

Domestic and family violence and co-occurring mental health issues and addictions: common stories in a reinforcing social system.

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Abstract

Reinforcing social systems and intergenerational violence act as formidable barriers to mothers' recovery-seeking efforts. A major concern for mothers is that their mental health diagnoses often serve as a vehicle to further disempower them. This is evident in our courtrooms, Department of Communities, Child Safety and Disabilities investigations, and mothers' disadvantaged economic status. As a consequence mothers' efforts to remain caregivers to their children while they strive to recover from trauma-based mental health and substance use problems resulting from domestic violence are severely compromised. It isn't the mothers' inability (such as with the 'perceived villain' notion) that should be in question, but their resilience and efforts to overcome the consequences of victimisation.

This poster will present qualitative data collated over 18 years in a dual-diagnosis 24/7 recovery centre which supported many hundreds of mothers who have strived to break free from the cycles associated with domestic and family violence. Using a pseudonym, Jess' story is told to represent the collective and persistently reported experience of women in similar situations up until 2014. A research project undertaken in 2009 in the residential centre mentioned has informed a proposed model for a service that is tailored specifically to meet the needs of mothers with co-occurring domestic violence, mental health and addiction challenges, their children and their families.

Though there are some dual parent/child therapeutic communities in existence in Australia, our government's policy focus arguably remains on short-term service responses. What is necessary is for social services to recognise the complex, multilayered impact of mental health issues and addiction on these women and their children. The goal is to challenge society and our policy makers to 'dig deeper' for effective responses across Australia, particularly in remote and Indigenous regions. It is through exploring the experiences and needs of women and their families, their struggle for wellness, and the aversive nature of our institutional frameworks, that a case is made for a more intensive trauma-informed, family-based, (parallel mother/child/ren) residential therapeutic community treatment model.

Keywords: *Domestic and family violence, mental health, addiction and substance use, parent/child residential treatment*

Introduction

‘The inter-relationships of trauma/violence, mental illness and substance use in women have been described by researchers as “profound” and “staggering”. As many as 2/3 of women with substance use problems report a concurrent mental health problem (e.g. PTSD, anxiety, depression) and they also commonly report surviving physical and sexual abuse either as children or adults. A Washington DC study showed that over 70% of women with mental disorders have co-occurring substance use problems and virtually all women with co-occurring disorders have a history of trauma’ (BCCEWH & CCSA, 2009)

An issues paper by Angela Taft (2003) summarises the global research that provides evidence for the inter-relationship between domestic violence, mental health issues (such as post-traumatic stress disorder) and substance use challenges. This story is not new. As the research shows, women exposed to intimate partner violence are highly likely to develop a mental illness (Australian Institute of Family Studies, 2010). It is notable that Taft (2003) offers a historical perspective on the contribution of gendering bias in society, particularly related to women and mental illness which has historically been attributed to the women’s personal psychopathology. This has allowed the socialisation of a blame culture toward women, particularly mothers and is reflected in social systems such as the Family Court of Australia’s decision making in regard to child custody arrangements (Dallam, 2005; Taft, 2003). There are powerful forces at work maintaining the victimisation of women and this is well documented (Taft, 2003).

Enriched environment

In the context of supporting mothers in a mental health dual-diagnosis residential centre for 18 years a body of qualitative evidence gives flesh to the quantitative research mentioned (Morris, 2014). The residential recovery centre referred to in this paper was able to provide an enriched environment that focused on the daily provision of a therapeutic milieu, modelling, skills and strategies, psychoeducation, case planning and goal-directed health achievement across all domains of biopsychical needs over mid- to long-term periods (up to two years). The model was family centred so that staff or volunteers participated in communal lunch and evening meals and other family-based activities. The centre additionally provided for cultural and recreational activities with the goal of providing a corrective emotional experience (Hartman & Zimberoff, 2004). Research evidence to support the brain’s capacity to recreate neural pathways and to respond to validating stimuli provides a

valid explanation for the centre's consistently positive outcomes (Garland & Howard, 2009). This paper argues for further residential recovery centres to be established in Australia for mothers with their children who are victims of domestic and family violence with co-occurring mental health and addiction challenges.

