Prioritising victim/survivor safety in Australian perpetrator interventions

A PRACTICE GUIDE

ΛNRØWS

Curtin University
Kent Street, Bentley, Perth
Western Australia 6102
Postal address: GPO Box U1987, Perth
Western Australia 6845

Prepared by
Mr Damian Green, Stopping Family Violence
Mr Rodney Vlais, Consultant
Professor Donna Chung, Head of Social Work, School of Occupational Therapy, Social Work and Speech Pathology, Curtin University
Ms Elizabeth Wheeler, Consultant Writer

Prioritising women's safety in Australian perpetrator interventions (Practice guide)

Please note that there is the potential for minor revisions of this guide.
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About this guide

This practice guide arises from our ANROWS-funded research on partner contact (PC) associated with men's behaviour change programs (MBCPs) for perpetrators of domestic and family violence (DFV). The research documented practice across Australia, with a view to improving the quality and consistency of support provided to women and children by current and future MBCPs and perpetrator interventions more broadly.

We found some important areas of consensus regarding PC and also some quite divergent practice and perspectives. As

such, this guide is reflective rather than prescriptive. In posing a series of questions, our intention is to invite practitioners and managers working in MBCPs—and in other innovative DFV-focused perpetrator interventions, such as fathering programs—to consider ways to deepen and strengthen their individual and organisational practice. We also hope that it will assist other DFV stakeholders to better understand partner contact work.

In many states, there are minimum standards in place that impact on PC. This guide complements those standards.

What is partner contact work?

The very naming of any support provided to adult and child victims/survivors of DFV has been, and remains, controversial. In our research, we used the term "partner contact", as this has been commonly employed in Australian policy and programming over the past 25 years; however, we readily acknowledge that there are other terms in use, some of which might more accurately reflect the nature of the work.

The origins of PC in MBCPs make it inherently gendered; the work has largely focused on women as partners and ex-partners of male MBCP participants. This is consistent with the gendered nature of DFV work more generally, and is reflected in this guide's use of the language of male perpetrators and female victims/survivors. This language is not intended to erase the diversity of victims/survivors or the needs of all adult and child victims, but instead reflects the evolution of the work within a specific and gendered context. While female pronouns are commonly used in this guide, we intersperse those with gender-neutral terms to recognise that men and gender non-binary

people are also victims of violence perpetrated by people who are male-identified.

We also recognise that the term partner contact fails to recognise the multiplicity of potential victims/survivors, such as those in Aboriginal and Torres Strait Islander or extended family contexts, beyond current and past intimate partners. Rarely has the use of DFV only affected the partner of the perpetrator. The term does not recognise children as victims/survivors, or the impact of DFV on relationships between adult victims/survivors and their children.

The term can also be somewhat misleading, given that practices often involve far more than simply "contact" with partners and ex-partners. Arguably, the word "contact" fails to encompass the multifaceted and complex nature of much of this work.

All of the above issues notwithstanding, for the purposes of this guide:

 Partner contact is a service provided in the context of a DFV-focused perpetrator intervention, to people who are affected by the perpetration of violence by a (prospective) participant in that intervention, and consisting of continuous risk assessment, safety planning and risk management, support, information and referrals.

The voices of women who used PC and who contributed to our research are included in this guide with quotes shaded rose.

The voices of PC practitioners who contributed to our research are included in this guide with quotes shaded grey.

Purposes of partner contact work

Research supports the idea that PC is an integral component of MBCPs and other perpetrator interventions, however, agencies and DFV practitioners vary in how they understand and characterise the purposes of that work. Purposes of PC may include to:

- promote adult and child victims'/survivors' actual and felt autonomy and safety

- hear and acknowledge adult and child victims'/survivors' experiences of DFV, and identify and validate ways that they have worked to keep themselves and others safe

- identify, respond to and manage ongoing threats to adult and child victims'/survivors' safety and wellbeing, within established risk assessment and risk management frameworks

- provide emotional and psychological support to victims/survivors

- promote and celebrate victims'/survivors' autonomy and freedom

- express and affirm victims'/survivors' worthiness of help and support

- privilege the voices of victims/survivors within the MBCP

- reach a cohort of victims/survivors who have not previously used or been offered DFV services

