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# Table of Contents

## Peer Reviewed

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gale, N &amp; Stone, C</td>
<td>Requirements for Specific Practice Models to Help Young People who have Experienced Domestic and Family Violence</td>
</tr>
<tr>
<td>Hannan, A</td>
<td>Over Her Shoulder: an examination of women’s perceptions of their relationship within the context of domestic violence</td>
</tr>
<tr>
<td>Husband, A</td>
<td>Domestic Violence outside the domestic sphere: An organisational response to domestic violence occurring during homelessness in young people</td>
</tr>
<tr>
<td>Kilroy, D</td>
<td>Providing Innovative Domestic and Family Violence Counselling and Prevention Programs with Women Prisoners</td>
</tr>
<tr>
<td>Winter, R</td>
<td>Risk or Vulnerability: Read Flags for Intimate Partner Violence</td>
</tr>
</tbody>
</table>

## Non Peer Reviewed

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pike, M</td>
<td>Can Brief Interventions, such as solution-focused interventions, support Health Professionals in Safety Planning with victims of Family Violence?</td>
</tr>
<tr>
<td>Rosevear, W</td>
<td>Translating Love into the Prevention and Healing of Domestic Violence</td>
</tr>
<tr>
<td>Shorten, H</td>
<td>Engaging the Family in Domestic Violence Cases: Bridging the Gap Between Child Welfare Agencies and Families Experiencing Domestic Violence</td>
</tr>
<tr>
<td>Vicary, D. et al</td>
<td>Caring Dads: Helping Fathers Value Their Children</td>
</tr>
<tr>
<td>Vicary, D. et al</td>
<td>Mothers in Mind: A New Response to Early Intervention, Support and Recovery for Women and Children affected by Abuse and/or Family Violence</td>
</tr>
</tbody>
</table>
Requirements for Specific Practice Models to Help Young People who have Experienced Domestic and Family Violence

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ABSTRACT: Experiencing domestic and family violence (DFV) during the critical developmental times of adolescence and emerging adulthood has consequences that are distinct from those of experiencing DFV during prepubescent childhood or full adulthood. Young people’s experience of DFV is a neglected area in both research literature and practice models to assist this group.

This paper sets out the evidence on the prevalence of DFV for young people, especially disadvantaged young people, as well as indications that this evidence underestimates the true extent of the issue. The discussion includes detailed analysis of the results and methodological challenges of a survey of youth homelessness shelters on the prevalence of DFV. Indications are that the prevalence of DFV is much higher for this group than currently available data suggests, based largely on the self-reporting of DFV by young people.

The paper also looks at the research on the effects of trauma during adolescence and young adulthood and from this outlines what a specific practice model to help young people who have experienced DFV would need to include. Such a model would need to address the effects of DFV on developing belief systems, identity, coping mechanisms and resilience. It would also need to be supported by further research on this neglected area.

Introduction

It is not widely recognised that young people’s experience of DFV is different to that of mature adults or pre-pubescent children. Too often the victims of DFV are described as “women and their children”. Young people are not merely passive witnesses to trauma. Even as witnesses they may experience trauma, but too frequently they are themselves the target of violence. If raised at all, the prevalence and impact of DFV on ‘young people’ and ‘children’ is discussed synonymously, as though trauma during critical developmental phases will not have specific impacts.

This lack of recognition means that there is little data on the prevalence or characteristics of young people and experiencing DFV, and little understanding of the specific impacts. The consequences of this are that the prevalence of youth’s experiences of DFV is often substantially underestimated, and that the significance and complexity of its impacts are
underrated. Not only are more young people affected than is generally acknowledged, the impacts of DFV during critical periods of development have substantial consequences that are not recognised. The combination of these errors obscures the critical need for a specific practice model for assisting young people who have survived/escaped DFV.

There is a need to outline what we do know about young people and DFV. This is attempted here along with results from a survey capturing some data about those young people in the homelessness services system who have experienced DFV. There is also a need to design a practice model for those, such as homelessness services workers, who assist these young people. At this stage further research is required to develop a full model, but the outline of a model is possible, and is presented here.

**Prevalence and Characteristics**

It is widely accepted that the data surrounding the prevalence of young people’s experience of DFV is incomplete and unrepresentative of current trends. A number of barriers to assessing the extent of young people’s exposure to DFV have been reported.

Many incidents of DFV, irrespective of the age of the victim, remain unreported. The NSW Bureau of Crime Statistics and Research interviewed victims of DFV and found that one half of the victims had reported their most recent incident of DFV to the police. Only 59% had reported at least one of their previous victimisation episodes to the police. Cited reasons for not reporting were fear of revenge or further violence by the perpetrator (14%), feelings of shame and embarrassment (12%) or a belief that the incident was too trivial or unimportant (12%). Ten victims stated that they had previously had a bad or disappointing experience with the police, while 8% thought the police would be unwilling to do anything about the violence (Birdsey & Snowball, 2013).

Further, socio-cultural differences in what is perceived and understood as DFV mean that it is not always reported or acknowledged as a social problem or indeed, one that requires attention. For example, the International Violence Against Women Survey (Mouzos & Makkai, 2004) found that stranger-perpetrated incidents were perceived as crimes more often than those perpetrated by known males (42% and 26%, respectively) but complaints to the police remained low regardless (27% and 10%, respectively). Further, women reported that they rarely sought assistance from specialised services or the police but opted to speak to
The majority of data used to inform policy is often collected from specialist women’s services. Therefore our understanding of DFV stems primarily from women’s (or mother’s) experiences, while those of children remain unreported. Yet, during additional analysis of the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) by Australia’s National Research Organisation for Women’s Safety (2015), it was observed that 54.2% of women who experienced violence by a current cohabiting partner had children in their care at the time of the violence. Of those, 57.8% of the children heard or saw the violence. For women who had since left their violent cohabiting partner, 77.5% reported that their children had seen or heard the violence.

The data that we do have on young people’s exposure to DFV illustrates the need for better understanding of this issue as they face greater challenges to overcoming the abuse than a mature adult in an equivalent situation.

DFV and family/relationship breakdown is the main reason given for accessing specialist homelessness services (SHSs) by 45% of children and young people under 25 (AIHW, 2015). Yet this likely underestimates the importance of the issue. Young people may be guarded and reticent to share their experiences (Fox et al., 2012), and so it may take a considerable amount of time before a young person feels safe enough to share their experiences. DFV may destroy their ability to trust others, particularly adults, and the stigma and shame young people associate with their experiences have contributed to its underreporting to SHSs and other agencies collecting data. For those that have experienced DFV from a very young age, they may view DFV as ‘part and parcel’ of their day to day and not recognise it as a key factor or, indeed, a problem.

Analysis of the data from the Australian Institute of Health and Welfare (AIHW) (2015) SHS report 2014/15 indicates that the gendered nature of DFV varies with age. The prevalence of DFV for male and female children is similar up to age of 14. As children grow, the prevalence for young females becomes much higher than for young males. The ratio changes to approximately 2:1 for ages 15-17, and over 5:1 for ages 18-24.

Young women are at a higher risk of intimate partner violence than older women, with those aged 18 to 24 twice as likely to experience sexual assault, and those aged 15 to 19 four times
as likely. The PSS (ABS, 2012) identified that 13% of young women (aged 18 to 24) experienced at least one incidence of violence in the 12 months prior, a rate higher than for any other age group surveyed.

We also know that there are certain cohorts of young people who are at greater risk of DFV such as Lesbian Gay Bisexual Transgender Intersex Queer Asexual (LGBTIQA+), Culturally and Linguistically Diverse (CALD) and Indigenous Australians as a result of various factors such as language barriers, cultural differences, homophobia/transphobia and racism. In some cases, young people can belong to more than one of these groups, placing them at further risk (LGBTIQA+ and CALD communities, where there are issues surrounding family ‘honour’ (Constable et al., 2011)).

Current data collection methodologies provide limited information about a complex issue. There are a myriad of areas that we believe require rigorous and immediate investigation, such as:

- How are young people accessing and utilising DFV services. Where are the service gaps? Do they differ in rural and regional parts of Australia?
- What needs to change in the current system for minority groups (e.g. CALD) to access relevant and culturally appropriate support?
- What about boys who are excluded from accessing women's refuge services? Currently, very few refuges accept boys over 15 years old (Families Australia, 2014). Where do they go? How many families are not seeking support due to lack of services that accept both their male and female children?
- Investigations into why the gendered nature of DFV varies with age. Is it at least partly due to a lack of reporting by young male victims? Could a lack of reporting be driven by a lack of services they can access? Might reluctance to report be driven by a perception that, because the typical perpetrator is male, they might not be taken seriously as a victim?
- We need to know more about the perpetrators. Do adult abusers stop committing violence against young boys at a particular age and, if so, why?

In their research, Mullender et al. (2003) highlighted two issues crucial to children’s ability to cope with DFV and its effects on them; the importance of being listened to and taken seriously as participants, and being actively involved in finding solutions and decision-making (CCYP, 2016). Given that we have known this for over a decade now, the absence of
any youth voice in tackling DFV is striking.

A Survey of Youth Homelessness Services

In an attempt to fill some of the above mentioned gaps in the data, a survey was conducted of thirty-five NSW services supporting young people experiencing homelessness, asking the following questions about the experience of DFV amongst the young people being assisted:

1. How many young people are accessing your service at present?
2. How many young people accessing your service (at present) have experienced domestic and family violence? (That you're aware of)
3. What is the average age of young people in your service who have experienced domestic and family violence? (Categories: [12-15] [16-17] [18-24])
4. How many of the young people who have experienced domestic and family violence had family members involved with domestic and family violence in the past?
5. In general who is the main perpetrator of violence in the majority of these young people's lives? (Categories: [Parent/guardian] [Other relative, e.g. sibling] [Intimate partner] [Non-family member e.g. housemate])
6. What do you need as a service provider to support young people experiencing domestic and family violence?
7. What is your relationship with your local DFV service(s)? (Categories: [No service present in my area] [No relationship] [No formal partnership but collaborate when required] [Partnership] [Partnership with Memorandum of Understanding])

The survey provided some key pieces of data in this under-researched area that are outlined below. However, given the need for further research in this area it is perhaps just as important to consider what data the survey failed to gather. A full discussion of the methodological challenges of this survey is included to help guide future research.

Key Findings

Prevalence: The most important finding of the survey was the indication that the prevalence of DFV amongst young people experiencing homelessness is much higher than previously estimated by data relying on self-reporting of DFV at initial contact. As stated above, AIHW (2015) data shows that 45% of children and young people under 25 accessing SHSs give DFV and family/relationship breakdown as the primary reason for needing assistance. Of the
thirty-two services in this survey that were able to state what proportion of their young people had experienced DFV, twenty-seven reported a proportion higher than the 45% in the data from AIHW (2015). Many services gave significantly higher numbers. Fourteen reported 80% or more, with half of those saying all of their young people had experienced DFV.

Intergenerational DFV: The high prevalence of young people experiencing intergenerational DFV was also an important finding. Of the twenty-three services that answered this question, thirteen reported that three-quarters or more of their young people who had experienced DFV had family members involved with DFV in the past. All but three services reported half or more with family members having experienced DFV.

Source of violence: Of the thirty-four services answering this question, twenty-six reported that parents or guardians were the primary source of violence for young people experiencing DFV.

Coordination with DFV services: Only around one third of services had a (formal or informal) partnership with a local DFV service. Most reported that the collaborated when required with their local DFV service.

Methodological Challenges

The survey was conducted by attempting to contact sixty-five services by phone. Unresponsive services were recontacted if possible. The survey was conducted across only two days to avoid the possibility of double counting young people moving between services. Thirty-five services responded. As well as common methodological challenges, such as the possibility of reporting bias, the following issues were encountered:

Varying accuracy: Although there was no question that assessed the accuracy of answers, the likelihood is that this varied widely. Speaking to survey respondents it was clear that in some cases they were giving exact figures from a client database. In other cases, particularly in the case of small services, workers simply knew all their current clients. It was also clear that some respondents were giving round-figure estimates.

Reporting prevalence data: The number of young people in each service ranged from 2 to 203, and there was a tendency for larger services to report lower proportions of young people
experiencing DFV. So, if the average proportion is weighted by the number of young people in the service, it is 59%. However, if a straightforward average of the answers of the services is taken, it is 68%. Noted accuracy was not assessed, but there did seem to be a tendency for larger services to be more likely to estimate, so the latter number is likely more accurate. However, given the likely extent of estimate answers, both numbers give a misleading sense of exactness. For this reason the key finding is reported as ‘numbers of services reporting above certain proportions’.

Lack of intergenerational DFV knowledge: This item had the highest frequency of ‘no data’. Eleven of the thirty-five services could not give an estimate. Many services simply do not collect this information.

Multiple sources of violence: The question on this asked respondents to nominate ‘in general, the main perpetrator’ of violence as: a parent or guardian, another relative, an intimate partner, or a non-family member of the household. Focusing on the most common source of violence can give a misleading impression that it is overwhelmingly the most common. Although the majority of services nominated parents and guardians as the most common source of violence, it was clear from conversations with respondents that intimate partner violence was usually a close second. The question was also not sufficiently nuanced since many services stated that it was specifically step-parents that were the most common source of violence. A question that allowed services to state proportions for a number of sources of violence might have garnered better data.

**Impacts on Young People**

As with our knowledge of the prevalence and characteristics of young people experiencing DFV, our understanding of the impacts of DFV on young people has significant gaps. However, a developing field of research that is beginning to fill the gaps in our knowledge of the impacts of DFV is that of focussing on complex trauma. Some of this research has focussed on child maltreatment. Child maltreatment only partially overlaps with youth DFV in that it includes behaviours, such as neglect, that are generally considered to fall outside the definition DFV. However, youth DFV is not a subcategory of child maltreatment because it encompasses sources of violence, such as intimate partner violence in young couples, which are not included in child maltreatment. Despite these distinctions, research on the effects of violent maltreatment of children is still relevant to our understanding of trauma experienced
during critical developmental phases and so is included here.

The relationship between wellbeing, stability and positive emotional health during adolescence (13-18) and emerging adulthood (19-25), together with satisfaction in later life, is well understood (Blakemore, 2012; Arnett, 2000; Emerson et al., 2015).

Trauma refers to an experience that creates a sense of fear, helplessness or horror, and overwhelms a person’s resources for coping (Hopper et al., 2010). A traumatic experience can be a single event, a series of events and/or a chronic condition. It can immediately impact on an individual or it can have delayed onset.

Research has shown that types of abuse rarely occur in isolation. The majority of individuals with a history of maltreatment, report repeated (chronic) exposure to several sub-types of DFV (Arata et al., 2005). This is multi-type maltreatment. Other forms of victimisation such as bullying have been found to co-occur with child maltreatment (Finkelhor et al., 2007), known as poly-victimisation. Thus, complex trauma is the culmination of multiple, interrelated and coexisting stressors or patterns of harmful events occurring over critical developmental periods and within specific relationship contexts (Courtois, 2004).

Complex trauma requires and deserves a targeted and individualised response; exposure to DFV is not a homogenous one-dimensional phenomenon (Jouriles et al., 1998). Every young person’s experience is unique – the outcomes may be debilitating for some, while positive for others (Lamont, 2010). There are a multitude of circumstances and factors that may impact on a child’s vulnerability or resilience to DFV, and each should be taken into account. Factors that may make an individual vulnerable include socio-economic disadvantage, social isolation and living in dangerous neighbourhoods while high quality peer relationships, positive school environment and child attributes may strengthen an individual’s resilience.

Further still, DFV is rarely an isolated event. It is something that potentially disrupts family functioning and may be one part of a broader ‘adversity package’ (Holt et al., 2008; Rossman, 2001). This may include a multitude of risk factors, e.g. parental substance abuse, mental health difficulties, unemployment, homelessness, social isolation and involvement in crime (Golding, 1999). It is important that all components of this adversity package are considered when supporting young people as “the presence of multiple stresses in a young person’s life may both elevate the risk of negative outcomes and possibly render indistinct
the exact relationship between DFV and those negative outcomes” (Campo et al., 2014).

Practitioners supporting young victims of violence do not always fully understand the effect of cumulative harm on them. One explanation is that traditional mental health diagnoses, such as post-traumatic stress disorder (PTSD), often do not adequately capture the effects of chronic and/or multiple types of victimisation (Briere & Spinazzola, 2005). The DSM-IV Field Trial for PTSD supported the notion that trauma, particularly prolonged trauma, that first occurs at an early age and that is of an interpersonal nature, can have significant effects on psychological functioning above and beyond PTSD symptomatology (van der Kolk et al., 2005).

Complex trauma is not currently recognised by DSM-V, the international classification manual of mental disorders. A flaw of the current classification system is that, following trauma, it often reveals no diagnosis, inaccurate diagnosis or inadequate diagnosis (van der Kolk et al., 2009). Failure to officially acknowledge the reality of trauma and abuse in the lives of young people, and the long-term impact this can have on them as adults, is one of the significant clinical and moral deficits of current mental health approaches.

Without this, victims/survivors risk being stigmatised with a multitude of diagnoses (Cloitre et al., 2009). Parallel diagnoses do not fully acknowledge the interaction of symptoms and social factors that result in the problems experienced by sufferers (van der Kolk et al., 2005). However, care must be taken to ensure that classification does not hide the realities of complex trauma (Bremness & Polzin, 2014). Individual differences in how chronic abuse is perceived and experienced means that there must be flexibility for workers to adapt approaches to suit the needs of each individual.

It has been shown that chronic child maltreatment reports are a strong general indicator of future negative health and behavioural outcomes, including behavioural, neuropsychological, cognitive, emotional, interpersonal and psychobiological disorders (Becker-Weidman, 2009; Jonson-Reid et al., 2012).

Those adults who reported experiencing more than one sub-type of maltreatment, demonstrated significantly poorer wellbeing than adults reporting a single form, or those reporting none (Higgins & McCabe, 2001; Jonson-Reid et al., 2012).
Six domains of potential impairment related to complex trauma have been outlined: (a) affect regulation including anger-management and being self-destructive; (b) information processing including attention, concentration and learning difficulties; (c) self-concept including guilt and shame; (d) behavioural control including aggression and substance abuse; (e) interpersonal relationships including trust and intimacy; and (f) biological processes including delayed sensorimotor development (Margolin & Vickerman, 2007). The impacts of trauma characteristically persist long after the trauma has ended (Bateman et al., 2014).

At each stage of child development, children and adolescents have various age and stage salient tasks to achieve in order to become a fully functioning human being (Gimson & Trewhella, 2014). Adolescence and emerging adulthood are distinct stages of the life cycle, particularly in terms of identity exploring and role experimentation (Arnett, 2000; Munsey, 2006).

Adolescence is a physical, social, emotional, cognitive and behavioural growth period of life (American Psychological Association, 2002). It is a time when behaviours are established, many of which are sustained across the life span. Young people choose a career path, develop their skills and competencies, establish an identity and obtain greater responsibility and independence.

Increased experimentation in adolescence can be linked to the development of resilience and coping mechanisms. It is these attributes that can help in overcoming adversity in adulthood. The coping mechanisms developed by adolescent victims of DFV to manage anxiety and distress include suicidality, substance abuse and addiction, eating disorders, self-harm and dissociation (American Psychiatric Association, 1993; Jaffe et al., 2012).

Arnett (2000) coined the term ‘emerging adulthood’ after finding that many 18-29 year olds have a shared perception of feeling ‘in-between’, i.e. taking responsibility for their lives yet still feeling like an adolescent. Emerging adults are still pondering their identity, especially relating to love and their career path. It is viewed as an age of possibilities and self-focus but also of instability (Munsey, 2006). Exploration in love becomes more intimate and serious than during adolescence, and an emerging adult is developing important character qualities vital to moving towards being self-sufficient. Emerging adults who lack fundamental cognitive, emotional, familial, societal, and cultural supports are also at risk of suffering adverse effects from trauma exposure (Becker et al., 2004).
For young victims of DFV, this transition period can be even more challenging than for other adolescents and emerging adults.

A Practice Model

Our growing understanding of the effects of trauma on young people allows us to begin speculating on what a model would involve for assisting young people who have experienced DFV by looking to a trauma-informed model of care and practice.

Although there is no universally agreed definition of trauma-informed care and practice (TICP), Hopper et al. (2010) developed a consensus-based definition based on their review of the literature. It is a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.

TICP requires practitioners to appreciate that an adolescent’s responses and coping mechanisms have developed in the context of trauma. It recognises the impact of external, socially embedded causes of distress, trauma and disadvantage (McKenzie-Mohr et al., 2012). The focus is not on what is ‘wrong with’ the adolescent, but rather on what wrong was done to the adolescent.

Principles of TICP differ slightly from one researcher to the next, but there are five generally agreed upon core principles (Hopper et al., 2010; Hummer et al., 2010; Funston, undated):

1. Understanding trauma and its impact
2. Safety
3. Ensuring cultural competence
4. Control, choice and autonomy
5. Collaboration

Understanding trauma and its impact

In the previous section we touched briefly on an individual’s unique disposition and personal experiences being key in determining whether or not it is traumatic. For example, a young
person who experiences one or two incidences of DFV may experience and interpret these events in the same way as a young person who has experienced chronic DFV.

Put simply, single traumas do not necessarily have a lesser psychological impact than repeated traumas. However, individuals who have encountered multiple and longer doses of trauma are at greater risk of developing complex trauma, especially when endured during the formative years of adolescence and emerging adulthood, interfering with their sense of safety, ability to self-regulate, sense of self, perception of control and self-efficacy, and interpersonal relationships. Typical maturation is disrupted as belief-systems and worldviews have developed both in the context of complex trauma and at a time when they are still developing and more sensitive. Their challenging behaviours and responses represent adaptive responses to past traumatic experiences (Bateman et al., 2014).

It is essential, therefore, that all services screen for trauma at first contact with the young person accessing their service. Currently, very few do. A study by Lewis et al. (2010) highlights the importance of identifying individual trauma histories. They found that a significant trauma-by-treatment-by-time interaction reveal that the different trauma groups responded differently to trauma.

Safety
Providing the young person with a physically and psychologically safe environment is the bedrock of TICP, primarily to protect against the risk of further traumatisation.

It is important to remember that incidences of DFV involve boundary violations and abuses of power, often by someone trusted. Young victims are likely to be mistrustful and to perceive services and their workers as a further threat rather than a helping hand. As a result, while their intentions are good, services and their workers may often – inadvertently – do more harm. Clinical set-ups may produce re-traumatising settings without being aware, such as, for example, using isolation or physical restraints, imposing policies and rules without exceptions or an opportunity for clients to question them, limiting participation in treatment plans, labelling behaviours and/or feelings, and disrupting counsellor-client relationships.

Practitioners should be aware of potential triggers. Re-traumatisation may occur when clients experience something that makes them feel as though they are undergoing another trauma.
This happens at an unconscious level and the individual may be left with unpleasant feelings that they cannot understand (Barton et al., 2012).

Trauma-sensitive environments need to be calming, predictable and reliable. To achieve this, it is not just practitioners who must adapt their way of thinking, but the organisation as a whole. Staff need to empathise with adolescents and be aware of how the impacts of violence and victimisation might have hindered a young person’s development and coping mechanisms.

Practitioners should not assume that an adolescent in their care is out of harm’s way. They should be informed of their rights and supported in obtaining police protection, where necessary.

Lastly, the safety and wellbeing of staff working with traumatised individuals mustn’t be forgotten. Workers in this line of work are continually in an emotionally charged environment. Providing ongoing supervision and support for practitioners will help to mitigate the impacts of vicarious trauma, as many practitioners will have experienced trauma themselves which may be triggered by client responses and behaviours.

**Ensuring cultural competence**

This can be achieved through providing a culturally safe and gender-sensitive service. Culture might impact on how a young person experiences and perceives trauma and violence. Trauma may have different meanings in different cultures and traumatic stress may be expressed differently within different cultural frameworks. Practitioners must be aware of their cultural worldviews and histories and how they may influence engagement with young people (Elliot et al. 2005). They might consider doing this by, for example, asking the young person to educate them on their culture. It will be up to each organisation to provide adequate training on how to engage appropriately with young people and ensure such cultural competence.

Practitioners must be sensitive to other individual differences amongst clients and attuned to the prejudices they may have faced as a result, e.g. sexual orientation, religion, age, economic class, disability and ethnicity. All of these characteristics may interact to create more or less stigma associated with violence and trauma.
Control, choice and autonomy

“People with complex trauma will often respond better to treatment when they are empowered in ways that are unique to them, and [practitioners] should not underestimate their patient’s ability to be useful and active in their own treatment” (Kezelman & Stavropoulos, 2012).

TICP should be tailored and individualised by adapting the therapy to the client rather than the other way round (Kezelman & Stavropoulos, 2012). The goal is to help young victims regain a sense of control over their lives and to build competencies that will strengthen their sense of autonomy (Bateman et al., 2014). Authoritarian or punitive treatment styles can cause re-traumatisation because patients re-live the experience of coercion and power used by the perpetrator.

An important characteristic of feeling empowered, is the ability to take charge of your life, to have conscious choice and control over your actions. Adolescents must be made aware that they have the right to refuse to answer a question, to refuse treatment and, within the limits of the organisation, to request different staff, modify their treatment plan and set limits. Adolescents should be involved in designing treatment services and be part of an ongoing evaluation of those services (Elliot et al., 2005).

Collaboration

TICP acknowledges the power imbalance in the patient-practitioner relationship and asks practitioners to do their best to flatten this hierarchy (Elliot et al., 2005). The trauma of a perpetrator having power over the adolescent is more effectively healed using a collaborative and empowering set up. While boundaries, which are a combination of warm and consistent, are important, these should be mutually negotiated and care should be taken to ensure that the client understands their significance and does not experience them as punitive (Bateman et al., 2014).

Practitioners and organisations need to ensure that communication is open and respectful. Trauma needs to be healed in a context in which the interpersonal relationships are the opposite of traumatizing. A RICH relationship is defined as one that offers respect, information, connection and hope (Saakvitne et al., 2000).
Conclusion

It should be clear from the above that young people experiencing DFV are likely to have distinct characteristics, and that the DFV is likely to have specific effects on young people. It should also be clear that not enough is known on both these subjects. Although challenging, as illustrated by the survey, further investigation is required. A better understanding is required to help young people, whose numbers are certainly higher than often estimated, escaping DFV. Further research towards a model, perhaps similar to the outline presented here, of assisting these young people is a clear necessity.

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Over Her Shoulder: an examination of women’s perceptions of their relationship within the context of domestic violence

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Paper Presented at the
2016 STOP Domestic Violence Conference
Brisbane (QLD) 5-7 December 2016
Over Her Shoulder: an examination of women’s perceptions of their relationship within the context of domestic violence

**Abstract:** This study investigated the partner relationship that exists in a domestic violence situation; specifically, how women perceive their relationship, before, during and after the violence occurs. The purpose of this study was to explore the role of the relationship in a women’s decision to stay or leave. Participants were recruited through a third party agency to ensure safety and privacy was maintained for all parties involved. Data was collected through a small focus group, divided into both an individual and group session. The women were asked to discuss how they perceive(d) their relationship before the violence began, during the violence, and after the violence had ended. A thematic analysis found four categories commonly experienced by all the women – wordlessness, survival, responsibility and control. The findings suggest that the relationship that exists within the confines of a domestic violence situation, has an intense and ongoing effect on a woman’s decision to stay or leave their partner. The results of this study give insight into the lived experience of domestic violence, suggest the appropriate practice knowledge and skills needed for effective intervention and indicate the aspects of domestic violence that require further investigation.

**Keywords:** Domestic Violence, Intimate Partner Violence, Women, Perceptions, Relationships

Domestic violence is defined as one individual’s abuse of power in relation to another by means of asserting dominance and/or control (Bird, Crofts & Schubert, 2014). A phenomenon that has existed through the ages, domestic violence is still a current social issue that effects individuals regardless of age, social status, gender, religion, sexuality and ethnicity. Affecting 1 in 3 Australian women at some point in their life, domestic violence is an issue that was only brought to the public stage in the last few decades (Chadwick & Morgan, 2009). Described by Cronin (2013) as ‘the tip of the iceberg’, there are many aspects
of research into domestic violence that has yet to be thoroughly explored. A particular focus of current research into the field of domestic violence, focuses on the reasoning behind a woman’s decision to either stay or leave an abusive relationship (Campbell, Dziegielewski & Turnage, 2005; Payne & Policastro, 2013). A factor that has had minimal exploration is the role of the relationship itself (Harlos, Ochoa-Shipp, Pulsipher, Swindler & Yamawaki, 2012). To assist in learning more about the lived experience of domestic violence, this exemplary study will look at the relationship, specifically how women view their relationship prior, during and after the occurrence of domestic violence.