Method

Through a variety of methods such as peer groups, individual surveys, observation during recovery processes, court support appearances, case notes, family feedback and forums, a common story emerged. Jess' (a pseudonym) story briefly describes key experiences for women who entered this residential recovery context predominately to get well enough to maintain a strong parental relationship with their children.

Case scenario

Jess is a thirty-year-old woman who has a history of family of origin domestic violence, paternal separation and ongoing relationship conflict with Mum, Dad and her previous partners. She left home/was 'kicked out' in adolescence and by then had had multiple sexual partners. She moved in with one male partner who she felt would stay with her. The physical and sexual violence began immediately. There was much intimidation and pressure for Jess to cover up her partner's criminal activities. In one incident he threatened her with violence if she did not agree to be the lookout person for a robbery. Jess went to accident and emergency several times for injuries sustained at the hands of her partner. However, because she covered these incidents up out of fear and intimidation, they could not be cited to support her claims of abuse at the hands of her partner.

Jess had two children to her partner, the second after he had served jail time for armed robbery. During the period that her partner was in jail Jess stayed with his brother who also sexually and physically abused her. She left her partner's brother and found cheap accommodation supported by working long hours in low paid domestic work while her first child was in day care or with friends. After her partner, who had finished his time in jail, moved back in with Jess the cycle of criminality and abuse began again until Jess left her partner.

Along with as yet unrecognised symptoms of trauma, Jess used cannabis and drank alcohol and this increased heavily as she struggled to cope with supporting herself and the two children.

On separation the children had intermittent contact with their father who was regularly using drugs and continued to be verbally abusive toward Jess, often in front of or by directly involving the children. Jess's drinking worsened until she was hospitalised after a suicide attempt. The Department of Child Services (DOCS) stepped in (after being referred by the hospital) and they issued an interim order for the children's father to have short-term custody. At this point her ex-partner was with another lady who also had two children of her own.

After Jess was released from hospital she was reunited with her children and took up short-term accommodation with her father. Jess reported during her stay in the residential recovery centre that her father would often denigrate Jess's self-image and was sexually suggestive toward her but Jess said that she had no other options if she wanted to keep the children. Jess continued drinking and according to witness accounts (friends of her ex-partner), Jess was seen smacking the children, experiencing extreme anger often directed toward the children and drink driving with them in the car (these allegations were used in evidence statements during the father's custody application to the courts).

After a second hospitalisation, the loss of her job and imminent homelessness, Jess became desperate. Without the support of her estranged family Jess asked her ex-partner to look after the two children for a while so that she could get help.

Jess came into contact with the residential recovery centre mentioned above as she was desperate to recover and take care of her children. Additionally Jess had been unable to source any other dual-diagnosis facilities in Queensland, Australia. However, her biological family again became involved because she was seeking help. At the time of her entry into the program Jess was homeless, was on Newstart Allowance and was later diagnosed with post-traumatic stress disorder (PTSD) and personality disorder. After several months in recovery Jess's ex-partner instigated custody proceedings for the children.

Jess struggled to get legal and family support and her attempts at recovery were consistently disrupted by the continuing bitter dispute between her and her ex-partner. Jess described the children as being coerced during this period and they eventually told the psychological assessor that they did not want to see their Mum. Jess was discredited during the court proceedings as a person who was mentally ill with alcohol issues who required treatment before she could have unsupervised access to her children. The Court ordered that Jess have fortnightly supervised and monitored visits with her children for two hours.

Her ex-partner, who allegedly regularly smoked cannabis, had a criminal history and one of battering (in particular his young daughter reported incidents of emotional abuse to her paternal grandparents) gained full custody.

Jess relapsed severely after the court decision, was hospitalised after taking a prescribed medication overdose and discharged herself from the residential recovery program. Jess remained adamant that her ex-partner was ‘only interested in the money that he would get from having the two children and that his new partner would be the one looking after them’ (Morris, 2014)

A common story

This is clearly a complex situation that is not easily resolved. It involves intergenerational domestic and family violence reinforced by the court process, and highlights gendered bias in regards to Jess’s mental illness (Chesler, 2013).

