Melbourne Research Alliance to End Violence Against Women and their Children: Submissions from Professor Cathy Humphreys and research team

Submission to the Royal Commission into Family Violence Victoria

Professor Cathy Humphreys – Co-chair of Melbourne Research Alliance to End Violence against women and their children, and Professor of Social Work, Department of Social Work, The University of Melbourne

Dr Lucy Healey – Senior Research Fellow, Department of Social work at The University of Melbourne

Dr Kristin Diemer – Senior Research Fellow, Department of Social Work at The University of Melbourne

Shawana Andrews – Lecturer in Aboriginal Health at the Melbourne School of Health Sciences

David Gallant – Research Fellow, Department of Social Work at The University of Melbourne

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Contact
Prof Cathy Humphreys
Professor of Social Work,
Department of Social Work University of Melbourne Parkville, Victoria, 3010
[redacted]

About the submitters

Professor Cathy Humphreys and Professor Kelsey Hegarty co-chair the Melbourne Research Alliance to End Violence Against Women and Their Children. The research alliance brings together researchers from across University of Melbourne who are engaged with research and policy development in the area of violence against women and their children.

This submission specifically draws on research led by Cathy Humphreys from the team based within the Department of Social Work in which Dr Kristin Diemer, Dr Lucy Healey (both Senior Research Fellows) and David Gallant (Research Fellow) who are also supported by Shawana Andrews (Lecturer in Aboriginal Health) from the School of Health Sciences. Their research contributes to the applied evidence base designed to strengthen practice and support the research-practice nexus and work with agencies in the field of domestic and family violence. The utilisation of research knowledge to strengthen evidence-informed practice is therefore a priority in our work. Cathy Humphreys is a well published author and researcher. In the family violence area she has published in collaboration with others: 13 monographs/books, 45 journal articles, 14 book chapters, and 17 publications on guidelines and briefings. Together this publication record provides a body of work contributing significantly to the research, policy and practice discourse in the domestic and family violence area in Australia and internationally.

Introduction

The late Ellen Pence violence spoke of organising around the notion of justice rather than violence itself: *Justice demands that the truth be told, the harm be repaired, and the social conditions that created and sustained the injustice in the first place be changed*.[1] Justice needs to be the bedrock of how we stop violence against women and children and respond to perpetrators. Justice also requires that the systemic issues that prolong and perpetuate violence be addressed. Until we overcome the fragmentation of the service system involved in violence prevention and response, systemic issues will continue. Our submission focuses on 10 different aspects of the family violence intervention system. However, we would like to make three points as caveats to our submission.

Firstly, the impact of the family violence intervention system which includes courts, police, child protection, specialist family violence services, other family support services, maternal and child health, corrections, disability, mental health and health services is limited by the broader context in which the lives of children, women and men are imbedded. The availability of affordable housing, access to legal aid and the ability to access Centrelink payments (even temporarily) which are set at a sufficient level for people to live on are crucial. These elements are foundational to an effective response to family violence. There are few choices that are available to victims of family violence when these pillars of social support are not in place.

Secondly, we will not treat our way out of the wicked problem of family violence. The primary prevention strategies which support respectful and equal relationships between men and women and their children are central to family violence intervention. We are not specialist researchers in this area and hence, we have not made a submission in this area. We do however recognise that this work is of primary importance and foundational to an effective response to family violence.

Thirdly, the Family Law arena which operates largely in the Federal jurisdiction continues to be siloed from the state based family violence intervention. This is profoundly problematic and circumscribes the lives of children, many of whom continue to live with post-separation violence and

[1] Ellen Pence was one of the pioneers who developed the Duluth model of responding to perpetrators and victims of family; see www.youtube.com/watch?v=v=orZM13MakVM

abuse. We would urge the Royal Commission to use its powers to address this 'Achilles heel' in family violence intervention and specifically as it relates to perpetrator accountability.

This submission

This submission is structured in the following way. We have written a series of 10 briefing or summary papers each with a specific focus on aspects of family violence intervention in Victoria. At the top of each briefing paper, we indicate the questions from the Issue Paper or the number of the Terms of Reference provided by the Royal Commission. Most submissions contain: an introduction to each paper; the context or background to the issue; the research we have undertaken to contribute to the issue; a key summary message; relevant evidence from our research and the literature; opportunities for policy and/or practice implementation; and a reference list. References with an asterisk authored by the research team are attached to each briefing to provide a more in-depth discussion on aspects of the briefing paper. The lead author of each summary appears on the front page of each paper underlined.