- provide opportunities for victims/survivors to receive information about the MBCP generally and/or the perpetrator's participation specifically

- provide opportunities for victims/survivors to inform the MBCP about the perpetrator's behaviour—including, but not only, to inform ways of working with him

- ensure the provider is well-placed to hear about and respond to any threats to victims'/survivors' safety or wellbeing arising from a participant's participation in their program, such as a perpetrator using his participation as a tactic of control, learning new tactics, or misrepresenting ideas learned in the program

- discuss with victims/survivors DFV statistics, dynamics, and patterns

- draw out and affirm victims'/survivors' own knowledge and awareness of the nature of DFV

- assist victims/survivors to identify, access and engage with other services

- identify and respond appropriately to adult and child victims'/survivors' practical needs

- assess the impact of a perpetrator's violence on the non-perpetrating parent's parenting capacity, relationship with her children and family functioning

- provide opportunities for victims/survivors to have input into program evaluation.

> [The role of the women's support service is] laying bare the extent of his manipulation (of her and his attempts to manipulate other agencies and the DVIP programme) and building trust in her own judgement, to counter his attempts at "crazy-making" … to develop her sense of how her needs are met or not within the relationship; highlights her actual experiences of him versus her idea of who he is to her; embark on her own journey of what she wants from her life; and to come to terms with the impact his abuse has had on her and her children, building on her conviction that she is the best judge of his change.
> Domestic Violence Intervention Program (DVIP), London

Questions to consider:

- Reflecting on our current practice, what does this suggest are the top five purposes we are working towards?

- Of the remaining purposes, which do we believe are within our capacities and remit? How might we strengthen our work towards these?

- Of purposes that are not within our capacity or partner-contact remit, who can work towards them with our victim/survivor clients? If there is a service gap, what will we do to address it?

Practice frameworks

We found considerable variation in the degree to which organisations and individual practitioners worked towards each of the purposes above. To some extent, this reflects resourcing, but it also reflects the practice frameworks that each brings to the work. For example, while some practitioners saw themselves as having a principally educative or empowering role, others saw their role as walking alongside victims/survivors on their long-term journeys of recovery—often in response to an identified lack of long-term emotional support within a service system that is increasingly oriented towards crisis management.

While our research informants articulated very definite views about their "job", these were not generally acknowledged as stemming from particular practice lenses or frameworks. Bringing these to light—and understanding how they are shaped by both patriarchy and underlying therapeutic and social change theories—will improve both the quality and consistency of practice by and within teams.

Program-instigated risk

In our research, few PC services raised the serious issue of program-instigated risk. This is both startling and concerning, as it has long been known that there are risks to victims/survivors associated with the provision of MBCPs. These include a perpetrator:

- learning new tactics of control

- appropriating the language and/or misrepresenting the idea or strategies of the program to further his own ends

- using his participation in a program as a form of emotional blackmail against his (ex-)partner, and/or as a way to gain a more lenient response from a court or child protection despite no reduction in risk

- coercing a victim/survivor not to report some or all of his behaviour

- minimising or relativising his use of violence—especially in relation to others in the program

- having his sexist portrayals of women (for example, as naggers or sex objects) reinforced by other participants in the program

- using further violence or control to manage feelings of distress, anger or discomfort that naturally arise in men's behaviour change work.

A further example of program-instigated risk is that a victim/survivor might decide to stay in an unsafe situation in the hope that her partner will change as a result of the program.

Clearly, there are many implications here for victims'/survivors' safety and wellbeing. Addressing program-instigated risk is an ethical obligation. This is even more important when PC is being provided by a separate women's service, by workers who are less familiar (or unfamiliar) with MBCP work.

> "[He] 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."

> "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."

> "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 …"

? Questions to consider:

- What are our underlying frameworks of practice for engaging victims/survivors? How are these reflected in our practice? Are all practitioners in our team on the same page?

- How do we ensure that all practitioners working with or on behalf of our service know a) what to look for in terms of program-instigated risk as a perpetrator progresses through a program, and b) how to look?

- What are our documented practices for addressing program-instigated risk? Do we follow them?