Mothers with similar stories have disrupted attachment experiences, low or no self-esteem, are often self-injurious or suicidal and have limited or no social and economic resources (Worley, Connors, Crone, Williams, & Bokony, 2005). Children born into this environment are inevitably drawn into the cycles that exist on multiple levels in the social and family systems (Diagram 1). We now know with the help of neuroscience that a child’s brain is impacted by early traumatic experiences and without a corrective environment that child has an increased risk of mental health and addiction problems (Hartman & Zimberoff, 2004; Howe, 2005).

Intervention in this cycle must be multilayered, robust and extend over a reasonable period of time to offer women an avenue of power to change their circumstances. Or to put it another way, to change their victimisation – they are often portrayed as the villain in need of punishment. (Chesler, 2013; Dallam, 2005). It should be said that ultimately these women and children are resilient and strong – they only require the opportunity to improve their circumstances. All our systems of response have the power to provide just such an opportunity.

‘She (Kurth, 2010, p. 1) explains the tactics used, often successfully, by a male supremacist to gain custody of children for the precise purpose of punishing the mother for leaving him or to force her to return. Inadequately trained professionals often fail to recognise these tactics for what they are, assuming,

instead, that the father's quest for custody is motivated by love for his children, whom he claims he must rescue from their "crazy" (or "drug-addicted," "promiscuous," "narcissistic," etc.) mother. For example, in the Shockome child custody case of Dutchess County, New York, the abuser actually provided evidence of his own ulterior motive: in a statement he wrote to his wife, he said that he had brought her to this country (she was a Russian citizen at the time) and that, therefore, she had no right to leave him. He further warned that she would "never get away from him." The family court judge nonetheless ignored this evidence and ruled against the mother who, at this writing, has not seen her children for five years.'

The cycle

A societal question lingers in response to Jess' experience and can be simplified in summary. The question is confronting if put in these terms. Are these mothers' victims or villains? It is asked as the notion of their apparent villainy is a key contributor to the system's perpetuation of generational violence (Meier, 2003). It is confronting that a large percentage of mothers entering the residential program were additionally portrayed in the court room as unable to care for their children and to blame for the consequent family breakdown (Chesler, 2013). The intimate partner, quite often male, had been abusive (emotionally, physical, sexually and at times spiritually) to the mother, and commonly toward the children and the pets (Dallam, 2005). Arguably this is a systematic reframing of the mother's powerlessness (which as seen in Diagram 1 is at the core of the violence cycle) into a notion of their 'villainy'. This reframing then abandons the mother and their children to further violence and ill health. Other key themes that consistently emerged are listed below.

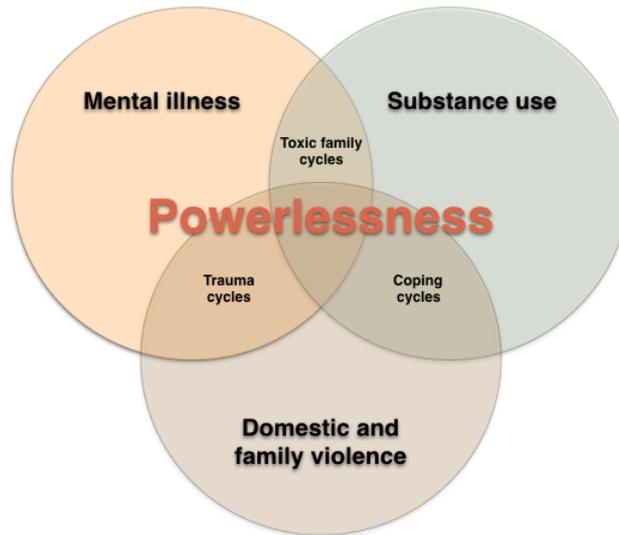


Diagram 1. The co-occurring cycles existing with domestic and family violence

Powerlessness within institutional frameworks

1. The mother has commonly been the primary care taker and provider for the children and the family unit, yet this is not recognised, let alone mentioned in family court settings,
2. The mother has attempted to be protective toward the children and they are often still a priority, yet this is not mentioned in family court proceedings nor taken into account,
3. The mother is trapped for a range of reasons that include having commonly been shaped by domestic and family violence experiences, often at the hands of her father, and this may be used against her in family court settings.
4. Social systems identify more readily the failure of the mother as opposed to the father's responsibilities within the system (Meier, 2003). The mother becomes the focus of legal assessments and actions while the father remains a bystander and commonly the 'good guy' (Dallam, 2005).
5. Perceptions of diagnoses such as personality disorder, PTSD, depression and the like if attributed to these women become powerful weapons and a means for the powerful to further, punish, control or demonise these women.
6. Addiction involving women commonly attracts more negative judgement from the criminal system than men accused of battering.

