with survivors to enhance men's programs. However, they indicated that funding agreements and strategic plans would need to be altered "in order to enable this reorientation in practice because currently, their remit was narrowly defined as providing services to women who have experienced DFV.

Discussion

The findings of this study highlight the ongoing challenges experienced by practitioners

working in the intersection of DFV and child protection. In particular, the findings point to numerous problematic policies and practices in the Australian context that validate Hester's observation (2012) of the systemic misalignment of the legal, social and human service system.

This study has found evidence of problematic policies and professional practices within DFV, CPS and health services – three central and overlapping elements of the Australian service system's response to protecting women and their children.

In the health context, the bifurcation of men who use violence and coercive control into separate and distinct categories of fathers and perpetrators is common and problematic (Heward-Belle, 2016). It denies the evidence that highlights that men who use DFV engage in a common pattern of abusive behaviour that is directed towards, and adversely impacts, both women and children (Radford & Hester, 2006). Public policy that promotes this bifurcation leads to myopic practices in which the 'elephant in the room' is not addressed and the most significant issue impacting women's and children's health and wellbeing is rendered invisible. It is hard to imagine this approach being applied to other high risk environmental factors. For example, if a parent was smoking around the child/ren, including in the car and their bedrooms, a health worker would not hesitate to address this as a harmful behaviour, and to point out the potentially lethal impacts of smoking on the parent and the rest of the family. In doing so they would offer assistance and resources towards behaviour change related to quitting or harm reduction. Fathers who use domestic violence and coercive control establish a potentially lethal and dangerous living environment for all family members wherein their abusive attitudes and behaviours are central features of their parenting practices (Bancroft & Silverman, 2012). Promoting healthy childhood development and maternal health necessitates that practitioners and policy makers deconstruct the arbitrary fragmentation of abusive men into distinct binary categories of fathers and perpetrators. This fragmentation embeds the dangerous notion that domestically violent men can be simultaneously good dads but poor partners.

In the statutory child protection context, the policy and ensuing practice of framing women survivors as "people associated with causing harm" – a common construction within many risk assessment frameworks – is problematic. It is an extension of framing DFV as a 'relationship problem' – a persistent and problematic by-product of traditional systems theory thinking that positions all family members as having equal power and equal responsibility for 'family

troubles.' Such a framing perpetuates misdirected practices that blame women survivors and exonerate men who use violence from becoming accountable for their abusive behaviours. This framing stands in opposition to feminist understandings of DFV predicated on research with perpetrators that illuminates how many domestically violent men singularly decide to use a pattern of violence and coercive control against women and children (Heward-Belle, 2016).

Gendered practices that frame women survivors as "people associated with causing harm" and disconnect men's use of violence and coercive control from their parenting practices (captured in the phrase, "we don't work with perpetrators"), creates a secondary level of risk for women and children. Moreover, technocratic, procedurally driven risk assessment processes that are not based upon feminist understandings of the experiences of women survivors of DFV produce practices that create a secondary level of risk for women and children (Gillingham, 2006). Such practices misdirect attention from fathers who use violence and control, instead focusing the gaze on women. This results in practices that frequently problematise their mothering rather than men's violence and coercive control (Laing et al, 2018). Such practices compound the risks faced by women survivors who turn to the legal and social service system for safety and justice.

Some participants described a different approach to statutory child protection work that was based upon a feminist, trauma-informed, all-of-family based approach. Descriptions of this approach exemplified gender equitable practices that placed responsibility for DFV firmly with those choosing to use violence and coercive control. This approach positions men's use of DFV as the central issue requiring intervention and men who use DFV are seen as being capable of change. Participants working from this approach spoke of directly engaging domestically violent men in conversations about their fathering practices, contribution to family functioning, and their use of violence and coercive control. These participants routinely included fathers in discussions to inform their risk and safety assessments, which were informed by a comprehensive understanding of the perpetrator's pattern of domestic violence. They described working with fathers to develop accountability plans that clearly articulated the concerns held by child protection workers and specified measurable goals to address their use of violence and coercive control. Many described using principles of motivational interviewing to engage men in conversations that could lead to behavioural change. Issues

affecting women's wellbeing and mothering which may include problematic substance use or experiencing mental distress are seen in the context of experiencing DFV. The safety of women and children is paramount and therapeutic work aims to contextualise any challenges in mother-child relationship as being symptomatic of DFV – rather than as a result of poor mothering.

These findings are similar to others (Heward-Belle, Lovell, Jones, Tucker & Melander, 2021) that testify to the hope and resilience of both the workforce and women survivors. Despite the many challenges practitioners continue to work in this complex space working alongside women towards increasing their safety and that of their children. Unfortunately, the small indicators of success that practitioners in this study use to stay hopeful (working collaboratively, being trauma-informed) do not fundamentally change the fragmented and siloed service system, nor the broader social conditions that embed violence against women.

Study Limitations

There are several limitations to this study. Firstly, there is potential for selection bias, as participants self-selected, and therefore it is possible those with strong views towards or against increasing cross-sector collaboration were more likely to opt-in. In addition, the relatively small sample size limits the generalisability of the findings more broadly. However, the even division of workers from across service types helps to mitigate this. And finally, there exists potential for interviewer bias, as interviews and focus groups were conducted by practitioners working in the field. However, this was mitigated by the use of experienced interviewers who according to best-practice, remained natural during interviews and focus group discussions, encouraged a free-flow of information and sought clarification where appropriate (Busetto, 2020). Additionally, the project engaged independent transcription services, engaged an academic lead and research assistant in the data analysis process and publication writing.

Conclusion

In 2013, when investigating what needed to change in order to address sexual abuse,

harassment and sexism in the armed forces, the former Chief of Defence David Morrison said: "The standard you walk past is the standard you accept." Notwithstanding the misaligned service system that does not meet the needs of survivors nor people who use violence, many practitioners voiced their rejection of the status quo. Many expressed the motivation to develop responses to families that are based upon feminist principles that promote gender equity, are person-centred, culturally respectful and violence informed. However, practitioners were clear that improvements in the way that they engage families experiencing DFV can only go so far. Wide scale cultural change that addresses the drivers of DFV is needed in order to create a society that values men, women and children equally and promotes respect. Policies that promote gender equity across all sectors of government and non-government services are needed to ensure that women and children who seek safety and justice are not held responsible for violence perpetrated against them and that those who choose to use violence and coercive control are held accountable and invited to become non-violent parents and partners.

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