Patriarchy and partner contact work

While PC has many stated and implied purposes, some are particularly valued by victims/survivors. The women who participated in our research listed many things that they appreciated about PC, including having their experiences believed and named as violence; emotional support from someone other than family or friends; a way to check in on what is healthy/unhealthy/abusive behaviour; help to redevelop and assert healthy boundaries; a reality check on gaslighting; validation in their parenting role and recognition of all they do to keep their children safe; and being supported to engage with other services and/or to make social connections. These valuable aspects of PC have also been identified in other research. Clearly, PC achieves many different purposes that are not dependent on the work that programs do with men as perpetrators.

Evidence suggests that many women feel safer when they receive information about the perpetrator from programs, when programs are "monitoring" the perpetrator, and when PC offers them information and creates space for their own action (including protective action). Research has found that these outcomes are valued highly by women, and can be attained irrespective of whether or not a perpetrator makes any significant changes to his own behaviour.

The existence of many different benefits to victims/survivors suggests the value of victims/survivors having access to PC in ways that are not contingent on their (ex-)partner's engagement or continued participation. A perpetrator's initial encounter with an MBCP (through intake and initial assessment) could be sufficient to trigger PC for his (ex-)partner, regardless of whether he subsequently joins or completes the program, or leaves at any point along the way.

This issue goes to the very heart of the purpose of PC. While its relative resourcing might suggest PC is ancillary to the "main game" of intervening with men, our and others' research shows that it might better be characterised as a core DFV intervention in its own right. This issue is discussed further in the Reach, duration and form of contact section.

Some PC practitioners have noted the possibility of a parallel process, in which women's needs are secondary to men's, as they are in society more generally. This may also play out at the level of interagency relationships. Other researchers have expressed concern that gender inequalities *between services* are inescapable, and contend this is a fundamental challenge for the development of partnerships between specialist women's services and MBCPs. They fear 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", with a range of patriarchal dynamics resulting in men's services and men's practitioner voices becoming privileged and potentially displacing those of their women colleagues.

> "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 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."

? Questions to consider:

- Looking at our current PC practices, does it appear that PC is ancillary to services to men?

- What resourcing is provided for PC work, relative to resourcing for engaging with the men?

- To what extent could we say with confidence that our practices place victims/survivors at the centre of our work?

- Are some of our current PC practices dependent on the man's participation in the program?

- What would it look like for our program to provide a service to victims/survivors in their own right?

Practicalities

Who does the work?

There is clearly a genuine and complex tension between PC being closely intertwined with the work with men so that professionals can inform each other's practice, and PC being independent from the men's work so that a victim/survivor is offered a service in her own right and a space away from having to take her (ex-)partner into consideration and talk about his—rather than her own—needs.

MBCPs are provided by many different kinds of agencies across Australia. Our research has identified four common models for PC within such programs, with the first being the most common:

- Intra-organisational within a team, with roles separated out. A single organisation delivers both components of the MBCP—men's work and PC. Each practitioner in the team delivers one of the two components.

- Intra-organisational within a team, with practitioners sharing roles. A single organisation delivers both components of the MBCP. Each practitioner within the team delivers both components (but might deliver to different clients, to avoid conflicts of interest and/or inadvertent breaches of confidentiality).

- Intra-organisational where partner contact is provided by a practitioner(s) who is not part of the MBCP team. This is seen, for example, in contexts where MBCPs are provided by specialist women's DFV services. Here, PC is provided by the agency's general pool of women's advocates, separate from the MBCP team.

- Inter-organisational: the MBCP is run by two organisations in partnership, with one running the men's group work and another agency undertaking PC. This is rarely conceptualised as co-provision, in which two different agencies each implement equally important aspects of an MBCP; it is more usual for MBCP providers to regard the arrangement as "outsourcing", with PC being set aside so that the program can focus on its "core" work with men.

Beyond finding broad consensus that it is not safe practice for the same practitioner to work with a perpetrator *and* the victims/survivors experiencing his violence, our research did not identify any one model that offered a clear advantage over others. Rather, each model has advantages and disadvantages. What matters most are opportunities for frequent, easy and preferably face-to-face communication between the partner contact worker and MBCP staff, and the PC worker's access to, and/or ability to provide, a range of services relevant to victims'/survivors' needs.