Powerlessness within intimate family systems

Notwithstanding the greater awareness of gender bias that exists in society and a deepening understanding of a trauma-informed framework it remains a challenge to engage the intimate space of the family nucleus. Quite often, mothers with co-occurring mental illness and substance abuse problems are trapped in a situation where they are perceived to be the problem based on the very real vulnerability of the needs neglect that they experience themselves (Howe, 2005). The ability to step out of their situation requires that another option exists for them to step into. Herein lies the complexity of response, given what we know of repair and recovery needs for the mother and also for the children, along with those of the extended paternal family members (Brunette, & Dean, 2002; Worley et al, 2005). However, defining the recovery needs of mothers and their children is a first step toward providing a framework for an effective response.

Recovery needs of mothers who have experienced generational violence with co-occurring mental ill health and substance use challenges.

1. A nurturing, validating or good enough environment.
2. Role modelling, shaping and models for self-valuing and identify formation.
3. Addressing unmet needs as a developmental necessity, learning functional coping strategies, managing symptoms toward recovery.
4. The opportunity to graduate the expression of new emotional, social and coping capacities in a stable economic, safe and supportive environment.

Recovery needs of children who have been witnesses and victims of domestic and family violence and who experience a life of chronic threat.

1. A safe and nurturing environment.
2. Role modelling, shaping and models that allow for healthy psychosocial development.
3. Needs met consistently and age appropriately, the capacity to manage life without chronic threat.
4. The opportunity to reconnect in a predictable, reliable and connected manner with caregivers.

Toxic family modelling cycles

Critically children's experience of systemic family violence creates an abandonment experience that is not easily resolved (Howe, 2005). Families provide the foundation for child development for each stage of their psychosocial need (Howe, 2005). However, in violent or dysfunctional contexts it is the profound disruption to their emotional needs that becomes the precursor of their own mental ill health and substance use problems later in life (Worley et al, 2005). Children are reliant on adults to ensure their safety and chronic threat has dire consequences for their brain development (Howe, 2005).

Themes that have emerged from the residential recovery setting have been that the violent partner sets the tone for socialisation of boys and girls. There is radical reinforcing of social norms where gendered bias is used as a model of blame directed toward mothers or their daughters (Meier, 2003). A concerning number of stories involve the male partner using this socialisation as method for coercion so that the children become unwilling partners with him in isolating and demonising the mother (Dallam, 2005). Feedback consistently given to residential centre staff by mothers was that they understood that their children needed to partner with their father against their mother, in order to survive.

One specific challenge is that the mother is also often needs neglected, having been raised in similar conditions of domestic violence experiences (Worley et al, 2005). In the residential centre described one of the significant goals was to support the mother in the recovery of her capacity to meet her own emotional needs in nondestructive ways (Howe, 2005).

Another issue that emerged was that while this process occurs, the mother does have a reduced capacity to meet the needs of her children (Brunette, & Dean, 2002). This core issue opens a vulnerability where other stakeholders such as the abusive partner can step in and further expose or manipulate this momentary vulnerability (Chesler, 2013). Yet all mothers had a goal of achieving wellness and finding ways to repair and better their parenting with their children.

Common requests from mothers in the residential recovery centre

1. Mothers asked for opportunities to learn parenting skills, often recognising their lack of functional parenting role models. Some mothers were highly motivated to attend positive parenting groups, however due to the requirement in these groups that parents had to be caring for their children at the time, this option was limited.
2. Mothers reflected during psychoeducational groups which discussed attachment, emotional development and issues such as validating environments that they had harmed their children. There was little or no opportunity to put into place their new skills to empower and also to ease this burden of guilt,
3. Mothers had high expectations from all other stakeholders within their world, from family to social services, to be well for their children. This constant pressure added additional stress in all of the cases and at times DOCS pushed for early reunification and did not recognise the recovery needs of the mother.
4. On occasions where mothers had restricted access to their children they became highly distressed and their focus was on their grief at the loss of their child or children, rather than on their recovery.