*The Big Question*

In today’s western societies, there has been a movement in providing women with the resources for them to leave their abusive situations (Meyer, 2012). However, with publication of horrific stories where women have ended up being killed by their partner, there is a question that the public are driven to have answered – why don’t they just leave? From this question a responsibility has been placed on researchers to answer it, explain the reasoning behind a woman’s choice to either stay or leave a violent relationship (Tiggman & Worth, 1996). Literature has found that the process of leaving an abusive partner is a complex one, in which a woman may leave and return a number of times before finally ending the relationship (Murray, 2008). In a 2014 study, Boonzaier, Gobodo-Madikizela & Shalkwyk examined this process and found that a number of variety of factors play a significant role in how a woman makes her decision to either stay or go (McDonough, 2010). Enander & Holmberg was a 2008 study that explored the factors that can influence a woman’s decision to stay or leave a relationship, it found that an abusive relationship is like a web where an array of factors makes it difficult to disentangle from it. Particular interest has moved to exploring the reasons why a woman is unable to leave, what are the factors that stop a woman from leaving her violent circumstances. Research has led to two trains of thought being formed, where a woman’s reasoning is motivated by either a victim mentality or a rational standpoint (Clark, Everson-Rose, Halasa, Khalaf, Shahrouri & Spencer, 2012).

The victim mentality was conceived from research that looked at the psychological wellbeing of women as being damaged or unhealthy, leaving them unable to break free of the relationship. One such piece of research was Fishel & Ryerson (1998) where it looked at learned helplessness wherein repeated control at the hands of their abuser leads to women believing they have no power and are unable to leave (Stoever, 2013). Other research looked
at the models around attachment and traumatic bonding as reasons for why women were unable to pull away from their partner (Duley, 2012; Gormley, McPherson-Halket, Mello, Pravder-Mirkin, & Rosenthal, 2014). Associated with internal issues of abandonment, dependency, love, guilt and fear, these models often result in the women being seen as victims to both their situation and their own flaws (Axsom, Rhatigan & Street, 2006). This ‘victim’ label invalidates women’s strengths within the relationship and ignores their ability to make informed choices (Collette, 2009; Dunn, 2005; Overstreet & Quinn, 2013).

In contrast, Meyer (2012) looked at the explanation of rational choice in women who choose to stay in abusive relationships. The study found that there is a process of risk evaluation undertaken when deciding to stay or go. This suggests women use a process of weighing the risks of leaving to the potential benefits and that staying is a rational choice made when risks supersede the benefits (Brohl-Perelli, 2004; Mele, Roberts & Woler, 2008; Meyer, 2012). Other interview based studies such as Axsom & Rhatigan (2006) came to the same conclusion by applying the Investment model and finding that some women choose to stay with their partner after evaluating the investing factors of the relationship (eg. shared children) and their consequential commitment levels (Rhatigan & Street, 2005). This illustrates an alternative viewpoint regarding women’s empowerment in situations of violence, where women are seen as having a degree of control over their situation and able to rationalise their circumstances before making an informed decision regarding their relationship (Calhoun, Cann, Truman-Schram & Vanallendael, 2000). The research by Meyer (2012) and Axsom and Rhatigan (2006) provides a foundation for the research described in this thesis, which is an exploration into the experiences of women whilst in an abusive relationship. Researchers have concluded that further exploration is needed to understand women’s rationale for staying (Douglas & Stark, 2010; Taylor, 2006).

A factor that has received minimal investigation is the intimate relationships between the victim and perpetrator itself. Discussion and recognition of the relationship as a significant element of the staying/leaving decision is under represented in literature (Bagshaw, Chung, Couch, Lilburn & Wadburn, 2000; Bookwala, 2002). Goodman, Liang, Tummala-Narra & Weintraub (2005) suggests that focus on women’s interpretations of the relationship could improve the understanding of why women stay in relationships (Martin, Nunly & Smith, 2013). As Cronin’s (2013) feminist research into the lived experience of domestic violence in older women suggests, the value of reclaiming the voice of the victims is significant. This
study will seek to understand the role of the relationship in a woman’s journey to leaving or staying in an abusive situation. By exploring the lived experience of the women who have first-hand knowledge, society’s understanding of what it is to live with domestic violence can only be improved.

**Method:** This study utilised a constructivist approach with a feminist perspective. This study utilises a constructivist approach in the exploration of women’s perceptions of their experiences with domestic violence. A constructivist approach aims to understand the world through the direct human experience and is based on the belief that knowledge derives from the reality of those who have this experience (Crotty, 1998, p. 43; Higgs & Trede, 2010, p.33; Mertens, 2005, p. 12). This study is designed to gain knowledge by focusing on the reality of each participant, and allowing understanding to be constructed through the participants’ engagement within the final data (Creswell, 2003; Knipe & Mackenzie, 2006, p. 197). A feminist perspective aims to identify, empower and provide opportunities to marginalised, powerless and oppressed groups, and therefore provides a guiding approach for the methodology and data analysis in this research (Collette, 2009, p. 38; Zosky, 2011, p. 202). Historically, women have experienced oppression at the hands of a patriarchal society; their experiences and their knowledge have often been disregarded and at times silenced altogether (Cronin, 2013, pp. 34-35). The fundamental principle of this research is to empower, it is designed to gain an understanding of women’s lived experiences by providing an opportunity for the women to have their voices heard and valued (Coombes & Morgan, 2013, p. 527)

Three women were used in this study, all of which were recruited through the domestic violence support agency Waratah - located in Bunbury, Western Australia; this was done as a means of maintaining privacy, and to ensure the safety of all parties involved. The three women selected pseudonyms that they would be identified by in both the data gathered, and the analysis. The women were all over eighteen years of age, had their abusive relationship end at least three months previously and had assigned workers with Waratah. The three women selected the following pseudonyms, from which they will now be identified by in this article: Em Bear, Ann Williams and Marissa Rivers. This study was designed to provide the women with a stage for their voices to be heard; to do this the qualitative method of a focus group was used. The focus group focused on the women’s lived experience of domestic violence by getting them to discuss their relationship at three stages – before the violence had occurred, during the violence, and after the violence had ended.
The focus group took place on the premise of the Waratah Support Centre, a neutral and secure location that the participants had visited before. The focus group lasted three hours including breaks. Prior to commencement of the focus group, all participants were required to read and sign both a consent and confidentiality form. This ensured that all participants were aware of their right to confidentiality, the rights of their fellow participants to confidentiality and the documentation of their agreeance to engage in the study. Other parties attending the focus group were also required to sign a confidentiality and consent forms, including the research staff. All participants then chose their pseudonym.

The focus group followed an agenda which was separated into four distinct sections – introduction, individual session, group session and debriefing session. The focus group was divided into both an individual and group session so participants would be able to produce their own input free of group dynamics and pressure. The individual session consisted of participants being presented with a scenario and asked to write down the first five to eight words that immediately came to mind. Participants were given ten minutes to write their words down. This process was conducted three times, each with a different scenario: the relationship before the domestic violence had begun, during the violence, and after the violence had ended. Each scenario was given 10 minutes, with the individual session being completed within 30 minutes.

A group session followed this individual phase in which the participants were presented with a large piece of white A1 sized paper. The piece was labelled ‘before’ and the participants were encouraged to write down the words they had listed in their ‘before’ individual brainstorm. The participants were prompted to discuss words that connected, surprised or related to their experiences before the abuse had begun, providing an opportunity for group discussion about their shared individual experiences. This process was repeated for the ‘during’ and the ‘after scenarios. Following an in-depth discussion the A1 group brainstorms were placed in order from ‘before’ to ‘after’ and the group was asked general prompt questions. Each scenario was given 40 minutes, with the group session taking around 2 hours to complete. Once the discussion had come to a natural end the group session for the focus group was concluded, and the recording was stopped. The debriefing session was then provided for the participants by the support worker staff member of Waratah Support Centre.
**Analysis:** The individual and group sections of the focus group were audio recorded. Notes were taken by the researcher’s supervisor during the focus group, they were used as points of consultation when initially analysing the data. The researcher transcribed the audio recording of the focus group verbatim; the transcript noted breaks, laughter and pauses to provide further meaning to the associated discussion (Bagshaw et al., 2000). Computerised copies of the brainstormings were made. Transcript of the focus group underwent a basic coding process in which four major themes were identified – wordlessness, survival, responsibility and control (Braun & Clarke, 2006). Notes and brainstormings were used to correlate with the codes found in the transcript (Lloyd-Evans, 2006).

At this point, two participants and the researcher met again at Waratah Support Centre and discussed the analysis. Participants were given the opportunity to read the focus group transcript and discuss the themes. Participants were encouraged to provide feedback on the analysis and the findings, this ensured no misrepresentation occurred in the final report (World Health Organisation, 2001, p. 16). The participant who had not been able to attend was provided a summary sheet of the analysis and the researcher’s contact details if they wish to discuss the findings. All participants agreed to the findings and gave their consent for the researcher to use the data analysis in her thesis.

**Findings**

**Wordlessness**

In this research, participants were asked to reflect back on their relationship and produce words they associate with their journey, from the beginning to the end. Wordless was a word that participants agreed best described their lived experiences and how they perceived their relationship as a whole. As participant Marissa Rivers states:

“….at the time I didn’t have the words, the language in my head to think about what words I would have used to describe the relationship…um, it’s hard to say…it’s just like having some sort of blinkers on inside your mind. So yeah, I don’t know what words I would have used at the time”

This difficulty in finding the words to describe their relationship was corroborated in research by Berns & Schweingruber (2007) in which participants, who had suffered domestic violence, had struggled to ‘make sense’ of their relationship. Upon further thematic analysis two subcategories were found to be contributing to this theme of wordlessness in women’s lived experiences; comprehension and silence.
Comprehension played a significant role in the women’s perceptions of wordlessness being a prominent element of their story. A lack of knowledge about what a healthy/unhealthy relationship was brought up on a number of occasions. Described by the women as naivety, lack of life experience and age were discussed as being factors in their diminished awareness of the true nature of their relationship.

“I really didn’t have any true idea about what a healthy relationships...at that age I was too young to know, to see it for what it. I was quite naïve”

The inability to spot the potential or signs of domestic violence is a common issue for young women when entering into a relationship. Literature supports these findings and indicates that women base their understanding of domestic violence on their own experiences and those of others (Berns & Schweingruber, 2007). Cordero (2014) suggests that although women experience abuse at the hands of their partner they don’t recognise it as domestic violence, or themselves as having lived experience of violence. As the quote above states, the participants were unable to see their relationship and the abuse for what it was, with the benefit of hindsight the participants could now reflect back and see the relationship as controlling and violent.

“I mean you don’t see that at the time but what I thought was attentive was actually quite controlling”

As Leslie Morgan Steiner, a survivor and advocate of domestic violence, states “I didn't know he was abusing me....I never once thought of myself as a battered wife. Instead, I was a very strong woman in love with a deeply troubled man” (Steiner, 2012). Being unable to comprehend the reality of their relationship situation left the participants of this study without the ability to ‘find the words’ to describe their relationship at the time.

Silence is an encouraged response to domestic violence; from historical societal expectations to threats from a partner, women are taught that staying quiet is their only option (Cronin, 2013). The women described a ‘fog’ that existed during the period of abuse, an all-consuming mass that dulled their ability to see clearly and find the ability to break the silence. As participant Marissa Rivers states:

“that there is still fear, at the back of you, almost a part of your brain...um even though you know you’re doing the right thing and you’re sort of clawing your way forward, there still a...like…the fact that you still speak is, it triggers this sort of fog, this confusion”

This literal loss of speech was addressed in Cronin (2013) in which her findings revealed that after the initial abuse or ‘ambush’, women are left in state of new victimhood where they are
unable to find their narrative as a result of debilitating emotional upheaval (Birnbaum & Buchbinder, 2010). The women were taught they had to stay silent as a means of avoiding further abuse, a method of survival throughout the relationship; this was such a necessity that the women remain in this taught behaviour cycle, in which they keep themselves silent (Cordero, 2014; Cronin, 2013). The wordlessness they experienced, and still experience holds a prominent role in how they perceived their relationships and its journey.

**Survival**

One of the biggest themes that rose from the data was survival, all participants disclosed the methods they had employed to survive through the relationship and eventually leave. Survival strategies can be seen as coping mechanisms, tools in which a woman maintains self-preservation by ways of stopping, avoiding and/or dealing with the abuse (Boreman, 2014). Each participant had their own unique journey of survival but all spoke of how they learnt to cope with their experiences of abuse. Consequently, two sub-categories were identified in the thematic analysis of the focus group transcribe: perfect wife and survival mode.

The perfect wife is often seen as someone who cooks and cleans, is always presentable and most importantly submissive to her husband and his needs. One of the women who participated described how she attempted to become the perfect wife:

“….be perfect enough for him not to get him upset or to have the house tidy enough or to have dinner on the table or his clothes laying out…you know you were just on eggshells or the time trying to make sure that you never stepped out of line, that you never did anything wrong”.

The idea behind the perfect wife persona is that a woman is the ideal partner, who never ‘does anything wrong’, she is less likely to anger her partner and consequently less likely to be abused. Davies, Lyon & Monti-Catania (1998) found that women use the persona as a means to calm and placate the abusive partner, if he feels that he is the dominant partner than he is less likely to attempt to control through abuse. The women spoke of this perfect persona as if it was a resorting strategy to subtly gain control; that if women were able to control the environment around the abuse then they are able to control the abuse itself. Participant Ann Williams disclosed the following:

“I was constantly trying to figure him out, trying to work out ‘well what is wrong here?’ I’m doing the best I can and I’m running as fast as I can…what’s the issue here? Why is he angry all the time? What’s just happened that’s just …..something’s being smashed or plates are being hurled around you know….chaos has erupted out of nothing…..”
As the literature indicates however, this often does not work and the partners would continue violence regardless of a women’s ability to be the ‘perfect wife’. Although research has found that abuse is in no way indicative of a women’s ability to keep a ‘perfect’ role, it has found that it is a common coping strategy that many women see as a significant element in their perception of surviving through their relationship.

Another survival strategy the women identified as using throughout their relationship was termed the ‘survival mode’. The goal of this survival mode was safety and it consisted of maintaining a hyper-aroused state through intense focus and detachment. During the relationship, the women were used to the spontaneous nature of the abuse and so were at an elevated level of alertness throughout their daily life. After the relationship had ended the women experiencing this hyper-alert state in the context of running away, waiting for the repercussion from the partner for leaving. As seen in one of the participant’s disclosing:

“I’m always thinking, ‘so where do I go with this?’, ‘where is far enough?’, ‘when is long enough?’…”

This hyper-alertness is corroborated in literature; described as living in a ‘war zone’, women who have experienced domestic violence rarely know when an attack will occur and often stay in a state of prepared waiting (Bauer, Quiroga & Rodriguez, 1996). As described by the participants there is a feeling of unrest even after the relationship has ended, the concept of safety is seen as either an illusion or a never reached ideal (Bauer, Quiroga & Rodriguez, 1996).

Another aspect of this survival mode was the participant’s detachment or stunting of their thinking/emotion whilst experiencing domestic violence in their relationship. The emotions the participant’s experience throughout the abuse was described as ‘overwhelming’ and as one of the participants describe – debilitating:

“you are just unfelt…you are drowning totally within a black hole of negativity and suffering, which really sucks you down and you feel like there’s no oxygen”

Cordero (2014) findings correlate with the experiences of this study’s participants, women would “disassociated from their bodies and minds as a means to cope with the abuse that was occurring to them at the time”. This detachment is an element of an atmosphere where there was no consideration of future, the focus is solely on the present – surviving day by day (Bostock, Plumpton & Pratt, 2009). This survival mode allowed the women to cope with the
abuse they experienced at the hands of their partner and eventually the repercussions of having decided to leave.

**Responsibilities**
Responsibility was a theme that carried throughout the timeline of the women’s relationships. Feelings of responsibility and the associated guilt and shame began at the beginning of the relationship and to a degree continued after the relationship had ended. The women spoke about their responsibility for the relationship; the feeling that they had been responsible for bringing violence into their families by engaging in the relationship to begin with. While the women did not see their partners’ actions as their fault, they described holding feelings of guilt that they had continued a relationship instead of leaving. Staying has been incorrectly recognised in society, and by women who have experienced violence, as a form of consent (Brohl-Perelli, 2004; Enander, 2010). Further analysis of this theme produced three subcategories: loving, protecting and hiding.

Manipulation is a common tool used by abusers to gain control over a victim. Perpetrators often resort to manipulation as a means of instilling compassion and commitment in the victim towards the relationship and himself. An example can be seen in the experience of one participant:

“For me, he came into my life with a huge chip on his shoulder. All the saga about his childhood, his hard life which kind of…it was said in a way that made me feel pity for him and so that tapped into my willingness to nurture him and to think ‘okay I’ll love him enough, I’ll fix him, I’ll heal him’…almost like the burden was on me to fix him with my love”

The concept of loving one’s partner enough to ‘fix them’ was a theme that ran throughout the course of this participant’s relationship and played a role in why she chose to stay. The promise of ‘till death do us part’ meant they saw an obligation to consistently work to improve the relationship, leave was not an honourable option (Cordero, 2014; Enander & Holmberg, 2008; Taylor, 2006).

Two of the participants discussed their experiences of raising children in their relationship, and the increased responsibility it placed on them. Having children was used as a tool for control by many of the perpetrators, as stated by Ann:

“The game is ramped up then because you’ve taken on enormous responsibility… a different level of control as you were unable to work and you had that extra responsibility to the children”
The introduction of children into the relationship was a catalyst for increased violence; Ann’s feelings of responsibility likewise increased as she now had the added pressure of ensuring her children’s ongoing protection and wellbeing. Responsibility for the children and the instinctual drive to protect them against all measures of harm can act as barriers that prevent an individual from leaving an abusive relationship (Murray, 2008). Whilst the participants did speak of the fear they felt for their children’s safety as reasons they remained in the relationship, one participant spoke of the role her child played in her decision to leave her relationship.

“I think my dropping point was my son…when I gave birth to him I realised I can do something right. And that’s when I thought ‘he needs to be safe and I need to get out’. And it took me almost two years to get out but I did…he gave me the strength to go”

This indicates that the factors that influence a woman’s choice to leave the relationship are individual to the person, and can be both barriers and motivators.

Traditionally, domestic violence was seen as a private matter that wasn’t to leave the confines of family (Cronin, 2013). With the recognition of domestic violence as a societal and public issue, people are encouraged to disclose and speak out about their experiences of abuse. Traditional values however remain an issue and can be seen in women’s attempts to hide evidence of abuse from the outside world (Crawford, Hill & Liebling-Kalifani, 2009). The women explored this theme in relation to friends/family and their knowledge of the abuse:

“I understood that it was hard for her [friend] to see him behave and treat me in that way….and that is kind of what keeps you secretive…because you know people will judge you. They will say ‘get out, it’s as simple as that’. They will say ‘why are you putting up with this? Get out…”

As described, there was a fear of being judged as if the abuse was something the women were to feel ashamed of. Studies have found that shame and embarrassment often lead to guilt as the women felt their responsibility of hiding the abuse was jeopardised (Enander, 2010). It is the fear and feeling of responsibility that can lead to women isolating themselves as a measure of concealment, inevitably creating a further barrier that keeps them from leaving (Buchbinder & Eisikovits, 2003).

**Control**

The women’s recollection of the three phases of their relationship indicated that control was a major theme for them. Control was indicated in the women’s descriptions of their partner and his behaviour; it was a fundamental motivation for domestic violence, and a primary method
for gaining the power perpetrators wish to exert over their victims (Lamphier, 2001). The women discussed how control was exerted over them by their partners and the impact it had on their journey during and even after the relationship had ended. The two subcategories identified in the findings were: process and power.

During the ‘before’ stage, the women discussed their courtship and the behaviours they can see as signs of potential abuse in hindsight. One such story was told by Ann Williams who describes the beginning of her relationship:

“I was pursued relentlessly so that’s kind of a different... He was relentless, obsessive, loving, protective, investigative... and that to me was disguised as love. That need to know everything about you, to be at your work before you arrive because he loves you. I thought that was love”

The ‘wooing’ step of every relationship differed in every woman but the word love was present in all. Research into the courtship of domestically violent relationships found a common theme of love, where women describe the experience as being charming, fun, positive and attentive (Fisher & Keeling, 2012). There was however also findings that explore the process of how control is slowly incorporated into the relationship. This courtship period is often seen as a period where the abuser encourages and builds the women’s commitment and dependence to him and their relationship - thus making it easier to increase control with a reduced risk of the woman leaving (Cordero, 2014; Wolfson, 2002).

Significantly participants in this research not only described the effects of domestic violence on their lives during the relationship but the effects that remain with them long after it ended. One such effect was the instinct to remain silent. As discussed previously silence was a taught behaviour that had been ingrained into the women from the beginning of the abuse. Therefore speaking out becomes a sign of defiance and fought against an enforced behaviour.

“…as you go through that process of normalising life you constantly… I’m constantly hit by little balls of terror because I am just starting to express myself…”

The woman describe an unconscious mechanism where they were fighting with themselves to break free of the restrictions that had been ingrained during the relationship. Dunaway (2002) address this phenomena, where the roles that are enforced in the relationship continue on even when the relationship ends. The control that the perpetrator had over the victim is transcending; the power of control that the women experienced and are still experiencing is evident in their perceptions of the relationship.
Discussion:  
*The Courtship*

This research looked at the couple relationship from the perspective of the women; it was examined from three stages, the before stage was associated with courtship by the participants. The research found that the courtship stage was associated with a lack of comprehension and the beginning of the control, by the participants. The women spoke of the lack of knowledge they possessed during the courtship stage of their relationship, they term this as naivety. The participants felt that their reduced understanding of what was healthy and unhealthy in a relationship led to an inability to comprehend the signs and speak out. One of the participants spoke at length about her ex-partner’s behaviour she thought of as loving and protecting in her courtship phase but now identified as the beginning means of control by her partner.

Literature on this stage of the relationship has a particular focus on the occurrence of courtship/dating violence. Whilst research has found that the ‘wooing’ stage of the relationship has been described as a charming, fun and positive experience, there are significant findings that indicate the courtship phase as a time where controlling and abusive behaviours begin (Cordero, 2014; Fisher & Keeling, 2012). Research on courtship violence has found that this lack of knowledge leads to vulnerability, a vulnerability that makes the women more susceptible to a perpetrator’s manipulation (Avni, 1991). This research associates the lack of understanding with the upbringing of an individual, which is those who were brought up in a patriarchal home are likely to lack an understanding of what an unhealthy relationship looks like, and consequently at risk of entering into a relationship that may become abusive (Avni, 1991). Although one of the participants did speak of her childhood, a clear connection was not established between the upbringing and the lack of insight during the courtship phase. This indicates a gap in literary knowledge of what makes a woman vulnerable during the courtship phase. The courtship phase was where the commitment, emotional attachment and investment began; it was also a time where the foundations of control were laid to build on in later stages (Wolfson, 2002). These findings suggest that further emphasis on early education is needed as a preventive measure, where those entering their first examples of romantic relationships are aware of what behaviours are unhealthy and/or signs of potential abuse. The findings also indicate further research is necessary to understand the prudence of the courtship phase of the relationship.
**The Juxtaposition**

A significant finding of this research was that the women’s experience of abuse was fluid and ever changing; the coping strategies they employed were often in juxtaposition. As discussed in the literature review, women’s responses are often seen as being of learned helplessness or rational thinking, victim or survivor (Axsom & Rhatigan, 2006; Fishel & Rynerson, 1998). This research found that during the abuse the women experienced times of being a helpless victim, and times of being a rational thinking survivor; times where they could not think clearly, and times where they could. The times where the women felt they had no control and no ability to think, they were simply surviving the situation.

Described as the ‘survival mode’, the women spoke of a state where they ran on adrenaline and were functioning, but unable to see outside of the ‘fog’. The women were unable to see outside of the situation, nor were they able to think rationally; this experience was due directly to the behaviours of their partners whose aim was to reduce the women’s power of authority. In contrast, the women also spoke of the responsibilities they held and the strategy of the ‘perfect wife’ they used whilst experiencing abuse. It was at these times that the women were able to rationally assess the circumstances and adapt, a process that portrays survivor not victim.

Literature on how women respond to domestic violence addresses both these states of being, but not at the same time; women are seen as either being of victim or the survivor, never both. Cronin (2013) describes the initial abuse as an ‘ambush’ from which the shock can lead to women being pushed into a victim state automatically. While women can find coping mechanisms to deal with the abuse, there are times where the ‘war zone’ can pull them back into victimhood (Bauer, Quiroga & Rodriguez, 1996; Birnbaum & Buchbinder, 2010). The literature suggests that as the abuse increases the women will develop new strategies to preserve their safety, manage their distress and regain some control (Berman et al., 2012). In this study, the women did develop rational strategies but the ‘fog’ remained, the two coincided throughout the ‘during’ stage.

Rational strategies are associated with empowerment; literature indicates that rational thinking enables a woman to take back some control and make decisions (Calhoun et al., 2000). It consists of detaching to a degree from the emotions of the situation and periodically weighing up the benefits and costs before making a decision (Axsom & Rhatigan, 2006).
women in this study used strategies that took into account the safety of themselves and their children; the ‘perfect wife’ strategy, for example, is a rational choice made in an attempt to placate the partner and reduce the risk of harm (Brabeck & Guzman, 2008).

Women’s responses to domestic violence are a particular focus in current research; literature attempts to understand a woman’s decision to remain in an abusive relationship by delving into how women respond to the violence. A gap was identified in how the literature sees women’s responses to domestic violence, rather than a woman being a ‘victim’ or ‘survivor’, this research has found that women’s responses to domestic violence are fluid and ever-changing. The findings indicate that there is a need for in-depth exploration into how women move between the ‘victim’ and ‘survivor’ responses, and how these perceived roles help them to survive in situations of violence and abuse. Furthermore, the findings suggest that practitioners must have a large degree of empathy in order to understand the experiences of their clients and adapt their practice in order to provide the flexible support need for the ever-changing circumstances they find themselves in.

_The Long Battle_

The ‘after’ stage follows the women’s experiences after the relationship had ended; a significant finding of this research is domestic violence still affects the lives of women long after the relationship had finished. Two of the three participants spoke of control that extended past the end of the relationship; one participant had her ex-partner stalk her 25 years after they had broken up, the other continually experienced psychological abuse from her ex-partner through the child they share custody for the past decade. This research found that women’s suffering does not end when the relationship does and, women are at risk of further damage even without the presence of the abusive partner.

It has been found in literature that the most dangerous time for a woman is when she has just left a domestically violent relationship (Bostock, Plumpton & Pratt, 2009; Murray, 2008). Research has found that men use domestic violence as a means to gain power over their partner, and when this power is threatened they are likely to use whatever means possible to regain control (Dunaway, 2002; Lamphier, 2001). This was experienced by participant Marissa Williams whose ex-partner went to extreme lengths to regain control, when she was
not responding to attempts of intimidation. Exploration is required to understand the lengths a perpetrator will go to gain back control, specifically the length of time after the conclusion of the relationship. The methodology of the focus group enabled the women to explore their journeys and provide valuable insight into the reality of what it is to experience domestic violence. The focus group enabled knowledge to be constructed by the realities of women who had experienced domestic violence (Crawford, Hill & Liebling-Kalifani, 2009; Kimes & Muehlenhard, 1999). This methodology provided a safe place for disclosure of a personal nature, and can be used when seeking to understand the factors that women consider when deciding whether to leave or remain in an abusive relationship.