This not to say, however, that the context in which PC is provided does not matter. We found that PC professionals' assumptions, skills and ways of working with victims/survivors were often a reflection of their organisation's role within the DFV system.

> "One of the things that you miss out on by not engaging an external service is the opportunity to have some of those discussions which could generate better practice ... '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?'"

> "We do both internal and external outsourced [methods of PC]. There is more communication when [we are] all sitting under one roof and in the same team—which is the biggest strength."

> [About PC provided by an external provider] ... "We've had this distance between us ... 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] 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, sharing appropriately."

? Questions to consider:

- How do we ensure there is meaningful, two-way communication between the PC practitioner and MBCP practitioners?
- How has the service system changed since our program's PC arrangements were set up? Are these arrangements still serving us well, or might it be time to consider a change?
- What are the strengths and weaknesses of our particular PC provision arrangements? What can we do to mitigate the weaknesses?

Supportive infrastructure

Our research identified a need for agency-level comprehensive policies and protocols to cover PC, relating to information sharing, referral processes, confidentiality requirements, risk assessment, safety planning and risk management, collaborative working arrangements, service delivery standards, participant service agreements, rights and responsibilities, supervision, and case management. All are predicated on an organisation having a strong understanding of, and commitment to, PC as an expression of gender equity and a fundamental element of perpetrator interventions.

Of course, all of these also require sufficient funding, and our PC informants emphasised that its absence is imposing a significant constraint on their practice. Many workers expressed frustration that, while PC is a requirement of MBCP work, funding does not reflect their caseloads or the complexity of their work. Our research suggests 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 for how long, and the quality and consistency of support provided. There are also calls for policymakers, funders and practitioners to consider how PC can best be practised in an environment of austerity and competitive tendering.

The issue of funding is not only limited to direct resourcing of PC. Practices are also shaped by what services are or are not available for victims/survivors in a local area. Where 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 underfunded partner contact services to step into that role.

As discussed above, our research suggests a need to constantly reflect on the potential impacts of patriarchy and bias as they present in this work. This is particularly important given that most PC is conducted by female practitioners. There are potential differences between female and male practitioners in terms of salary, support, professional development, networking opportunities, voice and status—both within and between agencies.

> "At times my case load has reached 70+ 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 ... This impacts the quality of service to these women."

> "The program is very much underfunded to meet the needs of the partner contact component of the program. We are funded five hours per week to provide support to each MBCP group [and have] 15–20 partner contact clients. This does not provide adequate time to complete comprehensive needs and risk assessments to all who consent to the service. That time alone will only cover the assessment and administration part of the partner contact and does not allow for follow-up every two weeks as specified in the minimum standards. The minimum standards and funding are completely misaligned."

Questions to consider:

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- Are there sufficient resources allocated to PC for our MBCP to operate safely and according to minimum standards?
- What, if any, differences are apparent in the ways that we monitor caseloads for PC and work with men?
- Do we take into account the capacity of the PC worker when deciding whether to assess or admit new men to our program?
- What are our practices to privilege the voices of female practitioners, including those who provide PC?
- To what extent do practitioners working with or on behalf of our program (including PC) have equity in terms of salary, support, professional development, networking opportunities, voice and status?

Skills and support for partner contact workers

Our research found similarities and differences between PC and other forms of DFV support for victims/survivors. The proactive contacting of women contrasts with DFV frontline services that are responding to reports and requests for service. Because they are sometimes the only staff member having direct contact with victims/survivors, PC practitioners require a high level of competency and autonomy to operate effectively and consistently.

We found that many PC professionals had little understanding of men's behaviour change theory and practice; some reported feeling actively discouraged from trying to learn more. This has serious consequences for the support and safety of victims/survivors. DFV professionals who are newly entering PC need careful induction into the principles and practices of men's behaviour change work, including cold-calling, what the research says about perpetrators "changing" their behaviour, and identifying program-instigated risk.

In many agency contexts, the sidelining of PC means that workers are at risk of isolation. The solution appears to be strongly integrating workers into the everyday work of the perpetrator program—regardless of what organisation provides the PC service. Supervision needs to be provided by professionals with specific knowledge of PC; communities of practice are also valuable.