Coping cycles

The capacity to cope with violence, terror and chronic threat while meeting fully the demands of raising children and quite often providing for the family is humanly impossible without something breaking (Diagram 1; World Health Organization, 2002). This context understandably leads to a person accessing coping strategies limited to those known. Quite often the models for coping come from dysfunctional families of origin and are provided for by the partner or associates, such as access to drugs or methods that are easily accessible such as alcohol. The use of substances is one of a number of means for a woman to attempt to cope so that she can meet her desire – to keep her family together. These and other methods of coping such as eating disorders, self-injury or other addictions can take hold and become a cycle with its own life. This is due to the biology of addictive cycles (Worley et al., 2005).

Given the challenges of overcoming serious addiction, in particular the expectation of a transition from faulty coping patterns to healthy coping, strategies must be realistic. Time is required for this transition to emerge and consolidate (Worley et al., 2005). In the dual-diagnosis residential recovery context ordinary stressors that arise with children present give

real-time opportunities for mothers to use new-found coping capacities to meet their children's needs with the support of staff and volunteers.

Common addiction problems of mothers in the recovery centre

1. A high percentage of mothers used a substance of some kind. A small percentage used gambling to cope.
2. Self-injury rates were high and most women had attempted suicide at some time.
3. Emotional regulation is a serious challenge for women diagnosed with personality disorder and PTSD, therefore, symptom management is necessarily a first priority with learning and practicing newly-learnt coping strategies a second priority.

Trauma cycles and transitional concerns

Professionals in human service sectors now know significantly more about PTSD, personality disorder and other mental health conditions and that assists in supporting trauma-informed practice frameworks. Research has helpfully provided evidence of the efficacy of a number of robust treatments for these conditions such as dialectical behavior therapy, cognitive behavioral therapy and acceptance and commitment theory (Australian Psychological Society Ltd, 2010). Biochemical intervention additionally assists with supporting mothers (and presently, an increasing number of children) to manage the symptoms (Worley et al, 2005).

However, effective prevention requires more than ad hoc interventions no matter how valid. For young children there must be a window of opportunity to provide an environmental condition conducive to healthy development (O'Connell, 2015). Research demonstrates that the condition required for children to achieve health and wellbeing relies specifically on caregivers who can provide a healthy environment for the child's developmental needs to be met (World Health Organization, 2004).

For the effectiveness of any intervention the significant adults in the children's life also require the capacity to provide for and maintain such an environment. Undertaking an intervention and then expecting the child to negotiate environments of chronic threat cannot reliably reverse the impact of abuse and neglect (Cunningham & Baker, 2007). The provision of stable environmental contexts for women and their children during and after recovery is a strong factor in breaking the cycles associated with domestic and family violence as summarised in Diagram 1.

Issues that were commonly reported by mothers in the residential centre regarding their future capacity to care for children in stable environments after their recovery

1. Most mothers had comorbid diagnoses such as borderline personality disorder PTSD, generalised anxiety depression and substance use problems. A smaller percentage of mothers were diagnosed with schizoaffective disorder, bipolar or schizophrenia. These issues required ongoing support both economically and psychosocially (transitional concerns).
2. Most mothers had experienced domestic and family violence in their family of origin and were engaged with family members where these issues had not yet been resolved.
3. Many mothers were dependent on family or on Newstart Allowance on entry to the residential recovery centre but were unable to work. They were economically disadvantaged.
4. Many mothers after strong advocating were provided a disability support pension. However, limitations after recovery such as low income, homelessness and a lack of employment were serious gaps in the capacity of mothers to reestablish themselves and their children in the community.

This knowledge informs the idea that a process of community reintegration after time in recovery is as important as the recovery itself.