The research explored women’s perceptions of their relationship when there has been lived experiences of domestic violence. Findings indicate that the women’s experiences of the relationship are significantly different in each stage, from the beginning to the end. This research found that the courtship was a time of naivety, where the women report that a lack of awareness led to signs of potential abuse being missed. The juggling women endured during the abuse consisted of periods where they felt incapable of thinking past functioning, and then times where they could think rationally and make decisions on how to protect themselves and their loved ones. Lastly the after stage was found to be an extension of the ‘during’ stage where women often experienced controlling and violent behaviours and ongoing danger. The insight provided through this research suggests that women who engage with support services require patience and options, that practitioners need to be able to provide different pathways and understand the time needed to consider all factors. This research indicates there is a significant gap in the current literary understandings of domestic violence and how women perceive their relationship; the findings suggest further investigation into women’s experiences could only improve field knowledge.

This qualitative study explored domestic violence from the perspective of the women whose partners abuse them. By collaborating with women, this research provides insight into women’s lived experiences of domestic violence and the complexity of the couple relationship. The women reflected on and discussed their experiences at three significant stages: before the abuse has begun, during the abuse, and after the abuse had ended. This research found that women view their relationship as a place of wordlessness, survival, responsibility and control. These findings indicate there are areas that require further
investigation. The finding also gave a clear indication into the skills and interventions need for efficient and effective prevention and intervention movements. It suggests that early education, empathy, flexibility and provision of options is vital to ensure a woman feels supported and empowered to make decisions regarding their abusive relationship. This study found that women’s experiences are complex and often misunderstood. It also indicates that research into the vulnerabilities of courtship, the women’s coping strategies and thinking processes during abuse, and the ongoing implications of experiencing violence are of great significance in generating understanding of domestic violence as a societal issue. By understanding the journey women take in their relationships, professionals may be better equipped to support and assist when women need it most.

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Domestic violence outside the domestic sphere: An organisational response to domestic violence occurring during homelessness in young people.

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Domestic violence outside the domestic sphere: An organisational response to Domestic violence occurring during homelessness in young people.

ABSTRACT: Considerable research and literature discusses domestic violence (DV) as a cause of homelessness. Limited literature explores DV occurring during homelessness in young people. Even the term ‘domestic violence’ makes an assumption about the spatial environment in which DV occurs, which can result in people who are experiencing DV during homelessness being overlooked. The lack of research regarding co-occurring DV and homelessness in young people is reflected in domestic and family violence literature, which primarily examines the experiences of adult women and their children who were housed prior to leaving a violent relationship. Additionally, discussion regarding co-occurring DV and homelessness are absent in both The National Plan to Reduce Violence against Women and their Children and the Rudd Government’s ‘White paper on homelessness’. Brisbane Youth Service (BYS), as a holistic provider of homelessness interventions for young people, is well positioned to reflect on experiences of working with young people who both experience and perpetrate violence within their intimate relationships while they are homeless. Young women experiencing violence during homelessness have reported a number of unique challenges including difficulty leaving their partner due to fear that they will experience violence from other people, seeking out or staying with partners who are known to be violent or intimidating in order to protect themselves from other forms of violence whilst living on the streets, and having difficulty finding safe spaces away from their partner when neither has a fixed address. This paper seeks to explore key issues within the literature, as well as share the learnings and reflections regarding how the youth sector can better respond to co-occurring Intimate Partner Violence (IPV) and homelessness. The practice reflections highlight the importance of holding young people perpetrating violence accountable, responding appropriately to people experiencing violence, supporting staff and ensuring that organisational responses do not inadvertently normalise violence. It is hoped that the paper can contribute to a developing awareness regarding young people’s experiences of domestic violence during homelessness and demonstrate that despite the complexity of this work there is much opportunity to develop practice to offer young people an appropriate response.

Keywords: young people, domestic violence, intimate partner violence, homelessness, youth homelessness
Introduction

Brisbane Youth Service (BYS) is a non-government organisation that supports young people aged twelve to twenty five years old. BYS assists young people “…to find and maintain housing, address physical and mental health issues and establish successful relationships and support networks” (Brisbane Youth Service, 2015). A significant number of young people accessing BYS report experiences of homelessness or housing instability. Over half of the young people assessed by BYS in the 2015-16 year were homeless (55%), either sleeping rough, couch surfing, living in a boarding house or in a crisis homelessness service. More than two thirds (68%) of young people rated their current housing situation as “Crisis/Very Serious” or “Serious/Concerning” and 63% of young people were living in unsafe, risky or unstable accommodation. A significant number of young people reported experiences of domestic and family violence (DFV) at the point of intake. The majority of young people seen by BYS reported past violence in their family/childhood home (67.5%), with almost 20% currently experiencing this form of violence. Current relationship violence was disclosed by 15% of young people, with 44% disclosing past relationship violence. More than a third (37%) reported that they had been threatened or experienced violence from someone outside of their family or relationship and 29% had experienced sexual or physical abuse or assault. Nearly one quarter of young people (24.5%) acknowledged that they had used violent, threatening or intimidating behaviours themselves and 40% of young people reported that they wanted help with violence-related issues. It is also important to consider the possibility that young people may under report their experiences of violence on first contact with services (Watts & Zimmerman, 2002).

Given the high rates of both homelessness and experiences of violence, BYS case workers have considerable experience working with young people who disclose experiences of co-occurring domestic violence and homelessness. BYS data shows that young people who are homeless report experiences of relationship violence at significantly higher rates than those living in public, private or family housing situations. At BYS, almost 60% of young people reporting current or past relationship violence are currently homeless and 58% of young people who report as homeless also report past or current experiences of relationship violence. While reporting rates are lower overall for current (15%) relationship violence compared with past relationship violence (44%), rates for young people who are homeless are still significantly disproportionately high compared to rates reported by young people who are in stable housing (public, private or family housing). It has become evident to the organisation that young people who experience co-occurring homelessness
and domestic violence face unique systemic and structural barriers to accessing support and safety.
The intention of this paper is to examine the issue of co-occurring domestic violence and homelessness, review current homelessness and DFV literature and reflect on the learning of Brisbane Youth Service. The author of this paper writes from the perspective of a frontline social worker however it is important to acknowledge that young people with a lived experience of co-occurring homelessness and domestic violence are the most authoritative and expert source of wisdom and information on this matter.

**Defining homelessness and intimate partner violence**

The Australian Bureau of Statistics (2012a) considers a person homeless “...if their current living arrangement: is in a dwelling that is inadequate; or has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of, and access to space for social relations”. The homelessness white paper identifies four main pathways into homelessness including housing stress, family breakdown (particularly as a result of DFV), poor life transitions (such as from the child protection system or prison) and untreated mental illness and substance use issues (Commonwealth of Australia, 2008).

Exploration of the intersection between homelessness and experiences of violence must include a holistic definition of the complex nature of relationship-based or intimate partner violence. Meth (2003) notes that the often used term ‘domestic violence’ defines intimate partner violence by its’ spatial dimensions rather than by a social relationship. As such, this paper uses the term ‘Intimate Partner Violence’ (IPV) to be inclusive of people who experience violence in an intimate partner relationship but not necessarily in a domestic space. The word ‘violence’ is intended to refer to behaviours broader than physical violence and encompasses all forms of violence. The Council of Australian Governments (COAG) (2011) notes that IPV is primarily defined by “...an ongoing pattern of behaviour aimed at controlling a partner through fear.” (p. 2). As such, IPV must be understood through the examination of elements of power and control present in the relationship (Domestic Abuse Intervention Project, n.d). Additionally, whilst this paper will consider the IPV experiences of people of all genders, most people who experience IPV are women (VicHealth, 2004; Australian Bureau of Statistics (ABS), 2012b).
Identifying The Gap

There is a strong acknowledgement in both DFV and homelessness literature that DFV is a common cause of homelessness, particularly for women, children and young people (Commonwealth of Australia, 2008; COAG, 2011; Homelessness Australia, 2013; Queensland Government, 2016; Healey, 2013; Jordan, 2012; Chamberlain & Johnson, 2013; Robinson, 2011; Malett et al, 2009). Much DFV literature examines the experiences of adult women and their children who enter homelessness as a result of leaving a violent domestic relationship (Heaven, 2009; Commonwealth of Australia, 2008; Homelessness Australia, 2012a; Murray, 2009).

Slesnick et al (2010) note that there are few studies examining young people’s experiences of IPV compared to studies examining the IPV experiences of adults. This is particularly surprising given evidence of intergenerational patterns of violence and knowledge that the negotiation of intimate relationships is a key developmental process in adolescence (Slesnick et al, 2010; Sith et al 2000). Slesnick et al (2010) studied the prevalence of IPV experiences in homeless youth in the United States of America (USA) and found that 35.4% of youth had been put down, called names repetitively or controlled by their partner or ex-partner. BYS’s own data shows even higher rates of relationship violence for young people accessing homelessness support services. Despite the acknowledged likelihood of under-reporting, almost half of young people assessed (44%) reported experiences of violence in a relationship.

The perception that domestic violence occurs within ‘domestic’ spaces results in people who are homeless and experiencing domestic violence being overlooked (Meth, 2003). Discourse in the Rudd Government ‘White paper on homelessness’ reflects these assumptions by proposing a strategy of addressing issues of domestic violence and homelessness by “helping women and children who experience domestic violence to stay safely in the family home” (Commonwealth of Australia, 2008, p. x). Implicit in this statement and strategy is the absence of consideration of both young people and of people who are homeless.

Both The National Plan to Reduce Violence against Women and their Children (The National Plan) and The Queensland Domestic and Family Violence Prevention Strategy 2016-2026 (COAG, 2011; Queensland Government, 2016) recognise that homelessness is often caused by domestic violence, but do not identify that domestic violence can occur during homelessness. In addressing issues of homelessness and domestic violence The National Plan refers to the
Commonwealth Government White Paper on Homelessness as a strategy rather than detailing a more in-depth and specific DFV and homelessness strategy (COAG, 2011). Whilst the attempt by Governments to address such significant social issues is commendable, there is a noticeable gap in both DFV and homelessness Government strategies, where the issue of co-occurring domestic violence and youth homelessness remains unaddressed. The invisibility of this issue is reflected by the absence of domestic violence prevalence statistics on people who are ‘sleeping rough’ (VicHealth, 2004; ABS, 2012b).

Young people’s experiences of violence during homelessness

There is a broad acknowledgement that witnessing, perpetrating or being victim to violence is a day-to-day reality for young people living on the streets (Robinson, 2011; Mallet et al, 2009; Jordan, 2012; Chamberlain & Johnson, 2013). Young people who are homeless often have past experiences of violence and abuse that are compounded by further experiences of violence (Robinson, 2011). Chamberlain and Johnson (2013) and Robinson (2011) note that young people are at risk of violence when living in temporary accommodation and when sleeping rough. Jordan (2012) asserts that experiences of violence during homelessness violate a sense of connection and home and may prolong a person’s experience of homelessness.

Literature examining young people’s experiences of violence during homelessness primarily focuses on violence perpetrated by a stranger or peer, or by the young person themselves (Jordan, 2012; Heerde et al, 2014). For example, Heerde et al (2014) notes that young people commonly report being physically assaulted, threatened with weapons and robbed as well as engaging themselves in physical violence (such as in ‘fights’) and robbery. In the small amount of Australian contemporary literature examining young people’s experiences of violence whilst homeless, there appears to be a lack of consideration for experiences of violence perpetrated by an intimate partner (Heerde, et al, 2014; Jordan, 2012). This is despite the serious risk of injury associated with IPV and knowledge that IPV experienced by young people who are homeless is likely to reoccur, is often severe and commonly includes acts of violence such as being beaten, burned or ‘knifed’ (Boris et al, 2002). Additionally, the Australian Institute of Criminology (AIC) (2013) reports that 122 people were killed by an intimate partner between 2008 to 2010, accounting for 66% of all homicides in Australia. Aboriginal and Torres Strait Islander people are more likely to die from IPV than non-Indigenous people, with 42% of homicides of Aboriginal and Torres Strait Islander people being perpetrated by an intimate partner (AIC, 2013). As well as this COAG (2011) note that
Australian “...Indigenous women and girls are 35 times more likely to be hospitalised due to family violence related assaults than other Australian women and girls” (p. 1). This is compounded by the over-representation of Aboriginal and Torres Strait Islander people in homelessness, with 25% of people experiencing primary homelessness in Australia identifying as Aboriginal or Torres Strait Islander (ABS, 2011).

The findings of the 500 Lives 500 Homes (2014a) survey of people who are homeless in Brisbane indicate that almost half (45.5%) of young people had experienced violence since becoming homeless, however no data relating to the context of this violence was collected (500 lives 500 homes, 2014a; 500 lives 500 homes, 2014b). This is unfortunate as the distinction between IPV and other forms of violence is important to understanding young people’s experiences of violence whilst homeless. Violence during homelessness that is perpetrated by a stranger or acquaintance will not share the same context of power and control present in IPV (Domestic Abuse Intervention Project, n.d). As such, the lived experience and associated psychosocial impacts on young people are likely to differ.

Meinbresse et al (2014) found that women who are homeless were more likely to know the attacker and to experience continued suffering following a violent attack. Additionally, with strong evidence of the association between youth homelessness and child abuse, it is relevant that Taylor et al (2008) found that cumulative experiences of violence like child abuse increases the risks of young people experiencing IPV. Intergenerational patterns of IPV present very high risks for young people who are homeless with nine out of ten of young people experiencing homelessness reporting that they had seen violence between family members at home (MacKenzie et al, 2016). According to the 2016 report on the Costs of Youth Homelessness nearly half (48%) of young people experiencing homelessness reported police coming to their home because of violence between parents on one or more occasions (MacKenzie et al, 2016). More than half (56%) of the young people sampled for that report had left home because of violence (MacKenzie et al, 2016). There is clear evidence for the need, in both research and practice, to clearly define the types and contexts of ongoing experiences of violence faced by young people who are homeless. In particular, further examination of young people's experiences of IPV during homelessness will be a meaningful contribution to understanding and preventing the impacts of these interacting complex issues.
Interagency collaboration or ‘joined up’ practice

Young people who are homeless experience barriers to accessing services such as lack of knowledge of services, health professional’s attitudes, financial constraints, inappropriate environments and transient behaviours that make it difficult to attend scheduled appointments (Dawson & Jackson, 2013; Dixon et al, 2011; Janssen & Davis, 2009). These barriers can lead to lost opportunities for early intervention and prevention that are likely to represent increased cost for government (Dawson & Jackson, 2013; Janssen & Davis, 2009). A lack of awareness of co-occurring youth homelessness and IPV may act as a barrier to people accessing services that are equipped to respond to their needs. Youth services may lack the experience of working with people experiencing IPV and Domestic Violence Services may lack the experience of working with young people.

Suggestions for improved service responses to young people experiencing homelessness include increased interagency collaboration, the development of outreach and street-based services, and health promotion strategies that are implemented onsite at youth services (Dawson & Jackson, 2013; Dixon et al, 2011; Janssen & Davis, 2009). Present in all of these suggestions is a theme of interagency collaboration and of bringing services to the spaces that young people who are homeless access. Goudie and Cornell (2009) and Crane and Livock (2012) also note the importance of interagency collaboration or ‘joined-up’ practice. Crane and Livock (2012) advocate for a ‘joined-up’ response that is person-centred, responsive, flexible and institutionally supported (Crane & Livock, 2012). Goudie and Cornell (2009) describe an integrated service model used in South Australia where government and non-government organisations collaborate to meet the multiple needs of young people experiencing homelessness. Aspects of this model may have utility in developing an integrated and collaborative practice response to young people across the homelessness, youth and domestic violence sectors.

Developing collaborative interagency responses is consistent with both the white paper goal of improving and expanding services and with The National Plan (Commonwealth of Australia, 2008; COAG, 2011). Additionally, with greater interagency collaboration between youth homelessness services and domestic violence services there may be increased opportunity to offer a more informed, comprehensive and integrated response to young people experiencing co-occurring homelessness and IPV.
An Organisational Response: reflections from practice

This section will draw on both relevant literature and experiential learning derived from hands-on service delivery within Brisbane Youth Service. A key observation from both broader published research and anecdotal experience is that there are specific barriers to supporting young people experiencing co-occurring homelessness and IPV. These barriers include difficulties engaging young people who are wary of agency intervention and/or have had negative experiences that cause them to mistrust disclosure to professionals; worker assumptions about the dynamics of IPV resulting in victims being miscast as perpetrators or mutual participants in violence; and systemic normalisation of violence as a part of the homelessness experience. With limited domestic and international research on this topic, anecdotal reflections of those who are working in the sector can contribute meaningfully to unpacking the complexity of co-occurring youth homelessness and IPV, as well as highlighting areas for further research (Slesnick et al, 2010).

Assumptions of ‘mutual’ Intimate Partner Violence

Evidence that IPV is predominantly experienced by women and perpetrated by men is clear throughout the literature (Australia’s National Research Organisation for Women’s Safety (ANROWS), 2016). Slesnick et al’s (2010) research with young people was consistent with this theme by showing that young women were twice as likely to be physically hurt by a partner than young males and that young people with a history of childhood physical or sexual abuse were twice as likely to be physically assaulted by their partner and fear for their safety. However, Tyler et al (2009) contradict Slesnick et al (2010) by arguing that IPV in homeless youth is often ‘bidirectional’, with women and men both experiencing and perpetrating IPV at similar rates and often within the same relationship. Despite claiming that IPV is often bidirectional in young people who are homeless, Tyler et al (2009) concedes that this view does not consider the context or frequency of violence, such as whether women using violence might be retaliating from violence inflicted upon them or acting to defend themselves.

Discussion of IPV as bidirectional without an examination of the context in which violence occurs contradicts the definition of IPV as it does not acknowledge IPV as pattern of behaviour or consider the inherent dynamics of power and control (COAG, 2011; Domestic Abuse Intervention
For example, Slesnick et al (2010) notes that female victims of IPV are more likely to report feeling fearful and sustain serious injury from violence than male victims. Whilst this is not to suggest that IPV cannot be bidirectional, the absence of the consideration of the context of power and control in the relationship reflects a narrow understanding of IPV.

Brisbane Youth Service has a long term commitment to reflective learning about the impact of IPV in the lives of young people, particularly those who access homelessness support services. BYS’s practice been informed by a trauma informed practice model and the Duluth Model, which draws on clinical tools such as The Power and Control Wheel and the Equality Wheel (Domestic Abuse Intervention Programs, 2011 & Blue Knot Foundation, 2012). With ongoing investment in skills and awareness training, BYS workers are supported to develop a nuanced understanding of domestic violence in the context of delivering holistic youth crisis intervention and case management. It is the anecdotal experience of BYS workers that, even when there initially appears to be ‘bidirectional’ IPV between young people, appropriate further assessment most often reveals that one member of the partnership holds dominant power and control. Consistent with published statistics, it is the experience of BYS workers that, in heterosexual relationships, even when there are occasions of what may appear to be bidirectional violence between young people who are homeless, the dominant perpetrator of IPV is most often identified as the man (ANROWS, 2016).

Having conversations about violence

Youth services should regularly ask young people about their experiences of IPV (Slesnick et al, 2010). Whilst such conversations must consider safety, the author agrees that asking the hard questions is key to good practice and facilitates supported disclosure by young people who may be unsure about what they should or should not say. In the author’s experience of working at BYS, a thorough IPV assessment that captures the dynamics of power and control is difficult to undertake. This is due to young people experiencing IPV often accessing the service with their partners. As such, due to the controlling nature of the relationship young people experiencing IPV may be reluctant or unable to see a worker in private. This makes it difficult for workers to find the appropriate time and space to conduct an assessment safely. Consequently, workers may struggle to understand power and control dynamics in the relationship. In the author’s experience, the absence of proper assessment has resulted in workers advocating that IPV be perceived as ‘mutual’ and that both young people in the relationship are viewed as victims and perpetrators. The assumption that IPV is mutual in cases where a proper assessment has not been undertaken may fail to capture
issues of risk and lead to missed opportunities for intervention. Additionally, these assumptions may inadvertently normalise IPV, such as by positioning IPV as typical of the violence experienced by young people who are homeless and living on the streets.

Engaging young people experiencing IPV is often more challenging when their partner’s controlling behaviour has escalated. This is a common theme, with the young person using violence often attempting to control whether the person experiencing violence can speak with a worker, how long they can spend with them and what they can disclose. Often workers must manage the tension of wanting to offer the person experiencing violence an opportunity for private discussion whilst being aware that such a discussion may increase the immediate risk to the person experiencing violence. Due to the fear of retaliation from their partner, it is common that the person experiencing violence rushes private discussions with a worker. This can further contribute to a diminished capacity of workers to make a thorough assessment and offer appropriate support. In situations such as this workers are required to be opportunistic in their interventions and engage in brief discussions in the moments when it is safe to do so. This involves workers being reflective about the unintended consequences that may arise from such discussions. Workers have also adopted other creative responses to facilitating discussions with young people experiencing violence such as setting up ‘code words’ or phrases that people can say to communicate to a worker that they need support and inviting young women for a ‘women’s health check’ in the medical clinic.

Whilst workers have found these strategies useful in creating opportunities for connection and support for people experiencing violence, they do not take the place of skillfully and confidently holding people using violence to account. Workers often manage the complexity of both the person using violence and the person experiencing violence being clients. Considering that many young people who use violence have themselves been victims of violence in childhood, workers must be able to hold empathy for the person using violence without excusing their behaviour (Tyler et al, 2009; Jordan, 2012; Slesnick et al, 2010). If workers do not manage such tensions, they may fail to hold the person using violence accountable and adequately demonstrate to the person experiencing violence that this is unacceptable. This can unintentionally lead to a situation where violence is normalised. Workers take steps to hold people using violence accountable in diverse ways such as by calling out controlling or violent behaviour when it is witnessed by workers, contacting police where necessary, facilitating discussions with people who identify as respondents in Domestic Violence Orders and supporting people to access appropriate behaviour change programs.
When both partners attend the service together all efforts are made to support both of them, but the right to safety for the person experiencing violence is always the most important priority. As much as is possible, within the limits of confidentiality, the person experiencing violence’s preferences about how workers respond when witnessing their partners use of controlling behaviours and violence will be considered. Additionally, their right to safely access the service should be prioritised which may mean that the person using violence is supported in other spaces or is advised that they cannot attend the service at certain times.

Worker attitudes and practice culture

There is a strengthening practice culture at BYS where young people using violence or controlling behaviours are spoken to about the unacceptability of such behaviours and held accountable. In order to practice from a strengths based perspective that values autonomy and self-determination, workers must hold the belief that people have the power to change violent behaviour. It should be considered that all people using violence have agency and make a choice to use violence and controlling behaviours.

Experiences of violence are common for young people who are homeless and as such it is also common to hear about and witness violence as a youth worker (Jordan, 2012). The author believes that this frequent exposure to violence puts workers at risk of becoming desensitised to and normalising violence. BYS’s response to IPV has developed considerably over recent years and desensitised or normalising statements regarding violence from BYS workers and external services are challenged and unpacked by colleagues and management alike.

Organisational training and reflective practice opportunities have underpinned the development of a strengthening practice culture at BYS that is focused on supporting young people experiencing violence and holding people accountable to change their use of violence. A trauma informed practice approach provides a strong foundation for workers supporting young people experiencing and using violence (Blue Knot Foundation, 2012). Through training and practice reflection meetings workers have identified important process and practice changes that have helped to strengthen the organisation’s response to IPV. Notwithstanding the complexities addressed in the previous section, this has included setting a standard practice of not meeting with couples together (except in situations where this is assessed as appropriate for the intervention), ensuring adequate
organisational communication around situations of risk, prioritising opportunities for engagement with both the person using and the person experiencing violence, running groups with young people about healthy relationships and developing interagency relationships with the domestic violence sector.

What young people face – remembering the individual impact

When we listen to the real stories that are shared by young people, we start to build a clearer picture of young people’s experiences, particularly that of young women experiencing primary homelessness who often rely on their partners for physical security and protection from other threats of violence. Young women experiencing primary homelessness have described entering relationships with men who are feared in their communities in order to provide them with protection from other forms of violence, such as sexual assault. Similarly, many young women, particularly those experiencing primary homelessness report that they are unable to find safe spaces away from their partner. This is particularly complex when the IPV is occurring in public spaces and when there are limited places of safety to seek refuge in.

Young people experiencing IPV and primary homelessness also report having shared social connections with their partner, such as with other young people who are experiencing homelessness. If young people experiencing IPV and primary homelessness choose to leave their partner they may also have to leave their friends and enter into the dangerous situation of sleeping rough on their own. Clearly, it can be hard for young people to leave relationships due to a lack of housing and the risk of other forms of violence associated with experiencing homelessness. These themes are not entirely absent from the literature. Alder and Baines (1996) note that young women experiencing homelessness are vulnerable to relationship based violence and often remain in such relationships due to the extreme sense of isolation and lack of social connection that results from homelessness. This understanding, however, needs to be more broadly unpacked and disseminated throughout the practice literature.

IPV represents not only a high risk during homelessness, but a critical barrier to young peoples’ capacity to move out of homelessness. It can be difficult for young people experiencing IPV to maintain supported accommodation tenancies due to their partner, or ex-partner, visiting the property unapproved. This can threaten the accommodation of the young person and may result in them returning to primary homelessness. Tenancy sustainment is also more difficult in situations
where a violent partner may inflict property damage. Furthermore, Slesnick et al (2010) asserts that effective intervention is essential because whilst experiencing IPV on the streets may be influenced by situational factors, it is possible that the young person will continue to experience violence in their relationships even if they do eventually have stable housing. This is supported by Boris et al (2002) who states that young people who are homeless are likely to experience multiple violent relationships.

Additionally, young people often report frustration about their experiences of attempting to engage with domestic violence services. For example, some young people have been unable to access refuge accommodation due to their age despite strong advocacy from BYS workers and young people themselves. Frequently young people are turned away from domestic violence refuge accommodation and referred to youth homelessness crisis accommodation. Unfortunately if there is no vacancy in such accommodation, or the homelessness crisis accommodation assesses that they are not equipped to deal with the inherent risks of providing refuge to someone fleeing IPV, these young people can fall through the cracks. Where the young person is aged under 18 years old BYS’s experience is that the child protection system is often under-resourced to respond in a timely or appropriate way. This creates a situation where young people have no choice but to remain in violent relationships and very high risk situations. It is a critical issue that there is a high risk that a 16 year old young woman who is sleeping rough and experiencing violence at the hands of her partner would fall through gaps between domestic violence, youth accommodation and child safety services. The immense impact of such systems gaps on individual lives should not be underestimated.

Whilst acknowledging the current limitation that the reflections presented here are derived from the experiential knowledge of front-line workers, rather than being representative of cross-sector knowledge, the issues raised highlight the clear need for better cross-sector research with young people who have a lived experience of co-occurring IPV and homelessness

**Conclusion and Recommendations**

In summary, systemic barriers, common misassumptions and a lack of research evidence to support effective responses are likely to impact the capacity of organisations and individual workers to respond to co-occurring IPV and youth homelessness. The limited literature published on the topic
is helpful to developing a foundational understanding, however substantial further research needs to be undertaken in order to provide a strong knowledge basis upon which to develop effective responses. Anecdotal and experiential learning presented here highlights the complexities involved in responding to and understanding the intersection between IPV and youth homelessness. With funded services generally focused on one or the other issue, there is a critical risk that the reciprocally compounding complexity of both IPV and homelessness will fall through the gap between specialised services. Further specialised research is needed to ensure that Domestic and Intimate Partner Violence literature, support resources and sector responses acknowledge the particular experience of homelessness as a context for that violence. Youth homelessness strategies need to dedicate resources and capacity development to responding effectively to violence within the homelessness context. By recognising that, for young people experiencing both issues, the resulting risk and complexity is often greater than the sum of the parts, we can develop specialist responses that more effectively meet the needs of particularly vulnerable young people.
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Providing Innovative Domestic and Family Violence Counselling and Prevention Programs with Women Prisoners

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Providing Innovative Domestic and Family Violence Counselling and Prevention Programs with Women Prisoners

ABSTRACT: Drawing on Sisters Inside’s 22 years of experience, this paper examines the nexus between women’s criminalisation and domestic and family violence (DFV), and challenges emerging myths. It explores what it takes to provide effective DFV prevention and support for women in a prison context. It highlights the escalated risk of re-traumatisation in this setting, and examines criteria to ensure safety for women participants. This paper also examines the impact of the prison context on therapeutic processes, progress and goals and proposes realistic expectations for prison-based DFV support services.

