Prioritising women's safety in Australian perpetrator interventions:
The purpose and practices of partner contact

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The purpose and practices of partner contact

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Acknowledgement of lived experiences of violence
ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include: 1800 RESPECT – 1800 737 732 and Lifeline – 13 11 14.

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PRACTITIONER SURVEY

WOMEN'S SURVEY

Abbreviations

ACT Australian Capital Territory

ANROWS Australia's National Research Organisation for Women's Safety

BIP Batterer intervention program

CALD Culturally and linguistically diverse

DFV Domestic and family violence

FTE Full-time equivalent

LGBTIQA+ Lesbian, gay, bisexual, transgender, intersex, queer and asexual

MBCPs Men's behaviour change programs

MoU Memorandum of understanding

NSW New South Wales

NTV No To Violence

PC Partner contact

WWP-EN Work with Perpetrators European Network

Executive summary

The importance of intensifying perpetrator accountability efforts and prioritising women's and children's safety to reduce domestic and family violence (DFV) has led to an increasing focus on men's behaviour change programs (MBCPs) as the main intervention response to perpetrators in Australia. Most research about MBCPs has focused on whether there have been changes in male participants' use of violence during and following program attendance. This project provides a different piece of the evidence jigsaw about MBCPs. It focuses on women's and children's safety through an examination of partner contact practice, an under-researched component of MBCPs that has little evidence available about its practice and impact.

Almost all DFV responses have been developed on the basis of violence occurring between heterosexual couples. Evidence continues to confirm, in the vast majority of these instances, that men have been the abusers and women victimised. Consequently, partner contact practice is inherently gendered as it has developed out of the men's behaviour change sector and has focused on women as the partners and ex-partners of the men in these programs. Thus, this report uses the language of male perpetrators and female victims/survivors. This is not intended to be exclusionary, but rather to reflect the evolution of the work within a specific and gendered context. For these reasons, the terms "woman" and "women" are commonly used in this report. However, the gender-neutral term "partner" is also used to recognise men and gender non-binary people who can be victims/survivors of men's or male-identified persons' use of DFV.

Partner contact (also commonly called victim support/contact) is a service provided as part of MBCPs, whereby women and children often isolated from service systems (Vlais, 2014a) can be offered appropriate and safe support. MBCP partner contact can increase accountability to women and children by both perpetrators and practitioners, and can offer a key source of data to triangulate practitioners' perceptions and perpetrators' self-reports of their violence, abuse and risk. Additionally, to some extent, it can mitigate the risk of collusion between facilitators and perpetrators as the partner's information and experiences are part of a facilitator's assessment, meaning that the facilitator is not solely reliant on their own observations of the perpetrator during MBCP attendance or on the perpetrator's self-report. Colluding with the perpetrator's account of intentions and events, when other perspectives have not been sought or checked, is a specific area that MBCP facilitators must consider when working with men, to ensure perpetrator accountability processes are not undermined or overlooked. At the level of contracting and managing MBCPs, there is greater potential for collusion if partner contact elements of programs are not adequately funded to ensure follow-up and support to partners and former partners. Furthermore, when partner contact eligibility is tied to the perpetrator attending the MBCP, and not the victim's/survivor's need for support, women and children can be left at risk. This project has focused on documenting Australian partner contact practices and identifying future developments to promote the safety of women and children and reduce revictimisation.

Project aims and methodology

The project had the following aims:

1. Document national practice of partner contact across Australian MBCPs, including the nature and types of arrangements used to provide the service (e.g. in-house contact workers, MBCP facilitator contact, partnerships, subcontracting of specialist women's services, outsourcing etc.).

2. Examine how MBCPs support the needs and safety of women and children through partner contact and its benefits.

3. Explore how certain populations—e.g. Aboriginal and Torres Strait Islander; culturally and linguistically diverse; diverse sexuality and gender—are catered for in terms of MBCP partner contact.

4. Understand MBCP partner contact in both urban and regional areas.

5. Improve the quality and consistency of support provided to women and children by current and future MBCPs and perpetrator interventions more broadly.

The project was an exploratory study conducted to ensure that the breadth of partner contact work being undertaken in Australia could be documented. It drew on a theoretical

understanding that DFV involves a pattern of behaviours being perpetrated by an individual that can result in those victimised feeling controlled, threatened, fearful and humiliated. The project was also influenced by theories of intersectionality which draw attention to how the dynamics of DFV, the social responses to perpetrators and victims/survivors, and the decisions and actions of those affected are influenced by their gender identity, race, culture, age, class, location, sexuality and other factors (Sokoloff & Dupont, 2005). The project adopted a mixed methods design that included a state of knowledge review (conducted as a scoping review), a national survey of MBCP providers about partner contact (n=131), in-depth interviews with managers, facilitators and partner contact workers (n=30), and a survey of women who have experience of their (ex-)partners attending an MBCP (n=18).

Key findings

The literature reviewed for this study suggests that victims/survivors found partner contact valuable when workers were centred on women's and children's needs, and when women could ask questions about the MBCPs and what to expect from those involved in them. Similarly, the practitioner survey and interviews described partner contact as having a positive impact on the lives of victims/survivors, even when the MBCP did not lead to any change in the perpetrator's violent and controlling behaviour. Some of the women participants also described similar positive outcomes from partner contact services, and some reported that where there was no partner contact provided, or it was very limited, their situations sometimes worsened. This included perpetrators blaming women for having to attend an MBCP, denying their violence altogether or minimising it to such an extent that they did not see any need to attend the program.

Furthermore, where there was no partner contact, or it could not be established, victims/survivors were not offered any explanations about how MBCPs operated or what changes they might or might not expect as a result of their (ex-)partner attending such a program. This meant that some victims/survivors were subject to further abuse, such as being told by the perpetrator that the MBCP practitioner thought the problem was with the victim/survivor. It also meant

that, in the face of women not receiving any information about DFV and/or the MBCP from a partner contact worker or MBCP facilitator, they could become disempowered by the experience.

The findings from the practitioner survey and interviews confirm that partner contact is labour intensive, as victims/survivors may not be expecting contact and are understandably reluctant to answer unknown telephone numbers. The work often involves a large number of calls to establish contact, and the amount of time available to devote to it is limited by available funding. This is a dilemma given that many victims/survivors are not connected to existing support and may be misled or be at greater risk while the perpetrator is attending an MBCP.

This study reveals that partner contact is not only limited in the number of women it reaches, but that its practices also vary considerably within and between Australian states and territories. The organisation and modes of partner contact work also vary, though mostly it is solely telephone contact, with some face-to-face meetings and discussions about the MBCP with the women. Partner contact work almost always involves referring women to support services, such as specialist DFV agencies, and legal or accommodation services. Partner contact workers in some organisations also offer direct support to women, such as counselling and advocating with other agencies on their behalf.

The findings confirm the existing research in that many of the women reached through partner contact have not previously been linked to other services or received support. This remains a critical role of partner contact because, as indicated above, a lack of contact can isolate the women further and put them at greater risk.

Some practitioners have focused on how they can increase understanding of MBCPs and provide greater transparency about the work they involve. One strategy that some MBCPs working directly with women's services adopted to meet these aims was to have workers from these services observe the men's groups. However, this rarely occurred, with 70 percent of the practitioners surveyed stating that specialist

women's services never or rarely observed the MBCPs with which they work.

Variations in partner contact practices may not only be the result of varying practice standards but also of differing funding and contracting mechanisms across Australian jurisdictions. Although standards of practice for MBCP partner contact predominated in the grey literature, these were not always underpinned by an evidence base. For example, a standard may only include a description of the method or methods to be employed without a rationale for or explanation of the utility of such methods.

Very few partner contact workers in the survey reported providing any form of direct support to children based on the partner contact model. Some partner contact workers provide intra- and inter-agency referrals to children's services, but the provision of support services to children has not been a key component of MBCP and partner contact services in any jurisdictions. Services for children whose fathers are undertaking MBCPs have been patchy and it has not been a major policy priority with perpetrator interventions. However, there is increasing acknowledgement of the importance of providing direct support to children and young people. This is an area requiring further consideration, especially given that partner contact is predominantly delivered via telephone, and the age range and developmental stages of children will require differential interventions.

Findings from the 18 women who shared their experiences of partner contact via a survey revealed a considerable variance in the quality and consistency of partner contact. Some of the women (n=7) reported very positive experiences of partner contact support, explaining they had developed meaningful and supportive relationships with partner contact practitioners beyond the duration of the MBCP. Others, however, had inconsistent or non-existent partner contact, and experienced continued violence towards them and their children during their (ex-)partner's time in the program and afterwards. This is contrasted with the results from the practitioner survey, in which most participants viewed their partner contact service as sufficient. These contrasting research findings signal the value of this current project in highlighting victim/survivor concerns and suggest more comprehensive and substantial partner contact for MBCPs would be beneficial.

The support provided to victims/survivors through partner contact should be determined by the broader constellation of available services within the local area or region in which a partner contact service sits. When neither partner contact services nor specialist local/regional women's and other victim/survivor services have the capacity to provide this kind of support, important victim/survivor needs can remain unmet. The research points to the importance of partner contact support being a service for victims/survivors that is not tied to a perpetrator's participation in the MBCP. Partner contact work requires adequate levels of funding to enable sufficiently intense and lengthy responses when no other local option exists.

Very little attention has been given to the provision of partner contact for particular cohorts of victims/survivors; for example, how partner contact sits within the context of holistic work with (extended) families in the context of Aboriginal and Torres Strait Islander family violence services has yet to be explored. Similarly, the research indicates there has been little consideration of the needs of women with disability, culturally and linguistically diverse (CALD) women, and lesbian, gay, bisexual, transgender, intersex, queer and asexual (LGBTIQA+) victims/survivors of DFV in partner contact. There was no mention of these groups in the literature or in practitioner responses.

The research findings demonstrate that, in most situations, partner contact work is secondary to interventions with the perpetrators. MBCPs are prioritised as they receive the most funding, and involve dealing with direct referrals from courts, other services and individual potential participants. In contrast, partner contact work generally involves outreach to victims/survivors who may or may not be aware that the perpetrator is going to commence a program. The funding and operationalisation of MBCPs mean that partner contact tends to be a secondary service.

Interestingly, the research found a number of promising practices and principles that indicate practitioners do understand the importance of providing consistent and quality support to women and children whether or not the perpetrators attend an MBCP. These supportive responses are offered with the limited resources that many participants

reported their services operate with. Partner contact services that were only available when the perpetrator was participating in the MBCP were viewed as the least valuable. An important issue raised by both practitioners and women was that it inadvertently set women up to be further controlled or dependent on the perpetrator, as his decision impacted on her access to support. Based on the research findings, the following recommendations are offered as a way forward in promoting the safety of women and children and increasing the accountability of those perpetrating DFV.

Recommendations

The following recommendations are proposed based on the findings of the research.

POLICY, PROGRAM AND RESEARCH

1. Develop national minimum practice standards for partner support as a component of MBCPs and other perpetrator intervention programs, to provide safe and supportive responses to victims/survivors, and to complement existing jurisdiction-based MBCP minimum standards.

2. Consider changing the appropriateness of the terminology, in the proposed national practice standards and elsewhere, from "partner contact" to a description that more accurately reflects the support provided to adult and child victims/survivors and the form of accountability it can provide to MBCPs.

3. Develop a communications strategy among Commonwealth, state and territory governments to promote the partner contact minimum practice standards, so they are accessible and seen as relevant both to partner contact workers and their counterparts delivering perpetrator interventions.

4. Incorporate program evaluations of MBCPs as a dedicated evaluation stream that specifically focuses on the partner contact component of the program, including data obtained from victims/survivors about their experiences of partner contact and the impact it has (or has not) made.

5. Instigate operational and ongoing internal reviews of MBCPs and more formal process evaluations that include a strong focus on the delivery of partner contact.

FUNDING AND RESOURCING

6. Formally recognise the national partner contact minimum practice standards within contractual arrangements and funding service agreements with MBCP providers and associated organisations, so that state and territory governments use them to promote safe and ethical service delivery to victims/survivors.

7. Fund and resource partner contact services in ways that enable national minimum practice standards to be met.

8. Resource partner contact so that victims/survivors have ongoing access to support, either from the partner contact worker or another services practitioner, that is irrespective of a perpetrator's MBCP attendance.

ORGANISATIONAL ARRANGEMENTS

9. Ensure that partner contact is delivered by designated workers, separate from the work with men.

10. Enable organisations to provide intervention components that do not prioritise perpetrators over victims/survivors.

11. Strengthen relationships between services where partner contact is delivered by a separate organisation to the MBCP provider.

TRAINING AND SUPPORT

12. Further strengthen existing jurisdiction-specific professional networks for MBCP facilitators and partner contact workers at the local level to promote integrated and effective support.

13. Develop and implement a national training strategy that more consistently equips the partner contact workforce with the practice frameworks and skills required to adopt national minimum partner contact practice standards.

14. Make quality supervision available for partner contact workers that is specific to their role.

15. Target workforce training and development specifically at areas and locations where there is limited expertise in responding to DFV.

16. Give further consideration and research to the role of child and youth contact workers through funded innovation trials with an evaluation component.

Introduction

Over the past four decades in Australia, there has been increasing recognition that a focus on working directly with perpetrators is required to end violence against women and children, prevent its occurrence and intervene earlier to reduce its duration and effects. This shift is reflected in the *National Plan to Reduce Violence against Women and their Children 2010–2022* (the National Plan) and the subsequent Action Plans, which prioritise responses to perpetrators and increasing perpetrator accountability (Council of Australian Governments, 2011).

In Australia, the main intervention programs for perpetrators of domestic and family violence (DFV) are commonly referred to as men's behaviour change programs (MBCPs). While MBCPs are the primary form of psychosocial intervention for perpetrators, they are still in their relative infancy (Morrison et al., 2016). When MBCPs first emerged in Australia they drew largely on the work of North American programs involving group work with men known to be perpetrators of DFV (Chung, 2015; Smith, 2013). In the early days, MBCPs were primarily community-based programs, not court ordered or directed. This has changed in recent decades, with most jurisdictions having a combination of court ordered and non-court ordered programs. There is a growing emphasis on court ordered programs with MBCPs as a component part of the justice response to the perpetration of DFV.

The primary intention of MBCPs in Australia is reflected in the various jurisdictions' policy documents (e.g. NSW Department of Justice, 2017; Family Safety Victoria, 2018). These indicate that the primary purposes of MBCPs include:

1. Promoting the safety of women and children.
2. Holding perpetrators accountable for their past and future actions.
3. Facilitating attitude and behaviour change among program participants.

To date, much of the focus on MBCPs has been on their core purpose and effectiveness. In Australia, debates about the effectiveness of MBCPs—that is, how to define their success and how to measure it—continue in the research literature (Day, Vlais, Chung, & Green, 2019).

As MBCPs have evolved and research increased, knowledge about male perpetrators has grown, with the first large-scale study by Edward Gondolf published in the early 2000s (Gondolf, 2002) through to more recent research (e.g. Aaron & Beaulaurier, 2017). There are also a small number of higher education programs focusing on working with perpetrators of DFV to support the workforce. Examples of these include Swinburne University's Graduate Certificate in Client Assessment and Case Management, and Central Queensland University's Graduate Diploma of Domestic and Family Violence Practice.

Furthermore, various jurisdictions in Australia have set minimum practice standards for the provision of MBCPs. For example, in New South Wales the Department of Justice's *Practice Standards for Men's Domestic Violence Behaviour Change Programs* (2017) include six principles on which the standards are based and a compliance framework for program providers. Similarly, in Victoria, Family Safety Victoria's *Men's Behaviour Change Minimum Standards* (2018) include ten minimum standards for the delivery of perpetrator interventions. However, there is no national, uniform or single set of program standards for MBCPs because the provision of such services is largely a state and territory responsibility. As a result, MBCPs vary nationally in pathways to participation, inclusion criteria and duration. They do, however, all involve individual assessment, group work for DFV perpetrators and, in some instances, individual interventions where groups are not suitable.

A recurring theme both in the research and in practitioners' accounts about DFV perpetrators is that perpetrators often deny and minimise their use of violence and coercion and do not take responsibility for their actions. Even if their use of violence is actually acknowledged, the victim is often blamed for causing the violence (Hearn, 1998; Reissman, Doychak, Crossman, & Raghavan, 2019). This commonly given perpetrator account, which cannot be condoned, has shaped how MBCP facilitators run sessions with male participants, as it means that what participants say about their use of violence cannot be taken at face value. This points to the importance of hearing from the victims/survivors of MBCP participants.

Appropriately, therefore, understandings of DFV perpetrators have also been informed by the experiences and accounts of those victimised. Hearing from and supporting victims/survivors promotes transparency for women and children and contributes to individual perpetrators being more accountable for their behaviour. This can also promote safety if victims'/survivors' safety needs are addressed. Engagement of victims/survivors as part of the MBCP response gives facilitators the opportunity to gain a picture of what has transpired that is not filtered through the perpetrator's lens. It can also offer partners or ex-partners a window into what goes on inside the group and what can likely be expected if perpetrators are participating in MBCPs. This aspect of the MBCP is often referred to as partner contact.

In Australia, and in some other countries such as the United Kingdom, a key component of MBCPs is partner contact or partner safety contact. This involves working with the partner and/or ex-partner of the perpetrator undertaking the program to provide support and information, including safety planning (No To Violence [NTV], 2006; NSW Department of Attorney General & Justice, 2012; Smith, Humphreys, & Laming, 2013; Vlais, 2014a). In those countries where MBCPs do not include partner contact, and thus are without direct victim/survivor information, MBCP practitioners' assessments of participants' risk, progress and victim/survivor safety are compromised. The findings of this research project show that the majority of MBCPs in Australia have partner contact as part of the program.

The partner contact component of MBCPs in Australia has evolved differently across and within jurisdictions as interventions with perpetrators have matured. There has been a growing body of research focused on the outcomes of MBCPs, however, this has rarely included evaluating partner contact and its contribution to program outcomes. Some researchers, such as Edward Gondolf (2002), have included partners and ex-partners in their research studies to identify whether or not there has been a change in violence following a program. However, these programs, in North America at least, did not offer partner contact.

In Australia, MBCP evaluation research has not always been publicly available, as contracted evaluations can only be used for internal departmental purposes, which has limited the available knowledge and accessibility to knowledge.

Consequently, there is limited publicly available research (including international research) about partner contact as part of MBCPs (Smith, 2013). In Australia, there is also limited publicly available knowledge about MBCP partner contact practices, specifically regarding the benefits and challenges of these practices as well as the experience of partner contact for victims/survivors. At the same time, Australian policy makers are looking at more comprehensive and effective ways to reduce men's use of violence against women, with MBCPs forming a key part of the response (e.g. the Council of Australian Governments' Third and Fourth Action Plans of the *National Plan to Reduce Violence Against Women and their Children* and the Recommendations of the Victorian Royal Commission into Family Violence).

The development of partner contact work within MBCPs has meant that its focus has been on working predominantly with women victims/survivors whose current or former male partners are attending MBCPs. Therefore, the practice of and research about partner contact has been concerned with women. Throughout this report the language of male perpetrators and female victims/survivors is used. This reflects what the work has involved to date and the groups with which research has been conducted. Thus, it is not intended to be exclusionary of other people experiencing DFV or of children; rather it is an accurate representation of current partner contact practice. The term "woman" is commonly used, as well as the gender-neutral term "partner" to recognise that men and gender non-binary people are also victims of men or male-identified persons' use of DFV.

In combination, the factors discussed above provided the impetus for us to undertake a national study of MBCP partner contact, as we considered it a timely contribution to the evidence about reducing violence against women and their children. In investigating the existing knowledge about partner contact, this national project also collected data about MBCP partner contact practice in Australia in order to document how it is operating, its strengths and its challenges. In doing so, the project also aimed to explore and promote policy and program responses that equitably

support women and children in a way that prioritises their safety and needs, holds men accountable for their abuse, and challenges the socio-political and cultural foundations supporting and minimising male violence against women. Learning more about women's journeys of support in the context of MBCPs contributes to understanding how DFV responses can help, hinder or replicate women's experiences of violence with the ultimate aim of establishing a stronger, more responsive perpetrator intervention system.

To gain a detailed understanding of partner contact practices across Australia, and to provide guidance on enhancing future practice, the project posed the following research questions:

- What are the range of approaches to partner contact across Australian jurisdictions?
- What do victims/survivors and practitioners identify as the strengths and weaknesses of partner contact practices?
- How could partner contact practices be improved in Australia?

Specifically, the aims of this project were:

- Document national practices of partner contact across Australian MBCPs, including the nature and types of arrangements used to provide the service.
- Examine how MBCPs support the needs and safety of women and children through partner contact and its benefits.
- Explore how certain populations—e.g. Aboriginal and Torres Strait Islander; culturally and linguistically diverse; diverse sexuality and gender—are catered for in terms of MBCP partner contact.
- Understand MBCP partner contact in both urban and regional areas.
- Improve the quality and consistency of support provided to women and children by current and future MBCPs and perpetrator interventions more broadly.

The project involved four main research activities to meet these aims:

- a review of published and grey literature about MBCP partner contact

- an online survey of MBCP providers about the purpose, methods and outcomes of partner contact
- interviews with MBCP providers to gather in-depth information about the challenges, strengths and areas of development for partner contact
- an online survey for DFV victims/survivors, whose partners or ex-partners had undertaken an MBCP, to find out about their experiences of partner contact, where it was provided, and to get their advice about how partner contact could be improved or enhanced to support them and their children.

The next section of the report outlines the methodology in detail, followed by the literature review, program provider survey findings and interviews, and women's perspectives. The conclusion draws together the key findings from the project and includes recommendations on how to improve and enhance partner contact in the future.

CHAPTER 1

Project methodology

Theoretical framework

The authors acknowledge that individual experiences of DFV are mediated by gender, class and access to economic resources, race and cultural identity, sexuality, locality, age, family and social supports, health and experiences of disability. This research is, therefore, embedded within an intersectional framework, which assumes responses to violence against women that target individual, community and socio-political levels are essential to its eradication (Chung, 2015). Intersectional feminism, which has its roots in the lived experience of black women and women of colour, brought to the fore the ways in which women experience multiple forms of oppression simultaneously (Crenshaw, 1991). This is increasingly shifting from being a political theory explanation to a methodological approach that is inclusive and justice seeking.

Intersectionality as a methodological approach has most often been used to examine the multiple and intersecting forms of power, oppression and discrimination that impact on women's experiences (Collins & Bilge, 2016; Crenshaw, 1991). In DFV research, the aim is then to contextualise how multiple forms of power and oppression—those associated with age, race, class, ability, sexual orientation, gender identification, citizenship and residency rights, class, Indigeneity, and rurality—intersect with and shape experiences and identity and cannot be considered in isolation from the others (Collins & Bilge, 2016). In this research about partner contact, a methodology underpinned by intersectionality was important because it offers a way of focusing on the power dynamics between the perpetrator and the victim/survivor and the power differentials between workers and victims/survivors, while supporting the multiple voices and perspectives that are critical to understanding partner contact.

In this study, intersectionality is applied to understand the systemic ways in which discrimination is compounded, by questioning how service design and practice might overlook, exclude or restrict the safety and support needs of certain groups of victims/survivors (more than others) and thus undermine efforts towards perpetrator accountability. This is important in this context because previous studies have demonstrated how the service system is responsive to some victims/survivors, while the needs and experiences of others are systematically excluded (Mackenzie, Conway, Hastings, Munro, & O'Donnell, 2015; Sokoloff & Dupont, 2005; Sosa, 2017). This project, therefore, looks at how partner contact within MBCPs is able to respond to victims/survivors in a range of circumstances, based on current funding, service design and practice. In this way it also considers how current partner contact practices may be less responsive to the safety and needs of some groups of women, or unintentionally privilege the perspective of workers or collude with perpetrators.

Research design

Based on the description of intersectionality outlined above, the research drew on the tenets of phenomenology, which assumes that for a social issue to be fully understood data must be collected from those with direct experience of the issue being studied. Therefore, this study collected data from those with lived experience, in this case victims/survivors and those involved in delivering services (Downes, Kelly, & Westmarland, 2014). It included four components:

- a scoping review of literature (state of knowledge review)
- a survey of MBCP providers nationally
- in-depth interviews with managers, facilitators and partner contact workers to examine areas for practice guidance more comprehensively
- a survey of women currently or previously in receipt of partner contact support.

The use of the latter survey with women is discussed later in the report. It is also relevant to point out that a key component of this exploratory study was to identify the range of partner contact models and practices, and that future studies would benefit from interviewing victims/survivors who received differing models of partner contact practice to better understand its impacts.

The components of this study constitute three data collection approaches—literature review, surveys and interviews—all of which are described in detail below. Incorporating these three approaches enabled triangulation of data and the development of a detailed understanding of partner contact

practice in the context of MBCPs. This is the first study of its kind to generate this level of evidence about partner contact and its capacity to promote the safety of women and children.

State of knowledge review

For the State of knowledge review, we employed a scoping review methodology to identify and examine the available research and literature about partner contact. Scoping reviews, sometimes also referred to as scoping studies, are a method used to collect a wide range of knowledge (i.e. map the available literature) on a topic. Unlike systematic reviews, which largely only report on research studies that meet a certain standard of scientific criteria or use specific methodologies, scoping reviews usually include a wider range of research evidence in their searching and reporting. Colquhoun et al. (2014) describe scoping reviews as

> a form of knowledge synthesis, which incorporate a range of study designs to comprehensively summarize and synthesize evidence with the aim of informing practice, programs, and policy and providing direction to future research priorities. (p. 1291)

They argue that scoping reviews are suited to areas of study that are either newly emerging, or when existing evidence exists across a wide spectrum—from published peer-reviewed journals through to grey literature—and the intent is to capture the state of knowledge. As partner contact is a relatively new and scarcely researched topic, and the purpose of this review was to inform policymakers and practitioners, we employed a scoping review.

As a project team of academic researchers and practitioner researchers we jointly developed a search strategy protocol (refer to Table 1). This involved preliminary searches being undertaken to establish key terms in search engines (both academic electronic databases and on the web). Comprehensive literature searches were then conducted following the development of this search protocol. Once initial results were obtained, as a team we considered whether there may be additional terms, key authors in the field, and further areas to search.

The following electronic databases were searched: ProQuest, PsychINFO, MEDLINE (Web of Knowledge), Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Scopus. The search protocol was modified as required, with some key concepts being searched separately when searches produced no results (Arksey & O'Malley, 2005; Sampson et al., 2009). Following a process of screening article headings and abstracts, and searching reference lists of included articles, 12 research articles met the inclusion criteria (refer to Figure 1).

Given the paucity of relevant literature, both qualitative and quantitative studies were included and no time limits were placed on the search. Quality assessments of articles were not conducted, however, the researchers cross-referenced and reviewed the articles and reports in accordance with the inclusion and exclusion criteria. The search strategy limits included the availability of full texts and publications written in English.

Table 1: Literature review search strategy

Search terms Concept 1	Concept 2	Concept 3	Concept 4	Additional search topics
"Men's behaviour change programs" OR "Batterer intervention programs" OR "Domestic violence perpetrator programmes*"	AND	AND	AND	MBCP development OR evaluation
"Perpetrator intervention programs"	"Provider practices" OR "Practice" OR "Approach" OR "Ways of working" OR "Service delivery" OR "Practitioner" OR "Responses" OR "Good practice" OR "Practice interventions" OR "Initiatives" OR "Partner contact worker"	"Partner contact" OR "Victim contact" OR "Victim support" OR "Assessment of victim needs and safety" OR "Assessment of women and children's needs and safety" OR "Risk identification"	"Family and domestic violence" OR "Domestic violence" OR "Intimate partner violence" OR "Domestic abuse"	Program effectiveness OR quality
"Integrated support services"		"Partner support"		Benefits of partner contact
"Work with perpetrators"	"Practice standards"	"Children support"		Program integrity
"Batterer programs"		"Partner safety support"		Triangulated data
		"Victim support and safety"		Measurement of success
Map to subject heading Tick "Focus" rather than explore	*Search in title and abstract only*	"Partner check process"		Program success
		"Victim advocacy services"		Intent of partner contact, consistency
		Search in full text		Women/victim engagement

		Separate searches
Limits		(?) Search concepts 1, 2 and 3
English language		AND
No time limitations		1, 2 and 4
Full-text available		

Figure 1: Record of electronic database searches
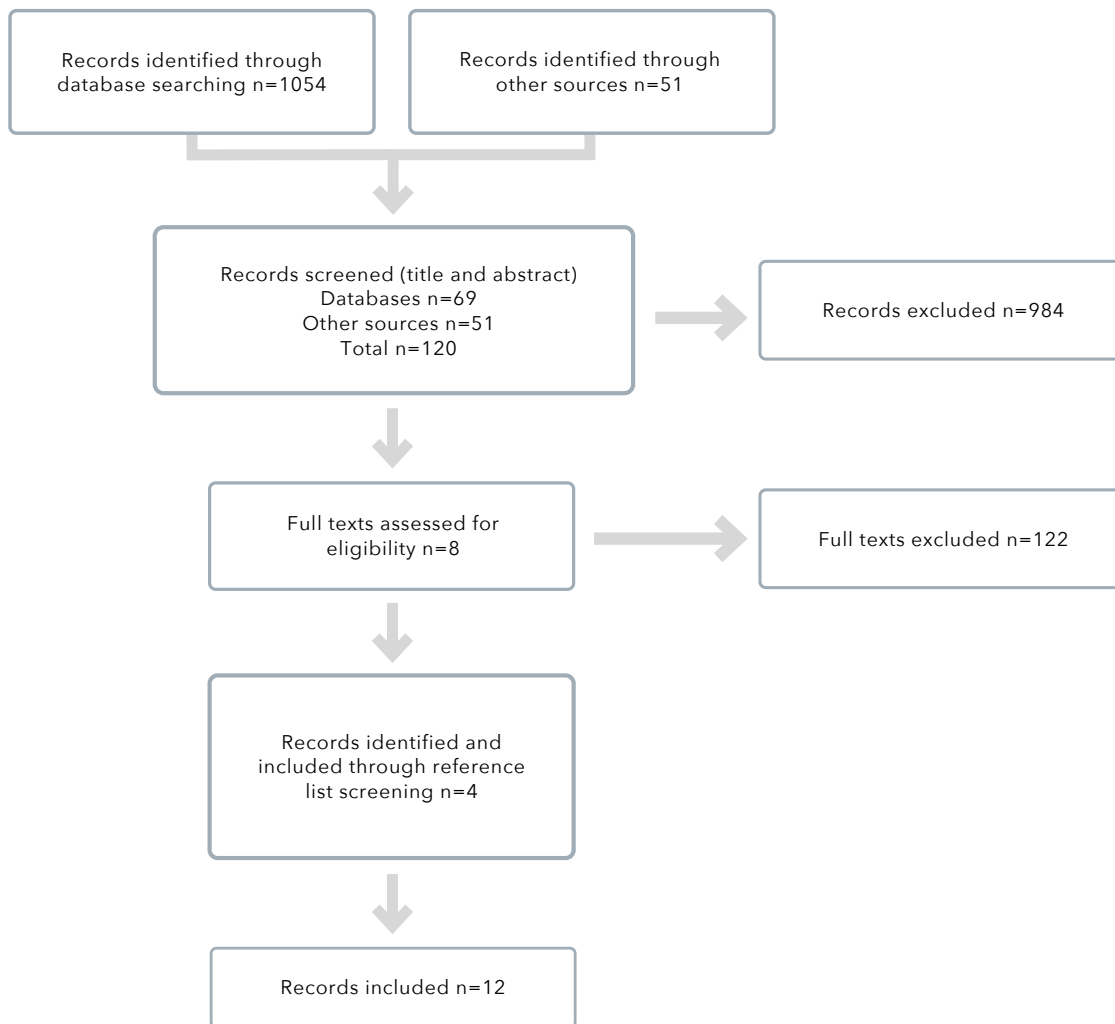
Inclusion criteria

Studies that reported on partner contact practices, specifically:

- contact from women's services
- partner contact workers
- MBCP facilitators that relate specifically to formal programs provided to perpetrators of DFV.

Broader service system responses such as that provided by the justice system or child protection services were not included.

Exclusion criteria

Studies were excluded that:

- reported on judicial and formal system responses (e.g. witness services) that focus on service provision responses only
- did not include victims'/survivors' (i.e. women's and children's) perspectives
- included police contact where no services/support were offered (e.g. witness statements).

Grey literature was included in the database search and further unpublished studies were found through Google. We then undertook a second stage of more targeted searching of websites of relevant national and international agencies and organisations, which resulted in a number of key evaluation and expert essays being identified.

Surveys

Practitioner survey

A total of 131 practitioners participated in the survey, the findings of which are presented in Chapter 3 of this report. Practitioner knowledge about understandings and experiences of managing or delivering partner contact support was obtained from quantitative and qualitative data collected through a Qualtrics online survey (Appendix A). This method was employed because of its ability to reach a wide range of participants across Australia, ensuring that location would not be a barrier to participation. The purpose of the survey was to gather information from as many and varied perspectives as possible about an aspect of DFV practice that has not been documented nationally.

Survey questions were designed to capture the experiences of practitioners and managers who provide MBCP and partner contact services, with the aim of gathering information about these practices across the various types of programs and contexts. Development of the survey was completed using information emanating from the literature review and the project team's expertise in the area. The survey was then piloted with six practitioners situated in four organisations located in Queensland, Victoria and Western Australia prior to it being administered to the broader sector. The pilot participants were chosen as they were known to the researchers and had indicated an interest in participating when it had been announced that the study was being conducted. This enabled the team to pilot the survey in a relatively short period of time and across different jurisdictions to enable any jurisdiction-specific terms or jargon to be removed, as the researchers were only based in two jurisdictions.

To assist with the distribution of the survey and to ensure the sample size was as large as possible, the researchers contacted peak bodies and other organisations to identify the range of agencies and their contacts that provided MBCPs and partner contact services. A total of 73 agencies were identified as providing MBCPs across Australia.[1] The team collated the key contact details of program managers and practitioners within each of the organisations, and contacted these staff seeking support for the project. If they agreed, they were provided with an anonymous survey link for them to distribute to relevant practitioners. Support was also sought from the relevant state peak bodies to help with promotion and dissemination of the survey, which was open between November 2018 and January 2019. One practitioner completed the survey in March 2019 after contacting the research team requesting the opportunity to participate.

Women's survey

Research that draws on an underpinning of intersectionality often uses individual interviews as a method to ensure that diverse and rich descriptions are elicited. As mentioned earlier in this chapter, previous research has demonstrated how women experience oppression and marginalisation, and how this is further compounded for those at the intersections of ableism, racism, sexism and other social divisions. In order to look more at how direct services and practitioners inadvertently contribute to and/or resist further marginalising victims/survivors, we focused on gathering data about service delivery. To achieve this, we included women's perspectives using a survey method that drew on the qualitative findings of previous partner contact studies (Opitz 2014; Smith et al., 2013).

There were also practical reasons for using a survey. Firstly, we anticipated it would be difficult to recruit women to the study as only a relatively small number would be eligible. Secondly, we had a limited recruitment time period. Thirdly, as such projects often rely on time-consuming practitioner referrals, if we had gone down this route we could not be sure practitioners might unintentionally only refer those women with whom they had regular contact, which might have biased the sample. Therefore, we opted for an online survey so we could promote the study more widely and also potentially recruit those who had ceased partner contact relatively recently.

Development of the women's survey was completed using information emanating from the literature review and the project team's expertise in the area. As with the practitioner survey, we sent an anonymous survey link to the identified MBCPs with a request for them to assist in identifying and distributing the survey to women who may have been in receipt of a partner contact service in the last 2 years. Support was also sought from the relevant state peak bodies to help with promoting and disseminating the survey. In addition to distributing the survey to MBCPs, it was forwarded to women's specialist agencies within each state, in recognition that women who experience DFV are often supported by these organisations. The survey was open between January and May 2019.

A total of 18 women participated in the survey, the findings of which are presented in Chapter 5 of this report. Feedback from women about their experiences of receiving partner contact support was obtained from quantitative and qualitative data collected through a Qualtrics online survey (Appendix B). Survey questions were designed to capture the experiences of

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1   A number of these agencies run programs at more than one site potentially involving multiple MBCP teams. Additionally, a few of the agencies have distinct branches each running their own MBCP.

women who have been in receipt of support from MBCPs as a way of gathering information about what they found helpful or unhelpful, to add depth to the information attained from practitioners. For the purposes of this exploratory study, we believe that the qualitative data gathered from the survey is a sufficient representation of women's voices and gives insights into their experiences of partner contact services.

Practitioner in-depth interviews

In total, 30 interviews were conducted with practitioners via telephone or face-to-face using a semi-structured interview guide (refer to Appendices C & D for the interview guide and associated materials). Sixteen of the 30 interviewees had completed the survey, nine had not and five were uncertain due to several MBCP workforce surveys all being conducted in the same timeframe. The 30 interviewees were from Western Australia (n=9), New South Wales (n=6), Victoria (n=6), Queensland (n=3), South Australia (n=3), the Australian Capital Territory (n=2) and the Northern Territory (n=1). Twenty-six organisations Australia-wide were contacted seeking participants for the study. These organisations were drawn from:

- those showing interest in the study following completion of the survey
- email recruitment advising of the interviews for the study
- word of mouth.

Out of the 26 organisations contacted, only two did not respond, and one declined because the partner contact worker was relatively new to the role. In general, many organisational participants were already aware of the project from the earlier survey and were willing to participate. An introductory call to the services helped to identify the relevant person to contact for interview, who was generally a manager or team leader overseeing the partner contact aspect of the MBCP. An email was then sent to this person outlining the research and participants required for the study. There was a high level of interest in participating in the research, although some barriers to participation were experienced as a result of a heavy workload or workers taking leave at the time when the interviews were conducted.

Sample

Twenty-eight of the 30 participants were female and two were male; of the latter, one held a supervisory position and the other a role as a men's worker. All female participants delivered partner contact, which is representative of the gendered nature of the role.

The majority of the providers were based in urban locations, where most MBCPs operate, and to a lesser degree in regional centres. This is because MBCPs are often not viable outside of urban and large regional centres as they rely on a group work approach that requires minimum numbers. However, a number of the organisations operating MBCPs in urban and regional centres also operated services in more remote areas. This enabled participants to draw on their experiences across multiple locations, which included how to respond to perpetrators when there is not an MBCP available. All of the participants were employed by not-for-profit organisations receiving government funding.

The majority of participants described their MBCPs as "voluntary" and not as programs that only received court ordered referrals. Four of the service providers described their MBCP as a mandated program, but most reported that a proportion of their program participants were attending as part of a criminal justice response. As such, most programs had a mix of court mandated and socially mandated[2] participants, with estimates from this project highlighting that 20–60 percent constituted some form of mandated participation. However, many practitioners indicated that it was typically not a very strong mandate as there were few, if any, consequences for non-participation.

The option to be interviewed face-to-face was available to participants in Perth, Western Australia, where the interviewers were based. All other interviews were conducted

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2   The term "socially mandated" is used to describe participants who are not required to attend by a court order or directed by an organisation with statutory authority. The term was developed because previous research and practice suggested that perpetrators did not voluntarily decide to attend, but were largely driven to attend due to a social consequence. This could include a woman advising they would leave the relationship if her partner did not seek assistance in stopping his violent behaviour, or that it may be beneficial for future Family Court hearings if the perpetrator was attending an MBCP and trying to make changes (see Chung, O'Leary, & Zannettino, 2004).

over the telephone with recording equipment used so that they could be transcribed. Interviews ranged from 30–90 minutes, with most taking 45–60 minutes.

Number of research participants recruited from each method

In total, 131 practitioners participated in the survey, in-depth interviews about partner contact were conducted with 30 practitioners, and 18 women completed the survey about MBCPs and partner contact.

Data analysis

Similar methods of data analysis were employed for both the practitioner and women's surveys, which used Qualtrics survey software to collect the data. The two surveys generated descriptive statistics from the frequency data—such as location, agency type and individual demographics—collected in the questionnaires. Cross tabulations were prepared, where appropriate, to assist in understanding the sample or to identify any trends in the data. Quantitative data are thus presented as descriptive statistics, with the figures and tables containing summaries of these statistics throughout the reporting of both surveys.

The main intent of the practitioner survey was to gather documentation on the extent, types and organisation of partner contact across MBCPs in Australia, as well as to identify areas for development and future improvement. Qualitative data were collected in the practitioner survey predominantly to provide additional information, for example, asking participants if any formal agreements existed between agencies in their local area as to how they could work together. The analysis of these data was largely done by producing lists of descriptions which were then categorised. The small number of qualitative items seeking views and perspectives were coded into wider ranging themes and sub-themes and these are presented later in the findings.

The women's survey had a number of open-ended data items to enable participants to explain any circumstances they considered relevant to their experience, and to provide feedback about the partner contact services they received and any suggestions as to how to improve them. The qualitative data generated were analysed using Nvivo software, with overarching themes common across the complete sample initially identified by comparing the data. The data were then divided between women who were with their partner at the time he was attending the MBCP and those who were not to investigate any similarities within the same groups and any differences between the groups. Responses were also compared between participants who had received partner contact services and those who had received minimal or no partner contact. Independent coding and analysis were undertaken by two team members to ensure quality; findings were collated and sent, along with the raw data, to the rest of the research project team, who then provided extensive feedback. This was also a means to promote trustworthy and credible findings (Shenton, 2004).

The information generated from the practitioner survey provided a platform from which the in-depth interviews were structured, allowing researchers the opportunity to explore areas of strength and also areas identified as requiring development. The in-depth interviews carried out with practitioners were all recorded, transcribed and subjected to content and thematic analysis. A phenomenological approach was utilised as it emphasises the centrality of individuals' perspectives and interpretations of events and experiences. In this instance, it meant privileging participants' perspectives of partner contact in understanding its strengths, weaknesses and areas for development.

Qualitative data analysis undertaken both for the survey and the interview components broadly involved the process of moving between the four main areas of data immersion, coding, creating categories, and identifying themes (Green et al., 2007). This required the researchers to develop an in-depth understanding of the data in order to categorise, compare and identify the key findings of the study. Comparison of the information generated from the interviews was made with evidence from the literature and survey data. Key findings are subsequently presented in each of the appropriate areas along with supporting quotations, where relevant, as a way of providing explanation and evidence.

Ethical considerations

This project met the research standards set by the Australian Code for the Responsible Conduct of Research framework (National Health and Medical Research Council, Australian Research Council, & Universities Australia, 2007) and was approved by the Curtin University Human Research Ethics Committee (approval number HRE2018-0173). These guidelines promote responsible research practices and integrity. The nature of the ethics process at Curtin University is such that considerations about the conduct of the research, including the potential burden and risk to participants and organisations, is identified and managed prior to data collection activities (involving people) occurring. A few community-based organisations also had internal research review committees that required the researchers to prepare an application seeking to undertake research with the organisation's employees. After approvals were received, the research team then proceeded with recruiting participants for the survey and interviews.

As with most research conducted with human participants, preserving anonymity was a key issue identified with this project. This was maintained through the de-identification of data, with both surveys and interviews not requesting any identifying information. To mitigate the risk of identification among a relatively small number of service providers participating in the study, such as those in a regional area or those working with a specific population group, any such identifying information has not been included in the presentation of findings.

Limitations

One of the limitations worth noting prior to the presentation of the findings is the considerable constraint on the sampling process, particularly the range of research participants who could be included in the study. Firstly, representatives from some non-government and government organisations advised they would not be supporting their employees to participate in the research, as it was not part of their employment with the organisation; therefore, we did not proceed to recruit potential participants from these organisations. Secondly, representatives from some government departments advised that they were unsure if permission would be granted to conduct the research and, even if it was, the timelines required for data collection may not be able to be accommodated. They also advised that representatives of departments required the right to prevent

the use of some data collected from their employees. Therefore, given the timelines, the considerable time and cost to complete ethics and other related processes, and the risk of data not being able to be used, we did not proceed with trying to recruit from these organisations. As researchers, we understand and respect the ethical and practical concerns, but at times this results in a limited sample. In this study it means that government employees delivering MBCPs are under-represented.

A limitation with the practitioner survey component of the project was that some participants did not fully complete all items in the questionnaire and left some items unanswered. It is appreciated that the length of the survey, which reportedly took 20–25 minutes to complete, may have led to this. Some participants may also not have known the answers to questions such as the estimated annual numbers of perpetrators that commence MBCPs in their agency.

In regards to the women's survey, the small sample size was unsurprising to the project team considering this is a relatively small population of women who can be hard to reach. This is indicated by the results that follow. We know from previous research that female partners of men who are referred to MBCPs have often experienced particularly severe and enduring levels of violence, which has impacted significantly on their health and wellbeing (Smith, 2013). This may mean that many women are justifiably reluctant to share their experiences with researchers. Regardless, the women who chose to participate shared enough information to provide a good level of insight into their experience of partner contact support. In addition, as we did with the practitioner survey as part of ensuring ethical research, we gave participants complete autonomy over what questions they did or did not answer, even though this resulted in not every participant completing every question. As the women's sample was self-selecting, it may have been biased towards participants who felt strongly about the MBCP their (ex-)partner attended. This could have included both participants who felt particularly negative about the MBCP and others whose experience was particularly positive.

The in-depth interviews with providers were similarly restricted, with some managers advising participants that there was a time restriction on their interview as it was not part of their paid employment. For example, one person advised us that their supervisor had said they could only spend 45 minutes being interviewed for the research.

Partner contact practices in men's behaviour change programs: A review of the literature

Overview

Although there is a growing body of research focused on the evaluation of MBCPs globally (Akoensi, Koehler, Lösel, & Humphreys, 2013; Arias, Arce, & Vilariño, 2013; Lilley-Walker, Hester, & Turner, 2018), very little empirical research has been conducted on the partner contact component (Smith, 2013). The vast majority of MBCP research focuses on the impact of group work on changing men's behaviours and attitudes, and on identifying both the program content and individual characteristics of perpetrators that are most likely to lead to a reduction in the use of violence. These studies are often designed to include the reports and views of partners and ex-partners, but are primarily concerned with what differences, if any, women identify once the perpetrator is undertaking the MBCP (Lilley-Walker et al., 2018). With a few exceptions (Alderson, Westmarland, & Kelly, 2012; Smith et al., 2013), most research about MBCPs has focused on what impact participating in the MBCP has had on the perpetrator rather than whether partner contact was valuable to their female partner or ex-partner. The purpose of this review is to provide an understanding of the organisation, role, practices and outcomes of MBCP partner contact from the peer-reviewed and grey literature.

The practice and purpose of any support provided to adult and child victims/survivors has been, and remains, an area of contestation, including the language used to describe the practice and associated outcomes. The term "partner contact" is used throughout this review as it has been commonly employed in Australian policy and programming over the past 25 years. However, it is acknowledged that other terminology is often preferred, such as "partner support", "women's advocates", "women's support programs", "women's contact workers", "women's support services", "family safety workers" and "independent support services".

Further to this, the practice of partner contact is inherently gendered since it has developed out of the men's behaviour change sector. Consequently, the vast majority of this work and the research around it have focused predominantly on women as the partners and ex-partners of the men in these programs. This is consistent with the gendered nature of DFV work more generally, and is reflected throughout this

review with the use of the term "perpetrators" for men and "victims/survivors" for women. This is not intended to exclude the vast diversity of relationships in which DFV may exist, or the needs of all adult and child victims/survivors, but instead reflects the evolution of the work within a specific and gendered context. The term "woman" is commonly used in this review for these reasons. However, the gender-neutral term "partner" is often used to recognise men and gender non-binary people as also being victims/survivors of men's, or male-identified persons', use of DFV.

The term "partner contact" can also be somewhat misleading, given that practices in Australia and internationally involve far more than simply "contact" with partners and ex-partners. Describing this practice as "contact" fails to encompass the multifaceted and complex nature of this work. The term also fails to recognise the multiplicity of potential victims/ survivors, such as those in Indigenous or extended family contexts, beyond current and past intimate partners: rarely has the use of DFV only affected the partner of the perpetrator. Nor does the term recognise children as victims/survivors, or the impact of DFV on relationships between adult victims/ survivors and their children (Callaghan, Alexander, Sixsmith, & Fellin, 2018; Sharp-Jeffs, Kelly, & Klein, 2018).

Because of these limitations, there has been some experimentation and divergence in the use of the term "partner contact" in recent Australian policy contexts, with "family safety contact" used in the updated Victorian MBCP minimum standards (Family Safety Victoria, 2018) and the generic term "support service" in the revised New South Wales standards (NSW Department of Justice, 2017). This review, then, begins with an introduction to MBCP partner contact that explores these considerations further and connects the practice to the broader DFV service system. The purpose and practice of partner contact is also discussed, drawing on key Australian and international policy standards and practice guidelines.

A review of qualitative research studies exploring the experiences of MBCP partner contact for women and children is presented, including consideration of what is understood to constitute quality practice. Key variables associated with

the delivery of partner contact services are also presented, with additional exploration of what the literature reports about the inclusion of children or child contact in MBCPs. The review also sought to consider partner contact practices among Aboriginal and Torres Strait Islander peoples, CALD groups, and people identifying as LGBTIQA+, but found very little peer-reviewed or grey literature that specifically discusses partner contact for these communities. Finally, commonly cited barriers and challenges associated with the provision of partner contact are described.

As previously discussed, a scoping review methodology was employed for this project. This review found that, aside from a small number of key academic research articles, the majority of the knowledge, reviews and research evaluations in this area exists in grey literature. As such, a scoping review was chosen because partner contact is a relatively under-researched area in DFV generally and in MBCPs specifically, and this form of review enables a wide range of published material to be included in the search. It also provides policy makers and practitioners with an accessible overview of available knowledge and evidence (Colquhoun et al., 2014). Detailed information around the scoping review methodology is provided in the methodology chapter.

Partner contact in MBCPs

The two central foci of partner contact work have been described as the safety and liberty of adult and child victims/survivors, and its role in offering practitioners working with DFV perpetrators knowledge about their violent and controlling behaviours (Smith et al., 2013) in addition to that provided by the perpetrators themselves.

It has been argued that partner contact provides an accountability mechanism for MBCP providers to women and children (NTV, 2006). This is because practitioners have to explain the direct practice component of the MBCP to partners, offer realistic expectations about what could change for the perpetrator over the life of the intervention, and ensure that women's reporting of perpetrators' actions and their impact on them and their children is privileged over the perpetrators' accounts. The latter is particularly

important, as there is practice and empirical evidence that perpetrators commonly deny and minimise their use of violence and abuse (Gondolf, 2012).

Partner contact is considered a vital component of MBCPs across Australia (NTV, 2006) and internationally, including, for example, much of Europe (Work with Perpetrators European Network [WWP-EN], 2018a), the United Kingdom (Respect, 2017), New Zealand (Polaschek, 2016), and Canada (Scott, Heslop, David, & Kelly, 2017). However, it is noted that the provision and practices of partner contact vary substantially within and across each of these jurisdictions (see, for example, Scott et al., 2017; WWP-EN, 2018a).

In some jurisdictions in the United States, partner contact is not provided or encouraged. This is because the batterer intervention program (BIP)[3] standards sometimes forbid contact with (ex-)partners by the organisation operating the BIP due to a belief that obtaining and using victim/survivor reports in BIP case planning and delivery can undermine the objective of victim/survivor safety (Maiuro & Eberle, 2008). In addition, a significant proportion of BIPs in the United States are run by clinicians in private, for-profit practice settings, which are often set up in a way that cannot easily incorporate the provision of parallel partner contact and support services (Cannon, Hamel, Buttell, & Ferreira, 2016).

It is important to note that while the availability and type of partner contact service offered varies across North America, there are varying levels of practice in liaisons with the victim/survivor advocate services that work with partners (Cannon et al., 2016). For example, in Colorado victim/survivor advocacy services work very closely with MBCP providers and probation officers as part of multi-disciplinary teams (Hansen, 2016). Furthermore, in some United States jurisdictions, unlike in most Australian jurisdictions, probation officers have direct contact with victims/survivors and can exchange information about these contacts with program providers.

MBCPs and other perpetrator interventions can also exacerbate risk for women and children (De La Harpe & Boonzaier, 2011; NSW Department of Attorney General & Justice, 2012; Vlais,

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3   The US term for MBCPs.

Campbell, & Green, 2019; Vlais, Ridley, Green, & Chung, 2017). This can happen when perpetrators attempt to use or manipulate their participation in a program as a tactic of control or entrapment against their victims/survivors, or "play" the perpetrator intervention system to avoid taking responsibility for their behaviour (De La Harpe & Boonzaier, 2011). A perpetrator's participation in a program can result in a range of unintended negative consequences in terms of victim/survivor safety, and reduced accountability for their violent and controlling behaviour.

McGinn, Taylor, McColgan and Lagdon (2015) conducted a review of qualitative studies that explored victims'/survivors' perspectives on MBCPs, and identified several negative impacts or side effects of MBCP participation for (ex-) partners including:

- additional family stress
- creating further means by which perpetrators became skilled in new/additional forms of abuse (through directly or indirectly learning new tactics from other participants in the program)
- "triggering" perpetrator abuse directed at the victim/survivor (e.g. when she does not "reward" him for his "cessation" of violence)
- increasing the risk to victims/survivors if, as a result of feeling safer due to their (ex-)partner merely attending an MBCP, they reduce attention to safety planning (McGinn et al., 2015).