The challenges

Mothers entering the centre were focused on getting well for their children in most cases. However difficulties related to childcare arrangements were disruptive to the mother's efforts at working through the recovery process. This was predominantly related to disruptive actions from their ex-partner, estranged family members or even the court processes where additional or unrealistic demands were placed on the mother (Chesler, 2013). There were high rates of recovery for other adults in the centre across a broad range of psychiatric conditions, addictions and relationship breakdown when people stayed between 12 months and two years. In comparison, though mothers made some significant gains in some areas, threats of losing their children, reunification pressures from Child Services or just the experience of absence from their children led to women leaving the recovery centre prior to the program completion.

The missing piece for mothers was their capacity to work together with their children and with other family members as they progressed through the treatment phases. The ability to include children in the process not only supports the mothers' recovery efforts but it is preventative for the children. The ability to provide in situ intervention that helps to shape and model positive parenting attributes with the mother is invaluable (Worley et al, 2005). Diagram 2 gives a brief summary of a proposed model that meets the key needs identified through the experience of supporting mothers' recovery efforts in the dual-diagnosis residential recovery centre.

Socio-political barriers to mothers accessing recovery with their children in dual-diagnosis residential treatment centres.

Though this paper does not specifically focus on the political aspects of developing the model it does advocate for policy makers to dig deeper into our economic pockets. An argument for this is that healthy family systems invariably create healthy societies. The residential recovery model is one legitimate way that a service can enter the sacred nucleus of the family space to empower the mother in her efforts to live a violence-free and quality life (World Health Organization, 2002).

A value-for-money measure for instance inevitably looks to short-term solutions that support the policy agendas of the day without producing sustainability measures for women and their children's overall health and wellbeing (Winter, 2014). It is questionable how one measures 'value for money' – now common language in the tendering process for the distribution of government funding. This is particularly incompatible language for a society that acknowledges the importance of and rights of women and children. (Worley et al, 2005).

The second access barrier is that there are few models of this type and a small amount of research for its efficacy (World Health Organization, 2002). One such model exists in America known as the 'village' with outcomes reporting a significant number of successfully restored families (Jackson, 2004). Additional evidence to support such a model can be found in assertive community treatment research, information from the private sector and models that focus on substance-use rehabilitation using the same or similar philosophies (Phillips, et al 2001; NSW Health, 2007; Odyssey House Victoria, 2015). However, one highly recommended method to measure outcomes could be through the establishment of dual-diagnosis residential parent child recovery centres in conjunction with academic research

networks. This process can firmly link the service with outcomes that are realistic if long-term sustainability of health for the family is the objective.

Conclusion

This paper proposes that the needs of mothers and their children can be met through establishing parent/child residential recovery centres for dual-diagnosed women and their children who have experienced chronic domestic and family violence (Worley et al 2005). However, the development of such would require governments to dig deep in terms of economic and structural support. This paper does not argue for residential recovery centres to be stand-alone propositions as existing service responses are valid and equally important. Rather it is argued that the proposed options of a mother/child, dual-diagnosis residential recovery centre that offers mid- to long-term treatment provides additional opportunities for desperate mothers who, rather than not being able to overcome these challenges as mentioned, simply require the best opportunity to do so. This proposal particularly extends its concern to mothers and children in remote and rural regions. As such, proposed sites should be strategically placed so that access is available to all mothers and their children in need across Australia.