Keywords: Debbie Kilroy, Sisters Inside, Australian women prisoners, criminalised women

Introduction

Sisters Inside specialises exclusively in responding to the needs of criminalised women and girls, and their children. We have been providing domestic and family violence (DFV) counselling for women in Queensland prisons continuously since 1994. Increasingly, DFV organisations are being subcontracted by corrective services departments throughout Australia to provide DFV education, prevention and counselling services in women’s prisons. These organisations generally have limited prior experience of working in a prison setting.

Based on Sisters Inside’s practice wisdom, this paper examines the transferability of current dominant models of DFV and sexual assault support and prevention services to a prison context. It details our learnings about the ineffectiveness and potential harm of applying mainstream models to work with women prisoners. In particular, it highlights the elevated risk of re-traumatisation in this setting, and examines the modifications required to ensure safety for women participants in both therapeutic and educational programs. These include perceived and actual independence of service providers from the prison system; a sophisticated understanding of DFV in the context of women’s lives; and developing viable expectations about possible outcomes of DFV services in a prison setting. Ultimately, this paper proposes a customised approach to DFV service provision for criminalised women.

The nexus between sexual assault and DFV services

In the wider community, sexual assault and DFV services are generally provided by separate specialist, often feminist, organisations. Workers and agencies often distinguish women’s sexual assault needs from their DFV needs. Whilst typically underpinned by shared feminist
values, distinct models of service are often employed to respond to these different needs. Sexual assault sometimes exists independent of DFV in the wider community however this is rarely the case amongst criminalised women.

Sisters Inside has been providing sexual assault counselling (and occasional group work) in Queensland women’s prisons since 1994. In practice, this means that we have been providing both sexual assault and DFV counselling to women prisoners. Our current 2 counsellors cannot think of a single woman to whom they have provided counselling whose experience of sexual assault was not associated with DFV. Amongst criminalised women, a history of sexual assault and DFV are highly interrelated.

Most women prisoners have grown up in DFV settings, and perceive violent relationships as ‘normal’. This leaves them highly vulnerable to being controlled by a violent partner. The majority of the women prisoners to whom Sisters Inside provides counselling and support first experienced sexual assault as a child in a familial situation. As a result, these women face complex trauma (including sexual, developmental and attachment issues). Secondary effects can include DFV, substance abuse, homelessness and poverty – which commonly lead to diagnosed mental health issues. These women have never had any view of themselves other than as a victim – that is, their vulnerability to violence is integral to their whole personal identity. This is further reinforced by prison culture and systems.

**Understanding the prison context**

It is important, before offering services in women’s prisons, to understand key characteristics of women prisoners, prison environments, the pressures under which women prisoners live on a moment-to-moment basis, and the implications of these for service design. Prison culture and systems particularly affect the provision of all aspects of sexual assault and DFV education, prevention, counselling and support.

**Women Prisoners**

Most women are imprisoned for minor, non-violent offences\(^1\). The evidence suggests that more than half the women in Australian prisons are not serving substantive sentences. In Queensland, for example, on any given day:

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• At least 30% of women prisoners are on remand (i.e. they have not been tried and/or sentenced).
• At least 20% of women prisoners are imprisoned for (often minor, poverty-driven) breaches of parole.2

Most women are in prison for very short periods of time. For example, in Queensland during 2015, the average stay across all women prisoners was less than 5 weeks3. This immediately sets up constraints, with implications for any DFV service dependent on progressive work over a period of time.

Between 80% and 98% (according to various studies4) of women prisoners have a history of DFV, with the majority having experienced childhood sexual assault and other forms of violence. Other key characteristics of women prisoners are:

• Aboriginal and Torres Strait Islander women are massively over-represented in prison populations throughout Australia (and are the fastest growing segment of the prison population)5.
• At least 10% of women prisoners come from other culturally diverse backgrounds and for many English is not their first language6.
• Most women prisoners come from highly socially disadvantaged and marginalised backgrounds – limited English language literacy and/or poor educational outcomes and/or unemployment and/or entrenched poverty and/or homelessness and/or childhood incarceration/care7.

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2 This information is generally not available on the public record. These figures are based on clear trends emerging from repeated emails from Queensland Corrective Services to Sisters Inside. On particular dates over the past 3 years, up to 40% of women prisoners have been on remand and up to 30% have been imprisoned for breach of parole.
3 Specifically, 4.96 weeks. Further, 94% of women prisoners in Queensland in 2014/15 were serving less than 12 months. Queensland Corrective Services (2015) SEQ Womens Re-entry Services: Industry Briefing, 17 December, Department of Justice and Attorney-General (ppt)
4 Many women report to Sisters Inside workers that they choose not to disclose their personal information (e.g. experience to DFV) to government or academic researchers. Our own survey found that 98% of women prisoners had a history of DFV. Government and academic studies consistently find reported rates over 80%. See multiples studies cited in Quixley & Kilroy (2011) op cit, p15.
5 Multiple studies cited in ibid, pp 18 & 24-25
6 Studies from Victoria and Queensland cited in ibid p29. Rates of incarceration of CaLD women in Victoria are typically higher than this with indications that at least 15% of women prisoners are from CaLD, particularly Vietnamese background.
7 Multiple national and state studies cited in Quixley & Kilroy (2011) op cit pp16-17.
• The majority of women prisoners have mental health issues and/or substance abuse issues and/or a cognitive disability\textsuperscript{8}.

Each of these, too, highlight the need for customised DFV services for criminalised women – both in prison and the community.

\textit{The Prison System}

Prisons are fundamentally violent environments, where women lose control of almost every aspect of their life, and their identity is effectively reduced to a number. Women are (officially and unofficially) controlled by the various hierarchies that exist within and between prison officers and prisoners. For example, fellow-prisoners who are team leaders in a women’s workspace hold power over women in their team; and many long term prisoners and long serving prison officers have established relationships which impact on both shorter term prisoners and new prison officers. One small example of dehumanising prison systems is the requirement that women submit a Request Form to access almost any form of service.

About 80% of women prisoners are grieving loss of their role as a mother of dependent children\textsuperscript{9} – a factor which significantly increases their vulnerability within the prison system, and places them in a substantially different position from male prisoners. Women prisoners have limited contact with their children and, often, limited access to information about their wellbeing. Many children are placed in care, which further adds to mothers’ anxiety. And, the tyranny of distance and poverty, and the trauma associated with their children being placed in care, is often even greater for Aboriginal and Torres Strait Islander mothers.

Women prisoners are supervised by prison officers with their own triggers, who have the power to reward or punish women for even the most minor infringements. Women are expected to comply with the (varying) whims of each officer. Too often, prison officers use derogatory and abusive language toward women, and behave in a manner reminiscent of past violent partners. Common prison practices such as strip searching (particularly in the presence of male officers) often re-traumatise women with a history of sexual assault. If women demonstrate emotional vulnerability, they are at risk of being locked in isolation. A

\textsuperscript{8} Multiple national and state studies cited in Quixley & Kilroy (2011) op cit p16 & 19
\textsuperscript{9} Multiple national and state studies cited in ibid p15
recent *innovation* in South East Queensland women’s prisons\(^{10}\) has extended the capacity of prison officers to behave in an arbitrary and inconsistent manner: individual officers can punish women through reducing their access to tension release (e.g. TV, *spend-up\(^{11}\)*) and denying contact visits with their children, which is highly traumatic for both the mother and her children. All these practices mean that women prisoners live in a perpetual state of anxiety and fear.

It is hardly surprising, therefore, that self-harm and suicidal ideation are common amongst women prisoners\(^{12}\). However, if women demonstrate emotional vulnerability, they are at risk of isolation (variously named in different jurisdictions e.g. *Crisis Response Unit, wet cells*) – under 24 hour lighting and surveillance (supposedly, in the interests of their mental health). Despite the fact that this practice is against all the best medical advice\(^{13}\), even prison psychologists function within strict rules around suicidal ideation: for example, they may be required to place women in isolation if they mention suicide (even if it’s talk of having been suicidal many years ago!)

And, over recent years, overcrowding has further escalated the many tensions inside prisons throughout Australia as women experience even greater loss of privacy, even less comfort, even poorer quality of food, and even less access to programs and services\(^{14}\).

Many women are desensitised, and accept unjust treatment (e.g. being punished for mental health issues) because they see punishment as normal. Too often, women have a poor sense of their own self-worth and have taken on the accusations of their perpetrator(s) – they blame themselves for any penalties they receive within the prison system and view themselves as fundamentally *bad*.

\(^{10}\) The *Incentives & Enhancement Program (IEP)*.

\(^{11}\) *Spend-up* – the capacity to purchase personal items. This can include purchase of culturally or religiously appropriate food and personal care items.


\(^{13}\) For example, the AMA talks about the importance of supportive human contact with trusted people in their lives for prisoners at significant risk of suicide, and explicitly recommends that … *A prisoner or detainee should not be put into seclusion solely on account of their suicidal ideation* (see: Australian Medical Association (2012) *AMA Position Statement on Health and the Criminal Justice System* at [https://ama.com.au/position-statement/health-and-criminal-justice-system-2012](https://ama.com.au/position-statement/health-and-criminal-justice-system-2012)).

\(^{14}\) Queensland Ombudsman (2016) op cit, pp27-43
Prison culture replicates women’s experience of DFV and perpetuates the DFV cycle. Women prisoners typically cope through drawing on their own established ways of surviving a violent environment. Their need to be constantly alert means that most women prisoners live in a state of hyperarousal. Depending on their background and experiences this may be expressed through anger (fight), depression (flight) or dissociation (freeze). Women’s state of mind has implications for service delivery, particularly in relation to enabling women to safely address DFV whilst living in a prison context.

**Accessing women prisoners**

All workers must have approval to enter prisons: a process that can take weeks or months. Once approved, there is no guarantee of entry to a prison on any given day. Prison authorities can refuse entry to service providers – most commonly, when the prison is locked down.

In order to access counselling from external providers in Queensland prisons, women must be added to the counselling List. The woman herself must submit a Request Form to see a counsellor (and, in doing so, disclose her history of abuse). Women report that these forms often disappear: some women report having submitted multiple Request Forms over many months. Sometimes a Sisters Inside counsellor hears of these requests through other means (e.g. she runs into the woman at Education, or hears about her request through another woman), and can approach prison staff directly to request that the woman’s name be added to the List. Sometimes, women are released having never known that her request was never processed – and, as a result, may be cautious about engaging with Sisters Inside (or other services) post-release.

**Counselling in the prison context**

Women see Sisters Inside as independent of the prison system. This is critical to the success of our counselling and group work inside prison. Their little remaining privacy is one of the few vestiges of dignity that women retain whilst in prison. For many women, the fact that their counselling interactions are strictly confidential is essential to their willingness to seek DFV support.

In 2014-15, we conducted a total of 768 counselling sessions in women’s prisons in South East Queensland. Women prisoners must self-refer to our counsellors: the rate at which they
do so, is a clear indication that each woman initially trusted Sisters Inside’s name before she had begun to build individual rapport with a particular counsellor.

**Creating a safe therapeutic environment**

As far as possible within systemic constraints, Sisters Inside counsellors create a safe place where women can be their authentic self, without fear of judgment or penalty (e.g. being placed in isolation for mental health issues).

*On the outside* (particularly in private practice), most women depart a counselling session to a home, financial security and some personal supports. A counsellor can plan for a 1 hour session (or similar) in a safe, therapeutic space. These pre-conditions simply don’t exist for most criminalised women. Whilst in prison, women leave a counselling session to an unsafe, unsupportive environment. Post release, most women leave a counselling session to a life of housing instability, financial insecurity and limited personal supports.

When seeking to address sexual assault and DFV in the prison context, it is an ongoing challenge to provide a safe therapeutic or learning environment. Despite the best efforts of Sisters Inside’s counsellors, the therapeutic environment in Queensland prisons is far less safe for women than in conventional counselling settings:

- Full privacy can never be guaranteed. Prison officers can enter the counselling space at any time without warning (e.g. to do a head count).
- The structure of sessions can be inconsistent. Each week the procedure may be different according to the preferences of the prison officer on duty at *Education*\(^{15}\) (e.g. some will bring over 3 or 4 women at once, which creates a pressure to have multiple short sessions; others will bring one woman at a time).
- The therapeutic process can’t be planned in the usual way. Women may be refused access by either the prison officer at their current location (workshop or residential unit) or the prison officer at Education.
- The counsellor doesn’t know how long each session will be. Prison officers can arbitrarily end a session at any time.
- Both a woman and her counsellor may be misinformed about whether counselling is available. Prison officers may give misinformation to either the woman (e.g. the

\(^{15}\) In Queensland, counselling is located at the Education Centre.
counsellor didn’t ask to see you …) or the counsellor (e.g. the woman didn’t want to see you …). This may leave a woman feeling abandoned, even if the counsellor has continually submitted requests to see her.

- Women may be transferred between prisons or released at short notice. It may take several weeks before the counsellor finds out that the woman has been transferred (and can request that she be added to the List at her new location).

Modifying therapeutic processes

It is critical that, before beginning to address traumatic events and memories, DFV counsellors address the woman’s safety, support and environment (including the prison environment). This can absorb a significant amount of time, and, as a result, Sisters Inside counsellors expect to take at least 3 times as long to achieve the same therapeutic goals on the inside, compared with outside prison.

A lot of time must be spent setting up before dealing with issues – for example, women need skills in coming out of trauma-processing quickly if necessary and she must be able to self-support before delving into any sexual abuse or DFV issues. Often, women will initially launch into sharing their story. It is important to slow women down so they are not left over-exposed if the session is arbitrarily interrupted or cut short. Undertaking small processes leave the woman minimally vulnerable if their session ends abruptly. Some of the key pre-conditions for effective counselling include:

- Normalising women’s emotional reactions to being in prison. This can include explaining their hyperarousal and its source: that this is normal in a prison environment because of the constant need to be alert.

- Helping women understand how the prison system and culture impacts their DFV-related behaviour. Many aspects of the prison replicate their experience of DFV, and the woman can be expected to revert to familiar patterns of response.

- Teaching women how to self-regulate within the prison environment. Mindfulness is a particularly useful tool in assisting women to function more calmly and better manage their DFV-related responses.

- Warning women about the likelihood that, no matter how carefully the session has been run, she may feel more vulnerable after leaving and may have greater sensitivity to her personal triggers. Some preparation for responding to these triggers
is an important part of optimising women’s safety following sessions, and enabling them to move forward and begin to address their DFV issues.

In Sisters Inside’s experience, criminalised women respond negatively to any counselling approach which treats the counsellor as the **expert** and the woman as a **client**. These **power-over** approaches to counselling tend to stereotype criminalised women and focus on the similarities amongst (but not differences between) women. A failure to focus on the uniqueness of each woman’s story can lead to over-generalisation and discounting of the woman’s experiences.

Over several years, Sisters Inside has developed a model of service, **Inclusive Support**¹⁶, which underpins all our services (including counselling). Using this model alters the whole context and framework for counselling:

- Counsellors focus on what they have in common with the woman (rather than seeing her as **other** or **client**), and work alongside the woman with an attitude of **peerness**.
- Counsellors recognise that there’s a **fine line** between herself and the woman – that, *it could have been me had I not had greater opportunities in life* (e.g. financial, emotional and environmental security).
- Counsellors implement a **power sharing** approach, where the woman identifies what she wants from counselling, what she’d like to focus on, and how she’d like to work together.
- Counsellors support the woman to make her own choices according to her own perception of her needs. This includes supporting women who make decisions the counsellor might not see as in her best interest (e.g. if a woman decides to return to a violent relationship the counsellor would support this choice and help her work out how to optimise her safety).
- Counsellors aim to find the uniqueness in every woman and her story, and avoid making generalisations about criminalised women and their needs. The counsellor recognises that each woman reacts to trauma very differently (including differently from other members of her family).

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• Counsellors actively acknowledge the impact of environmental factors on each woman’s capacity to address DFV (e.g. homelessness, financial insecurity, family history, imprisonment).

**Education programs in the prison context**

Group work has all the vulnerabilities of sexual assault and DFV counselling, but with the multiplier effect of interactions between women, which adds enormously to the complexity. Women cannot leave the group and go to a safe place where they have security, can access support, have the ability to disengage from thinking, or can distance themselves through distraction afterwards. Women are returning to a fundamentally violent situation which replicates their DFV experiences. Every group member must be capable of supporting herself before she leaves the room, otherwise greater harm than good may come of her involvement in the program.

Sisters Inside has conducted occasional educational programs about sexual assault in the context of DFV in prison. We have also observed some of the consequences of programs run by other organisations. In our experience, safe and effective education programs about DFV conducted in women’s prisons:

• Expect to cover a fraction of the content of a similar program run in a community setting.
• Are careful to keep women safe amongst each other.
• Recognise the importance of prison hierarchies in women’s safety in the group.
• Identify any possible hierarchies that exist within the group amongst women prisoners, and be conscious of the potential impact of these on each woman’s safety.
• Validate each woman and her particular, unique experiences and vulnerabilities.
• Recognise that women may be triggered by other women’s trauma.
• Stop interactions which might escalate or leave women vulnerable.
• Stop interactions which might create expectations of a higher level of disclosure and vulnerability than suits every woman in the group.
• Slow down processes to enable management of disclosure to a level which will minimise the risk of re-traumatisation, and ensure that women’s stories do not go too deep.
• Work from where the group of women is at, rather than delivering pre-packaged, textbook programs designed for women in community settings.

• Resolve issues immediately as they arise (in case of interruption) and NEVER leave issues unresolved at the end of the session.

**Contextualising DFV in the lives of criminalised women**

Too often, ANY woman leaving a violent situation loses (at least some of) her existing support systems. However, she doesn’t yet have a new, established environment to move to. She is left, suspended between two worlds – her familiar reality and an unknown possible future. Her value and status exists in her familiar support system: it is difficult for her to get a sense of self in a new, unfamiliar realm. All workers with women escaping DFV will be familiar with this scenario.

We know that DFV is no respecter of class or race – it exists in all communities. However, the impact of DFV on criminalised women, particularly Aboriginal and Torres Strait Islander women, is different to the impact on women from more privileged backgrounds. Criminalised women are distinguished from most women in the wider community by other circumstances in their life. They are more likely to have limited education (or even literacy) and many have a long (often multi-generational) history of unemployment. Entrenched poverty and the risk of long term homelessness for themselves and their children significantly reduces criminalised women’s capacity to escape DFV. Most criminalised women have lived within a system of entrenched (often multi-generational) DFV, including sexual violence, since childhood. Many have lost custody of their children – in some cases, solely on the basis of their short imprisonment on remand or for a minor offence. These, combined with resulting mental health and/or substance abuse issues, significantly reduce women’s capacity to visualise an alternate future. Worse, criminalised women are often excluded from DFV support services, such as women’s refuges.

If a woman is to have any prospect of a violence-free life post-release, a variety of supports MUST be put in place, alongside DFV services, while they are in prison. These may include establishing means for the woman to access income upon release (e.g. purchasing identification, making Centrelink arrangements), ensuring her access to housing, maintaining her relationship with her children, and/or beginning to develop the necessary tools for future
employment (e.g. access to short and long term education opportunities in the industry area suited to her interests and skills).

Following release from prison, women are even more disadvantaged, and therefore more vulnerable to DFV, than before their imprisonment. The other issues confronting a woman upon release may be TOO overwhelming, and even the smallest safety strategy can be lost or forgotten when she has to confront the realities of functioning in the wider community. For example, being homeless generally puts a woman in survival mode and at immediate risk of returning to her default behaviours. Reunification with her children is commonly a key motivator for women to develop a violence-free, crime-free life: without adequate support, failure to regain custody of her children can lead to a loss of motivation and loss of hope for a better future. Similarly, women with a history of substance use will often revert to drugs in order to cope with the many challenges they face post-release. And gaining or losing employment could shift everything: gaining employment can generate genuine hope for a woman in her capacity to live independent of a violent situation; loss of employment can lead to her losing all hope.

Criminalised women often return to violent settings in order to meet some of their own, and their children’s, basic needs. Too often, women are forced to choose which of their needs to address (e.g. weighing up personal safety against food/shelter/stability). Too often, women will enter (or return to) a violent situation in order to stay out of prison – that is, to avoid homelessness or loss of financial security for both themselves and their children. Areas in which women may need support in order to stay out of a violent setting are as varied as: housing, income, practical (e.g. food, transport, furniture, clothing), cultural, family reunification, parenting, mental health, substance abuse, physical health, dental, employment, education, training and moral support.

Whilst in prison, Sisters Inside counsellors begin to address one element of a woman’s many needs – that is, beginning to process her DFV experiences and gain some insight into her experiences and possibilities for an improved future. Our counselling or group work is not seen as an end in themselves. Sisters Inside as a whole organisation is designed to address the complex, multi-faceted needs of women which collectively contribute to women’s criminalisation, recidivism and ongoing vulnerability to DFV. We provide a support system whilst women are re-establishing their lives and, ultimately, a long term safety net for all
criminalised women. There is little or no value in providing DFV services without providing access to a similar level of comprehensive support in all areas of a woman’s life.

**Myths about the nexus between criminalisation and DFV**

A myth growing in popularity is the idea that if DFV is solved, women’s criminalisation will be solved. A solution-focused approach simply doesn’t work with this cohort of women. *Easy answers* developed in the prison context are rarely transferable to a community setting. Addressing a single, isolated aspect of women’s needs fails to recognise the wealth of evidence about the many contributors to women’s criminalisation (including imprisonment itself).

DFV issues cannot be fixed whilst the woman is in prison – a *solution-focused* approach fails to recognise the particular complexities and vulnerabilities of criminalised women’s experience of sexual abuse and DFV. The best plans in the world cannot fully equip women to address the complex, inter-related issues that will emerge for them post-release. Once they leave prison, women face a myriad of issues which place them at risk of returning to a violent family setting and/or prison. Without post-release support to address these other issues and needs, any DFV work undertaken whilst in prison is, at best, useless: at worst, an experience of *failure* further erodes the woman’s confidence in their capacity to live a violence-free life and reduces the likelihood that they will try again to leave a violent family setting. Any serious attempt to optimise women’s capacity to live a violence-free life post-release must include the capacity to respond quickly to each woman’s barriers to safety.

Similarly, some have suggested that women see prison as a *place of safety* to which they choose to escape from DFV. Many women end up being criminalised as a result of DFV however this must be distinguished from any intention to escape to the (supposed) *safety* of prison. Any woman who has been in prison is under no illusion that prison is a *safe place*!

Too often, police *blame the victim* and charge criminalised women in DFV situations. Many approach violent situations with inadequate understanding of the consequences of prolonged abuse for women and fail to identify the source of the violence. Or, the stigma and discrimination associated with having been in prison leads to police charging the woman because of her criminal (and/or mental health) history alone, rather than a dispassionate assessment of the DFV situation. Or, women who have returned to a violent setting may react
to violence or intentional provocation with violence: where the man is stronger than the woman, she may use an object to protect herself and incur harm. Or, an accumulated history of abuse may lead to situational over-reaction to a ‘trigger’ by a woman. Too often, police collude with perpetrator to market the idea that incidents such as these are her fault, and the woman herself believes this.

Treating these, and other, situations as an attempt to be re-imprisoned fails to recognise the systemic sexism and racism that underpins many women’s imprisonment.

**Conclusion**

Mainstream models of DFV prevention and support services cannot be readily transferred to a prison context. More than this, application of community-based models of service in the prison environment can cause genuine, long term harm to women prisoners and their children. It is critical that any DFV-related work inside prisons is underpinned by a sophisticated understanding of women prisoners’ history of disadvantage and marginalisation; the context of DFV in women prisoners’ lives; the prison system and its impact on women survivors of violence; and systemic constraints on service provision in prisons. This understanding can only lead to a very different, customised approach to DFV service provision for criminalised women.
RISK OR VULNERABILITY: RED FLAGS FOR INTIMATE PARTNER VIOLENCE

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Abstract

The increase in focus on violence amongst current or former partners reveals a chronic problem characterised by a complex suite of individual indicators and social determinants. This paper examines the current thinking about risk factors for perpetrator escalation of intimate partner violence as well as looking at victim vulnerabilities which exacerbate the risk of lethal assault. As no individual factor can explain more than ten percent of risk or vulnerability, we need to look at models which embrace complexity. I present a framework which identifies the combination of factors which present the likely catalysts for intimate partner homicide and discuss how this might be useful for screening and risk assessment.

Keywords

Intimate partner violence; risk factors; vulnerability; victim; offender.

Introduction

In Australia, one in six women and one in nineteen men have experienced physical or sexual violence from a current or former partner since the age of 15 years (Australian Bureau of Statistics 2013). It is most common for women to experience the violence from an ex-partner. The ABS estimates that almost three quarters of women with experience of intimate partner violence have encountered more than one incident of violence. Almost two-thirds report having children in their care at the time the violence occurred. Thus a substantial number of Australian adults and children are vulnerable to experiencing or witnessing intimate partner violence with potential
harm of exposure and experience ranging from anxiety disorders to severe physical impairment and death.

**Signpost argument**

The contemporary way of looking at violence between intimate partners is in terms of risk factors which might help to understand whether there are pathways or common characteristics for becoming a victim or perpetrator. The practice of risk assessments originates in clinical psychology – where tools were developed to assess dangerousness in criminal and psychiatric populations. The tools identify individual and situational factors which psychological research has shown to characterise the risk of repeat assault and the potential of violence escalation including the potential to inflict severe injury or homicide (Hare and Vertommen 1991; Cooke et al. 1999; Webster et al. 1997; Grann, Belfrage, and Tengström 2000; Dolan and Doyle 2000; Pacific Institute for the Study of Conflict and Aggression 2001). Risks, in this literature, are discussed in terms of a deficit model and the risk of perpetrating lethal and sub-lethal violence is often linked to specific deficits of health or education, or the presence of poverty or addiction (Andrews, Bonta, and Wormith 2006; Brady 2000; Cohen 1997).

The relationship between risk and vulnerability is symbiotic; the presence of risk implies the potential for vulnerability. In Australia, “vulnerability” is used for broad descriptions of social groups that face inequalities and discrimination as well as tight classifications of those people who are reliant on others for care or requiring special treatment by services (Bartkowiak-Théron and Asquith 2012). Vulnerability is thus also discussed in terms of deficit yet recent literature suggests that new models of vulnerability are required. For example, Gilson (2013) urges us to revalue vulnerability as ‘a complex and ambiguous experience and a multi-faceted condition’. Luna
(2009) describes layers of vulnerability, which might be broadly differentiated categories of individual and situational, in a set of layers rather than groups to which people are allocated. Some of these categories are under the control of the individual and others are not. She argues that a person might be rendered vulnerable under a particular set of circumstances so that when circumstances change again, the individual is no longer vulnerable. This is also likely to be the case with risk factors for offending. Thus we need to look at new frameworks for intimate partner violence which can incorporate complexity and heterogeneity in order to reflect the real world that police and victim services encounter with each violent relationship.

To examine the nexus between risk and vulnerability I propose that we examine the social space in which intimate partner violence occurs. The work of Pierre Bourdieu provides some useful frameworks in the concepts of habitus and social, cultural and economic capital (Bourdieu 1986). The habitus is the product of socialised norms that guide individual behavior and thinking; it influences the identity, actions and choices of the individual. The habitus provides an organising structure for the inherent qualities of mind or character in an individual and has been produced by the conditionings associated with a particular class of conditions of existence. The different types of capital also help to form a person’s internal character and shape their behaviour in response to social stimuli. Bourdieu (1984) visualised society as spheres of action/fields. Each field has its own power structures based on the specific field, habitus and capital(s) involved and the set of rules that governs the field (Winter in press; Grenfell 2014). In the field of intimate partner violence, we observe habitus associated with relationships/romantic love and where the capitals that the victim and perpetrator bring to their relationship manifest themselves in their actions, reactions, intentions, values and prejudices. The stimuli that both the violent aggressor
and their victim respond to can be conceived as either risk or vulnerability. These risks and vulnerabilities will manifest differently dependent upon the individual’s variation in capitals but these will still fit into the clinical categories outlined in Figure 1. My argument is that as well as a complex system of layers, I propose risk and vulnerability, in the situation of intimate partner violence, can be conceptualised as multidimensional—think of a Rubik’s cube—and propose the utility of a model which uses the layering concepts proposed by Luna (2009) with elements of Bourdieu’s notions of social fields and habitus (Winter in press) to produce a dynamic model which will reflect the heterogeneity of the factors involved in any intimate partner violence incident. It is the complex array of drivers for risk and vulnerability that is at the heart of what makes intimate partner violence such a challenging matter to address, and drives us to constantly seek new ways to explain the dynamics of violent relationships. The potential utility of this highly visual model is in training for practitioners responding to family violence where unidimensional models of risk or vulnerability fail to demonstrate the complexity involved in responding to intimate partner violence.