Several of our informants flagged concerns about the practice of facilitators undertaking PC, noting the potential for inadvertent disclosures. While there is always a need to ensure victims'/survivors' experiences and needs inform work with program participants, this should not come at a cost to victims'/survivors' safety. This is not, however, only an issue of saying the wrong thing to the wrong person. Some PC workers expressed concerns about conflict of interest, a tension that has also been pointed out in the context of other research.

> "I definitely don't advocate for the same worker working with the men, working with her ... I feel that that 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 ... because you then have to try and remember who told you what."

> "When we're engaging so closely and supporting the victim ... to then put on that different hat [as a casual facilitator], and be actively supporting him, was very clearly a conflict in my mind."

Questions to consider:

- What are our understandings of the similarities and differences between PC and other forms of service delivery for victims/survivors?

- Do our PC practitioners have access to supervision that is specific and appropriate to their role? Does supervision reflect both the similarities and differences between PC and other work with victims/survivors?

- How do we induct PC practitioners to our program? In particular, how do we ensure they can speak knowledgeably about how our program operates and why it is important not to base safety decisions on "him changing"? (See also questions on program-instigated risk above.)

- Does our PC worker have opportunities to network with PC workers from other organisations, as part of formal or informal communities of practice? Does management create space for and encourage this?

- Given that we are accountable for what happens as a consequence of the man enrolling in our program and have a clear priority on the safety of victims/survivors, how do we ensure an independent, rights-based, victim-centred service for them, that is not influenced by a "perpetrator's point of view"? (Work with Perpetrators European Network, 2019)

Ongoing risk assessment and risk management

Their relationships with victims/survivors mean that PC practitioners can often provide unique insights into risk assessment, risk management and case reviews. This is especially important given that it is generally not possible to gauge an accurate assessment of risk based on the perpetrator's self-reports alone.

Our research found that jurisdictional risk assessment tools are regularly used in the course of PC. Frequency of use varies between organisations, with some using a tool weekly or at every contact, and others using them at MBCP stages and/or when an incident arose. Many PC workers applied the tools within narrative processes, rather than working through them in linear fashion; this approach was seen as more appropriate to the supportive and sometimes quasi-therapeutic context of working with victims/survivors.

Risk assessment tools are generic and largely designed to be used in any DFV context. This may partly explain program-instigated risk being significantly under-acknowledged in the findings of our research. This issue needs to be uppermost in the thoughts of all professionals working within the context of men's behaviour change, including in PC.

Risk assessment is best when it is informed by a variety of sources; likewise, risk information is most useful when it can be accessed by other parts of a service system and when multiple agencies work together towards managing risk and supporting safety. PC workers are well-placed to both obtain and share information across programs and agencies, and to contribute towards multi-agency risk management discussions and actions.

Safety planning is an important part of PC, regardless of a person's level of risk. Many jurisdictions have practice guidance, tools and templates for DFV and other practitioners to assist victims/survivors to develop and/or enhance a safety plan, and also to plan for or with their children. Research strongly supports face-to-face contact for the purposes of risk assessment.

Communication with men's practitioners

In our research, we asked PC professionals to provide information about the regular and routine processes used to exchange information about perpetrators and (ex-)partners between the PC service and MBCP facilitators.

Regular (weekly or fortnightly) face-to-face meetings, email and/or telephone calls were the most commonly utilised methods of information exchange. Case review, safety meetings or weekly handover meetings were some of the more formal processes mentioned. Some facilitators of women's survivor groups also participated in group supervision with MBCP practitioners, although this was not common.

Exchanges of information were reported to increase when risk and safety concerns were identified by either MBCP or PC staff, which is consistent with evidence that higher risk necessitates more attention. However, our research also highlighted that *all* MBCP and PC work is improved by exchange of information.

Questions to consider

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- How might we strengthen lines of communication between PC practitioners and those who work with men?
- How do we draw on information acquired through PC for the purposes of managing perpetrator-driven risk?
- How do we ensure that the expertise and perspectives of PC practitioners are at the centre of our risk management work?
- Do all of our staff who work with men have access to information provided by victims/survivors, and if so, how do we manage inadvertent disclosures to men of information given in confidence by them?
- Do all of our PC practitioners have access to case notes about, and information provided by, perpetrators?
- How do we inform victims/survivors about our information-sharing practices? To what extent can victims/survivors control what information is shared with whom (within the bounds of our duty of care to respond to serious or imminent risk)?