Briefing Paper 1:	Risk assessment and risk management
Briefing Paper 2:	Accountability for perpetrators of family violence
Briefing Paper 3:	Addressing alcohol and other drugs in family violence intervention
Briefing Paper 4:	Responding to children living with family violence
Briefing Paper 5:	Enhancing collaboration and information sharing with the Family Law system (Confidential Submission)
Briefing Paper 6:	Keeping women and children safe at home
Briefing Paper 7:	Closing the data gaps on family violence
Briefing Paper 8:	Responding to women with disabilities in the context of family violence and disability services
Briefing Paper 9:	Responding to family violence in Aboriginal communities
Briefing Paper 10:	Working towards integrated governance in addressing family violence

Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 1 on 'The role of risk assessment and risk management in the response to family violence'

Authors: Cathy Humphreys, Lucy Healey, Kristin Diemer

The role of risk assessment and risk management in the response to family violence

Relevant to Royal Commission into Family Violence Issues Paper questions: 2 and 3

Introduction

A strength of the FV reforms in Victoria has been the development of the Common Risk Assessment Framework (CRAF). This framework provides a joint understanding of risk assessment and risk management for professionals across different organisations. The CRAF has been the foundation for training about FV across the sector and the government continues to recognise and fund the Domestic Violence Resource Centre Victoria (DVRCV) to undertake the training. This has created a large body of professionals trained in a basic understanding of FV across Victoria. This is a significant achievement. The development of Risk Assessment and Risk Management Panels (RAMPS) across Victoria will also be a significant achievement that has the potential to address more effectively the accountability of the perpetrator and the safety of women and their children in cases identified as high risk.

There are still areas of (largely mainstream) services, such as the disability services, that require skills and training in preliminary identification and assessment of family violence in order to respond in an informed and consistent way to victims and perpetrators of family violence, regardless of where they enter the system (see accompanying briefing papers in this submission, numbers 8/disability and 9/governance). This briefing paper, however, focusses on the more general challenges relating to risk assessment and risk management to inform family violence intervention.

Two attachments are provided to support this briefing paper: the Expert evidence from Cathy Humphreys provided to the Coronial Inquest for Luke Batty; and the paper written with Professor Nicky Stanley on risk assessment and risk management of domestic violence. The paper is informed by research undertaken in the UK on police risk assessment and risk management (Humphreys et al, 2005), The L17 Triage pilot the Northern Metro Region, Victoria (Humphreys et al, 2014); the synthesis of risk assessment issues in the child protection area undertaken with Professor Nicky Stanley (Stanley and Humphreys, 2014); and the SAFER evaluation of the implementation of the Police Code of Practice on Family Violence (papers forthcoming; internal report to Victoria Police).

Key Message

The evidence in the Luke Batty case points to three critical issues: (1) the dangers associated with the failure to share information between professionals; (2) the failure of most professionals involved to undertake and document a risk assessment (Magistrate Goldsborough stands out as an exception); (3) the failure of the police to escalate their risk management strategy to act with urgency in relation to the seriousness of the risks identified is indicative of the dangers of risk management not flowing from risk assessment.

Challenges

- Problems will arise if the RAMP, high-risk response becomes the only response to women and children living with family violence. RAMPS will only respond to the 10% of women who the

interagency recognise as at the highest risk of serious assault or fatality. The majority of women and their children living with FV will not experience this response and their needs must not be ignored.

- A current development is occurring with Victorian Police to explore a risk assessment which is based on a tiered response to family violence in which there is transparency about the urgency of response to cases. My personal view based on research in the UK, is that this is an appropriate development given the level of demand that is currently overwhelming the response. A validated tool could assist front line police to ask appropriate questions at the FV incident and provide greater guidance for risk assessment and management.

- The specialist FV sector however has been concerned that the risks involved of inaccurately assessing women and defaulting to responding only to those women at high risk are too great if a tiered response is developed. Police usually only identify a limited amount of the risk and the specialist sector undertakes the more extensive safety planning and risk assessment following the immediate crisis.

- Critical to the development of risk assessment in Victoria is that the Police and other sectors continue to align their risk assessment processes.