Structured risk assessments for intimate partner violence

Assessments of dangerousness have always been conducted by police, mental health professionals, welfare workers, criminal justice workers and other service providers, in the course of investigations, diagnosis and decision-making, but in general these assessments have not always been formal. In the last twenty years or so, most police jurisdictions have begun to employ some type of tool or framework to structure their decision-making and effectively triage the responses to incidents of intimate partner violence. Using the police tools, violence between current or former partners is framed according to the risk profile or likelihood of reoffending by looking at specific risk factors and calculating a score that approximates the degree of risk
(Arizona Coalition Against Domestic Violence 2002; Association of Chief Police Officers 2005; New Zealand Police Service 2004; Richards 2001, 2003; Welsh and Farrington 2005). These risk tools are laundry lists of behaviours which identify perpetrators 'at-risk' or 'most likely' to re-assault and, as outlined above, have evolved from assessments of dangerousness developed for clinical populations. Most police tools include factors which can be classified into five main categories: dispositional; historical; clinical; contextual; and, current behaviours (see Figure 1 below) (Winter in press).

**Figure 1 Categories of risk of intimate partner violence**

Risks for violence in the dispositional category include elements derived from the perpetrator’s demographics (age, ethnicity, gender, social class), the basic personality structure of the offender, as well as their levels of anger, impulsiveness and psychopathy (Moore et al. 1997). Historical influences on risk of violence include family of origin, work status, previous violent behaviour, criminal history and historic health issues. The offender’s history might include previous physical or sexual abuse (Gondolf 2001); arrests and incarcerations (Tweed and Dutton 1998); and issues such as hospitalisations and treatment compliance (Byron 2004; Dutton and Haring 1997; Nestor 2002; Robbins, Monahan, and Silver 2003).

Risks for violence in the category of clinical factors would include any diagnoses, symptoms, functioning, fantasies or substance abuse. Relevant issues might be diagnosed personality disorders (Richards 2001); diagnosed depression or anxiety
disorders (Bryon, 2004; Nestor, 2002; Prins, 1999) delusional behaviour, violent fantasies or suicidal ideation (Bryon, 2004; Nestor, 2002; Prins, 1999; Robbins, 2003) and alcohol or drug abuse (Campbell, 2003; Gondolf, 2002; Nestor, 2002; Norko, 2005; Robbins, 2003; Rodriguez, 2001). Contextual factors that influence the risk of violence against a partner might include issues around stress, level of social support and access to the means for violence. Stressors include separation, financial difficulties (Saunders 1995; Margolin, John, and Foo 1998), conflict over custody or access to children, or a pregnancy or new birth (Taft 2002; Richards 2003; Martin et al. 2004). Other contextual factors include the quality of the relationship, infidelity, issues with living arrangements, arguments, grief or loss, social supports and access to the victim as well as access to weapons (Richards et al. 2004). The final set of risk factors commonly found in police risk assessment frameworks relate to the current behaviours exhibited by the violent partner and includes conduct which is considered to indicate serious escalation to the point of lethality. As well as escalation of violence toward the partner in either frequency or severity (Walby and Myhill 2000; Metropolitan Police (UK) 2001), factors related to current behaviours include:

- credible threats of serious harm (McGrath 2003; Laing 2002);
- violation of contact orders (Carlson, Harris, and Holden 1999; Young, Byles, and Dobson 2000);
- extreme attachment or emotional dependence on victim (Dal Grande et al. 2001; Krakowski and Czobor 2004);
- actual or attempted strangulation or suffocation (Richards 2003; Campbell et al. 2003);
- stalking (Palarea et al., 1999);
- hostage-taking (Campbell 2001);
- assault or abuse of children or pets (Armstrong 1998; Saunders 1995; Walby and Myhill 2000);
- and property damage (Winter and Julian 2005).

Depending on the seriousness of the behaviour described in each class of factors and also the frequency which the behaviours are occurring (e.g. escalation
of increasingly serious violence or controlling behaviours) will be reflected in the final ‘risk score’ allocated to the violent relationship. In practice, first response officers’ interview the victim of intimate partner violence using a risk assessment tool that allocates a numeric score to selected risk markers; these scores are summed to create a risk score that estimates the level of risk of re-victimisation, and provides a categorical indicator of the seriousness of the violence e.g. High, Medium or Low risk of escalation.

Actuarial assessments have their strengths and weaknesses but are widely used. In theory, the adoption of a structured tool promotes the implementation of a graduated intervention which responds to the needs of the incident at hand as opposed to yes-no, in-out dichotomies associated with the concept of dangerousness (McSherry 2004), although in practice some officers find risk assessment tools confusing and cumbersome to use in the field. The logic behind using a risk paradigm involves identifying factors that are seen as causal, while recognising that it can be difficult to isolate catalysts (Farrington 2000). It has been further recognised that any risk dimension (clinical, historical, contextual or dispositional) does not act in isolation, and any factor within a dimension alone will not predict abusiveness (Norko and Baranoski, 2005). In fact, none of the individual risk factors have been found to predict more than ten per cent of violent behaviours (Margolin, John, and Foo 1998). The main benefits of police use of this style of actuarial instrument is that they standardise police response while shifting focus from blunt concepts of dangerousness to focus on probabilities (Winter and Julian, 2005).

Returning to the synergetic relationship between risk and vulnerability; we tend to use the language of vulnerability as well as the language of risk when discussing violent relationships. Most of us are used to thinking about vulnerability in terms of deficits in
human social or economic capital, which is the domain of the socially excluded. Vulnerability is negatively construed and something to avoid or even feared. Using the tenets of the risk paradigm shown in Figure 1, we might also formulate a matching body of offender behaviours—using these same categories of historical, clinical, dispositional, contextual and current behaviour factors—that render a victim of intimate partner violence more vulnerable. Some vulnerability factors will be identical factors as those described as contributing to the likelihood of offending (such as drug use or health issues) but others will be unique to the vulnerable person. Current behaviours of both the potential offender and victim might also exacerbate the victim’s vulnerability. In both cases of risk and vulnerability, we can argue that using categories and subgroups, and subsequently reducing this to a numerical score, can be simplistic and can obscure complexity. Hence I propose a model that can reflect multiple risk/vulnerability factors as well as provide the potential to portray individual differences and for mutability. The lay person is familiar with the cube model—and its inherent ability to change which makes it a useful model to explore. The multiple faces of the cube presents opportunities to overlay individual differences onto categories of behaviours. This provides us with a model that can embrace movement in both foregrounded and backgrounded factors.

A multi-dimensional model

If we imagine the five main dimensions of risk as proposed in Figure 1, the Rubik’s cube of risk of intimate partner violence might look like Figure 2. Police arriving at an incident will be attempting to investigate in a highly dynamic and emotionally charged environment which will contain a variable number of risk factors; at each incident there will be different combinations of current lethality predicting behaviours,
historical risks, clinical factors or contextual triggers reflecting the individual differences at the core of the violent behaviour.

As figure 2 illustrates, the cube model allows -- instead of single dimensional risk categories as we might be used to discussing – us to use Bourdieu’s notion of fields to create visual dimensions and the use of colour in conjunction with spatiality can demonstrate the complexity involved. The current behaviour categories are those which comprise the highest risk of lethal violence and so in this model we will use the colour red to denote their status as ‘red flags’.

Rather than a one dimension list of risk factors; the cube model enables several faces to be used to represent the unique set of factors involved in any violent incident. Each couple’s habitus will have different patterns depending on current circumstances, quality of the relationship, stressors, health issues and criminogenic triggers. In the next section I will describe how this model might work in practice through adding details on which behaviours or issues might be manifested in each risk category.

![Figure 2 Categories mapped to layer model](image-url)
Testing the model

In a classic example of an incident of intimate partner violence, illustrated in Figure 3, we see that there are a large number of red flag markers in evidence in the current behaviour category; and these are present through the offender having violated contact orders, having strangled and stalked the victim, taken children hostage, damaged property, made threats and the victim reporting a significant escalation in both the severity and incidence of violence. The contextual issues that exist in this example are marital separation, a pregnant victim, plus other children and stepchildren involved and where the offender has contact with the children – and there is access to firearms. These are all factors which predict intimate partner homicide (Campbell 1995). In the clinical category (white squares), in this case the offender has a diagnosis of depression, combined with a history of substance abuse and symptoms of borderline personality disorder. The offender also has a criminal history involving use of violence against others, is unemployed since a work injury and has a family history where using violence is normalised. Both victim and offender are in their 30s with low educational attainment; the offender has an explosively angry personality, is impulsive and is obsessed with stereotypical gendered roles in the household division of labour.

In this example the risk to victim and children are extremely high; we see an offender who has no problem with using violence, is impulsive and depressed; and has already used behaviours that indicate lethality. The violation of contact orders and previous criminal history indicate that low level social controls such as family violence orders will not protect the victims. The utility of the coloured cube model is that the preponderance of red flags is immediately visible; which can alert responders to the potential severity of a subsequent incident. There being four clinical risk factors
in play might alert police or other service providers to potential changes in behaviour and the fact that the context factors (blue) relate to the likelihood of highly emotional scenarios which might exacerbate behavioural tendencies toward using lethal force.

Figure 3 Example of layers of risk

Using the cube framework to focus on vulnerability of the victim in the example incident, we can see that the same dimensions apply but the operationalisation of each factor is different; because they reflect the factors that the victim brings to the situation. In comparing Figures 3 and 4, we see that some of the victim vulnerability characteristics coincide with the risk factors of the offender but others are unique to the victim’s disposition, history and clinical issues. In the red flag categories, as well as having existing contact orders in place, being a victim of stalking and escalating violence including sexual violence, the victim has been controlled by their partner, socially isolated and is emotionally and financially dependent in this relationship. The victim also suffers depression and has a history of substance abuse; there is a mental health diagnosis of anxiety and a high level of fear and hypervigilance. The victim is
separated after a low quality relationship; has a young baby as well as older children in her care who are not the biological children of the offender. She is in the peak category of vulnerability for victimisation of intimate partner violence being female in the 18-44 years age group. Although she is 30 years old, her partner is 39 and an age difference of >8 years is indicated as a vulnerability factor (Coker et al. 2000; Easteal 1993). She has low self-esteem, and is living in a situation characterised by low socio-economic indicators. As well as a long history of abuse in the relationship, the victim has a history of abuse in her family of origin and has symptoms of PTSD.

Returning to Luna’s model of situational and essential vulnerability in relation to the vulnerability version of the cube we can see that many of the victim’s situational vulnerabilities have the potential to be mutable – if the victim can disentangle themselves from the relationship with the abusive partner. Some factors will then move to the category of historical vulnerabilities. Dispositional vulnerabilities will be difficult to transmute depending on their essentiality to her profile e.g. she will age and
possibly improve her social situation and self-esteem but she will always be female of a certain ethnic background with a history of abusive relationships which continue to increase her likelihood of victimisation. As with the offender risk cube, the victim vulnerability cube will allow response teams to triage and target safety plans and social supports for the unique factors at play in this incident at this stage of this particular relationship. If we were to use this model for the next incident at which police attend, with a different offender and victim, the cube might show only one red flag and different contextual, clinical and historical issues to exemplify a less dangerous scenario in which different actions are required by police and support agencies.

Conclusion

This analysis has explored the ways in which we might conceptualise the risks and vulnerabilities involved in intimate partner violence in a way that represents complexity, heterogeneity and mutability. It has proposed a nexus between risk and vulnerability and argued that Bourdieu’s concepts of field, habitus and capital are helpful to illustrate the dynamics behind multiple factors at play when examining a romantic relationship that features violence. The framework of a Rubik cube has been proposed as a new way of conceptualising both risk and vulnerability factors which embraces Bourdieusian theory. The major innovation provided by the cube metaphor is that it illustrates the interactions between and within features of victim’s lives, demonstrates how each family violence situation is different, and is a useful model for simply and effectively representing what a multi-layered correspondence analysis might look like when applied the factors involved in intimate partner violence. The utility of this framework being that it is dynamic, highly visual and allows for some complexity while reflecting heterogeneity and thus it is presented as a useful model
for describing the variations that impact on intimate partner violence. The model thus offers utility for the training of police and other response agencies in its ability to convey background influences as well as lethality factors. Further, being visually evocative, the model does not restrict analysis to a laundry list of risk factors, nor falls into the trap of calculating false negatives and false positives which are the risk of actuarial tools (Winter and Julian 2005).

However, like other models that have been proposed to help us understand the complexity of intimate partner violence, the Rubik’s cube analogy falls short because it is still too rigid, and collapsing categories to fit the model does not allow for enough variables. The standard Rubik cube has a fixed number of colours. Each face of cube has nine panes able to be allocated to each colour, but in any incident of intimate partner violence not all categories might be relevant while subcategories of each dimension might be more numerous than the rigid colour combinations of the cube allow. As with actuarial tools this model will not capture the ambiguity which is a common feature of incidents of intimate partner violence. In spite of these challenges, the model will have utility in helping first response workers to understand the complexity of the incidents they are required to investigate and the addition of Bourdieusian concepts to the risk/vulnerability conversation provides a new way of looking at intimate partner violence in a way that is both structured and nuanced.
References


Can Brief Interventions, such as solution-focused interventions, support Health Professionals in Safety Planning with victims of Family Violence?

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Can Brief Interventions, such as Solution-focused interventions, support Health Professionals in Safety Planning with victims of Family Violence?

ABSTRACT: This paper explores how health professionals can apply more effective intervention methods during safety planning with victims of family violence. Safety planning is creating a plan to keep victims safe while living in an environment of family violence and ongoing harm. The health professional in partnership with the victim enacts basic safety strategy actions. Intimate partner violence should be reframed as "patterns of cumulative harm" (NZ Family Violence Death Review Committee, 2016, p. 50). Appropriate language to describe family violence also helps us to better understand appropriate safety planning responses. Each help-seeking approach becomes an opportunity to interrupt the "spiral of violence". Safety responses should be matched to the risk and immediate needs of the victims (Thompson, Rivara & Thompson, 2000). The empowerment of the victim to resist violence and make choices to keep her (and children) safe is not often possible on her own. Safety planning interventions in family violence endeavor to increase the victim's life skills, foster victim engagement and participation in specialist support services - to reach an outcome of keeping victim(s) safe and reducing harm. Victims of intimate partner violence are more likely to use health services and present to health providers twice as often as non-victims (Gracia-Moreno et al, 2014). A health system that focuses on prevention and early intervention for victims of family violence reduces the long term impact of violence on victims, but also reduces long-term health costs. Health professionals often say that providing brief interventions with victims of violence are "outside of their professional scope of practice". This argument can be understood as many are not well informed or trained in providing brief interventions. A serious weakness with this argument is that many victims of violence will never see an expert in family violence intervention and a generalist brief intervention may be the only intervention that could be of benefit to them. Brief and timely interventions; that provide the outcomes sought (such as safety); and reduce further harm to victims of violence are needed in the current fiscal health environment. A health budget to train staff and have an integrated family violence brief intervention service is "a crucial step for the long-term sustainability of any intervention and to increase staff motivation" (Gracia-Moreno et al, 2014, p. 8). They should access training to develop competencies in brief family violence interventions - to identify and manage victims of family violence safely. This ability would support them to overcome barriers and make reducing harm of family violence every health professional's business.

Keywords: Family Violence; Safety-planning; Health Professionals; Brief Interventions; Solution Focused interventions

INTRODUCTION:

My engagement and interest in this topic stems from my deep concern about how health professionals can apply more effective intervention methods during safety planning with victims of family violence. Safety planning is described in literature as the ongoing support that follows the identification of a family violence victim. It is all the actions to endeavour to support victims to achieve their safety (Gracia-Moreno et al., 2014; Colombini, Mayhew, Ali, Shuib, & Watts, 2012). Safety planning in family violence intervention follows identification of a victim by routine inquiry and a positive disclosure. It is mainly about devising a plan with the victim for what to do when their safety is threatened. Safety planning starts where the helper engages with the person in order to activate an integrated response and collaborative actions to keep the victim(s) safe. It is supported by consultation and referral to specialist family violence services to activate collective actions to keep the victims safe, understanding that the entrapment family violence causes may prevent the victim to take action alone (Wilson, Smith, Tolmie, & de Haan, 2015). In contrast to what often happens by just giving pamphlets with information and increasing victim empowerment, safety-planning interventions should endeavour to increase the victim’s life skills to keep themselves safe (Falb et al., 2014). It should foster victim engagement, encourage participation in support services (Malpass et al., 2014) – to reach an outcome of keeping victim(s) (often a carer of children) safe and reducing harm (NZ Government Report to United Nations, 2015). The health professional

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facilitates access to potentially helpful services to mitigate harm in dangerous situations and “enacts safety actions in partnership with the victim” (Family Violence Death Review Committee, 2016, p. 30).

Evidence in recent research revealed inadequate and poor quality responses when women disclose family violence to clinicians. It highlights the challenge a health professional face in responding to family violence (Wathen, MacGregor, Stibbald, & MacMillan, 2013; Hegarty et al., 2010). Health professionals seldom applied appropriate interventions and often lacked appropriate training (Feder et al., 2011). There is increasing concern that health practitioners need to be prepared for the emotional reactions that women/victims can experience after their personal disclosure of intimate family violence (Wathen et al., 2013; Malpass et al., 2014). The initial enquiry for family violence could be traumatic in itself. “Validation may in fact, be the most important ingredient in the GP’s response” (Malpass et al., 2014, p. 9). Asking about violence initially, validating their experience and providing brief interventions can start the wheel towards change. A study by Hegarty et al. (2013) concluded that routine enquiry about violence, without an offered structured intervention to victims with a positive disclosure, has little effect. To date there has been little agreement on what interventions would help family violence victims achieve safer lives (Hegarty et al., 2013). In an earlier study Hegarty et al. (2010) advised that it is pivotal to expand evidence based knowledge on the optimal method of effective responding following routine enquiry for family violence.

Wilson et al. (2015, p.27) suggest we seriously consider “the role of individual safety planning”. According to this review safety planning is a trauma-based intervention that “becomes an opportunity to interrupt the spiral of violence” (Wilson et al., 2015, p. 63). Therapeutic communication, additional to effective risk management, may increase the identification of intimate partner violence and motivate the victim to engage in safety planning (Paterno & Draughon, 2016; Malpass et al., 2014). Safety planning requires timely, supportive and informed interventions (Hegarty et al., 2013; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Boyko, Kothari, & Wathen, 2016). Their conclusion is that clinical conversations with family violence victims have a powerful impact on achieving both positive and negative safety outcomes. Liebschutz et al. (2008, p.5) describe positive outcomes as when the victim experiences a “shift in self-esteem, perception of the violent relationship, or awareness of alternatives, eventually empowering her to seek help for the abuse”. Informed intervention thus requires that the helper understand the complexities of family violence, risks associated with violence and appropriate intervention strategies (Wathen, Sibbald, Jack, & MacMillan, 2011). Training that is more effective is required in this area of work and future research is needed to evaluate various safety-planning interventions (Valpied & Hegarty, 2015; Fellmeth, Heffernan, Nurse, Habibula, & Sethi, 2015; Gregory et al., 2010; Schoening, Greenwood, McNichols, Heermann, & Agrawal, 2004).

New Zealand is one of the first countries in the world to have a national Ministry of Health [MoH] funded Violence Intervention Programme (VIP), where health services engage in interventions to reduce the impact of family violence (Fanslow & Kelly, 2016). Health professionals are trained in family violence intervention; how to ask routine questions to identify victims, and how to explore about risks. Health professionals usually gather information, assess risk according to the victim’s disclosures and refer the victim to appropriate specialist support. What actually happens in real practice after a routine enquiry, during the risk assessment and safety-planning phase, are often unclear. This research hopes to explore the safety-planning intervention that follows.
My first research questions will explore what health professionals do after routine enquiry and a positive
disclosure about family violence in one district health board. The question will be asked, however, whether
health professionals feel adequately equipped to support victims with effective brief safety planning
interventions. This will be followed by a training workshop for health professionals.

I began to realize the significance of the work of Steve De Shazer, Insoo Kim Berg and their team (1986) during
the first Australian and New Zealand Solution Focused Conference in Queensland, Australia in 2013. I have
since incorporated many of the ideas of solution focused brief interventions (SFBT) in my own practice. De
Shazer (1988) describes solution-focused approaches as non-directive and client-led, and makes the assumption
that clients have the personal resources to deal with their difficulties. In the training workshop I will explore
methods and tools that might be utilized during SFBT interventions in trying to achieve engagement and might
lead to integrated safety planning actions with victims. The second research question will explore the subjective
outcomes for health professionals of the training in brief solution (safety) focused training such as the usefulness
(or not) and contribution (or not) to competence and confidence in family violence intervention.

Family violence and safety planning

There is a degree of unease and dissatisfaction, by current experts in this field, around the use of everyday
language about ‘family violence’ (Wilson et al., 2015). Inappropriate language will prevent understanding of the
complex issues regarding family violence, and also prevent an appropriate response to reduce the impact of
violence. Wilson et al. (2015) suggest for helping services to use new language to describe family violence. The
New Zealand Family Violence Death Review Committee’s fifth report reframes intimate partner violence as
“patterns of cumulative harm” (2016, p. 50). This report challenges the widely held view that family violence is
a series of isolated incidents of violent behaviour. It argues that isolated incidences of violence fail to
acknowledge the significance of ongoing cumulative patterns of harmful behaviour. These are “escalating
patterns of harm by an abuser who uses coercive control and manipulation to maintain a women’s silence and
reinforce her entrapment” (Wilson et al., 2015, p. 26). It is known in practice that violent patterns of harm can
spiral out of control and cause lethal and long term harm for multiple victims (NZ Family Violence Death
(2002) conducted studies of adults and the lifelong effect of witnessing intimate partner violence as children. In
general terms, these adults are more likely to abuse alcohol and illegal drugs and to suffer chronic depression.
The family violence victim has very little control over the perpetrator’s violent behaviour and her/his children
are also harmed by the violence (Borowsky & Ireland, 2002). The harm is cumulative and has intergenerational
harmful effects (Edwards, Anda, & Dube, 2005). Intimate partner violence is a crime against a person’s
autonomy and ultimately destroys lives (Herbert & Mackenzie, 2014). Ongoing long-term family violence has
severe consequences for the physical and mental health of the victim and children (Walton, Aerts, Burkhart, &
Terry, 2015; Borowsky & Ireland, 2002). The empowerment of the victim to resist violence and make choices to
keep her (and children) safe is not often possible on her own.

In the proposal I refer to victims/survivors as “she” and “her” but this does not mean that I do not recognise that
women can be perpetrators and men victims. I will hereby clarify the context and meaning of terminology that is
used in this proposal as following:
Brief interventions: *a short, purposeful, non-confrontational, personalised conversation with a person about an issue and any associated risks and harm*

Family violence: *is ongoing, escalating and cumulative patterns of harmful behaviour by an abuser who uses coercive control and manipulation to maintain a women’s silence and reinforce her entrapment. One family member against another family member perpetrates it. It includes child abuse and neglect, intimate partner violence and elder abuse*

Health Services: *refers to services focused on improving health, including public health and population-level services for individuals*

Intimate partner violence: (IPV; also called partner abuse) *is physical or sexual violence, psychological/emotional abuse, or threats of physical or sexual violence that occurs between intimate partners*

Routine enquiry: *is an enquiry, either written or verbal, by health care providers to an individual about their personal history of intimate partner violence, child abuse or neglect. Unlike indicator-based questioning, routine enquiry means routinely questioning all individuals, or specified categories of individuals, about abuse*

Risk assessment: *is a thorough assessment of the violence that has occurred to offer appropriate medical follow-up, formulate an understanding of risk of future violence the victim(s) are facing and to respond/engage appropriately to keep victims safe*

Safety planning: *is creating a plan to endeavour to increase the possibility that potential victims will not suffer harm while they are living in an environment of family violence*

Appropriate language also helps better understand appropriate safety planning responses (Wilson et al., 2015). Safety responses should be matched to the risk and immediate needs of the victims (Thompson, Rivara, & Thompson, 2000). The risk and health assessment therefore becomes key to effective risk management, and pivotal to safety planning (Gulliver & Fanslow, 2015). It is important to note that many victims actively try to stop the violence they fear and meticulously try to follow safety plans. Experts in this field argue that family violence is a form of entrapment and that victims cannot overcome this entrapment alone. Reaching a safe outcome depends on a collective response (Family Violence Death Review Committee, 2016).

Malpass et al. (2014) implemented a collaborative study, utilizing a qualitative design, with service–users that disclosed family violence. The family violence survivors were interviewed regarding issues with professional responses they encountered. This study found that the victims did not engage with clinicians when they were insufficiently trained in family violence and responded by just providing pamphlets with helpful links to further support. Poor outcomes also followed when health professionals spoke with victims in places that were not private enough or prescribing solutions that they have to follow (Wathen et al., 2013). They argued that routine enquiry for family violence, followed by a passive referral (pamphlet only) to a community specialist service, is an ineffective response. Some family violence survivors experienced hope for the first time if clinicians provided informed care (Malpass et al., 2014). If the first contact followed up with timely specialist/advocate support it
enhanced their experience that help is available (Wathen et al., 2013). Unfortunately, without a collaborative response, and seamless wrap-around support systems following a disclosure, lasting safe outcomes are seldom achieved (Fanslow & Kelly, 2016).

As victims of family violence suffer trauma, the impact of violence can have immediate harmful emotional effects such as distress, shock, disturbance, suffering and pain. Safety planning interventions are thus described as trauma-informed care. Machtinger, Cuca, Khanna, Dawson Rose, & Kimberg (2015, p. 195) suggest that the first step for every staff member in a health practice is to access training about the impact of trauma, on the health and wellbeing of patients, and then to “develop trauma-informed skills to communicate more effectively with patients” Machtinger et al., (2015, p. 195), illustrate trauma-informed care (Figure 1) in the diagram below:

![Trauma-Informed Care Diagram](image)

**Health professionals and brief interventions**

Victims of intimate partner violence are likely to use health services and present to health providers twice as often as non-victims (Garcia-Moreno et al., 2014; Hegarty et al., 2010). Malpass et al. (2014) argue that women see health professionals as potential sources of support. Sometimes the help-seeking crisis shifted their readiness to make changes in their lives. Some women stated that they “needed that push from their doctor” (Malpass et al., 2014, p. 5). Research reports that a majority of victims (76.7%) have told at least one person (family and friends 58.3%) about their partner’s violence (Maxwell, Barthauer, & Julian, 2000) with no apparent change in the victim’s outcome. In contrast, other research has shown that lasting change mostly happens when family violence has been disclosed to a formal service, such as health services and their staff (Machtinger et al., 2015). Families and friends tend to minimize risks by denying or blaming the perpetrator or victim’s behaviour (Koziol-McLain & McLean, 2015). Health professionals, within their brief clinical encounter, have a crucial opportunity to engage with a possible victim, assess risks and keep the woman safe or prevent death (Hewitt, 2015).

In a recent project the demands on time and workforce capacity provided most of the barriers to brief family violence interventions (Taranaki District Health Board [TDHB] Emergency Services VIP Project: Final Report, 2015). During this project it was common to hear TDHB health professionals’ comments on the burden of the expectations regarding family violence intervention and systemic barriers that cause the lack of effective supportive interventions. Unfortunately there are no simple answers. The key problem with this explanation is
that it does dispute theory on the positive impact of brief interventions. However, the focus and commitment of health professionals (within resource constraints), by providing brief effective safety planning interventions, could reduce the harm of family violence (Gracia-Moreno et al., 2014).