Reach, duration and form of contact

REACH

There are many different people directly affected by a man's use of violence. Some will still be in his life; others will not. They include sexual or romantic partners, recent former partners, children and step-children, and parents. To some extent, the purpose of PC will determine who a program reaches out to, but funding also informs this decision. It is important that the criteria and rationale for contact are clearly established.

Regardless of a program's capacity regarding the form and duration of support it can provide, the known benefits of PC and the potential for program-instigated risk mean that there is *always* a case for reaching out to adult victims/survivors who are still in a relationship with a program participant or who are separated but co-parenting with him.

Given that violence often escalates post-separation, there is also a strong case to extend an offer of support to a victim/survivor if the relationship ended within the previous two years, or if program staff believe—for any reason—that risk continues.

When a victim/survivor is already supported by a DFV service, it might not be necessary to provide a full complement of PC services; however, it is important to critically evaluate the capacities of a third-party provider to provide PC as a distinct service—especially given that PC encompasses more than crisis support and risk management. This situation might necessitate additional protocols and processes to ensure quality and timely communication between workers in different agencies.

> "We can continue to have contact with a victim for a prolonged period of time, where most women's DV services have a shorter time frame, such as six weeks."

> "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. Ideally, I think support should be funded for 3 months plus after he is out of the program as this may be a period of increased risk."

> "I am aware that the funding does not allow ongoing contact once the man finishes group; however, it seems unfair for that woman's support to be determined by the man's behaviour."

DURATION

Research supports not linking the provision of PC to a perpetrator's participation in a program. For example, his premature departure from a program is an established point of increased risk; likewise, him refusing to share his partner's contact details, or program staff being unable to establish any contact at all with his partner, might be cause for concern.

As well as having safety ramifications, this is a values-based position: a victim/survivor should not be penalised by her (ex-)partner's lack of engagement, nor should his engagement provide a program-sanctioned way to further control her. Seeing PC as a service in its own right, with men's behaviour change work providing a context for initial contact, might help to reframe thinking about duration. Research supports this position; however, it clearly also has resource implications.

> "Women are offered ongoing contact after program ended, given often [child protection authorities, family law court, and criminal justice system] and other agencies [are] still in their lives. Often advocacy and support at appointments becomes the main area of work … [These] services are sometime in women's lives for years and some women come in and out of contact as they need or certain dates are approaching. Other women want to stay engaged to keep the focus on particular matters, and they become stronger and more themselves through this ongoing contact."

Questions to consider:

- What are our criteria for who is offered PC? Are these sufficiently broad for us to feel confident that victims/survivors are not missing out? If not, what might we do to reach out further?

- Are our services to victims/survivors contingent upon a perpetrator's participation in our program? If yes, how does this accord with the purposes of our PC? What are the impacts on victims/survivors? Is the contingency intentional (i.e. a reflection of how we conceptualise our role)?

- Are we sufficiently conscious of the elevated risk that can be associated with a man prematurely ending his participation in the program? Do we have the PC capacity to intensify PC for a period when this occurs?

FORM OF CONTACT

It is widely recognised that face-to-face MBCP work with perpetrators is much more effective than work via phone. However, we found that capacity constraints often mean that PC is phone-based in the majority of contexts, with scant attention paid to the ways that this might significantly compromise the safety and effectiveness of the work. Phone-based contact can, for example, limit the depth and comprehensiveness of risk assessments with victims/survivors, with these being conducted in a more cursory, "tick the box" fashion. Likewise, communication solely conducted by phone is less likely to achieve the strong, trusting relationship between PC practitioner and victim/survivor that is necessary to ensure the latter feels comfortable to disclose intimate and/or sensitive information about her circumstances.

Our research suggests that an initial face-to-face encounter, supplemented by telephone and/or email communication and at least occasional face-to-face contact thereafter, is a solid benchmark for good practice.