Indeed, intervening with the perpetrator through MBCP work can increase hope that his abuse will lessen and possibly end, potentially influencing women's decision-making around safety (Opitz, 2014; Respect, 2017). Further, the points at which men stop attending a program or complete a program can be times of elevated risk for women and children, with increased support and safety planning vital at this time (Smith et al., 2013; Vlais, 2014b). MBCP practitioners, therefore, have a responsibility not only to identify and monitor how each man's participation in the program might result in adverse outcomes for victims/survivors, but to hold the safety of women and children at the centre of all their work with men (Rajagopalan, Price, Langston, & Potter, 2015; Smith, 2013).

(Ex-)partners of men engaged in MBCPs have also been found to have different experiences and needs than women living in refuges or those who are already accessing specialist women's services (Gondolf, 1998; Howard & Wright, 2008; Smith et al., 2013). The literature has often noted that (ex-)partners (and children) of MBCP participants frequently have relatively little or no contact with formal support services (Chung, Lucas, & Justo, 2009; Smith et al., 2013). Men's attendance at an MBCP can, therefore, create a pathway for these women to be contacted and offered support, even though they may not describe their experiences as DFV or have not sought support previously.

There is no substantive evidence about the characteristics of women who take up the offer of MBCP partner contact compared to other cohorts of victims/survivors. It is possible, however, that in the future there may be a greater number of female (ex-)partners who will have some contact with the DFV service system than has occurred in the past. This is due to DFV integrated service systems across Australia becoming more proactive in routinely offering a wider range of support to women and children, together with an overall increase in the proportion of men participating in an MBCP following various perpetrator-focused policy reforms (Vlais, 2014b). This does not necessarily mean, however, that the contact with victims/survivors will align to a perpetrator's participation in a program, particularly as significant escalations in demand for services for adult and child victims/survivors—stemming from integrated service system reforms and increasing community confidence in formal service system responses—have resulted in many such services becoming short-term, crisis-driven and compartmentalised.

Partner contact services, irrespective of whether a victim/survivor has or has not received other specialist DFV services, can support the struggles of women and children to obtain an "expanded space for action" in their lives (Kelly & Westmarland, 2015; Smith et al., 2013). The proactive nature of quality partner contact practice can also be beneficial given that one of the most significant barriers to women accessing support involves the fear of not being believed and heard, and of receiving judgmental or punitive responses (Gondolf, 2002).

It is argued that current responses and processes associated with addressing DFV need to do more to recognise and acknowledge the multiple impacts of DFV on women's and children's lives, such as loss of income, risk of homelessness and transition, poor mental and physical health, and fewer opportunities for employment and study (Domestic Violence Service Management [DVSM], 2018; Goodman & Epstein, 2005; Opitz, 2014). These diverse impacts are often overlooked when there are narrow conceptualisations of what success means in terms of perpetrator interventions or programs, and when the outcomes for adult and child victims/survivors are not central to service system responses. At the MBCP level, partner contact can offer a more direct and alternative perspective on whether the program is making a difference to adult and child victims/survivors (ANROWS, 2019). It offers much greater detail about men's behaviour than administrative data, which is only relevant if the perpetrator's actions come to the attention of authorities and are recorded.

Westmarland and Kelly (2013) have sought to clarify both the meaning of success in MBCPs, and the broader efforts needed to address men's use of violence, by moving beyond the limited focus of recidivism and ending physical violence. While changes in physical violence remains an important measurement, it fails to reflect the extent of change that is often hoped for by adult and child victims/survivors (Mackay, Gibson, Lam, & Beecham, 2015; Vlais et al., 2017). Interviews with women revealed far more nuanced and covert notions of success, which may seem like subtle changes but are experienced as significant and life-enhancing for women (Westmarland, Kelly, & Chalder-Mills, 2010; Westmarland & Kelly, 2013).

Through this research, success was reframed as involving:

- an improved relationship with the (ex-)partner characterised by respect and effective communication
- women having an "expanded space for action" in their lives to enact their struggles for a restored voice, dignity, choice-making and improved wellbeing;
- safe, positive and shared parenting
- men's enhanced awareness of self and others, including the impact of their violent behaviour on their (ex-)partner and children

- safe and healthier childhoods for children in which they feel heard and cared about (Westmarland & Kelly 2013, pp. 1098–1106).

Furthermore, success was seen as encompassing women's and children's liberty and ability to live dignified and meaningful lives as defined by them (Vlais, 2014b; Westmarland & Kelly, 2013). This notion of success potentially provides room for services and the broader service system to recognise women's and children's existing efforts to work towards and build upon their safety, to resist the violence they are experiencing, and to respond to that violence in the context of the full complexity of their lives—in other words, to follow their lead (DVSM, 2018; Wilson, Smith, Tolmie & de Haan, 2015).

Integration and collaboration

Opitz (2014) notes that despite MBCPs being contracted to undertake partner contact within their programs, research with women across three Australian jurisdictions indicated that partner contact was not routinely conducted. The Diemer, Humphreys, Laming and Smith (2015) survey with MBCP providers in Victoria, for example, explored collaborative processes across the sector and indicated that partner contact workers mostly operated within MBCP provider teams. In this context, they found a lack of established links with relevant services external to MBCP providers that could assist partner contact workers to provide more comprehensive support to women and their children (Diemer et al., 2015). Further, program integration into the broader service system of support for women and children was found to be underdeveloped (Diemer et al., 2015).

Opitz (2014) suggests that strong partnerships and processes across the service system could bridge the gaps for MBCP providers to have more effective contact with (ex-)partners, and to improve their work with men. Various challenges to successful partnerships within an integrated service response have been highlighted, however, including funding constraints and competitive tendering contexts (Opitz, 2014). Diemer and her colleagues (2015) reported relatively poor collaborative processes between MBCPs and other sectors, attributing this to the early stage of integration reforms, the siloed nature of funding, a lack of cross-agency mentoring opportunities, and limited understanding of the expectations

of good practice models. They did note that this variable and developing stage of collaborative work between MBCPs and other organisations is not due to a lack of willingness (Diemer et al., 2015). Indeed, program providers generally have good intentions regarding the importance of partner contact (Vlais, 2014b).

It is widely accepted that creating formal collaborative and responsive processes between the whole system—namely MBCPs, law enforcement, justice-based agencies, child protection and family support services, specialist women's services and other human service organisations—is vital in responding effectively to men who use violence and to ensuring the safety of women and children (Day, O'Leary, Chung, & Justo, 2009; Vlais et al., 2017). However, while service system integration in many Australian jurisdictions is slowly improving, apart from a few exceptions, a consistent and coordinated response to women and children is not yet a reality. There are also calls on policy makers, funders and practitioners to consider how partner contact can best be practised in an environment of austerity and competitive tendering (Opitz, 2014; Smith et al., 2013; Vlais et al., 2017).

In relation to multi-agency partnerships, Logar (2015) and Castelino (2014) argue that gender inequalities between services are inescapable, and it is therefore challenging to build partnerships between specialist women's services and MBCPs. They suggest that the entry of men's services into a field historically led by women and women's services will generally not result in a "level playing field". Rather, a range of patriarchal dynamics will result in men's services and men's practitioner voices becoming privileged and potentially displacing those of their women colleagues. Additionally, it must be acknowledged that power imbalances can be reproduced easily and can lead to, or reinforce, gender inequality if the conditions for gender-based privilege are not identified, monitored and responded to between and within services (Logar, 2015). This can often include consideration of the labour process, such as whether there is parity of salary between those working directly with perpetrators and those working in survivor support services, and if there are differences in access to free or subsidised training or in caseload size relative to the organisations' staffing complement.

Logar's (2015) view is that to resist the likelihood of such unequal power relations between men's and women's services, female victims/survivors must be offered support by independent, human rights-based and gender-sensitive organisations. She argues that the practice of partner contact being delivered by perpetrator program providers is problematic and requires reassessing. In her view, women should receive support from specialist services that work only with women, with advocates who "stand by their side uncompromised by any consideration concerning the work with perpetrators" (p. 11). Indeed, the Istanbul Convention on addressing violence against women asserts that perpetrator programs must work closely in collaboration with, but separate to, specialist women's services and themselves provide no direct support to women (Council of Europe, 2011). This is also the position held by the Work with Perpetrators European Network (WWP-EN, 2019), which argues for specialist women's services to provide partner contact in collaboration with MBCPs:

> If perpetrator programmes need to be accountable in terms of the services that must be available to victims the logical consequence is that there are three ways in which this can happen. One is a tight partnership with independent women's support services, the second is women's support services directly connected and set up by perpetrator programmes themselves, the third are perpetrator programmes set up directly by independent women's support services that provide the services themselves. (pp. 13–14)

However, the WWP-EN (2019) highlights that establishing such partnerships is "complicated territory", which may be difficult to negotiate in a competitive, contractual environment such as Australia. It argues (WWP-EN, 2019) that this issue requires attention, as it is the ethical responsibility of perpetrator programs to prioritise women's and children's safety. Furthermore, without an independent partner contact response, WWP-EN argues that these programs cannot ensure they are not overly influenced by perpetrators' perspectives. These are important points of debate because they demonstrate how closely linked partner contact is to accountability and its pivotal role.

As mentioned earlier, partner contact can often be backgrounded in MBCP evaluation research. Two Australian

studies found that the partner contact of MBCPs often takes second place to program work with men in terms of general focus, practitioner attention and resource allocation (Opitz, 2014; Smith et al., 2013). The studies also found that while MBCP providers emphasise the importance of partner contact, several indicators (including some women's experiences) point to this work receiving (sometimes significantly) less priority than the providers' work with men. Smith and her colleagues (2013), therefore, suggested that MBCP partner contact operates as part of independent and specialist women's support and advocacy services, as it does in England and Scotland (Ormston, Mullholland, & Setterfield, 2016; Respect, 2017). Others, however, have argued that although there is a role for specialist women's services to hold MBCP providers accountable in prioritising victim/survivor experiences and voices, program providers also have an essential role in partner contact (Opitz, 2014). Thus, a starting point in addressing existing gaps may be a dedicated MBCP partner contact service with strong, established partnerships with specialist women's services (Opitz, 2014). The debates about how MBCP partner contact should be best organised and operate reflect broader contention about the fundamental purpose(s) of the practice.

Purpose and approach to partner contact

A number of Australian and international jurisdictions have minimum standards to guide MBCP work, with most including partner contact in these standards. State minimum standards in Australia have broadly similar expectations regarding partner contact, though generally with little prescription concerning how it should be practised. At the time of conducting this State of knowledge review (2018) there were minimum standards in place in New South Wales, Queensland, Victoria and Western Australia (Day et al., 2019). The Northern Territory, Australian Capital Territory and Tasmania did not have minimum standards for MBCP work, while standards for South Australia were being drafted, with development continuing to ensure a focus on intervention prior to contact with the criminal justice system.

The commonly stated central purpose of MBCP partner contact across these minimum standards is the safety and wellbeing of women and children. This aligns with the broader fundamental goal of MBCP service provision, which is to work towards safety, human rights, freedom and autonomy of adults and children affected by men's use of DFV (Department for Child Protection and Family Support, 2015; Family Safety Victoria, 2018; Grant & Mitchell, 2010; NSW Department of Attorney General and Justice, 2011, 2012, 2017; NTV, 2006; Respect, 2017; Vlais, 2014a). Detailed Australian practice guidance about MBCP partner contact work located during the research period includes *Towards safe families: A practice guide for men's domestic violence behaviour change programs* (NSW Department of Attorney General and Justice, 2012), and the earlier *No To Violence minimum standards manual* (NTV, 2006). More recently, Family Safety Victoria's (2018) *Men's behaviour change minimum standards* provides some level of practice guidance with varying amounts of detail.

Purpose and approach

The underlying rationale for the approach to partner contact that has evolved is based on the following principles described by Vlais (2014b, p. 23): "seeing women in their own right (not just as partners or former partners of the men, and not just as parents)" and "noticing and validating women's sense of agency".

These remain important foundational principles because of the dynamics of DFV whereby perpetrators commonly minimise their use of violence and coercion (Hearn, 1998), and victims/survivors rights to safety and freedom have to be upheld. Partner contact is a key site for redressing the denial and minimisation, often coupled with victim blaming (Reissman et al., 2019), to which victims/survivors have been subjected. It does this by acknowledging their perspectives and offering alternative accounts of the perpetrators' violence and its impacts. Vlais (2014b) operationalises the underpinning principles by drawing on an analysis of DFV minimum standards documentation and research evidence. He explains that partner contact can enable comprehensive and dynamic risk assessment through identifying and managing the safety needs of victims/survivors and their children, and working with other agencies to respond to the threats and risks posed by the perpetrator. Building trust with the victims/survivors provides an opportunity to collaborate in safety planning (Vlais 2014b).

In terms of the perpetrator's MBCP participation, there are two related aspects. The first is working with women and older children to provide accessible information about the operation of the MBCP and the perpetrator's participation in it. The second is to offer some insights into the realistic and likely levels of change for perpetrators, including that there may not be progress or that the dynamics of DFV may change (Kelly & Westmarland 2015; Vlais 2014b). Partner contact also provides a means by which victims/survivors contribute both their knowledge to the assessment of risk the perpetrator poses to them, and their perspective of how the MBCP is impacting on the perpetrator's actions outside the program. This can offer MBCP facilitators insights into a participant's attendance and actions in the program that would not otherwise be available (NSW Department of Attorney General and Justice, 2012; NTV, 2006).

Partner contact is also a mechanism of external accountability that can draw attention to any unintended or adverse outcomes for adult and child victims/survivors as a result of a perpetrator's attendance at an MBCP that might otherwise not be known (Respect, 2017; Swedish Association of Local Authorities and Regions, 2018). Vlais (2014b) and Lamb (2017) also argue that partner contact and MBCPs more generally should also focus on restrengthening and repairing the mother–child bond, which has often been harmed by perpetrators' sabotage tactics. As such, perpetrators' responsibilities as fathers should be a focus of intervention, particularly around the impact of DFV on their children and what reparation would be possible.

To realise this purpose requires a practice approach that is DFV informed, based on working in partnership with victims/survivors, and that recognises the time involved in developing trust in such an approach (Kelly, Sharp, & Klein, 2015). The focus of partner contact practice can involve providing direct support, advocacy and referral, as well as space for victims/survivors to consider and decide on options—all of which are central to a DFV-informed approach.

Partner contact practice

The United Kingdom and European minimum standards state that partner contact should be provided by a service independent of the MBCP (Respect, 2017; Uligaj & Batenkova, 2017). The Scottish Caledonian system emphasises that partner contact should be an independent service for women in their own right so they can manage risks to their safety and wellbeing generated by service system interventions (both by the Caledonian system men's program and other perpetrator interventions). Such an approach also enables the voices of victims/survivors to shape the development of services (Grant & Mitchell, 2010).

In the United Kingdom, minimum standards are developed for community-based MBCPs by Respect, a non-government organisation that also accredits programs. The Respect standard that pertains to partner contact is the most comprehensive among those reviewed. The purpose and details of "how" to do MBCP partner contact work are quite specific in their instructions to practitioners; this specificity enables measurement against the standards. In Western Australia, the practice standards for MBCPs stipulate that the purpose of partner contact is to support victim/survivor safety and to manage risk, in addition to preparing women for the perpetrator's participation in an MBCP. This includes:

- the provision of information about the rights of women and children in regards to safety and legal protection
- the limitation of MBCPs, including the possibility that violent and controlling behaviour may continue
- the content areas covered by the program
- what the program provider will do if the perpetrator breaches a court order or commits any act of violence against the woman or child
- an outline of support services and resources available (Department for Child Protection and Family Support, 2015).

Common among the partner contact standards is that they are tailored to the individual needs of women and children (Department for Child Protection and Family Support, 2015; Family Safety Victoria, 2018; Grant & Mitchell, 2010; NSW Department of Attorney General and Justice, 2011, 2012, 2017; NTV, 2006; Respect, 2017). These needs may include health, mental health, housing, financial and managing substance use (Family Safety Victoria, 2018). As such, partner contact workers are expected to make referrals to address all of those needs deemed relevant by the adult victim/survivor and their family (Family Safety Victoria, 2018).

However, beyond the partner contact practice descriptions presented in the standards and guidelines mentioned, there is very little literature about it. In part, this shortcoming can be attributed to the different approach to partner contact taken in the United States, which has meant that research drawn from American BIPs rarely includes or considers this practice in its findings.

The experiences of partner contact for women and children

There are, however, some qualitative studies that have explored the impact of partner contact on women and children (e.g. Howard & Wright, 2008; Opitz, 2014; Smith et al., 2013). These studies support the idea that partner contact is an integral component of MBCPs in that it:

- validates and recognises women's distressing experiences of abuse
- assists victim/survivor safety
- enables opportunities for women to provide and receive information
- improves victim/survivor knowledge and awareness of the nature of DFV and of service system options
- contributes to broader benefits for women's wellbeing.

Although these qualitative studies do not serve as experimental or quantitative forms of evaluation, it is extremely difficult to undertake a rigorous evaluation of the partner contact component of MBCP work that is independent of the effects of other program components on victim/survivor safety and wellbeing. As such, at the time of writing no quantitative studies focusing specifically on partner contact evaluation had been identified. Thus, qualitative methodologies drawing on the experiences and perspectives of victims/survivors remain important in documenting the impact of partner contact services and processes.

Variability in partner contact practices: Longevity and quality

Qualitative research studies of partner contact have found that women's experiences are highly variable, from not receiving

any partner contact through to contact that was a critical lifeline linking women to supports (Kelly & Westmarland 2015; Opitz, 2014; Ormston et al., 2016; Smith et al., 2013; Vall, 2017). These studies reveal significant variability and inconsistency in the provision of partner contact in regard to its longevity and quality. Opitz (2014) identified in her Australian study that women were not consistently contacted, with the few women who had engaged in formal support initiating it themselves rather than being provided with any proactive service outreach. Further, 19 of the 25 women who participated in this study had no information formally provided to them about their (ex-)partner's participation in the MBCP, and no partner contact was conducted (Opitz, 2014).

Smith et al. (2013) found that there was a continuum in Victoria that ranged from not receiving any partner contact through to being part of an integrated response. Seven of the 15 women participants in this study received minimal support, four described changes in support over time, and four reported an integrated response from DFV support services (Smith et al., 2013). Some women experienced increases in support during the course of the study, and this was attributed to improvements in police practice, and to programs receiving additional funding to employ dedicated partner contact workers (Smith et al., 2013). Some women, however, remained unsure about the nature of the partner contact service being provided to them (Smith et al., 2013). When the service system was unable to protect women or to offer any helpful response, their situation was exacerbated (Smith et al., 2013).

Project Mirabal, a United Kingdom multi-site perpetrator outcome study, similarly reported considerable variability in the amount of time women received support for and the quality of that support (Kelly & Westmarland, 2015). The Caledonian system evaluation in Scotland corroborated these findings, identifying a variation in contact with eligible partners across women's services that ranged from 61–91 percent (Ormston et al., 2016).

Opitz (2014) and Smith et al. (2013) found that some women receiving "standard" partner contact did not feel it was improving their safety and that risk remained imminent. Both these studies noted that, for women, partner contact

was not regular and ongoing, and that face-to-face, ongoing risk management was generally unavailable and did not continue beyond when the man either completed or stopped participating in the MBCP. In the absence of partner contact, Opitz (2014) found that women formed their own ideas and received limited (and sometimes misleading) information from the men about the program. One woman questioned how the MBCP could work with the men without knowing anything about the victim/survivor (Opitz, 2014).

The United Kingdom research showed variation in the level of information that women received about the program and the men's attendance (Kelly & Westmarland, 2015). This ranged from frequent and detailed briefings, to having only basic knowledge about the program structure, content, and the overall extent and quality of support available to them (Kelly & Westmarland, 2015).

An evaluation of perpetrator programs in Nordic countries and territories found approximately one-third of MBCPs failed to provide information about the program to partners, and around half did not share information about the specific approaches and limitations of the program. Some programs indicated that they do not inform the (ex-)partner in times of heightened risk (Vall, 2017). Findings from a continent-wide evaluation of European perpetrator programs revealed that two thirds provided partner contact, but that a significant number of programs did not fulfil at least some of the related national and international MBCP partner contact standards (Geldschläger, Gines, Nax, & Ponce, 2014).

Smith et al. (2013) highlighted the importance of providing or continuing partner contact beyond the perpetrator's completion of the program. They found that some women became more emboldened during the course of the perpetrator's participation in the program to "draw lines in the sand" regarding his behaviour, and to hold him accountable to any promises he might have made to change his behaviour. For these women, their efforts to hold their (ex-)partner accountable often increased as he was nearing completion of the program. Smith et al. (2013) argued that some perpetrators will respond to this increased resistance and attempts to hold them accountable by attempting to suppress it through

an escalation of violent and controlling behaviour. In this respect, continuing partner contact beyond the perpetrator's completion of the program was considered vital for ongoing risk assessment and risk management, and to support victim/survivor agency and struggles for freedom from violence (Smith et al., 2013).

The importance of validation and recognition to women

A Victorian study of partner contact experiences, commissioned by the Inner South Community Health Service (now Star Health), found that the validation women experienced through connection with partner contact workers was of significant benefit to them (Howard & Wright, 2008). Even those women who reported the MBCP as having no positive impact on the behaviours and attitudes of their (ex-)partner claimed that this validation was important for them (Howard & Wright, 2008). Similarly, Smith et al. (2013) reported that women in their study felt that the partner contact worker was someone with whom they could talk without being judged, and saw value in the fact that the worker knew their (ex-)partner (Smith et al., 2013).

A mixed methods evaluation of the Te Manawa Services men's program in New Zealand, which included a Family Support Service (FSS) offered to partners, ex-partners and children, similarly reported that the FSS provided recognition for women affected by abuse and violence (Denne, Coombes, & Morgan, 2013). One woman from this study explained the ways in which partner contact may assist in preventing women's voices being lost in the service system: "Where someone like me could be lost in another service, another system, I might not have got any support" (p. 109). Research by Ormston et al. (2016) and Austin and Dankwort (1999) similarly reported that women appreciated partner contact workers confirming their non-culpability, and that being subjected to DFV was not viewed as their personal deficit.

The New Zealand study also reported that partner contact assisted women with the process of healing (Denne et al., 2013). Women expressed appreciation for not being rushed, feeling understood and for the partner contact worker being

sensitive and sympathetic in their approach (Denne et al., 2013; Howard & Wright, 2008). Notably, other women have emphasised the significance of the initial call they received from a partner contact worker stating: "It felt great that someone bothered to call" and "It was such a relief—to be able to talk about it, at last" (Howard & Wright, 2008, p. 24). Partner contact may provide the first, or one of very limited, contacts with formal support services and is, therefore, an important pathway into the wider service system.

A sense of safety

A significant finding across the studies reviewed is that women reported feeling safer as a result of partner contact, and that this was separate to, and independent of, any changes in their (ex-)partner's behaviour (Denne et al., 2013; Howard & Wright, 2008; Ormston et al., 2016; Smith et al., 2013). Women often did not identify changes in a perpetrator's behaviour as a factor that increased their feelings of safety, but rather felt safer as a result of additional perpetrator-focused information and monitoring, and an improved space for action (Denne et al., 2013; Ormston et al., 2016). Denne et al. (2013) noted:

> The women who said their (ex-)partner did not benefit from the men's Programme often still highly recommend Te Manawa Services due to the level of support and help they personally received. They said that, regardless of their (ex-)partners' processes of change, their safety and wellbeing was increased significantly as a result of the spectrum of services and support offered to the families of men on the Programme. (p. 121)

Howard and Wright (2008) described how, for some women, confirmation that their (ex-)partner was attending the MBCP brought relief; they felt it was useful to have the partner contact worker confirm their partner's attendance, even if they did not feel they wanted to talk in great length about themselves. Similarly, the Caledonian evaluation found that women believed that the integrated system enabled them and their children to feel safer, because men were being monitored and women received updates on their (ex-)partner's involvement in the MBCP (Ormston et al., 2016).

The women who participated in the Te Manawa Services FSS evaluation described how a built-in process of reflection on the men's degree and types of behaviour change enabled them to make informed decisions regarding both their safety and the future of the relationship with their (ex-)partner (Denne et al., 2013). They also considered safety planning and advice about upcoming events or circumstances that might compromise their safety and wellbeing (for example, child custody changes) as beneficial (Denne et al., 2013). The women's service in the integrated Caledonian system provided similar support, which was described by women as increasing their safety (Ormston et al., 2016). This included extensive advice and support regarding safety planning and negotiating specific situations, such as actions to take if their (ex-)partner breached court orders, better home security, and issues related to phone and technology use (Denne et al., 2013; Ormston et al., 2016). Women also identified the workers' support and encouragement to contact police when breaches of orders occurred as significantly helpful (Ormston et al., 2016).

Conversely, Howard and Wright (2008) found that women did not explicitly report that the partner contact they received increased their feelings of physical safety. One woman said she only began to feel safer once she ended the relationship. Another, who had suffered significant physical injuries from the assaults inflicted by her ex-partner, described how the feeling of being unsafe was ever present. This everyday reality experienced by many women is often unable to be mitigated by individual support workers (Howard & Wright, 2008; Smith et al., 2013).

While partner contact was largely viewed as having a positive impact on the safety of women and children, Opitz (2014) highlights the importance of considering the complexities associated with this practice. Although the men participating in MBCPs may understand there will be partner contact, they may still pressure or coerce their partner or ex-partner about what was said or what to say and not to say in the future. The content of discussions between the worker and (ex-)partner is not disclosed to the man; the management of this information remains a complex area requiring further exploration.

Opportunities to provide and receive information

In a number of studies, women highlighted the value of reciprocal information sharing (Denne et al., 2013; Howard & Wright, 2008; Ormston et al., 2016; Smith et al., 2013). A key finding of the Te Manawa Services FSS evaluation, for example, was the opportunity for women to inform the service of their (ex-)partner's progress and receive feedback around his engagement with the MBCP. Gaining knowledge about the content of the MBCP helped victims/survivors to understand the program, and to develop trust that their (ex-)partner's use of violence was being addressed appropriately in the MBCP (Denne et al., 2013). Women also felt affirmed by workers stating that victims/survivors know best about whether their (ex-)partners were making progress in the program (Austin & Dankwort, 1999).

Similarly, Howard and Wright (2008) reported that women saw partner contact as a way to suggest topics for discussion in the men's group. This provided hope that men might change their behaviour, and a sense of empowerment that the women were contributing to helping their (ex-)partner focus on what needed to change, in a way that was anonymous and indirect.

For women whose partners did not communicate with them about the program, the partner contact information sharing process was particularly useful (Denne et al., 2013). Women also noted that being informed about the techniques and strategies the men were learning assisted them to identify unfamiliar behaviour possibly stemming from the techniques taught, such as walking away for a "time out" (Denne et al., 2013). Knowing that the FSS was familiar with their (ex-)partners' stories and progress, and thus was well placed to address their safety needs, increased the women's sense of security and confidence.

Contrary to this, however, women spoke about their frustrations associated with the confidentiality rules related to information sharing, that they would like to have known more about what was taking place so they could form their own opinion of the staff's assessment about their (ex-)partners' engagement in, and commitment to, the program (Denne et al., 2013; Ormston et al., 2016). As one of the participants

noted in the Scottish study by Ormston et al. (2016), this was important for the women "just to let us know what they're working on so we can expect if there is any backlash from it" (p. 40).

Opitz (2014) noted that the women in her study often spoke about their lack of involvement during the intervention process with their (ex-)partner, and how they wanted to be involved. The women felt they could value-add to the process and contribute indirectly to stopping the violence by providing information about substance use, home behaviour, and overall by facilitating the privileging of women's and children's voices in MBCP provision (Opitz, 2014).

Affirming victim/survivor experiences

Women reported that they appreciated the increased concern for their safety that partner contact provided. They also spoke of how support from the partner contact worker enabled them to discuss their experiences of violence and abuse in ways that enabled them to make greater sense of the patterns and types of abuse their partner or ex-partner used against them. This included consideration of how they were impacted by non-physical forms of psychological and emotional abuse (Denne et al., 2013; Howard & Wright, 2008). The partner contact engagement highlighted to them the ways in which their (ex-)partner had minimised and normalised DFV (Denne et al., 2013). Opitz (2014) similarly found that women felt validated by workers explaining that psychological abuse was a deliberate tactic by their (ex-)partners that had serious impacts on self-esteem and confidence. An outcome women reported about the Caledonian system was that it offered them a broader perspective, beyond their own experience, about how DFV perpetrators operated (Ormston et al., 2016).

Broader impacts on women

Women also reported broader impacts on their lives as a result of the support they received from partner contact or integrated women's service workers. For example, the Te Manawa Service in New Zealand provided a group program for women whose (ex-)partners were in the MBCP (Denne at al., 2013), and women participating in a parallel group program described reduced feelings of isolation (Denne et

al., 2013; Howard & Wright, 2008). The women spoke of the group helping to restore a sense of belonging, connection, confidence and wellbeing, as well as contributing to their reconnecting with friends and family (Denne et al., 2013). They appreciated having space for themselves within the group environment, which engendered hope and strengthened their knowledge and skills for the future. Ormston et al. (2016) also reported increases in women's confidence, which was attributed to the support and encouragement provided by the women's workers.

In addition, women reported improved physical health as a result of the support they received for attending medical appointments and dietary planning, along with a general sense of reduced stress and improved mental health (Howard & Wright, 2008; Ormston et al., 2016). Furthermore, women indicated a reduction in substance use and an increase in pride, with a number noting they had previously sought help from mental health and dedicated substance misuse workers. The impact of partner contact, and the subsequent relationships built with specialist women's workers, was highlighted as a significant factor in addressing their alcohol use (Howard & Wright, 2008; Ormston et al., 2016). Gains in financial independence were also reported which impacted positively on women's financial and employment circumstances. For some this resulted in increased confidence to pursue changes in their career (Howard & Wright, 2008; Ormston et al., 2016).

Smith et al. (2013) reported that some women felt more able to hold their (ex-)partners to account, voice expectations regarding their behaviour and take action if they chose to, such as leaving the relationship, because of the accountability and support aspects of partner contact. This is particularly important when women's sense of agency has been previously eroded as a result of coercive control.

Practice implications

The quality of MBCP partner contact is arguably dependent on at least three factors:

- adequate resourcing
- an integrated systems approach so that women can be offered support
- skilled staff, both those responsible for partner contact

and those working directly with perpetrators, as they have to skilfully use the partner information in their interventions (Denne et al., 2013; Opitz, 2014; Ormston et al., 2016).

Victims/survivors have found partner contact to be valuable because of its flexibility around their needs and circumstances, including:

- the worker coming to the home and fitting in with the woman's needs and schedule (Denne et al., 2013; Ormston et al., 2016)
- partner contact support being available whether or not the perpetrator was attending the MBCP (Howard & Wright, 2008; Ormston et al., 2016)
- partner contact workers navigating the complex service systems with the victim/survivor to get her needs met (Howard & Wright, 2008).

However, Smith et al. (2013) reported that in regional areas, co-location of MBCPs and other DFV services can create conflicts of interest and service accessibility issues for women and children.

Everyday practice considerations

Rajagopalan et al. (2015) have provided some discussion regarding the complexities of partner contact and quality practice, in particular, navigating confidentiality, information sharing and the appropriate use of men's disclosures. In situations where the perpetrator discloses a current incident of violence in a group session, it is critical that the MBCP worker follow up with the partner contact worker so they can both support the woman and continue with practical measures to reduce her isolation and increase safety as needed (Rajagopalan et al., 2015). However, they note this requires the partner contact worker to be sensitive about their communication with the victim/survivor so that their relationship is not jeopardised.

Opitz (2014) discusses the co-existence of love and hope for women experiencing violence and abuse, as this can lead to women being ambivalent about seeking help. Opitz (2014) argues that this may not be addressed if there are strict time constraints on partner contact, and suggests the following

approaches in relation to providing quality support through partner contact:

- create the conditions for conversations about competing feelings within a relationship for women
- deconstruct patriarchal societal and cultural understandings about love, romance and relationships—and the pressures for women to conform to these—from a feminist perspective using narrative style questions.

Smith et al. (2013) also point to the gendered conditioning of women to be "grateful" for any positive changes in their (ex-)partner, and the importance of this insight. Women were found to be grateful for any form of partner contact and apologetic for wanting more time, as opposed to feeling deserving of additional support and of living a life that is free from violence and abuse (Smith et al., 2013). Consequently, partner contact approaches that are integrated, genuine, flexible and ongoing can play a vital role in providing a different standpoint to patriarchal ideas that women are undeserving of help (Smith et al., 2013). Women have noted how proactive and persistent practice is highly valued, explaining that they would not have engaged in the partner contact service if the worker did not continue to let them know the service was available (Howard & Wright, 2008; Smith et al., 2013). This is in stark contrast to examples of "thin" partner contact, such as those described in some evaluations where women workers send a letter to the partner every 3 months to remind them that the service is still available to them.

Other partner contact practices identified as valuable include:

- maintaining an overarching principle of holding men accountable rather than seeing the women as solely responsible for children's safety
- close collaboration between women's and men's services, resulting in the service being better equipped to meet the needs of women
- keeping victim/survivor files open for 2 years (Ormston et al., 2016).

In contrast, most partner contact obligations in Australian programs are linked to a perpetrator's engagement with the MBCP, so last only as long as perpetrator participation and are largely delivered by a sole worker employed by the MBCP provider (Vlais et al., 2017).

Points of debate about the delivery of partner contact

There have been various debates about how best to deliver partner contact. Minimum standards and practice guidelines have been developed that stipulate or provide suggestions about different aspects of partner contact (Department for Child Protection and Family Support, 2015; Family Safety Victoria, 2018; Grant & Mitchell, 2010; NSW Department of Attorney General and Justice, 2011, 2012, 2017; NTV, 2006; Respect, 2017), and key variables include:

- the agency providing partner contact
- eligibility for partner contact
- frequency of contact
- when contact begins
- form of contact
- duration of contact.

These key points of debate are discussed in the following sections.

The provider of partner contact—Intra-agency or inter-agency

There have been calls to debate the arrangements and structure of partner contact provision, in particular, whether it should operate within MBCPs where a sole partner contact worker is employed by the MBCP provider, or be delivered by a specialist women's service through a memorandum of understanding (MoU) or contract arrangement with the provider (Vlais et al., 2017). One argument for the latter approach has traditionally been that it can also act as an additional form of coordination, accountability and/or transparency between perpetrator and victim/survivor services. Examples of this position being adopted include the Caledonian system in Scotland (Grant & Mitchell, 2010) and the European Network of Working with Perpetrators, both of which were discussed earlier in this chapter.

Australian jurisdictions have not taken a similar position in their standards of practice (Department for Child Protection and Family Support, 2015; NSW Department of Attorney General and Justice, 2012, 2017). In Australia, the majority

of partner contact arrangements are intra-agency with the same agency delivering the MBCP. Although they are usually independent of the MBCP service provision, there are also organisations where a female MBCP facilitator undertakes the partner contact (Vlais et al., 2017). In contrast to the United Kingdom and European position, Western Australian standards stipulate that partner contact by an external agency can be an ongoing arrangement:

> Partner contact can be provided by an external agency, through a partnership with a local victim support service, or internally through a designated partner support worker. The provision of partner contact by an external agency may be an ongoing arrangement and/or could be used in circumstances where a support agency is already providing domestic violence advocacy and support services to the woman and children, and it is considered that they would be best placed to provide the services that would ordinarily be offered by a partner support worker. This should be considered in circumstances where the partner support worker is having difficulty contacting or engaging the woman. (Department for Child Protection and Family Support 2015, p. 10)

In Western Australia and New South Wales, if partner contact is provided externally, standards stipulate that there must be a MoU stating the obligations of the external agency providing the partner contact (Department for Child Protection and Family Support, 2015; NSW Department of Attorney General and Justice, 2012, 2017). If it is provided within the MBCP provider agency the partner contact worker must be linked to that program area to promote effective communication about participants and their (ex-)partners. In New South Wales, there is an additional element in that the MoU between agencies must address how information is to be provided to victims/survivors (NSW Department of Attorney General and Justice, 2012, 2017).

In a Canadian study, Tutty, Knight and Warrell (2011) conducted research with two distinct partner contact services, one operating as part of the MBCP provider team, and the other through an external specialist women's DFV service. A higher number of women opted for contact with the specialist women's service than when contact was offered by the men's program provider. This was attributed to some

partners being an existing client of the women's service. The authors of the study, however, warned against the success of programs being measured by the number of women deciding to engage with the partner contact worker. They emphasised that partners choose not to be contacted by partner contact workers for a multitude of reasons and that this should not be considered a failure of the program, as women have a right to decline such services (Tutty et al., 2011). Some women have reported that they do not wish to engage in partner contact especially after separating as they see "his violence as his problem" and they have moved on (Chung et al., 2009). In terms of understanding the value and contribution of MBCP partner contact, it is equally important to record the number of women not opting to engage with the service and the reasons where this is known.

An important consideration around engagement is that the voices of adult and child victims/survivors who have declined service, refused contact or who have never been successfully contacted are largely missing. This is unfortunate as they are likely to have some important perspectives about why they decided not to engage with partner contact.

A survey of WWP-EN member organisations about partner contact practice showed that all but one of the 15 member organisations across the 12 European countries that responded reported they offer partner contact services including "support, protection and rehabilitation activities for (ex-)partners in different ways" (Uligaj & Batenkova, 2017, p. 9). Just over half of the responding organisations (54%) combine perpetrator programs with victim/survivor support services, whereas 31 percent provide perpetrator programs and refer women to external victim/survivor support services that are actively working with (ex-)partners. Only 8 percent of organisations noted that they have formalised partnerships with victim/survivor support services. There is currently no comparative evaluation of the differing organisations of partner contact (Uligaj & Batenkova, 2017).

In Australia—specifically in Queensland, Victoria and the Australian Capital Territory—there are at least five specialist women's DFV agencies running MBCPs and partner contact that have this arrangement. In this sense, working with men through the MBCP becomes a new service that the agency

integrates in the context of ongoing specialist services to women and children. In theory, at least, this context potentially minimises some of the risks of privilege and bias described earlier and offers an alternative structure for integrating service delivery.

Eligibility for partner contact

As perpetrators may have more than one partner, and there are questions about victims/survivors existing outside of an intimate relationship with a perpetrator, issues of eligibility for partner contact are often raised. The United Kingdom's Respect (2017) standards seem to be the most wide-ranging in this regard by stating that partner contact should be offered to any adult who is at risk from the perpetrator, except when doing so would compromise the victim's/survivor's safety. In situations where partner contact is provided to more than one victim/survivor of a perpetrator, different workers are allocated to each and procedures are established to prevent multiple victims/survivors from meeting at the service (Respect, 2017). Similarly, Victoria has a wider eligibility criteria, including working with the perpetrator's current and relevant former partners, as well as family members including children, if they are identified as being impacted by the perpetrator's violence (Family Safety Victoria, 2018).

In Scotland, the Caledonian system is organised around three components: a men's, a women's and a children's service (Grant & Mitchell, 2010). In practice, this enables partner contact to involve engagement with women around the MBCP while also offering a wider ranging response that is not tied to the perpetrator's participation in the MBCP. An evaluation of this system found it contributed to women's safety:

> Staff and stakeholders also highlighted the ability of the System to provide women with a broader perspective on their partners' behaviour which could help them make more informed choices about the future of their relationships. For women with particularly controlling partners, being able to coordinate appointments with Men's Workers also helped Women's Workers support women safely (by enabling them to see women while their partners were with their Case Managers). Even when it was thought that the man's behaviour had not changed, these aspects

of the System were viewed as enhancing women's safety. (Justice Directorate of the Scottish Government, 2016, p. 3)

Australian jurisdictions also seem more narrowly focused, by including only current partners as eligible for partner contact (Department for Child Protection and Family Support, 2015; NSW Department of Attorney General and Justice, 2011, 2017). Some program providers offer contact to "recent" former partners in the same fashion as current partners, with a recent separation defined as one that occurred any time in the last 3 months to 2 years.

The European MBCPs' eligibility criteria for partner contact also appear to be narrow. The European IMPACT project found that most MBCPs involve contact with current partners, with less than two thirds providing any additional contact with ex-partners (Geldschläger et al., 2014). New partners arising through relationships formed by the men during the course of their participation in the program were only contacted by half of the programs in the evaluation (Geldschläger et al., 2014). This was even lower in an evaluation of Nordic programs, with less than 20 percent contacting new partners (Vall, 2017), although most programs contacted both the current and ex-partner. The relatively lower rate of providing partner contact to new partners could arise, at least in part, from perpetrator hesitancy to discuss any new relationships they are developing and to provide contact details of the new partner. The new partners may also have no experience of his violence at that time, so their experience would be inconsistent with previous partners.

Frequency of contact

The majority of MBCP standards and practice guidelines state that women, and where appropriate children, should determine the pattern of contact that is suitable for them, with more or less contact carried out at the discretion of the women (Department for Child Protection and Family Support, 2015; Family Safety Victoria, 2018; Grant & Mitchell, 2010; NSW Department of Attorney General and Justice, 2011, 2012, 2017; NTV, 2006, 2018; Respect, 2017). Western Australian standards emphasise that partner contact should commence as early as possible. The standards state that contact should first occur about the time the perpetrator is undertaking an

MBCP initial assessment, and should reoccur at least weekly (Department for Child Protection and Family Support, 2015). New South Wales standards are less prescriptive, with timely and flexible partner contact delivery methods promoted as key to service effectiveness (NSW Department of Attorney General and Justice, 2011, 2017).

Within the Scottish Caledonian system, men's service workers meet with (ex-)partners at three key review points, with additional meetings occurring if the man is using his participation in the program as a tactic of control or abuse against the woman (Grant & Mitchell, 2010). United Kingdom Respect (2017) standards stipulate contact details for a victim/survivor be given to the women's independent support service within 24 hours of the perpetrator accessing the intervention. In addition, every possible effort should be made to ensure successful contact within one working week, particularly if there are particular risks and safety concerns.

Commencing partner contact at an early stage of the MBCP and continuing the service for the long term is vitally important for a range of reasons. These include risk assessment and risk management purposes, and ensuring that women have accurate information about the program rather than relying on potentially distorted explanations from the perpetrator (Opitz, 2014). The Daphne III IMPACT evaluation of European perpetrator programs found 83 percent of the programs surveyed attempt to make contact with the partner at the time the man commences the program; 66 percent make contact in crisis or risk situations; 63 percent when the man drops out of the program; 51 percent at the end of the program; and 40 percent conduct follow-up contact (Geldschläger et al., 2014). Making contact at the beginning of programs was common with Nordic perpetrator programs, but only half of them made contact during and/or at the end of the program (Vall, 2017). This indicates that the main efforts (or resources) around contact with (ex-)partners are focused on the period when the perpetrator is referred to and/or commences the program. Following these early efforts, further contact with victims/survivors drops off significantly, which would indicate that support for adult and child victims/survivors is much less likely once the program has started. In Australia, partner contact duration was often influenced by whether or not initial contact had been made: when this had not occurred

there was less likely to be follow-up or further attempts at contact over time (Chung et al., 2009).

Program providers face several barriers to commencing partner contact as early as some might like, including:

- situations where the (ex-)partner's contact details can only be sourced from the perpetrator (the most common scenario in Australia and in many other jurisdictions) rather than from other agencies as part of an integrated response
- (ex-)partners being understandably hesitant to respond to calls that do not have call-display information
- gatekeeping tactics by perpetrators to deny their (ex-)partners access to partner contact
- the service not leaving phone messages for safety reasons
- women feeling over-burdened by having to navigate complex service systems
- the reality of women managing so many facets of their family's lives, in the context of reduced emotional and physical capacity caused by the perpetrator's tactics of coercive control. (DVSM, 2018; NSW Department of Attorney General & Justice, 2012)

No To Violence (2006) emphasises that partner contact arising from safety concerns is imperative and must be carried out in addition to the recommended points of contact. This is commonly accepted as crucial practice in partner contact— the flexibility to make ad hoc, additional contacts with victims/survivors when risk issues are identified through whatever means, for example through the perpetrator's disclosures in the program, reports from victims/survivors, information received from sources such as other agencies in an integrated response, or the intensifying or introduction of new dynamic risk factors. The *Towards Safe Families* practice guide emphasises the importance of intensifying partner contact when a perpetrator discontinues with a program for any reason, including if he is excluded by a program provider (NSW Department of Attorney General & Justice, 2012). The United Kingdom Respect practice standard has a similar emphasis (Respect, 2017). This is in recognition that program discontinuation—whether initiated by the perpetrator or the program provider—can represent a time of heightened risk for adult and child victims/survivors.

Duration of contact

Much of the literature asserts that partner contact support should continue to be available to women and children following men's completion of an MBCP (Howard & Wright, 2008; Opitz, 2014; Smith et al., 2013; Vlais, 2014b). This is a time of heightened risk for some adult and child victims/survivors, as outcomes stemming from a man's participation in an MBCP are often incremental with some or many patterns and tactics of coercive control remaining after program completion. Continuation of, or relapse into, the use of physical or sexualised violence and controlling tactics is not uncommon (Day et al., 2019; Polaschek, 2016; Vlais et al., 2017). Additionally, ceasing partner contact at the point of program completion has been recognised as potentially leaving women and children without support at a time of often increased vulnerability (Vlais, 2014b).

United Kingdom Respect (2017) standards take a broad and flexible approach, stating that partner contact beyond risk assessment and safety planning should draw on women's accounts and experiences to inform their intervention with the perpetrators. The Caledonian system women's services manual states there may be occasions when it is appropriate to offer ongoing support due to high levels of risk (service-generated and other) and vulnerabilities (Grant & Mitchell, 2010). These standards are more focused on the intent and outcomes of partner contact than on prescribing aspects of practice.

In Australia, the former NTV (2006) standards suggested that partner contact occur up to 6 months after the perpetrator exited the program, and the cessation of contact should be at the discretion of the victim/survivor. The current Victorian minimum standards, however, do not specify the duration of contact (Family Safety Victoria 2018; NTV, 2018). NTV (2006) and NSW Department of Attorney General and Justice (2012) state when a woman is no longer being provided a partner contact service, a handover plan to an appropriate service or an exit plan must be formulated and implemented, and an exit interview completed. The New South Wales standards emphasise that long-term access to emotional and practical support via the partner contact worker must be provided to women and children, or that other referral options be initiated in its absence (NSW Department of Attorney General and Justice, 2011, 2017).

Form of contact

There are various modes of partner contact, including telephone-based, women's support groups, individual face-to-face sessions, outreach visits (when safe to do so), and provision of information. Depending on the partner's preferences and safety needs, a combination of forms of contact should be made available (NTV, 2006) but, in practice, most is telephone-based. The *Towards Safe Families* practice guide found that email is now becoming a preferred form of contact and recommends women be given assistance to maximise online security (NSW Department of Attorney General and Justice, 2012).

MBCP partner group sessions run with the men's group facilitators have also been used as a form of partner engagement and contact (Denne et al., 2013). This practice can build trust between MBCP practitioners and the women attending and provide them with an opportunity to ask questions or raise concerns about the program (Grant & Mitchell, 2010).

One study revealed that when contact was made by MBCP providers via a letter inviting women to call, very few women noted or remembered having received the letter (Opitz, 2014). Findings from Smith et al. (2013) and Howard and Wright (2008) provide support for having face-to-face contact with (ex-)partners where possible, an unsurprising result given the complex array of issues that can potentially be addressed through partner contact.

The role of MBCPs in supporting children

There is a large body of research focused on children and young people who have experienced DFV (Taylor, 2019). Studies demonstrate that children, like their mothers, can be direct targets of a wide range of coercive controlling behaviours and tactics used by their fathers. As a result, children's experience of DFV is often much more than being "exposed to" or "witnessing" the perpetrator's violence against their mother (Callaghan et al., 2018; Lamb, 2017; McLeod, 2018; Stark & Hester, 2019). However, Vlais (2014b) claims that historically, even with this level of evidence, children's needs and voices have not been sufficiently assessed, incorporated

and prioritised in MBCPs. This is supported by Lamb, Humphreys and Hegarty (2018) who argue that anecdotal evidence also suggests that the voices of children are still not being heard in MBCPs. While the impact of violence on children is raised in some MBCPs, the volume of content incorporated that relates to their experiences is significantly varied (Stover, 2013).

The focus of MBCPs on children's relationships with their father after DFV has taken place has been limited (Lamb et al., 2018). This is a crucial consideration in the development of partner contact services, given the tactics that many perpetrators use to denigrate a mother's parenting and her relationship with her children (Fish, McKenzie, & MacDonald, 2009; Heward-Belle, 2017; Lapierre et al., 2017). Vlais (2014b) argues that, in a similar way to working with women about their expectations of MBCPs and supporting their decision-making, working with children (when age appropriate) around managing their expectations and providing them with direct support is equally necessary. Further, for programs where resources are limited and lacking in appropriate expertise, strong partnerships with other family and child protection services are emphasised as essential (Vlais, 2014b). Alderson et al. (2012) also suggest that direct contact with and support for children and young people can safeguard them against falling through service gaps.

Recent revisions of Victorian and New South Wales MBCP minimum standards have significantly elevated the prioritising of children, for example in emphasising the need for MBCPs to provide both child and adult victims/survivors with information about the program (Family Safety Victoria, 2018; NSW Department of Justice, 2017). Victoria has also reframed partner contact as "family safety contact". This is a significant shift, because while there have been calls for a greater focus on children in MBCPs for some time, the inclusion of children in what was formerly partner contact practice is new.

It is important here to distinguish between child contact work—currently conducted by very few MBCP providers in Australia or overseas—and other services that MBCP providers and partner agencies can offer to children. Some providers, particularly large human services and non-government organisations, have well-established family support programs

or children's therapeutic counselling that MBCP teams can draw upon as support options for children. There are also a small number of MBCP providers working collaboratively with intensive family support services towards the common goal of maximising children's safety and wellbeing (Centre for Innovative Justice, 2016), although this is not yet common practice. Of crucial importance here is the degree to which separate agencies work with perpetrators and child and adult victims/survivors in a joined-up and informed way, through solid information sharing and joint case planning practices.

Only a very small number of MBCPs in Australia have, or are providing, child contact services in parallel with adult victim/survivor partner contact (Vlais, 2014b), despite the fact that *Towards Safe Families* states that direct contact with children by the partner contact worker or a designated child support worker is the optimal response for addressing children's needs (NSW Department of Attorney General and Justice, 2012). However, any child contact arrangements ought to prioritise the ongoing impacts of DFV on the child, and whether they feel safe, over the father's priority for a relationship with his child. An ongoing dilemma in the area of child contact and DFV is the differing assumptions of the agencies involved. Hester (2011, p. 850) argues there are

> systemic contradictions that appear to exist between the three areas of work on domestic violence, child protection and child contact, arguing that these can be perceived of as operating on separate "planets", each with their own cultures, laws, policies and practices.

It is recognised that child contact can be a point of post-separation coercive control, distressing for the child who is fearful or worried about such contact and about being subjected to future violence and abuse (Holt, 2017). Following separation, victims/survivors may consent to child contact for a number of reasons, including fear that trying to prevent contact may escalate the perpetrators' violence; the child's wish to see their father; pressure from wider families; and a perception that if contact is supervised, it may reduce the risk of further violence towards the child and mother (Hardesty & Ganong, 2006).

In Australia, Family Law parenting orders can also complicate the situation, in instances where fathers may have access to

their children despite DFV workers having assessed that such contact is not always in the children's best interest (NSW Department of Attorney General and Justice, 2012). In her research with children experiencing DFV and in contact with MBCP practitioners, Lamb (2017) found the latter were wary about how to engage with children of the fathers in their programs, as they were concerned they could compromise the children's wellbeing if their contact with them was not productive. There are various complexities and dilemmas about child contact in the context of DFV. However, it is important that children and young people have access to a specific service that supports their needs in relation to DFV. In Australia to date these types of services have been limited.

An evaluation of Project Mirabal in the United Kingdom also identified the need for more dedicated support services for the children of men in MBCPs (Kelly & Westmarland, 2015). This would require a significant increase in resources for these services, because at the time of the study there were only three providers delivering support to children whose fathers were attending MBCPs. Importantly, these three services were flexible in their delivery based on the children's needs (Kelly & Westmarland, 2015). Alderson et al. (2012) found that in the small number of cases where integrated children's support was provided as part of the MBCP, children were better able to rebuild their self-esteem, speak openly about their experiences in a safe environment, and understand that the violence was not their fault. Consequently, feelings of stability among the children increased (Alderson et al., 2012).

In New Zealand, Te Manawa Services include a Youth and Parenting Programme that women have found useful for their children to work through issues and concerns arising from living with abuse and violence (Denne et al., 2013). Again, this type of service is not widely available. Women also noted that although men did not always stop using violence against them, they did become more engaged in addressing their relationship with, and behaviour towards, their children (Denne et al., 2013). By contrast, women in the Caledonian evaluation reported that their (ex-)partner's parenting did not always improve, and expressed a need for a stronger emphasis on children in the Caledonian system overall (Ormston et al., 2016). However, both workers and women in the system felt there had been some positive outcomes for children, including: children having someone

to talk to about their experiences and being able to identify their own needs; and workers being able to share information about the violence and abuse with other services such as the child's school, as well as capacity-building the parenting skills of men and women (Ormston et al., 2016). These findings stand out because the Caledonian system is providing one of the most comprehensive responses to children's needs of any MBCP. The children's service acts as an advocate for the child, addressing needs they have as a result of being a victim/survivor of DFV, across educational, social, health, welfare and other service sectors (Macrae, 2014).