Health professionals in TDHB have commented to me that providing brief interventions with victims of family violence is “outside their professional scope of practice”. This argument is understandable as many are not well informed or trained in providing brief interventions. A serious problem with this argument is that many victims of violence will never see an expert in family violence intervention and a generalist brief intervention may be the only intervention that could be of benefit to them (Falb et al., 2014). Some disciplines have better expertise for certain tasks or interventions than others based on their “scope of practice”, training and competence (Rata, 2012). The Vulnerable Children’s Act (2014) requires that all front line clinical health professionals have competencies to respond to family violence and identify vulnerable children and adults. The best mix of practitioners, doctors, nurses, social workers and iwi services should work together to respond to the needs of individual children at risk. Competence is the knowledge, skills and values disciplines claims to have and is demonstrated by the predicted and repeated behaviour of practitioners (Rata, 2012).

The cost of family violence interventions within health systems also does not occur in a vacuum. Health systems all over the world are facing tough fiscal times, and funding priorities are deeply political. The MoH perspective, while more medical interventions can be provided for many patients, is that affordability is an issue in itself (Coleman, 2016). The NZ health systems focus on early intervention and the prevention of the impact of family violence - ultimately also reducing associated long-term health costs (MoH, 2015). Regimented services, functioning in silos and limited workforce capacity, all challenge the provision of timely, supportive and effective safety planning with victims of family violence (Wilson et al., 2015). To perform to a high standard, the health system needs more than a skilled workforce and resources. “It needs a shared view of its overall purpose and the direction it is going, combined with effective ways of working” (Minister of Health, 2016, p. 1). One question that needs to be asked, however, is whether health professionals are adequately equipped to support victims with effective brief safety planning interventions.

Brief solution focused interventions

A supportive professional model of intervention; brief and timely; provides the outcomes sought (such as safety); and reduces further harm to victims of violence is needed in the current health environment. The existence of a health budget to train staff and having an integrated family violence intervention service is “a crucial step for the long-term sustainability of any intervention and to increase staff motivation” (Gracia-Moreno et al, 2014, p. 8). It is necessary to clarify exactly what is meant in theory by brief family violence interventions in health services (Falb et al., 2014). It should ideally consist of brief education, supporting and enabling the victim to engage with collective activities to increase their safety. Brief interventions can encourage change for people who are at risk of harm and a well-conducted timely intervention can have a significant positive impact. Health professionals often have brief but significant relationships of trust with people using their services (Malpass et al., 2014; Wathen et al., 2011). This allows for “the development of rapport and understanding of the issues service-users face” (Matua Raki, 2012, p. 3).
In the late 1990s the solution-focused brief therapy (SFBT) intervention model spread all over the world with the very distinct feature that ‘the client knows best’ (De Shazer, 1991). Other clinicians describe SFBT as *constructive talking* on subjects that foster hope, such as resources, progress, and a preferred future (Furman & Ahola, 2001). De Shazer et al. (1986) introduced “Scaling Questions” in brief interventions for respectful inquiry into people’s traumatic or distressful experiences in various settings. Simm, Iddon and Barker (2014) argue that SFBT focus on “achievable goals and can be easily learned and practised by all health professionals”. SFBT is relatively recent talking-therapy that developed around the late 1980s (De Shazer, 1988). I will explore how health professionals could utilize SFBT interventions in safety planning interventions in my research.

In these interventions, the family violence trauma and its consequences are not ignored or denied, but the goal is to explore what the victim wants to achieve as preferred future (Durrant, 2013). It is presented as an empowerment model of intervention (Scott, Royal, & Kissinger, 2015). The health worker facilitates conversation with the patient/person to build a detailed picture of a ‘preferred future’ by asking what the person wants to achieve. What else? How? What else? How?(De Jong & Berg, 2012). What follows then is acknowledgement that people have, within their experiences, a wealth of skills, resources and strengths. These skills and strengths that they can draw on are both known and unknown to them (Bakker, Bannink, & Macdonald, 2010). The usefulness of this solution-focused (SF) approach means that the person or victim engages and explores options available in planning for a ‘preferred future’ (such as a safe outcome). SF intervention techniques include inviting problem-free talk, eliciting detailed descriptions of the victim’s goals and noticing and complementing the person on their existing strengths and abilities (Macdonald, 2007). Complex problems may not necessarily require complex or lengthy solutions (Watzlawick, Weakland, & Fisch, 1974). This means that small steps can change a vicious cycle of problem maintenance to problem resolution (Simm et al., 2014).

The literature on SF interventions indicates that change and adjustment become inevitable when people experience themselves as competent and successful in finding solutions to problems (Macdonald, 2007). It may be better to focus on the possible, changeable and people’s strengths to overcome the challenges, (Asay, De Frain, Metzger, & Moyer, 2015), rather than the overwhelming. SF brief interventions remind the person of past successes from a strength perspective and build on developing coping skills and resilience (Durrant, 2013). These interventions are client-centred, inviting the person to envision their preferred future (such as safety), start taking action to move in that direction whether small increments or larger changes (Macdonald, 2007).

Andrew Turnell (2013) has applied the SF approach in family violence intervention and is an international advocate for applying SF ideas in child protection work, working with survivors of torture and trauma (Turnell & Edwards, 1999). His work offers an empirical and replicable model to evaluate not just risk but also safety. His work highlights that danger has these days become easier to evaluate than it is to describe what ‘more safe’ would look like (Turnell, 2013). His study offers a practical approach in child protection by beginning to spell out specifically who will be doing what in and outside of the family to ensure children’s safety. He utilizes the assumptions of brief SF interventions that aim to elicit, amplify, and reinforce competency, capability, cooperation, collaboration, and motivation for change. In contrast with other interventions that aim to repair what has been broken, his approach is that the most effective safety planning for victims of violence is to find ways to amplify competence and efficacy in individuals and families (Turnell, 2013). His work in child
protection, and other practitioners that also utilize brief therapy, provide a stepping stone that can help us find constructive ways of ‘talking about solutions’ (safety-planning) and finding dignified approaches in managing human change in family violence intervention (Furman & Ahola, 2001; White & Epston, 1990).

From the previous explanation of trauma-informed care it is clear that supportive care is delivered by trauma-informed interventions. These skills include advocacy, education, emotional support, collaboration and collective safety initiating activities (Chetwin, Gregg, Fielding, & Fanslow, 2013). These interventions are appropriate constructive responses in managing human change. Case studies by Southwick and Charney (2012), focussing on the effect of trauma, have pointed out that specific life skills, and appropriate social support, improve resilience in people. Resilience increases the ability of trauma victims to cope with ongoing challenges in life. In contrast with this concept, victims of intimate partner violence experience loss of their autonomy; their sense of control over life; self-esteem; freedom; expectations; opportunities; income and coping skills (Landenberger, 1989). The long-term effect is overwhelming and erodes the victims’ competence and confidence.

Most research literature in the field of family violence has only focussed on the debilitating effect of violence on victims and not on what constitutes effective brief safety planning interventions. The “victims of family violence need the best helpers they can get to secure their and their children’s safety and protection” (Wilson et al., 2015, p.30). To support this approach we have to have a critical approach to better understand and describe victims’ huge challenges and find better ways to increase victims’ safety and dignity. Recent research literature has reported evidence that an effective strategy for safety planning during family violence intervention has resulted in staff feeling more competent and confident in supporting victims (Eden et al., 2015). Gulliver and Fanslow (2016) advocate for effective services to those less at risk before violence escalates.

The 2013 World Health Organisation [WHO] report and guidelines suggests that all health-care providers are trained in women-centred trauma response to family violence survivors (Gracia-Moreno et al., 2014; Crombie, Hooker, & Reisenhofer, 2016). It is clear in literature that not all USA health systems implement a family violence intervention programme. A study in Pennsylvania examined factors associated with routine questioning for family violence, and women’s experience of counselling as a strategic response. The findings were that women with a recent experience of IPV engaged more effectively with a safety planning response (Swailes, Lehman, Perry, & Mccall-Hosenfeld, 2016). This could be that they have experienced recent family violence trauma and it motivated them to engage with timely supportive interventions. A cross-sectional observational study in Florida revealed that only 35% of health settings implemented comprehensive family violence assessment and response programs (Williams, Halstead, Salani, & Koemer, 2016). When health services staff have an increased awareness of the impact of family violence trauma on women, and provide a safe, informed and supportive environment, their interventions are deemed more effective (Anyikwa, 2016; Pickering, Ridenour, Salaysay, Reyes-Gastelum, & Pierce, 2016; Ansari & Boyle, 2016).

Forsdike, Tarzia, Himarsh, & Hegarty (2014) believe that health services’ response to family violence is crucial to reduce the impact of intergenerational violence. The Family Violence Assessment and Intervention Guideline (Fanslow & Kelly, 2016) describes New Zealand's national health services’ response to reduce the high incidence of family violence in society. The 2002 guideline reinforced that violence is not usually disclosed
without direct questioning - naming the abusive behaviour (NZ Ministry of Health, 2002). Family violence intervention in health services is implemented in a six-step intervention process (Fanslow & Kelly, 2016, p. 124) illustrated in the following flowchart:

Figure 2: Intimate Partner Violence Flowchart (Fanslow & Kelly, 2016, p.124)

The six steps (Fanslow & Kelly, 2016, p. 124) are identification, support, risk assessment, safety planning, referral and documentation. Gulliver and Fanslow (2015, p. 1) state “Risk assessment must be considered as a piece in the wider puzzle of risk management.” Risk management therefore is risk assessment, effective safety
planning and referral to specialist family violence intervention services. Safety planning is illustrated as step four within the IPV intervention flowchart (Figure 2, IPV Flowchart, p. 11).

A review of current research literature and practice guidelines provides many definitions on brief interventions that could be utilized in safety planning interventions. Brief intervention is usually described as a short, purposeful, non-confrontational, tailored conversation about an issue related to a risk assessment. It has been successfully implemented in many studies to support people with substance abuse problems. The purpose is “to support the person to think about their substance abuse behaviour, to make a connection between their behaviour and any associated risks and harms” (Humeniuk, Henry-Edwards, Ali, Poznyak, & Monteiro, 2010, p. 3). The key term here is ‘brief’. It requires the ability of the helper to engage promptly and effectively. There is a correlation between effective engagement with service users and the effectiveness of the brief intervention. People with more severe problems are likely to benefit from more comprehensive assessment and intervention. The role of the brief intervention worker is to refer this group to specialist treatment services (Matua Raki, 2012, p. 8). The level of this intervention depends on the level of risk and the person’s readiness to change behaviour associated with the risk. Previous studies have not focused on what effective services to those less at risk could look like.

Gulliver and Fanslow (2016) recommend that the government develop an overall strategic framework to address intimate partner violence. Their argument relies heavily on a systems approach to address the impact of family violence, whereas this research will focus on just one part of the overall framework. I will investigate if brief SF interventions might support health professionals with safety planning.

RESEARCH METHODOLOGY AND RESEARCH DESIGN:

This research will explore the actual application of new knowledge on health practitioner practices in family violence intervention. As a pragmatic researcher this study will investigate health professionals’ own subjective experience of the new knowledge of brief intervention strategies, and their impressions of the outcome for them of the application of the new knowledge in family violence interventions. Through research I will explore barriers and issues in family violence interventions, such as time and workforce capacity constraints, lack of competence and confidence and how it affects safety-planning intervention.

I ultimately hope to utilize the research to support health professionals to take on board more effective brief safety planning interventions. This may indirectly prevent or reduce cumulative harm to the multiple victims of family violence. This research might improve the health practitioners’ response to family violence by increasing their confidence and competence (or not).

A mixed methods sequential design is chosen for this research as it will bring together both quantitative and qualitative approaches to the research (Creswell, 2014). Two research questions will be explored. In phase one the first research question asks what health professionals do after routine enquiry and a positive disclosure of family violence. In phase two there will be training opportunities for health professionals, aiming to enhance their competency and confidence in brief family violence safety planning interventions. The second research question will explore outcomes for health professionals in brief SF interventions training from their own
experience and subjective point of view. The Mixed Method (MM) sequential design is illustrated by the flowchart as follows:

**MIXED METHODS SEQUENTIAL RESEARCH DESIGN**: Can brief interventions, such as solution-focused interventions, support health professionals in safety planning with victims of family violence?

**PHASE 1: RESEARCH QUESTION**
“What are health professionals doing after routine enquiry and a positive disclosure of family violence in one district health board?”

**PHASE 2: RESEARCH QUESTION**
“What are the outcomes of a brief training intervention for health professionals?”

Figure 3: Flowchart showing the mixed methods sequential design to be implemented
Literature Review:

The literature review process will begin with the exploration of literature to answer my first research questions and continue throughout both phases of the research. I will endeavour “incorporating my research methodology to appraise and analyse literature” as suggested by Aveyard (2014, p. 42). The review will include searching and critical appraisal of previous studies in this area of research to answer the first research question. The results and recommendations for practice will be utilized to develop the training activity in phase two of the research. The literature review will utilize the Wallace and Wray (2006, p. 92) “simple categorization system” to identify useful literature purposefully. The literature will cover four categories: theoretical literature, research literature, practice literature and policy literature (Wallace & Wray, 2006, p. 92). The hierarchy of evidence will first include research literature and studies that utilized surveys and questionnaires to explore health practitioners’ perceptions of delivering interventions with family violence victims. Studies that explore victims’ perspectives will also be included to explore aspects that can inform health professionals during their skills development and training. Observational studies and studies that compare effectiveness of different brief interventions will also be included. Studies about the impact of violence on victims, and wider system responses will be second on the hierarchy of evidence as it can contribute to additional criteria and knowledge to refine the analysis of the evidence to answer the research question. The critical appraisal of each paper will be followed by a summary of the content of all the papers and studies included in the review (Aveyard, 2014; Punch, 2005). Topics of interest will be further developed in the literature review. Literature that could answer the research questions, such as literature on health professionals’ training, skills, interventions, confidence, competence, satisfaction, collaboration, making appropriate referrals, barriers for intervention and safety planning outcomes will be reviewed.

CONCLUSION

I believe that health professionals should access further training to develop competencies in brief family violence interventions. These competencies are to identify and manage victims of family violence safely. This ability would support them to overcome barriers and make reducing harm of family violence every health professional’s business.

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List of Figures:

*Figure 1*: Machtinger et al. (2015, p. 195. Illustration of trauma-informed care.

*Figure 2*: VIP Intimate partner violence intervention flow chart. (Fanslow & Kelly, 2016, p.124)

*Figure 3*: Flowchart showing the mixed methods sequential design to be implemented.
I understand that abuse is the absence of Love, so healing and prevention comes from learning and applying how Love works. We are attracted to the notion of Love but can we translate it to its functional ingredients to make it “user friendly and possible”.

Working with thousands of victims and perpetrators, shows me that people who don’t value themselves often turn to power, substances or denial seeking relief. These are the ingredients in abusive relationships.

I understand that need shows itself in behaviour. I find it most efficient to address the need and “feed the baby”, rather than saying “that crying behaviour is socially unacceptable and you should modify it”.

We have understood Pavlov in seeking to change behaviour by using reward and punishment. However, I think we have collectively thrown out reward and hung on to punishment. I assess that in the main we have regressed from Pavlov, in that we have not yet begun to address need.

It may make the speaker feel good to say: “that behaviour is unacceptable” and while this can have a role in setting a limit, it may not assist the hearer know how to relate respectfully or get their needs met in healthy ways.

I think we become wise and efficient if we can understand and address need.

We want learning and respectful safety to be the outcome and we need to understand that rejection and punishment alone may not deliver that outcome. When I visited Mt. Isa with the Domestic Violence Prevention Council, I heard first hand that for some individuals the fear of going to prison did not act as a deterrent to violence and certainly for a person affected by alcohol or drugs the better judgement function of the frontal lobe of the brain may not function to link action with outcome or consequence. This does not justify abuse, but we must address these issues if we are to prevent abuse.

My observations are that valuable people, value people. People who don’t value themselves often use other people to get their needs met at someone else’s expense. My main aim in helping victims and perpetrators is to help each regain a sense of personal value.

I will share a Relationship Dynamics Model that I have developed in helping people have healthy relationships with themselves and others. I find it useful in the healing and prevention of abuse.
If we don’t look at the dynamics of a relationship, we are at risk of blaming the individuals. So then it is either my fault or your fault. I find the blame is likely to shut down communication. Healthy interaction benefits both people, unhealthy interaction doesn’t help anybody. So by looking at the dynamics we have room to learn.

I think the foundation of a healthy relationship is a sense of acceptance. When we feel accepted we can open up and communicate. If we really feel accepted, we feel safe to be honest in our communication. That includes being free to say “Yes” and “No”. If our honesty is met with acceptance, the outcome is safety and trust. I will illustrate these healthy dynamics across the spectrum of relationships including lovers, friends, healthy respectful-enemies, healthy professional-client relationships and a healthy self.

In looking at unhealthy dynamics, I observed that they are based purely on need. Need is not bad, as when we accept ourselves and each other, we except that need is part of being human. However, if need is the only foundation of the relationship, we are vulnerable to use each other to meet those needs.

People can use each other in many ways. Some people seek to buy each other, others manipulate. People who don’t accept themselves are most likely to use power as a substitute way to feel safe or “valuable”, putting themselves up and others down. Some use each other by judging or prejudging, seeking safety by putting others in “boxes” or using labels. Some may use information as a weapon and so gossip.

Others may be dependent on the approval of others and so sacrifice honesty in seeking acceptance. I like to contrast dependency with trust. In a dependent relationship, I’m afraid to be honest, in a
trusting relationship, I’m free to be honest because I know you accept me. Some people seek to “fix other people” or tell them how to run their life as a way of denying running their own.

Sometimes in my work as a doctor I have automatically wanted to fix and “rescue” victims of Domestic Violence. One lady taught me well that to value her, I needed to respect her choice to actually stay in the violent relationship. She has grown up with an alcoholic father. She adapted by trying to be perfect but then developed anorexia. He partner was a Heroin addict but moved over to the “legal drug” alcohol and under its influence became violent with blackouts he couldn’t remember. He would rape her and degrade her in abusive ways beyond imagination.

I found a refuge for her but she chose to stay. I learned that in the abuse her choices were not respected so in helping her, the essential ingredient was value her by giving her choices and respecting them. As her sense of worth grew from this interaction she started to protect herself and set boundaries. Even though he was not my patient at the time, vicariously he realised he had a problem and needed to ask for help. He went to detox and then rehab and made good progress in recovery. Unfortunately when he came home, he then become very controlling, emotionally and financially until he realised he needed help beyond stopping drinking. He needed to regain a sense of personal value to not put others down seeking relative value through control. He accepted counselling and recovery group support so he could then let go addiction, power and control.

Both parents now treasure each other and relate as equals with respect. There has been proactive healing within the whole family, including the children. I am fortunate to now be a god father of a grandchild.

If I had acted on my desire to “rescue” and justified pressuring her to take the path that I thought was safest, she most likely would have disengaged from help if she didn’t chose to do what I suggested.

She taught me the inextricable link between feeling valuable and having a choice. Take choice, people feel raped. Give choice, people feel respected.

I have learned that I can’t “fix” or change any other human than myself, so now I never try and hence, never fail.

I would like to see every presentation of Domestic Violence as an opportunity to invite the parties to choose which path would meet their needs best. For example, do you need a safe place? Do you need to separate or if you stay, how can we achieve safety? Would you like Relationship Counselling? Would you like Mediated Resolution options if the Adversarial nature of a Court process doesn’t meet your needs? Would you like to address an Alcohol or Drug Problem to reclaim the ability to have healthy interaction rather than on-going future loses.

Sometimes when I suggest this people react angrily and say: “Alcohol and Drugs are not an excuse for Domestic Violence” and it is true there is NO EXCUSE for Domestic Violence. However as it is a major correlate of Domestic Violence we can’t afford to deny it or we will never end it.

Denial and Power are always elements of abusive relationships and if we deny the reality we can participate in the problem. That is why I alerted the Queensland Government when they didn’t
mention alcohol and drugs at all in the latest Domestic Violence Strategy released in November, 2016. We must work from reality to intervention, not just perception to intervention.

This also applies to the issues that see working with male and female victims and male and female perpetrators. I also see Domestic Violence in the LGBTI communities and it is vital that we don’t assume who is the victim or the perpetrator. Individuals need to feel safe to ask for help. We can’t afford to make any victim invisible if we are to value people and heal and prevent Domestic Violence.

The last way I list that people may use each other is that some may use people as objects, using them and then discarding them. (eg. -use you for today, dump you tomorrow, use you for your image or your money and reject you for your differences or mistakes.)

If ever someone uses us, the outcome is that we feel devalued. So my working definition of abuse is: “abuse is using somebody else to get your needs met at their expense”. Ab-use is the Abnormal Use of a person, as a “rung in a ladder” to get to where you may want to go.

When you listen to victims you hear them say that they feel devalued, dirty or degraded by the abusive treatment of others.

In survival, some people can become dependent on denial or power to feel safe. Denial might manifest as keeping a secret or never allowing someone to be close. Denial might manifest as a tough exterior or mask, acting as “straight” when you are gay.

Power might show itself as needing to be “on top” or “in control” to feel safe. People who don’t have individual power may form a gang and put others down to make themselves look “tough”. Some people may seek to be “perfect” as a way of avoiding the vulnerability of criticism.

Each of these survival methods has limits and can’t restore the value of the person or the freedom to have vulnerability, intimacy or trust in future relationships. I don’t want people to be limited by Survival, everyone deserves to Thrive.

It is vital that victims find safe places where their honesty can be met with acceptance so that they can regain a sense of personal value and so be honest to let the perpetrator own the abuse rather than to blame themselves for what someone else did to them.

As people regain their value they can regain a sense of freedom in being honest to protect themselves, to say “Yes” or “No” and set boundaries to achieve true safety. In learning how healthy relationships work, individuals can regain personal value, independence and safety that allows the trust of intimacy – being vulnerable with safety. The feeling that “I am running my life now”.

These are the dynamics of love whereas survival dynamics are rooted in fear. I assess that all humans, despite their diverse experiences, long for a journey from fear to love. Some have never had love modelled to them. Abuse is the absence of Love, so healing and prevention comes from restoring love.

In my work I found that 6% of victims went on to become perpetrators. This smashes the myth that all victims become perpetrators. I also found that more than 90% of perpetrators had been victims. My understanding of the difference in these two figures is that victims who regain their value, don’t
become perpetrators. Victims who don’t regain their value may become dependent on power and
denial and so do not see a limit until they go past it or find themselves doing things they never
thought they could, like turning to power. I don’t seek to judge or excuse, but I do seek to
understand so that there can be fewer victims and fewer perpetrators and less abuse.

Anger is the healthy reaction to abuse. Anger is a sign of our value. If someone acts to devalue us
anger is there to motivate us to say “Fair go, mate… I don’t deserve to be a ‘doormat’ “. If we link
our anger to denial, we can become a ‘time bomb’. If we link our anger to power, we may justify
revenge and treat people badly because we were treated badly. I have never found this to make
things better. I have known a victim to kill a perpetrator in seeking revenge, only then to commit
suicide. I have seen many victims who suppressed their anger and lack of worth until pushed passed
a limit that they didn’t see and then kill the perpetrator.

Revenge may restore power, but it can’t restore value. I want victims to regain their value so that
they can be an equal and use honesty to set boundaries to protect themselves. This is Resolution,
the restoring of value.

Love is a gift. It is about valuing yourself so that you are free to value others. It is being free “to treat
others how you’d like to be treated” : (the old ‘Golden rule’ and Resolution) rather than “treating
people badly because we have been treated badly”: (Revenge). Love is a revolution.

We have a choice to build a resolution culture rather than a revenge culture. Resolution restores the
value of victims and perpetrators, whereas revenge is a recipe for endless war.

As a doctor I am committed to follow the Hippocratic Oath of “First do no harm” so the we don’t
make things worse instead of better. I am convinced that “petrol doesn’t put out fire”.

We have a simple choice.

We could spend our lives trying to sweep out darkness or we could simply bring light into darkness.
It is love that gets rid of fear. Fear brings denial and power-dependency, the ingredients of abuse.

We like the word love, but we need to break it down to its pragmatic ingredients of acceptance and
honesty, so that those who have never experienced it can understand it. It is best taught by
modelling rather than preaching.

Nelson Mandela said: “No one is born hating another person because of the colour of his skin, or his
background, or his religion. People must learn to hate, and if they can learn to hate, they can be
taught to love, for love comes more naturally to the human heart than its opposite”.

Martin Luther King said: “Darkness cannot overcome darkness; only Light can do that.”

Hate cannot drive out hate; only Love can do that.”

He said: “The ultimate weakness of violence is that it is a descending spiral begetting the very thing it
seeks to destroy. Instead of diminishing evil, it multiplies it.

Through violence you may murder the liar but you cannot murder the lie, nor establish the truth.
Through violence you may murder the hater, but you do not murder hate...

Returning violence for violence multiplies violence, adding deeper darkness to a night already devoid of stars.”- Martin Luther King.

My personal life motto is..... “To make Love infectious”.

Enjoy spreading it.

Dr Wendell J. Rosevear O. A. M. M. B., B. S. DipRACOG. FRACGP. J. P. (Qual.)

See Attachment of “Relationship Dynamics Model” Dr. Wendell J. Rosevear 1990. Welcome to share.
RELATIONSHIPS DYNAMICS MODEL

UNHEALTHY

BASIS

NEED

Stress

- Buy
- Manipulation
- Power: Dominance
- (Pre)Judge
- Gossip
- Dependency
- 'Fix-it'
- Partial

USE

ABUSE

HEALTHY

ACCEPTANCE

COMMUNICATION: HONEST

Person
Body
Choices
Needs
Time

TRUST

Dr. WENDELL J. ROSEVEAR 1990
Engaging the Family in Domestic Violence Cases:

Bridging the Gap Between Child Welfare Agencies and Families Experiencing Domestic Violence

Heather Shorten, MSW, LGSW
On a warm August day in 2015, Jane a young mother of two small children was approached by her ex-boyfriend while she and her children played at the playground. Jane’s ex-boyfriend had just stolen a car and forced Jane and her two children into the car at gunpoint. Jane fearing for her life and the lives of her children did not resist. Once in the car, Jane’s ex-boyfriend took her and the children on a high speed police chase across state lines. After about an hour, Jane’s ex-boyfriend stopped the car and escaped on foot before the police arrived, leaving Jane and her children unharmed physically but scared and shaken.

When the police arrived on the scene and approached the car they found Jane and her two children scared and crying. The police immediately arrested Jane and began interrogating her in front of her children. Child Protective Services was called and Jane’s children were taken away from her. Jane was incarcerated and later informed that she was being accused of child endangerment and neglect, because her children were not properly restrained in the vehicle, and because she made the decision to get into the car with her ex-boyfriend and failed to protect them, they were placed into foster care.

Jane had done everything she thought necessary to protect herself and her children before that fateful day in August. She had left the man who was abusing her, she had relocated and kept her address a secret, she obtained a protection order and she and her children were engaged in therapy and other services to help them cope with the effects of living with domestic violence. After more than a month Jane was still working towards reuniting with her children, she was labeled as a child abuser by Child Protective Services and her name was added to the state’s child abuse registry. To make matters worse the Social Worker assigned to Jane’s case was not knowledgeable of the dynamics of domestic violence and was hostile and disrespectful to Jane.

Unfortunately this scenario is all too common when the worlds of child welfare and domestic violence intersect. Too often victims of domestic violence are re-victimized by the policies and procedures of child welfare agencies that don’t have services and policies that meet the needs or address the dynamics of families experiencing domestic violence. However; there are many groups working on changing the policies related to child welfare issues and practices.
**Introduction**

The most recent figures from the AIHW indicate that during 2013-14, there were 198,966 Australian children suspected of being harmed or at risk of abuse and/or neglect. As of September 30, 2015, it was reported that there was an estimated 427,910 children in foster care throughout the United States (AFCARS Report, 2015). The types of harm most commonly substantiated across Australia were emotional abuse and child neglect. Children who witness domestic violence are also typically categorized as having experienced emotional abuse (AIHW, 2015). In the United States 61% of children were removed from their homes because of allegations of neglect (AFCARS Report, 2015). The high proportion of substantiations of emotional abuse is a relatively new phenomenon (AIHW, 2011). The inclusion of children who have witnessed domestic violence is likely to be one of the key reasons for the high rates of substantiated emotional abuse (Holzer & Bromfield, 2008). As a result child welfare Social Workers are more likely to encounter families effected by and/or experiencing domestic violence, therefore it is extremely important for Social Workers and other mandated reporters to be able to recognize the signs of domestic violence and work effectively with these families.