- The risk assessment for children is also an important stage of development and this also needs to be aligned across Victoria.

- Accurate risk assessment is based on information sharing in the context of high levels of confidentiality.

- Risk assessment must lead to effective risk management strategies otherwise it is a useless exercise in sharing information to no effect. Victoria has been stronger on agreeing the process for risk assessment rather than necessarily agreeing the process for escalated risk management.

- Risk assessment is an art rather than a science and should be recognised as preventive rather than predictive. Care will need to be taken that a needs led practice with women and children is not over-ridden inappropriately by risk management strategies which have some potential to disempower women in their decision-making.

- Formal pathways through which risk assessment from RAMPS inform Family Law decision making are important but currently unaddressed developments.

The practice of perpetrator risk assessment and risk management

Risk assessment and management as an aid to multi-agency family violence intervention is growing in popularity nationally and internationally. While police forces have had a significant role to play in driving the use of risk assessment and management models, the women's sector supporting victims have also actively engaged with and supported the process in many regions and countries (Davies et al., 1998; Stanley &

Humphreys, 2014; Thomson & Goodall Associates, 2013). A particularly attractive feature of family violence risk assessment and management models is their potential to fulfil multiple functions and improve the quality of decision-making. A summary of this is provided by Robinson (2003, p8) in relation to police practice, though is equally applicable to other organisations such as child protection. It includes:

- Providing a structured guide for responding officers to gather detailed and relevant information at the scene of the incident.
- The ability to provide other agencies with information which will give a better service to victims by specifying their particular needs, especially in relation to safety.
- A more systematic recording of a 'paper trail' of evidence with which to inform prosecutors, particularly if victims are not in a position or willing to be involved in the criminal prosecution.
- The prioritisation of scarce criminal and civil justice resources to help assist police and other agencies to identify those victims in the most dangerous situations who need more resources from the police and other agencies to support their safety and prevent the escalation of severity over time.
- The enhancement of multi-agency partnership working through a shared view of risk and information sharing processes to support the safety of workers from other agencies involved with the family, e.g. health visitors and social workers, as well as the victim and children.

Some warnings have been raised about the development of risk assessment and risk management tools. Firstly, the priority on the most dangerous perpetrators may leave many women and children without an adequate and safe intervention. Secondly, the risk factors are indicative not predictive and serious cases may be left out of a system which only prioritises intervention to high risk cases. Thirdly, risk assessment may be seen as an end in itself, rather than a mechanism through which to inform the management of risk. Finally, the risk assessment and risk management needs to actively enhance the policing response and not overwhelm police with administrative paperwork (Holder, 2008).

The evidence base for the development of risk assessment models/tools draws on several different, though overlapping, areas:

- Murder and serious crime reviews (Richards, 2003; Websdale, 1999).
- Victimisation and crime surveys and reviews of policy and agency data (Walby and Allen, 2004; Campbell et al., 1995).
- Analysis of perpetrator characteristics and contexts (Dobash and Dobash, 2002; Gilchrist et al., 2003).

A number of different risk assessment models have now been developed in Australia, the UK and elsewhere. Together these models have been used to develop and enhance both police and multi-agency working in relation to family violence. Most of the risk factors are similar, though the way in which they are weighted to inform actuarial assessments may vary. For instance, recognition that 'obsessive jealousy and highly controlling behaviour' is the most sensitive marker of dangerousness is highlighted by the South Wales MARAC evaluation, which showed that its presence as a risk factor makes 11 of the 14 other risk factors significantly more likely to occur (Robinson, 2004, p. 3). Other models are driven by a focus on the perpetrator and, in particular, on the escalation of repeat incidents (Hanmer, Griffiths, & Jerwood, 1999), while still others focus on a mixture of victim and perpetrator issues drawn from factors associated with homicide and serious incidents of physical and sexual assault (CAADA, 2012). The major differences in the models occur around the process of risk management.

Common Risk Assessment Framework

In Victoria, very significant support has been provided for a common risk assessment and risk management framework (the CRAF) to be adopted across all organisations and professionals involved in family violence intervention. Government has continued to support the training of multiple organisations in relation to the CRAF since its inception. It provides the foundation for training of professionals across a wide range of organisations in basic understanding of family violence risk assessment. As with other risk assessment and risk management frameworks, the set of factors, which are associated with escalating risk of domestic violence, are recognisable and aligned with other domestic violence frameworks. The police L17 family violence incident report form list a similar set of risk issues which should alert them to the factors of relevance to assessment and management of domestic violence. To date, Victoria has made considered decisions not to introduce an actuarial tool, weightings to the risk factors, or a tiered approach. Instead there has been a consistent preference for risk assessment based on training to understand the risks and highlight the important role of professional judgement.