The identification of issues of risk to children's safety and wellbeing is a crucial pillar of any work by MBCP providers to assess the needs of children and advocate for them (Vlais, 2014b). Recent Victorian research with specialist DFV practitioners has demonstrated the overwhelming need for specific tools and practice guidance to assist with this (Fitz-Gibbon, Maher, McCulloch, & Segrave, 2019). Unfortunately, few instruments currently exist to assist program providers to do so, including in situations where they have no direct contact with children (Fitz-Gibbon et al., 2019). The *Assessing Children and Young People Experiencing Family Violence* practice guide is a rare example (Victorian Department of Human Services, 2013). Published in Victoria to assist MBCP providers to assess the safety, development and stability needs of each child affected by a perpetrator's use of violence, the guide brings together available information rather than having to rely on direct contact with the child. However, recent research indicates that this aspect of practice guidance has yet to be widely implemented in the Victorian DFV sector (Fitz-Gibbon et al., 2019).

A recent evaluation of the Caring Dads program for fathers who perpetrate DFV, which originated in Canada (Scott, Kelly, Crooks, & Francis, 2006), provides insights from children whose fathers participated in a perpetrator intervention program (McConnell, Barnard, Holdsworth, & Taylor, 2016). Children were aware that their dads were attending a program, and explained their fathers had spoken to them about wanting to be better dads and referred to behaviours that they needed to change (McConnell et al., 2016). Some children hoped their relationship with their father would improve, while others recognised that their father was only attending because he was required or mandated to complete

the program by social services and family courts. Some were optimistic about their fathers learning and changing, and that this would result in them having more time together and, ultimately, lead to reunification. Others were less hopeful, as they were uncertain about why their fathers were attending the program and concerned about what would happen if they were not able to change (McConnell et al., 2016). These children commonly felt guilty or responsible for their fathers needing to attend the program.

Research with children whose fathers are attending MBCPs shows that children rarely know that he is involved in such a program (Alderson, Kelly & Westmarland, 2013; Lamb, 2017; Rayns, 2010). However, as indicated previously, recently updated Victorian and New South Wales minimum standards for MBCP work now recommend informing children, where appropriate, about the program their father is attending. The implementation of this new standard will be an important shift in monitoring children's understandings and experiences.

Addressing children's needs for safety, stability, development and healing can also be an issue to explore through partner contact with the children's mother (NSW Department of Attorney General & Justice, 2012). Crucial to this approach is working with mothers in ways that are informed by the perpetrator's patterns of coercive control and, in many cases, the tactics he uses to undermine her parenting, sabotage her relationship with the children, and put up barriers towards her arranging services to meet her children's emotional, social and physical health needs (Macvean et al., 2015; Mandel, 2014).

It has been argued that it can be difficult to develop trust and engage sensitively with mothers about the impact of the perpetrator's use of violence on children's safety and wellbeing in situations when the sole modality for partner contact is telephone-based rather than in-person meetings (Vlais, 2014b). This presents a quandary given that information provided by mothers can often be the most crucial for MBCP providers to gain a sense of how the perpetrator's violence impacts their children, and the specific risks his behaviour poses to each child (Victorian Department of Human Services, 2013).

An issue of relevance outside the scope of this project is adolescent violence in the home, in which some adult victims/

survivors experience violence from both their partner and their child (Elliott, McGowan, Benier, Maher, & Fitz-Gibbon, 2017). At present, there are few Australian programs that work intensively with mothers and teenage children, both separately and together, in situations where a child is or has been violent to their mother in a way that is connected with their father's use of coercive controlling behaviour in the family.[4] As there is little practice guidance available in this area, it is an issue requiring attention in the context of MBCP partner contact.

Partner contact and intersectionality

The small body of literature about partner contact is based on MBCPs for men who have been violent and abusive to female intimate partners, and may also have perpetrated violence towards other family members. Consequently, literature about social contexts and experiences outside of a heteronuclear family context is even more scant. There are, however, emerging bodies of research relevant to this area of practice.

Aboriginal and Torres Strait Islander peoples

Consistent with the findings of this review, in the context of mainstream programs Opitz's (2014) study highlighted a significant lack of consideration of Aboriginal and Torres Strait Islander men and their families in regard to partner and victim/survivor contact and support. Similarly, our literature search found no Australian qualitative studies of partner contact focused on specific findings for Aboriginal and Torres Strait Islander women and their families.

What is available is a scoping review by Gallant et al. (2017) that examines existing Australian and international Indigenous men's programs addressing family violence, which are developed and run by community controlled organisations. The authors identified that holistic approaches to programs in an Aboriginal and Torres Strait Islander context must be multidimensional in their approach and involve work with men, women and children (Brown & Languedoc, 2004; Gallant et al., 2017). To demonstrate this holistic approach to addressing the complexities of Aboriginal and Torres Strait

Islander family violence, the authors developed a multifaceted model that includes the interaction of three components: community engagement, healing and service provision. Although it does not use the terms "partner contact" or "child contact", it suggests that features of the healing component involve men, women, children, young people, Elders, victims/survivors and perpetrators. This whole-of-family approach to providing support for Aboriginal and Torres Straight Islander families potentially bypasses the need for a specific service for adult and child victims/survivors, as support for all is a central component of many of these service models. However, scant literature currently exists that explores these models, with even less known about the relationship between the interventions available to men and the supports offered to adult and child victims/survivors.

In recent years, some Aboriginal and Torres Strait Islander men's family violence programs have recruited dedicated family safety workers who take a holistic family-focused perspective while also maintaining a strong focus on the safety of women and children. Although there is no written literature yet describing this emerging practice, anecdotal accounts suggest that these family safety practitioners might operate outside of the tight parameters that characterise much partner contact within mainstream services. These include less reliance on telephone-based contact, a flexible outreach component, and a stronger focus on a wider range of the needs of women and children stemming from family violence and the impacts on them of intergenerational disruption and trauma caused by colonisation and racial oppression.

Internationally, some research has suggested that notions of "whole of family" and/or community safety approaches are an essential consideration for DFV interventions that provide support for First Nations peoples. Gregory (2008) described the development of a culturally sensitive DFV program for Māori men and discussed how the program involved the provision of a range of services to support women and children. The MBCP facilitators worked closely with the women's and children's services to discuss issues related to safety and accountability (Gregory, 2008).

Denne et al.'s (2013) study of Te Manawa Services in New Zealand sought to determine if they were "adequately meeting the needs of their Māori clients and [if] the qualitative component of this study allowed for Māori clients and their (ex-)partners to provide accounts of their specific experiences" (p. 17). Te Manawa offers a men's program, a women's program, partner/family support services, and a youth and parenting program, all of which are interconnected. Overall, the study found similar partner/family support outcomes to those of mainstream programs, while highlighting the importance of culturally safe and interconnected responsive content:

> Although few Māori clients participated in the qualitative component of this research, those that discussed the cultural aspects of the course expressed that they enjoyed and connected with the inclusion of Māori belief systems in the set Curriculum. (Denne et al., 2013, pp. xiv–xv)

The research indicated that applying the Whare Tapa Wha approach[5] in the program made the experience particularly meaningful for the Māori participants by increasing their engagement and comprehension of the program's content (Denne et al., 2013). The study also highlighted the importance of responses being both integrated and culturally relevant and that this was an important aspect for future development.

It is clear that partner/family support within an Aboriginal and Torres Strait Islander context needs further research. Based on what little is available there are many similarities with mainstream responses, but with some important and notable additions. Paramount among these are the ongoing impacts of colonisation and racism and the addition of culturally relevant content, with the more integrated nature of service delivery requiring further investigation. Looking internationally, the limited evidence available would support the need for, and importance of, support for both adult and child victims/survivors when responding to perpetrators in all communities.

Culturally and linguistically diverse communities

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5   The Whare Tapa Wha Approach is a Māori-developed model of wellbeing. There are four dimensions and if one of these dimensions is not in balance, people's wellbeing is impacted. The four dimensions are: Taha tinana (physical health), Taha wairua (spiritual health), Taha whānau (family health) and Taha hinengaro (mental health). In running a program for men using violence these four dimensions underpin the program.

MBCPs have been adapted for specific CALD communities in Australia, New Zealand, the United Kingdom and North America (Vlais et al., 2017). However, there is limited documentation and evaluation of culturally responsive programs, with those available not describing the precise practices adopted in these MBCPs to meet the culturally specific needs of the groups involved. As specialist CALD MBCPs are not widely available, mainstream MBCP practitioners have had to try and adapt their work to the individual CALD men referred to them (Shepard & Pence, 1999). Suggestions for further developing responses to CALD men's use of violence include training bicultural DFV practitioners to support men from particular cultural cohorts to interface with mainstream services (Vlais, 2017). Similarly, mainstream women's DFV services have also had challenges in offering support services to CALD women, due to language and cultural barriers as well as the difficulties involved with supporting those who remain in an abusive relationship (WWP-EN, 2018b, p. 11).

In Australia, CALD-specific MBCPs currently exist only in Victoria and include programs in Vietnamese, Arabic and a recent trial in Harzaragi, in addition to a program in English specifically for men from nine South Asian countries.[6] For some of these programs, partner contact is provided by specialist bicultural women's DFV practitioners employed by a multicultural women's DFV service. However, as these programs are relatively new developments (with the Vietnamese program the first in 2013), there is to date no literature documenting partner contact provision in these contexts.

Internationally, an example of a CALD-specific MBCP is the Al-Aman program in the United Kingdom, which provides an Arabic-language support program for women and children, perpetrator interventions delivered in a one-to-one format, and a community engagement strategy (Roberts, Jawad, & Buris, 2013). The program describes itself as a service for women offering safety planning, emotional support via telephone and one-to-one support sessions (Al-Aman Family Safety Project, n.d).

A final consideration in relation to CALD women experiencing DFV is that it is important not to assume their abusive partners are from the same cultural, racial or linguistic background. There can be particular issues around safety and power imbalances where perpetrators are English-speaking Australians and the victim/survivor does not speak English or have residency rights in Australia.

Lesbian, gay, bisexual, trans, intersex, queer and asexual (LGBTIQA+)

Many MBCPs in Australia include gay and bisexual men within their eligibility criteria, and have some knowledge of specific supports they may require. However, participating in mainstream programs can be a challenging and/or unsafe experience for these men, as it can be for some LGBTIQA+ perpetrators without cisgendered privilege or who do not identify as gender-binary male, as Vlais et al. (2017, p. 59) explain:

> The FDV field, as a whole, has yet to make a transition from a feminist understanding of DFV to an intersectional feminist one … the absence of an intersectional framework has resulted in a lack of space or visibility for people with diverse sexual orientations and/or gender identities. This is seen in how poorly the DFV service system has made itself accessible for people from LGBTIQA+ communities (Aleksandrs & Phillips, 2015; Horsley, 2015), or adopted the language and understanding to challenge heterosexist and heteronormative dominance. This has been the case for MBCP providers as much as for other parts of the service system. (Lloyd, 2015)

Our research study identified only three Australian perpetrator intervention programs focusing specifically on LGBTIQA+ communities. The longest running—the ReVisioning program run since 2005 by Thorne Harbour Health in Victoria—has expanded from its initial focus on working with gay and bisexual men and their families towards providing services to perpetrators across the whole LGBTIQA+ community.[7] More recently in Victoria, drummond street services has been developing specialised DFV interventions both for perpetrators and victims/survivors,[8] while ACON and

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6   See for example a Vietnamese MBCP delivered by Relationships Australia Victoria. Retrieved from https://www.relationshipsvictoria.com.au/courses/relationship-education/course/210/8

7   See https://thorneharbour.org/lgbti-health/relationship-family-violence/revisioning/

8   See https://www.queerspace.org.au/our-programs/futures-free-from-violence/

Relationships Australia are collaborating in New South Wales via an ANROWS grant to develop specialist interventions for LGBTIQA+ perpetrators who use violence against female partners.[9] However, literature is yet to emerge on how partner contact practices might differ in these settings from mainstream contexts.

Partner contact in the context of cognitive impairment

In relation to male perpetrators with disability, the only area our study identified that had a specific program response was for those with cognitive impairment. Apart from one specialist MBCP in Yukon, Canada focusing on perpetrators with cognitive impairment, there appear to have been few attempts to adapt DFV perpetrator intervention programs specifically for this cohort (Vlais, 2017).

Borg, Vlais and McCartney (in press) have speculated that partner contact with the (ex-)partners of men with cognitive impairment faces some additional challenges that can make this work more complex. In addition to intersecting (and multiplying) the gendered pressures on women to care for the emotional, relational and logistical lives of men in a patriarchal society, partners might feel added pressure to make allowances for the perpetrator's use of violence due to his disability. This intensified reliance that a man with a cognitive impairment might have on his partner can make it difficult for MBCPs to implement the core practice of "generalisability" when working with this cohort of perpetrators. The requirement, as identified in the literature on working with people with disabilities on concerning behaviours, is to increase the focus on how the perpetrator implements behavioural and attitudinal changes in their daily milieu. If his partner is his one key link to helping him make adaptations in his daily and relational life that are needed because of his cognitive impairment, focusing on generalisability without making her feel even more responsible for his behaviour can be quite challenging (Borg et al., in press).

Barriers to partner contact

Partner contact is widely recognised as a vital component of

MBCPs, but a number of barriers and challenges exist that impede the ability of services to conduct quality partner contact. One frequently cited barrier is a lack of long-term and adequate funding allocation (Smith et al., 2013; Vlais, 2017), which is discussed in detail below. In addition, the extensive and multifaceted nature of partner contact is often underestimated in terms of the time involved in engaging with adult and child victims/survivors, as well as the resources needed to meet identified needs through this engagement (Rosenbaum & Leisring, 2001; Tutty et al., 2011; Vlais et al., 2017). As a result, the provision of best practice partner contact work is often considered to be beyond the capacity of many MBCPs (Opitz, 2014; Vlais et al., 2017).

There is little in the literature regarding the resources required for partner contact. However, Vlais (2014b) and Kneale (2015) have postulated that it should require, at a minimum, a 0.6–0.8 full-time equivalent (FTE) dedicated role for MBCPs working with approximately 100 men per year, with smaller programs having at least a 0.4–0.5 FTE dedicated role. Despite arguments that partner contact could be a justifiable focus of approximately half of a program's resources, it is often confined to a maximum of 1 or 2 days per week (Vlais, 2014b).

Fixed price and competitive tendering processes are common in Australia, where the price to deliver an MBCP is fixed or funder driven. Consequently, very few partner contact services are independently funded/contracted and, as such, many providers argue that partner contact requirements have emerged within tenders and contracts without the funding and resources necessary to perform these services. This tension between the different priorities for funding received leaves many program providers with the unenviable task of budgeting services according to contractual requirements and best compromise, rather than a best practice service delivery model (Vlais et al., 2017).

MBCP practitioners identify other barriers to partner contact. These include perpetrators not providing correct contact details for their (ex-)partner so they cannot be contacted by the partner contact worker, difficulty in making contact due to the time constraints of the partner contact worker role and, in some contexts, a limited number of adult and child victims/

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9   See www.anrows.org.au/node/1310

survivors who want to engage when contact is successful (e.g. Opitz, 2014; Tutty et al., 2011). Further, victims/survivors have also noted they are fearful of engaging with services for reasons including previous poor service experiences, feeling ashamed, or being fearful that their children will be removed from their care (Denne et al., 2013; Gregory & Erez, 2002; Opitz, 2014; Rosenbaum & Leisring, 2001).

It is also widely understood in the MBCP field that some perpetrators actively attempt to keep their (ex-)partner from responding to any contact by a partner contact worker, or to coerce them into declining the offer of services when contact is made. These gatekeeping tactics can (deliberately) accentuate victim/survivor shame about being in an abusive relationship and may underpin their worry about how authorities and others will respond if they disclose the specifics of the violence.

Conclusion

This chapter has provided an overview of the findings from the scoping review of literature and documentation available about MBCP partner contact from national and international sources. Despite the relative dearth of peer-reviewed, published literature compared to that pertaining to interventions with DFV perpetrators, the documentation available points to some common themes.

There are a number of existing minimum standards, and a much smaller range of more detailed practice guidance, that can be used to support and develop partner contact practice. These stipulate the purpose, approaches to engagement with (ex-)partners and the elements of quality practice. They fall largely into either a description of intent or purpose of MBCP partner contact, or prescriptions and guidelines of how and when partner contact services and practices should operate and who should be offered partner contact. There is some variation between the level of prescription about how the partner contact service should be organised, for example intra-organisationally or delivered by an agency external to that providing the MBCP. Apart from these variations in arrangements of partner contact, particularly regarding whether support is provided by a designated partner contact worker within an MBCP or by specialist women's services,

overall the mandated standards are similar and findings from research evaluation studies reveal consistent themes.

In the relatively small number of available research and evaluation studies focusing on partner contact practices, the vital and unique role partner contact can play is well supported. Although based entirely on qualitative research with moderate sample sizes (generally n=20 or less), these studies overwhelmingly demonstrate the difference that quality partner contact can make to women's and children's sense of felt safety, and to their overall lives. It appears that the most beneficial partner contact practice is flexible, involves a wider and more holistic service delivery focus than "a series of contacts", gives information to victims/survivors about the MBCP and the perpetrator, and has the capacity for some face-to-face session time.

In much of the literature reviewed, women participants emphasise the value of a partner contact practice that is proactive, genuine, ongoing and non-judgemental. Notably, women describe the positive and significant impact that partner contact has had on their lives, even when the MBCP did not lead to change in their (ex-)partner's violent and controlling behaviour.

In the rare situations where child contact is conducted parallel to, and integrated into, both MBCP interventions with the father and partner contact with the mother, a number of benefits have been identified. However, the introduction of adequate (or indeed any) funding for child contact work requires consideration. Indeed, while the Victorian minimum standards have reframed partner contact as "family safety contact" in an effort to consider children's experiences and needs, there is little or no literature or practice guidance on how to do so.

The literature attests to women's experiences of partner contact services being highly variable. These contrasting experiences reflect existing service systems that are not yet adequately integrated in Australia. Further, despite widespread efforts and good intentions regarding partner contact, the role is often insufficiently funded and can be seen as a less important adjunct to the group interventions undertaken with men.

This raises a number of considerations for funders, policy makers and practitioners.

It is evident that discussion and revision of the meaning of "success", and the outcomes to which MBCPs across the service system aspire, is central to progressing and further emphasising the role of partner contact. As important as this is, perpetrator intervention work is not just about "changing the perpetrator". Having a sufficiently multi-faceted and sophisticated understanding of the objectives and benefits of this work is crucial to unlock its full potential to contribute towards the safety, human rights, freedom and autonomy of adult and child victims/survivors from violence and abuse.

Key findings: Practitioner survey

This section reports on the key findings that emerged from the survey carried out with MBCP practitioners between November 2018 and March 2019. The survey aimed to capture information about partner contact practice in the context of MBCPs across Australia. An outline of the survey participants' characteristics is presented, followed by a summary of the information and emerging themes within each of the key areas examined. General feedback and suggestions about partner contact support are also provided. Data from participants located in regional and remote areas have been differentiated throughout the analysis, where this is considered to be useful.

Participant characteristics

Number by state and territory

A total of 131 practitioners participated in the survey, with the data indicating a wide range of responses across the states and territories. Victoria was slightly over-represented with 32 participants, compared to the proportion of Australian programs in that state, and Queensland slightly underrepresented (refer to Figure 2).

Area type

There was a broadly accurate spread of program respondents across urban, regional and remote areas: 46 percent of participants identified as working in a capital or large city; 36 percent in a regional city or its immediate surrounds; and 17 percent in remote communities (refer to Figure 3).

Roles

The 131 survey participants occupied the following roles:

- 32 partner contact workers employed by an MBCP provider to undertake partner contact work only
- 15 partner contact workers employed by another agency external to the MBCP to provide a partner contact service
- 12 MBCP facilitators or practitioners
- 19 MBCP facilitators and partner contact workers
- 26 MBCP coordinators or team leaders
- 13 senior managers
- 3 CEOs.

Nine respondents selected "other" roles and two did not provide a response. "Other" type roles included: general counsellor working across various programs; manager; senior psychologist; practice development officer; MBCP team leader and facilitator; MBCP case manager; facilitator for a family violence program other than an MBCP; and men's DFV program facilitator for a non-MBCP (refer to Figure 4).

Organisation details

Employer type

Eighty-six percent of the survey participants were from non-government organisations that deliver MBCPs. We experienced difficulty in accessing practitioners from government-based organisations due to their requirement of meeting lengthy approval processes, which accounts for the relatively low number of participants from these agencies. This means that Corrective Services-operated DFV perpetrator intervention programs were not significantly represented (refer to Figure 5).

Perpetrator groups

The following is a break-down of participants' responses about perpetrator groups with which the MBCPs work:

- Eighty-two participants said their agency's MBCP only caters for men who perpetrate violence in heterosexual relationships.
- Sixteen stated their programs were for men in heterosexual relationships as well as gay and bisexual men.
- Eleven said their MBCP accepted referrals for all male perpetrators—heterosexual, gay and bisexual men (cis and trans), as well as non-binary people.
- Seventeen participants stated their program involved various combinations of two or more of the following categories: male perpetrators in heterosexual relationships; gay and bisexual men; trans-masculine, intersex and queer-identified men; women perpetrators; and adolescents who use dating violence or violence against family members. Nine of these responses included a focus on women perpetrators and eight on adolescent perpetrators.
- Five participants did not provide a response to this item.

To summarise, 65 percent reported their agencies' MBCPs were working exclusively with cisgendered men who perpetrate

Figure 2: Number of survey participants by state and territory

ACT	
NSW	
NT	
QLD	
SA	
TAS	
VIC	
WA	
Not provided	

Australian Capital Territory	1
New South Wales	22
Northern Territory	5
Queensland	23
South Australia	8
Tasmania	3
Victoria	53
Western Australia	15
Not provided	1
TOTAL	**131**

Figure 3: Area type

A capital or large city	
A regional city and its immediate surrounds	
A rural or remote community	
Not provided	

A capital or large city	60
A regional city and its immediate surrounds	47
A rural or remote community	23
Not provided	1
TOTAL	**131**

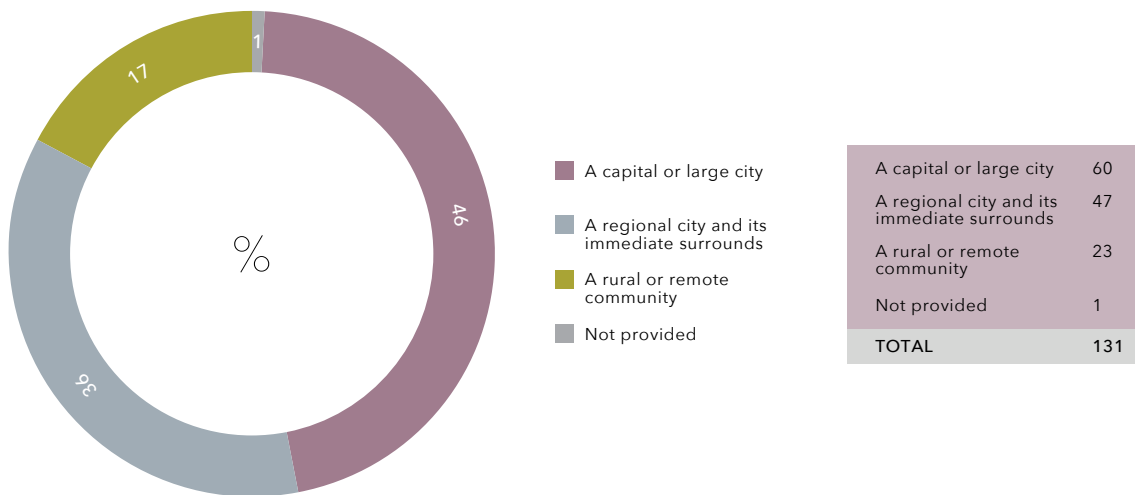**Figure 4:** Participant roles*
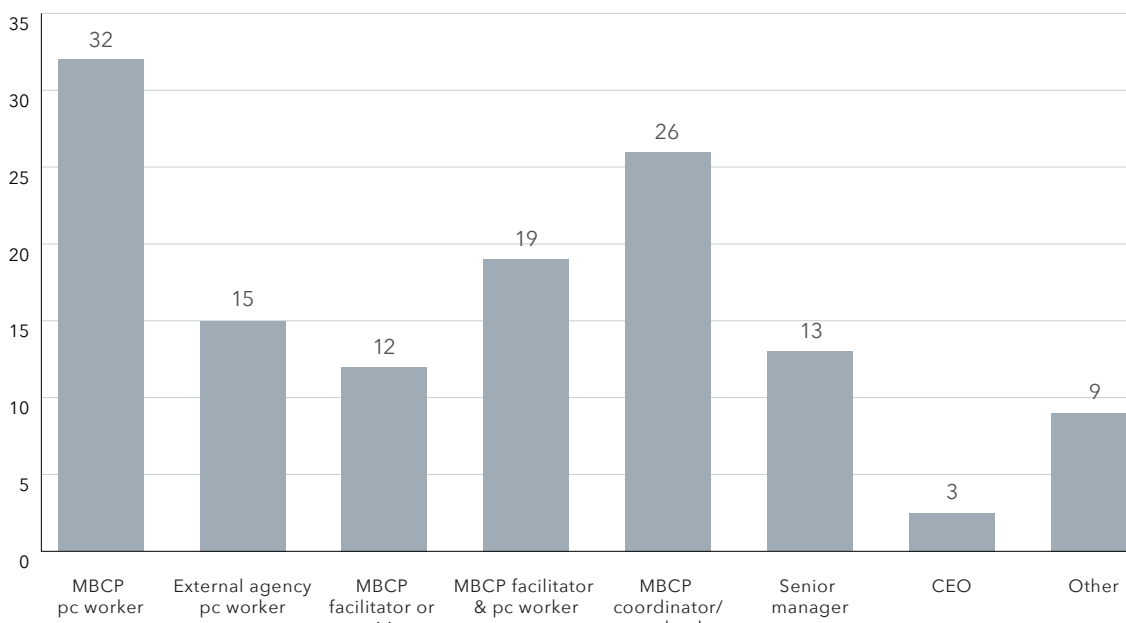
*Missing values n=2

Figure 5: Employer type*

8% ■ Government agency or statutory authority

86% ■ Non-government organisation (such as a charity or other not-for-profit or community based organisation

6% ■ For-profit organisation (i.e. a private company)
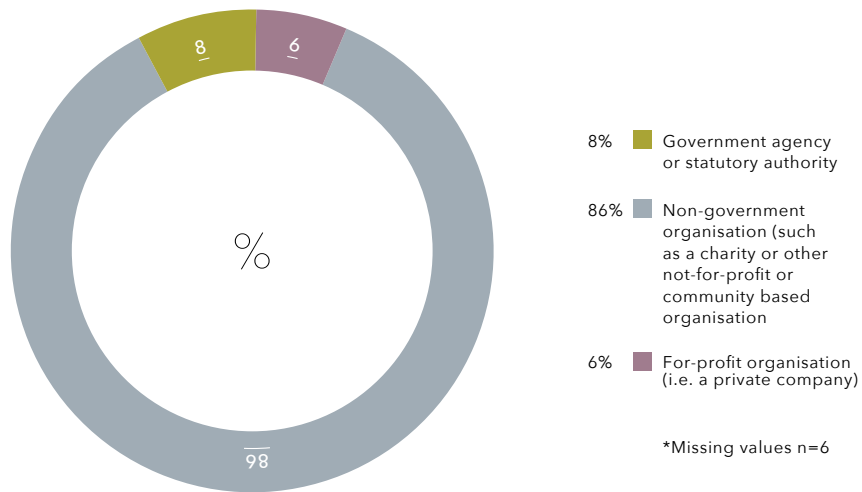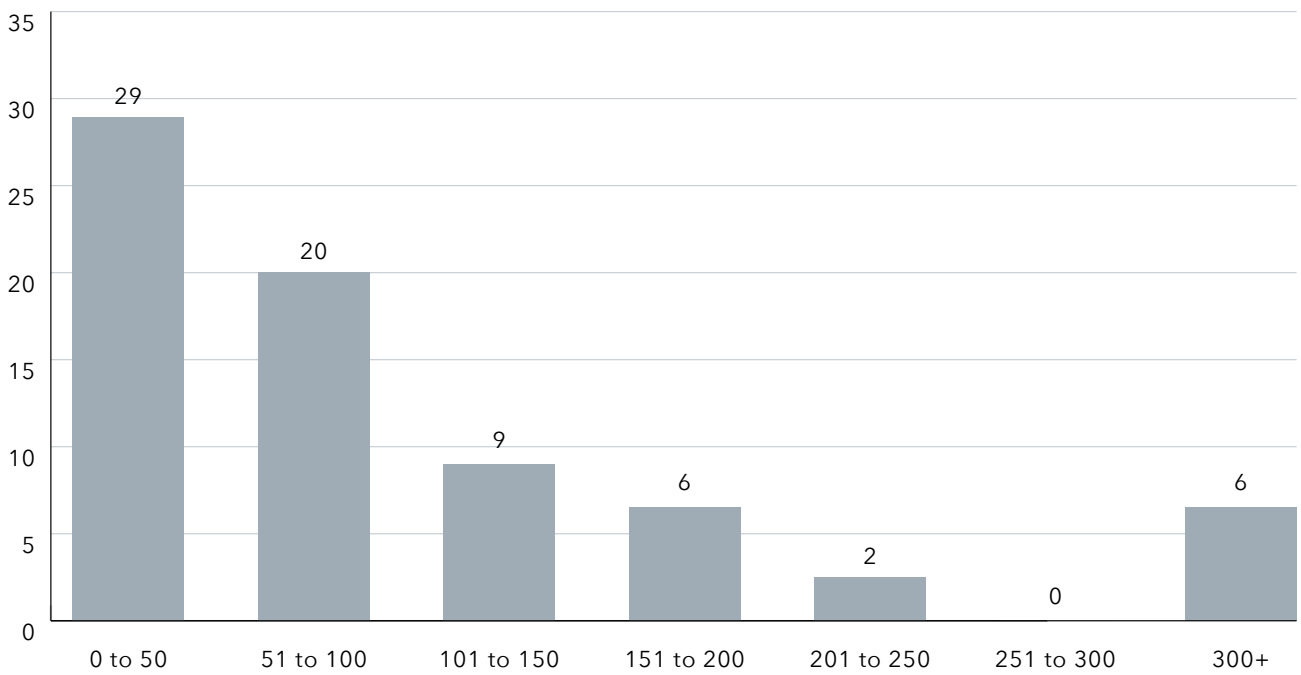
*Missing values n=6

Figure 6: Number of perpetrators*

*Missing values n=43

violence in heterosexual relationships; 1.6 percent solely with gay and bisexual men (cis and trans), as well as non-binary people; and the remaining one third, or 33.7 percent, had MBCPs that catered for all perpetrator groups. Although not really an accurate representation of the perpetrator groups supported by MBCPs—rather this has captured information about the MBCPs with whom the survey participants work— it is reflective of the support system being geared towards addressing gendered violence.

Number of perpetrators commencing MBCPs

To gain an estimate of the number of perpetrators presenting at MBCPs, the survey included a question asking participants to estimate the annual number of perpetrators who commence with an MBCP after the initial assessment session (even if they do not complete the program). Responses were grouped into categories and are depicted in Figure 6.

Two thirds of survey participants (n=88) were able to estimate the annual number of perpetrators commencing an MBCP. Some large providers of MBCPs appear among the survey participants, with around 26 percent (n=23) responses indicating they cater for more than 100 perpetrators. Around 33 percent estimated that up to 50 perpetrators commenced the MBCP in a year, with 23 percent estimating 50–100. Around 18 percent of responses said they did not know, or did not provide adequate information on which to report.

Participants in regional areas and remote communities indicated that the majority of programs cater for less than 100 perpetrators. One quite large program in a remote area (more than 300 participants per year) reportedly catered for both men and women perpetrators. Around one third of respondents in regional communities did not know or did not provide any information about the number of perpetrators commencing programs.

Agency providing the partner contact service

Of the 117 respondents, 62.4 percent were employed in an agency that ran an MBCP, and had another agency provide partner contact services to female (ex-)partners of men attending their agency's program. Just over one third (37.6%) said their employing agency offered partner contact but not an MBCP. Fourteen respondents did not complete this item.

Role of partner contact workers

The organisational arrangements for partner contact were reported by 128 of the 131 respondents. The findings reveal:

- In the total sample, 83 (65%) of the partner contact services were provided within the MBCP agency but delivered by workers not delivering MBCPs. The sub-sample of remote communities had a lower percentage with only 45 percent reporting this to be the case.

- Thirty-four (26.5%) stated that MBCP group-work facilitators also delivered the partner contact component of the work, although this does not necessarily mean that they themselves provide the service to the partners of the men in the specific groups they co-facilitate.

- Across the total sample, only eight (6.3%) said partner contact was provided by an external agency. However, amongst the remote sub-sample, 18 percent of participants reported they used external arrangements.

- Three (2%) reported the MBCP had no formal partner contact service, with these respondents all located in regional or remote communities.

From the descriptive information provided, there is evidence of various kinds of arrangements among agencies that undertake the partner contact role. While most reported having dedicated partner contact workers, there are many with overlapping roles, including MBCP facilitators and partner contact workers who work with both perpetrators and partners. Partner contact workers who acted as women's advocates with specialist domestic violence agencies were also represented, but only in small numbers. Some partner contact workers are managed directly by the MBCP, while others are sub-contracted to the MBCP to provide the service.

Funding arrangements

To gain a sense about funding arrangements, respondents were asked whether the MBCPs with which they worked received specific funding to carry out partner contact. Of the 118 respondents to this question, 41.5 percent reported "yes", 42 percent said "no" and 16 percent were "not sure".

Participants were then asked a further question about whether another organisation linked to the MBCP receives funding to conduct partner contact. Of the 117 respondents to this

question, 7.7 percent reported "yes", 67.5 percent said "no", and about 25 percent were unsure if this was the case. No major differences were noted in the responses for regional and remote areas.

Partner contact in practice

Perception of the work

Of the 98 respondents to this question, 75 (76%) stated they considered partner contact work to differ from other specialist work with victims/survivors of domestic violence, 19 (20%) said it was similar and four (4%) were unsure. Twenty respondents did not answer this item. When asked for further descriptive information about the similarities and differences, there was some variation in responses. Many of the qualitative responses referred to there being both differences and similarities.

Similarities

Those aspects of partner contact practice mentioned as being similar to other specialist domestic violence work generally centred on risk assessment, safety planning, referral, validation and the emotional support provided to women.

Differences

Differences in partner contact practice related to several areas, including:

- the focus of the work—working with information available from both the victim/survivor and the perpetrator
- the close link between the partner contact service and the MBCP
- the difficulty in contacting and engaging women
- the partner contact service often being women's first contact with specialist domestic violence support services
- the nature and duration of support provided.

In relation to the nature and duration of support provided by partner contact services, this was generally described as being relatively short-term and not therapeutic. However, there was some indication that differences may exist between services (or perhaps individual practitioner's understandings), with a number of respondents also describing the work in a more long-term sense. Participants seeing it as being more short-term, and thus limited in nature, often made reference to referring women to other services for ongoing support:

> Partner contact workers only work with the partners for a short time mostly while the perp[etrator] is attending the MBCP and referrals are made to other services for more ongoing support for the partner. (Partner contact worker, regional area)

In contrast, other respondents viewed partner contact as a longer term response:

> In my experience, partner contact work is about addressing long-term needs of the client and a lot more to do with emotional and psychological support. Usually women accessing FV support services are at crisis or high needs time in their journey, whereas a lot of my clients will want to speak about their experiences of the violence and often are out of the risk period. There will always be some women who are in high needs/risk/crisis period but these are by far the smaller group. (Partner contact worker, urban area)

The different explanations offered by survey respondents about the nature and duration of partner contact support point to there being a lack of uniformity in how this service is provided, and how it is contracted within and across Australian states and territories. For example, if it is provided within an existing women's support service there is more likelihood of continued support for the partner, whereas in other instances this may not be possible.

Areas of focus

Survey participants were provided with eight options about potential areas of focus for partner contact work and asked to rank them from highest to lowest priorities. These were then ordered in priority, according to the mean number of participants who selected each area, with the lower the mean rating, the higher the level of priority it was given. The results are outlined in Table 2.

Table 2: Priority areas of focus for partner contact work

Area of focus	Mean rating
Supporting women to address their practical needs arising from the perpetrator's use of violence	4.14
Restoring the partner's confidence as a parent and her bond/relationship with her children	4.26
Counselling to support the partner's healing and recovery	4.33
Assessing the impact of the perpetrator's behaviour on children and the risks to their safety, development and well-being	4.57
Conducting formalised risk assessments	4.59
Obtaining the partner's perspective about the man's behaviour at home, to help evaluate the man's progress through the program	4.72
Noticing and validating women's sense of agency and resistance to the violence	4.8
Safety planning and risk management	5.06

"Supporting women to address their practical needs arising from the perpetrator's use of violence" was identified as the highest priority for partner contact work, and "safety planning and risk assessment" as the lowest. Notably, the results suggest that participants did not see "obtaining the partner's perspective about the man's behaviour at home, to help evaluate the man's progress through the program" as the highest priority area of partner contact work. However, it should be noted there are some limitations with this question that made it difficult to interpret the results accurately.

Firstly, the question did not explicitly state that 1 was the highest priority and 8 the lowest; rather, this was implied. It is appreciated that this may have been interpreted differently by survey respondents, which may have significantly influenced the results. Secondly, not all participants ranked every option, meaning there was not an equal spread of results, which similarly impacted on the findings. Three participants provided feedback about their justifiable concerns with ranking these areas of focus, which were mainly attributed to the key areas listed being seen as equally important:

> Assessing risk to the woman is equally as important as assessing risk to the child. This question poses what appear [to be] some inherent problems when scored this

way. It may provide a false understanding of what can sometimes be a nuanced conversation with affected family members and cover, equally, all the key areas listed above. They are all routinely focused on by our workers. (MBCP facilitator or practitioner, urban area)

Collecting contact details

Ninety-eight percent (n=128) of respondents reported that MBCPs routinely require perpetrators to provide them with information on, and contact details of, their female (ex-) partners; only 2 percent did not (n=3). There was a general consensus that providing this information was a condition for participation in the program, although there appeared to be variance with the level of flexibility around this. Most of the responses categorically indicated that a man's participation is contingent on providing partner contact information; not providing it will immediately exclude him from the program. Many others suggested there is some flexibility around this depending upon whether the man refuses or is unable to provide the information. Refusal was generally reported as resulting in ineligibility for the program, with a few respondents recognising that men can withhold or manipulate this information as a further tactic of control.

Where it was assessed that men were "unable" to provide women's contact information, the MBCP facilitators or the partner contact service would do what they could to locate it, which might include contacting courts or police. In these circumstances professional discretion based on an individual assessment seemed to be the key determinant of men's program participation:

> We still offer him a place in the group, and facilitators will work with the perpetrator to address barriers to providing that information. Sometimes it may take a number of weeks before the perpetrator gives their (ex-)partner's details. Sometimes we may ask for this information from Corrections staff or [the] referring agency. Sometimes we never get this information. Sometimes the perpetrator may provide a number that is no longer in use or simply the wrong number. (Partner contact worker, urban area)

Some participants expressed awareness of the complexity involved in pressuring men to provide women's contact details and the potential for this to impact on women's safety:

> In our mandated program, we are unable to refuse perpetrators to participate as they are court ordered. However our policy in the "voluntary" program is not to accept a perpetrator who refuses. We hold exceptions for those who say they no longer have the victim's[/survivor's] contact details, and we are also highly aware that pressuring the men to get these details may lead to some further perpetration of violence (stalking, threatening the victim[/survivor] not to speak to us). We also hold general discussions with perpetrators about what their refusal of partner contact tells us—they may be hiding something or preventing the victim[/survivor] from having a voice. (MBCP facilitator and partner contact worker, regional area)

Numerous respondents referred to "nothing much" happening when men do not provide these details. The following comment from a partner contact worker expresses concern regarding the perception of there being no consequences for men who do not comply with this requirement:

> The [referrer] are the body who ask perpetrators for women's contact details. There don't seem to be any consequences if the men don't provide them, and they often don't, or they provide inadequate or inaccurate information. It does

not prevent them participating in the MBCP group. Our organisation then pursues contact details through [the] police. (Partner contact worker, urban area)

A comment from one respondent referred to the perceived inequity (and potential impact on safety) associated with women's access to support being reliant on the perpetrator's willingness (or not) to provide her contact details:

> [If men are] denied inclusion [into] the program … we will seek to obtain partner contact [information] and provide that to [the partner contact service] anyway for contact attempts. We believe that his refusal to consent shouldn't deny his partners/ex-partners a right to support. (MBCP coordinator or team leader, urban area)

Court ordered and mandated referrals

For court ordered and other mandated referrals, 33 percent of respondents stated the frequency they were able to obtain (ex-)partners' contact details from the referrer as "often"; 45 percent "sometimes"; and 21 percent "never". Respondents in regional areas reported similar results. The only notable difference was 29 percent of participants in remote areas reporting "never" obtaining partners' contact details from the referrers, which is somewhat higher than the overall sample. Only one third of respondents stated that they are able to obtain partner contact details through such referrals.

These results could indicate that services do not prioritise obtaining partners' details through other services when men are mandated to attend an MBCP. While it is appreciated that at times this would require a woman's consent, the question remains as to whether the referring agent actively seeks to attain this consent—or, if they have no contact with her, what kind of attempts they have made with other agencies they know to work with her, and that could be approached about gaining her consent to share her details with the MBCP provider.

Assessing risk

Of the 94 responses to this survey item, 83 (88%) reported that one or more formal risk assessment tools were used during partner contact to assess the risk to partner safety,

while 11 (nearly 12%) reported the use of no formal risk assessment tools. Some agencies used more than one type of formal assessment tool, which appeared to be those developed and also used by government agencies. Others reported using a formal assessment tool in conjunction with internally developed assessment tools. The most common formal tools utilised were jurisdiction-based common risk assessment frameworks.

When and how the tools are used

The majority of participants reported using risk assessment tools during their interactions with women on a regular, ongoing basis, most frequently at initial contact, and then each time workers had contact with women throughout the support period. There appeared to be some variance around the regularity, with some claiming the tools were used weekly while others used them at assigned points of time: for example, at initial contact, mid-program, end of contact and after any new incidences occurred.

A number of respondents referred to the way in which they incorporated risk assessment into their conversations with women:

> Partners are engaged initially in an informal conversation around the relationship and her experiences. Through that process I am exploring her levels of resistance, understanding how the abuse and violence is impacting on her and the children, their wellbeing and parental bond, what's currently in place, who knows about the abuse and the patterns of power and control. The [domestic violence safety assessment tool] will then be completed in a more fluid and organic way, assessing previous history and current concerns and we will then explore safety planning. (MBCP facilitator and partner contact worker, urban area)

Exchange of information with MBCPs

The survey asked respondents about the regular and routine processes between the partner contact service and MBCP facilitators that were used to exchange information about perpetrators and (ex-)partners. The majority indicated that regular face-to-face meetings, email exchanges and/or telephone calls were the most commonly utilised methods through which this occurred. Case reviews, safety meetings or weekly handover meetings were some of the more formal processes mentioned. Facilitators of women's survivor groups were also said to engage in group supervision with MBCP practitioners, although this was not a commonly cited approach. Regular updating of information and case notes in databases, which could be accessed by both partner contact workers and MBCP facilitators, was another way of exchanging information.

These communication methods were reported to take place most often on a weekly or fortnightly basis. Some met at predetermined times over the course of the group; others only when changes in risk or safety were determined. A number of respondents indicated that information can also be exchanged through more informal, incidental discussions, particularly when workers were co-located in the same office. There were also suggestions, mainly from participants in regional and remote locations, that the exchange of information between MBCP facilitators and partner contact services can be irregular or not at all.

Use of information by MBCP facilitators

Of the 87 responses provided, 67 (77%) identified that the information attained from partner contact is used to inform program delivery and interventions with men. A further 31 (36%) identified that the information is also used to assess risk, monitor safety and determine a way of supporting the needs of women and children (see types of referrals and supports offered, below). Four respondents said this information was not used in any way by MBCP facilitators. Although this is a relatively low number, it is concerning in that it suggests that partner contact is not being carried out in the way it is intended. There were no substantial differences detected between the responses from participants in regional and remote areas and those in urban areas.

Program delivery and interventions with men

Respondents identified a number of areas where partner contact information was used specifically with men, including: informing group discussion topics; holding men accountable;

reducing collusion; monitoring behaviour; and gauging men's progress in the program. One of the more detailed responses is provided here as a way of explaining how some programs incorporate partner contact information into their practice:

> If recent high-risk incidences have occurred during the week—such as physical or sexual assaults, separation, any changes to circumstances that increase risk to partner—facilitators will strategically ensure that the perpetrator "checks in" so that a risk assessment is performed in the group through a process of Q and A about "how things are going at home". As a partner contact worker, I would then request back from facilitators what was shared by the perpetrator in group. We would then decide as a team whether we would or would not share this back with the partner. We consider all information to be connected to risk. I also ask partners if there is anything specific they would like the facilitators to know, and how we might share this information in a way that doesn't identify them, not even to the facilitators and especially to the men in group. (Partner contact worker, urban area)

One respondent commented about MBCP facilitators not changing the content of a group session, despite this being a requirement of the program:

> It, in theory, is used to monitor men's disclosure and progress in the group. It is also used to inform the topics and focus of the group. However, the program is usually already structured to address the issue and the facilitators will not do very much to alter the content, in my experience. (Partner contact worker, urban area)

Some considered the confidentiality of the information provided by women which, if not managed appropriately, could have significant consequences on women and children's safety, demonstrating the difficulty associated with this work. The following quotation explains the considerations made around confidentiality and the exchange of information, and also what practices this particular agency employs to manage collusion:

> We need to be judicious in the info[rmation] sharing—all our workers including the male facilitators work with the women victims who come to the service for assistance, this is to enhance their practice wisdom with women's experience of [domestic violence]. This helps with ensuring

no collusion with the [perpetrators] they work with. The info[rmation] sharing of specific victims needs to walk a fine line. Important to not overburden the facilitator working with a specific [perpetrator]. Because of our feminist underpinnings and the practice wisdom, as well as our connections with the Duluth model[10] and also our systems with the observer comments, most info[rmation] exchange flows the other way where the facilitators pass on concerns to the advocate who then follows up with the woman with revisiting safety plans or other support as warranted. This is a delicate balance supported by strong skilled knowledge, practice wisdom, feminism and service policies. (CEO, regional area)

Risk, safety and support

In addition to the work with men, respondents also identified that the information attained from women was related to assessing risk, monitoring safety, and determining their support requirements. There was evidence that many partner contact services rely on referral to other agencies to provide women with longer term support.

Proportion of women offered support

Figure 7 depicts the estimated proportion of (ex-)partners who were offered partner contact support in the last 6 months, regardless of whether or not they accepted the offer (n=104):

- Seventy-six percent of practitioners estimated that women were offered support 80–100 percent of the time.
- In 13.5 percent of responses, practitioners said support was offered in 60–80 percent of cases.
- Just under 6 percent said women were offered support 40–60 percent of the time.
- In 2 percent of responses, practitioners thought women were offered support in 20–40 percent of cases.
- In 3 percent of responses, practitioners said women were offered support in 0–20 percent of instances.

Interestingly, the participants in regional areas and remote communities reported similar results to their urban counterparts (refer to Figure 7).

Figure 7: Proportion of women offered support
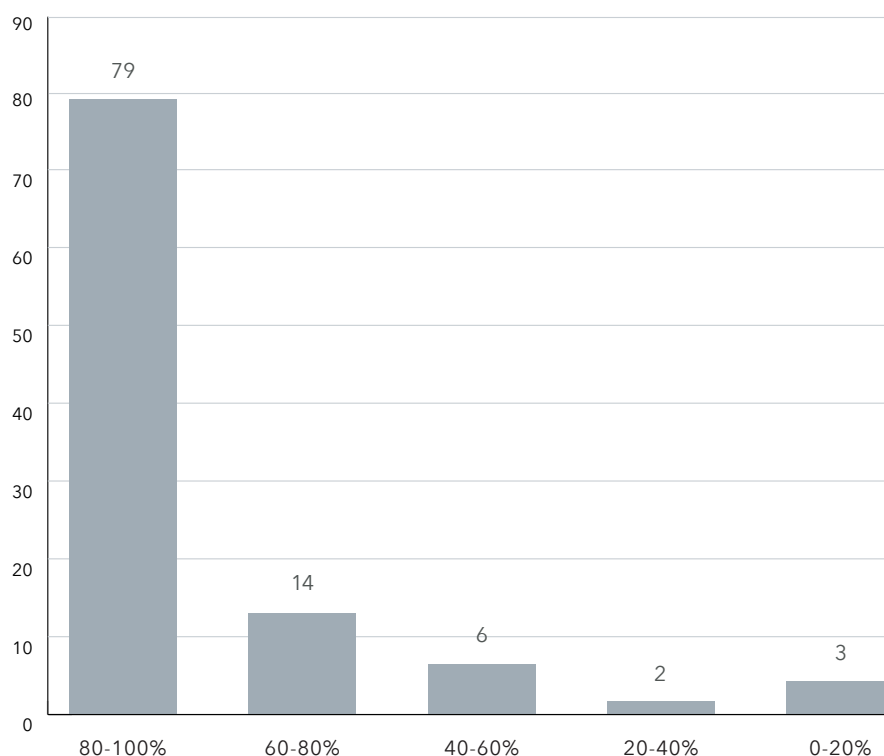
Engagement of partners

Rates of engagement

Figure 8 demonstrates practitioners' views about partners' rates of engagement in capital or large cities, regional areas, and remote communities. Participants' responses suggest that in regional areas and remote communities, the rates of engagement are generally lower than in the urban areas. Overall, the data indicate that although in the majority of cases support is offered to the (ex-)partners of men participating in MBCPs, it is estimated that only around half of these women engage or accept support from a partner contact service.

Methods of initial engagement

One hundred and six practitioners provided responses to the question about the methods through which partner contact services initially engage with (ex-)partners to seek their consent for contact. As respondents could select more than one method, 32 (30%) made more than one selection, demonstrating they employ a variety of means when they initially contact women (refer to Figure 9). Twenty-two respondents reported using "another process", although qualitative responses were only provided by 13 people, which included: face-to-face discussions; home visits; text messages only; text and telephone calls; text, telephone calls and a letter; telephone calls with a follow-up letter, along with a safety pack with information and resources; and letter only if no telephone number is provided.

The information detailed shows that telephone contact only is the most utilised means through which the initial engagement of women in partner contact support is carried out. Notably, text message is also used by a minority of providers as a first point of contact. Two respondents who reported using text messages said this would only occur if safe to do so. There were no noticeable differences in initial engagement methods in the responses provided by participants in regional and remote areas.