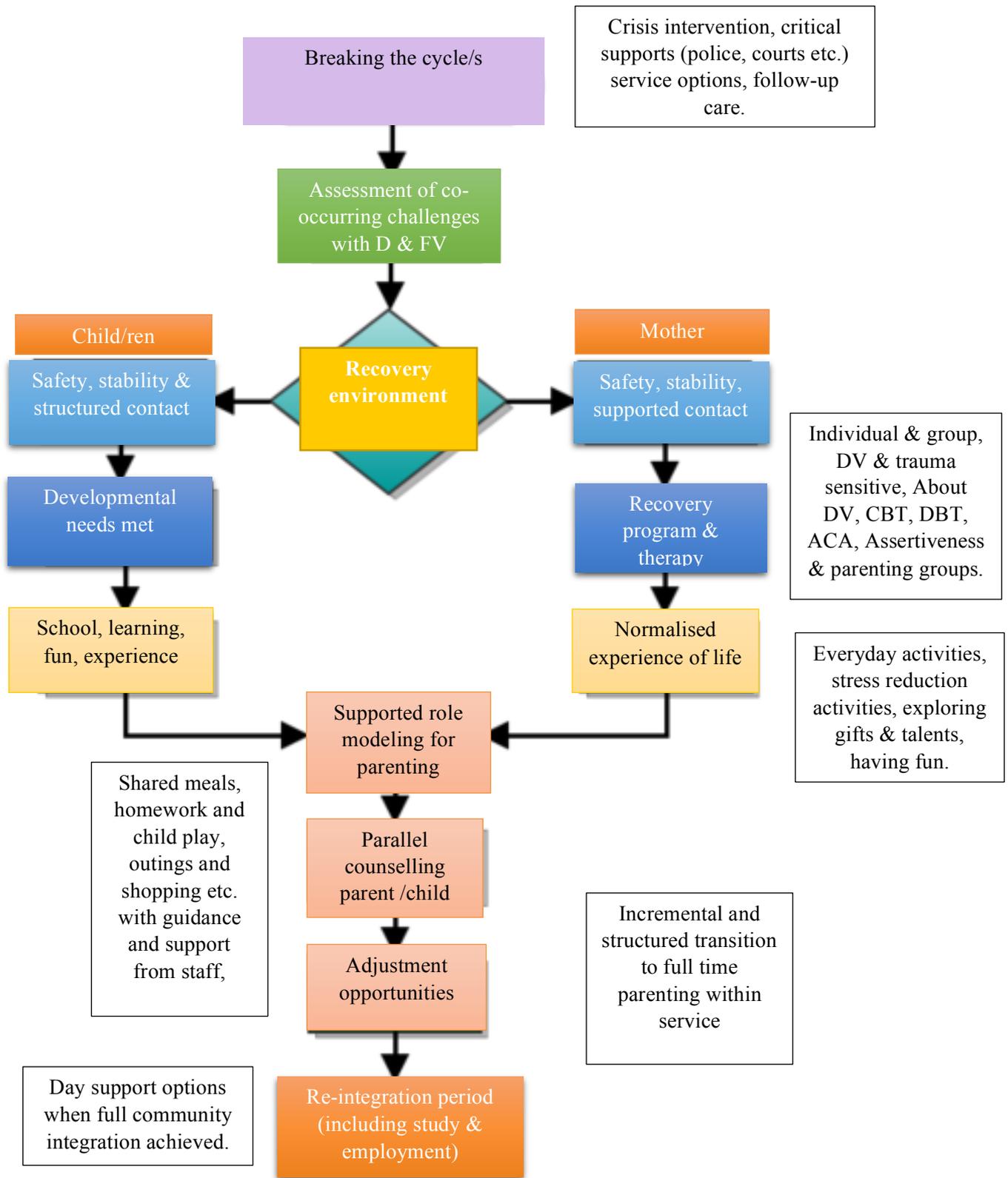


Diagram 2. A model for a co-occurring domestic and family violence, mental health and addiction, parent/child residential recovery centre.