Developments of a tiered response

The overwhelming demands placed upon the FV intervention system in Victoria have led the Victorian Police to begin to explore a new, tiered approach to FV Incidents with changes to the L17. The potential changes are broadly aligned with the CRAF in terms of risk factors (moving from a tick box approach to short questions), and the tiered approach may be primarily applicable to risk management in relation to the timing/urgency of the internal response by police. Potentially, the approach may provide a greater consistency of response by police to victims and perpetrators of violence with greater attention to children in the proposed risk assessment. The developments in the L17 are in the process of preparation for broader consultation. An essential aspect of this development will be that it supports and aligns with risk assessment and management in the wider system of family violence intervention.

High-risk response

The Multi-Agency Risk Assessment Conferences (MARACS) were developed and tested in South Wales. The model emerged out of the intensive work, relationship building and trust which developed between the Cardiff Women's Safety Unit and the South Wales Police Force and other agencies involved in the multi-agency domestic violence intervention (Robinson, 2004). The model has proved successful in addressing the needs of high risk adult victims and also assisted in managing the workforce demands on police. It is now being adapted and implemented across England and Scotland. The MARAC involves an 'actuarial response' plus professional judgement, plus victim perception to identify approximately the highest 10% of severely at risk victims.

In Australia, several states, including Victoria have now adopted multi-agency, high risk panels based on the MARAC model. This is potentially a very positive development. In Victoria, a more co-ordinated response to high risk families through the RAMPs (Risk Assessment Management Panels) is being developed. Two demonstration sites in Geelong and Heidelberg produced a positive evaluation (Thomson and Goodall, 2013) and a concerted effort has been made to consult between departments and community sector organisations to produce the details of a model for the future roll out across 17 sites in Victoria. The high level, confidential information sharing, the development of a plan of action, the focus on the perpetrator of domestic violence, and case management support for women and their children at high risk of serious harm or death provide the basis for a much needed, tighter and strengthened response to domestic violence.

In the UK, an early evaluation of the MARAC system, on which the RAMPs are based, has shown that victims of violence are safer with a significant reduction in perpetrator recidivism (Robinson, 2006). It is however recognised that further evaluations are required to fully establish the effectiveness of the model.
A further note of caution is raised, that significant infrastructure support through training, the development of manuals, MOUs, agreement about data bases, and adequate resourcing will be needed to ensure that the model is meets its objective to provide strengthened accountability and enhanced safety for high risk victims of family violence. A RAMP on 'a shoe-string' is potentially dangerous as the model is designed to work with the most high-risk perpetrators where homicide, serious assault and stalking are real possibilities. Poor practice may have serious consequences.

Family violence risk assessment for children

Less developed are the risk assessment tools for children living with family violence. This is a complex area. While all child protection departments throughout the Western world struggle with the inundation of referrals of children living with domestic violence largely, though not exclusively from police, there has not been an actuarial tool developed to regularise or create a consistent practice in this area (Jaffe et al, 2014). It remains an area where professional judgement is needed, rather than judgement supported by validated tools. The problem is that the safety of children is dependent upon risks associated with the perpetrator, risk factors associated with their primary carer (usually their mothers), and the effectiveness of protective factors which surround the child. Guidance has been developed in Victoria (through the CRAF) and elsewhere (for example, the Barnardos Matrix (Bell & McGoran cited in Stanley et al, 2010)). However the lack of development in this area is exemplified by the primary UK website which provides practice guidance and resources for the MARAC high risk initiative in the UK (http://www.caada.org.uk/index.html). It makes the following statement in relation to the Risk Identification Checklist:

> *This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation. (http://www.caada.org.uk/marac/RIC_for_MARAC.html p.5)*

The role of risk assessment and information sharing in the death of Luke Batty

There is much to be learnt in the tragic Luke Batty case from examining the level of expertise involved in assessing risks and from the failures in sharing vital information. The following is an extract from the expert report of Cathy Humphreys to the Luke Batty Coronial Inquiry (the numbers indicate the paragraphs in the expert report).