Support provided to former partners

Engagement of former partners

Of the 107 participants responding to this item, the vast majority (91.5%) reported no variation in the way they would make contact with former partners in comparison with current partners. Only 3.7 percent said there was a difference in the process used, while 4.7 percent were unsure. One regional respondent reported that attempts to engage with former partners can vary significantly between individual workers depending on their understandings and practices. A remote-area respondent was one of the five people who selected "unsure", and explained that they did not have a women's advocate for at least 3 months, which impacted their ability to provide a partner contact service to former partners.
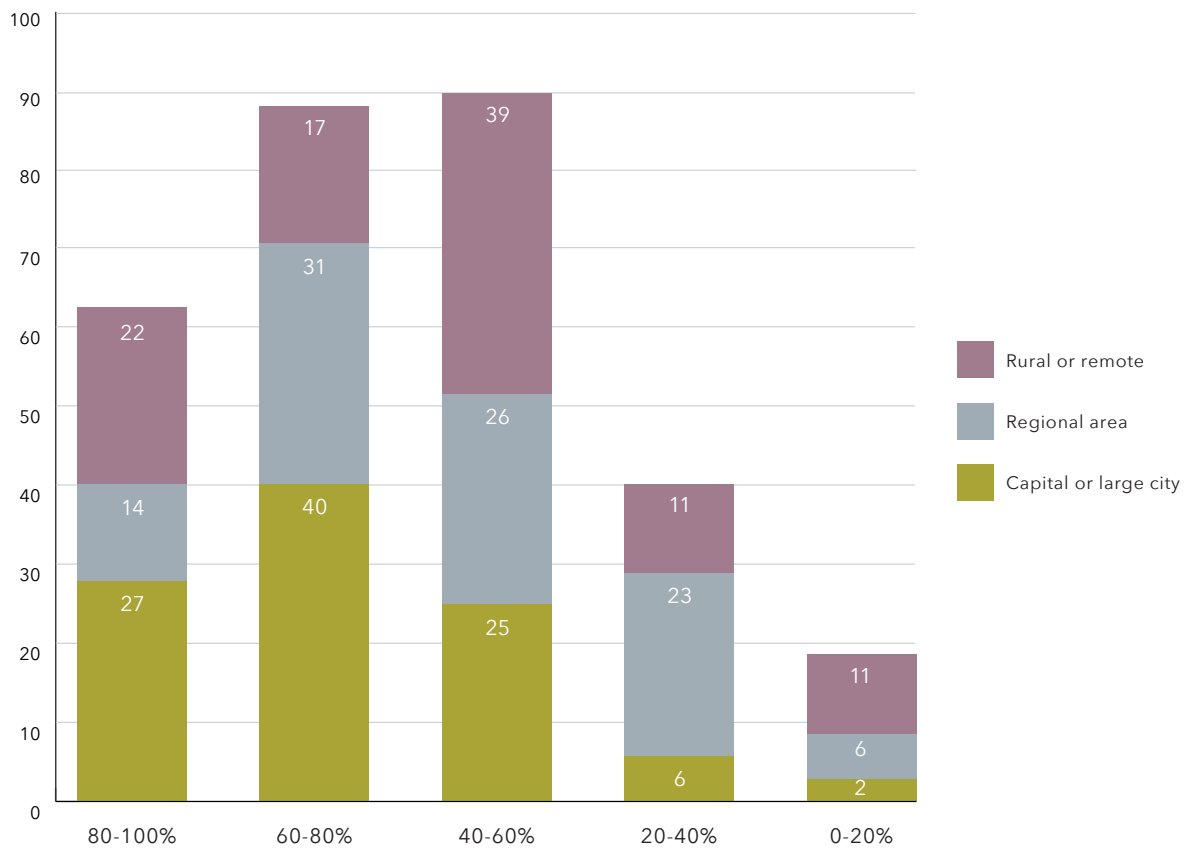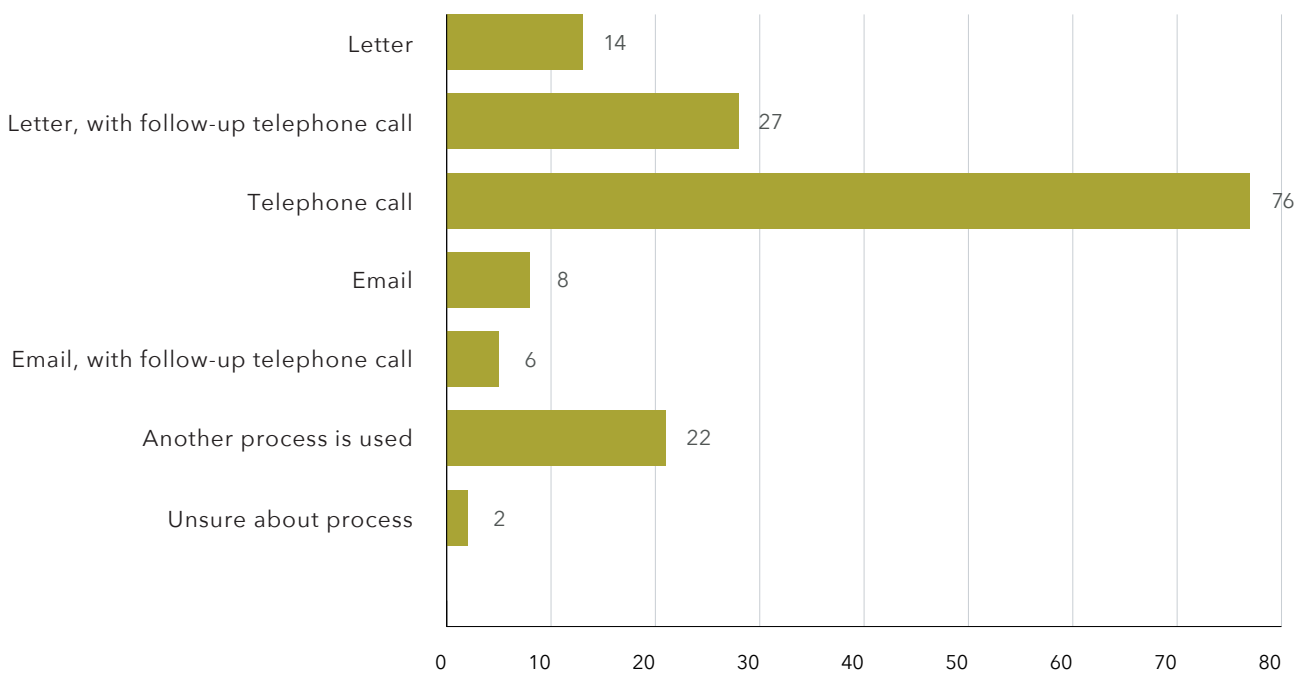
Figure 8: Partners' rates of engagement

Legend:
- Rural or remote
- Regional area
- Capital or large city

Figure 9: Methods of initial engagement*

*Missing values (n=25)

Eligibility criteria and support offered to former partners

Thirteen of the 88 respondents (nearly 15%) to this question indicated there were no eligibility requirements for former partners to be offered support. The remaining respondents listed various eligibility criteria, which included: length of separation; significance of the relationship or some kind of ongoing connection with the perpetrator, particularly if there are children involved; whether a woman had been identified as a victim/survivor of the perpetrator's violence; and if victims/survivors are listed on an intervention order. Victim/survivor consent was also reported as a factor influencing whether former partners were offered support. Approximately half of the 75 respondents who did indicate eligibility requirements stated that the sharing of children with perpetrators was a significant factor in determining whether support was offered. Recent separation was also identified by around 20 percent of respondents as an influence on the offer of support. However, concern about this process was expressed by one respondent:

> I believe that the program does not go far enough in asking for former partners' contact details and this is glossed over. Previously in another agency [the partner contact service] would be [for] partners or former partners [over] approximately [the] past 2 years, and/or those who share children. (Partner contact worker, remote community)

Support offered to former partners with children

In relation to the safety of children, the survey included a question about whether partner contact workers were able to extend contact to all former partners whose children had current contact with the perpetrator. The findings from respondents (n=97) indicate that around 75 percent would routinely offer this service to former partners, with a further 17.5 percent offering it sometimes.

Support offered to current and former partners, recently separated from perpetrators

In response to a further question about the routine practice of offering partner contact support to current and former partners with whom a perpetrator has recently separated,

more than 77 percent of 98 respondents said this would be offered routinely; 14 percent reported this to be sometimes, but not routinely; 5 percent rarely or never; and 3 percent were unsure. Participants from regional areas reported similar results. However, there was a slight variability in the responses from participants located in remote communities, with only 65 percent of the 17 respondents reporting partner contact support being offered routinely; 24 percent stating this would happen sometimes, but not routinely; and 5 percent saying it never or rarely occurred.

Partner contact methods

The partner contact methods used by 96 of the 131 respondents were as follows:

- Twenty-three (24%) reported that all partner contact is telephone-based, with no face-to-face contact other than in exceptional circumstances.
- Fifty-six (58%) reported that partner contact is predominantly telephone-based, with a small proportion of partners also receiving face-to-face contact when requested.
- Thirteen (14%) offered a relatively equal mix of telephone-based and face-to-face contact.
- Four (4%) said the majority of partner contact was face-to-face; notably, all four were located in remote communities.

Despite the limited resources with which most partner contact services operate—evidenced by the significant proportion of respondents stating that their partner contact service was not specifically funded—it is clear that the majority at least attempt to make available a level of face-to-face contact for some partners, in certain circumstances, even if this isn't necessarily the norm (refer to Figure 10).

Duration and frequency of partner contact

To gain a sense of the duration and frequency of partner contact, survey respondents were asked to provide information about commencement; the stage and regularity that partner contact is offered; the frequency with which it is offered; and at what point it ceases. The results are presented below.

Figure 10: The way partner contact occurs*
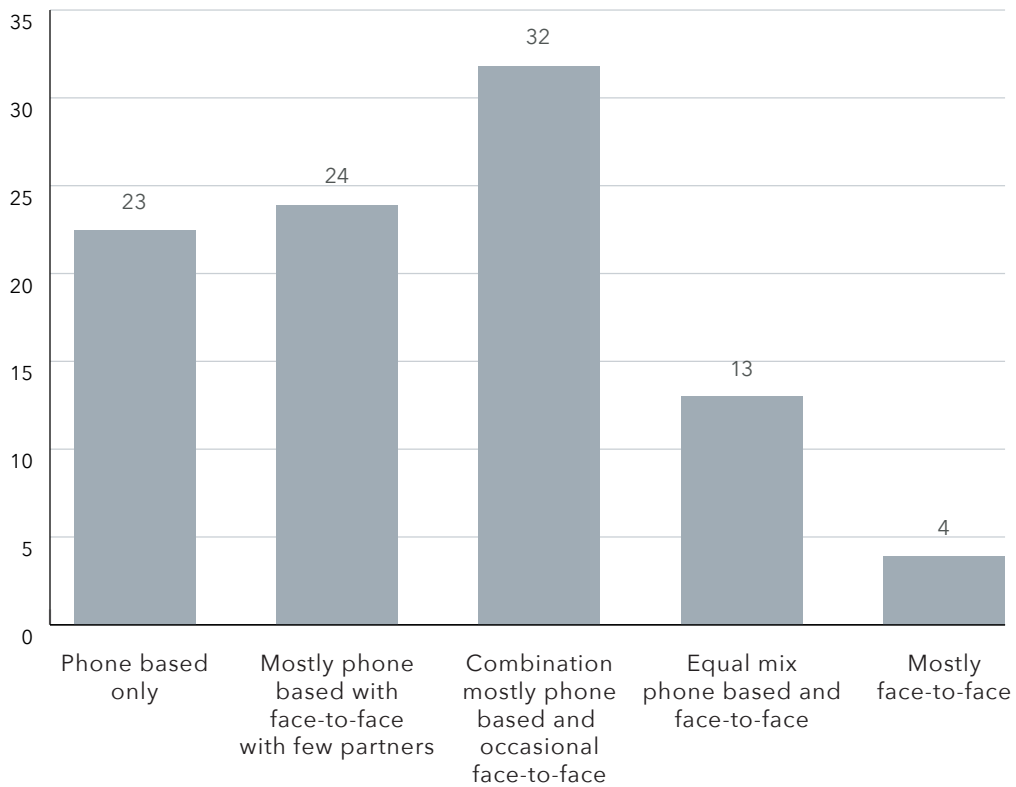
*Missing values n=35

Figure 11: Commencement of partner contact
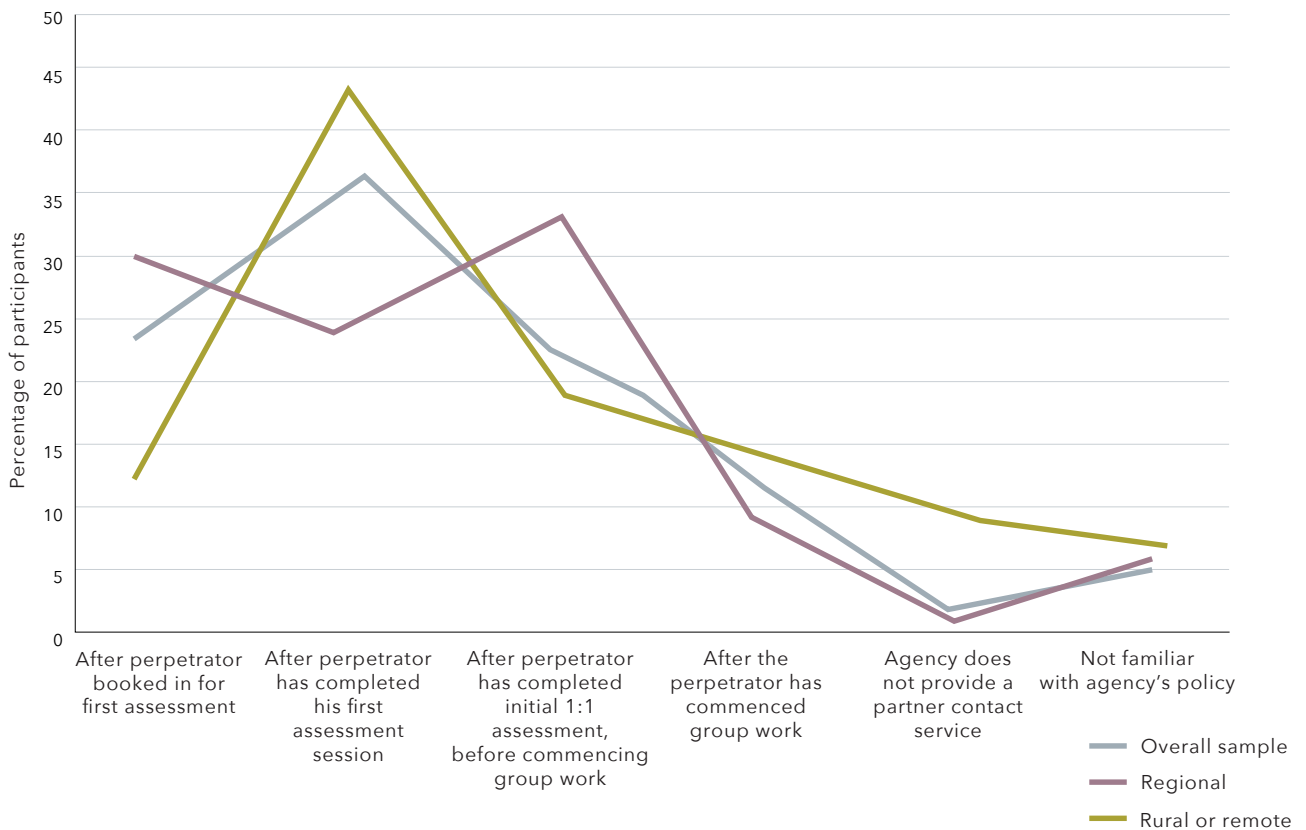
Commencement

Survey respondents were asked about their agency's policy relating to the commencement time of partner contact. Of the 95 respondents to this question:

- Twenty-three (24%) said this occurred as soon as possible following the perpetrator being booked in for his first assessment session (when partner contact details are already available via the referrer or through an initial telephone-based intake call with the perpetrator).

- Thirty-four (36%) reported this was carried out as soon as possible after the perpetrator has completed his first assessment session.

- Twenty-two (23%) stated this was done as soon as possible after the perpetrator has completed the initial one-to-one assessment phase, and ideally before he commences the group work component of the program.

- Thirteen (13.5%) reported partner contact commencing as soon as possible after the perpetrator has commenced the group work component of the program.

- One person said their agency did not provide a partner contact service.

- Two people (2%) said they were not familiar with their agency's policy around this (refer to Figure 11).

Differences were noted in the responses from participants in regional and remote areas. A higher proportion of remote participants reported partner contact commencing after a perpetrator completed his first assessment session. In contrast, regional participants reported a higher proportion of partner contact commencing after the perpetrator completed the initial one-to-one assessment, but before commencing the group work component of the program. Overall, the results are promising, in that they suggest that agencies recognise the importance of commencing partner contact as soon as possible after referral (refer to Figure 11).

Stage and regularity that partner contact is offered

Survey respondents were asked to provide information about the regularity with which partner contact support was offered, at the various stages of a perpetrator's involvement with MBCPs. The results are visually depicted in Figure 12.

There are some notable aspects to the data. Responses suggest that:

- When a perpetrator commences a program but does not complete the initial assessment, partner contact support is estimated to be routinely offered by less than 37 percent of respondents.

- Fifty-five percent of respondents identified that partner contact is not offered routinely if a perpetrator completes the assessment but does not continue with the program.

- Forty percent of respondents reported that partner contact is not routinely offered to women when men are on wait-lists to start a program.

- More than 40 percent of respondents identified that partner contact is not routinely offered once a man completes a program, despite program completion being a time of potentially higher risk for some partners.

- When a perpetrator is assessed as unsuitable to commence a program, less than 25 percent of respondents routinely offered partner contact, which means that 75 percent of respondents believed this to be carried out on an ad-hoc basis or not at all.

These findings are concerning, particularly as this population of women have limited if any contact with specialist services and may be associated with perpetrators with higher risk behaviours.

Frequency of contact

Frequency of partner contact support, outside of specific safety concerns, was explored with participants. Of the 97 respondents to this question, weekly contact occurred with 15 percent of the sample; fortnightly with 38 percent; monthly with 16.5 percent; and at the "beginning, middle and end" with 11 percent. Around 18 percent of participants selected the "other" option (refer to Figure 13).

Those who provided qualitative information for "other" described contact as being either a few times per week; weekly until completion of a 4-week workshop, then reduced thereafter in an outreach capacity; every 3 weeks; or varied depending on the needs and wishes of the woman. One response also suggested the frequency of contact can be

Figure 12: Stage and regularity that partner contact is offered

	Routinely	Sometimes, but not routinely	Rarely	Never
When a perpetrator commences but does not complete the initial assessment	35	24	14	22
When a perpetrator completes the comprehensive assessment but does not continue with the program	42	27	14	12
When a perpetrator is assessed as eligible and suitable for the program and is on a wait-list to commence	56	11	12	14
For a period of time after a perpetrator has completed all requirements of the program	53	26	9	5
When a perpetrator is assessed as unsuitable	23	24	22	24

Figure 13: Frequency of contact

Prioritising women's safety in Australian perpetrator interventions: The purpose and practices of partner contact
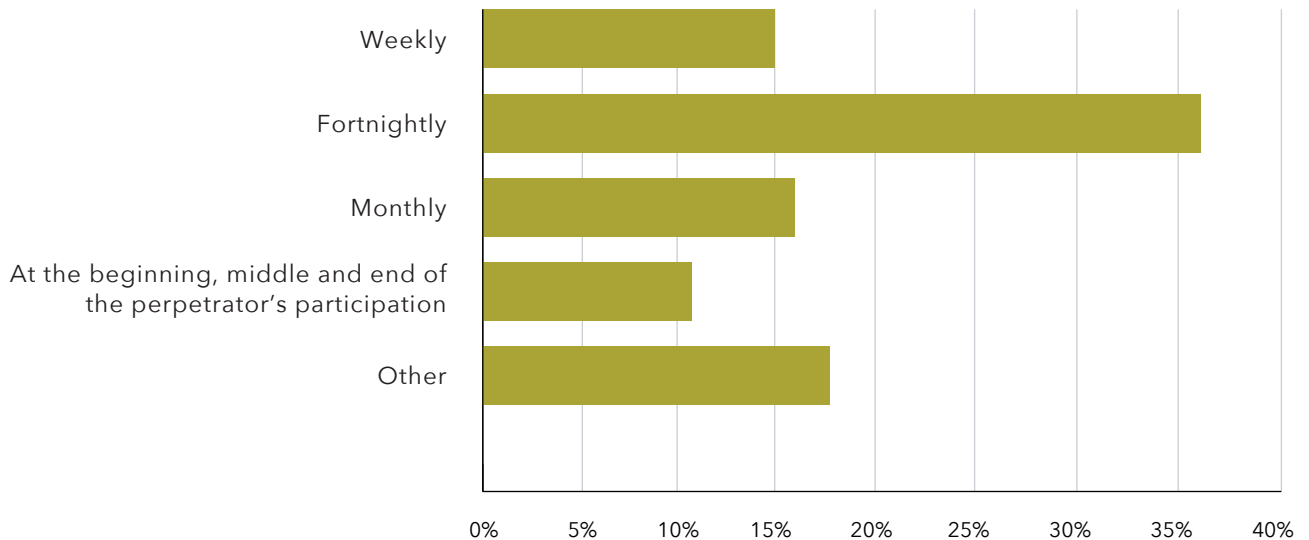
Figure 14: Proportion of women referred to specialised supports services

Proportion of women referred

■ Over half of cases ■ 25 to 50% ■ 10 to 25% ■ Infrequently (less than 10%) ■ Never
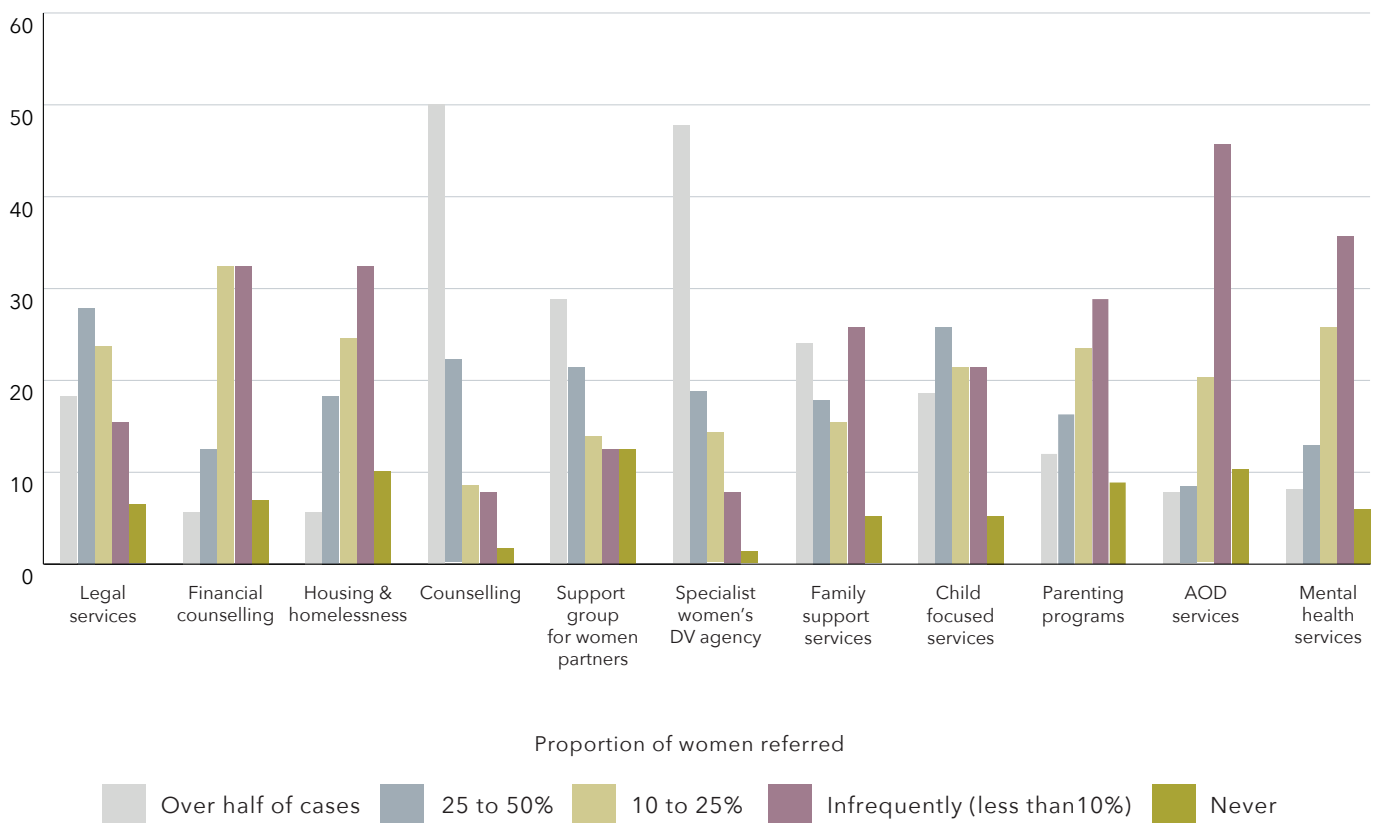
impacted by workload capacity:

> It would depend on the woman's risk, wants and needs. It is also sometimes affected by our capacity, e.g. if workload peaks, we may reduce contact to monthly that would otherwise be more often. We don't do this if risk is high though. (Partner contact worker, urban area)

Regional and remote responses mirrored the results of the larger sample, in that the highest frequency of contact was said to occur on a fortnightly basis.

Opportunity to attend partners' group sessions

Of the 97 participants who responded to the question about whether partner contact services offer women an opportunity to participate in a partners' group session at some point in the program, 27 (28%) responded "yes", 66 (68%) said "no" and four (4%) were unsure. Participants in regional and remote areas indicated similar results, although notably more than 80 percent of respondents located in regional areas said that partners were generally not given an opportunity to attend such a group.

Types of referrals and supports offered

Survey respondents were asked to indicate the frequency with which they provided referrals to a number of support services, including legal services, financial counselling, housing and homelessness services, counselling, support groups for women, specialist women's domestic violence agencies, family support services, child-focused services, parenting programs, alcohol and other drugs services, and mental health services.

Figure 14 shows that referrals to counselling and specialist women's domestic violence support agencies are the most frequently made, while referrals to alcohol and other drugs services, housing and homelessness services, parenting programs, mental health services and financial counselling are the least frequent.

Support following perpetrator exiting MBCP before completion

When a perpetrator has dropped out or been exited from a program before completing all of its requirements:

- Fifty-seven of the 97 (59%) respondents, half of whom were from regional and remote areas, indicated their agency would continue to offer partner contact support to partners, determined as necessary by the woman.

Figure 15: Partner contact support following perpetrator exiting MBCP before completion
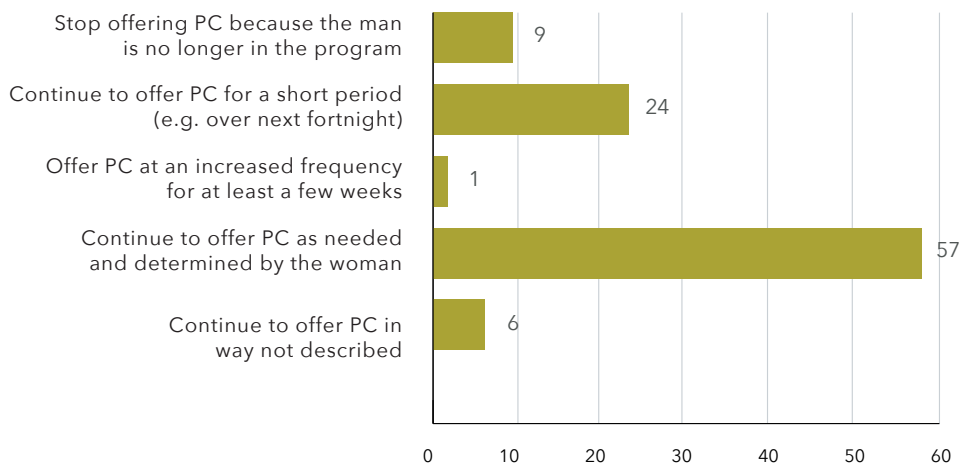
Figure 16: Number of months of support offered following perpetrator exiting MBCP prior to completion
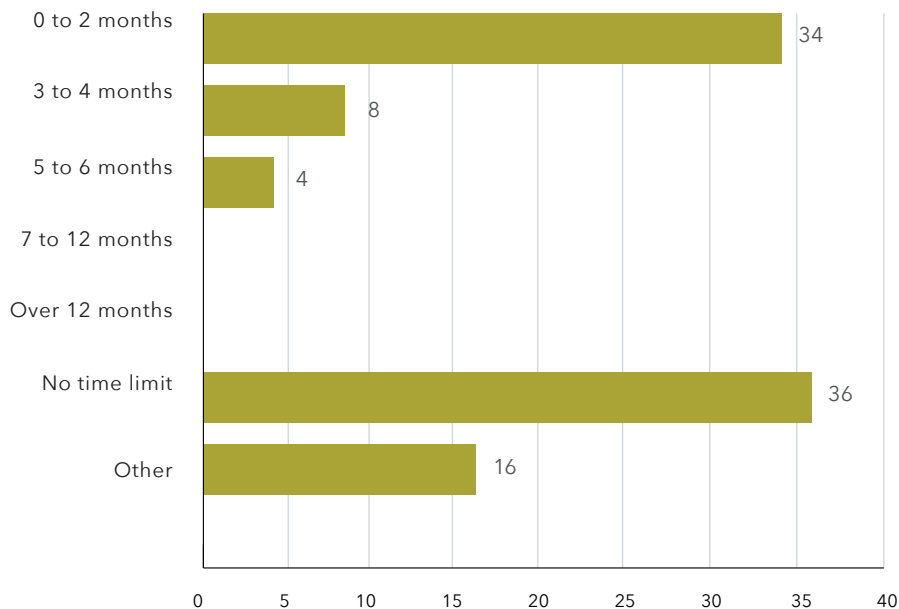
- Twenty-four (25%) said their agency would continue to offer partner contact to the partner for a short period of time (e.g. over the next fortnight); again around half of these were from regional and remote areas.
- One person said their agency would offer partner contact support at an increased frequency at least for a few weeks.
- Nine (9%) said they would stop offering support, six (6%) of whom were from regional and remote areas.
- Six (6%) said they would offer support in a way not described (refer to Figure 15).

Among the few responses provided that described the way in which they would offer support, most indicated they would ensure that partners are connected with another support before the partner contact service finishes, or continue to provide support as needed while still working towards closure. Another said the support would continue on an informal and ongoing basis.

Length of partner contact provided

Survey participants were asked to provide information about the estimated number of months for which partner contact is routinely offered, after a perpetrator drops out or is exited before completing all program requirements. Of the 98 respondents:

- thirty-four stated that partner contact is routinely offered for up to 2 months
- eight said this was offered for 3–4 months
- four for 5–6 months
- thirty-six reported there being no time limit—this was offered as needed, and determined by women.

Figure 17: Number of months of partner support offered following MBCP completion
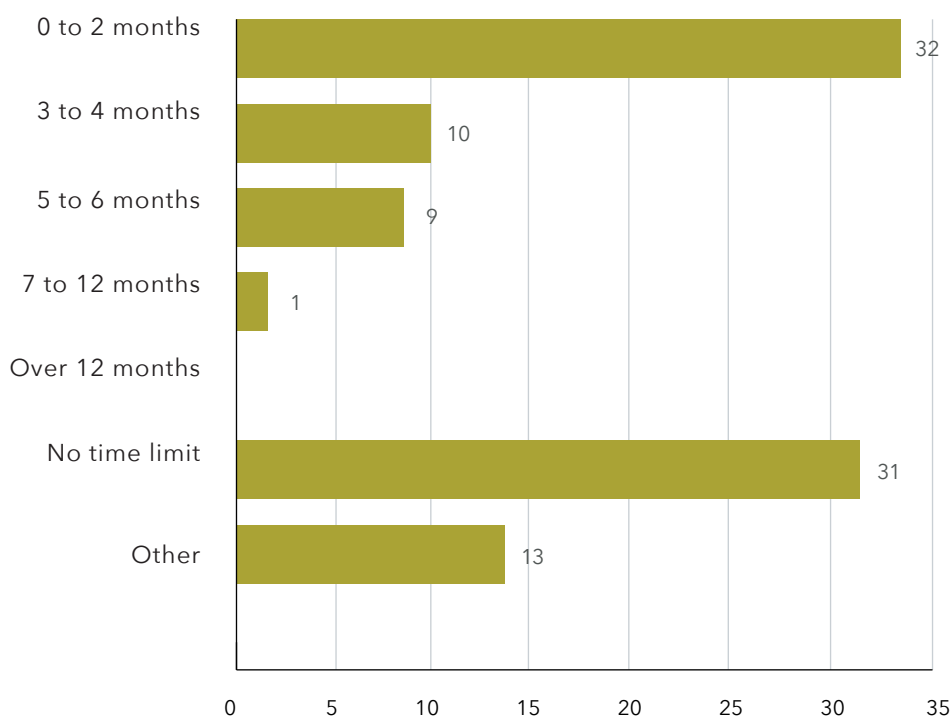
The remaining respondents selected "other", the descriptive responses for which indicated that many programs do not offer ongoing support or offer only minimal support by contacting partners 1–2 more times. However, similar to previous responses, before exiting the woman from the service a number of respondents indicated they will refer her to other services for ongoing support. There were also some respondents who shared that either no support was offered or they were unsure about the arrangements, with most of these participants located in regional or remote areas (refer to Figure 16).

Support following perpetrator completing MBCP

Participants were also asked to provide information about the estimated number of months for which partner contact is routinely offered following a perpetrator completing all program requirements. Of the 96 responses:

- thirty-two (33%) suggested that partner contact support was offered for up to 2 months
- ten (10%) reported this as occurring for 3–4 months
- nine (9%) for 5–6 months
- one (1%) for 7–12 months
- thirty-one (32%) indicated there was no limit, as this was continued as needed and determined by the woman (refer to Figure 17).

It is important to note that these results do not mean that partner contact was *routinely* offered to all partners for these periods, as about 25 percent of respondents stated in a previous question that partner contact was offered sometimes but not routinely after the man ended his requirements in the program.

Of the 13 (13%) respondents who selected "other", eight (8%) reported no partner contact support being offered. Descriptive information indicated that, consistent with other parts of the survey, there was evidence that some partner contact services would make referrals to other relevant support services at the time of their final contact with women, or in situations when the service was unable to continue providing support. The following comment made by a participant located in a regional area may reflect the challenge that practitioners contend with in providing a service they know is very much needed: "It is supposed to be for 6 months afterwards; however, this has not happened." (MBCP coordinator or team leader, regional area)

Number of contacts following MBCP completion

The survey also asked for descriptive information about the number of agency contacts that services would aim to provide to partners following a perpetrator completing a program. Responses indicated that much variability exists between programs:

- Thirty-three out of the 74 (45%) respondents indicated their program would have three or less contacts. There appears to be a notable proportion that do not see partner contact as a regular service, but more of a "checking in"

service at particular points.

- Four (5%) participants suggested their service attempted to have between six and nine contacts.
- One (1%) said their agency would aim for 25 to 50 contacts.
- Two (2%) others suggested their agency would have around 20–27 contacts.

Some of the survey respondents provided more descriptive than quantitative information:

- Twenty-eight (38%) suggested the number of contacts was not specified because it depended on the risks to, and the needs of, women.
- Two (3%) referred to funding contracts as determining both the number of partner contacts required and when partner contact stops.
- Ten (14%) referred to the frequency of contact by their organisation (rather than the number of contacts), which ranged between weekly, fortnightly and monthly.
- Four (5%) stated that contact was only provided once the MBCP had finished.
- A number of respondents working in regional and remote communities referred to a lack of resources in either their agency, or the agency providing the partner contact when it was offered externally, as restricting the length and frequency of contact and the difficulty in making contact in remote areas where (ex-)partners may live a considerable distance from the service location.

Support following perpetrator exiting MBCP

Participants were asked about the partner contact and support provided to victims/survivors once the perpetrator had exited the MBCP, regardless of the reason for exiting, and a total of 86 participants responded. The findings show considerable variability, ranging from no partner contact services being offered after the perpetrator exits through to no limits being placed on victims'/survivors' access to partner contact support. In summary, it was reported that when the perpetrator exited the MBCP the following partner contact was available:

- no future partner contact sessions (n=5)
- one to two partner contact sessions (n=27)
- three partner contact sessions (n=7)

- five partner contact sessions (n=2)
- six partner contact sessions (n=4)
- nine partner contact sessions (n=1)
- fifteen to 20 partner contact sessions (n=1)
- no upper limit on partner contact sessions (n=31)
- unknown (n=8).

Encouragingly, 31 (36%) did not specify an upper limit on the future partner contact services offered by their agency. These results are promising, as they indicate that partner contact workers recognise there is a potentially higher risk for partners when perpetrators drop out or are exited from programs. In response, it would appear that they attempt to continue or even escalate partner contact support at least for a brief period, or as needed by a woman, despite the limited resourcing of this role.

Overall feedback about support following perpetrators exiting MBCPs

Survey participants were invited to provide comments or feedback about the duration and frequency of partner contact following a perpetrator leaving a program. Limitations of program funding were identified as a significant factor impacting on the support that could be provided:

> Previously time limits have been able to be quite flexible and determined based on the needs of the women. However, due to recent funding changes and funding ending in June 2019, our agency is now having to focus more on linking to other services fairly early on so that all women have access to alternat[iv]e services if they are going to require this. (Partner contact worker, regional area)

Although funding of partner contact seemed to be dependent on a man's participation in a program, partner contact workers appeared to offer more than what they are funded for when the partner contact was offered by a women's service (regardless of whether the service was part of the MBCP agency or independent of it):

> We are not funded to work with women once the man is no longer in the program; we just create capacity to do this due to recognition of risk issues after he exits. (Partner contact worker, urban area)

Figure 18: Views about sufficiency of partner contact practice
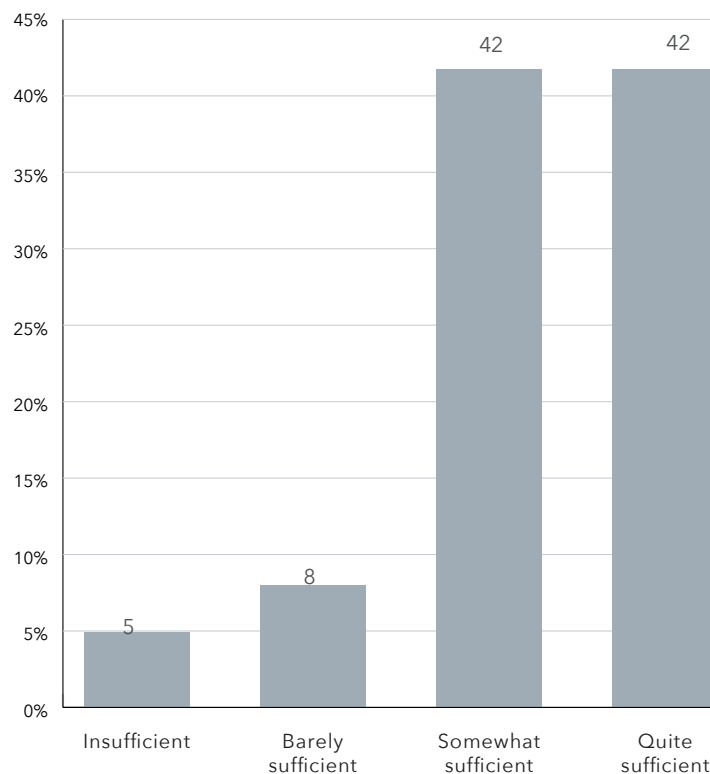
Many respondents suggested that the duration and frequency of support provided beyond a perpetrator leaving a program would be tailored to a woman's needs. However, there did appear to be some limitations around this should support be wanted or needed for a longer time:

> We try to tailor this to [a] woman's needs. If her needs continue beyond what we have capacity to support her with, we would ensure we find alternative support and warm-refer her to this before we close her file. (Partner contact worker, urban area)

As mentioned previously, referral to other services for longer term support was seen as a common means through which partner contact services could ensure that women were provided with ongoing support beyond the MBCP. One respondent referred to women not being informed of a perpetrator's attendance or exit—a potentially concerning practice in terms of risk management—which meant that partner contact support continued in the same manner. However, this did not seem to be a common approach:

> In the interests of not breaching confidentiality, the partner/former partner is not informed of his [the perpetrator's] attendance or exit, so partner contact continues as outlined at [the] beginning of service. (Partner contact worker, regional area)

The following quote also indicates the way in which partner contact support is impacted and managed in remote locations:

> Because our clients are based in remote Indigenous communities, follow-up supports [are] provided for 6 months *on completion* only. [Management of] risk for the female [that arises from] MBCP participant early exit is provided by community-based agencies [rather than our program]. (Senior manager, remote community)

A number of participants also referred to some women requiring partner contact support for some years after the man has completed or ended his participation in the program.

Views about sufficiency of partner contact practice

Survey respondents indicated they had fairly divided views about the adequacy of their agency's partner contact practice:

> If the three men's groups in our region are full and are all running there are potentially 36 active participants in the MBCP at any given time. Many of these participants have identified two or three current or former partners. This makes the advocate's caseload enormous. It is also required to keep open files for participants who have completed the program to allow for follow-up with the

women at 3 and 6 months post-completion. At times my caseload has reached 70-plus clients. The women's advocate role is only funded for 15.2 hours per week. I am certain that there are many women in need of support that I am incapable of supporting due to the limited time constraints. Therefore, I feel that this impacts the quality of service to these women. (Partner contact worker, regional area)

Participants also expressed their concerns that without a dedicated partner contact worker, consistency of support can be heavily impacted:

Partner contact is undertaken on top of a counselling caseload and other commitments—groups, intake activities etc. So it is not a dedicated role, but an add-on that can be tricky to administer consistently. (Partner contact worker, regional area)

They also made suggestions about the priority given to women and children relative to perpetrators in programs:

A greater dedication of the role as a separate process from the MBCP would enable it to operate with less risk to facilitators and with greater coverage of ongoing regular contact with women, as well as better closing the gaps in communication around issues such as safety with referring services or referral services. (Partner contact worker, regional area)

The following respondent, while stating that the partner contact service was sufficient in attending to women's needs, felt there was a gap in adequately meeting children's needs:

The biggest gap is not having a children and young people's advocate in the program. This is essential for kids. If the dream would become a reality and every program had both roles we would be able to offer joint meetings, sessions with women and their kids, groups etc. This would then offer a very high service to all that need it. (Partner contact worker, remote community)

Additionally, there were some various critiques and comments offered about the adequacy of partner contact in general, including:

- the focus of MBCPs being on men rather than women
- difficulties in contacting or engaging women
- the view that more effort is needed in sourcing the contact details of partners
- a lack of understanding by workers delivering the service about what partner contact support entails
- inadequate existing policies and protocols around partner contact
- the belief that when partner contact support is not sufficient, this can put women at higher risk.

Again, funding and resourcing were referred to as impacting the sufficiency of partner contact support, and featured more heavily in comments from participants located in regional and remote locations:

[There is a] lack of resources to be able to do the follow-up that is required after the men have finished and to make regular contact throughout the group. I have 48 women at the moment and 2 days to work with them. I feel that they are not given a good service and are still at risk because of this. (MBCP facilitator and partner contact worker, remote community)

We have one worker who does a great job, however her caseload is very high which means she can't get to everyone as often as she would like …We are not funded for partner contact, which I believe is also a problem for us as an agency. (MBCP facilitator or practitioner, remote community)

Children's support

The survey also aimed to gather some broad-based information about the level and nature of support provided to children. Overall, responses indicate that individual partner contact practitioners have limited direct contact with children, possibly demonstrating recognition that this is an area of specialist work. In addition, the range of services offered, and how each agency goes about offering these services, appears to vary substantially between program providers.

Collaboration between partner contact services and MBCPs

Respondents were asked whether their agency, or any other agency they work with, offers direct contact with and support for children who are impacted by a perpetrator's use of violence, in a way that collaborates with the partner contact service and the MBCP. Of the 90 responses, 54 (60%) said yes and 36 (40%) said no. The "yes" response was larger than the researchers expected given that most MBCP provider teams do not have a dedicated position, or the specialist expertise, to have contact with children. This suggests that many MBCP providers are conscious that other services within their agency (outside of the MBCP practitioner team), and/or other organisations, are having direct contact with children who should be "in the orbit" of the partner contact service's collaborations.

Assessing children's risk and needs

In response to the question seeking information about the role that partner contact takes in assessing risk to children resulting from a perpetrator's behaviour, a range of answers were provided. The majority of participants reported that assessments for children were carried out through the protective parent, usually the mother. This mostly involved conversation and discussion about children's experiences, with some also mentioning they used the same formal risk assessment tool, such as the Common Risk Assessment Form (or similar depending on the state or territory), that they used with women. They indicated that some assessment tools had a section dedicated to capturing information about children, the impact of the violence upon them, and what supports (if any) are required:

> In the assessment tool, there is a part where children's details are asked for, and there are certain questions around how they are going, their behaviour, and if they were exposed to violence, then follow-up questions around whether they have already been referred to a children's program. If they have not, then the worker can support the (ex-)partner through the process if that is what she chooses to do. If children are old enough/their parent agrees/it is appropriate, then the partner contact worker might have a conversation with them. (MBCP facilitator and partner contact worker, regional area)

Notably, the above participant also mentioned speaking directly with children, subject to their developmental level and their mothers' consent, although this was not reported as a common approach.

Some respondents said a dedicated children's risk assessment tool was utilised, although this did not seem widespread. Rather, there was a sense that practitioners ensured they always considered children in their assessments with women, and would offer support, information and referrals if mothers identified this as necessary. Issues associated with providing support for children through partner contact work were inferred, with a number of responses specifically referring to the job as being difficult or limited. The reliance on telephone calls as the predominant partner contact medium was cited by several respondents as restricting the type and level of support available for children.

While most participants suggested that carrying out an assessment of children's risk and needs through direct contact with the mother was an appropriate level of support, there were a minority who considered this to be insufficient. A few suggested group work with men as being another means through which children's needs were identified, although the small number of participants who referred to this method indicates this may not be a widespread practice:

> [Children's needs are identified] through supporting the case formulation of the relationship and program participants' pattern of behaviour, the [domestic and family violence] risks and potential impacts of the behaviour. They [partner contact workers] give feedback to facilitators and provide peer supervision and guidance on issues related to children's development and wellbeing within the context of [DFV]. (MBCP coordinator or team leader, urban area)

Form of support

Working in collaboration with child protection agencies and referrals to children's services appeared to be the most common form of support provided to children. Children's counselling, both individual and group, was the most frequently cited form of support recommended, which seemed to be dependent upon what services are available in the area. A number of participants' agencies appear to have counselling programs available within their organisation for

Figure 19: Adequacy of assessment

The way services are offered to children

Participants indicated that partner contact workers were mostly responsible for providing referrals for children's support direct to service providers, in consultation and negotiation with the mother. Sometimes, information about appropriate support services for children is given to mothers to follow up on if this is preferred. A few respondents suggested such referrals were done "face to face", but it was unclear if this was with the mother and/or the child.

Sharing information between agencies

Of the 86 survey participants, 66 (77%) reported that information about children was shared with services and agencies working with affected children, in addition to statutory child protection agencies. Thirteen (15%) said it

children, along with family counselling (involving mother and child/ren) and individual counselling for both mothers and children. One respondent highlighted how an absence of counselling services available in the remote area where she worked was a significant gap in their provision of support for children:

> This is an area we need to develop as a community—at this stage there are very few services available that focus on addressing the impact of trauma from [family violence] on children. As members of the [community body], we have identified this as being a massive gap in services in [our regional town] and surrounds. (MBCP coordinator or team leader, remote community)

was not shared and six (7%) were unsure. The purpose of this information sharing was said by 46 of the respondents to be related mainly to ensuring child safety and managing or monitoring risk. Twelve responses referred to the importance of sharing information as a way of further supporting children's social and emotional wellbeing, while eight referred to it as part of mandated reporting requirements. Notably, most responses focused on children's safety rather than issues relating to their wellbeing, development, and the broader impacts of the violence they experienced.

Addressing the impact of violence on the partner's capacity to parent

Adequacy of assessment

Survey respondents were asked for their general view about how well their agency's partner contact service assesses the impact of the perpetrator's violent and controlling behaviours on their (ex-)partner's capacity to parent. Of the 88 responses received, 14 (16%) said they thought this was carried out insufficiently; 27 (31%) that it was done sufficiently with "some" partners, but not with others; and 47 (53%) reported it was undertaken sufficiently with "most" partners (refer to Figure 19).

Support provided

Qualitative information was then requested about what is done through partner contact to address the impact of the

perpetrator's violent and controlling behaviours on their (ex-) partner's capacity to parent. Generally speaking, responses were quite brief and broad. The brevity and lack of detailed responses regarding *how* partner contact services identify and address the impact of the perpetrator's behaviour on the woman's capacity to parent contrasts with approximately half of the respondents. They stated that they do this sufficiently with most mothers.

The most commonly cited approaches were discussion, along with providing information, resources, support and referrals to appropriate services. These frequently appeared to involve the use of educational-type conversations designed to highlight the impact of violence and abuse on children and on parenting. A few participants referred to using David Mandel's Safe and Together model as a foundation for their practice, while others found the Duluth Wheel useful in explaining the impact of violence on children. Some participants referred to the importance of providing a woman with positive social responses that emphasised her acts of resilience as well as perpetrator accountability to be important. Three reported they would share with MBCP facilitators any information from their assessment and discussions with women that might be useful. Four respondents indicated they thought that overall this was an area where very little or nothing was done.

Program evaluation

Overall, responses pointed to practitioners having a broad range of understanding about what program evaluation is, and the activities that are used in the process. Of the 89 respondents, 51 (57%) reported that partner contact information was routinely used to assist in the evaluation of the program, 21 (24%) stated it was not used and 17 (19%) said they were unsure.

Tools utilised

Respondents were asked whether one or more formal tools—generally, existing or published evaluation tools used by multiple agencies—were used during partner contact to help evaluate program outcomes. Formal tools were said to be used by 37 (41%) respondents, with 30 (34%) claiming they were not used and 22 (25%) unsure. There was significant variation in the types of tools used for program evaluation. The qualitative information provided indicated that, contrary to the above, most appeared to be informal type tools, developed "in house" by respective organisations, rather than being formal instruments.

When and how they are used

Sixteen of the respondents who provided qualitative information about when and how these evaluation tools were utilised said this only occurs when the perpetrator completes or exits the program. Twenty respondents indicated these tools were used to undertake evaluation at various intervals throughout the program, with most reporting they were used at the beginning and end of the program. Other responses included the tools being used at the beginning, during and after the program; quarterly; every 10 weeks; and at each contact to measure progress a minimum of three times. Two participants indicated their organisation used program evaluation tools three months after the program had finished.

Information collected

There also appeared to be inconsistency between programs with regard to the type of information routinely collected to assist with MBCP evaluation. Ten participants reported no information was collected or program evaluation carried out. Of those who did collect information:

- eight did so from partners about the MBCP and any contact they had been having with their partner
- six said feedback from perpetrators was collected
- thirteen stated that information was attained from multiple sources, including feedback from family members, perpetrators and MBCP facilitators (separately); psychometric testing pre- and post-group; informal feedback from referrers (e.g. police); and perpetrator recidivism data.

One participant also provided a comprehensive response as to how each man's level of risk was rated in an ongoing, dynamic way—as high, medium, moderate or low based on well-defined risk indicators—to assist with program evaluation.

Overall, approaches to program evaluation appear to vary substantially between providers, including significant disparity

in how information from partner contact is used to assist in evaluating outcomes. For example, there are differences in what tools are used, how formal or informal the evaluation activity is, and what sources of information are combined. Additionally, there appears to be little uniformity in the type of evaluation methods undertaken, which makes collecting data to assist with developing an evidence base difficult. Similarly, interpreting data and evaluations is inherently problematic when the methods and measures, as well as what is being evaluated, differ so greatly between programs.

Relationship between MBCPs and specialist women's domestic violence services

The majority of the 129 participants (87%) indicated there were specialist women's domestic violence services in their locality, although there was variance in whether any of them had formal written agreements in place with the MBCP. The remaining respondents, who reported no specialist women's domestic violence services in their locality, were mainly in regional and remote areas.

The question asked specifically about "formal" agreements, policies or protocols with specialist women's domestic violence service providers. However, there was a sense from the qualitative answers provided that some respondents may have referred to policies and protocols within their agency about sharing information with women's services, rather than an actual MoU or protocols co-signed between the MBCP provider and a designated women's service. Policies and protocols were said to cover a range of areas, including information sharing, referral processes, confidentiality requirements, risk assessment, safety planning, collaborative working arrangements, service delivery standards, participant service agreements, rights and responsibilities, the purpose of supervision, case management, and expectations of funding agreements in relation to the delivery of partner support.

Exchange of information

Respondents were asked to provide information about whether the MBCP provider they worked with had any formal written agreements, policies or protocols in place with specialist

women's domestic violence service providers. It should be noted that formal agreements in this context do not necessarily mean written agreements. Sixty (47%) of the 130 respondents reported having formal agreements in place, 36 (27%) said there were none and 33 (25%) were unsure. Broadly speaking, responses describing these policies or protocols referred to when and how information was shared, further details of which are outlined below.

When information is exchanged

The majority of respondents identified risk and safety concerns as the key reason for sharing information about clients. Many suggested information was mostly exchanged at the time men were referred to MBCPs, and then following this when any changes to risk or safety were identified.

How information is exchanged

Most participants reported that there were regular, formal mechanisms in place to facilitate the exchange of information, such as face-to-face and telephone meetings, email correspondence and electronic access to files. Some of the specific means through which information was shared included weekly case coordination meetings, exchange of written documentation through commonly accessed paper files and databases, formal multi-agency collaboration meetings, and regular conversations between MBCP facilitators and women's partner contact workers. Attaining the consent of partners to share information with external agencies was identified by many respondents as critical to the process. Legislative requirements were also commonly referred to as providing the framework for which information about risk and safety can be shared between services. In some states, new information-sharing policies are in the process of being introduced to facilitate easier information sharing between services.

Observing MBCPs

Of the 117 responses about the regularity with which practitioners from specialist women's domestic violence services observe MBCPs:

- 57 (49%) indicated this "never" occurred
- 25 (21%) said this occurred "rarely" (at most once per year)
- 25 (21%) reported this occurred "sometimes" (two or three

Figure 20: Regularity of women's services observing MBCPs
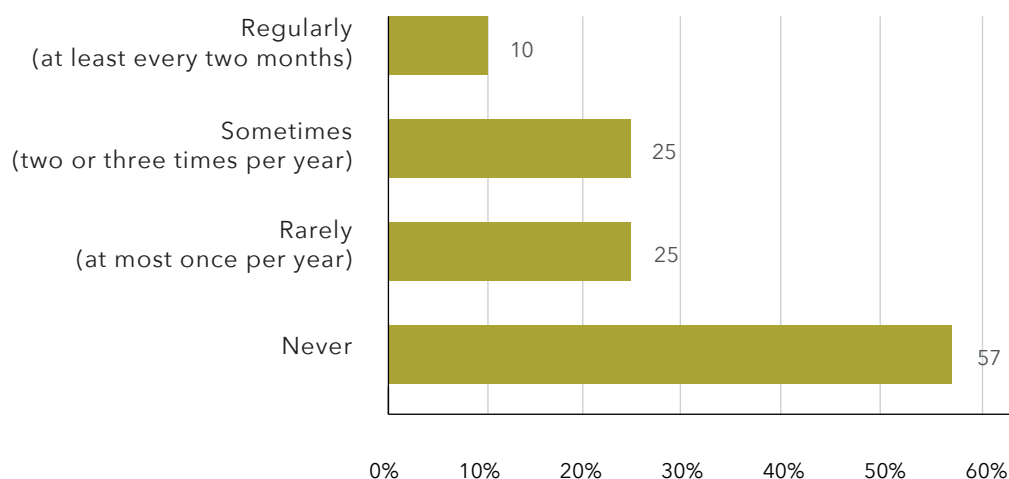
times per year)

- 10 (8.5%) said this occurred on a "regular" (at least every 2 months) basis
- more than 70 percent in regional and remote areas also said this "never" occurred.