Making contact and engaging

Many jurisdictions require MBCPs and other perpetrator interventions to attempt contact with (ex-)partners early in the process of perpetrator assessment and/or engagement. While our research supported this requirement, it also highlighted that this is rarely straightforward in practice. PC can be stymied by a range of difficulties making contact with victims/survivors, and by the challenges of engaging victims/survivors who might be scared and/or have more pressing concerns. It is not uncommon for perpetrators to gatekeep access to services or otherwise run interference on support being provided to their (ex-)partner, using it instead as another tactic of power and control.

Understanding victims'/survivors' context is key to both making contact and engaging them. Many of the PC professionals and victims/survivors we interviewed noted that perseverance is important—victims/survivors might take time to trust and feel confidence in what PC offers them, especially if they haven't themselves reached out for support.

> "[The] information-sharing scheme allows us to contact courts directly to access the summary of the application of the [intervention orders], which has partner's details on there. Police summary reports sometimes list [the affected family member's] details."

> "I think you really have to be tenacious and persistent; you don't give up on the first phone call ... [I want to know] that I've tried every possible way to make contact, because generally speaking, once I do make contact, most of them stay really engaged."

> "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."

Questions to consider:

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- What is our organisation's practice when a perpetrator is obstructing access to his (ex-) partner? Are there additional steps we could take to minimise the possibility that a victim/ survivor will miss out on our support due to a perpetrator's tactics of control? How do we weigh up the safety implications in a situation like this? Who is ultimately responsible for decisions about how we respond? If this is an individual practitioner's responsibility, what support and supervision do they require to make these kinds of judgement calls?

- Are we fully utilising the opportunities afforded by our jurisdiction in terms of information sharing within the DFV system? What organisational protocols and/or relationships are in place that would facilitate us (routinely) obtaining contact information about victims/ survivors from those sources rather than from perpetrators?

- What do we do to strike a balance between proactively and repeatedly offering support to victims/survivors, while respecting their right to not engage? Are there points that we could and/or should reach out to victims/survivors again even if they have declined our support initially? (For example, when the man is nearing completion of the program?)

Appropriate referral & case management

DFV occasions a range of possible supports including for legal, financial, housing, health, social services, parenting, educational (with respect to children), spiritual and other needs. While PC can meet some of these needs, workers almost always report limits on their capacities, if not also their skills, expertise and knowledge. As such, referral is generally seen as an appropriate way to provide a tailored response to the many, varied and complex needs of victims/survivors.

Our research found that external referrals, while needed, were often a source of frustration or difficulty for PC practitioners. They reported that the process needed to be carefully managed, and that the relationship between services and the client was a source of worry. Their concerns included whether the referral would be taken up by the other agency and/or their client; whether the client would receive the quality/depth of services they required; and whether further referral needs would be handled appropriately.

Research by others has highlighted the importance of continuity of support and of keeping external referrals to a minimum. This does not mean that victims/survivors should never be referred out: that same research identified the "guiding" nature of PC as beneficial in assisting women to negotiate complex service systems. Difficulty arises, however, when there is not a service available to pick up the referral, or when a woman (understandably) does not want to begin afresh with a new worker or agency.

There are few MBCPs in which case management is explicitly part of PC; however, many of our informants acknowledged that a case management role was necessary to adequately support the needs of some victims/survivors. Case management was seen as a desirable service to provide within the context of PC, especially in underserviced areas. At the very least, many PC professionals try to undertake some level of case planning, even if that is simply assisting victims/survivors to move towards articulating their hopes for their experience of PC.

> "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."

> "We partner well with other organisations, so they appear to women that the referral is within the organisation."

> "Often advocacy and support at appointments [with referred-to agencies and services] becomes the main area of work."

Questions to consider:

- What is our practice in case planning for victims/survivors and how might we enhance this?

- What do we know about victims'/survivors' experiences when they are referred to additional services outside of our agency? Do they experience it as seamless, or are there problems we need to address?

- What are the circumstances in which we sometimes need to refer a victim/survivor out of our service? For example, once we can no longer provide PC because the limits of our service have been reached?

- What information accompanies victims/survivors when they are referred out of our service? What, if any, duty of care do we continue to hold, and how do we satisfy that?