3. [redacted]

3.1 [redacted]

3.2 [redacted]

3.3 [redacted]

3.4 [redacted]

3.5 [redacted]

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3.6

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Opportunities for practice and policy development

The development of RAMPS, the changes to the L17 Police risk assessment form, and the development of family violence risk assessment for children living with family violence are indications of the shifting territory in Victorian family violence intervention. Key practice and policy changes all have the potential to be positive steps towards supporting good practice in family violence intervention. A strength of Victorian policy and practice has been the development of frameworks and tools which are common or aligned. It will be essential to maintain attention to these strengths as the field progresses.

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Contact: Cathy Humphreys; [redacted]

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Domestic violence and child protection: exploring the role of perpetrator risk assessments

Cathy Humphreys

Alfred Felton Chair of Child and Family Welfare, University of Melbourne, Melbourne, Victoria, Australia

Correspondence:
Cathy Humphreys,
Department of Social Work,
University of Melbourne,
Queensbury Street,
Melbourne,
Victoria 3010,
Australia
E-mail:
cathy.humphreys@unimelb.edu.au

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ABSTRACT

This article explores the issue of severity in relation to domestic violence and provides a number of reasons for the necessary engagement by workers with such a contentious issue. The specific role that the assessment of the risks posed by the perpetrator which has now developed in some police forces in the United Kingdom is examined, and its relevance to child welfare intervention discussed. A range of factors are identified that heighten the risks of increased violence. These include prior sexual assault; stalking and controlling behaviour; substance misuse and mental-health problems; separation and child contact disputes; pregnancy; escalation including the use of weapons and psychological abuse; attempts and threats to kill; child abuse; isolation and barriers to help-seeking. The ways in which perpetrator risk assessment can be used to inform the filtering of referrals to the statutory child care agency, enhance multi-agency working, provide a structure for the assessment of the perpetrator, enhance partnership-working with survivors (usually women) and inform the protection strategies for workers are explored.

INTRODUCTION

The discourse on risk in child protection work has been a source of controversy and challenging discussions, much of which has occurred in this journal (Christie & Mittler 1999; Krane & Davies 2000; Houston 2001; Little *et al.* 2004). Objectivist approaches to risk assessment that highlight the importance of social science in contributing to a rationalist approach to predicting risk (Pecora 1991) are juxtaposed against more subjective approaches, which are more concerned with meaning, interpretation and uncertainty rather than predictability (Parton 1998). Critical realism (Houston 2001) and ideas drawn from systems theory, especially second-order cybernetics (Ison, 2006), do not pose these perspectives as dualisms. In the latter case, Ison invites those interested in praxis to increase their critical awareness (and therefore their repertoire for action) of the ways in which they use first-order empirical research (often but not always based on positivism) and the times when they are working from second-order understandings of the world as constructed by their observation and interpretation. He argues that both have a role to play in effective praxis.

This article engages firstly with the changing discourse on domestic violence and severity and then focuses on a particular aspect of risk assessment, namely, domestic violence assessments used by police and their potential role at different stages in domestic violence and child protection intervention. This discussion does not stand outside the wider risk assessment debates and is clearly informed by them. However, a very pragmatic approach has been taken to this aspect of domestic violence risk assessment through an exploration of the praxis of risk assessment and the way in which it can be deployed as a tool to address a number of issues involving child protection intervention where there is domestic violence.

An evaluation of the implementation of a police domestic violence risk assessment model brought to light the development of policing work in this area and its relevance to statutory child care work, particularly given the high levels of referral from police to children

and families' teams following a domestic violence incident where children are present (Humphreys *et al.* 2005). The changing discourse in relation to severity of domestic violence, and the continuous criticism of the way in which statutory children and families' teams engage with the intersection of child abuse and domestic violence (Hester *et al.* 2000; Holt 2003), have also been formative.

THE CHANGING DISCOURSE ON SEVERITY AND DOMESTIC VIOLENCE

This discussion has been prompted by the observation that there have been a number of shifts in policy and practice which are significantly changing the domestic violence discourse in relation to severity. Weedon defined discourse in the following way:

> Discourses are ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and the relations between them. (Weedon 1987, p. 108).

Discourse is therefore more than language, and it includes the process through which we come to define and act in relation to a specific subject.