Overall, these findings demonstrate that a relatively low proportion of specialist women's services practitioners observe MBCP group sessions even "sometimes". That 70 percent of specialist women's services never or rarely observe the program with which they are working (refer to Figure 20) is a significant finding.

The type and nature of relationships

Respondents provided an array of further qualitative information about the relationships that MBCPs have with women's specialist domestic violence services. Most indicated there were relatively strong links in place, with a number of mechanisms identified as supporting and enhancing these relationships. These were mainly formal connections developed through attending interagency training, meetings and supervision, and included networking and stakeholder meetings, group supervision, post-review group meetings and perpetrator accountability panels.

Membership of multi-agency networks, reference groups and high-risk team meetings were other means through which these services were connected. Some agencies also encouraged observers as a way of facilitating relationships not just with women's services, but with the broader community:

> We have observers at every session drawn from our community, [police], an occasional magistrate, social work students, psych[ology] students, service providers including women's service workers when they go on the

roster. I try to encourage observers from our broader community on the basis that our community has high level [DFV] so the community needs to support a program that works towards stopping the violence towards women. We have [Aboriginal and Torres Strait Islander] men observe now and then. Observers can be female or male, we have a roster. If no observer is rostered for a session, a worker or student from our service does it. (CEO, regional area)

Respondents also described the relationship between women's practitioners (including women's advocates and refuge managers) working directly alongside MBCP facilitators. In some places, men's and women's services were co-located as part of delivering integrated responses to families. Participants also identified that regular referrals to women's organisations that provide services such as home safety upgrades and counselling for women and children were important. In organisations that are both a specialist domestic violence service and an MBCP provider, these relationships are inherent.

A few comments suggested that, in some areas, the relationship between men's and women's services needed to be developed or strengthened:

> Currently no formal links. Would like for this to change but currently feel that the specialised service operates in a silo. (MBCP coordinator or team leader, urban area)

> We have a good relationship with one of the women's domestic violence services in our area. We'd like to have better contact with the other women's domestic violence service in our area, which services crisis clients, but many attempts have been made to build on this relationship from our service perspective and have not been met with enthusiasm. (MBCP facilitator and partner contact worker, regional area)

General feedback and suggestions

Survey participants were given the opportunity to provide general feedback and suggestions about partner contact practice, including how adult and child victims/survivors can be better supported while perpetrators are participating in MBCPs, and the factors or considerations that complicate the provision of partner contact work. Responses were classified into some broad themes, outlined below. Notably, inadequate funding and resourcing was a significant issue emerging in this section, and throughout the survey, as impacting the intensity and quality of partner contact support.

Funding and resourcing

Participants felt strongly that increased funding and resourcing for partner contact practice was necessary to improve support for adult and child victims/survivors. Respondents indicated that this component of MBCPs is severely underfunded, with not enough hours provided in the role to meet the demands of the work:

> More financial resources that will ensure that partner contact workers are funded alone. Some male participants have up to three previous partners so potentially the partner contact should be contacting them all. Add up the number for us and that's potentially 360 a year without funding and the partner contact worker is only employed for 2 days a week. (MBCP coordinator or team leader, remote community)

Notably, the comment below refers to this being a reflection of broader gender inequities:

> Another component that would be useful would be to have more hours assigned to this role. The MBCP facilitators are paid for 5 hours times two facilitators and so an equivalent resourcing of the support to women and children would appear to be necessary, yet this is not the status quo. We talk about the Power and Control Wheel within the program, and that often women facilitators are paid less than men; well, the same is true of the partner contact workers being given less hours to do more work than the men's workers. (Partner contact worker, urban area)

Similarly, the following comment explains how inadequate funding impacts directly on workload capacity. This often results in men's supports being prioritised over women's, and the introduction of eligibility requirements that limit the amount of support that many women receive:

> It comes down to funding/resources. We don't have enough time to speak with the number of clients we offer partner contact services to, and the perpetrator's work takes precedence over the victims, when it should be equal. (MBCP facilitator and partner contact worker, regional area)

Additionally, more flexible funding to assist in meeting the diverse needs of women and children, as well as increasing the number of women who can be supported, was suggested:

> More funding with brokerage attached to allow the service provider to provide the level of support needed to these women and children. [And] that partner support funding be made more widely available to women who are partners (current or ex) of males where there has been violence. Our service and associated funding is only able to accept referrals where the males are under supervision of the Community Corrections team, which reduces the support available to a significant number of women and children in our area (Partner contact worker, regional area)

Focus and quality of support for women

A strong and related theme that emerged from our research was improving the focus and quality of support for women through partner contact practice. This included the capacity to deliver face-to-face (as opposed to telephone only) and case management support for women and children on a longer term basis if needed. Participants also identified that equipping services to provide support to women and children regardless of the perpetrator's engagement with the MBCP was important; that is, a woman's eligibility for support should not be connected with the perpetrator's level of engagement.

Despite some participants stating their organisation's partner contact practice was "quite sufficient" in providing a high-quality service, these same participants thought improvements

were still necessary, particularly around resourcing:

> I believe we provide a high-quality service, but resourcing is always an issue. We have 1.6 [FTE] women's advocates who support in excess of 120 women at any one point in time, so time constraints can limit the scope/depth of support provided. (Partner contact worker, urban area)

Earlier findings of the survey identified that more than 85 percent of participants believed partner contact practice to be either "quite" or "somewhat" sufficient. The research team noted that, among these respondents, several provided feedback about areas they believe needed to improve. This could mean that participants think there is potential to provide a more comprehensive partner contact response with a greater amount of funding and resources.

Support for children

Many survey participants also identified the need to increase support for children (and subsequently funding levels), in particular, more specialised support in the form of dedicated children's workers, children's groups and whole-of-family type group sessions. They also suggested improved children's assessments and the introduction of supervised access provisions for perpetrators prior to exiting programs.

Whole-of-family services

Survey respondents proposed providing whole-of-family type services and group programs for women and children, such as psychosocial assessments, social groups for women and children, and incorporating Safe and Together model principles.

Program evaluation and guidelines

Respondents recommended improving program evaluation and guidelines around partner contact practice. In particular, they suggested developing policies and procedures for service provision that is founded on evidence-based practice and indicates the suitability of the program to hold funding.

Collaboration between services

Participants felt it was necessary to improve collaboration between services, particularly around information sharing, in order to support women and children more effectively, improve the quality of partner contact support, and hold men more accountable for their behaviour. Improved collaboration was specifically described as being essential to providing integrative type responses to women and children, having greater transparency within the service system and collating information about perpetrators' behaviour that was often held by multiple agencies:

> Greater transparency within the service system. Contact and engagement can be difficult to achieve, however it is possible other services are able to be [a] conduit for information. Also, being able to map out the perpetrator relationships based on the information different agencies have so that the gaps and overlaps can be better identified and improved response coordination can be offered. The context in which partner contact occurs also needs to be clearer as this has some differences to traditional women's services. (MBCP coordinator or team leader, urban area)

Practitioner expertise, training and support

Respondents noted that the skills and expertise of practitioners, both MBCP facilitators and partner contact workers, impacted the provision of appropriate support. Several proposed the need for increased training and supervision of MBCP facilitators, particularly around collusion and managing the use of information in group work with men, understanding partner contact worker roles and the impact of DFV on women and children, and the way in which gender inequality can play out in service provision:

> I believe that the facilitators need regular check-ins about collusion with the men. I believe that their involvement with only perpetrators narrows their lens and that women and children are often forgotten in the picture. It would be good if more of them worked with victims alongside their work. Failing that, it would be good for the facilitators to have regular group supervision that is provided by [federal health organisation] for all service providers, and for there to be a compulsory minimum annual attendance. This assists my work as a partner contact worker as we often find ourselves deep in countertransference and I become the invisible woman and they perpetrate against me during our meetings. It's something I know that is pervasive in this work and have discussed this at length

with my supervisors, both internal and external. (Partner contact worker, urban area)

Respondents also mentioned the necessity of training for partner contact workers, although not as strongly or as frequently as for MBCP facilitators. In particular, improving supervision and support of partner contact workers was suggested as an important facet of the work, both from a risk management perspective and so they are not working in isolation:

> … time, resources, complexity, training, skill and experience of partner contact workers who often work in isolation; therefore, proper supervision and knowledge shared between workers is lost or missing. (Partner contact worker, urban area)

The following comment from one respondent reiterates this sentiment, perhaps highlighting a need and want of practitioners to become more confident in this area of work:

> There need to be networks for the [partner contact workers] to be able to learn from each other and support each other. We seem to often be only one worker in each organisation doing this role and so it is work being carried out in isolation, without specific training, support or guidance. Basically (with professional judgement) I am making it up as I go along as there is no one else to ask or learn from! (Partner contact worker, remote community)

Increased training opportunities for both MBCP facilitators and partner contact workers in regional and remote areas was also proposed, which suggests there is a lack of well-trained and qualified practitioners in these areas.

Contacting and engaging women

Consistent with findings reported earlier, numerous respondents suggested that one of the key issues in partner contact work is the inability to contact or engage with women, which can make the work time and labour intensive. There was a suggestion that more flexibility around the partner contact services' methods and hours of operation may be needed to accommodate women's responsibilities and support their engagement.

Service arrangements

Concerns were also shared as to how the partner contact service was arranged and managed, for example when:

- clients and partner contact services are located in different geographic areas
- there is no capacity to meet with women face to face
- generalist rather than specialist family violence organisations receive funding to carry out partner contact (and thus do not have a family violence lens)
- there is a lack of value placed on partner contact in comparison to the work with men
- there are power dynamics between MBCPs and women's agencies, and government and non-government organisations
- partner contact practitioners work with both victims/survivors and perpetrators (of different partners).

Possible issues experienced with the same agency managing both MBCP and women's groups were also raised:

> Safety is also the key concern, and always needing to consider the risk of unintended consequences of info[rmation] sharing. As a women's advocate from the same service who runs the MBCP, sometimes women are wary of having anything to do with someone from the same service who is connected with the perpetrator. This requires clear communication of my role, including its separation from the facilitator work, and an unwavering commitment to women's safety, wellbeing and men's accountability for their violence in my messaging to women. This is complicated by poor systems responses, poor and inconsistent accountability mechanisms, and frequent feedback that, despite the MBCP being based on solid evidence, men continue to perpetrate violence, or choose to use what they've learnt to become more sophisticated in their use of coercive control. (Partner contact worker, urban area)

Finally, some of the comments referred to partner contact support provided in the context of the Court or Corrective Services. This raised concerns about:

- the consistency of support

- the lack of consequences for men who do not complete a (mandated) program or breach intervention orders
- community corrections officers' limited understandings of DFV
- the inflexibility of the MBCP curriculum that prevents women's feedback being an active part of the response to men.

Partner contact in regional and remote areas

Some of the issues raised about partner contact support in regional and remote areas were related to low staffing levels, volume of work (across all agencies), fewer services for women to access and the difficulty in meeting best practice standards when there are limited workers available to undertake different roles. There was also recognition of the difficulties that women can face in seeking support due to the lack of anonymity in small towns. As mentioned earlier, ways to combat this include increased availability of training for practitioners in regional and remote areas, and improving professional support networks to mitigate the impact of working in relatively isolated areas. The survey as a whole captured subtle differences in partner contact services in regional and remote areas, such as the greater likelihood of the partner contact service being externally provided, compared with urban settings where it was provided by the MBCP organisation.

Tension between men's and women's services

Throughout the survey, respondents made a number of comments suggesting that partner contact is often seen as the second priority to the work carried out with men, alluding to a tension that may exist between men's and women's services. Specifically, the superior number of resources given to working with men compared to those for partner contact and supporting children were seen as being a parallel inequity to the gender inequality in our wider society. There were a number of respondents who suggested that the men's workers needed more accountability around women's experiences, as the men's interventions take up too much space relative to the partner contact components. They also mentioned that men's workers are not working closely enough with the partner contact workers and, thus, do not understand their role sufficiently. As pointed out earlier, this can result in the

reinforcement of gender inequalities in service provision.

The following comment is further evidence of the tensions that may exist between the views and practices of partner contact and men's workers:

> Partner contact should commence from the [man's] first point of contact with the service, as a means to advise a woman of the man's intention and to provide us with the first possible option for contact. This does not occur. The partner contact component of the program I am involved in is not sufficient and puts women at higher risk and allows the man to take control of the narrative — dictating to services that he "is participating". They also give out certificates at the end. I do not believe we should "reward" a man for thinking about a process of change to not murder or harm his partner/ex-partner or children. (Partner contact worker, regional or remote community)

Complexities of the work

The survey overall captured a real sense of the complexities involved in providing adequate, effective and safe support to women and children when men continue to perpetrate violence. The following quote demonstrates how well-intended interventions can, in fact, introduce new risks, which some survey respondents aptly recognised as an inherent part of the work:

> Some men may intimidate their partners into speaking well of them to the partner contact worker. Some men control the partner's access to their telephone, making contact difficult. Sometimes partner contact raises tension in the home, and then the man blames the partner contact worker for upsetting their partner. Sometimes the female partner also blames the MBCP for raising tension in the relationship. Balancing the need to protect the woman's confidentiality, while also using the information she has provided to inform the work with the man, can be tricky. For example, if he says all is well and she discloses that he has been violent over the last week we cannot challenge him directly. But we can continue to direct conversations around the issue[s] of denial, defence mechanisms and shame that prevent authentic honesty and how these things obstruct rewarding intimacy in relationships. (MBCP facilitator or practitioner, urban area)

Key findings:
Partner contact workers' perspectives and experiences

The national survey of partner contact practitioners provided a detailed description of the form and organisation of partner contact, its perceived benefits and some of the common challenges it faces. This chapter provides a more in-depth discussion about partner contact practice on a daily basis, both in working with MBCPs and other agencies, as well as how practitioners view the work and the benefits they see for victims/survivors. It also explores the challenges in providing both a perpetrator response and partner contact services outside of the traditional urban setting working with couples who have been in heterosexual relationships.

In discussing the findings from the 30 in-depth interviews, descriptors about the state or territory in which they live have not been included after direct quotes as some jurisdictions had a small number of respondents and may be identifiable. To ensure anonymity, descriptors have either been limited to participants' roles and locality (urban, regional or remote), or the term statewide has been used where a participant's employer had a statewide responsibility that included MBCPs.

Service context

MBCP organisational arrangements for partner contact

Four main organisational arrangements were identified for partner contact from the practitioner surveys and interviews:

- Intraorganisational within a team, with roles separated out: a single organisation delivers both parts of the MBCP—men's group work and the partner contact—with different practitioners within the team delivering the two parts.
- Intraorganisational within a team, with practitioners sharing roles: a single organisation delivers the MBCP—both the men's group work and the partner contact services—with the women practitioners in the team possibly facilitating both groups and undertaking partner contact.
- Intraorganisational, where partner contact is provided by a practitioner(s) not part of the MBCP team: for example, when MBCPs are provided by specialist women's DFV services, and partner contact is provided by the agency's general pool of women's advocates separate to the MBCP team.

- Interorganisational: the MBCP is run across two organisations with one agency running the men's group work and the other delivering partner contact.

The most common organisational arrangement for partner contact among those surveyed was the first one: intraorganisational, with roles separated out. Those working within this arrangement viewed its strength as facilitating regular and in-depth communication opportunities, as workers were all in one office and could easily share information about risk or other changing circumstances. In addition, it enabled an agreed understanding of DFV, and of the core purpose of perpetrator interventions, with trust already built between workers in the same organisation:

> We have one of our crisis workers who acts as the women's advocate … that's working quite well because of her various connections in the organisation, so knowing who is who, what's going on, being part of the mentor team, and being part of the high-risk team means that she holds an awful lot of information that can be helpful in her role. (Interview 1, manager and supervisor, regional and remote service)

> I think one of the strengths is that you can then have really close consultation within your agency. (Interview 5, manager, statewide service)

Although these benefits also apply when partner contact is provided by one or more practitioners within a team that is responsible for interventions with the men, such arrangements are contentious and can carry a significant degree of risk. This is outlined in more detail later in this report.

Interviewees believed there were also benefits to the partner contact aspect of the MBCP being delivered by a different organisation to that of the men's program. When a close working relationship between two agencies developed, it was argued that it could offer another perspective and provide insights not available within a single agency:

> One of the things that you've missed out on by not engaging an external service is the opportunity to have some of those discussions which could generate better practice in the sense of, you know, "Okay, you guys view

it this way, we view it this way. Why do you see it this way? Why do we see it this way? What does collaborating look like?" And, in that collaboration piece, it might give ways of improving practices or different ways of thinking. (Interview 15, FDV coordinator, statewide service)

However, some participants involved in this form of organisational arrangement raised reservations about it:

> I think it's been a problem, in that because we've had this distance between us, we haven't—neither side has fully understood the kind of dynamics and the challenges and the ins and outs of each other's role, and I think that would really strengthen the work on both sides … But yeah, I do think more closeness between the services is better. I guess there is the risk around boundaries and needing to be mindful about how much is shared, [and] sharing appropriately. (Interview 30, PC worker, urban service)

Several participants reported that their organisations had tried both intra- and interorganisational arrangements, and mostly had returned to an internal provision of partner contact predominantly due to relationship and expediency issues:

> [There are] more strengths when working from the same organisation—we do both internal and external outsourced. There is more communication when [we're] all sitting under one roof and in the same team—which is the biggest strength. (Interview 27, PC worker, statewide service)

> One of the difficulties when the [partner contact worker] was at the women's refuge or at the women's centre is them being able to attend enough meetings with the men's programs, so there's pros and cons for both ways. So if the [partner contact worker] in another organisation has the freedom to stay connected, and to be able to offer services and all of that sort of stuff within the organisation, that's a good thing. But we haven't found that to be the case. And so often … we get it all set up but within a short period of time that [partner contact worker] hasn't become available or hasn't had the time to catch up with the women. And so it has worked better for us to have the [partner contact worker] here. (Interview 1, manager and supervisor, regional and remote service)

When both components of the MBCP—the men's group work and partner contact—were delivered within a single organisation, they generally had separate workers providing these services. Five of the 30 participants reported that their organisation had a worker in the dual role of delivering both, but the majority did not consider this to be a good practice in MBCPs, as the following views typified:

> … keeping the two bits of work separate because I definitely don't advocate for the same worker working with the men, [and] working with her. To me, I feel that [this] is actually unsafe practice unless they were an extremely skilled practitioner. I've had to do that in the past and thank goodness we moved away from that— that was quite early on—because you then have to try and remember who told you what. (Interview 15, FDV coordinator, statewide service)

> So, I think the purpose of going in there to give a victim's perspective to the men, or the offenders of what it's like, I think that's legitimate and I think that could be beneficial. But as far as going there to fill in as a proper co-facilitator when we're engaging so closely and supporting the victim, to then put on that different hat, and be actively supporting him, was very clearly a conflict in my mind. (Interview 7, PC worker, regional service)

In contrast, one participant described the dual role as beneficial:

> I'm not sure if I could function or operate in another way of running partner contact where I'm receiving information from a third party who's doing it. I really like and appreciate the way that we do it because I feel that I am the one that is hearing directly from her and she's my main client and so then I am able to … whatever she says is informing the way that I'm engaging with the man and informing the questions that I'm asking him. (Interview 22, PC worker and MBCP facilitator, statewide service)

Referral and engagement of partners and ex-partners

The primary method of gaining access to a partner's or ex-

partner's[11] details for the purposes of partner contact is directly from the man referred to the MBCP. Participants at MBCPs are required to give this information for admission into the program, whereas other providers do not exclude solely on that basis. Participants attested to the worker skill sometimes required to elicit accurate partner contact information:

> One of the requirements for a man entering into our program is that they must provide us with the contact details of their current partner as well as an ex-partner if they share children. And so if they are not able to provide us with that, then they're not eligible to enter the group. So we get that information during the assessment and we verify that information. (Interview 22, PC worker and MBCP facilitator, statewide service)

> It's explaining to the guy to give up his partner and children's details and past partner and children's details … and it is described to him in a conversation that the program is around the women's advocate being able to contact your partner and children around what their needs are and things like that. So, for me, it depends how it's sold to the man at that intake. (Interview 4, PC worker, regional service)

> Seventy to 80 percent of the men will provide their partner details. This is not compulsory but has a high response when asked. (Interview 25, MBCP facilitator/manager, statewide service)

Interview 22's response is common among MBCPs that are court referred or directed and among some self-referral programs. However, the second two responses show that not providing partner contact details will not preclude MBCP participation in other services. In some instances, the details cannot be provided because the victim/survivor has changed her contact and living arrangements as part of a safety plan.

When partner contact details are unavailable, either because

they are not known to the perpetrator or the perpetrator is unwilling to provide them, interview participants explained they then usually contacted other agencies or services that may be involved with the partner, for example, the police, child protection agencies or lawyers:

> I check these names with our database [from the women's service as] we often have had contact with the women … I can also note if he has not disclosed all [of] his victims. (Interview 28, PC worker, regional service)

> If the men don't have any contact with the women as part of a restraining order, we make every effort to contact the people that the men are in contact with, like the women's lawyer … we contact the lawyer and see if we can get in touch that way. (Interview 8, team leader, PC services, statewide service)

This is possible when an agency is part of a wider coordinated or multiagency DFV response, which enables them to draw on other stakeholder relationships to augment the contact information received from program participants. Interviewees commonly reported that persistence was key to partner contact, along with engagement as identified in previous research described in the earlier literature review (Howard & Wright, 2008; Smith et al., 2013). They described having to contend with continuing resistance, such as giving inaccurate details, as well as men who did not have the information:

> In partner contact I think you really have to be tenacious and persistent; you don't give up on the first phone call. So I think you really take [on] a challenge knowing that I've tried every possible way to make contact. Because generally speaking, once I do make contact, most of them stay really engaged. So it tends to be a bit of a challenge for me to make sure I've tried every possible way to contact. (Interview 20, PC worker, MBCP facilitator/manager, urban service)

As the survey results showed, some organisational arrangements for partner contact involved one agency running the men's group and another undertaking the partner contact. This relies on a strong working relationship to ensure all information and risk are discussed and efforts coordinated. One partner contact worker who worked in this form of arrangement discovered it is not always helpful:

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11   As noted earlier in this report, when using the term partner or ex-partner we are referring to the adult who experienced DFV which led to the perpetrator attending the MBCP. Unless otherwise stated we are not referring to new partners of perpetrators who do not have a direct association with his referral to the MBCP. Throughout this section of the report the term partner contact also includes ex-partners unless otherwise stated.

There is little accountability from them [the MBCP] as to ensuring men provide partner details. (Interview 30, PC worker, urban service)

Notably, it seems there is a considerable difference between urban and regional/remote areas when obtaining partner information in some parts of Australia:

In the metro area, 24 percent we don't get contact details for, and the regional, 72 percent. So, that will give you an indication of the higher level of contact details and limited information we receive in the first instance. (Interview 6, PC worker, statewide service)

Because one of the things with the perpetrators that we get … in a regional or remote area, is that perhaps the men are in a different place and have different attitudes; they're much more redneck for example. And so the chances of our advocate being able to access the women's numbers from the men is quite small. The men say things like they don't know their number or they can't have anything to do with her or she's gone or so on, or they'll give a phone number but it then turns out to be his phone number. So, we've got a few tricks in our small community where we can often access her number through other ways, but getting the numbers for the partners and getting men to front up to their responsibilities about ensuring that their partner is safe is not very easy. (Interview 1, manager and supervisor, regional and remote service)

The success of contact varied greatly among participants. Some indicated that when they had the correct partner contact details, women's engagement was estimated to be between 50 and 75 percent.

As partner contact work requires intense effort to make initial contact with partners, even slight changes to funding can make a difference to safety and accountability:

Funding has been cut so I used to follow up with 90 percent of the women, now [I'm] only able to follow up with 40–50 percent of all referrals. (Interview 28, PC worker, regional service)

Others reported quite low rates of initial and ongoing engagement, often attributed to a reliance on telephone-based contact and the cold calling of victims/survivors:

A lot of the time, we don't get any contact: either the phone number is no longer working or not valid. Even for our regional areas, building connections with women in those regional areas really does require more in-person contact for them to build the trust there. (Interview 5, manager, statewide service)

About 30 percent engagement rate … I think because they've got other priorities, they've got families, they're trying to manage jobs or find work, and [partner contact] is just an additional thing to think about. They want to get on with their lives basically. (Interview 16, PC worker, statewide service)

The low rate of take-up for partner contact was attributed to the busyness of women re-establishing their lives and their day-to-day commitments, or not wishing to be involved as they see the violence as "his problem" to address. Another explanation was that women might not be expecting the contact, which can be a deterrent to engagement:

So they might not even be expecting a call … next thing they've got someone ringing them, you know, to talk about that again. So it's quite different from those women having the opportunity to be the ones that actually reach out and ask for service. (Interview 15, FDV coordinator, statewide service)

This was exacerbated when (ex-)partners were contacted a long time after the couple had separated:

So, for me to cold call them 2, 3, 4 years later, is really inappropriate. And really I don't think that's being trauma informed or whatever words you want to use or whatever theories you want to use, I think that's really inappropriate. (Interview 6, PC worker, statewide service)

Some participants also identified the importance of keeping the door open to future contact when the initial service offering was refused: "If a woman has declined contact with PC, we would attempt to recontact her and try to engage." (Interview 28, PC worker, regional service)

This study confirmed previous research (Chung et al., 2009) suggesting that (ex-)partners were unlikely to be already engaged with other DFV support services. Some participants provided estimates as to the percentage of clients who had existing DFV service engagement, with responses ranging between 5–50 percent.

While partner contact workers respected a woman's decision not to have contact or involvement with the service, it created an ethical dilemma for them when they had information about the man that showed increasing risk. Worker responses to this dilemma included contacting the woman again after partner contact was declined, as well as contacting child protection services as long as the family were known to have involved them before:

> If we think there is any perceived risk from the men in the group, we will talk to the women and if needed also talk to child protection [services]. If engaged with the partner then we always go back to her to ask about improvements or safety concerns that may come up in group. We are careful about the information shared—it's about women and children's safety. There may be some information that is not shared to the men's team/facilitators if risk is deemed too high and we work with other external sources. We don't contact [child protection services] without the women's knowledge and hopefully with the women's support. Transparency is important. (Interview 23, team leader, regional and remote service)

The majority of participants reported working hard to find other contact options for connecting with the partner when risk is increasing:

> If ongoing high risk is flagged but there is still not contact [with the victim/survivor], it comes down to informed consent. We have different levels [at which] we can be involved with the client, i.e. call her if we identify increased risk, if he stops group, [or] once he has finished or exited from group. (Interview 8, team leader, PC services, statewide service)

> Most of our contact is done face to face, we try home visits. Trust your gut. We may go back to [child protection service] to see when they last had contact … [and] also discuss with police and ask them to flag on the police

system … We may just ask other agencies to see if the client is around—housing etc. (Interview 23, team leader, regional and remote service)

One regional service reported using the local "grapevine" (usually word of mouth), as telephones are often destroyed by perpetrators. If a woman had declined the service but the risk has increased, some services tried to recontact after a few weeks to see how they are going and to get engagement at a later stage.

Organisational arrangements and the implications for information sharing

In relation to information sharing, and access to information more generally between the program facilitators and the partner contact worker, having both parties in the one organisation was viewed as making these processes easier. Participants reported that sharing information with external organisations and stakeholders occurred to some degree, but flagged concerns about ensuring that information from, or about, the partner did not get back to the perpetrator. This was based on participants reporting that some organisations use databases to record client information, to which both the men's worker and the partner contact worker have unrestricted access.

Two participants reported that their organisations have detailed policies and procedures designed specifically to keep the information separate, which they felt was important from a safety and risk perspective:

> There's a different work group, I guess, for the women's work. For example, when I click on a woman's name, if it's in our particular work group, I can see all of the notes and documents and things. However, if I click on the man's name, I don't see any of that. So that's in a separate work group. The men's notes and documents can only be seen by the facilitators. They can't see the women's documents or notes and vice versa. My manager can see both sets … Something that we always think about is the unintended consequences of any of the information sharing. Nothing that the women tell us is said back to the men but it will certainly inform, if you share it, the facilitator's risk assessments. (Interview 24, PC worker, urban service)

In services where the provision of partner contact was highly segregated or delivered by different agencies, information sharing was a major consideration. Some participants thought that sharing policies and procedures led to necessary connections being made, but others highlighted numerous difficulties. In particular, although information was routinely shared upon referral, this only occurred in a limited way thereafter:

> I would like to receive more information from [MBCP on] attendance, if the man is passing [completion, and] the man's behaviour in group. [There is only] limited information informing partner contact on how the men are going. We would like more information sharing. [MBCP] has limited information from the police but partner contact is able to provide more information. (Interview 26, PC worker, urban service)

> [There is little] contact beyond [the MBCP] referring the partner to them … Communication is one sided; if [partner contact worker] believes the partner is at increased high risk then they will contact [the MBCP]. (Interview 25, MBCP facilitator and manager, statewide service)

Multiagency hubs and "one-stop shops" were particularly highlighted as a means of improving information sharing between different agencies:

> [Our team] has men's and women's workers in the same office, [with] daily opportunities and discussions occurring. They may drive for outreach together also. Services include case management, counselling, children's support, weekly family meeting and outreach. [There is] information sharing between [the] women's, men's, [and] children's [workers] and [their] manager, [and] also family safety meetings with [police], child protection, etc. (Interview 25, MBCP facilitator and manager, statewide service)

Partner contact worker role

A practice that has evolved in MBCPs is for the partner contact worker, or in some cases victim/survivor advocates, to attend and observe the men's group work sessions. In some instances this has included co-assessing progress and safety with the men's facilitators at the end of each session, while in others it involves providing some overarching comments or noting

any concerns. It was viewed as one form of accountability, whereby the victim/survivor support/women's advocates are able to view how the men's group work was run and how men engaged with the intervention. This process obviously would not be in place under an intra-organisational arrangement in which the facilitators also provide partner contact.

The interview participants expressed a variety of views about the practice of observation by victim/survivor support/women's advocates, with some considering it to be an important part of the partner contact role:

> I think it's good that women's advocate workers have an understanding of men's behaviour change programs and vice versa. I think their presence in the room can also support the men's behaviour change workers in having an understanding of women's work, and even sort of point [to] where they feel that the women's or children's voices could have been brought in a little bit more … So if they at least have some understanding of what group sessions look like, and what the challenging looks like, they can also feel more confident [as to] when they can say, "Well, actually that's not something that would have been said in group." (Interview 15, FDV coordinator, statewide service)

This participant's organisation did not have the practice of observation in place, but hoped this would change in the future:

> I've been wishing for that since I started. I'm really interested in how that works. That's another of the limitations about [the particular model used]. They have a rule that they enforce very emphatically that nobody should attend at a group who's not a formal attendee or a trained facilitator. So far that has not been allowed to happen. I think that has been a conversation that's come up periodically. I wouldn't entirely feel certain that it will never happen, but it certainly seems to be a real challenge, and it's not. (Interview 30, PC worker, urban service)

Others noted that this was the intent of the service model, but that it rarely happened in practice, mostly as a result of time limitations and competing commitments:

> Okay, so part of the job description is to sit in on programs as part of my victim support role is concerned. So, part of the role description was … to occasionally, or periodically,

sit in on the other programs with the men. I haven't done that for that purpose at all … it's ultimately come down to capacity at the moment. (Interview 6, PC worker, statewide service)

Some participants felt that this was not in the best interests of the program or staff, or at the very least had the potential to put the worker in a difficult situation:

It's too difficult for her [partner contact worker]. She's got the woman's story in her head. And then she watches the men in the program, minimising, denying and blaming, so her own health and wellbeing [suffers]. It doesn't mean that she doesn't understand the program and that she hasn't got good links into it but observing is not a really good idea. (Interview 1, manager and supervisor, regional and remote service)

The limitation is that it's sometimes really hard holding what the women say, knowing that the men are saying one thing, which I know is completely different to what's being said [by the women]. (Interview 20, PC worker and MBCP facilitator and manager, urban area)

In the following comment, the participant explains how the agency changed its practice following the experience of the partner contact worker observing the men's group while also working with women partners:

Just sitting as an observer in the group and I was working with the partners over the phone … So I'd have a disclosure from her … and then I'd be sitting there observing his participation in the group … We don't do it like that now because I said, "Stop, this isn't okay." So now the partner support worker never works with the men. The partner support worker just works with the women and that works much, much better because you don't have to hold all of that information. (Interview 12, team leader, regional service)

One participant from a regional area explained it was not safe to have the partner contact worker observe the perpetrator group program, as this would place the safety of the victim/survivor and the victim/survivor advocate at risk if they were later seen in the community. This perspective demonstrates the additional pressures and constraints on providing partner support in regional and remote areas, including on practitioner anonymity in their community.

Service delivery

The vast majority of partner contact work is conducted by telephone, with 60 percent (n=18) of the interviewees providing only phone contact. Once partner contact is established, some services offer face-to-face and/or outreach appointments when needed (i.e., on a case-by-case basis):

So with the blend of services that women want, often women want home visits. So part of our program is I will do a home visit with this woman, providing he [the perpetrator] wasn't in the home because of the risks. (Interview 4, PC worker, regional service)

A few services reported contacting women upon referral of services, so partner contact could commence while the man is being assessed. However, most services did not contact the women until perpetrators had been assessed as suitable and accepted into the MBCP. The main reason for partner contact not commencing earlier was the limited resources available. Importantly, the vast majority of practitioners reported that their agency would endeavour to make contact with women earlier, if there was known to be a high or increased risk from perpetrators:

I suspect what I'd be guided to do is call her anyway, acknowledge that we know that you didn't want any support from our service, we just wanted to quickly pass on some information to you, because this came to light and we're concerned for your safety. And then, just see what her response was like with that. (Interview 30, PC worker, urban service)

One participant reported that their local service dealt with this situation very differently to most of the others, with the men's group work delivered by one agency and partner contact by another. The participant, who was from the partner contact agency, reported that only if a woman took up the option of partner contact did information sharing and safety planning occur between the two agencies. This was because the connection between the MBCP and victim/survivor support

is explicitly severed once the woman declines the service:

> When a woman has declined the service, we feed this back to [mandated MBCP] and close the file … If [mandated MBCP] identifies risk for the women, they will not contact us if we are not in contact [with] the women. Once the file is closed, it's closed until another referral comes through. (Interview 26, PC worker, urban service)

This seems to be reflective of the contracting environment in human services, where the amount of contracted resourcing prohibits a more comprehensive, and in this instance, safe response, in which important information about risk is shared and managed.

Most services are contracted and funded to stop partner contact with women when perpetrators exit the program, but they do offer referrals or provide further information. Many will continue to support women if required, especially until a referral has been made for a support service, but for some this is time limited and has capacity implications. Limitations of contracting often define what partner contact will involve rather than being victim/survivor or client centred:

> A frustration is we stop [partner contact] with the women when the man is no longer in the program. Some exceptions are when women are high risk and young vulnerable women … We will never just cut women off when he's removed. We will always try and ensure that women have the support and safety planning in place before our support ends. (Interview 26, PC worker, urban service)

Some workers use their discretion to provide ongoing partner contact, as they consider it a safe and ethical way to work even when the agency procedure is to end partner contact when the perpetrator ceases participation in the MBCP:

> Partner contact does not finish when the man finishes the program. Technically our contract says this but it's not in the way we practise. (Interview 24, PC worker, urban service)

> By right, once a man is no longer in a program, the partner contact stops. Sometimes I find that my contact with them [the victim/survivor] continues on … In general, partner contact doesn't continue on for very long after the

man has finished because I won't have anything more to report on the man. (Interview 22, PC worker and MBCP facilitator, statewide service)

Interestingly, one of the interviewees viewed the starting and stopping of partner contact around the man's participation as women experiencing yet another form of perpetrator control, as his non-attendance or completion impacted her right to partner contact.

The differences between the above quotes demonstrate how partner contact approaches may vary with the degree to which it is seen as an independent service operating in its own right and whether or not it is linked to perpetrator participation in the MBCP. When asked how they thought partner contact should operate, many participants responded that they believed the way their organisation delivered partner contact was best practice. This was a consistent theme throughout the interviews despite the significant differences in practices across the various organisations. However, it contrasted sharply with the experiences of women, outlined in the next section, who by and large reported partner contact as non-existent or insufficient.

Contracting clearly places limitations on and influences the partner contact service available to women. The discretion of services and workers to operate beyond the contract points to the ethical importance of partner contact being victim/survivor centred and not perpetrator centred.

Policies and guidelines associated with partner contact

Half of the participants were not familiar with any external guidelines and practice standards in relation to partner contact, and were unsure if their organisation followed any. Most were partner contact workers and were unaware of the MBCP standards related to perpetrator group work and partner contact work.

This limited awareness of standards, and subsequently the practice guidance around partner contact, was a consistent theme throughout the interviews. In jurisdictions where

standards currently exist, they typically include information that is relevant to the provision of partner contact support. Some organisations had developed their own practice manuals, and others reported documented processes that guided the relationship between the partner contact and perpetrator work of the MBCP. However, mostly this element was left to practitioners and supervisors to manage:

> With partner contact … we followed some of the guidelines set out in the practice guidelines by I think it's Child Protection [department responsible for DFV guidelines in that jurisdiction]. So those are some of the frameworks that influence the work that we do and I think staff and managers attend ongoing training and they bring back material that we then incorporate into the basic manual, and at the moment we're looking at expanding and refining some of the content within the [men's] group as well. (Interview 8, team leader and PC service, statewide service)

The limited awareness about practice guidance and standards, confirmed in the survey results, could be why partner contact has a less prominent role in MBCPs. As the literature review showed, some MBCPs internationally do not even include partner contact in their programs. This finding is important because it demonstrates that information about partner contact standards needs to be communicated more widely across services, so that it is accessible and relevant to partner contact workers and their counterparts delivering the MBCP.

More broadly, all participants indicated that their organisation has internal guidelines and/or policies and procedures for working with DFV:

> So in terms of being DV-informed, it's across the agency with regards to assessing and managing domestic violence. And then it trickles down to the specific program, so the [program name], the men's behaviour change program. It's linked with partner contact. (Interview 8, team leader of PC services, statewide service)

However, a couple of participants did not view their service's DFV policies as providing specific guidance for partner contact practice:

> Expectations of roles and responsibilities need to be clearer and it's up to management to follow this up [and] to review written documentation to improve the processes in place

and the expectations at this current point. (Interview 26, PC worker, urban service)

Support provided to women

This section of the findings provides descriptions of what partner contact practice involves, as the literature review revealed that there was very little published literature describing the work. It starts with an understanding of what role partner contact plays in an MBCP, and then describes the characteristics of the work.

Purpose and practice of partner contact

Most participants see the key purposes of partner contact as promoting women's and children's safety and offering a form of accountability and transparency to women. Some also described partner contact work as having a central role in supporting women to understand their experience of DFV and its connection to being a wider community problem.

> Like, you do see that it is a very different person that you're calling out in a more rural area in comparison to metro. A lot of the time they are from a lower socioeconomic status area. They may not be as highly educated and so their understanding of what's going on might not be as developed either. So you really do have to work quite a lot more with those women to try and get them to understand their situation, recognise what's going on and then actually leave it if it's safe to do so, or at least put in a really appropriate safety plan. (Interview 14, PC worker, regional service)

Although identifying DFV as a wider social concern is an important means of resisting victim blaming, there is a tendency reflected in the above account to presume that DFV is much better understood by those in higher socioeconomic strata—an attitude that can fuel myths about DFV only occurring among less advantaged groups in the community. Similarly, another participant discussed using the cycle of violence as a way of explaining DFV to women:

> … also, to educate women on the cycle of violence and the different types of violence, and to do some real hard-core basic learning with these women as well. (Interview 28, PC worker, regional service)

However, the cycle of violence is a disputed idea in contemporary practice and could be misleading to women (e.g. Carrington, 2014; Campbell, 1990).

To encourage women who may be understandably reluctant to engage with partner contact, many participants emphasised the importance of promoting connection and conveying authenticity in their interactions:

> The role is really around partnering with them [victims/survivors]. So we're here to support you, we are aware of the complexities that would—are likely to exist for them. We're not here to judge them and we're here for their safety and to support them in whatever they feel they need in order to keep safe or be safe. (Interview 15, FDV coordinator, statewide service)

> So, ultimately, once I've gained their trust and that, I'm not just saying, you know, "Hello, and here I'm going to refer you on". I always try and gain their trust first, and that may take a few phone calls, it may take a few months, and then I'll go, "Hey, have you thought about this". And then, obviously it's in their best interests, and then I'll try and take them to another service, so I do try and build up rapport first. Otherwise, it is that cold call, "Hey, do you want this?" "Yes." "Here's a phone number." And it's just not authentic. (Interview 6, PC worker, statewide service)

The differences between the above three quotes attest to the marked differences in how these workers view women victims/survivors of DFV. In the first quote victims/survivors are seen primarily to need "education" from the worker, whereas in the last two quotes working alongside victims/survivors and building trust is a key aspect of partner contact.

Consistent with the survey findings, the vast majority of participants felt that partner contact work differed to other specialist work with victims/survivors in some key ways. The main difference for interviewees was that they reached out to women, rather than women seeking out a service or support. This then required the worker to be skilled at making contact that may or may not be expected, and establishing rapport when contact was made. Partner contact work often involves considerable amounts of time being spent just trying to make contact, whereas when women are seeking out services for themselves there is more time for activities such as assessment, case management and intervention:

> We are reaching out to women for support rather than the women reaching out to us. Many women would like support but have not reached out. (Interview 2, PC worker, regional service)

> … it's offering them [victims/survivors] information, support, advocacy and referrals for themselves and their children as well as supporting women to understand what domestic and family violence is, how it's impacted on her and the kids, [and] try to support her to be looking after herself in all the DV and all the things that she's experienced. So increasing her sense of self and her self-agency in this. (Interview 4, PC worker, regional service)

> I think one of the main differences is that [the] partners that we have contact with may or may not be accessing support services on their own. They may not be currently experiencing harm, that's one difference. They may not have any contact with … we call it partner contact but really the women who are engaged may not be the current partner. So it can be an ex-partner and they're currently going through court for custody of the kids or something like that, so these women may not access women's support services because they may not feel like they need it at that point. (Interview 22, PC worker and MBCP facilitator, statewide service)

In contrast, another participant's description highlights that a role of partner contact is somewhat like triangulating data to assess the level of risk and identify progress from the victim/survivor's perspective. Secondarily, the role is to refer as appropriate, but not to undertake the intervention with the victim/survivor:

> It's not necessarily about the woman's healing in the process, it's about us to be able to assess for their risk and provide them [with] information so that they can also assess their own risk. And it's also an opportunity for us to see if there are changes … if they're still in contact with the perpetrator, are they noticing changes are happening and are they noticing that their behaviour has actually … that there's some demonstration around change. And then the other part to it is to be able to link them in with services so that they can do some more of that healing work. (Interview 5, manager, statewide service)

This difference also reflects that there is no single way in which partner contact operates around Australia or what aspects of it are prioritised. There is agreement that the intent of the work is to keep women and children safer by reducing the likelihood of further victimisation. However, how this is best achieved is variable as it is based on how MBCPs are operated across different jurisdictions.

Another key way in which some participants described partner contact work as differing from other services was in its active involvement with the men's workers, and efforts to find out about the men directly:

> Partner contact does differ to other specialised DFV services; we are working towards the men's behaviour change as well as women's safety. We have to have a close relationship with the MBC aspect and work collaboratively. (Interview 28, PC worker, regional service)

Another participant explained that the foundations underpinning partner contact work differed to that of other work with victims/survivors, as it is a way of working that involves all parties to bring about change:

> I reckon it's very different. So, for me, the work is around … there's a sense of hope around change … I believe in the men's behaviour change program and, for me, I believe that nothing will change unless the worker is there with the man and supporting the woman and kids through that … So I think us initiating the call and the invitation to be a listening ear and to be there for the woman is very different, because the DV services, women contact them so that's a major difference. But we invite women in and I think we build a different level of trust in [the] relationship … I feel like I'm in a really privileged position because I get to hear how the guy's going in the group. I get to hear whether there is some evidence of change. I get to hear that from the woman and her kids as well. (Interview 4, PC worker, regional service)

Importantly, the survey responses found that a significant difference in the work of partner contact is the close association between the partner contact worker and the MBCP. While most participants in the interviews were able to identify that a formal link between the two did exist, and was available

if needed, the link was often focused on particular changes and incidents rather than being an ongoing relationship:

> There's not a day we can actually all catch up, given that some are running day groups, some are running evening groups, I'm only working 18 hours per week, most of those are only working part-time as well. So, it's really just what's going on with the attendance sheets, and what's going on with the risk, how I prioritise the victims. (Interview 6, PC worker, statewide service)

> Risk is asked at every call, response required. This is provided back to the facilitators via email … Constant communication via email between facilitators, PC, team leaders and managers … As risk arises, case management meeting organised to determine best support for women. (Interview 8, team leader of PC services, statewide service)

In the following situation, the partner contact being delivered by a separate agency to the men's program had no routine contact:

> We get very little back from the men's group, to say this has come up and it's highlighted a risk. Like, occasionally—it does occasionally happen—but it's not very frequent really, interestingly … I think to some extent, the men kind of know what not to say in there, possibly. (Interview 30, PC worker, urban service)

In contrast, many participants described weekly meetings or regular information exchanges that focused more on risk and safety than program-related content. Workers also shared that competing priorities and workload pressures often resulted in a more reactive rather than proactive relationship between the services:

> At the moment, it does feel like it's really ad hoc. It almost feels like you've got all this client caseload and you going, okay, what ones do I think … because you know you can't get to all of them. So, just in your own head and your own gut feeling, going okay, who do I think is most at risk today? (Interview 6, PC worker, statewide service)

Very few of the partner contact workers interviewed were able to share much in-depth information about the men's program. With a few notable exceptions, the majority of

workers performing the partner contact role provided limited responses to the contextual questions about the delivery of the men's program and approach. Although the interviews did not explore the reasons for this lack of knowledge, one participant noted that they were explicitly forbidden from having access to the program information, which made the process of informing women about the program problematic:

> We are not allowed to have access to the [MBCP] program to see what they do there … so we can't discuss it with women. What we've been given is a one A4 page summary … I mean, it's almost useless, I think, in terms of giving women any idea of what change she could be expecting with a man, if he was serious about changing, there's a real lack of adequate transparency. (Interview 30, PC worker, urban service)

A focus on safety

Promoting safety through risk assessment, risk management, referral and advocacy was consistently identified as the main purpose of partner contact. However, as has been raised in the literature review, how safety is defined and its promotion measured is rarely discussed:

> It's doing a whole lot of risk and safety management with her and having those conversations to understand how she sees her safety, what does that look like, because we throw the word around a lot. But, you know, I don't know that a lot of women really understand what we talk about when we talk about safety … supporting her to understand her sense of safety. And I guess getting her to name, because she knows already, but to name the risks that he poses to her and how we can support her in that, whether it's referrals or, you know, enhancing safety plans with her. (Interview 4, PC worker, regional service)

In relation to how safety is planned in conjunction with various parties, all participants reported that information from partner contact is sought in team discussions, sometimes with other agencies (i.e. police, child protection, education providers), to identify risk. Overall, supervision came through strongly as the predominant training, oversight and risk management mechanism within the services. However, in terms of improving practice to identify risk and promote safety, there appear to be limitations in developing these opportunities through supervision, which was mainly

identified as being provided in an "informal" sense when sought. Only a small minority of interviewees reported having formalised processes in place around supervision and how it related to the work. Although many participants reported feeling as though they had adequate supervision in meeting their needs, they also indicated that most supervisors did not directly observe practice and instead relied heavily on self-reporting and reflective practice.

Managing expectations

In addition to risk and safety, several participants identified that their role often included an element of managing women's expectations of the likely changes that perpetrators will make during the course of the MBCP, and that this can best be done by keeping women informed of men's participation. This is particularly critical where women are remaining with partners, because there is not always an understanding of the ways and time in which individuals make changes. This is especially important with perpetrators of violence, who often do not view themselves as having problems that require change:

> And, also, being able to manage the expectations of women who may be staying in the relationship because he's doing a men's program. So I really want to unpack that, as this is a good thing that he's doing this, but that doesn't stop the risk as well. So I'm really clear that [it's not just], "Oh thank goodness he's finally getting help". Though I think we can make differences, I've got to also be making sure that there's still a bit of reality on, that this is only just one thing that they're doing, so safety has still got to be paramount in all of that. (Interview 20, PC worker & MBCP facilitator/manager, urban service)

> But also, to let them know that he is on the [MBCP] and that the program doesn't always offer great outcomes or positive outcomes, in the sense that particularly while he's going through the program, that certain, you know, discussions in the program, certain modules are going to trigger him and could escalate the violence … that his behaviour is not going to be perhaps as predictable as it once was. Whereas before, the victim will obviously often be able to predict their behaviour in that respect, they know his triggers, they know his little signals. Where [now] it may be a little bit different so just to be mindful of those kind of things. (Interview 6, PC worker, statewide service)

One participant described how managing expectations also related to ensuring transparency around the MBCP and accountability of perpetrators:

> … to keep women informed of how a man is presenting in group, some of the stories of change that he's reporting and verifying the stories with them. And it's also, I think, very, very useful in encouraging the men to be accountable in group so they know that this is quite a transparent process, and whatever they say in group may or may not be spoken about outside of group either with the referrers or with lawyers or independent children's lawyers or the partners or ex-partners. (Interview 22, PC worker & MBCP facilitator, statewide service)

Flexible support

Most participants spoke about how partner contact work needed to be tailored to the needs of the individual women and their families. Similar arguments have been presented in other areas of DFV practice, whereby the goal—safety—remains the same but the pathways of response need to vary according to circumstances.

Many participants reported that support options had to be provided both for women exiting the relationship and for women who were living with their partner who was in the MBCP. This was particularly relevant for services operating in regional areas:

> So saying, "I'm happy to be guided by you, what kind of contact you want, how you want it and when and where." So there is that flexibility and, of course, there's formal paperwork to do on doing home visits or attending appointments. But I think we have to be flexible. Particularly in a rural area, a regional area, you have to be flexible to meet her needs when … [it suits] her. (Interview 4, PC worker, regional service)

> One of the first things I will say to women is, "If you want to be with him, that's fine, you know, I'm not here to judge. I'm not here to tell you that you have to leave him. You want to be with him, I want you to do that [in] the safest way possible for you and/or your children." (Interview 28, PC worker, regional service)

You know, I say to women, "Look, I'm here to walk alongside of you no matter what, no matter where you go. If you stay with him, if you leave him, if you're kind of weighing things up, I'll just walk alongside of you no matter what." And, for me, that's about building trust with a hundred percent respect for her choices and giving information so that she's making fully informed choices. (Interview 4, PC worker, regional service)

> I mean, as far as we're aware, we're the only ones in the state working with families where domestic violence… is, that family want to stay together. Otherwise to get a service you have to actually leave the relationship to [get] a particular service. I think that impacts on children and families … especially when we're working with Aboriginal families, the history around Aboriginal families, around removal. (Interview 25, MBCP facilitator and manager, statewide service)

Two participants explained that their service did not offer partner contact support unless women were exiting or had left the relationship.

Referral and support options

As mentioned previously, referral and support are major roles of partner contact. Referrals are one way that partner contact workers can tailor their responses to the varying circumstances of the victim/survivor. For example, if a woman requires specialist legal or housing advice and support—resources that workers are not trained to provide and that the organisation does not have available internally—they would refer her to another agency that could provide this support:

> I think also another downfall is I think no matter what, where you're able to, I think you need to refer out because the reality is the agency cannot be there 24/7 for a victim or victim/survivor. So we want them to be referred into and have access to services that are going to be in their local area. (Interview 5, manager, statewide service)

> When [we encounter] complex issues we will always refer on as our service scope does not include case management. Always working with risk assessment and women's safety.

Therapeutic support is the biggest need for referral out. (Interview 26, PC worker, urban service)

Several participants did feel that their organisation offered the additional and often specialist services, separately from the MBCP, which enabled them to meet the varied and complex needs of victims/survivors. In particular, participants from larger organisations reported that they could access a wide range of support services, such as child and youth programs, accommodation, financial counselling and general counselling. Although not delivered as part of the MBCP service, participants also identified that meeting a broad range of support needs was vital but often outside of their own capacity or remit.

External referrals, while needed, were often a source of frustration or difficulty for workers. The process needed to be carefully managed, as the relationship between both services and the client was a source of worry:

Hard to build up the trust with women and then try to refer out of the program, risk of losing the partners … We try to partner with outside specialists so they come into the program areas so partners get to know the outside agency before a referral out … It's hard when you have built up the trust with women and decide to utilise additional services for referral, [as] we run the risk of losing this person. However, we partner well with other organisations, so they appear to women that the referral is within the organisation. (Interview 23, team leader, regional and remote service)

Children's services

Participants indicated that their services ask about children in their assessment. For example, one participant explained how she liaised with schools in order to obtain information about how children are presenting and whether the school had any concerns with the father. Group content in men's programs often includes discussions and sessions about the impacts of DFV on children. However, services for children are thin on the ground, with most of those that are provided through partner contact having neither the capacity nor scope to provide services directly to children. While some services are able to offer internal referrals for children's counselling or parenting programs, they seem to vary in their focus and capacity to respond to children in the context of DFV.