- What protocols, practices, partnerships and networking opportunities might boost our confidence to refer?

Discussing and supporting children's needs

DFV has a deep, long-lasting and very significant impact on children and young people. This means that it is both difficult and imperative to talk with women about their children's safety and wellbeing. These issues are highly complex and the Victorian practice guide *Assessing children and young people experiencing family violence* is recommended reading.

Our research suggests that providers of perpetrator interventions rarely have the capacity to actively reach out to children and/or see them as primary clients in their own right. This is largely a question of funding; however, some informants also believe the MBCP workforce is mostly unskilled to provide the specialist responses that children and young people require.

In the context of perpetrator interventions (including those targeting fathering), children's needs are most likely to be addressed via PC with their mother and/or via intra- and inter-agency referrals to specialist children and young people's services.

Our research also indicated that PC practitioners tend to focus more on issues of children's safety and less on broader impacts of DFV on children's wellbeing. Many of the victims/survivors interviewed for our research said they would have liked *support* for their children (especially in the form of counselling), but that none was offered.

In addition to continuing to make appropriate referrals, our literature review suggested that there are many ways that PC professionals could respond to the many needs that arise for children and young people, such as by working with mothers to:

- assess risks to children's safety, stability and development
- explore and name the perpetrator's impact on family functioning, on her capacity to parent, and on her bond with her child/ren
- identify and name aspects of the perpetrator's parenting that are problematic
- make case plans for children
- assess and enhance their children's understanding of their father's participation in the perpetrator intervention.

Medium-term goals might be for PC professionals to attempt assessment of the impact of the perpetrator's behaviour on the safety, wellbeing and development of *each* affected child, drawing on information from a range of sources, and also to contribute to case/care planning for each child. Neither of these would necessitate an organisation directly engaging with or providing a service to the child or young person.

Of course, the burden of responding to the needs of children should not fall on non-perpetrating parents and PC practitioners alone. Practitioners working with men need to ensure that they draw on information about the non-perpetrating parent's experience and needs as a parent; this should inform all facets of the program's work.

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Questions to consider:

- To what extent do we assess risks to children's wellbeing and development, not just their safety, in the course of PC? What about exploring and naming the perpetrator's impact on family functioning, on a victim's/survivor's capacity to parent, and on her bond with her child/ren?
- Do we ever make case plans for children? If not, why not?
- Does our PC work include discussing with non-perpetrating parents how their child understands and/or is impacted by their father's participation in the perpetrator intervention? If not, how could this be incorporated into our practice?

Where next?

Our research clearly demonstrates the need for partner contact to involve integrated, genuine, flexible and ongoing support, regardless of a man's involvement in a program. It is clear that current levels of funding for perpetrator interventions do not consistently (or even commonly) enable these core features of safe and accountable partner contact practice. Partner contact services need sufficient funding so that partner contact:

- can include in-person sessions or face-to-face outreach support where indicated, rather than relying entirely on the telephone as the medium of contact

- is not tied to a perpetrator's participation in the program, and can, for example, be provided to (ex-) partners of perpetrators who do not complete comprehensive intake and therefore do not start the program, and can be provided for a significant period after the perpetrator ends 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 and on children and young people, and work towards assisting developing case plans for medium- and long-term recovery and wellbeing.

Lack of resources notwithstanding, there are clear ethical responsibilities for providers of perpetrator interventions to ensure that program-instigated risk is identified and addressed, and that gendered power dynamics embodied in program operations (including in parallel processes) are named and actively countered. These practices reflect patriarchy, rather than resourcing, and would go some way towards addressing some of the pressures on PC practitioners as they strive to fulfil the purposes of PC.

We found a significant discrepancy between the skills, understanding and nuance required of PC practitioners and the training and professional development available to them. PC needs to be seen as a DFV specialisation in its own right, and workforce development resourced accordingly. Work to establish communities of practice—across agencies and even across jurisdictions—could commence immediately.

Finally, our research also revealed significant differences in uptake of PC by eligible victims/survivors, although explaining those differences was beyond scope. More research is needed to determine what organisational and micro-practices might be associated with these higher rates of partner engagement.

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to Reduce Violence against Women & their Children