The women's movement to support survivors has been equivocal about engaging with the severity of domestic violence. A woman's right to define the impact of domestic violence on her life was seen as the starting point for respectful engagement with her experiences (Davies *et al.* 1998). It was also argued that severity too often equated with physical violence and that this minimized the profound impact on the woman's mental health. Violence does not have to occur often for a regime of control and domination to be established (Herman 1992). An 'open door' policy developed in women's refuges as a function of this 'women-defined' approach to domestic violence. These women of course brought their children with them who were also affected by living with domestic violence (Mullender *et al.* 1998).

However, a number of interrelated issues have 'forced' an engagement with the issue of severity and therefore reluctantly with the complexities of risk for both survivors (usually women) and children.

Firstly, domestic violence is a significant social problem that is becoming more widely reported. Prevalence studies across 10 countries in Europe consistently show one woman in four experience domestic violence (Council of Europe 2002). The Department of Health estimated that 750 000 children were living with domestic violence in the United Kingdom (Department of Health 2002). The first UK prevalence study of 2869 young adults indicated that 26% had witnessed violence between their parents at least once, and in 5% the violence was chronic (Cawson 2002). Of those children living with domestic violence, 23 500 each year will live in a refuge, escaping from the violence with their mothers (http://www.womensaid.org.uk/). In no sense is it either possible or advisable for all these children to be routed through the statutory child care agency. Decisions need to be made about which children are more likely to be at risk of significant harm and alternatively where other informal or community-based services would more appropriately meet their needs.

Secondly, as the feminist project to bring the issues of domestic violence to the surface has become attached to 'the unstoppable juggernaut of child protection' (Featherstone & Trinder 1997), collisions have occurred between the differing approaches and focus of intervention. Voluntary sector agencies offer services to women (and some men) and children based on their choice to use these services. It is recognized that potentially all survivors of domestic violence, including children, need help, information and support. An undifferentiated notion of domestic violence is therefore relatively unproblematic, particularly as services are generally rated highly by service users (Mullender *et al.* 1998; Robinson 2003).

Referral to the statutory child care sector is more complex. While some women have a positive engagement with statutory social workers, a substantial proportion find the experience negative, and their fear of losing their children and sense of surveillance increases their anxiety (Holt 2003). Moreover, inundating the statutory child care agency with referrals may actually increase the risk of harm, as those children in greatest danger may become lost in the 'debris of referrals' and not receive a service. Many children may be better serviced through community based services. This approach contrasts to countries where domestic violence is subject to mandatory reporting or where police forces refer all children where there is a domestic violence incident.

Thirdly, national prevalence studies of domestic and family violence show high rates of both men and women who say they have experienced physical abuse from an intimate partner. In the UK study, 13% of women and 9% of men report being subjected to incidents of domestic violence in the past year (Walby & Allen 2004). Such data can obfuscate the gendered nature of intimate-partner violence and point to the need to engage with the issue of severity (as well as

the issues of context and self-defence). When the most heavily abused are considered, based on the frequency of attacks, the range of forms of violence and the severity of injury, women are overwhelmingly the most victimized. Among people subjected to four or more incidents of domestic violence from the perpetrator, 89% were women. Eighty-one per cent of all attacks were attacks on women (Walby & Allen 2004). Moreover, women are twice as likely to be injured, and three times as likely to report living in fear, than men (Mirrlees-Black 1999). When domestic homicide is considered, two women in the United Kingdom die each week. In short, while it is it far from ideal for children to be living in circumstances of high conflict, and any incident of physical abuse will be frightening for children, the arena where there are more likely to be concerns about significant harm to children is where violence is chronic and serious (see Note1).

A fourth issue has been brought to prominence in the child contact arena and has been flagged in earlier articles (Featherstone & Trinder 1997). There are high numbers of allegations of domestic violence that arise in the child contact arena, featuring in an estimated 16 000 (24%) of contact applications. Some of this violence will prove to be lethal to women and children (Richards 2003; Saunders 2004). In other circumstances, post-separation stalking and violence, although not fatal, will be terrifying and traumatizing (Humphreys & Thiara 2003). Child contact will often provide the route through which this destructive violence and significant harm to children continues (Buchanan *et al*. 2001). However, some child contact, particularly supported and supervised contact, is able to be established even where there has been a previous domestic violence incident (Aris *et al*. 2002). Risk and safety assessments need to be undertaken to inform decisions made about where contact should never be recommended and what levels of protection are required to try to ensure safe contact. The complex issue of severity is one issue that can inform these assessments.