Participants whose agency offered children's services through the partner contact service reported relatively low participation by children beyond casual meetings, such as when the children were present when the worker met with the victim/survivor:

Ideally, it's the [partner contact] workers who would pick up on the children and their issues when they were dealing with the mother, but only 6 percent of our clients are children. So, it's probably [due to] protectiveness of not trying to get them involved in these contexts that parents don't bring them to these sorts of meetings and discussions, that they become invisible. (Interview 9, practice supervisor, statewide service)

However, work with victims/survivors and perpetrators as parents of children was a feature of both the men's work and partner contact work:

Often with the men I find, especially if they're Family Court referrals or something like that, their focus is really not on their partner and the damage they've done to her. So sometimes engaging with them through their children is really the way we can … you can actually start to look at their behaviours and look at the impacts on the people around them. (Interview 20, PC worker, MBCP facilitator and manager, urban service)

Part of [the intake process] with making partner contact is finding out what [victims'/survivors'] needs are and also including what their children's needs are as well, and what they're having difficulty with and what would they like support in, which is not only for themselves but their children … It's also asking around strengths of the victim/survivor, so where do they see that they're actually really strong, and how well are they doing in those areas in supporting their children—around stability and routine and nurturing them—and just providing [for] them around the children's safety and trauma. (Interview 5, manager, statewide service)

Many participants were concerned about the lack of direct services available for children, with partner contact seen both as a pathway for this type of support and as a way of strengthening partner contact practice:

> I believe every program needs a specialist children's worker, child and youth worker, who can work alongside the women's advocate, because if you can get hold of the women … I always ask them where they're at, what happens for their kids, what do they think that they need and how we can get that happening and helping the children to understand the change. If dad's going to a program, you know, the change that he might be making can be pretty scary for the kids as well as for the mum. So that's a really big gap for us, I believe. (Interview 4, PC worker, regional service)

Participants reported that most partner contact workers relied on intra- and interagency referrals for children and young people's services. While these services were viewed as helpful, some participants mentioned that if they were within the wider MBCP it would provide a more joined-up and specific response to the family members. Of the few organisations providing services to children affected by DFV, most were often limited further by restrictions on age and availability. A particular hurdle identified was where services required the consent of the non-referring parent to enable the children to participate. A participant from one of the two services that did not require consent from the non-referring parent explained she would also still ask the mother if the father was aware and in agreement with the child attending the service, due to the heightened risk this could present if he was not in agreement. However, she went on to explain that this is also a dilemma, as seeking agreement for the child's participation could be an opportunity for the perpetrator to exercise power and control over the mother and child.

In addition to funding being a barrier to the provision of children's services, some participants mentioned that there was only a limited workforce with the skills to offer the services. A further obstacle for those providing services to children was that they needed to work around children's schooling and other commitments so there were limited times during which they could be offered.

Consistent with calls in the literature (Alderson et al., 2012; Lamb et al., 2018) for greater consideration of children's perspectives in MBCPs, the study participants indicated that additional content about children's experiences was required:

> I think what is missing is solid conversations with men about the impact of their abuse on children. And how on earth we can neglect that is beyond me … But I think there's a lot more that they could do in terms of raising men's awareness about the impact of abuse with children. (Interview 30, PC worker, urban service)

> In terms of that impact that the violence has on children, I think it's an underutilised perspective across the whole sector. Again, as we have previously discussed, my perspective would be that classic MBCPs in the community sector use the impact that the violence has on the partner and empathy is the change agent. I think very much the intensive fathering programs, which [program for fathers who use violence] would be part of, probably use that lens of the impact of violence on the child and their relationship to that child and I think that that's a very important lens. (Interview 9, practice supervisor, statewide service)

These findings corroborate the evidence in the literature about the need for specific DFV-informed services for children and young people to address the impacts of that violence, and for MBCPs and related programs to include more focus on the consequences of perpetrators' abusive actions for their children and their future relationships with their children. It appears, however, that the opportunity for children to receive this support largely comes down to service availability in the area in which they live.

While the focus of the study was on partner contact, there were still calls for greater content on fathering and children in the men's program component. This is interesting because there continues to be scepticism about the value of rational talking therapies for DFV offenders and MBCPs. However, the primary response of participants to address these concerns is to add/increase the content in MBCPs in the absence of any other intervention options. The engagement of children and young people in relation to their father's or stepfather's involvement in an MBCP requires further attention, as to date it has been only a limited focus.

Meeting diverse and complex needs

All participants indicated that their partner contact and MBCPs generally could respond to people with a wide variety of complex needs. In addition, almost all identified language as a central consideration, with others speaking specifically about their work with Aboriginal and Torres Strait Islander men and women, CALD communities, LGBTIQA+ communities and people with disability.

Language and the use of interpreters

Language was frequently cited as a significant consideration when engaging with and offering support to victims/survivors, including Aboriginal and Torres Strait Islander and CALD women partners. Language considerations are not unique to partner contact work or even DFV, but are common across health and human services. They include having only a limited number of interpreters available for particular dialects, services lacking the funding for interpreter services, and concerns about what is being conveyed to the woman during her interview:

> We still have the same thing that comes through often [in regional/remote areas], there could be language barriers. A lot of the time, whether you're working with the perpetrator or with the victim/survivor, English is their second or third language, so that's why it's so important to have the opportunity to have that in-person contact as well. (Interview 5, manager, statewide service)

Participants described potential issues when using interpreters within the context of DFV:

> Hard to get a female interpreter as they are randomly allocated. If we get a male interpreter, we will hang up. Sometimes we can book an interpreter in. We understand it's specific to cultures: Chinese tend to have wider family support. Sri Lankan/Indian, we don't use male interpreters as they don't let her speak and they interpret to their own words, not what we are asking. (Interview 14, PC worker and MBCP facilitator, regional service)

> I've been trying to get into contact with a woman who's quite geographically isolated [and] doesn't speak English, and so I've been engaging with the interpreter service to try and make contact with her. But then the language that she speaks, there's only two interpreters on their books and they're both male interpreters. So there's concerns, I guess, around is it appropriate for there to be a male interpreter? Is it likely that they might be known to each other in the community? (Interview 24, PC worker, urban service)

The majority of participants reported that they had interpreter services available but would refer to other services if necessary. Some suggested that their partner contact service provision, with its goal of keeping victims/survivors safe, would not differ for a woman requiring an interpreter. However, it may be that the services and support put together for non-English speaking women may need to differ from those offered to English-speaking women.

Participants did not specifically mention situations where the perpetrator speaks English but the victim/survivor does not and the difficulties she might face in these circumstances. Situations where only the perpetrator speaks English can also be used to further obfuscate coercive and abusive behaviour towards a partner who may have limited English language proficiency. There is also the likelihood that the victim/survivor will have limited opportunities to disclose and seek help regarding DFV, particularly if interpreters are not available and practitioners rely on the perpetrator to explain the situation.

Cultural and linguistically diverse participation

The partner contact literature review did not uncover any key research on women from CALD backgrounds, nor did participants identify how diversity of culture, language or race influenced their practice. The response was largely one of tailoring or modifying their work around individual circumstances. This is consistent both with the earlier theme of partner contact being flexible in what it offers to women, and that this is largely unexplored territory within the context of partner contact and MBCPs more generally:

> We've had a couple of people who have come from the Middle East, I think maybe from Iraq or Iran, but very, very few. Like, I'd probably say four, three or four in the last 6 months. And in those cases, I've only used

an interpreter once, and I've referred that person onto another agency. And the other couple I've contacted, really just go, "No, everything's okay". (Interview 6, PC worker, statewide service)

In the description below, the participant thinks about the experiences of CALD communities and DFV, and how cultural and living circumstances may influence the safety of victims/survivors:

They are the minority of our clients but, for us, I think that CALD is something that just highlights another risk, I guess, because of the barriers around language, because what we're finding is that there's [a] higher safety risk because of wanting to stay in the relationship because there's visa repercussions, there's commitments to family back home around financial support. Sometimes they've got their children in their home country and they're here and rocking the boat, so to speak, or leaving the relationship is going to jeopardise their relationship with their children or their other family members or jeopardise their residency. (Interview 12, team leader, regional service)

One group of CALD women who may be more likely to be engaged through partner contact are those whose partners' first language is English, as they are more likely to be referred to an MBCP as English speakers. However, we do not have available administrative data to know how commonly this occurs, and no practitioner participants discussed it in this study.

Overall, it would appear that only a limited number of CALD women would be involved in partner contact because very few MBCPs can accommodate perpetrators who are not proficient in English. In discussing their experience working with CALD women more generally in DFV, one participant explained that when the women did engage, the range of supports involved were often greater as the mainstream way of doing things cannot just be modified for any group. Referring the women to specialist CALD services was viewed as the main way of addressing this concern:

There are language barriers, often [for] migrants, we try to get them into the office and [offer] support through

interpreter services. They often do not know their rights. Culturally, abusive behaviours may be accepted from the[ir] culture, [which are] not allowed in Australia. We may need to refer partners out to multicultural services to get support in their own language. (Interview 13, PC worker, urban service)

Although interview participants did not talk at length about CALD women and partner contact, it is notable that language remained a significant barrier and that referring them to specialist services was a common option.

Aboriginal and Torres Strait Islander participation

In contrast to the relatively small amount of discussion about CALD communities, a much higher number of participants raised the importance of cultural considerations for Aboriginal and Torres Strait Islander families, as a significant number of men from these families have attended MBCPs. Cultural considerations were relevant both to Aboriginal and Torres Strait Islander and mainstream programs, especially in regional and remote areas where participants reported that up to 50 percent of program participants were Aboriginal and Torres Strait Islander men:

So, about 50 percent of the [large regional town] men are Aboriginal or Torres Strait Islander, mostly Aboriginal and about 100 percent or 99 percent of the [small regional/remote town] [mainstream] programs. (Interview 1, manager and supervisor, regional and remote service)

Given this situation, all services that include partner contact must be able to meet the needs of Aboriginal and Torres Strait Islander women and families in a culturally responsive way. Participants providing partner contact for Aboriginal and Torres Strait Islander programs described some of the considerations around their practice, and reported the following changed ways of working from their mainstream approach.

Contextual issues

- There could be difficulty in contacting women partners as they may be living in a different area to where the

program is delivered or in a very remote area or their information may be out of date (as was the case for many women). These delays in being able to make contact can result in men completing the program before contact is made with a partner or ex-partner.

- There can be differences in perspectives between agencies, where one agency might not share a woman's contact details with the partner contact worker at another agency due to the possibility that this could put the woman at greater risk.

Practice shifts and considerations

- When MBCP facilitators are local Aboriginal and Torres Strait Islander people who are well known in the community, they may have family members attending the program. All workers need to be aware of cultural and family implications and offer alternatives, such as working with individuals separately where appropriate, which will prevent participants from coming face-to-face with family members running programs.

- Aboriginal and Torres Strait Islander men's family violence programs can be seen as men's business, so are not always appropriate for women observers to attend.

- Workers should be aware of not imposing a mainstream approach that focuses on the couple as the centre of intervention. They require an understanding of complex family and community systems. There may be a lot of family violence within these systems of relations that need Aboriginal and Torres Strait Islander ways of understanding and responding.

Support for partner contact service and workers

In general, participants reported they were well supported in the partner contact role within their organisation, which they felt had prepared them for the role. Regular supervision and mentoring of new workers were the main mechanisms through which partner contact knowledge and skills were developed among participants. In relation to training and development, none of the participants were aware of any specific partner contact training. One participant mentioned that their agency was currently developing a specific training package around specialist women's work as it relates to integrated approaches and working with men's programs. The agency was developing the training in recognition of the different demands and practices of workers (typically women) who are undertaking this role between parties and services. Some participants suggested that policies and guidelines around partner contact delivery would be beneficial as the roles were now a part of the MBCP response.

While very few participants reported having received specific DFV training tailored to the role, most felt that this was needed to help support their work. When asked about the type of training required, participants identified a range of areas. Some of these concerned foundational ideas while others were more specific to undertaking the work, and included:

- domestic and family violence general training
- client-led approaches to practice
- introduction to interagency working and referrals within coordinated approaches
- women's advocacy
- gendered analysis and approach to risk assessment and safety planning
- experience of running or observing MBCPs
- DFV and the law.

Overall, supervision came through strongly in the interviews as the main training, oversight and risk management mechanism within the service. However, only five of the 30 interviews reported having formalised processes in place around supervision and how it related to their work.

The value of the partner contact role

Interview participants raised the issue of the value of partner contact in various ways. Some felt that a lack of resources reflected a perception of the work as low value, while others spoke of how partner contact work should be valued more highly because of the difference the work can make to women and children:

I think, given that the women and children are the primary clients of MBCPs, I would really like to see more emphasis

on partner contact. There's a lot of networking meetings for men's behaviour change groups and lots of training for men's behaviour facilitators involved in men's behaviour change groups. But really that needs to shift so that there's either equal weight given to the partner contact workers as well, because they're really managing the primary clients. And, therefore, we need to ensure that there is enough support [and] training available to those workers as well. (Interview 8, team leader of PC services, statewide service)

Evidence about the value of partner contact to MBCPs

Very few participants were aware of whether the information and data from partner contact work was used to contribute to the evaluation of MBCPs. For most, reporting and evaluation appeared to serve an administrative rather than a practical purpose for women's perception of men's change.

Two participants reported that their organisations undertake evaluation activities, and felt that information around partner contact had been incorporated into this process. Another participant, however, wasn't clear around the findings or how they were used. Only one participant was able to articulate clearly the outcomes measured for evaluation in relation to partner contact:

> It reinforces and validates the work that we're doing because we're getting positive outcomes from being involved with the women. So, in a sense, that's how, I guess, we use the data to not just inform the program but also our practice and validating the work that we're doing as well. I think it's really powerful in many ways and it goes beyond just the program developing, as in developing the program and changing the program. (Interview 8, team leader PC services, statewide service)

A few participants had commenced collecting forms of data to begin to show how partner contact contributed to the MBCP efforts. There was a clear sense among these participants, however, that the numbers did not necessarily represent the work:

> The two things we look at there are … the client's skills that she's achieved for her and her family's future safety. It's the same thing, have they increased, remained the same,

et cetera. And also, their knowledge for their future safety, and that's in regard to, obviously, DFV and how are they going to use that knowledge in the future. (Interview 6, PC worker, statewide service)

> One of the data things that I started collecting was the amount of communication that was going on between the clients and other agencies. In that 6-month period, I had 230 contacts with DFV services. So, you know, when we look at 230 contacts with DFV services, compared to the outcomes that we're reporting on, and that is the victim reports, [they are] actually completely different things. (Interview 6, PC worker, statewide service)

> By using feedback forms that we administer to the women after the program, we can actually see whether or not the men are making and have sustained behaviour change during the 5 months after the workshop. (Interview 23, team leader, regional and remote service)

Future directions for partner contact

Funding, lack of staffing and resources, and time restrictions were common issues that impacted both the quality and quantity of partner contact service provision. This was often raised in the context of the telephone being the dominant form of partner contact and the need for more face-to-face opportunities and capacity:

> My personal preference as much as possible would be face to face. Because I think, you know, I know there's some conversations around letters not being safe. Well, phone calls aren't really that safe either. Like the only way you would have any real, or when they have any real, sense of safety is actually face to face, which obviously can't happen all the time given how spread out everything is, for those in regional centres in particular. (Interview 15, FDV coordinator, statewide service)

A common theme across the interviews was that more capacity for case management and long-term support is necessary. Many participants felt there was currently very little capacity for more intensive or longer term supports, but these are a significant need for many of the clients:

Most times I find that we do stay involved just because there's not enough case management capacity in this area in domestic violence. (Interview 24, PC worker, urban service).

We want to see the systems work and we want to see proper funding as well and we are aware that as well as the crisis response, the women need long-term trauma support, women and children do. (Interview 1, manager and supervisor, regional and remote service)

I guess just being able to have enough time in our day to be able to sort of really support these women with as much help as we can, to really probably step up and do a bit more case management rather than safety checking. But [we] really [must] have that one person take that woman and really be able to support her for as long as she needs. (Interview 20, PC worker, MBCP facilitator and manager, urban service)

The first of these quotes attests to how partner contact practices can be shaped by what services are or are not available for victims/survivors in the local area. When specialist women's DFV services do not have capacity to provide case management, or other forms of post-crisis support (except perhaps in cases of very high risk), pressure can fall on under-funded partner contact services to do so. This is a role that could potentially be embraced by these services if the requisite funding was made available.

Another dissatisfaction among participants was the limited focus on partner contact as part of the overall MBCP approach, with one noting that:

It's really interesting to me, and this is probably my opinion, but there's all of this allocation of funding for men to attend this program and then there's this piecemeal section of it that is about partner support … And it just speaks to me about male entitlement I have to say, because I think that the way that the funding has been designed is part of the problem that feeds or supports attitudes around domestic violence. There's more available to the men than there is the women. (Interview 12, team leader, regional service)

Partner contact work has expanded as part of an MBCP response in Australia since programs emerged in the 1980s. However, it has tended to be overlooked in the rush to see if working with perpetrators in groups can bring about changes in their attitudes and decrease their coercive control and violent behaviours. Although it has been long recognised that perpetrators commonly deny, minimise and take no responsibility for their use of violence, this recognition has not resulted in large amounts of research about what is happening for the victims/survivors in this context. These interviews, along with the survey, are an attempt to rectify this through documenting what is happening on the ground in partner contact practice. The next section of the report looks at the experience of women whose partners or ex-partners undertook MBCPs.

Key findings: Women's survey

This section reports on the key findings that emerged from the survey carried out with women between January 2019 and May 2019. The survey (see Appendix B) aimed to capture information about women's experiences of MBCPs, with a particular focus on the support they were given, including what they found helpful and unhelpful. We present an outline of the survey participants' characteristics followed by a summary of the information and emerging themes within each of the key areas examined.

Although there was a fairly wide spread of participants across urban and regional areas, there was only a limited amount of information that demonstrated any significant differences in the quality and consistency of partner contact support in these areas. However, where there appears to be some variance, this has been reported on accordingly. As the survey was anonymous, pseudonyms have been used to represent the research participants.

Participant characteristics

Number by state and territory

A total of 18 women undertook the survey, with Figure 21 showing the states and territories in which participants reside. Despite significant efforts being made in promoting the survey through various agencies and other communication media, there were no survey respondents from the Australian Capital Territory, Northern Territory or Tasmania.

Area type

Of the survey respondents, 44 percent reported living in a capital or large city, and the remaining 56 percent in a regional or remote community (refer to Figure 22).

Figure 21: Number of survey participants by state and territory

QLD	
SA	
WA	
NSW	
VIC	

Australian Capital Territory	0
Queensland	3
New South Wales	4
Northern Territory	0
South Australia	1
Tasmania	0
Victoria	6
Western Australia	4
TOTAL	**18**

Figure 22: Area type

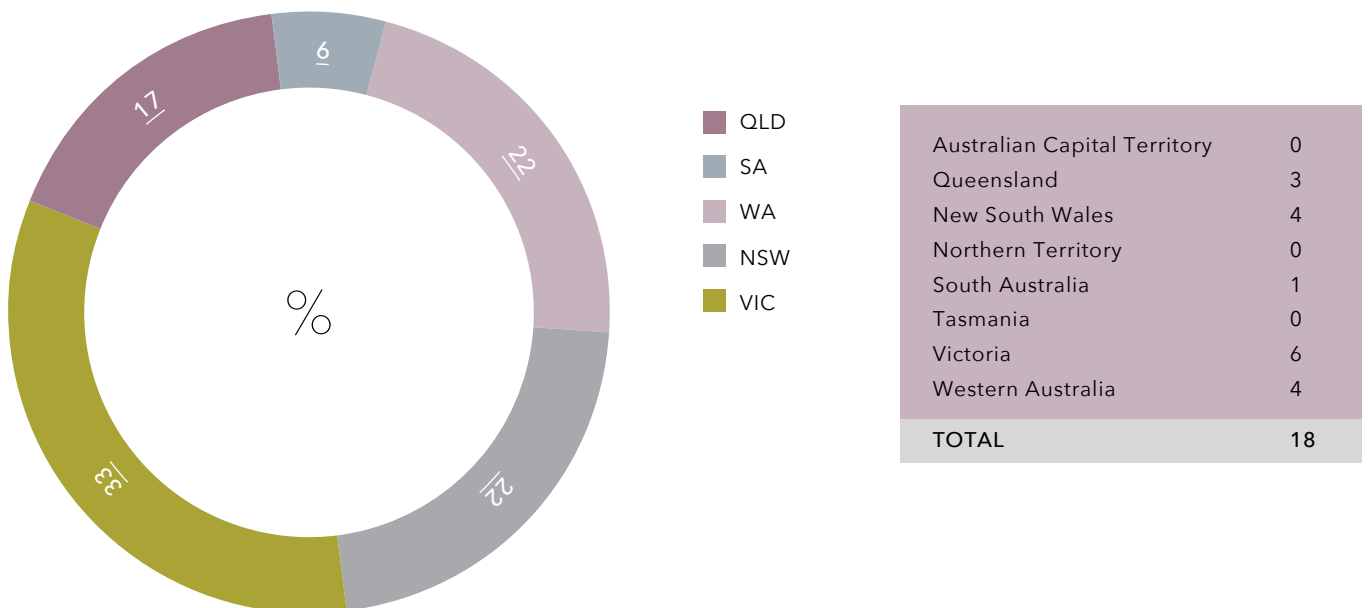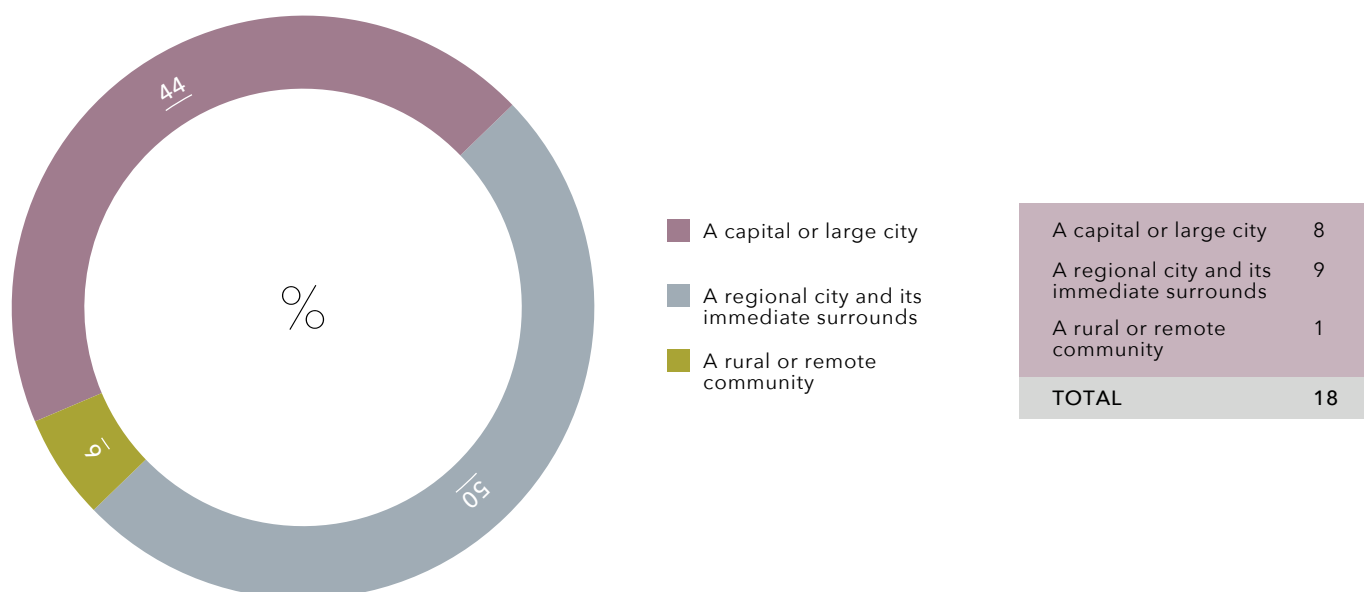|	
A capital or large city	8
A regional city and its immediate surrounds	9
A rural or remote community	1
TOTAL	**18**

Age

The majority of participants were between 35–44 years of age at the time the perpetrator commenced in the MBCP (refer to Figure 23). This is also the largest age group of those accessing specialist domestic violence homelessness services (Australian Institute of Health & Welfare, 2019).

Number of children

All but one survey participant reported having children in their care at the time the perpetrator participated in the MBCP. Of those with children:

- nine reported having one or two children in their care
- four reported having three or four children
- one reported having six children.

Note that three participants did not report particulars about the children in their care at the time of the MBCP.

The children's ages ranged from 2–24 years, with nine participants having children aged 10 and under. Six had children aged 11 and above, and seven of these were older than 16. A combined total of 33 children were reported to be in the care of the 14 women who responded to this question.

Citizenship

Fifteen participants reported being Australian citizens at the time the perpetrator was attending an MBCP, two advised they were permanent residents and one did not provide any information.

Country of birth

Eleven of the 18 participants reported their country of birth as Australia, with four born in the United Kingdom and one in Iran. Two did not provide this information.

Cultural/ethnic identity

Of the 18 respondents, one identified their cultural/ethnic identity as being Australian Aboriginal, nine as Australian, three as English and one as Middle Eastern, with four participants not reporting.

Preferred language

Seventeen survey respondents reported their preferred language as English, and one did not provide information about this.

Physical health

Survey respondents were asked to provide information about whether they had any long-standing physical health conditions, impairments or disabilities that have lasted, or are expected to last, 12 months or more. Of the 15 responses, 11 reported they did not, two experienced anxiety and depression, one was living with complex post-traumatic stress disorder and the other with chronic pain. Pancreatitis and rheumatoid arthritis were other conditions with which participants were living.

Figure 23: Age of participants
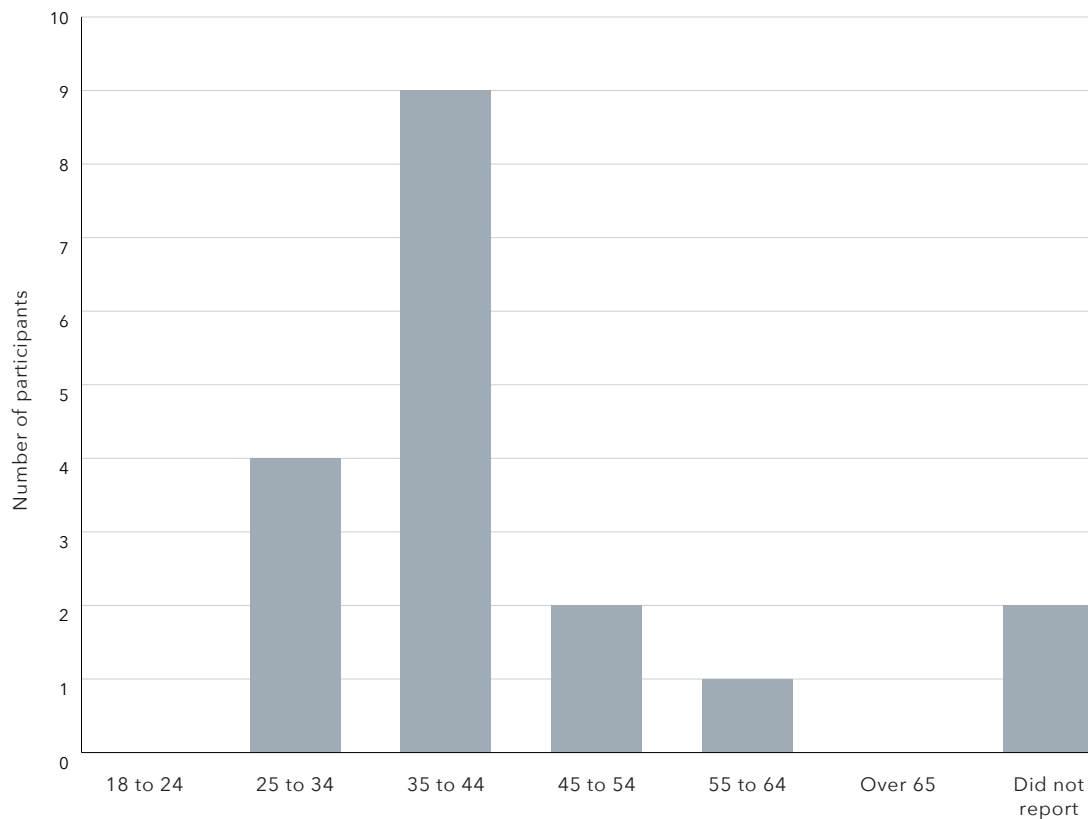
Source of income

At the time the perpetrator was in the MBCP, participants reported their main sources of income as employment (9), self-employment (3) and Centrelink payments (4), with two not providing any information.

Relationship with perpetrator

Length of relationship

Of the 15 responses provided, eight reported the length of the relationship they had with the perpetrator as more than 10 years, three had been together for 5–10 years, and four for less than 5 years.

Duration of abuse

Respondents were asked to give a sense of the length of time they experienced abuse from the perpetrator up until he was accepted into the MBCP:

- seven of the 16 responses (44%) reported this to be more than 5 years
- four (25%) reported between 2–5 years

- four (25%) between 1–2 years
- one (6%) for less than a year.

Of those participants in relationships for more than 10 years, only one reported experiencing abuse for 1–2 years, with the remainder reporting more than 5 years. The results suggest that most of these women experienced abuse for a significant period of the relationship before the perpetrator was accepted into a program.

Relationship status

Survey participants were also asked to provide information about the status of their relationship at the time the perpetrator was accepted into a program. Of the 17 responses:

- six reported they were permanently separated
- three said they were together and also living together
- two stated they were together but not living together
- two said they were temporarily separated
- four reported "another description", including being divorced and separated but living together.

One participant said the perpetrator was incarcerated and another shared that she was in a cycle of leaving, then returning (refer to Figure 24).

Figure 24: Relationship status
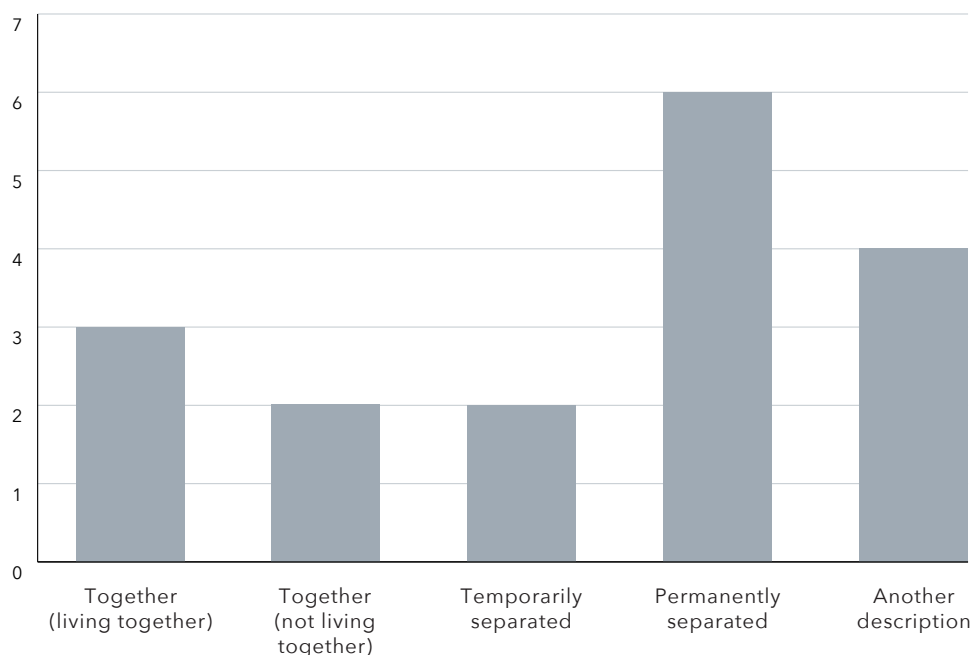
Length of separation

Of the ten participants who identified they were separated from the perpetrator at the time he was accepted into the program, five had been separated for 1 year or less, two reported it was between 1–2 years, and three between 4–7 years.

Living arrangements

In terms of living arrangements, at the time the perpetrator was accepted into a program most of the participants reported living independently with their children (47%), followed by living with their children and partner (29%) (refer to Figure 25).

About the perpetrator

Age

Results suggest that most perpetrators were above the age of 35 years when they were accepted into a program (refer to Figure 26).

Citizenship status

Fifteen participants reported the citizenship status of the perpetrator to be either an Australian citizen or a permanent resident, with three respondents not reporting.

Source of income

Participants were asked to provide information about the perpetrator's main source of income at the time he commenced the program. Results are as follows:

- seven reported him being in employment
- five stated his main source of income as Centrelink payments
- one said he was dependent on her income
- one reported him as being unemployed, and was not sure if he received Centrelink payments
- one said he was incarcerated and therefore not receiving an income
- one did not know
- two did not provide any information.

The findings suggest that a large proportion of the male perpetrators were not in regular employment.

MBCP attendance

Of the 18 responses provided, five participants reported the perpetrator as "currently" attending an MBCP, with 13 reporting that he was not. Eight of the respondents stated the perpetrator had been court ordered to attend the MBCP, eight said he had not and two were unsure. Most male (ex-) partners of the women had participated in more than one MBCP, with:[12]

- three being first-time attendees of an MBCP
- thirteen having attended one MBCP previously
- two having attended two or three MBCPs previously.

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12 While not the purpose of this research, this finding validates previous commentary, practitioner-based evidence and qualitative research with perpetrators that journeys towards non-violence, and engagement of perpetrators by the system, can be long-term, stop-and-start and spread over many years (Vlais & Campbell, 2019).

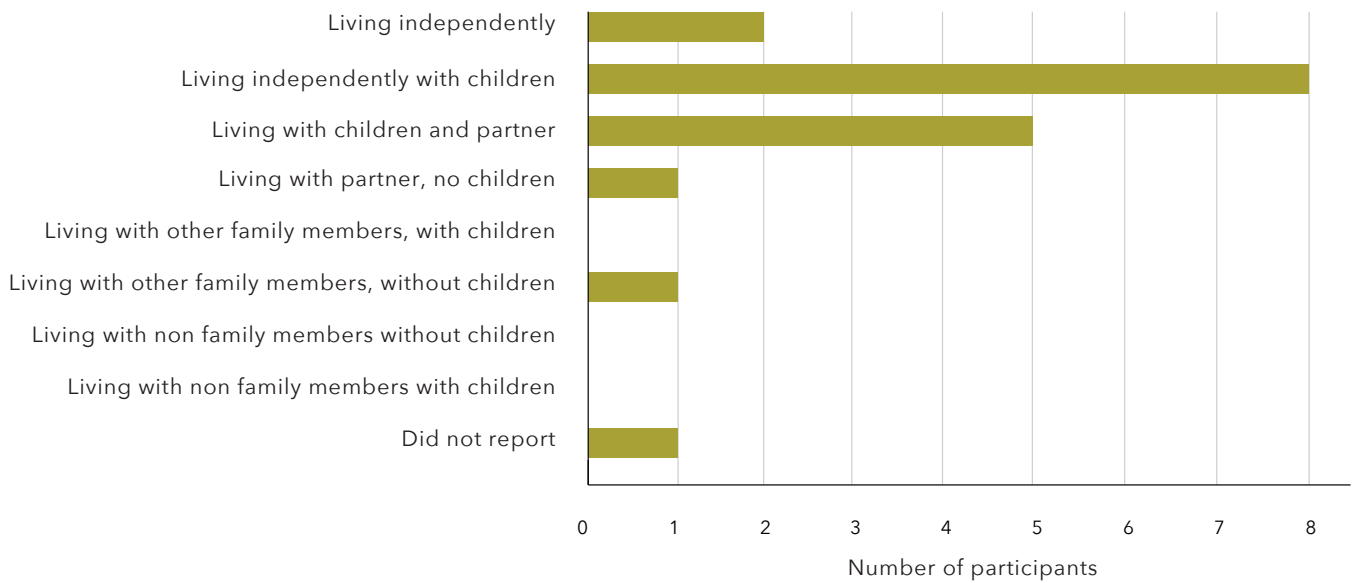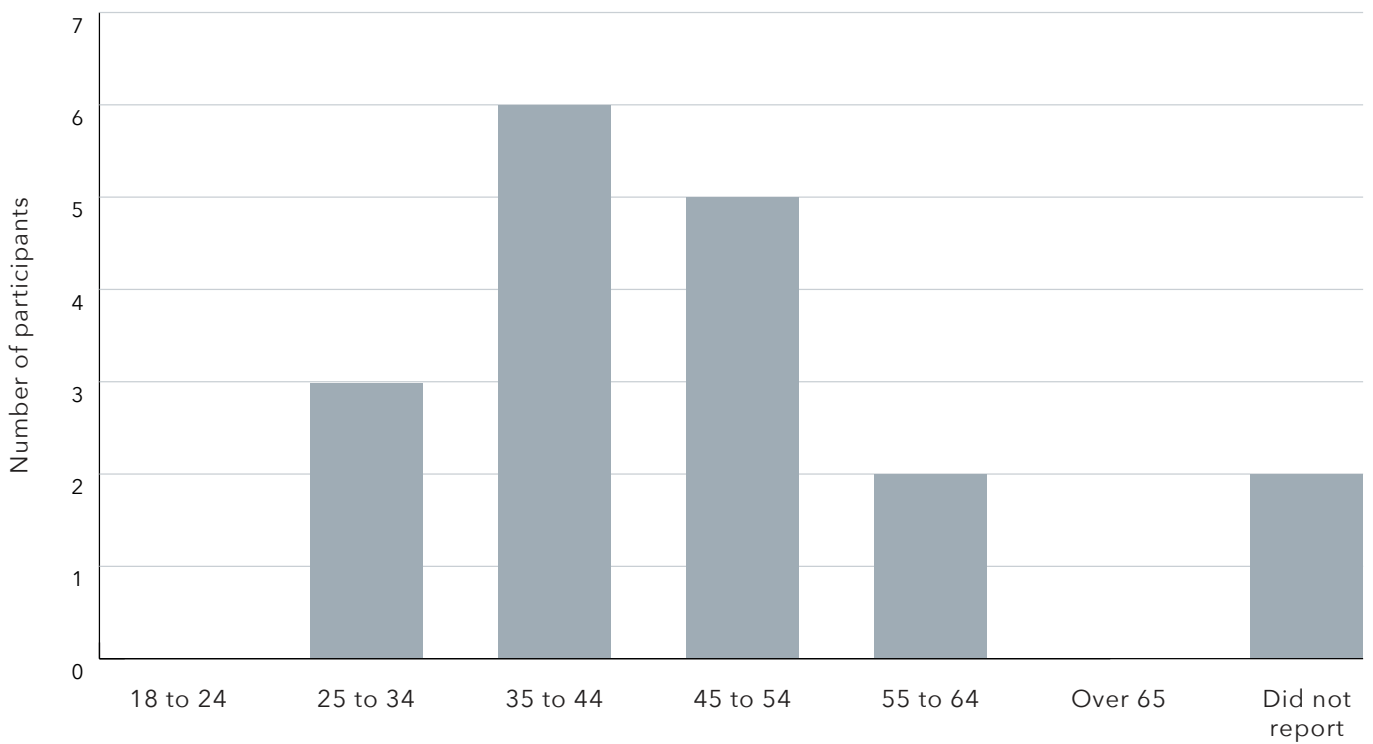**Figure 25:** Living arrangements

Figure 26: Age of perpetrators

In relation to when perpetrators had attended prior programs:

- eleven were in the last 5 years
- two were more than 5–10 years ago
- two were more than 10 years ago.

MBCP completion rates

Respondents were asked about their knowledge of whether the perpetrator fully completed or withdrew from the MBCP. Five participants said the perpetrator completed the program; seven said they did not complete the program; three said perpetrators were currently attending; and three were unsure.

Number of weeks completed

Of the five survey participants who reported that the perpetrator had completed the MBCP, two had been in programs that went for 9–12 weeks, and three in programs that went for more than 12 weeks.

Of the seven respondents who identified the perpetrator as not completing the MBCP, three completed 5–8 weeks, one between 9–12 weeks, one more than 12 weeks, one completed less than 4 weeks and one was unsure as to how many weeks had been completed. For the three participants who reported the perpetrator as still attending at the time of the survey, one had completed 5–8 weeks and one more than 12 weeks, with no information provided for the remaining perpetrator.

It is difficult to make any kind of interpretation about these data, due to the variance that exists between the content and length of the programs. What we can say, however, is that from this sample, a significant portion of perpetrators did not complete the MBCP. There are also a number of women who reported being unsure as to whether the perpetrator completed the program or not, possibly indicating that they have had limited involvement with a partner contact service.

Reasons for non-completion

Those who provided further descriptive responses about their understanding as to why the perpetrator did not complete the

MBCP gave various reasons, though it should be noted that one participant said she did not have any information about this. The reasons provided here give a sense of (ex-)partners' experiences, which mostly indicate that perpetrators had a level of choice about their participation:

> He completed 1–2 modules of eight weeks [full program is four modules]. The MBCP was … closed … and he never reengaged after [he did a few 1:1 sessions with one of the MBCP workers]. He stated he felt he did not need to continue; he was always resistant to attending but while not exactly court ordered, attendance was part of his Section 32 Mental Health Act for 6 months after an incident. (Sophie, New South Wales)

> He said he couldn't afford it even though he was working and didn't support myself or his children in any way, shape or form. (Isabella, Western Australia)

> He was arrested on a return to prison warrant. (Charlotte, Queensland)

> He didn't want to. (Ava, New South Wales)

> They moved him to a different correctional centre, which did not offer the same program. (Madison, New South Wales)

> He said, "I was told I don't need to do it, there's nothing wrong with me, it's your fault". (Patricia, Victoria)

This latter quote is reminiscent of Optiz's (2014) finding of how, in the absence of partner contact, many perpetrators were able to distort and lie about their participation in the program to their (ex-)partners, as a means of using their participation as a weapon against her.

Impact of non-completion on partners

Survey respondents were asked about the effect that perpetrators not completing a MBCP had on them. Figure 27 demonstrates that, for the majority of participants, their experiences either worsened or there were no difference or changes noted.

Figure 27: Impact on partners when perpetrators do not complete MBCP
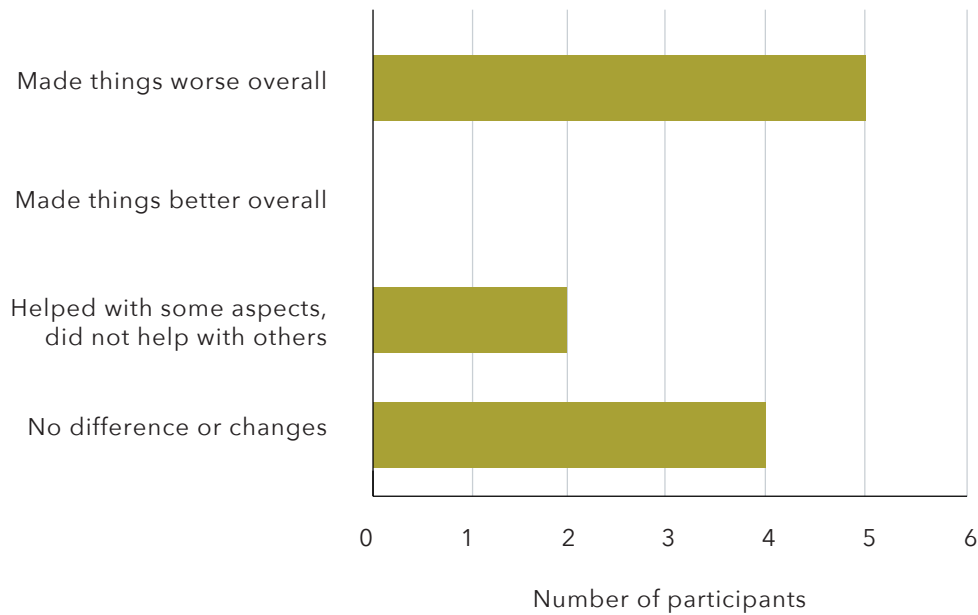
The survey produced some insightful and concerning qualitative responses about partners' continued experiences of violence following perpetrators exiting an MBCP. Several participants explained how perpetrators expressed resentment at having to attend the program, for which they held their (ex-)partners responsible, and that there was little change in their behaviours.

The following quotes describe some of the participants' experiences when perpetrators did not complete a program. They create an impression that women felt unsafe as a result of the perpetrators' behaviour in the lead-up to men exiting the program:

> I felt that his choice to not complete the program was negative, as I had requested him to attend after years of escalating coercive control, emotional abuse and physical violence against myself and our children. Each week he would attend, he would raise issues at home and often become emotionally and verbally aggressive as he had been challenged by the MBCP—he would seek for me to disagree with him so that he could start an argument. He felt that he did not need to attend the program and would push back against what the facilitators were saying when at home, seeking for me to agree with him that they were wrong, or that what was being addressed did not apply to him etc. I often felt scared and had to manage my responses to ensure he didn't get angry with me about this, i.e. agree with him to minimise his anger. He also manipulated terms and expressions learned at the MBCP, e.g. would say that I was being coercive, controlling [or] abusive if I was being assertive about my own boundaries. The partner support worker … became concerned that addressing specific behaviours with him might be linked via her [she was also a facilitator in the group he attended] and have a negative impact on me, so I was linked to another support worker as a safeguard. (Sophie, New South Wales)

> He was in complete denial and was saying that as I was attending [victim support program] I was the one with the problem not him. His behaviour got progressively worse and he breached the [violence restraining order] 14 times. (Isabella, Western Australia)

> It made things worse because it caused conflict between him and me. The expectation of him completing it and rehabilitating was no longer a strength, and I no longer felt safe. (Madison, New South Wales)

> I have no contact currently, however I have witnessed more arrogance in family court and been told by mutual friends that he now believes I was being overly dramatic and he was justified. (Evelyn, New South Wales)

> I ended up leaving when I could; took me another 2 years of hell. (Patricia, Victoria)

These quotes provide a sobering reminder of how program attendance can escalate risk and introduce new opportunities for some perpetrators to practise coercive controlling tactics. In contrast, there was little or no comment from the partner contact practitioners in their interviews concerning the importance of partner contact in checking whether perpetrators were using their participation in the program as a tactic of control against their (ex-)partners. Given these

Figure 28: Impact of MBCPs on perpetrator behaviour

MBCPs impact on perpetrators' behaviour

Respondents were also asked about whether participation in the MBCP made any difference to a perpetrator's behaviour, and were given five options from which to select a response. Two respondents indicated they experienced a positive difference; six said that no difference was noticed; four stated they thought MBCP participation helped with some aspects, but did not help with others; five suggested participation made things worse; and one said it was too early to tell (see Figure 28). In general, there was a sense that MBCPs had limited positive impact on the behaviour of the perpetrators connected with this sample.

Survey respondents were asked to provide further descriptive information about their experiences. The respondent who indicated it was "too early to tell" did report feeling less controlled, presumably as the perpetrator was still currently in a program.

Positive differences noticed

Although they were in the minority, some participants reported positive and significant differences in perpetrators' behaviour:

women's experiences, this needs to be a stronger focus in the partner contact role.

He wasn't happy at the beginning and blaming me for sending him to this program, now he is like a different person. He appreciates it now. Because he has more peace with himself and his children … My daughter never answered his call before because she used to cry and was upset for days after each time she talked to him … She is now contacting him without getting stress and worries. My children went to see him a few weeks ago and they said, "For the first time we sat at dad's house and watched a movie. He never complained about you mum or anyone else. He even made my favourite food and said, 'Don't cook anything for tonight I will send some food for tea and bring it when I drop [the youngest child who sees him every Sunday]'". In return I do the same thing … we appreciate how [and] what he is doing now. (Olivia, Western Australia)

My husband felt more supported by me and he had a better understanding of what was going on between us thanks to this program. (Ava, New South Wales)

Helped with some aspects, not others

In contrast, the following quotes demonstrate the changes—not all positive—that partners have seen in perpetrators' behaviour as a result of attending an MBCP:

While his more overt physical violence, threats and aggression reduced, this may also have been due to the apprehended domestic violence court order [and]

threat of prison and also his abstinence from alcohol as part of the AVO and commencing alcohol and drug counselling. I found that he became more adept at subtler emotional abuse and coercive control and often used/abused concepts introduced by the MBCP. He respected the male facilitator, due to his lived experience, but often denigrated the female facilitator to me. He also minimised the effect of his behaviour on myself and our children as he "wasn't as bad" as other men in the group. (Sophie, New South Wales)

He no longer questions any of my decisions or [makes] comments about my behaviour. He takes complete responsibility for his past behaviour in our relationship. It has made things difficult as he no longer communicates his wants, desires and needs, concedes that he is wrong in all circumstances without arguing, and appears to be depressed. (Kate, Victoria)

These comments provide an interesting contrast. In the first quote, the differences in the perpetrator's behaviour towards his partner clearly appear to be about other parts of the perpetrator intervention system placing external controls on him rather than the MBCP having much influence. In the second quote, the perpetrator appears to have had a change in his thinking, which is reducing his use of violence and, possibly, the level of fear she is experiencing. Although the participant mentions her perception that her partner may be depressed, it is also possible that he was using withdrawal as a coercive control and silencing tactic.

Made things worse

Some of the descriptive comments provided by participants support the previous assertions, which suggested that perpetrators can often manipulate information learned in the group, minimise or find excuses for their behaviour, and hold women responsible for having to attend the program. Five of the women who experienced an increase in violence following a perpetrator's attendance at an MBCP described their experience:

[Partner] uses what he is taught against me. He twists things and doesn't feel the violence is his fault. He says he has "core hurts" from his upbringing and uses that as

an excuse. (Mary, Western Australia)

My ex was in, and still is in, complete denial about his behaviour to myself and the children. He has engaged his wife, my ex-best friend, and his family to engage in abusive practices both online and by sending his friends to my house. (Isabella, Western Australia)

Made him more bitter towards women and particularly the woman who brought the [domestic violence order] against him. (Abigail, Queensland)

He has heard of others doing more physical damage so now he believes he doesn't have a problem and he is more angry at the fact I pressed charges. (Evelyn, New South Wales

He was worse. More controlling, more jealous, stalking increased and neither my kids or I felt safe with him at all. (Patricia, Victoria)

Specific ways MBCPs make a difference for women

Participants were asked to select from 10 pre-determined responses regarding the specific ways in which a perpetrator attending an MBCP made a difference to their lives. They were encouraged to select all responses that were applicable, and these are outlined in Figure 29.

The responses suggest that participants held some quite mixed feelings. Two indicated they felt more controlled. One woman noticed an improvement in the way her (ex-)partner communicated and the other had a greater sense of safety. Six suggested they experienced positive differences overall, and reported improvements in communication, wellbeing, decision-making and safety. The remainder reported negative experiences—feeling more controlled, and less safe—or no difference in the perpetrator's behaviour.

The five respondents who selected "other" referred to a range of ways in which the perpetrator's attendance at an MBCP had negatively impacted them. Some of the negative behaviours by perpetrators they described included using the

Figure 29: Ways the MBCP made a difference

An example of the ambiguity felt by survey participants is provided here to give a sense of the complexity that women and children face. One respondent thought that, although the perpetrator did have a better awareness and understanding of the impact that domestic violence has had on her and the children, in her view their children continued to remain unsafe around him. This same participant shared the following about the distinct uncertainty she felt as to whether the program had made a difference to his parenting and their children:

> Difficult to answer. I felt he had a theoretical understanding of the impact on the children, and a wish to change his parenting, but this did not necessarily translate into action. (Sophie, New South Wales)

Respondents were asked to share further views about how the program has made a difference, positive or negative, to themselves or their children, with their responses reiterating that most had mixed or negative experiences. The quotes below demonstrate the variety of partners' experiences of perpetrators' behaviour following their participation in a program. They show continued abuse and controlling-type behaviours, as well as denial and blame:

program to control them further, an increased sophistication in the tactics of emotional abuse and coercive control, and being more openly insulting about women. Respondents also reported that a perpetrator's attendance at a program helped to improve their own insight about his behaviour. In one case, it also assisted in family court proceedings as his unwillingness to change was documented and provided to the court.

MBCPs impact on perpetrator's parenting and/or children

Survey respondents were also asked to select the specific ways in which a perpetrator's attendance at an MBCP impacted on his parenting and/or children. Respondents were encouraged to select all that were applicable from 10 pre-determined responses (refer to Figure 30).

Consistent with the findings reported above, the responses showed some mixed feelings about the effect of the MBCP on the perpetrator's parenting and/or children. While four respondents reported there being a positive difference overall, most also reported negative experiences or no difference in the perpetrator's behaviour in this area. Those who selected "anything else" implied that the perpetrator continued to exhibit harmful behaviours towards their children, and blame towards themselves (as the partner) for their behaviour.