Traditionally child abuse and neglect cases are opened in the mother’s name, even in cases of domestic violence, where the mother herself is also a victim. When we do this we re-victimize the victim and label her as a child abuser. We create a case plan for the victim that may not be in the best interest of the family. Often times we don’t engage the perpetrator or include him in the case plan. When we do this, it hurts our chances of effectively helping this family and may put them at further risk for domestic violence. Child welfare workers, domestic violence advocates, family courts, law enforcements and other social services professionals need to be armed with the tools, resources and interview skills to effectively engage families experiencing domestic violence, ultimately leading to keeping children safely in the home through partnerships with the victim and intervening with and engaging the perpetrator.

**History of the problem, from a US perspective**

In the 1990s, the child welfare system was experiencing an increase in caseloads, rising from an estimated 400,000 children in out-of-home care in 1990 to 570,000 in 1999. Compounding this is the problem of high rates of employee turnover within the child welfare system, and workers often carried caseloads far exceeding the recommended standards. While efforts were made to keep families together, few resources were available to address the factors that complicated family stability such as domestic violence, substance abuse and mental health. In some instances these very issues and the lack of services to address them undermined the case planning process that workers are required to conduct
to ensure a child’s safety. Another response was for Child Protection Services to screen out cases of children exposed to domestic violence, without determining the nature of their exposure, the level of trauma they may have experienced or the type of assistance they might need. During the early 1990s there was increased political pressure and legislative initiatives designed to shift the child welfare system’s focus away from reunification and strengthening the biological family to adoption. As a result child welfare systems shifted their focus away from preserving families and placing children up for adoption if strict timelines were not met.

While domestic violence resources and services for victims were expanding in the 1980s and early 1990s, few resources and services were being developed to address perpetrator accountability. Only recently has the child welfare system begun to openly discuss the dynamics of cases involving domestic violence that the men who abuse women often remain in the lives of those they abuse. Traditionally, the child welfare system, criminal justice system and domestic violence advocates encouraged women to leave their abusers as a means of addressing safety. As service providers working with victims of domestic violence we must realize that it may not be the woman’s wish to leave her partner. It may not be economically or culturally feasible, and in many instances leaving may be more dangerous than staying. With increased awareness of the dynamics of domestic violence we can work with the victim to assist her in accessing services and resources that will keep her and her children safe and appropriately engage the perpetrator in services that will hold him accountable for and reduce or eliminate his violent behavior.

**Impact on children**

Children are put at risk by domestic violence in several ways. Research has shown that domestic violence places children at high risk for physical abuse; men who frequently abuse their wives, frequently abuse their children. The presence of domestic violence can also be linked to fatal child abuse cases (Childwelfare.gov). Families also come to the attention of child protective services when a child is injured while trying to stop an assault on their mother. It is important to remember that there are families in which the child is never directly assaulted or neglected by his or her parents but they may be emotionally harmed as a result of witnessing repeated physical abuse and threats against their mothers, or witnessing the aftermath of an abusive episode. There is much research that suggests that children who are exposed to domestic violence are more likely than their peers to experience difficulties associated with behavior, social and emotional problems. In general, boys exhibit more externalized behaviors (e.g., aggression and acting out), while girls exhibit more internalized behaviors (e.g., withdrawal and depression) (Moylan et al., 2010). Research indicates that males exposed to domestic violence as children are more likely to engage in domestic violence as adults; similarly females are more likely to be victims (Brown & Bzostek, 2003).
Exposure to domestic violence is also linked to higher rates of delinquency and substance abuse, and is one of several adverse childhood experiences (ACEs) that have been shown to contribute to premature death, as well as risk factors for some of the most common causes of death in the United States, including alcohol abuse, drug abuse, smoking and obesity (For more information see the Adverse Childhood Experiences study at www.acestudy.org).

The National network to end Domestic Violence September 2012 census found that in the U.S. 18,968 children and 16,355 adults found safety in Emergency shelters and transitional housing, and 5,815 children and 23,186 adults received advocacy and support through non-residential services (National Network to End Domestic Violence, 2013).

Despite these facts, research suggests that children’s risk levels and reactions to domestic violence exist on a continuum, and while some children show signs of maladaptive adjustment, others show incredible resiliency. Some factors that influence the impact domestic violence has on children include, the nature of the violence. Children who witness severe and frequent forms of violence or fail to see their caretakers resolve conflicts may undergo more distress than children who witness fewer episodes of violence and experience positive interactions between their caretakers. Younger children appear to exhibit higher levels of emotional and psychological distress than older children. Children often have heightened anxiety levels and fear immediately after a violent event. Fewer observable effects are seen in children as time passes after a violent event (Rosewater & Goodmark, 2007; Edleson, 2004). It is important for child welfare caseworkers to consider these factors when assessing a family for safety and determining if a child has been abused or neglected. Some protective factors to assess for are social competence, levels of self-esteem, intelligence and supportive relationships with adults, particularly with the non-offending parent. It is important for domestic violence, child welfare and other Social Service professionals to understand the impact of trauma on child development and how to minimize the effects without causing additional harm (Child Welfare Information Gateway). Some children in the face of violence need regular opportunities to participate in family activities safely; the chance to remain in the same school to ensure continuity with teachers and friends; and the opportunity to participate in extracurricular activities and after-school programs that connect them to their peers and other caring adults (Family Violence Prevention Fund, 2007). Children experiencing symptoms of trauma require additional services. However; the child welfare system and domestic violence services frequently have little to offer in the way of services to children who have been affected by domestic violence.

**Impact on Victims**

The standard procedure in the US, in the majority of child welfare cases where there is a co-occurrence of domestic violence the case is opened in the mother’s name. This is often
regardless of whether she is the abuser or a victim herself. The practice of opening the case in the mother’s name can lead to charges of failure to protect her child. “Mothers generally are the primary caregivers of their children and as a result are often the easiest parent to engage or punish.” (The Family Violence Prevention Fund, 2007) The result being the family entering into the child welfare system and the mother placed into a position where she may need to meet the requirements of a case plan that was developed without her input and may not be appropriate to her circumstances. Often, case plans include goals such as leaving the perpetrator, obtaining a protecting order, going into a domestic violence shelter, couples counseling or keeping the children away from the perpetrator. However, these goals may be contrary to the victim’s plans, may put her and the children at increased risk for violence and may not be financially feasible. Attention to the mothers can be useful if it involves listening to her and addressing her needs for safety, support and services; however too often the attention turns into mother-blaming, extending the shame and guilt she may already feel victimized by domestic violence. Therefore, it is important for child welfare caseworkers to remember that the victim is the expert on her situation and her partners’ behavior. This is an important step in building an effective relationship with the victim. Focusing on the mothers has also constrained the strategies available to reach the men involved in these families, to work with them and to hold them accountable for their behavior. The mandates and policies built into these systems often discount the male’s role in the family, especially when he is not biologically related to the child.

The domestic violence movement began with a focus on women; its spoke to empowering women to achieve freedom from violence. These principles often dismissed a man’s role as partner and father. Furthermore, neither the legal structure that recognizes domestic violence as a crime, nor the services that were developed to support victims of domestic violence took their role as mothers, their interests in some cases in staying with their partners, or the needs of their children into account (Family Violence Prevention Fund, 2007). Too often battered women lose their children in custody disputes and to foster care, because the court and Child Protective Services assumed that because they were victims of domestic violence, they could not be good mothers. Decisions regarding custody and visitation often require women to keep in contact with the father of their children, possibly putting the victim at risk for further violence during visitation exchanges. Moreover, judges unfamiliar with the dynamics of domestic violence were forced to choose between sympathetic and appeasing abusive fathers willing to share custody of their children with their spouses and frustrated, depressed or angry women seeking to shelter their children from abusive partners. Too often the batterer simply looked like the better parent and as a result was awarded custody (Jaffe, Lemon & Poisson, 2003). The focus should be on keeping the child safe in the home with the non-offending parent.
**Engaging Perpetrators**

Only in recent years have Social Service programs started to consider the offenders relation to the abused. Traditionally victims were told to leave the abuser. As a result of this practice the perpetrator was often not engaged or held accountable for his abusive behavior. In some Domestic Violence programs advocates were discouraged from engaging perpetrators without the appropriate training. It is vital for workers to have the skills and confidence required to engage the abuser when responding to domestic violence cases. This ability to engage is one step toward creating an effecting partnership and a safe environment for the family.

In some cases it is beneficial for children to maintain a safe relationship with the abuser, provided he is able to commit to non-violent behavior. The perpetrators case is often treated separately from the mother and child, which can lead to inappropriate case planning because the family unit is not considered. Just as in the case of the victim, the perpetrators case plan needs to be individualized. It may or may not include reunification of the family. By developing expectations for the abuser it becomes more possible for child welfare agencies to monitor families for protection and support (Family Violence Prevention Fund, 2007). Generally there has been a lack of supportive services to address the needs of the abuser. They are usually referred to batterers intervention or anger management programs. Too often the batterer is referred to an Anger Management program, whether it is appropriate or not.

It is vital that child welfare caseworkers know the difference between Anger Management and Batterers Intervention programs and how to determine if Anger Management is needed. Anger Management uses techniques to control a person’s expression of anger so as to be more respectful and appropriate to others. Therapeutic techniques include cognitive restructuring, reducing exposure to the causes of anger and relaxation techniques. (psychologydictionary.org) In contrast, Batterer Intervention programs focus on making appropriate choices and building people skills. Programs provide contact with partners, asses substance abuse and mental health status and make referrals (Massachusetts Health and Human Services). While courts mandate that men participate in these programs, there is very little follow-up and no protocol’s or structure other than to record attendance in the programs. In addition increasing numbers of batterer intervention programs are addressing parenting, however it has yet to become standard practice. “Recent studies about how to reach non-abusive men have shown that men are more likely to develop empathy around children’s experiences rather than around the experiences of the women with whom they are involved.” (Family Violence Prevention Fund 2007) As a result new programs are developing that involve non-violent men as role models and mentors. In some cities these programs are referred to as Fatherhood Initiative.
The evidence on the effectiveness of the tools used to hold batterers accountable is mixed. Batterers intervention programs do not work for all men and many do not address the specific issues of men of color who are likely to be over represented in these programs. In addition, a criminal response may not be effective for all men but it is often the de facto choice for many systems seeking accountability. Because of these and other problems there can be no certainty that the children will remain safe even if the batterer is held accountable. Without a guarantee of safety, the Child Welfare System will continue to place the responsibility of keeping the children safe on the abused mothers, affectively relying on the victim to stop the violence against her and changing the perpetrators pattern of behavior. Therefore, we must develop appropriate strategies to hold batterers accountable by recognizing that changing the behavior of men with a history of violence is essential to preventing future violence.

**Challenges of Responding to Domestic Violence**

Historically programs and services designed to stop intimate partner violence have been viewed as separate from the goals of protecting abused children. Responding to allegations of child abuse and neglect was a task for the child welfare system, while the job of protecting battered women was left to community agencies, law enforcement and the courts. Research suggests that nearly 30 million children in the United States will be exposed to some form of family violence before the age of 17, and there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011). Despite these alarming numbers and the fact that adult and child victims are often found in the same family child welfare and domestic violence programs generally respond to the victims separately. Because each system was focused primarily on the safety of one victim, conflicts sometimes arose. Some child welfare advocates were concerned that domestic violence programs did not address the safety of the child and only focused on the victim’s needs. While some domestic violence advocates felt that child protective services caseworkers re-victimized the victim by blaming her for the violence, removing her children and charging her with child abuse or neglect. These conflicts arise because the two systems often develop their policies, practices and procedures independent of each other. As a result the two systems often failed to communicate and coordinate with one another to determine what’s in the best interest of the family (Carter & Schechter, 1997).

In the United States, 21 states and Puerto Rico have passed legislation that broadens the definition of child neglect to include children who witness domestic violence (Child Welfare Information Gateway, 2008). Australia has also expanded their definition of child neglect to include children who witness domestic violence (Holzer & Bromfield, 2008). However, some
research suggest that expanding the legal definition of child maltreatment may not be the most effective way to address the needs of children exposed to domestic violence. Because exposure to domestic violence affects children in different ways, child welfare caseworkers are cautioned against assuming that witnessing domestic violence alone constitutes child maltreatment or warrants child protective intervention (Edleson, 2004; Hughes, Graham-Bermann, & Gruber, 2001).

**Recommendations for promoting collaboration**

It has become increasingly clear that it is in the best interest of women and their children for child protection agencies and domestic violence advocates to collaborate in more effective ways. Community leaders should first join together to establish responses to domestic violence and child maltreatment that provide meaningful help, supports and services for families. In addition communities should hold violent perpetrators responsible for their behavior and provide legal interventions and services to stop this violence.

Despite their differences, child welfare advocates and domestic violence service providers share common goals that help to bridge the gap between them. Some of these goals include:

- Ending violence against adults and children
- Ensuring safety for the child
- Protecting adult victims so their children are not harmed by violence
- Promoting parents’ strengths
- Deferring child protective service involvement if the child is safe

In order for the two systems to be able to achieve these goals there must be effective and cooperative collaboration. Effective collaboration begins with trust building. To build trust child welfare and domestic violence organizations must build strong, sustained relationships. These relationships are essential to generate a level of trust, especially when conflicts of role or practice arise. This gives individuals a safe place in which to address their concerns professionally rather than personally. Developing mutual trust involves getting to know more about why an individual holds the views that they do, as well as finding common connections, interests and experiences. A skilled facilitator can assist in this type of dialog which can enhance understanding and build trust. Once trust has been built, the next challenge is learning to listen to each other. Listen to and understand other people’s points of view and find ways to work together toward a common goal. Collaboration is ongoing, players may change, altering the dynamics of the group and requiring new orientation. Sometimes new parties can offer new ideas, stimulating participation, generate new energy and reignite the commitment of the collaboration. Other times the inclusion of new participants can set the collaboration back.
Due to mistrust among the various social service agencies and judicial agencies that encounter families experiencing a co-occurrence of domestic violence and child maltreatment, sharing information have been a problem. The unwillingness or inability to share information has created barriers to creating appropriate case plans for families, because the systems were unaware of one another’s involvement. Some information sharing has been designed to ensure that the child is safe. For example, knowing that a child has been taken to a shelter with the victim allows child welfare to discontinue their investigation or seek further court involvement. Information sharing also helps domestic violence service providers to understand more about mandated reporting responsibilities in the event that they are working with a mother who may be suspected of abusing her children. Information sharing helps child welfare caseworkers become more domestic violence informed which helps to dissipate the stereotypes about victims. However, it is important to remember that with information sharing child welfare caseworkers and domestic violence advocates need to be aware that sharing the victims personal information, such as her address or phone number can put her and her children at risk.

Program Recommendations

In the past 15 years, stakeholders, researchers and service providers have worked to improve the response to families experiencing a co-occurrence of domestic violence and child maltreatment. Pioneering programs have been designed to address the problems within and across the systems. These new programs aim to support a child welfare system under strain, provide more comprehensive services to domestic violence survivors, create new roles for men who want to help families in crisis, address the many unmet needs of children who witness or experience family violence, and support prevention strategies that offer great promise to keep women and children safe (Family Violence Prevention Fund, 2007).

Some experts in the field assert that families and their children who show minimal evidence of harm resulting from exposure to domestic violence, and who have other protective factors present in their lives, may benefit more from voluntary services in the community (Edleson, 2006). A child welfare practice known as the differential response reflects this belief. A differential response allows child welfare agencies to approach the issue of domestic violence in a family centered, nontargeting way. This helps to ensure the safety and well-being of the children as well as the adult victim. A differential response also allows child welfare caseworkers to assess whether the family can be helped by services and supports outside of the child welfare system and dependency courts.

With a differential response social workers must meet with the adult victim first and separate from the alleged abuser to establish a safety plan for the adult victim and her children (Sewyer & Lohrbach, 2005). It is important to keep the safety of the victim and her children in mind when attempting to schedule meetings with her that do not include the
alleged abuser. Once a safety plan is discussed with the victim, the alleged abuser is contacted with a focus on concerns related to the children being exposed to violence. Safety plans are developed with the adults with the intent of reducing the risk and/or recurrence of physical and emotional harm to the child. Families are then referred to community based services that can provide them with the assistance needed to address the violence, with the hope of preventing further government intervention (Sawyer & Lorhbach, 2005).

In addition to a differential response, child welfare agencies across the United States are adding new protocols and practices designed to better address the needs of families experiencing domestic violence and to provide caseworkers with a better understanding of the dynamics of domestic violence. Different types of case consultation and family and group conferencing are being used by child welfare agencies. Multidisciplinary teams and case consultations are designed to bring together frontline child welfare workers with domestic violence advocates and other professionals working with a family. In case consultations, child protection workers call on experts in other disciplines for assistance in considering the information and options in a particular case (Family Violence Prevention Fund, 2007). In the past this approach has included domestic violence advocates who have served as consultants to a child protection team in reviewing cases in which they were trying to develop accountability for abusive men and link them with services.

Multidisciplinary teams function somewhat more formally and usually involve more participants, including substance abuse and mental health counselors and other family support professionals who may engage with the family or their children in other settings (Family Violence Prevention Fund, 2007).

Family Team Conferencing (FTC) or sometimes referred to as Family Team Meetings (FTM) are another significant practice that is gaining in popularity. This strategy brings family members and their support network (family members, neighbors, advocates, clergy and other services providers) together, which allows them to have a greater impact on child welfare decision making. By recognizing that a large proportion of these families face compounding safety issues as a result of domestic violence, agencies are developing guidelines to help workers determine when the use of FTC is appropriate, and when the risks make it counterproductive or potentially dangerous. FTC can also provide a space to recognize the mother’s strengths, such as the ways in which she has protected her children, or that her children never miss school despite the domestic violence or other underlying issues related to the abuse.

Essential elements that make FTCs work are trained facilitators, adequate time to ensure that the family brings allies, and careful homework to determine whether and how the abuser should participate. In some cases it is more appropriate to hold a separate FTC with the perpetrator, using the same preparation, facilitation and follow up. Family Team Conferences involving abusive fathers, when carefully conducted, offer an opportunity to
increase a circle of accountability and support for his behavioral change (Family Violence Prevention Fund, 2007).

Team Decision Making (TDM) is a form of group conferencing that is used whenever a foster care placement issue arises. TDM allows for all of the key participants, including the family and community partners to be involved in the decisions (Family Violence Prevention Fund, 2007).

Domestic Violence Specialist are increasingly being added to the staff of child welfare agencies and courts across the United States. The role of the Domestic Violence Specialist is to understand and advocate for the needs of abused women and advise child welfare caseworkers about safety planning, protection orders, support and services. Because of their prior experience as advocates, many specialists have been able to reach out to battered women differently than in the traditional relationship between social worker and client (Family Violence Prevention Fund, 2007). As previously stated, the child welfare system has traditionally been focused on the child’s situation, the social worker relates to the mother with the assumption that she has either abused or neglected her children and that she is responsible for stopping the abuse against her. Domestic Violence Specialist have turned that relationship around, by relating to the mother first as a victim or abuse herself, but also as someone who has strengths which she can draw upon. The Domestic Violence Specialist is someone who is on the victim’s side, with the expertise and resources to help her. It can be helpful for Domestic Violence Specialist and social workers to work in tandem, as it can allow social workers to develop their interviewing skills and ability to engage families exposed to domestic violence.

The Greenbook Initiative recommends include but, are not limited to the following in regards to safety and advocacy in the child welfare system:

- Child protective services should develop case monitoring protocols and staff training to identify and respond to domestic violence and to promote family safety.
- Agency policy must state clearly the criteria under which children can remain safely with the non-offending parent; the assessment required to determine safety; and the safety planning, services, support, and monitoring that will be required in these cases.
- Child protective services should make every effort to develop separate service plans for adult victims and perpetrators, regardless of their legal status vis-à-vis the child.
- Child protective services should avoid strategies that blame the non-offending parent for violence committed by others.
- Parenting programs should re-examine their procedures, policies and curricula to ensure that safety for adult victims and information about domestic violence are integrated into programmatic activities.
Domestic violence service organizations should support and organize regular cross-training activities with agencies and groups that deal with child welfare.

Domestic violence service organizations should train staff regularly to understand, recognize and respond to child maltreatment.

Domestic violence shelters should consider the needs of battered women with boys over the age of twelve and families with substance abuse and other mental health problems.

The juvenile court should prioritize removing any abuser before removing a child from a battered mother.

Generally, judges should not order couples counseling when domestic violence has occurred.

The juvenile court should know what batterer intervention services are available in the community as well as the quality of those services, and should be able to track the progress of any parent who is ordered to participate in those services.

Batterers’ intervention programs should participate regularly with cross-training activities with the agencies and groups that deal with child welfare.

The juvenile court should ensure that all participants in the court system are trained in the dynamics of domestic violence, the impact of domestic violence on adults and children, and the most effective and culturally responsive interventions in these cases, including safety planning.

Minimum competencies for child welfare professionals to work with survivors of domestic violence as recommended by the Florida Coalition against Domestic violence (FCADV) include but are not limited to the following:

- Interviewing skills to engage survivors
  - Comfortably discusses child safety concerns in a non-blaming manner
  - Elicit information about the perpetrator’s pattern of coercive control and battering
  - Discuss and document the survivor’s actions to ensure the child’s safety and well-being

- Recognize the protective efforts of the survivor by assessing for and respecting strengths as they relate to day to day actions taken to help ensure child safety and well-being

- Partners with the survivor to develop the case plan that supports child safety and survivor identified needs

Minimum competencies for child welfare professionals to work with domestic violence perpetrators as recommended by FCADV:
Interviewing skills to engage perpetrators
- Accurately accesses and recognizes coercive control and battering tactics
- Comfortably discusses child welfare concerns in a respectful manner without colluding
- Ability to keep the focus of the interview on batterer’s behavior and impact on the family.
- Is able to develop a perpetrator focused safety plan that includes actions that are directly related to controlling danger threats to the child created by the perpetrators violence.
- Is able to develop a case plan with perpetrator input that focuses on measurable behavior change related to coercive control and other diminished caregiver protective capacities.

Conclusion

Over the recent decades there has been heightened awareness, understanding, and knowledge of the co-occurrence of domestic violence and child maltreatment. As a result much more is now know about the risks and disruptions children face when their caregiver is abused. There is also increased understanding about the resiliency that some children show when exposed to domestic violence, and there is greater understanding and recognition of the protective capacities of the non-offending parent. More is also known about the challenges faced by the courts, child welfare systems and domestic violence service providers who seek to keep safe those who are in danger and to hold perpetrators accountable.

Research suggests that the most effective approach to reducing family violence is to build comprehensive partnership within and among child and family serving systems. Unfortunately these programs are only reaching a small portion of the children and families affected by domestic violence, much more work is need to expand these services so that all families have access to them possibly reducing the number children being removed from the non-offending parent and placed in foster care.

In addition to the services and programs discussed in this paper, there also needs to be increased focus on the kinds of prevention that can stop violence against women and children before it begins.
Resources for further information

Child Protection in Families experience Domestic Violence: User Manual Series
- Provides basic information about Domestic Violence and addresses the overlap between child maltreatment and domestic violence.  

Domestic Violence and its Role in Child Welfare
- Provides information on the intersection of Domestic Violence and Child Welfare  

Extraordinary Advocates
- Provides training and coaching to Social Service Professionals regarding the co-occurrence of Domestic Violence and Child abuse  
  www.ExtrodiaryAdvocates.com

Safe and Together Model
- Centers on five critical building blocks to improve case practice and decision making in Domestic Violence cases where children are the focus  
  www.EndingViolence.com
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Psychology Dictionary

www.psychologydictionary.org


Caring Dads: Helping Fathers Value Their Children

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Caring Dads: Helping Fathers Value Their Children

“Getting a second chance to be a good father”

Caring Dads – Participant 2016

Abstract

Australian STOP Domestic Violence Conference being held at the Mercure Brisbane, 5 - 7 December 2016.

Caring Dads – A Victorian Trial

The Children’s Protection Society and ReGen, in partnership with the Universities of Toronto and Melbourne, Changing Ways and funded by DHHS and Gandel Philanthropy will be undertaking a Victorian state government funded trial of Caring Dads across Victoria. Caring Dads is a Canadian intervention program for fathers who have neglected or physically and/or emotionally abused their children; exposed their children to domestic violence or are deemed high-risk for these behaviours. The Caring Dads program is a 17-week, empirically-based, manualized group parenting intervention for fathers, systematic partner contact with mothers to ensure safety and freedom from coercion, and ongoing, collaborative work with referrers and with other professionals involved with men’s families.

The Caring Dads group component combines elements of parenting, fathering, and child protection practice to enhance the safety and well-being of children. Program principles emphasize the need to enhance men’s motivation, promote child-centred fathering, address men’s ability to engage in respectful, non-abusive co-parenting with children’s mothers, recognize that children’s experience of trauma will impact the rate of possible change, and work collaboratively with other service providers to ensure that children benefit (and are not unintentionally harmed) as the result of father’s participation in intervention. The Caring Dads program can be located as part of a continuum of service.

The Caring Dads trial will take place in three sites across Victoria; North East Metropolitan Melbourne, Inner West Metropolitan Melbourne and Gippsland. The trial will take place over three years and work with up to approximately 120 men and their families. The evaluation will be overseen by the Universities of Toronto and Melbourne and feed data into an international randomised control trial of the program occurring in a number of countries. Findings of the evaluation will be widely disseminated as they are completed.
**Keywords**: Family violence, perpetrator program, partnership, parenting intervention, Victorian trial.

**Introduction**

Family violence is prevalent in Australia, impacting on Australian families and weighing heavily on the systems that support them. The Australian Bureau of Statistics (2013) report that in Australia, 1 in 3 women have experienced violence, 1 in 5 women have experienced sexual violence since the age of 15, and one woman is killed by her current or former partner almost every week. Over half of women who experience family violence have children in their care (National Crime Prevention, 2001).

In Victoria the Royal Commission into Family Violence (State of Victoria, 2014-2016) has drawn particular attention to the impact of family violence on children, highlighting that “the negative effects of family violence can be particularly profound for children, who can carry into adulthood the burden of being victimised themselves or witnessing violence in their home” (Royal Commission into Family Violence, 2016).

The inadequacies of current system to hold perpetrators to account was also emphasised by the Commission. “Efforts to keep victims safe must be strengthened through a consistent and rigorous approach to perpetrator accountability. Bringing perpetrators into view and assisting them to change behaviours is essential to reducing family violence.” (Royal Commission into Family Violence: Report and recommendations, 2016)

In Victoria, existing men’s behaviour change programs have largely focussed on the relationship between men who use violence and their partners. In her submission to the Royal Commission, Katreena Scott (Ph.D. C. Psych), co-creator of the Caring Dads program, emphasised that “…fathering is a very strong motivator overall, so it tends to be easier for a system to engage men in the project of becoming better fathers than it might be to becoming better partners” (Royal Commission into Family Violence: Report and recommendations, 2016).
CPS provides a broad range of services to children and families in the North East of Melbourne. Agency records indicate that 65 to 70% of CPS client families have been affected by family violence, with family violence a current concern for many of those who access the service.

ReGen is an alcohol and other drug (AOD) service that operates in the North West Metropolitan area of Melbourne and similarly has identified a high prevalence of family violence being experienced by its service users. There is an international body of evidence linking the misuse of alcohol and to a lesser extent drugs such as methamphetamines with the frequency and severity of family violence and child protection concerns (Braaf, 2012; Battams & Roche, 2011). Substantial anecdotal evidence suggests, that men and women participating in ReGen therapeutic AOD programs frequently disclose that they use, witness or are victims/survivors of violence.