References

- Australian Institute of Family Studies. (2010). *Issues for the safety and wellbeing of children in families with multiple and complex problems*. Canberra: Australian Government. Retrieved 2015, from <https://aifs.gov.au/>
- Australian Psychological Society. (2010). *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review*. Flinders Lane, Victoria, Australia. Retrieved 2015, from www.psychology.org.au
- BCCEWH & CCSA. (2009). 'Trauma-informed approaches in Addiction treatment'. *Gendering the National framework*. Canada: Canadian Centre on Substance Abuse British Columbia and Canadian Centre on Substance Abuse. Retrieved 2015, from www.coalecing-vc.org
- British Columbia Centre of Excellence for Women's Health (2009). *Gendering the National Framework*. Canada: British Columbia Centre of Excellence for Women's Health. Retrieved 2015, from www.coalecing-vc.org
- Brunette, M & Dean W. (2002). 'Community mental health care for women with severe mental illness who are parents'. *Community Mental Health Journal*, 38(2). Retrieved 2015.
- Chesler, P. (2013, December 23). 'Can 'Good Enough' Mothers Lose Custody of their Children to Violent and Abusive Men?' *Argument & Critique*, pp. 1–5. Retrieved 2015, from www.phyllis-chesler.com/1219/can-good-enough-mothers-lose-custody-of-their
- Cunningham, A & Baker, L. (2007). *Little eyes, little ears: How violence against a mother shapes children as they grow*. Ontario: Centre for Children & Families in the Justice System (London Family Court Clinic, Inc). Retrieved 2015, from www.lfcc.on.ca/little_eyes_little_ears.html
- Dallam, S. (2005). *Are 'Good Enough' Parents Losing Custody to Abusive Ex-Partners?* Baltimore, USA: The Leadership Council. Retrieved 2015, from www.leadershipcouncil.org/1/pas/dv.html#l1
- Garland, E & Howard M. (2009). 'Neuroplasticity, psychosocial genomics, and the biopsychosocial paradigm in the 21st century'. *Health & Social Work*, 34(2), 191–199.
- NSW Department of Health. (2007). *Drug and alcohol treatment guidelines*. Sydney: NSW Department of Health. Retrieved 2015, from www.health.nsw.gov.au
- Kurth, J. (2010). *Domestic violence, abuse and child custody: legal strategies and political issues*. In T. Hannah & B. Goldstein, (eds.), ch. 4, pp., 1–28). USA, Civic research Institute Inc.
- Hartman, D. & Zimberoff, D. (2004). 'Corrective Emotional Experience in the Therapeutic Process'. *Journal of Heart-Centered Therapies*, 7(2), 3–84. Retrieved from citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.467.8398...
- Howe, D. (2005). *Child abuse and neglect: Attachment, development and intervention*. New York, USA: Palgrave Macmillan.

- Jackson, V. (2004). 'Residential treatment for parents and their children: the village experience'. 2(2), 44053. Retrieved 2014, from V Jackson, *Science & Practice Perspectives*, 2004 at ncbi.nlm.nih.gov
- Meier, J. (2003). 'Domestic violence, child custody and child protection: Understanding Judicial resistance and imagining the solutions'. *Journal of Gender, Social Policy and the Law*, 11(2), 657–731. Retrieved from www.atria.nl/
- Morris, B. (2014). 'Quest Care: psychiatric dual-diagnosis residential recovery centre'. *A service model*. QLD.
- O'Connell, M. (2015). 'Domestic violence support services for children fall short, Victims commissioner tells Adelaide symposium'. *ABC News*. South Australia. Retrieved 2015, from www.abc.net.au/news/2015-09.../domestic-violence...services.../6802962
- Phillips, S., Burns, B., Edgar, E., Mueser, K., Linkins, K., Rosenheck, R., Robert, R & McDonel, H. (2001). *Moving assertive community treatment into standard practice*. 52(6), 771-9. Retrieved 2010, from www.ncbi.nlm.nih.gov/pubmed/11376224
- Odyssey House Victoria. (2015). *Home-about us*. Retrieved 2014, from Odyssey House Residential Rehabilitation: www.odyssey.org.au/index.php?option=com_content&view.
- Taft, A. (2003). *Promoting women's mental health: The challenges of intimate/domestic violence against women*. NSW: Domestic and family violence clearinghouse. Retrieved 2015, from www.austdvclearinghouse.unsw.edu.au
- Winter, M. (2014). *Silent voices, invisible violence: welfare to work and the exploitation of single mothers who have experienced domestic violence*. Thesis. Lismore, NSW: Southern Cross University. Retrieved from epubs.scu.edu.au/cgi/viewcontent.cgi?article=1453&context=theses
- World Health Organization. (2002). *World report on violence and health*. Geneva: World Health Organization. Retrieved 2015, from www.who.int/violence_injury_prevention/violence/world.../full_en.pdf
- World Health Organization. (2004). *The importance of care-giver child interactions for the survival and healthy development of young children*. Department of Child and Adolescent Health and Development. Geneva: World Health Organization. Retrieved 2015, from whqlibdoc.who.int/publications/2004/924159134X.pdf
- Worley, L., Conners, N., Crone, C., Williams, V., & Bokony, P. (2005). Building a residential Treatment Program for dual diagnosed women and children. *Womens mental health*(8), 105–111. doi:10.1007/s00737-005-0083-y