Figure 30: Impact of MBCPs on parenting and/or children
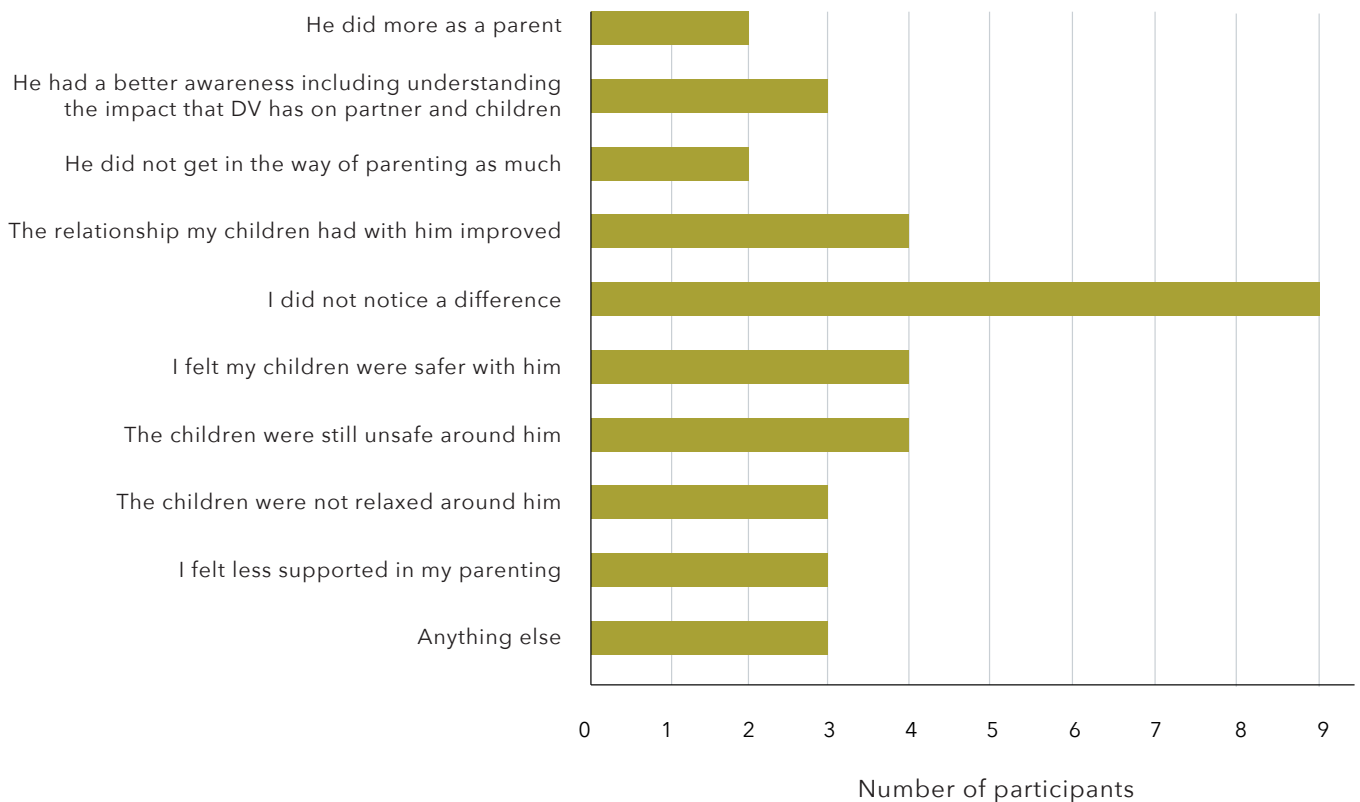
He kept saying he had changed and there was nothing wrong with him because he did a program. (Mary, Western Australia)

I don't think it has had impact on my ex as his behaviour is unchanged or worse and as such he returned to prison. (Charlotte, Queensland)

He would come home angry and take it out on the children by yelling at them. (Ava, New South Wales)

It gave him the language to "justify" his behaviour. It didn't help that he was attending this "course" during the 6 months he was denying assaulting me. To get into the course, he had to admit that he had done it, that he was remorseful and that he wanted to change. So on one hand he was all, "Yes, I did it and I'm sorry", and on the other he was denying the violent, abusive behaviour despite photographic evidence of bruises etc. (Jenny, South Australia)

Not completing the MBCP was also related to impacting a perpetrator's capacity to change, and his relationships with his children:

Made him think about the impact of his behaviour on the children; at least he can't say he doesn't know. But I find

this raised shame and often stopped him from changing his behaviour—not the fault of the MBCP. I feel if he had completed the program this would have changed—change is a long-term process. (Sophie, New South Wales)

He commenced the program in [correctional centre] and was moved mid-program to [correctional centre]. The non-completion and disengagement from support in [correctional centre] had an extremely negative impact on my children because they became estranged from their father. The children were impacted by trauma even more so. He got dependent on a drug called buprenorphine in that centre and continued to engage in illegal activities in the centre. Our children had no contact with him for 18 months as a result. (Madison, New South Wales)

Respondents who experienced no changes in a perpetrator's behaviour were asked to provide their thoughts about why the program had not made a difference. Most referred to perpetrators having to want to change; in their view this is an individual process that takes time, insight and commitment:

Because he doesn't believe that *he* is the problem. It is the three women he married who are the problem. If we hadn't just pissed him off all the time, he would have been fine! I left him more than 11 years ago, and he *still* denigrates me to the children with absolutely disgusting language which I have screen shots of. (Jenny, South Australia)

Figure 31: Other programs helpful for perpetrators
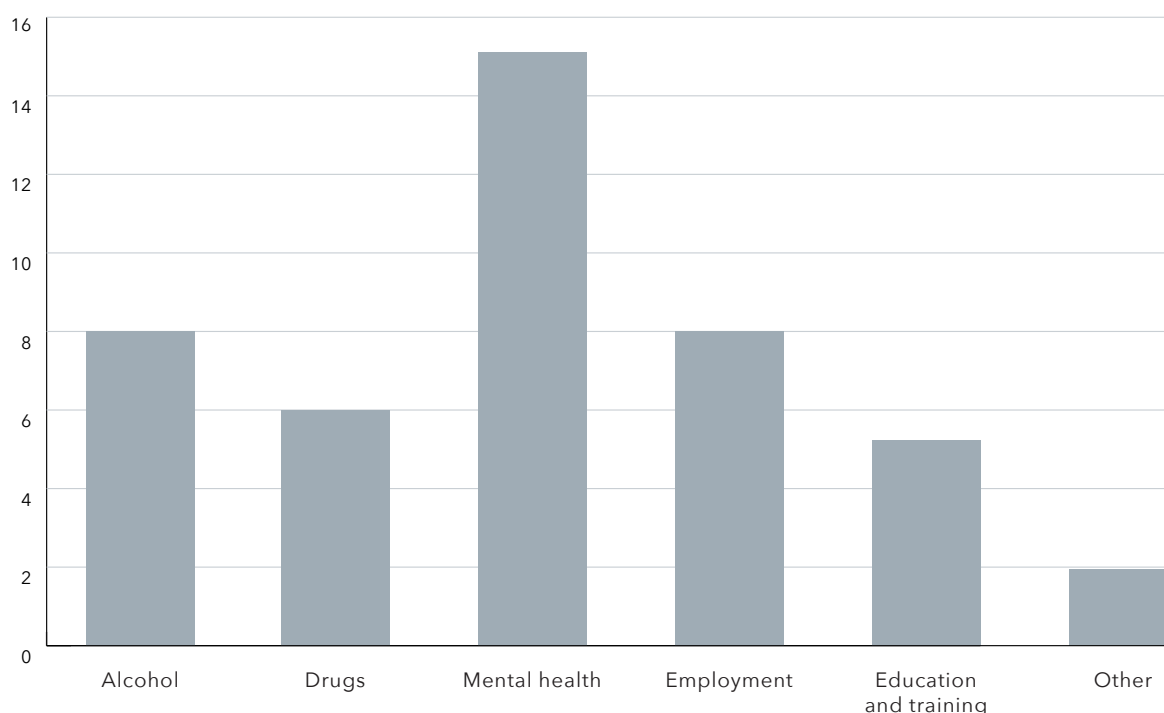
Because he is incapable of change. Some people are just incapable sadly! (Patricia, Victoria)

My thoughts are that he has an undiagnosed mental condition and never believes he is in the wrong about anything and everyone is out to get him. Therefore, he does not see the need to change himself and made comments that he has to sit around "with wife bashers and he's not a wife basher" etc. (Charlotte, Queensland)

He has to want to change. The court should have ordered he repeat it or do therapy but they gave up on him. (Jessica, Victoria)

Two of the participants suggested that there needed to be an increase in programs and supports for perpetrators and for children. In particular, one suggested that improvement is needed in the Corrective Services context.

Other programs and support needed

Survey participants were also asked about other programs they considered would be helpful for perpetrators to attend, in addition to an MBCP. This is represented in Figure 31, which shows that all 15 respondents to this question believed that programs centred on mental health would be helpful.

Most participants selected more than one option, which could indicate that many of these perpetrators had multiple, problematic behaviours. For example, nine participants identified that programs addressing drugs, alcohol, mental

health and employment would be beneficial, and four suggested programs for mental health and education and training. Some of the "other" programs suggested included counselling, parenting, and parenting children with disabilities.

Women's experience of partner contact support

Engagement

Of the 18 respondents, 13 were contacted by MBCP staff or a partner contact worker about the perpetrator's involvement in the program. Five said they did not receive any contact. The method of initial engagement was most commonly by telephone, with eight of the 13 respondents stating this was their primary form of communication. They were also contacted through a combination of telephone and email, text message or letters, and one respondent said she contacted the partner contact service herself.

Those who were not contacted were asked what they would have liked or found helpful had they been contacted. Responses centred on wanting more support for themselves, and information about the perpetrator's engagement and progress with the program. The following comment is an example of how one woman living in a regional area felt particularly powerless and unsafe, as she did not have adequate information about the perpetrator's progress. It also appears that a lack of funding impacted on the quality of support she received:

Figure 32: Frequency of contact

Frequency of contact

Survey participants were also asked to indicate the frequency of contact by the partner contact service. Figure 32 demonstrates that most were contacted fortnightly, although a significant number were contacted on an occasional basis.

Number of contacts

Survey participants were then asked to share information about the estimated number of contacts they had with the partner contact service. Figure 33 shows that, for most participants, this appeared to be 3–10 times.

Types of supports and referrals offered

Survey respondents were asked to give an indication about the types of supports or referrals the partner contact service provided, including legal services, financial counselling, housing and homelessness services, counselling, support groups for women, specialist women's domestic violence agencies, family support services, child-focused services, parenting programs, alcohol and other drugs services, and mental health services.

Figure 34 shows that specialist women's domestic violence support agencies were the most frequently made referrals, followed by counselling and legal services. Referrals less frequently reported were parenting programs, alcohol and other drugs services, and housing and homelessness services.

I would like to have been told of some courses he could have done and how I can be helped in the situation I'm in. I was always told that as funding is being reduced they don't have enough funds [so] they cannot help me. I would have liked to offer my side of the story, yet when I contacted the [program name] they told me they didn't speak to the other party. I asked them, "How on earth would they know if his actions have changed?" They didn't listen to me at all. I felt useless and in danger. (Isabella, Western Australia)

Point of first contact

Survey participants were asked at what point the partner contact service was in contact with them. Of the 14 respondents:

- five reported the partner contact service had contacted them after the perpetrator had started the group work component of the program
- three said this occurred after the perpetrator had booked into the first assessment session, but before it had taken place
- one stated this had occurred after the perpetrator had started his assessment process, but before the group work had started
- one participant reported she was contacted by the partner contact service before he had engaged with the MBCP
- four reported they were not sure at what stage they were contacted.

Figure 33: Number of contacts
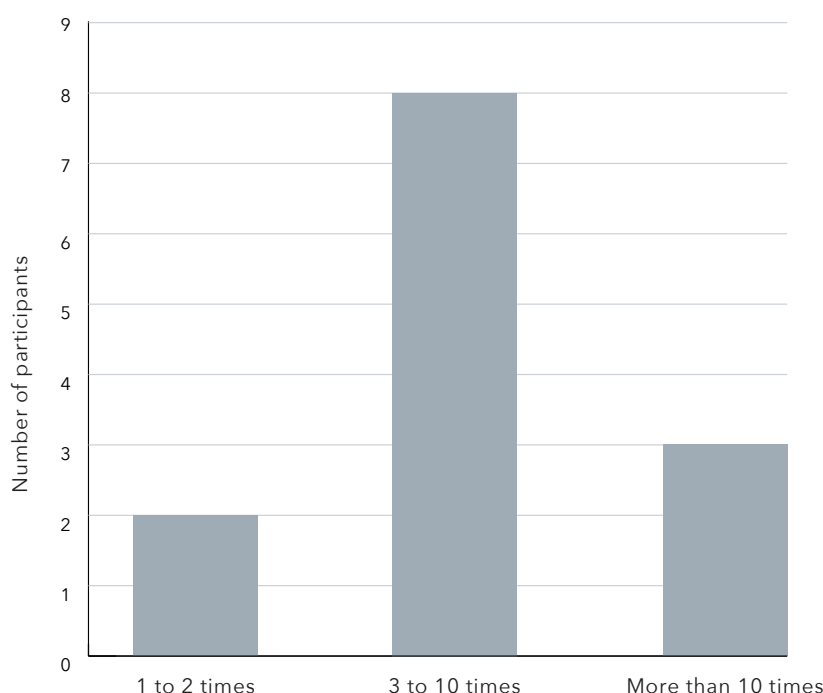
Most indicated having a variety of referrals made to differing agencies, in a reflection of the impact that DFV can have on multiple areas of women's lives. Notably, there were a number of participants who reported they were not provided with any supports or referrals; of these one said she already had supports in place.

Children's support

Ten of the 16 respondents advised they were not offered supports or referrals for their children. Those who were offered support indicated that children's counselling services were the most common type of referral.

Other supports and referrals considered helpful

Survey participants were asked to indicate what other supports or referrals they would have found helpful for themselves and their children. Their responses indicated that these participants and their children experienced and felt a distinct lack of support:

> Any referral would have been helpful! I literally had no support and didn't even get support from the shelter I ended up in. (Jenny, South Australia)

> All of them. There was no help available and we had to wait another risky and painstaking two more years before I could save enough to leave him. (Patricia, Victoria)

We didn't have any and I [would] appreciate if I can have [support] for my youngest child and myself. (Olivia, Western Australia)

> Hard to know when I don't know what exists. I had a feeling if I asked for a particular type of support they'd have found it for me. (Jessica, Victoria)

For some of the participants living in a regional area, limited availability of supports was evident:

> At the time a women's support group was not available, if there was I would have liked to attend; there is one commencing soon but I am unable to attend due to work and the nature of my work. To my knowledge there wasn't a child's support worker linked to the MBCP, and there is very little support available in our rural area for children. I would have liked them to have the opportunity to find out in age-appropriate ways about the MBCP and have their voice heard and safely fed back to their dad. (Sophie, New South Wales)

> My six children suffer from serious DV affected behaviour. They are physically and verbally abusive. [Child mental health service] have said they cannot help and we should relocate. [Child protection agency] have said they cannot help and there are no services to help them. (Isabella, Western Australia)

Figure 34: Types of supports and referrals offered
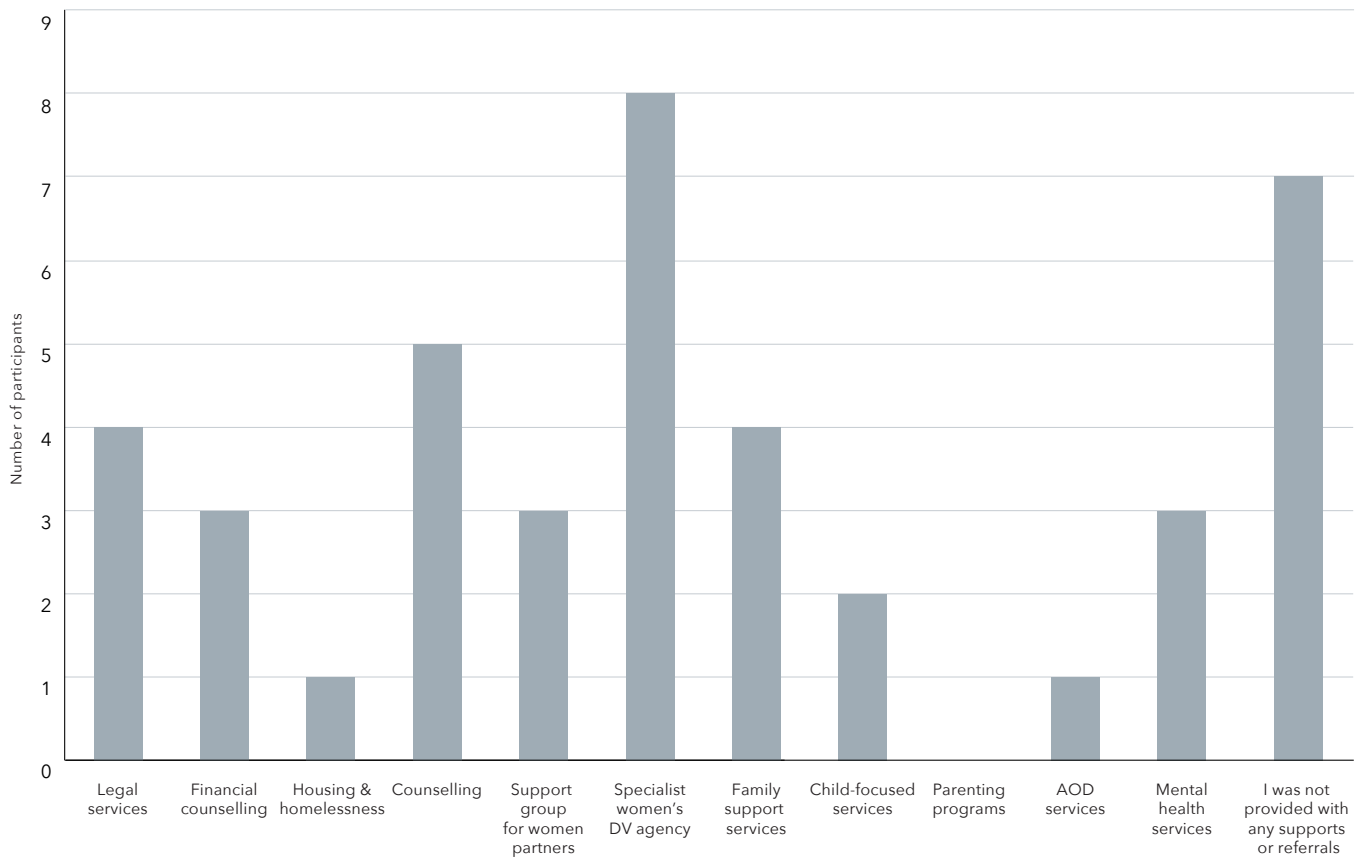
Attendance at MBCP information session

Eleven of the 18 participants said they had not been given an opportunity to attend an information session about the MBCP in which the perpetrator was participating. Two said they were given the opportunity, four were not sure if this was the case and one person did not provide this information.

Ongoing support

In relation to whether participants were offered ongoing support by the partner contact service following the perpetrator exiting an MBCP (whether this had been completed or not), six reported they were, nine were not, two advised their (ex-) partner was still currently in the program and one participant did not provide this information.

Of the six who reported being offered ongoing support, two said this was for 1 month following, one for 2 months and one over 6 months. Two did not provide any further information about this.

The results indicate that only a relatively small proportion of women were contacted by a partner contact service, at least

for a brief period, following the perpetrator exiting the MBCP. This is in contrast to the findings of the practitioner survey, in which many of the respondents suggested their agency would continue to offer, at some level, partner contact support to partners following a perpetrator exiting a program. It is concerning that half of this sample reported they were not contacted by a partner contact service at what is recognised as a potentially higher risk time for partners.

MBCP and partner contact service evaluation

Eight respondents indicated they were asked for feedback to help evaluate the perpetrator's progress during the MBCP, while nine said they were not (one did not reply to this item). Similarly, nine reported they were asked for feedback about the support they received from the partner contact service, while eight said they were not.

General feedback and suggestions

Survey respondents were asked to provide general feedback and suggestions about the helpfulness of the MBCP for perpetrators' behaviour, their experience of the partner

contact service and suggestions as to how women's and children's safety can be improved.

Helpfulness of the MBCP for perpetrator's behaviour

Respondents were provided with an opportunity to rate the level of helpfulness of the MBCP in reducing perpetrator violence and abuse. On the scale, ranging from 0–10, 0 was allocated as "not helpful at all", 5 as "kind of helpful" and 10 as "extremely helpful".

Of the 18 respondents:

- four did not provide any information
- eight gave a score of four or below (three of these were zero)
- two gave a score of five
- four provided a score of seven or above.

The mean of responses was 4, which is fairly consistent with responses in other parts of the survey. This suggests that, overall, respondents did not find the MBCP was overly effective in reducing perpetrators' use of violence. Notably, five of the participants selected 0 or 1, and two selected 9 or 10 on the scale.

Participants were also asked whether they thought there were any ways in which the MBCP would benefit the perpetrator into the future. Again, there was some ambiguity around this, with nine stating they were unsure, five saying they thought not and only three selecting yes. One participant did not provide any details.

Most of the descriptive answers they gave in support of their responses showed much scepticism, perhaps even a loss of hope, about perpetrators being willing or able to change their behaviour. For example:

> The emotional and verbal abuse still continues, not quite as severe. (Mia, Victoria)

> I think my ex[-partner] is beyond help. His behaviour has become progressively worse over the years. His behaviour towards our children has also become worse … I don't

think he can change he has had so much support and services offered but no help. (Isabella, Western Australia)

> He is still not finished the program but not sure if all these changes will be permanent after program finishes. (Olivia, Western Australia)

A number of participants also referred to the perpetrator not taking responsibility for his behaviour, which in some cases resulted in the partner being blamed:

> He doesn't believe he needed to be there, he is not like the others in the program and continues the same behaviour and blames me for everything. (Charlotte, Queensland)

> He thinks he is "cured" and doesn't take kindly to any criticism from me. (Mary, Western Australia)

Helpfulness of the partner contact service

Respondents were provided with an opportunity to rate the level of helpfulness of the partner contact service in the provision of support. On the scale, ranging from 0–10, 0 was allocated as "not helpful at all", 5 as "kind of helpful" and 10 as "extremely helpful".

Of the 18 respondents:

- two did not provide any information
- five rated the service as two or under (three of these zero)
- two gave a score of five
- nine rated the service at seven or above (six of these were ten).

The results suggest that, overall, respondents found the partner contact service to be fairly effective in providing them with support. Notably, seven of the participants selected nine or ten and four selected zero or one, also indicating there to be a level of variability in participants' experience of a partner contact service.

Descriptive responses indicate that participants found it helpful to have someone to talk to, who could provide ongoing support

and validate their experiences. In particular, the provision of emotional support and being able to speak with someone outside of family or friends was identified as important. The following comments are examples of the ways in which participants found the partner contact service helpful:

> Validating my experiences—[domestic and family violence] is such an isolating experience and it was positive to have someone to speak to who was able to reflect the common experiences of other women. The worker also allowed me to check in about what was healthy/unhealthy/abusive behaviour by my partner as I learned to redevelop and assert healthy boundaries. There was so much gaslighting and projection by my partner that this was really helpful to be able to regularly "reality check" with someone; she could also incorporate this into the MBCP. (Sophie, New South Wales)

> Nice to have someone to talk to who is not family or friend—they don't take his side. Helped me to realise that I am a good mother as I have [been] trying to keep myself and [my] children safe. The worker has provided me with specialist female family violence workers to talk to [who] can support me. The worker is always available to take my call on the days that she works. (Alice, Victoria)

> Just the emotional support through a really difficult time and providing information to me to help me heal with the referrals given; but really just the check-ins and wonderful support. (Charlotte, Queensland)

> Having someone I could communicate with who had advice and other services I could work with to help me meet my needs. (Ava, New South Wales)

> The letter documenting his behaviour [was the most helpful aspect]. (Jessica, Victoria)

> Checking on my safety. (Olivia, Western Australia)

Other aspects cited as being important included feeling safer, understanding more about the perpetrator's behaviour, including when risk had elevated, and the availability of the partner contact service when they needed it:

> I felt safer. It also helped me hear the positive stuff he would tell me about the program but he would turn it into negative. I think because it was not me telling him, it was the program, it let me understand it was not me. It made it stand out how bad my life really was even though I could see it but the program made it easier for me to leave. [Amelia, Victoria]

> The warning about his anger on one occasion. (Evelyn, New South Wales)

Some participants could not speak highly enough of the service they received from, and the relationship they developed with, the partner contact worker:

> [Partner contact worker] was amazing and could not have been more supporting or helpful. For the first time I felt like I didn't have to navigate this whole situation on my own. I can't thank her enough. (Charlotte, Queensland)

> Having someone to talk to that was not judgemental. She is a legend. (Ava, New South Wales)

In contrast, participants shared several comments about receiving little or no support, or inconsistent support that was considered unhelpful:

> It could and should have provided some support but didn't. (Patricia, Victoria)

> Considering all I got was a couple of phone calls telling me he was doing the program and that he'd finished, anything would have been helpful. (Jenny, South Australia)

> Besides receiving [one] warning from a facilitator about being in possible danger no assistance was offered. (Evelyn, New South Wales)

> I didn't receive any support [from the MBCP partner contact service]. I only received support from [an external support agency]. (Isabella, Western Australia)

One participant identified that the provision of information would have been particularly helpful in addressing her needs,

however, this was unfortunately not the case:

> I didn't get any information—everything I know I found out for myself, often a long time after I needed to know. (Jenny, South Australia)

For another, the overlapping role of the facilitator and partner contact worker impacted significantly on her experience of support. Although not identified in this sample as being a common occurrence, it is considered particularly important feedback:

> The decision was made to transfer me to another partner support worker, as mine was also a facilitator in my partner's MBCP group. While I completely understand that this decision was made for safety, I found it hard as I had developed a safe, trusting relationship with the worker and felt that (again) [my partner's] behaviour was impacting on my own support. (Sophie, New South Wales)

Other information and supports that participants identified as being useful included legal support, safety planning, and information about the MBCP and other services with which the organisation is involved.

Suggestions for improving women and children's support

There were a number of suggestions made by respondents about how women and children can be better supported while men are attending a program. These were mainly focused on improving children's supports, particularly counselling services for children and families. A suggestion was also made to have dedicated children's workers available to listen and validate children's experiences. In addition, a respondent proposed limiting children's contact with perpetrators until the latter can demonstrate a change in their attitudes.

Other suggestions were made around the MBCP itself, including increasing the length of programs, incorporating a parenting focus and monitoring men's behaviour outside of the program more closely:

> There needs to be more of an input if the women choose this, as the [program name] group had no idea what he was doing to myself and the children outside of the

program. When I contacted them, all they could tell me is they cannot even confirm he is part of their group even though it was court ordered for him to be. They were very unhelpful. (Isabella, Western Australia)

I was certainly unprepared for the "pushback" against the issues raised by my partner and how this sometimes led to anger and aggression by him at home after attending. While he would appear to be agreeing in the group, he would come home and get angry, particularly about what the female facilitator had said, and be aggressive to me regarding this. (Sophie, New South Wales)

Discussion and conclusions

The aim of this project, one of the first national studies to document partner contact practices in Australia, is to provide policy makers, practitioners and researchers with an overview of research about MBCP partner contact. It has achieved this by focusing on descriptions and analysis of how partner contact currently operates in Australia, incorporating the perspectives of both providers and partners about their experiences, and identifying future areas for improvement and development. With the majority of the research about MBCPs focused on debates about program effectiveness, in particular whether perpetrators' violence and abuse is reduced, there has been very little research about the partner contact aspect of MBCPs.

MBCP partner contact is a complex area of work and requires a practitioner who can delicately balance the hopes and fears of the victims/survivors, while capably managing risk in order to work in their best interests. However, some studies (Opitz, 2014; Smith et al., 2013) have shown a number of concerning situations where women and children may be exposed to further risk of violence and coercion as a result of inadequate partner contact processes. Such examples underline the urgency of ensuring that comprehensive partner contact is part of all MBCP provision. Partner contact workers are also in the position of having to depend upon and trust the skill of MBCP facilitators in being able to identify risk, share information and purposefully and ethically use the information provided by the victim/survivor so as not to put them at greater risk.

Furthermore, any support provided to women and children who have experienced DFV is an ongoing process, which should not end once perpetrators have exited the MBCP. As Vlais (2014a) notes, support for women and their children needs to be intensified and continued beyond this point, whether that support comes from a victims'/survivors' group or a DFV practitioner. Current evidence about partner contact and its resourcing suggests that it has been of secondary importance and an "add on" to the intervention with male perpetrators, rather than a critical component of the overall MBCP.

The findings of this study confirm previous Australian research that partner contact is common in MBCPs (Vlais, 2017). Unsurprisingly, the review of existing literature in Australia

and internationally showed that partner contact was highly variable. For example, in some North American MBCPs there is no partner contact, while in many European and United Kingdom MBCPs partner contact is a key component of the program and there are well developed guidelines for practice (Cannon et al., 2016; Lilley-Walker et al., 2018). In Australia, partner contact is not universally provided and varies from making contact by phone through to a face-to-face service that enables victims/survivors to engage with an integrated response.

Another area of concern in the literature is the lack of both direct responses to and services available for children of men attending MBCPs and children who have lived with DFV more broadly. While programs such as Caring Dads are being implemented in some jurisdictions, these are not as yet widely available. The large body of research exploring the various impacts of DFV on children and parenting relationships has not translated into the development of available service responses for children in their own right. This has led to recent developments in Victoria, where there is a shift from the use of the term partner contact to "family safety contact" to reflect the intention for children and young people to have appropriate support.

The findings from the research show a detailed picture of the organisation, variation, challenges and strengths of MBCP partner contact work consistent with much of the literature. The collaboration and coordination required to undertake this work effectively requires highly coordinated services, skilled and determined practitioners, and a network of DFV responses that can work in alignment to promote and not compromise women's and children's safety. Partner contact work relies heavily on the web of services, of which it is a part, to be able to support the safety of victims/survivors and promote accountability.

Our research findings offer a detailed account of the current state of partner contact in Australia. Both the literature and the findings suggest that partner contact has been the "overlooked" and "undervalued" component of MBCPs. Its importance is signified most strongly in women's accounts of what transpires when partner contact is absent or inconsistent during their (ex-)partners' attendance at MBCPs.

Partner contact is a labour-intensive process during which workers need to establish contact, usually involving multiple attempts, and then establish trust. The proactive contacting of women by partner contact workers contrasts with DFV frontline services that are responding to women's reports and requests for service. As part of the partner contact process, workers find out about women's experiences and work with facilitators from the men's groups, all of which requires a high level of competency and trust to function effectively and consistently. It is through this process that they can best promote women's safety along with providing support not previously in place.

Findings from the worker survey and interviews suggest that, in addition to skilled staff, to be effective partner contact work needs resourcing in ways that reflect both the difficulty of contacting women and their continued need for support beyond their (ex-)partners' attendance at MBCPs. Without this understanding, and without enabling workers to continue trying to make contact, women and children will remain isolated and at risk. To link women's access to partner contact and support based on perpetrators' engagement with the MBCP is unethical. It also further places the perpetrator in a position of control, as his (ex-)partner's access to partner contact is subject to his service use. This has been recognised in both the international research and the experiences of participants in this current study.

Inconsistencies in what is offered to victims/survivors

The literature highlighted how variable and inconsistent partner contact responses are for victims/survivors, ranging from reports of them making the situation worse (Opitz 2014) to finding them highly valuable, regardless of whether or not the men's program made any difference to a perpetrator's actions and risk (Ormston et al., 2016). In recognising this, policy makers and advocates have produced practice standards that aim to promote safety planning and perpetrator accountability, and reduce revictimisation.

However, the major, overarching finding of this research concerns the marked inconsistencies across partner contact

practice and services that occurred in the following ways:

- It is clear that services differ in their capacity to respond to victim/survivor needs.
- The variation in services is considerable, from the capacity to provide a relatively small number of telephone-only contacts that are tied to the perpetrator's participation in the program, to the inclusion of face-to-face support over a longer time period.
- Due to capacity constraints, in many situations the provision of partner support remains secondary in prioritisation and resourcing to the work with the men.

These capacity constraints have a range of implications for partner contact practice. Firstly, it is widely recognised that face-to-face men's behaviour change work with perpetrators is likely to be much more effective than attempting this work using the telephone as the sole medium. Yet capacity constraints relegate partner contact to phone-based work in the majority of contexts, with little attention given to the substantial compromises in practice and service effectiveness that are likely to result. To name one such compromise, the predominant reliance on phone-based contact can restrain the depth and comprehensiveness of risk assessments with victims/survivors, and may result in these assessments being conducted in a more rushed and "tick-box" format.

A second compromise, which to some degree reflects varying levels of capacity constraints, is the variation in the extent to which partner support is offered as an independent service in its own right, not one tied to the participation of an (ex-) partner in an MBCP. For example, some partner contact services initiate and offer ongoing support to victims/survivors even if perpetrators do not proceed beyond the intake and assessment process for an MBCP. Some partner contact services continue to provide support for months after a perpetrator has completed the program, while for others partner support ceases at, or soon after, this point.

This variation appears to be associated both with capacity constraints as well as with a third major inconsistency: the underlying purpose and objectives of partner contact. Our research found strong consistency among partner contact services concerning some objectives of the role, such as

supporting women's safety. However, services differ in the extent to which they "conceptualise" partner contact: this can be as a multi-faceted service addressing a range of victim/survivor needs related to the impact of the perpetrator's violence on her and her children, versus a much narrower series of "contacts" to check on her safety and to learn about the changes the perpetrator might or might not be making through the program. How the broader organisation, within which partner contact sits, conceptualises its role can potentially have as much influence as funding constraints on what it is ultimately able to provide.

A fourth inconsistency, as per the wider DFV field, is the significant variability of the practice frameworks that underlie partner contact practice. Our research did not explore these practice frameworks in depth. However, the practitioner interviews revealed several differences, for example, between the practice of educating victims/survivors about DFV compared to following their lead—recognising that they already engage in acts of resistance against the violence—and providing them with the support they require (DVSM, 2018). Our research indicates that these practice frameworks are rarely articulated or discussed in the field, an unsurprising outcome given the lack of specialised training and reflective practice opportunities targeted specifically at the partner contact role.

Fifth, the degree of collaboration between men's and women's practitioners, including what information they share and under what circumstances, differs markedly in the field. In some situations, partner contact workers and men's practitioners—even if working within the same organisation—share relatively little information with each other due to organisational or program policies and procedures. In others, the potential exists for strong collaboration between these workers, but is inconsistently realised. Some partner contact workers expressed frustration at their work being underprioritised, and inherently valued less, in relation to the work done with the men, thereby affecting the degree of collaboration.

Sixth, partner contact services differ substantially in the extent to which they can focus on children's needs arising from the impact of DFV. A small proportion of MBCPs are associated with a partner support service, which also has the capacity to conduct direct contact with children under some circumstances. Others might be part of organisations that run relevant children's counselling or child-focused support services in other program areas, to which child victims/survivors can be referred. Potentially at least, collaboration can occur between women's, children's and men's practitioners across program areas within these organisations. In a large proportion of partner contact service provision contexts, however, neither of these options are available. This contrasts with a clear finding from the victim/survivor interviews concerning their wish for partner contact to be associated with the offer of direct support for their children through a counsellor or child contact service.

There also appears to be little formal assessment of the impacts of a perpetrator's violence on children's safety, wellbeing and development, even in terms of conducting such assessments based on the parents'—particularly the mother's—reports. This finding is consistent with a recent large survey of specialist DFV practitioners in Victoria that demonstrated a major gap between the stated importance of conducting formalised assessments of the impacts of perpetrator violence and patterns of coercive control on each individual child, and actual practices to this effect (Fitz-Gibbon et al., 2019). The authors located only two available tools (developed in Victoria and Ireland respectively) designed to support practitioners to conduct such risk assessments with children in DFV contexts.

These and other inconsistencies, revealed through the practitioner survey and interviews, were reflected in our study's accounts of women's experiences of partner contact. Consistent with previous Australian studies (Opitz, 2014; Smith, 2013), women reported a wide range of experiences of partner contact. For a large proportion, partner contact was either not offered or was insufficient to meet their needs and those of their children. This contrasted with the experience of the minority of women in our study, who highly valued and appreciated the support they received. These experiences affirmed previous Australian research that found partner contact, when it is sufficiently resourced, can make an important difference to women's lived experience and their journeys/struggles towards freedom from coercive control (Howard & Wright, 2008). Indeed, some of the strengths the

women in our study associated with the proactive approach of partner contact were connecting isolated women to support, as well as validating their experience when they had previously not been believed. For some women, partner contact opened up options for having a safe and violence-free future.

Research on the Scottish Caledonian system (Ormston et al., 2016) and the New Zealand Te Manawa Service (Denne et al., 2013) shows that suitably resourced partner contact that sits within a strong and established integrated response can provide important outcomes for adult and child victims/survivors. However, the question of scale and governance also needs consideration to enable a strong response.

The importance of service context

There is a dearth of published literature about the complex contexts of families and individuals experiencing DFV, and how this impacts the ways in which both perpetrators and victims/survivors will find an MBCP and partner contact response useful. However, the findings from this study indicate that the context and circumstances in which DFV is occurring are highly influential to partner contact practice. For example, living in a remote location requires a different partner contact response to the city: it may be there are no services and the worker is the only support; a lack of anonymity creates a risk for the victim/survivor; and the geographical isolation of the area itself may be a risk factor for revictimisation (Smith, 2013). Given the limited capacity of many partner contact services, they have to tailor their responses to the circumstances in which they operate and to their own service limits. This is not unique to partner contact practice, but it is a constant theme in the work.

The literature review pointed to how influential the DFV system of service responses, within which the MBCPs and partner contact sit, is to safety outcomes (Kelly & Westmarland, 2015; Ormston et al., 2016; Smith et al., 2013). This was corroborated by the findings of our study, which indicated the importance of the broader constellation of services to victims/survivors within the local area or region to partner contact impact. The study's multiple research streams point to the need for some (ex-)partners of men in MBCPs to be

offered longer term support that is more intense than what can currently be provided by many partner contact services. For some victims/survivors, this includes the need for a case management response. However, when neither partner contact services, nor specialist local/regional women's and other victim/survivor services, have the capacity to provide support of this kind, crucial needs can remain unmet. As our research points to the importance of partner contact support being a service for victims/survivors that is not tied to perpetrators' participation in an MBCP, there is an onus for partner contact work to be funded sufficiently to enable intense responses when no other local option exists.

The literature about the organisation of partner contact was somewhat divided. Some advocated for partner contact to be delivered by a women's service independent of the MBCP (Grant & Mitchell 2010; WWP-EN, 2019), while others had a preference for it being delivered by the same organisation running the MBCP (Department for Child Protection and Family Support, 2015). Across Australian sites, the organisational contexts for the delivery of partner contact varied substantially, not aligning to either end of this continuum. When partner contact was delivered by a specialist women's DFV service provider—either via arrangement with a separate agency running the MBCP intervention or because the MBCP is delivered by the specialist women's service provider itself—this represents quite a different service provision context than when a large, multi-faceted agency is in charge of delivery. In the former contexts, the partner contact provider is likely to have a tradition of delivering services to women in their own right—that is, not tied to the perpetrator's participation in a program. The range of other services provided by the agency can also be highly influential, for example, when intraorganisational referrals to specialist children's services are available with the potential for information sharing and collaboration across women's, men's and children's workers.

Service provision reflecting broader gender inequality

Scholars and gender-based activists have previously reported on how the introduction of male practitioners

and allies into the violence prevention and response field can reflect broader societal patterns of male privilege and power disparities (Apps & Gregory, 2011; Castelino, 2014; Macomber, 2015; Vlais, 2013). These include the benefits and prioritisation that men's practitioners can attract from entering into this space, and how the voices of women's practitioners and women-centred services can be marginalised and silenced through the process. Castelino (2014), for example, argues that we cannot assume a "level playing field" when men's services are introduced into service systems, or that women's and men's practitioners and services will automatically relate as equals. She argues that male practitioners and men's work are likely to benefit from being elevated in ways that are not available to their women colleagues, and consequently likely to be less accountable.

It could be argued that broader patriarchal processes play out in the provision of women's and men's DFV services. An area where this is evident is in the superior level of resourcing for interventions with men compared to that provided for programs working directly with adult and child victims/survivors when the perpetrator is attending the MBCP. In this way partner contact can be seen as a secondary service that supports "the main game" of delivering a program to the men.

Alternatively, the direct work with male perpetrators could be an important contributor to an existing service system that helps to support the goals of victim/survivor safety and accountability. In essence, this is the difference between partner contact work merely providing a "check in" on partner safety and on how the men are behaving at home, versus the concept of men's behaviour change interventions being implemented in a flexible manner based on the needs of women and children as reported by victim/survivor-centred services (Vlais et al., 2017). These two competing visions contrast the need for partner contact as a secondary support service to driving men's behaviour change interventions, and the perpetrator interventions themselves contributing towards and providing support for victim/survivor-centred services.

The findings from this study demonstrate that, in most situations, partner contact work is clearly positioned as secondary to MBCP interventions with men. This relative positioning of men's and women's work is influenced by a range of factors, but broadly reflects disparities in which of the two is more highly valued, and in accountability within and across DFV service teams. The irony of the parallel political processes involved in these disparities was not lost on several of the partner contact workers we surveyed and interviewed.

Perpetrator use of program participation as a weapon

Confirming the findings of Opitz (2014) and Westmarland and Kelly (2013), this study found that victims/survivors reported shifts in the way that perpetrators undertaking MBCPs were abusive and controlling. Important insights from the women highlighted how some experienced changing forms of abuse when their (ex-)partner attended an MBCP, such as the perpetrator moving to greater verbal abuse or controlling actions like verbally and emotionally shutting out the female partner. Others used their participation in the program as a weapon against their (ex-)partner, blaming her for having to attend an MBCP due to his own violent behaviour attracting police attention and his subsequent referral to a program.

Indeed, while some women described perpetrator changes in attitudes and behaviour that were positive, others reported that their (ex-)partner became more controlling and violent while in the program or that no difference was made to his behaviour in either direction. This finding corroborates previous research showing how perpetrators can use their participation in an MBCP to further control and entrap their (ex-)partner in a variety of ways (Opitz, 2014). This has important implications for the provision of partner contact, such as the need for vigilance by partner contact workers in proactively assessing for indicators that the perpetrator's participation in the program is being used against their (ex-)partner.

Although not the focus of this study, the women's survey data corroborate previous research about the inaccuracy of recidivism as an indicator of MBCP success (Vlais &

Green, 2018). Women living with perpetrators who change their forms and patterns of abuse, or increase their violence as they blame the victim/survivor for having to attend an MBCP, will not be captured in records of recidivism as these changes are often subtle and not reported.

It is not the purpose of this study to provide reflections on the efficacy of MBCP work; the number of women involved was small (n=18) and does not reflect a representative sample. However, given that the majority of the women's (ex-)partners had participated in at least one MBCP previously, it does suggest that many perpetrators have long-term, entrenched behaviours that can be difficult to change.

Further considerations

In future research, further consideration could be given to information sharing between partner contact workers and MBCP facilitators, with particular attention paid to the practices of seeking consent from (ex-)partners to share information they disclose via partner contact. Although this aspect of partner contact practice was beyond the capacity of our research, it is an area of practice that would be beneficial to document as it is quite specific to DFV. As highlighted previously, what is considered relevant and acceptable to share varies significantly between different organisations and services.

Additional issues are how consent is sought from the victim/survivor, and what types of information are shared with the men's practitioners and under what circumstances. While state- and territory-based, DFV-specific laws provide guidance on information sharing between agencies, including on when the client's consent is required, there are additional complexities involved when information is shared between different members (i.e. partner contact and group work facilitators) within the same, often small, team, and where team members are likely to share client database and case file systems and possibly sit within the same room. However, the findings generated from this project do provide new information about the detailed work of partner contact and important considerations for the future.

Conclusion

This research has highlighted the varying practices of partner contact, some inherent ethical dilemmas and tensions associated with women's and children's safety in this work, and the difference it can make to women's lives. Both the literature and the research strongly show how MBCPs are not organised in ways to include those workers who engage with children and young people about how they experience their father attending an MBCP. This is beginning to be recognised as an area for service development and there are moves being made in this direction. However, careful consideration must be given to developing this area, as it cannot just be a copy and paste of adult victim/survivor partner contact work for a different target group. It requires further deliberation both of how it might look in the future and of complicating factors such as whether children and young people from perpetrators' previous relationships would be part of the service response.

Little attention has been given in the literature or in current practice in Australia to the provision of partner contact for particular cohorts of victims/survivors. For example, how partner contact sits within the context of holistic work with (extended) families in the context of Aboriginal and Torres Strait Islander family violence services is yet to be explored. However, much can be learnt about this from the recent inclusion of family support workers associated with perpetrator interventions led by Aboriginal community-controlled organisations such as Kornar Winmil Yunti (South Australia) and Dardi Munwurro (Victoria).

Similarly, little consideration of the specificities of partner contact in relation to women with disability and LGBTQIA+ victims/survivors of DFV were found either in the literature or in the responses of practitioners to the survey or interviews, with practically no mention of either group. It is important that DFV programs for perpetrators are developed to include supportive and safe partner contact responses. We hope that this research can stimulate discussion about where to go next in establishing safe and responsive partner contact practices for all cohorts of victims/survivors.

This project has focused on sharing the state of knowledge about partner contact, and undertaking primary research to

document the practice in Australia, and report on women's experiences of it. To date, partner contact has received less research attention than other DFV service responses to women and children, despite the literature pointing to its importance in connecting victims/survivors to safe and supportive responses. The findings of our research confirm those of previous work, that many victims/survivors were not connected to services when partner contact commenced.

Partner contact is often still an adjunct to the men's group work of MBCPs, which is reflected in its usually limited resourcing. However, when able to be resourced with capable workers, partner contact makes a large and important difference to victims'/survivors' lives by providing a judgement-free space where they feel heard, respected and able to move forward with their lives. Unfortunately, current research suggests that partner contact practice is still highly variable and so remains somewhat of a service provider lottery for women and their children.

The invisibility of children in partner contact practice research, practice documentation and the research findings from this study is an important area that requires development. The way in which MBCPs address the impact of a perpetrator's behaviour on a woman's parenting, and how this operates in the context of children's needs and safety, is also an area of future focus.

In Australia, partner contact is provided both within organisations that deliver MBCPs and by organisations external to the MBCP provider. In this study, practitioner participants identified pros and cons for each approach, however, the key aspect for success seems to be that partner contact workers are independent in their assessment, support and advocacy for victims/survivors. What seems to matter most is the resource commitment and time allocated to partner contact as a program component of an MBCP, and that the victim/survivor has continuing access to partner contact and support regardless of whether or not the perpetrator is attending the MBCP.

MBCPs, and the perpetrator intervention system more broadly, have largely been built on a number of assumptions, including:

- perpetrators and victims/survivors usually speak and read English
- heterosexual coupledom is the primary site of DFV
- women victims/survivors have to be willing to separate from their male partner and keep their children safe in their care
- adults experiencing DFV are able-bodied and not reliant on others to undertake daily activities
- victims/survivors have access to services where they live
- service system parts can be accessed to respond to the array of issues that follow separation, such as housing, access to money and food, transport and so on.

When such assumptions are then embedded in DFV policies and programs, individuals and communities outside of these "categories" experiencing DFV may be overlooked, have their experiences minimised, and be ineligible or unable to access supports that are relevant to them. Consequently, policy intentions, such as women and children having a right to safety, might not be able to be realised.

In relation to the implications for partner contact practice, some workers had very little to no contact with individuals outside of the categories described above. Other workers did at least include an interpreter in their existing response, although they did not view this as an adequate response. Some participants even described partner contact as not being a viable option for some individuals and communities. Those living in regional and remote areas spoke of the lack of service options for referrals, the problem of ensuring anonymity and the likelihood of knowing the partner contact workers, all of which led to a heightened threat to safety. An overarching finding was that providing partner contact that is relevant to victims'/survivors' experiences and needs cannot be done without the DFV responses to perpetrators also being more able to respond to the intersectionality of people's lives.

This research project provides new evidence about the state of partner contact in Australia and internationally, and poses some challenges in moving forward to promote the safety of women and children, reduce revictimisation and increase perpetrator visibility and accountability. Several recommendations are presented in the ensuing final section of this report to make a contribution towards these goals.

CHAPTER 7

Recommendations

Findings from this research project give rise to a number of recommendations to improve the quality and consistency of support provided to women and children by current and future MBCPs and perpetrator interventions more broadly. In particular, while there will always be differences in partner contact practice as a result of local contextual and service provision variables, our findings indicate that the marked degree of inconsistency between jurisdictions and geographical areas needs to be addressed at a national level.

These recommendations accompany a recently published, broader set of recommendations that focus on improving program quality and outcomes in men's behaviour change programs, arising from a research study in which partner contact was recognised as a priority area of work (Day et al., 2019).

POLICY, PROGRAM AND RESEARCH

1. *Develop national minimum practice standards for partner support as a component of MBCPs and other perpetrator intervention programs so as to provide safe and supportive responses to victims/survivors, and to complement existing jurisdiction-based MBCP minimum standards.*

Existing jurisdiction-based minimum standards for MBCPs have not resulted in consistency and quality in partner contact practice. This might in part be due to problems arising with program provider adherence to minimum standards and the lack of compliance monitoring systems. However, it is not possible to determine the extent to which it is the existing MBCP minimum standards relating to partner contact, or the lack of awareness or adherence to them, which is producing great disparities in partner contact practice.

This study contributes to the evidence for minimum partner contact practice standards, evidence that was not available to inform prior or even recent updates in MBCP minimum standards (such as those in New South Wales, Victoria and South Australia). Rather than waiting for this evidence to inform the next iteration of these and other jurisdictional minimum standards—which is not likely for several years, given the finding of Day et al. (2019) that the average gap between standards updates within Australian jurisdictions

is approximately 11 years—this issue needs to be addressed in the near future and at a national level.

Similar to the recommendations identified by Day et al. (2019), these minimum partner contact practice standards should be based on sufficiently detailed, articulated and nuanced practice principles rather than practice prescriptions. Although minimum practice standards are recommended to promote consistency, optimal partner contact practice should also be delineated.

Recognition that equal priority in formulating these standards should be given to working with partners relative to working with perpetrators is essential. These standards must also be based on the underlying ethic that partner contact practice should be victim/survivor-centred rather than perpetrator-centric, and should not be tied to a perpetrator's participation in the program.

2. *Consider changing the appropriateness of the terminology, in the proposed national practice standards and elsewhere, from "partner contact" to a description that more accurately reflects the support provided to adult and child victims/survivors and the form of accountability it can provide to MBCPs.*

The term "partner contact" does not reflect the often multi-faceted and complex nature of the work (i.e., it involves more than "contact"), nor the reality that DFV usually involves a multiplicity of victims/survivors, including children. Indeed, phrasing this work as "contact" inherently frames it to be of secondary importance to the "program" work with the men.

The term used for this work varies between and within jurisdictions; this recommendation is not about replacing this diversity with a single, nationally agreed-upon term. As such, our research continues to use the term "partner contact" so as not to privilege any single preferred term. Rather, we recommend that the terms employed attempt, where possible, to avoid both the use of the term "contact" and referring exclusively to adult intimate partners. Possible job titles include "victim/survivor safety and support advocate" as these terms emphasise the intended outcomes of the practice.

3. *Develop a communications strategy among Commonwealth, state and territory governments to promote the partner contact minimum practice standards, so they are accessible and seen as relevant both to workers and to their counterparts delivering perpetrator interventions.*

Our findings demonstrated a relatively low awareness among practitioners of existing MBCP minimum standards relating to partner contact. The importance of a communications strategy in relation to national partner contact practice standards cannot, therefore, be underestimated.

4. *Incorporate program evaluations of MBCPs as a dedicated evaluation stream that specifically focuses on the partner contact component of the program, including data obtained from victims/survivors about their experiences of partner contact and the impact it has (or has not) made.*

Our literature review struggled to find any evaluation of MBCPs using quantitative methodologies that included a significant evaluation component focusing on the partner contact process—at least in peer-reviewed journals. Even at a local level, small-scale MBCP evaluation activity needs to include a focus on victim/survivor experiences of the partner contact process.

5. *Instigate operational and ongoing (internal) reviews of MBCPs and more formal process evaluations that include a strong focus on the delivery of partner contact.*

Regular operational reviews are essential to gauge a sense of program integrity and to help determine whether a program was delivered as planned. Operational reviews focus on how participants journeyed through the program (including what variables might have affected their participation), what types of program components were offered to whom and what the take-up rate was, which cohorts of participants found certain program components to be more or less accessible, and how particular program components were implemented and to what volumes. Such operational reviews should devote significant attention to partner contact components rather than focus exclusively, or even mostly, on those relating to perpetrator intervention.

FUNDING AND RESOURCING

6. *Formally recognise the national partner contact minimum practice standards within contractual arrangements and funding service agreements with MBCP providers and associated organisations, so that state and territory governments use them to promote safe and ethical service delivery to victims/survivors.*

While funding service agreements and service contracts are not an effective means of monitoring compliance with minimum standards (Day et al., 2019), their inclusion in contract documentation would assist in communicating their importance. This recommendation is innately related to the funding required for partner contact services to have the capacity to meet minimum practice standards and to deliver safe and ethical practice.