As organisations with a long-standing commitment to improving the health and wellbeing of vulnerable families CPS and ReGen have a shared understanding of the need for systematic action to prevent the intergenerational transmission of family violence. The partnership between the two agencies was developed in recognition of our shared values, complimentary skills sets and a proven capacity to work in collaboration.

The demand on existing men’s behaviour change programs in Northern Melbourne is currently exceeding the capacity of these programs. Caring Dads provides an opportunity to harness the motivation of fathers before tertiary systems intervene, and provides Child Protection with an additional resource, thus reducing reliance on options that inevitably place responsibility for the protection of children from family violence on their mothers, often victim/survivors in their own right.
About Caring Dads

The Caring Dads program was created in Canada in 2001 by a community-university partnership between Changing Ways and the University of Toronto. The program was developed in consultation with a Community Advisory Committee including women’s advocacy services, child protection, corrections, the family court and mental health services. Caring Dads provides specialised group-based education and counselling for 8 to 12 fathers at a time. The program has four key components, including:

1) A rigorous assessment process to determine suitability for the program and identify individual needs.
2) A weekly, 2-hour group session for fathers conducted over 17 sessions and delivered by two facilitators.
3) A Mother Contact component, involving systematic contact with mothers to ensure safety and freedom from coercion. Where possible, existing service providers are drawn upon to perform this function and avoid duplication.
4) A collaborative model of case management for participating fathers, to ensure that child safety and wellbeing in enhanced as a result of fathers’ involvement in the intervention.

Caring Dads uses motivational interviewing, cognitive behavioural therapy and parent education to improve men’s recognition and prioritisation of the needs of their children, understanding of child development, and support for their children’s relationships with their mothers. The program assists fathers to develop the skills to listen to their children, use praise, show empathy for their child’s experiences of abuse and counters the distortions that underlie men’s abuse of their children and/or their children’s mothers (Reference website).

The program is structured to (1) develop sufficient trust and motivation to engage men in the process of examining their fathering, (2) increase men’s awareness and application of child-centred fathering, (3) increase men’s awareness of, and responsibility for, abusive and neglectful fathering behaviours and their impact on children, and (4) consolidate learning, rebuilding trust and planning for the future.
Caring Dads – CPS and ReGen Pilot

CPS was established in 1896 and evolved from the Victorian Society for the Prevention of Cruelty to Children (VSPCC). The agency became CPS in 1971. CPS is 120 years old this year (2016). In Victoria during the 1920’s through to the mid 1980s CPS was responsible for investigating reports of child abuse and neglect and providing temporary emergency care for children. In 1985 Department of Health and Human Services took over as the state’s child protection authority. Today, CPS operates in the North East Melbourne Metropolitan Area and provides a diverse, evolving range of services which include Child FIRST, Integrated Family Services, Early Years Education and Care programs, Counselling for children and young people who have been abused or are displaying sexually abusive behaviors, Fathers Programs, Mentoring Mums, and Family Violence programs. CPS is also a site for a number of large research and evaluation projects.

ReGen is the leading AOD treatment and education agency of UnitingCare Victoria and Tasmania. ReGen is a not-for-profit agency, which has over 40 years’ experience delivering a comprehensive range of AOD services to the community. ReGen's services are consistent with the harm minimisation framework that has underpinned national and state drug strategies for more than 25 years (see www.regen.org.au). In keeping with these strategies, ReGen is committed to minimising the health, social and economic harms to individuals, families and communities resulting from alcohol and other drug use through their provision of a comprehensive range of evidence-based services that integrate established research findings. ReGen provides a continuum of services, ranging from online information/advice, AOD education programs and family support groups, to outpatient and inpatient treatment programs. As a nationally Registered Training Organisation, ReGen also provides workforce development training, consultancy and mentoring for AOD workers and other allied health professionals. ReGen has emerged as a leader in the development of family inclusive approaches to treatment through the establishment of programs targeting the needs of family members in their own right.

Staff from across CPS and ReGen participated in a 2 day in-house Caring Dads training in May 2016, facilitated by two of the program developers, Dr Katreena Scott (University of Toronto) and Tim Kelly (Executive Director, Changing Ways). The training addressed the rationale, tools, processes and delivery style of the Caring Dads program and provided staff opportunities to practice delivering parts of the programs. The training covered best-practice in relation to
child-centred fathering for men who have been abusive in their parenting and the accountability principles of the program as they relate to children, women, men and the communities within which the program will be delivered.

After the training was completed, ReGen and CPS recruited two facilitators, one from each agency, who were employed for the 3-year trial period. The staff selected have complementary experience as senior workers in relevant areas of work including therapeutic group work facilitation, working directly with individuals and families affected by family violence and AOD use issues, extensive knowledge and understanding of the Victorian Child Protection system, working with men who use violence, working with men involved in the criminal justice system, implementation of new programs and working within a collaborative partnership model.

CPS and ReGen’s Caring Dads program became operational in mid-August 2016 with the aim of starting the pilot group on 20 September 2016. With such a limited time-frame available to recruit the goal of 10 fathers for the group, the priority was to develop promotional material and relevant documents such as the referral, consent to participate and assessment forms. Initially it was envisaged that recruitment of fathers for the pilot group would come from within CPS and ReGen’s pool of service users, so the Caring Dads facilitators undertook a number of face-to-face meetings with staff to promote the program and explain the eligibility criteria. It soon became evident that to achieve a reasonably sized initial group, referrals would need to be sought from external agencies. Caring Dads was thus heavily promoted to potential referral points including Child Protection, Men’s Behaviour Change programs, Men’s Referral Service, Community Health Services, Maternal and Child Health Services, local hospital social work departments and family violence network meetings. This process highlighted the strong interest in Caring Dads across the sector and resulted in numerous enquiries.

The Caring Dads facilitators encouraged referring agencies to consult with them before submitting a referral so that the eligibility of the father could be discussed and determined. This was deemed important for two reasons - the program was new to the sector and thus its purpose and structure was unfamiliar to referrers; and secondly the initial group was aimed to consist of fathers with a certain level of insight into their abusive behaviour to allow the facilitators a greater opportunity to learn the program content whilst delivering it for the first time.
Prior to the first group commencing, 13 enquiries were received from ReGen, CPS, Child Protection, a local hospital, a specialist Family Drug Treatment Court and a mother. This translated into 8 referrals, of which 7 were accepted to progress to assessment for the pilot group. The majority of these referrals came from ReGen, Child Protection and CPS. In all 7 cases, the Caring Dads facilitators consulted with the referrer about the presenting issues for each family and made telephone contact with the fathers to discuss the nature of the group, their willingness to participate and to inform them of program requirements including informing the mothers of their children about their involvement. Facilitators then conducted comprehensive face-to-face assessments with each father. The assessment sought information pertaining to their experiencing of family violence as children, their history of violent behaviour, history of legal interventions and compliance with such, previous participation in parenting and/or men’s behaviour change programs, the quality of their family relationships, their attitudes around family violence and other factors relating to their risk of family violence such as access to weapons. All 7 were deemed suitable to participate and all agreed to do so by signing the Participation Agreement. Where appropriate, mothers of the children were contacted and informed of the involvement of the fathers in the program at which time they were offered to the option of a referral to a specialist family violence support service.

The 7 fathers represented a range of family circumstances – 2 remained married to the mother of their children, whilst 5 were separated from the mothers and were living apart. Three of the fathers had step-children in addition to their own biological children and all played a significant role in their upbringing. Child Protection were actively involved in monitoring 4 of the families, whilst one father had had recent Child Protection involvement. This father was also in a relatively new relationship and was having some contact with that woman’s son, so she was also contacted as part of the Mother Contact program. Two fathers had current Intervention Orders restricting them from having access with their children/step-children. One of these fathers was having supervised contact with his biological child and another was having unsupervised contact with his daughter. Three of the fathers had been employed but their primary role was carer of their children. The remaining fathers were either unemployed or employed part-time or casually. The children’s ages ranged from 6 weeks to 12 years and the fathers from 28 to 52 years of age. The fathers came from three cultural backgrounds – Anglo-Australian, Indian and Lebanese – and over half of the 7 participants resided in Hume/Moreland Local Government Areas.
Six fathers commenced the Caring Dads pilot group. The seventh participant reported being unable to attend due to commencing fulltime employment and indicated that he would consider participating in 2017. Due to the timing of the commencement of the 17 session program, it was decided to run the group twice per week for the first 5 weeks to allow it to conclude prior to the summer holidays starting. Despite the initial intensity of the program, it has been well attended and group participants have contacted the facilitators if unable to attend a session. Only 1 out of the 6 group members has exited the program and it is anticipated that the remaining 5 will see the program through to completion. The group member who decided to exit after Session 5 did so due to finding the frequency of the program problematic as a sole parent, and hard to manage during a period of high conflict with the mother of his child and uncertainty surrounding the care arrangements of his children. His children are under the supervision of Child Protection and the father has stated his intention to undertake Caring Dads in 2017.

Prior to the group commencing and during the group work program, the facilitators have had access to supervision with Tim Kelly in Canada via Skype. This forum allowed the facilitators and program manager to discuss queries relating to set-up, intake and assessment processes, presenting issues of fathers and then to engage in reflective practice during the program.

**Preliminary Observations**

Facilitators of Caring Dads have made a number of preliminary observations at this early stage of the program. Firstly, it is ideal that potential referrers discuss the program with facilitators before submitting a referral so that the program can be explained in detail and the eligibility of the father be screened as there has been some misunderstanding about the nature of the program. This has included referrers believing it is a parenting skills program for fathers who have not necessarily displayed abusive parenting behaviours. It is anticipated that this will reduce as the program becomes better known within the sector and in the meantime efforts to promote the program will need to continue and referrers are encouraged to consult with facilitators prior to discussing the program with fathers. Through promoting the program, the facilitators also noted some anxiety that workers hold in being able to confidently overt their concerns around family violence to fathers. Facilitators have therefore offered to meet with fathers and their workers jointly to support these conversations and discuss the program and benefits of participating in it. Another observation in the initial set-up phase was services that work with families finding it difficult to reach the fathers as they primarily work with mothers.
and children. This is proving to be a significant obstacle in promoting the Caring Dads program to fathers.

In terms of the Mother Contact aspect of the program, 5 mothers and 1 current girlfriend were contacted via telephone and none of these women wanted referral to family violence support, whilst one did not respond to messages left. One mother’s contact details were unavailable, another mother had passed away and one mother was unsuitable to contact as she was considered by Child Protection to be acting abusively towards the father of her children. It appears appropriate for those mothers who are already well connected by support services to be communicated with via those services rather than have an additional worker contacting them from Caring Dads to avoid overloading them. Facilitators are mindful that due to the nature of family violence and the effect it can have on women, mothers contacted may be reluctant to discuss abuse they have or are experiencing.

In terms of adapting the Canadian program to an Australian urban context, there have been minimal changes needed. The main difference was replacing the term “batterer” with phrases such as “fathers who use violence”. Adapting the intake and assessment forms was also necessary to reflect the demographic information required. Any changes made were done in consultation with the Canadian program developers.

Running the first 10 sessions twice per week was too intense and will not be repeated in the future. Although unavoidable on this occasion, it is worth noting that the facilitators observed that it affected the group participants’ ability to complete take home tasks and provide them with sufficient time to process the content of the sessions. The group participants themselves expressed how challenging they found it attending twice per week, given the confronting nature of the group and the limited time they had to reflect on and process what they had discussed and learned.

In regards to how the fathers have responded to Caring Dads, facilitators have observed that the varying levels of insight and defensiveness that they present with appears to have been a beneficial aspect for the group as a whole. The fathers present as being at different stages within the change process, with some fluctuating back and forth between stages from week to week whilst others appear to be moving forward and changing their mindsets and reducing their abusive behaviours. This diversity has been useful as group members who have allowed themselves to lower their defences, self-reflect and develop their insight have shared this experience with the group and encouraged other group members to do the same. Fathers have
also been able to witness the defensiveness of other group members and thus consider what that means for those fathers’ children and use that experience as a mirror to reflect on their own behaviour.

**2016 Caring Dads Pilot Group Participant quotes:**

- “It’s a hard message delivered in an easy to digest way”
- “Made me think about my own father more”
- “Made me have an appreciation of what the other guys in the group are up against”
- “People wouldn’t have referred us here if they didn’t think we needed it”
- “The role plays were really good because it is good to observe people actually doing it”
- “I controlled myself and talked him out of his anger. That felt good”
- “Message of a sledgehammer delivered with a velvety softness”

**Future Direction**

From 2017-2019, ReGen and CPS will run three Caring Dads groups each year alongside two additional Victorian sites which are based in Inner Western Melbourne and Gippsland. These sites will each run three groups over the 3 year period. With each group containing -12 participants, up to 324 fathers will have the opportunity to participate in Caring Dads. These groups will be comprehensively evaluated by The University of Melbourne, the results of which will feed into the current evaluation of the program being run by The University of Toronto.

**Conclusion**

This paper provides an overview of the collaborative effort and steps undertaken to implement the Caring Dads program in Melbourne. The initial pilot program is underway and already providing valuable learnings on the cross cultural transferability of this Canadian program. Other learnings to date have been the value in having joint facilitation by clinicians of 2 organisations. This has allowed for significant diversity of skill sets to be brought together for the benefit of the client’s experience.

Initial feedback from the participants has been incredibly positive. While the men have acknowledged at times that they find the content material confronting, they have also been able
to clearly articulate that they believe they are learning to see things from their child’s perspective.

There is still plenty of work to be done with regards to effective program promotion, liaison with referral agencies and assessment of participants to ensure those who will benefit most are engaged. The collection of program data has commenced and with further program roll-out in the new year we are looking forward to the evaluation of outcomes when sufficient program throughput has been achieved.

References


Caring Dads Website


ReGen Website: www.regen.org.au

Mothers in Mind: A New response to early intervention, support and recovery for women and children affected by abuse and/or family violence.

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Paper Presented at 2016 Australian Stop Domestic Violence Conference Brisbane, 5-7 December.

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Mothers in Mind: A New response to early intervention, support and recovery for women and children affected by abuse and/or family violence.

“The best things about MiM was the feeling of solidarity among the group, the friendships and knowing I am not alone”

Mothers in Mind – Participant 2016

ABSTRACT: In July 2016 the Children’s Protection Society (CPS) began trialing and evaluating the Mothers in Mind (MiM) program in Victoria Australia. Mothers in Mind was developed in 2006 by the Child Development Institute (CDI) in Toronto Canada. Mothers in Mind is a preventative, trauma and attachment informed, mother and child, play based group program for mothers who have experienced abuse or trauma (e.g. childhood abuse, family violence, sexual abuse etc.) and have pre-school children under the age of four. The MiM program focuses on the needs of mothers who have found that their experiences have made parenting their child/ren difficult. MiM is a ten week program that assists mothers to learn ways to manage stress, develop healthy self-esteem and respond to their children in a child centered, supportive, sensitive and effective manner. The program supports women with young children becoming the mothers they aspire to be.

CPS will trial and evaluate three MiM groups in North-East Metropolitan Melbourne with a view to adapting the model to the Australian context. Once the trials have been completed and the intervention refined, CPS will incorporate the program as part of core business of the agency. CPS envisages delivering this program more extensively as part of the organisation’s broader family violence service platform. In the long-term CPS plans to extend the implementation of the program further afield by establishing (1) a community of practice in partnership with other agencies and (2) offering facilitation training to other service providers wishing to implement the program across Australia. CPS is committed to disseminating the findings of the Mothers in Mind evaluation as they come to hand.
Keywords: Family violence, trauma and attachment informed, play based program, Victorian trial, community of practice.

Introduction

Family violence has a profound impact upon the Australian community and broader human service systems. The Australian Bureau of Statistics Personal Safety Survey (2013) reports that in Australia, 1 in 3 women have experienced violence, and 1 in 5 women have experienced sexual violence since the age of 15. On average, at least one woman a week is killed by a partner or former partner in Australia (Australian Institute of Criminology, 2015). Analysis of the Australian Bureau of statistics Personal Safety Survey found that just over half of women who experienced violence by a current cohabiting partner had children in their care at the time of the violence, and 77.5% of women who experienced violence by a former cohabiting partner had children in their care at the time of the violence (Cox, 2015). To tackle the issue of Family Violence in Victoria the Royal Commission into Family Violence (State of Victoria, 2014-2016) and the Victorian Government Department of Human Service’s Roadmap for Reform: Strong Families, Safe Children (DHHS, 2016) have collectively provided an opportunity to re-examine how the child and family service system can be improved to help prevent neglect and abuse, intervene early, keep more families together through crises, and secure better futures for children who cannot live at home.

The CPS operates in the North East Melbourne Metropolitan area and has identified family violence as a common presenting issue in families accessing services. Data suggests that 75% of families receiving support from the Agency have either currently or previously experienced family violence. Further, Northern Integrated Family Violence Services (2016) report that the North East Metropolitan area of Melbourne has the third highest number of family violence orders in Victoria. While there is a clear demand for family violence services in the region, there is very little targeted support available across the current service system to support mothers and very young children who have experienced family violence and other relational trauma. It is CPS’s view that the service system is currently failing mothers and their children at risk of, or subject to, family violence and more support is needed. There is an urgent need to
trial new evidence-based approaches that target family violence prevention and early intervention, with a particular focus on the well-being of the child.

According to literature most mothers who experience family violence also experience significant difficulties in their parenting role for example greater parenting stress and compromised parenting capacity. Mental health conditions such as depression, anxiety, low self-esteem, post-traumatic stress are also highly attributed to women who have experienced family violence. It is not uncommon for women who have experienced family violence to lose confidence in their ability to parent effectively, particularly if their parenting is undermined or criticised by an abusive current or ex-partner, leading to isolation and unhealthy coping mechanisms (Hooker, Kaspiew & Taft, 2016).

Children who have witnessed or have been exposed to family violence suffer significant impact to their physical, psychological, emotional, social, developmental, cognitive and behavioural well-being (DHHS, 2013). Children often develop mental health disorders and exhibit challenging behaviours as a direct result e.g. aggression, oppositional behaviour, limit-testing (DHHS, 2013). Such conditions and behaviours leads to further parenting challenges. Family Violence can disrupt a child’s attachment to their mother commonly resulting in avoidant, ambivalent or disorganised attachment. This adversely impacts the quality of the relationship between mothers and their children with mothers often experiencing negative maternal attributions, difficulties soothing and comforting their child and other attachment related difficulties.

Australian and international research demonstrates that intensive early intervention for mothers and children can help to ameliorate the detrimental effects of abuse and neglect (Gimson & Trewhella, 2014). Interventions that are attachment focused assist mothers in developing their understanding in the importance of attachment, allowing the child to begin to experience a more secure attachment relationship than they could previously (Golding, 2008).

Mothers in Mind (MIM) is a Canadian program specifically designed to meet the parenting needs of mothers who have experienced family violence, childhood abuse, neglect or sexual assault, and have children under the age of four. MIM was developed by the Child Development Institute in Toronto. The Child Development Institute (CDI) is a children’s mental health organisation that offers family violence, early intervention, and early learning programs. The Mothers in Mind (MiM) program is a trauma and attachment informed, mother
and child, play based group program for mothers who have experienced abuse or trauma (e.g. childhood abuse, family violence, sexual abuse etc.) and have pre-school children (under four years). The program focuses on the needs of mothers who have found that these hurtful experiences have made parenting difficult. The ten week program helps mothers learn ways to manage stress and other challenging feelings, foster healthy self-esteem and respond to their children in a sensitive, supportive and effective manner. The program supports women with young children working towards becoming the mothers they aspire to be.

The structured MiM program enables mothers to (1) talk about parenting issues and learn from other mothers who have had similar experiences, (2) build a positive mother–child relationship and get a chance to spend some quality time playing with their child, (3) discover helpful ways to cope with anger, worry and stress in a safe and supportive environment, (4) increase their confidence in responding to their children in a sensitive and caring manner, (5) learn how to support young children who may also have been exposed to hurtful behaviours, (6) explore and learn what helps children feel safe and secure, and (7) find practical ways to take some time out for themselves during this busy stage of life.

When observing a MiM group for the first time the program configuration appears to look like a mother-child supported play group. That is mothers play with their children and have guided group discussions. The content of those discussions is the unique feature of MiM. The safety and comfort of the group allow the participants to discuss the impact trauma has had on their parenting. For example topics that may be explored in the group include (a) how the mothers feel triggered when they breastfeed their baby, (b) how toddler’s tantrums can remind them of the perpetrator/abuser, and (c) how hugging or having close physical contact with their child doesn’t always feel good. Such discussions occur regularly and are central to a MiM group. The Child Development Institute has found that these discussions are necessary for healing and that many women won’t talk about such issues in regular play/parenting groups.

The MiM program can be located within the prevention or early intervention stage of a continuum of service. The aim of MiM group work is to intervene early and efficaciously in the lives of young children whose mothers have suffered violence/abuse in order to improve child outcomes and reduce the number of children requiring a tertiary child protection response. The program provides mothers with information about child development, parenting techniques, reflective parenting, appropriate expectations and stress management techniques within a unique program structure which combines both dyadic and group work interventions.
Mothers in Mind – CPS Trial

The Children’s Protection Society (CPS) was established in 1896 and evolved from the Victorian Society for the Prevention of Cruelty to Children (VSPCC). The agency became CPS in 1971. CPS is 120 years old this year (2016). In Victoria during the 1920’s through to the mid 1980s CPS was responsible for investigating reports of child abuse and neglect and providing temporary emergency care for children. In 1985 Department of Health and Human Services took over as the state’s child protection authority. Today, CPS operates in the North East Melbourne Metropolitan Area and provides a diverse, evolving range of services which include Child FIRST, Integrated Family Services, Early Years Education and Care programs, Counselling for children and young people who have been abused or are displaying sexually abusive behaviors, Fathers Programs, Mentoring Mums, and Family Violence programs. CPS is also a site for a number of large research and evaluation projects.

Given CPS’s experience of working with large numbers of women experiencing family violence, or with a family violence history, 65-70% of family services clients (CPS, 2016), the Agency committed to establishing a service model that supported mothers who had experienced abuse or trauma (e.g. childhood abuse, family violence, sexual abuse etc.) and had pre-school children under the age of four. After significant research and consultation CPS subsequently decided to trial the Mothers in Mind program utilising existing program staff and funding with a view to adapting this Canadian model to the Australian local context. CPS envisages that Mothers in Mind will become part of core service delivery for CPS once the trials have been completed and the program refined.

CPS partnered with the Child Development Institute of Toronto through a service licensing agreement to implement the Mothers in Mind program in Victoria. The CPS Mothers in Mind trial will be evaluated, reviewed and refined within the current context of the Victorian the Royal Commission into Family Violence and the Victorian Government Department of Human Service’s Roadmap for Reform: Strong Families, Safe Children.

In April 2016, and prior to the commencement of the Mothers in Mind program, staff from across CPS participated in 2 day in-house training conducted by Dr Angelique Jenney, Director Family Violence Services at the Child Development Institute. This training specifically addressed the following topics: 1). Understanding the program logic and development of MiM, 2). MiM program objectives, 3). Eligibility criteria and assessment, 4). Program components
and service delivery, 5). Clinical skills required by MiM facilitators (e.g. self-reflective practice), 6). Information pertaining to trauma informed practice and the impact of violence and trauma on toddlers, 7). Impact of violence and trauma on parenting, 8). Risk and protective factors, 9). Identifying moments of connection and disconnection, 10). Gender roles, mother blaming, gendered inequality, 11). Information regarding Infant and toddler mental health and development and attunement and attachment, and 12). Adaptations of the model and program evaluation. The training was supplemented by case studies and role plays to ensure that all participants were familiar with content and had experience in delivering each element of the program.

After the training was completed CPS selected two MiM facilitators from this pool of trained staff to trial the first program. Both of the staff members selected have extensive experience in the delivery of therapeutic group programs with vulnerable and at risk mothers and their children and both workers have significant experience working with families affected by family violence. Both staff members had also been involved in the development, implementation and evaluation of supported playgroups for vulnerable families. The facilitators also had access to the Team from the CDI in Canada and regularly skyped to prepare for the group, undertake reflective practice during the group and review the outcomes post group. This active support from the Mothers in Mind team in Canada was invaluable.

To determine eligibility of the participants for the first group the facilitators undertook a comprehensive assessment of the women and children referred to the program. The majority of the referrals to the first group were from within the organisation although some participants were referred by other non-profit family services organisations. As part of the assessment each family met with the facilitators prior to the group starting, as part of a 2 hour assessment process which included a face to face interview with mother and child(ren) and psychometric testing. The assessment also included family violence risk assessment and safety planning. During the assessment phase, the mothers were given a space to share their story and get to know the facilitators. They were also provided with information regarding what to expect from the group. Upon completion of the group the participants completed post-test psychometrics and questionnaires to ascertain the efficacy of the intervention.

To date the Children’s Protection Society has completed two Mothers in Mind groups with 16 participant mothers and 20 children. Findings from these groups have illustrated that mothers have been able to talk about parenting issues and learn from other mothers who have had similar
experiences. The groups have provided an opportunity for mothers to build a positive mother–child relationship and spend quality time playing with their child. Further, the group participants have discovered helpful ways to cope with anger, worry and stress and have increased their confidence in responding to their children in a sensitive and caring manner. Additionally they have learnt how to support their children and explore and understand what helps children feel safe and secure and find practical ways to take some time out for themselves during this stage of their life.

Thematic data from the groups also indicated that many of the mothers were struggling with ongoing legal issues (i.e. divorce, separation, intervention orders etc.) and/or current (or historical) child protection involvement. Many of the mothers had a deeply entrenched distrust of the service system. Many has experienced frustration is navigating the service system to find support and guidance. This mistrust and frustration resulted in many of the women not seeking a service or avoiding programs that may be of assistance. A number of women reported feeling socially isolated and others were struggling with depression and other mental health issues. Others had a history of childhood trauma which in a number of cases included sexual abuse. During the MiM group many of the women were supported by the Facilitators to access services that would address their specific personal and or family issues.

2016 MiM Participant quotes:

• “I could ask and talk about anything about myself and my 2 year old son”
• “I’ve noticed positive changes in myself”
• “I have become more confident in asking for help”
• “I am able to respond to [my daughter] more positively using techniques that have been suggested at group”
• “people with similar experiences and similar situations are able to share their knowledge and experience and I could ask questions”
• “the books given each week ….. make explaining feelings/emotions easy”
• “MiM gave me an opportunity to vent each week instead of burying it inside. Knowing there is support and help available was reassuring”
• “I understand my child better and I understand she’s going through a difficult time too”
• “I hope I keep in touch with other mothers that I’ve met”
• “the ability to talk about my situation and not be judged”

By undertaking the pilot MiM program, with the Canadian team’s support, CPS were able to review the program and content to ensure that it was adaptable to an Australian context. The CPS MiM facilitators and support team found challenges regarding evaluation (i.e. language used in forms/ size of evaluation forms and time taken to complete etc.). Similarly some content was modified for the Australian context and some context specific themes in the books was also adjusted. All of these MiM program and content alterations were done in conjunction with the developers at CDI Toronto. The MiM version developed from the first CPS pilot will be used in groups going forward – content and material may still need to be adjusted over time.

CPS has three MiM groups scheduled for 2017. The agency is looking at ways of further developing the program to meet the needs of specific client groups (e.g. CALD mothers and children). CPS is also establishing an Australian MiM Community of Practice to facilitate opportunities for other practitioners around the country to share their experiences, ideas and developments. The Community of Practice will also draw upon the expertise of the Canadian team from the CDI and it is envisaged this team will provide input into the virtual community of practice space.

Conclusion

CPS’s experience in trialling the Mother in Mind program has demonstrated that the model provides a valuable intervention for mothers (and their children 4 years or younger) who have experienced family violence, childhood abuse, neglect or sexual assault. Data from the groups to date illustrate that MiM helps mothers learn ways to manage stress and other challenging feelings, foster healthy self-esteem and respond to their children in a sensitive and effective manner. CPS will continue to offer this program, as part of its mainstream services, to mothers (and their children) and work with the Child Development Institute in Toronto to further refine the program and its evaluative components. CPS will undertake a more detailed evaluation of the MiM program over the coming years and will report these findings as they become available.
References