7. *Fund and resource partner contact services in ways that allow the national minimum practice standards to be met.*

The evidence from this project's multiple research methods demonstrate the need for partner contact to involve integrated, genuine, flexible and ongoing support regardless of a man's involvement in a program. The findings also suggest that the level of funding has a direct impact on who can be offered support and under what circumstances, when support can be offered and its duration, and the quality and consistency of the support provided.

It is clear that current levels of funding for MBCP work do not consistently (or even commonly) enable the core features of safe and accountable partner contact practice. For example, partner contact services need sufficient funding so that the work:

- can include in-person sessions and/or face-to-face outreach support where indicated, rather than relying entirely on the telephone as the medium of contact
- is not tied to the perpetrator's participation in the program so that it can, for example, be provided to (ex-)partners of perpetrators who do not complete comprehensive intake and therefore do not start the program, and for a significant period after perpetrators end their participation in the program

- can assess the impact of the perpetrator's tactics of coercive control on the parenting capacity of the non-perpetrating parent
- can assist in assessing the risk and impact of the perpetrator's violent and controlling behaviour individually for each affected child and their relationship with the non-perpetrating parent
- can assist in developing case plans oriented towards meeting each affected child's set of needs, and in collaborating with relevant child-focused services (provided intraorganisationally and/or by external organisations and sectors) as part of implementing these plans.

Indeed, given the findings of our research, it is questionable whether partner contact practice that is not funded to provide the above capacities would meet the minimum ethical thresholds of safe and effective practice.

8. *Resource partner contact so that victims/survivors have ongoing access to support, either from the partner contact worker or another service's practitioner, irrespective of a perpetrator's MBCP attendance.*

Eligibility for partner contact and related support services to women and children should not be linked to a perpetrator's attendance at an MBCP, as this can place victims/survivors at risk of further violence and abuse from the perpetrator. Removing partner contact and related support based on a perpetrator's eligibility is unsafe and unethical, as it can be another means by which the perpetrator has control over the victim/survivor, in this instance by being able to impact the support they receive.

ORGANISATIONAL ARRANGEMENTS

9. *Ensure that partner contact is delivered by designated workers, separate to the work with men.*

Our findings indicate the benefit of having different practitioners work with perpetrators and partners. These include prioritising and maintaining the focus of support on victim/survivor needs and safety, and mitigating the impact of practitioners occupying dual roles with the perpetrator

and victim/survivor—particularly around the safety of workers and women.

10. *Enable organisations to provide intervention components that do not prioritise perpetrators over victims/survivors.*

There are many ways in which services can attempt to correct the social bias that has allowed the work with men and/or male practitioners to be "elevated" at the expense of partner contact and women colleagues. Some examples of this include allocating resources more evenly between the two components of the program, and funding practitioners working with victims/survivors to participate in training on par with men's practitioners (who in some jurisdictions are offered free competency-based training at the Graduate Certificate level).

11. *Strengthen relationships between services where partner contact is delivered by a separate organisation to the MBCP provider.*

This can occur through both informal and formal methods, such as meetings and joint training; there is a need for management to support practitioners to develop and maintain these networks as an integral part of their work. Our findings reiterate that partner contact work is labour intensive and a cost to the organisation delivering the service, which must be specifically factored in when applying for funding.

Additionally, it is important that MBCP providers understand that for specialist women's DFV services to provide partner contact, they need to prioritise an intensity and longevity of work with particular women that they might not otherwise triage in this way, particularly when the risk might not be immediate or severe. The expectation of providing partner contact should not, of course, be "relegated" to these services. In turn, specialist women's services providing partner contact have to adapt current practice for this cohort of women, as partner contact provision has some differences and additional considerations to women's advocacy and support work undertaken outside the context of an MBCP.

TRAINING AND SUPPORT

12. *Further strengthen existing jurisdiction-specific professional networks for MBCP facilitators and partner contact workers at the local level to promote integrated and effective support.*

The work of partner contact needs to be highlighted in existing jurisdiction-based professional MBCP networks. In particular, opportunities are required for partner contact workers *across MBCP providers* to support and learn from each other through community-of-practice initiatives. Service contracting and competitive tendering have increased the levels of competitiveness between MBCP providers in recent years, which we have found has resulted in less willingness by program providers to come together and share practice. Our findings also demonstrate the need for partner contact workers across agencies to share innovations and discuss complexities through community of practice activities.

13. *Develop and implement a national training strategy that more consistently equips the partner contact workforce with the practice frameworks and skills required to adopt the national minimum partner contact practice standards.*

Given the marked inconsistencies in partner contact practice found in our research, it is vital that workforce and practice development strategies are not developed and implemented in a piecemeal, jurisdiction-specific approach. While community of practice strategies can be jurisdiction-specific (see Recommendation 11), a national approach to practice development, involving national standards and a national training approach, is required.

14. *Make quality supervision available for partner contact workers that is specific to their role.*

The findings of this study indicate that an increased level of supervision and support is needed for partner contact practitioners, as this is a highly complex area of work requiring reflective and reflexive practice. This supervision needs to be sufficiently regular, and fine-tuned towards the actual practice of partner contact.

15. *Target workforce training and development specifically to areas and locations where there is limited expertise in responding to DFV.*

Findings suggest there may be a need to develop the DFV workforce, particularly in the areas of child- and youth-centred support and culturally responsive support services, so as to understand complex family and community systems. This is particularly pertinent in regional and remote areas where there is already a limited workforce, and exploring the opportunity to partner with tertiary institutions may assist in producing a high standard of practice education. Specific strategies which then attract and retain these specialised workers in areas outside of the urban region may be necessary.

16. *Give further consideration and research to the role of child and youth contact workers, through funded innovation trials with an evaluation component.*

There is very little documented evidence or practice-based descriptions of child contact work. The small number of practice models that do exist range from child advocacy-focused approaches, such as the Children's Service of the Caledonian system, through to therapeutic individual counselling or support groups. Given our research findings on increasing MBCP prioritisation towards assessing and addressing children's needs and experiences, funded innovation trials are required to help identify promising avenues of practice.

This research project specifically addresses Recommendation 16 of Day et al. (2019), that "research to identify quality practice in partner support and safety work is urgently needed" (p. 9). The other six recommendations explicitly proposed by Day et al. (2019) in relation to MBCP partner support are also supported by this research project, and are as follows:

- Recommendation 8: Safety and accountability planning should be prioritised in sector and practice development efforts as a potentially high-impact way to improve the quality and effectiveness of MBCP provision.

- Recommendation 10: A national MBCP outcomes framework should be developed to engender some consistency in evaluation frameworks and evaluation activity, and to help build the evidence base.

- Recommendation 12: Australian jurisdictions should consider shared work to develop the equivalent of the European Project Impact outcome evaluation tools and researcher–practitioner partnerships.

- Recommendation 13: A suite of outcome evaluation tools should include victim-centred measures that focus on exposure to coercive control.

- Recommendation 14: Evaluation plans should include measures of impacts on adult and child victims/survivors that do not rely on changes in the perpetrator's behaviour.

- Recommendation 17: Partner support and safety work needs to be properly funded and prioritised, rather than remaining secondary relative to resources allocated to engaging perpetrators (Day et al., 2019, pp. 8–9).

In summary, this project documented a wide range of partner contact practices currently being implemented across Australia. The findings show that practices vary considerably and tend to be driven by funding arrangements and historical ways of working following the widespread introduction of MBCPs across jurisdictions. The organisation and funding of partner contact services to date has not enabled them to grow and develop or to offer specialised responses that take account of the intersecting and wide-ranging needs of the victims/survivors. However, this is also largely the case with the group work component of MBCPs only just beginning to move beyond heterosexual English-speaking men as the primary target group.

Practitioners have provided details of the benefits of partner contact, as well as what is required for these services to operate more comprehensively as they currently face considerable challenges. Women whose partners or ex-partners attended MBCPs have also provided accounts of their experiences and suggested important improvements in the organisation of MBCPs generally and partner contact specifically. Although

children and young people have generally not been included in such arrangements, workers have provided referrals to mothers for their children to access services in some situations.

In moving forward, this research project, along with other ANROWS perpetrator projects, provides clear strategies for future developments that can ensure greater visibility over perpetrators' actions, and enhance safety, support and accountability for victims/survivors from a wide range of circumstances.

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Practitioner's survey

Q1.

Project Title:	**Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact**
HREC Project Number:	**HRE2018-0173**
Principal Investigator:	**Professor Donna Chung, Head of Social Work (Curtin University)**
Research Partners:	**Mr Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant)**

Thank you for considering participating in this research project. The information following is provided to let you know more about the project, what your participation would require, how data is protected and the confidentiality considerations that will be made. It should not take long to read. If you agree to participate, tick the box to indicate you have read and understand what the project involves. Participation is voluntary, it is your choice to take part or not.

What is the project about?

The purpose of this research is to understand how Men's Behaviour Change Programs (MBCPs) support women and children through their partner contact practice. The project will contribute to improving MBCPs, identifying quality practices and processes for partner contact to develop future practice, training, and minimum standards.

This practitioner survey is part of a larger national study where we are also seeking women's experiences of partner contact support. MBCP practitioners and partner contact workers around Australia are being asked to participate in an anonymous, on-line survey, some of whom will also be approached to participate in a face-to-face interview. Women receiving support from a MBCP are also being invited to complete an anonymous, on-line survey about their experiences.

Who is doing the research?

The project is being carried out by Professor Donna Chung (Curtin University) in conjunction with industry partners Mr Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant). The project is funded by the Australian National Organisation for Women's Safety (ANROWS).

What will I need to do?

If you choose to participate, you will need to complete an anonymous, on-line survey which is estimated to take up to 30 minutes. Aside from your time, there will be no cost to you for taking part and you will not be paid for taking part.

Q2.
Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

Given the sensitive nature of family and domestic violence, there is potential for participants to experience some level of discomfort or distress. If this is the case for you, you may contact Donna Chung, Principal Researcher for the project and

experienced social worker on (08) 9266 3340 or via d.chung@curtin.edu.au or your Manager who can take steps to support you.

Alternatively, the following support services are available for you to contact:

- 1800 RESPECT (1800 737 732), the 24 hour national Sexual Assault, Family and Domestic Violence Counselling Line; or
- Lifeline on 13 11 14 or their Crisis Support Chat Service at www.lifeline.org.au/crisischat (7pm to 4am AEST, 7 days a week).

To download these details to keep as a reference, please click here .

Who will have access to my information?

The information collected in this research will be non-identifiable (anonymous). This means that we will not be collecting individual names. No one, not even the research team, will be able to identify your information. Any information we collect and use during the research will be treated as confidential. Only the research team and the Curtin University Human Research Ethics Committee will have access to the data. Electronic data will be password protected. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the research has ended and then will be destroyed. The results of this research may be presented at conferences or published in professional journals. As the information collected from you is anonymous, you will not be identified in any results that are published or presented.

Will you tell me the results of the research?

We will not be able to send you any results as we will not be collecting any personal contact details that will allow us to contact you.

Who can I contact about further information about the project?

Further information about the project can be obtained by contacting Professor Donna Chung, Principal Researcher on (08) 9266 3340 or via email d.chung@curtin.edu.au. Alternatively, Ms Sarah Anderson, Research Assistant for the project can be contacted on (08) 9266 5196 or via email sarah.anderson@curtin.edu.au. To download these details to keep as a reference, please click here.

Curtin University Human Research Ethics Committee (HREC) has approved this study (approval number HRE2018-0173). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08)9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Survey Information and Instructions

Q3.
Survey Information and Instructions

This survey may take up until 30 minutes to complete. If you are not able to finish the survey in one sitting it will automatically save your progress, provided you use the same internet browser on the same computer. You can re-enter the survey through clicking on the survey link again. The survey will be open for 4 weeks.

We will not be asking or recording any identifying information. This means, however, that if you start the survey and decide you no longer wish to participate, you will need to go back and delete your responses prior to closing the web browser. Any responses left in the survey may be included in the research. Withdrawal carries no negative implications (current or future) and will not affect your employment in any way.

The survey is a mix of multiple choice and open ended questions. The questions will ask you about the organisation you work with along with the services and support provided to women and children. There will be space for you to share your thoughts and experiences in your own words. The information you provide will be non-identifiable and only the research team will have access to the data. Please only share what you feel comfortable sharing. You can choose to complete or not complete any question.

On completion of the survey, your answers will be automatically submitted. You are able to change your responses up until you press on the arrow on the final page. We will tell you when you have reached this point.

The information you give to us will be analysed by the research team in conjunction with information provided by women receiving support as a way of developing a comprehensive understanding of partner contact practice and identifying areas working well as well as those needing improvement.

Consent to Participate

Q4.
Consent to Participate

I have read the information regarding this research. I believe I understand the purpose, extent and possible risks of my involvement in this project and voluntarily consent to take part. I understand that I may withdraw from the research project and to do so, I will need to delete any information I have entered prior to closing the web browser. Participation, or not, will not affect my employment in any way.

I understand that this project has been approved by the Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).

○ I agree with the above statement and wish to take part in the project

○ I do not agree with the above statement and do not wish to take part in the project

Organisational context

Q5. **In which state or territory do you currently work?**

○ Australian Capital Territory

○ New South Wales

○ Northern Territory

○ Queensland

○ South Australia

○ Tasmania

○ Victoria

○ Western Australia

Q6. **In what suburb/town do you usually work?**

[   ]

Q170. **What is the postcode of the area you usually work in?**

[   ]

Q7. **What would best describe the area you work in?**

○ a capital or large city

○ a regional city and its immediate surrounds

○ a rural or remote community

Q8. **Which of the following best describes your current role? If you work in more than one role, please only tick your main role.**

○ Partner contact worker employed by an MBCP provider

○ Partner contact worker employed by another agency that provides partner contact work for the MBCP provider

○ MBCP facilitator or practitioner

○ MBCP facilitator and partner contact worker

○ MBCP coordinator or team leader

○ Senior Manager

○ CEO

○ Other (please specify)

[   ]

Q9. **Does the service you work with arrange:**

○ A MBCP program with no formal partner contact service

○ Partner contact provided by MBCP group work facilitators

○ Partner contact provided by workers within my agency

○ Partner contact provided by an external agency

Q10. **Is your employer run by:**

○ a government agency or statutory authority

○ a non-government organisation (such as a charity or other not-for-profit or community based organisation)

○ a for-profit organisation (i.e. a private company)

○ Other (please specify)

[   ]

Q11. **Which groups of perpetrators are included in the MBCP. Please select all that apply.**

☐ Male perpetrators in heterosexual relationships

☐ Gay and bisexual men

☐ Trans-masculine, inter-sex and queer identified men

☐ Women perpetrators

☐ Adolescents who use relationship violence against family members

☐ Adolescents who use dating violence

Q12. **Are there any (other) organisations that provide specialist women's domestic violence services in your locality/geographical area?**

○ Yes

○ No

Q13. **Does the MBCP provider you work with have any formal, written agreements, policies or protocols with any specialist women's domestic violence service providers?**

○ Yes

○ No

○ Unsure

Q14. **Very briefly, what do these policies or protocols cover?**

Q15. **Under what circumstances does the MBCP provider and specialist women's domestic violence service providers exchange information about clients?**

Q16. **Do practitioners from specialist women's domestic violence service providers observe MBCPs?**

○ Never

○ Rarely (at most once per year)

○ Sometimes (two or three time per year)

○ Regularly (at least every two months)

Q17. **Please outline anything else about the links the MBCP you work with has with specialist women's domestic violence service providers in your area.**

Q18. **Does your agency receive specific funding to conduct partner contact?**

○ Yes

○ No

○ Not sure

Q19. **Does another organisation linked to the MBCP receive funding to conduct partner contact?**

○ Yes

○ No

○ Unsure

Services and supports offered to women and children

Q20. **Does your employer offer or arrange a support service to female partners or ex-partners of men attending a MBCP?**

○ Yes

○ No

Q21. **Who provides this service?**

○ a dedicated partner contact worker who has no contact with perpetrators in the MBCP

○ a partner contact worker who has contact with perpetrators in the MBCP, but not perpetrators who are current or former partners of the women that the worker provides support for

○ a partner contact worker who also has contact with the current or former partners of the women that the partner contact worker provides support for

○ Unsure

Q22. **Please feel free to provide any clarifying information in relation to this.**

Q23. **The following questions relate to the MBCP that your agency runs or provides partner contact for:**

Q24. **In a recent typical year, how many perpetrators do you estimate would be assessed as eligible and suitable, who would at least commence the MBCP?**

Q25. **Does the MBCP routinely require the collection of information and contact details of female partners or ex-partners from the perpetrator?**

○ Yes

○ No

○ Unsure

Q26. **If a MBCP participant refuses (or is unable) to provide partner contact information, what happens?**

Q27. **For court ordered and other mandated referrals, are you able to obtain the partner's or ex-partner's contact details from the referrer:**

○ Often

○ Sometimes

○ Never

Q28. **How is information from partner contact used by facilitators in the MBCP?**

Q29. **Of the men attending the MBCP over the last six months, what percentage do you estimate your agency *offered* partner contact to a current, former, or new partner (regardless of whether it was accepted or not)?**

○ 80 to 100%

○ 60 to 80%

○ 40 to 60%

○ 20 to 40%

○ 0 to 20%

Q30. **Over the past six months, what proportion of partners or ex-partners who were offered partner contact support do you estimate have taken up the offer?**

○ 80 to 100%

○ 60 to 80%

○ 40 to 60%

○ 20 to 40%

○ 0 to 20%

Q31. **What is the typical process used to offer partner contact support to new or current partners?**

☐ Letter, inviting woman to participate

☐ Letter, with follow up telephone call offering partner contact support to a woman

☐ Telephone call, offering woman with partner contact support

☐ Email, inviting woman to participate

☐ Email, with follow up telephone call offering woman with partner contact support

☐ I am not sure what the process is

☐ Another process is used. Please outline

Q32. **Is a different process used to offer partner contact to former partners?**

○ Yes

○ No

○ Unsure

Q33. **Can you briefly outline the difference in the process used?**

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Q34. **Could you describe any eligibility criteria for a former partner to be offered partner contact?**

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Q35. **When a perpetrator has contact with the children of a former partner who he has not been in a relationship with for some years, is partner contact offered to that former partner:**

○ Routinely

○ Sometimes, but not routinely

○ Rarely

○ Never

○ Unsure

Q36. **When a perpetrator is in a current relationship and was also in a previous relationship that recently separated, partner contact is offered *to both* his current and former partner:**

○ Routinely

○ Sometimes, but not routinely

○ Rarely

○ Never

○ Unsure

Q37. Over the past six months, how often has the partner contact service provided partners or ex-partners with referrals to the following services, whether these services are provided by an external agency or your own:

	Frequency				
	Never	Infrequently (in less than 10% of cases)	10-25% of cases	25-50% of cases	Over half of cases
Legal services	○	○	○	○	○
Financial counselling services	○	○	○	○	○
Housing and homelessness services	○	○	○	○	○
Counselling services	○	○	○	○	○
Support groups for women partners	○	○	○	○	○
Services from specialist women's domestic violence agency	○	○	○	○	○
Family support services	○	○	○	○	○
Child-focused services	○	○	○	○	○
Parenting programs	○	○	○	○	○
Alcohol and other drug services	○	○	○	○	○
Mental health services	○	○	○	○	○

Q40. The following are some of the potential areas of focus for partner contact work. Please rank these from highest to lowest priorities in this work, as you see it:

	1	2	3	4	5	6	7	8
Supporting women to address their practical needs arising from the perpetrator's use of violence	○	○	○	○	○	○	○	○
Noticing and validating women's sense of agency and resistance to the violence	○	○	○	○	○	○	○	○
Conducting formalised risk assessments	○	○	○	○	○	○	○	○
Safety planning and risk management	○	○	○	○	○	○	○	○
Obtaining the partner's perspective about the man's behaviour at home, to help evaluate the man's progress through the program	○	○	○	○	○	○	○	○
Counselling to support the partner's healing and recovery	○	○	○	○	○	○	○	○
Assessing the impact of the perpetrator's behaviour on children and the risks to their safety, development and well-being	○	○	○	○	○	○	○	○
Restoring the partner's confidence as a parent and her bond/relationship with her children	○	○	○	○	○	○	○	○

Q41. Do you consider partner contact work to be different from other specialist work with victim-survivors of domestic violence?

○ Yes

○ No

○ Unsure

Q42. **In what way do you think partner contact work is similar and/or different from other specialist work?**

[blank text box]

Q43. A range of practical and logistical issues can delay the commencement of partner contact beyond what would be ideal. However, in terms of your agency's policy, the intention is to commence partner contact:

○ As soon as possible after the perpetrator has been booked in for his first assessment session (when partner contact details are already available via the referrer or through an initial phone-based intake call with the perpetrator)

○ As soon as possible after the perpetrator has completed his first assessment session

○ As soon as possible after the perpetrator has completed the initial 1:1 assessment phase, and ideally before he's commenced the group-work component of the program

○ As soon as possible after the perpetrator has commenced the group-work component of the program

○ Contact as needed only (e.g. for risk or safety issues)

○ My agency does not provide partner contact

○ I am not sure what my agency's policy is around this

Q44. Please choose which of the following best describes the means through which partner contact typically occurs:

○ All partner contact is phone-based, no face-to-face contact is provided aside from exceptional circumstances

○ With most partners, partner contact is entirely phone based, however a minority of partners are offered a combination of phone-based and face-to-face contact

○ Most partners are offered a combination of mostly phone-based contact with occasional face-to-face sessions (if the partner would like this)

○ Most partners are offered a relatively equal mix between phone-based and face-to-face contact

○ Most partner contact is done face-to-face

Q45. Does the partner contact service offer partners an opportunity to participate in a partners' group session?

○ Yes

○ No

○ Unsure

Q46.
Is partner contact offered:

| | Regularity | | | |
| | Sometimes, | | | |
	Routinely	but not routinely	Rarely	Never
When a perpetrator commences but does not complete the initial comprehensive assessment phase	○	○	○	○
When a perpetrator completes the comprehensive assessment but does not continue with the program	○	○	○	○
When a perpetrator is assessed as eligible and suitable for the program and is on a wait-list to commence	○	○	○	○
When a perpetrator is assessed as unsuitable	○	○	○	○
For a period of time after a perpetrator has completed all requirements of the program	○	○	○	○

Q47. **When a perpetrator has dropped out of the program or has been exited before completing all program requirements, does the agency generally:**

○ Stop offering partner contact because the man is no longer in the program

○ Continue to offer partner contact for a short period (e.g. over the next fortnight)

○ Offer partner contact at an increased frequency for at least a few weeks

○ Continue to offer partner contact in a way not described above. Please describe

[   ]

Q48. **In your view, how sufficient is the agency's current partner contact practices towards providing a high quality service to all that need it?**

○ Quite sufficient

○ Somewhat sufficient

○ Not very sufficient

○ Quite insufficient

Q49. Please feel free to provide some clarifying information around this.

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Q50.
Except for additional contacts required to address specific safety concerns, which of the following best describes how frequently (on average) the partner contact service aims to have contact with current or former partners of men participating in the MBCP?

○ Weekly

○ Fortnightly

○ Monthly

○ At the beginning, middle and end of the perpetrator's participation in the program

○ Other, please describe

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Q51. Over how many months after a perpetrator completes the program is partner contact routinely *offered for*?

○ 1 to 2 months   ○ 7 to 12 months

○ 3 to 4 months   ○ Over 12 months

○ 5 to 6 months   ○ Other, please specify ☐

Q52. How many partner contacts, on average, does your partner contact service aim to have with the partner during this period after the perpetrator has completed the program?

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Q53. Over how many months after the perpetrator drops out or has been exited before completing all program requirements, is partner contact routinely *offered for*?

○ 1 to 2 months   ○ 7 to 12 months

○ 3 to 4 months   ○ Over 12 months

○ 5 to 6 months   ○ Other, please specify ☐

Q54. How many partner contacts, on average, does your partner contact service aim to have with the partner during this period after the perpetrator has dropped out or been exited from the program?

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Q56. Please feel free to provide any comments or feedback.

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Q57. **Please describe through what regular and routine processes does the partner contact worker or partner contact service and the MBCP practitioners/facilitators exchange information about the perpetrators and the partners or ex-partners?**

Q58. **Are one or more formal risk assessment tools used during partner contact to assess the risk to partner safety?**

○ Yes

○ No

Q59. **Please state the specific name(s) or type(s) of tool(s) that are used?**

Q60. **When and how are these tools used as part of the partner contact process?**

Q61. **How does the partner contact service help to assess the risk that the perpetrator poses to the safety and well-being of the partner's children?**

Q62. **In your view, which of the following best describes how the impact of the perpetrator's violent and controlling behaviours on the partner's parenting is assessed during partner contact:**

○ The impact of the perpetrator's behaviour on the partner's parenting is not sufficiently assessed

○ These issues are sufficiently assessed with 'some' partners whose parenting is affected by the perpetrator's behaviour, but not with most partners

○ These issues are sufficiently assessed with 'most' partners whose parenting is affected by the perpetrator's behaviour

Q63. **Could you describe how the agency typically addresses the impact of the perpetrator's violent and controlling behaviours on the partner's parenting?**

Q64. **How does the partner contact service help to identify children's developmental, practical, emotional and other needs arising from the impact of the perpetrator's violence?**

Q65. **Does your or another agency offer direct contact with and support for children who are impacted by MBCP participants' use of violence, in a way that collaborates with the partner contact service and the men's behaviour change work with the men?**

○ Yes

○ No

Q66. **Please outline what form this direct contact with children takes (e.g. individual sessions, children's support group, other format)?**

Q67. **What children are eligible or prioritised for this service?**

Q68. **How are children offered this service?**

Q69. **Does the partner contact service share information with services and agencies working with affected children of the women being provided with support, even if not done in this collaborative way?**

○ Yes

○ No

○ Unsure

Q70. **Please feel free to provide any clarifying information around this.**

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Q71. <u>**The next few questions relate to program evaluation. When answering these questions, we would like you to consider how programs are evaluated in terms of the impact the program has on perpetrators behaviour in conjunction with outcomes on partners and children**</u>

Q72. **Is partner contact information routinely used to assist in the evaluation of the program?**

○ Yes

○ No

○ Unsure

Q73. **Are one or more formal tools used during partner contact to help evaluate program outcomes?**

○ Yes

○ No

Q74. **When and how are these tools used as part of the partner contact process?**

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Q75. **What other information is routinely collected in addition to these tools, to help with program evaluation?**

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Feedback and Suggestions

Q76. **This is the final page of the survey. If you wish to change any of your answers, please do so prior to clicking on the forward arrow below. Once you have pressed on the arrow, you will not be able to change your responses.**

Q77. **To help us with future service planning, do you have suggestions around how adult and child victims can be better supported while perpetrators participate in Men's Behaviour Change Programs?**

Q78. **Please outline any factors or considerations that complicate the provision of partner contact for the MBCP you work with?**

Q79. **Please feel free to provide any other comments or suggestions.**

Women's survey

Q1.

Project Title:	Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact
HREC Project Number:	HRE2018-0173
Principal Investigator:	Professor Donna Chung, Head of Social Work (Curtin University)
Research Partners:	Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant)

Thank you for considering participating in this research project. The information following is provided to let you know more about the project, what your participation will require, how data is protected and the confidentiality considerations that will be made. It should not take long to read. If you agree to participate, tick the box to indicate you have read and understand what the project involves. Participation is voluntary, it is your choice to take part or not.

What is the project about?

The purpose of this research is to understand how Men's Behaviour Change Programs (MBCPs) support women and children through their partner contact practice. The project will contribute to improving MBCPs, identifying quality practices and processes for their partner contact service to develop future practice, training, and minimum standards.

This survey is part of a larger national study where we are also seeking practitioner's experiences around providing a partner contact service. Women receiving support from a MBCP are being invited to complete an anonymous, on-line survey about their experiences. MBCP practitioner's and partner contact workers around Australia are also being asked to complete an anonymous, on-line survey, some of whom will also be invited to participate in a face-to-face interview.

Who is doing the research?

The project is being carried out by Professor Donna Chung (Curtin University) in conjunction with industry partners Mr Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant). The project is being funded by the Australian National Organisation for Women's Safety (ANROWS).

What will I need to do?

If you choose to participate, you will need to complete an anonymous, on-line survey which could take up to 30 minutes. Please ensure you use a safe computer, in a safe location.

Q2.
Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

We understand that domestic violence is a personal and sensitive topic and while we have taken care in how we've worded the questions, it is possible you may become distressed as some issues may re-surface while completing this survey.

Where you can go for support.

If you feel you need support or to speak with someone, the following services are available for you to contact:

- 1800 RESPECT (1800 737 732), the 24 hour national Sexual Assault, Family and Domestic Violence Counselling Line; or
- Lifeline on 13 11 14 or their Crisis Support Chat Service at www.lifeline.org.au/crisischat (7pm to 4am AEST, 7 days a week).

You may also contact Professor Donna Chung, Principal Researcher for this project and experienced social worker on (08) 9266 3340 or d.chung@curtin.edu.au for debriefing and referral.

To download these details to keep as a reference, please click here.

Who will have access to my information?

The information collected in this research will be non-identifiable (anonymous). This means that we will not be collecting individual names. No one, not even the research team, will be able to identify your information. Any information we collect and use during the research will be treated as confidential. Only the research team and the Curtin University Human Research Ethics Committee will have access to the data. Electronic data will be password protected. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the research has ended and then will be destroyed. The results of this research may be presented at conferences or published in professional journals. As the information collected from you is anonymous, you will not be identified in any results that are published or presented.

Will you tell me the results of the research?

We will not be able to send you any results as we will not be collecting any personal contact details that will allow us to do so.

Who can I contact about further information about the project?

Professor Donna Chung, Principal Researcher can be contacted on (08) 9266 3340 or via email d.chung@curtin.edu.au. Alternatively, Ms Sarah Anderson, Research Assistant for the project can be contacted on (08) 9266 5196 or via email sarah.anderson@curtin.edu.au. To download these details to keep as a reference, please click here.

Curtin University Human Research Ethics Committee (HREC) has approved this study (approval number HRE2018-0173). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08)9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

Survey Information and Instructions

Q3.
Survey Information and Instructions

This survey is to be completed on a safe computer, in a safe location of your choice. You will need to allow up to 30 minutes to finish it. If you are not able to complete the survey in one sitting, it will automatically save your progress provided you use the same internet browser, on the same computer. You can re-enter the survey through clicking on the survey link again.

We will not be asking or recording any identifying information. This means, however, that if you start the survey and decide you no longer wish to participate, you will need to go back and delete your responses prior to closing the web browser. Any responses left in the survey may be included in the research. Withdrawal carries no negative implications (current or future) and will not affect the services you receive in any way.

The survey is a mix of multiple choice and open ended questions. Some of the questions will ask you about the Men's Behaviour Change Program and support you received including what you found helpful and unhelpful. You will also be asked to provide some information about yourself, your children, as well as the man who participated in the Men's Behaviour Change Program. There is room for you to describe your experiences in your own words. Please only share what you feel comfortable sharing. You can choose to complete or not complete any question.

On completion of the survey, your answers will be automatically submitted. You are able to change your responses up until you press the arrow on the final page. We will tell you when you have reached this point.

The information you give to us will be analysed by the research team in conjunction with information provided by practitioners as a way of developing a comprehensive understanding of partner contact practice and identifying areas working well as well as those needing improvement.

Consent to Participate

Q4.
Consent to Participate

I have read the information regarding this research. I believe I understand the purpose, extent and possible risks of my involvement in this project and voluntarily consent to take part. I understand that I may withdraw from the research project. Participation will not affect any services or supports I receive now or in the future.

I understand that this project has been approved by the Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).

○ I agree with the above statement and wish to take part in the project

○ I do not agree with the above statement and do not wish to take part in the project

Survey promotion

Q5. **How did you hear about this survey?**

☐ Media (e.g. radio)

☐ Partner contact worker

☐ Support or advocacy worker from another support agency

☐ Friends or family

☐ Another means, please describe

About the Men's Behaviour Change Program

Q6.
Is your partner or ex-partner currently attending a Men's Behaviour Change Program?

○ Yes

○ No

Q7. **Has he attended a Men's Behaviour Change Program in the past?**

○ Yes

○ No

Q8. **How many times has your partner or ex-partner previously attended a Men's Behaviour Change Program?**

Q9. **What year(s) did he attend a program?**

[   ]

Q10. <u>**The following questions relate to the Men's Behaviour Change Program that your partner or ex-partner most recently attended:**</u>

Q11.
What State did he attend the program in?

○ Australian Capital Territory

○ New South Wales

○ Northern Territory

○ Queensland

○ South Australia

○ Tasmania

○ Victoria

○ Western Australia

Q102. **What would best describe the area that he attended the program in?**

○ a capital or large city

○ a regional city and its immediate surrounds

○ a rural or remote community

Q12. **Was your partner or ex-partner ordered by a court to attend the program?**

○ Yes

○ No

○ Unsure

Q13. **Did he fully complete the program or withdraw?**

○ Still attending

○ Fully completed

○ Did not complete

○ Don't know

Q14. **How many weeks did he complete?**

○ Four weeks or less

○ Five to eight weeks

○ Nine to twelve weeks

○ More than twelve weeks

○ Unsure

Q15. **If he did not complete the program, what's your understandings as to why?**

Q16. **If he did not complete the program, how did this effect you?**

○ Made things worse overall

○ Made things better overall

○ Helped with some aspects, did not help with others

○ No difference or changes

Q17. **Please describe the reason for your answer**

Q18. **If he is currently attending, how many weeks has he completed so far?**

○ 1 to 2

○ 3 to 5

○ 6 to 8

○ 9 to 11

○ More than 12 weeks

○ Unsure

Q19. **Do you feel the program has made a difference, positive or negative, to your partner or ex-partner's behaviour?**

☐ Yes, I noticed a positive difference

☐ No, I did not notice any difference at all

☐ Helped with some aspects, did not help with others

☐ Made things worse

☐ It's too early to tell

Q20. **Feel free to provide any further comments around how the program has made a difference, positive or negative, to your partner or ex-partner's behaviour.**

Q21. **In what particular ways, if any, did your partner or ex-partner participating in the program make a difference to you? Please select all that apply.**

☐ I felt less safe

☐ I felt more controlled by him

☐ I did not notice a difference

☐ I felt safer

☐ I felt less controlled by him

☐ Improved how my partner or ex-partner spoke to me

☐ Helped him communicate openly and respectfully with me

☐ Contributed to me being able to have a stronger voice in the relationship and make choices

☐ Improved my wellbeing including my self esteem and self worth

☐ Anything else?

Q22. **In what particular ways, if any, did the men's program make a difference to his parenting and/or your children? Please select all that apply.**

☐ He did more as a parent

☐ He had a better awareness of others, including an understanding of the impact that domestic violence has had on me and the children

☐ He did not get in the way of my parenting as much

☐ The relationship my children had with him improved

☐ I did not notice a difference

☐ I felt my children were safer with him

☐ The children were still unsafe around him

☐ The children were not relaxed around him

☐ I felt less supported in my parenting

☐ Anything else?

Q23. **Is there any other way you feel the program has made a difference, positive or negative, to you or your children?**

Q24. **If his participation in the program has not made a difference, either good or bad, do you have any thoughts on why there has been no change?**

Support offered to you while he was in the Program

Q25. **Did the Men's Behaviour Change Program staff or partner contact worker contact you about your partner or ex-partner's involvement in the program?**

○ Yes

○ No

Q26. **How did the service initially contact you to offer you with partner contact support? Please select all that apply.**

☐ by letter

☐ by letter and they followed up with a phone call

☐ by phone

☐ by email

☐ by email and they followed up with a phone call

☐ Another process was used. Please outline

Q27. If known, at what point were they first in contact with you?

○ After your partner or ex-partner booked into his first assessment session, but before that assessment session occurred

○ After your partner or ex-partner started his assessment process, but before he started groupwork sessions

○ After your partner or ex-partner started groupwork sessions

○ Not sure

○ Another stage (please describe)

Q28. Approximately how often did the service have contact with you?

○ Weekly

○ Fortnightly

○ Monthly

○ Occasionally

○ Other, please describe

Q101. Overall, can you indicate how many times you had contact with the partner contact service?

○ 1 to 2 times

○ 3 to 10 times

○ More than 10 times

○ Other, please describe

Q29. What would you have liked or found helpful should you have been contacted?

Q30. **What kind of supports or referrals, if any, were you provided with by the partner contact service? Please select all that apply.**

☐ Legal services

☐ Financial counselling services

☐ Housing and homelessness services

☐ Counselling services

☐ Support groups for women partners

☐ Services from a specialist women's domestic violence agency

☐ Family support services

☐ Child-focused services

☐ Parenting programs

☐ Alcohol and drug services

☐ Mental health services

☐ I was not provided with any supports or referrals

☐ Anything else?

> [   ]

Q31. **Were you offered any supports or referrals for your children? (e.g.) children's worker to help them**

○ Yes

○ No

Q32. **Can you briefly outline the specific supports or referrals you were offered for your children?**

Q33. **What other supports or referrals would you have found helpful for yourself or your children (that you were not offered)?**

Q34. **Were you given the opportunity to attend an information session about the Men's Behaviour Change Program your partner or ex-partner was attending?**

○ Yes

○ No

○ Not sure

Q35. **After your partner or ex-partner finished the Men's Behaviour Change Program (whether this was fully completed or not), were you offered further support by the partner contact service?**

○ Yes

○ No

○ Not applicable, my partner or ex-partner is still currently in program

Q36. **How long after he finished the program were you offered support by the partner contact service?**

○ 1 month

○ 2 months to 6 months

○ Over 6 months

Q37. **Were you ever asked for any feedback to help evaluate your partner or ex-partner's progress during the Men's Behaviour Change Program?**

○ Yes

○ No

Q38. **Were you ever asked for feedback about the support you received from the partner contact service?**

○ Yes

○ No

Q39. **Can you please indicate on the scale how helpful the Men's Behaviour Change Program was in relation to reducing his violence and abuse?**

	0=Not helpful at all					5=Kind of helpful				10=Extremely helpful	
	0	1	2	3	4	5	6	7	8	9	10
Scale of helpfulness											

Q103. **Looking to the future, are there ways you think the Men's Behaviour Change Program will have benefited him?**

○ Yes

○ No

○ Not sure

Q104. **Can you please explain your answer?**

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Q40. **Can you please indicate on the scale how helpful the partner contact service was in relation to providing support to you?**

	0=Not helpful at all					5=Kind of helpful				10=Extremely helpful	
	0	1	2	3	4	5	6	7	8	9	10
Scale of helpfulness											

Q105. **Looking to the future, are there ways you think the partner contact service will have benefited you?**

○ Yes

○ No

○ Not sure

Q106. **Can you please explain your answer?**

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About You

Q44. **What is your sex?**

○ Female

○ Male

○ Transgender

○ Intersex

○ Prefer not to say

Q45. **What was your age at the time your partner or ex-partner commenced in the Men's Behaviour Change Program?**

○ 18 to 24

○ 25 to 34

○ 35 to 44

○ 45 to 54

○ 55 to 64

○ Over 65

○ Prefer not to say

Q46. **Did you have any children in your care?**

○ Yes

○ No

Q47. **Please provide the sex and current age of each child (e.g. female, 4 years old; male, 8 months)**

	Child details	
	Sex	Age
Child 1		
Child 2		
Child 3		
Child 4		
Child 5		
Child 6		
Child 7		
Child 8		

Q48. **How would you best describe your living arrangements at the time your partner or ex-partner was in the Men's Behaviour Change Program?**

○ Living independantly

○ Living independantly with children

○ Living with children and partner

○ Living with partner, no children

○ Living with other family members with children

○ Living with non-family members without children

○ Living with non-family members with children

○ Other living arrangement not mentioned. Please describe

Q49. **In which state or territory do you currently reside?**

○ Australian Capital Territory

○ Queensland

○ New South Wales

○ Northern Territory

○ South Australia

○ Tasmania

○ Victoria

○ Western Australia

Q50. **In what suburb or town do you live in?**

Q100. **What is the postcode of the area you live in?**

Q51. **What best describes the area you live in:**

○ a capital or large city

○ a regional city and its immediate surrounds

○ a rural or remote community

Q52. **At the time your partner or ex-partner was in the Men's Behaviour Change Program were you:**

○ an Australian Citizen

○ a Permanent Resident

○ Temporary Resident

○ Other (please specify)

Q53. **What is your country of birth?**

Q54. **What is your cultural/ethnic identity?**

Q55. **Is English your first or preferred language?**

○ Yes

○ No

Q56. **What is your preferred language or the language your speak at home?**

Q57. **Do you have any long standing physical health conditions, impairments, or disabilities that have lasted or are expected to last 12 months or more? Please exclude those that are due to ageing.**

○ Yes

○ No

Q58. **Would you mind writing down what these are?**

Q59. **At the time your partner or ex-partner was in the Men's Behaviour Change Program, what was your main source of income?**

○ Employment

○ Self employment

○ Centrelink payments

○ Dependent on partner or ex-partner's income

○ Self-funded retiree

○ Other (please specify)

About the man in program

Q60. **What year did the relationship with your partner or ex-partner commence?**

Q61. **Up to the point of your partner or ex-partner being accepted into the Men's Behaviour Change Program, could you estimate how long you experienced violence and abuse from him?**

○ Less than 1 year

○ 1 to 2 years

○ 2 to 5 years

○ More than 5 years

Q62. **In addition to the program for violence and abuse, are there any other programs you think would be helpful for your partner or ex-partner to attend? Please select all areas of concern that apply.**

☐ Alcohol   ☐ Employment

☐ Drugs   ☐ Education and training

☐ Mental health   ☐ Other, please describe

Q63. **At the time your partner or ex-partner was accepted into the Men's Behaviour Change Program, what would best describe your relationship him:**

○ Together - residing together

○ Together - not residing together

○ Temporarily separated

○ Permanently separated

○ Another description?

[   ]

Q64. **How long had you been separated?**

[   ]

Q65. **What was your partner or ex-partner's age at the time he participated in the Men's Behaviour Change Program?**

○ 18 to 24

○ 25 to 34

○ 35 to 44

○ 45 to 54

○ 55 to 64

○ Over 65

Q66. **If known, what is your partner or ex-partner's citizenship status?**

○ Australian Citizen

○ Permanent Resident

○ Temporary Resident

○ Not known

Q67. **When your partner or ex-partner entered the Men's Behaviour Change Program, what was his main source of income?**

○ Employment

○ Self-employment

○ Centrelink payments

○ Dependent on partner's income

○ Self funded retiree

○ Other (please specify)

[   ]

Feedback and Suggestions

Q68. <u>**This is the final page of the survey. If you wish to change any of your answers, please do so prior to clicking on the forward arrow below. One you have pressed on the arrow, you will not be able to change your responses**</u>.

Q69. **To help us with future service planning, do you have suggestions around how women and children can be better supported while men participate in Men's Behaviour Change Programs?**

Q70. **Please feel free to provide any other comments or suggestions.**

Practitioner interview guide (Semi-structured)

Curtin University

RESEARCH PROJECT: Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact (PC)

Contextual Information

1. What is the name and purpose of the agency you work for?
2. What state/territory do you work in?
3. What type of area do you work in? (e.g. urban, regional and immediate surrounds, rural/remote)
4. Is the service run by a government, non-government, for profit, or not-for-profit organisation?
5. What is your role and responsibility within your agency? (Ensure you record if participant delivers PC).
6. Did you participate in the recent practitioner survey about PC practice?

MBCP Organisation

7. How is PC organised and delivered?
8. What are the two or three main sources of referrals of men to your MBCP?
9. On average, roughly what proportion of men in your program are provided with a hard mandate – i.e. a corrections or court order – to attend the program?
10. What proportion are referred by child protection or the family court?
11. Does your program have self-referred participants?
12. Does your MBCP adhere to any specific external standards or guidelines? If yes, what are these?
    a. Are there any agency specific MBCP or DFV standards, guidelines or policy documents that inform your work? If so, can you describe their influence? If they are not publicly available, would we be able to have a copy – we would not cite or attribute these to your organisation in any reporting?

Support provided to women

13. How do you describe the main purposes of PC? Do you think it's different from other specialist FDV work with women? In what ways?
14. Could you take me through how partner contact works for your organisation from start to finish?
    a. How does partner contact usually commence from making contact onwards?
    b. How is it first offered? When does the first contact often occur? At what point does your involvement with the partner stop?
15. Under what circumstances is a partner referred to other agencies for support? How are decisions made about the support the PC worker provides as opposed to what other services provide?
16. How does PC contribute towards ongoing risk assessment, in the context of other information that's being generated (e.g. through observing the man's participation in the program)?
    a. In what ways does the PC worker actually talk through with other practitioners about risk issues? How often does this occur?
    b. How are changes in risk recorded?

17. Is the PC response provided to women for diverse backgrounds?

    a.   If yes, what does this look like?

    b.   If no, what typically occurs?

18. Often, it is difficult to make contact with partners/ex-partners. In situations where you suspect a woman is at high risk yet can't make contact, how do you manage this dilemma?

19. From your experience, how do you think PC should operate? What prevents this from happening?

20. If you work in a regional area, are there any specific issues about PC provision that you experience? Can you describe these?

21. Do you feel that victims needs vary when perpetrators are mandated to attend as part of a criminal justice response? Do you believe PC can and should meet those needs? If so, how? If not, why not? Can you please describe your experiences of PC practice with victims in these circumstances?

22. If you (or your agency) are employed directly by the MBCP to undertake PC, what do you think are the strengths and limitations of this type of arrangement?

23. If you (or your agency) are employed by a separate agency to undertake PC, what do you think are the strengths and limitations of this type of arrangement?

24. In your experience, what would you describe as the optimal organisational and practice arrangements for PC that would best promote women's safety?

Children's support

25. What information does the MBCP and PC worker routinely have about children and young people?

26. Does the PC response involve any direct work with children or young people? If yes, what does this look like?

27. How does the PC service help to assess the risk that the perpetrator poses to the safety and wellbeing of the partner's children?

28. How are children connected with PC and the work being done with men?

29. If there is a dedicated children's services worker/agency, are there regular flows of information between this worker, the PC worker and MBCP facilitators? Can you describe how this works?

Organisational support

30. Can you describe how you record information about PC? e.g. do you open a file, use a template etc.

31. How is PC data routinely used in relation to perpetrator assessment and intervention?

32. How are PC workers supported in their role, formally within the organisation?

33. What support and training is provided to these workers?

34. How often do PC workers, if ever, attend the MBCP? If they do not attend, why? If they do attend, how does this influence PC practice?

35. Do you undertake PC and also work with the perpetrators? If so, how do you manage the dual role?

36. Do you feel like you have had adequate training for your role? Can you think of any (further) training that would benefit you in this role?

37. Is PC information used in program evaluation? Are you able to outline how your agency uses PC information for evaluation purposes?

Sample recruitment email for interviews

Curtin University

RESEARCH PROJECT: Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact.

Hello,

I am contacting you in relation to a national research project we are involved with. The project aims to understand more about how men's behaviour change programs (MBCPs) support women and children through their partner contact practice.

Specifically, we would like to invite you or relevant practitioners in your agency to participate in a one-hour, face-to-face interview to share your experience of partner contact support. This will add to information we have already collected from practitioners in a recent survey. Women who have been in receipt of this kind of support are also being invited to complete a survey about their experience. Alternate methods for the interview will be considered if this is preferred or more convenient (e.g. via Zoom, Skype, or similar).

The project is being carried out by Professor Donna Chung (Principal Researcher, Curtin University) in conjunction with industry partners Mr Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant) and is being funded by the Australian National Organisation for Women's Safety (ANROWS). Further information about the research is provided in the attached document. Curtin University Human Research Ethics Committee (HREC) has approved this project (HRE number HRE2018-0173).

If you agree to participate, you will be contacted by a member of the project team who will make appropriate arrangements for the interview. Aside from your time, there will be no cost to you for taking part and you will not be paid for taking part.

Before you decide if you would like to contribute, please read the following information which outlines what your participation would require, how data is protected and the confidentiality considerations that will be made. Participation is voluntary; it is your choice to take part or not. If you have any questions or would like further information, please do not hesitate to contact Ms Sarah Anderson, Research Assistant for this project via sarah.anderson@curtin.edu.au.

Thank you for considering contributing to this important piece of work which ultimately will help to benefit women and children's safety and wellbeing.

Donna Chung (Principal Investigator)
Professor

School of Occupational Therapy, Social Work and Speech Pathology
Curtin University

(E) d.chung@curtin.edu.au
(T) (08) 9266 3340

Curtin University

PARTICIPANT INFORMATION

RESEARCH SYNOPSIS: Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact.

Within Australia many men's behaviour change programs (MBCP) guidelines and standards highlight the importance partner contact, although very little is documented in terms of the practice and the underpinning literature. The need to ensure women and children are provided with appropriate support is a well-established expectation of the perpetrator intervention system. Furthermore, some women first enter the service system as a result of partner contact highlighting the importance of this as an opportunity for meaningful engagement. partner contact may also act as a key accountability and quality assurance measure within perpetrator interventions and provide a means of minimising collusion and increasing accountability around self-reporting.

Whilst recognised as imperative, there is currently very limited research in the Australian context around 'how' partner contact is incorporated into program delivery. This project will provide a deeper level understanding of the way in which MBCPs support women and children through partner contact. The project involves a number of research activities: a review of literature, a survey of MBCP providers nationally which will be complemented by in-depth interviews with managers, facilitators and partner contact providers. Women who have or are currently receiving partner contact support from a MBCP are also being invited to complete an anonymous, on-line survey about their experiences. The project will contribute to improving MBCPs, identifying quality practices and processes for partner contact to develop future practice, training, and minimum standards.

What will I need to do?

You may have already completed an on-line survey. We would now like you to consider taking part in the next stage of the project, which requires meeting with a researcher for a one-hour, face-to-face interview to provide more in-depth information about partner contact practice. Alternate methods for the interview will also be considered if this is preferred or more convenient (e.g. via Zoom, Skype, or similar). Aside from your time, there will be no cost to you for taking part and you will not be paid for taking part.

What are the possible benefits of the research project?

The possible benefit from this research is to improve the quality of services provided to women and children, thereby also improving the future safety of families.

What are the potential risks associated with participating in this research project?

The possible risks to participation are minimal; however, given the sensitive nature of family and domestic violence, there is the potential for participants to experience some level of discomfort or distress during the interview. If this is the case for you, please notify the Researcher or your Manager who can then take steps to support you. Alternatively, Professor Donna Chung, Principal Researcher for the project and experienced social worker can be contacted on (08) 9266 3340 or d.chung@ curtin.edu.au for debriefing and referral.

Can I withdraw from the project?

You have the right to withdraw from this part of the project at any stage. Withdrawal carries no negative implications (current or future) and will not affect your employment in any way. Doing so ensures that any data you have provided is excluded from the study, provided it has not yet been reported.

Do I have to participate?

Participation is completely voluntary; you are not obliged to take part. If you do decide to take part, please complete the attached consent form prior to participating in the interview. Whether or not you decide to participate in the study will not affect your employment in any way. You will not be rewarded for participating nor penalised for choosing not to participate. The information you provide will be completely confidential and will not be used for any purposes other than those stated above.

What will happen with the information I provide?

All information obtained in this research will be retained by the researchers and treated as confidential. Only the researchers and Curtin University Ethics Committee will have access to the data. The data attained from the interviews and on-line surveys will be analysed and key themes or concepts will be identified. A report which summarises the findings will be provided to ANROWS, the national research organisation for domestic violence and funder of this project. The results of this research may also be presented at conferences or published in written reports or journals. You, or your organisation, will not be identified in any results published or presented. All information collected will be stored at Curtin University in a locked cabinet and on a password protected computer. It will be retained for at least seven years after which the data will be destroyed.

Who do I contact with any questions about the project?

If you have any questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project then you should contact the Principal Researcher, Professor Donna Chung at Curtin University in Perth via email d.chung@curtin.edu.au or telephone (08) 9266 3340. Alternatively, you can contact Ms Sarah Anderson, Research Assistant for the project via email sarah.anderson@curtin.edu.au.

What if I have a complaint or concern?

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2018-0173). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

If I want to participate, what do I do?

If you have decided you would like to contribute to this research project, please contact Ms Sarah Anderson, Research Assistant for this project via sarah.anderson@curtin.edu.au. She or another member of the project team will be in touch with you to make appropriate arrangements for an interview.

Thank you for considering participating in this important research project.

Donna Chung (Principal Investigator)
Professor

School of Occupational Therapy, Social Work and Speech Pathology
Curtin University.

(E) d.chung@curtin.edu.au
(T) (08) 9266 3340

Curtin University

CONSENT TO PARTICIPATE

RESEARCH PROJECT: Prioritising women's safety in Australian perpetrator interventions: the purpose and practices of partner contact

Principal Researcher:	Professor Donna Chung, Curtin University
Research partners:	Mr Damian Green (Stopping Family Violence) and Mr Rodney Vlais (Consultant)
Curtin University Human Research Ethics approval number	HRE2018-0173

I have read the provided Participant Information for this project and understand its contents.

- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I understand this project has been approved by the Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007) – updated March 2014.
- I understand I will receive a copy of the Participant Information.
- I have had an opportunity to ask questions about the project and I am satisfied with the answers I have received.

Consent to Audio Recording

Please indicate whether you consent to having your interview audio recorded. The recording will be transcribed and used to assist with data analysis:

- ☐ *I consent* to having my interview audio recorded.
- ☐ *I do not consent* to having my interview audio recorded.

Participant Name

_____

Participant Signature

_____   Date _____

Declaration by researcher: I have supplied Participant Information and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

Name of Researcher

_____

Signature

_____   Date _____

ANROWS

ANROWS

ANROWS