A HEALTH WARNING

A problem in the area of domestic violence and child welfare has been that the *Framework for the Assessment of Children in Need and Their Families* (Department of Health 2000) is inadequate as guidance in this area (Calder 2004). The couple of paragraphs on an ungendered notion of 'parental capacity' provide only a starting point for a complex area.

In response to this perceived gap, there are now a number of new assessment frameworks available (Calder 2004; Children and Family Court Advisory and Support Service 2005; Healy & Bell 2005; Radford *et al*. 2006) that can provide an adjunct to the assessment process where there is domestic violence. These frameworks have many commonalities that involve an exploration of areas of both risk and protective factors in relation to perpetrators, survivors (usually the child's mother) and children. The framework provided by Healy & Bell (2005), for example, identifies nine areas for assessment: (1) the nature of the abuse; (2) the risk to the children posed by the perpetrator; (3) the risks of lethality; (4) the perpetrator's pattern of assault and coercive behaviours; (5) the impact of the abuse on the woman; (6) the impact of the abuse on the children; (7) the impact of the abuse on parenting roles; (8) protective factors; and (9) the outcomes of women's past help-seeking.

The concentration in this next section of the article on the risk assessment of perpetrators by police and some multi-agency forums is therefore only one aspect of more complex assessments needed to inform child protection work. However, it highlights specific issues in this area of intervention and the potential of perpetrator risk assessment to shift aspects of child protection practice where there is domestic violence.

POLICE MODELS OF DOMESTIC VIOLENCE RISK ASSESSMENT

Like statutory children and families' teams, police are coping with very high numbers of domestic violence incidents. A UK snapshot of key service responses to domestic violence showed that police receive a call for assistance with domestic violence every minute on average (Stanko 2000). Examples from two police forces indicated that in London police were called to more than 109 500 incidents of domestic violence in 2004 (Richards 2004), while West Yorkshire, recorded 35 103 incidents (Humphreys *et al*. 2005). An analysis of 60 randomly selected cases showed that in West Yorkshire, almost 50% resulted in a referral to social services.

Different police authorities are using or developing domestic violence risk assessment tools to assist them to prioritize their work. Most of the tools are based on those factors that have been associated with lethality and serious assaults (Richards 2003, 2004; Robinson 2003).

Most of the factors are common across the models, although some models foreground some factors as

more important than others (Richards 2003). Given the harmful effects on children living with domestic violence (Hester *et al.* 2000), combined with the earlier discussion regarding the need to engage with the issues of risk and severity, and the fact that in some areas there is now automatic referral by police to social services where children are present at domestic violence incidents, it is worthwhile digressing briefly to review some of the evidence that is consistently associated with heightened risks and are present in all models. These factors include: sexual assault; stalking and controlling behaviour; perpetrator substance misuse and mental-health problems; separation and child contact; pregnancy; escalation; attempts/threats to kill child abuse; and isolation and barriers to help-seeking.

Sexual assault

The British Crime Survey showed that at least 54% of rape and serious sexual assaults were perpetrated by a male partner or former partner (Walby & Allen 2004). Women who report having been sexually assaulted are also more likely to be seriously injured (Richards 2003) and are more likely to be the subject of further violent attacks (Campbell 1995). Sexual assault by a current/former partner is one of the most consistent indicators of repeat victimization and potentially lethal violence (Robinson 2003). The analysis of serious physical and sexual assaults in London showed that in at least 10% (25) of cases children witnessed the rape of their mothers (Richards 2003).

Stalking and controlling behaviour

Obsessive controlling behaviour such as watching, following and constant phoning of the partner/former partner indicates heightened risk. The evaluation of serious domestic violence offenders in Cardiff suggesting that 'perpetrator is jealous or controlling' is a particularly important risk factor, as it makes 11 of the 14 other risk factors significantly more likely to occur (Robinson 2004, p. 3). In one analysis of homicide and intimate-partner violence, over-possessiveness and jealousy were noted in 26% of men (Dobash *et al.* 2005), while in another study jealousy and controlling behaviour were reported in 67% of homicide cases (14 of 21 cases; Richards 2003).

Substance misuse and mental-health problems

There is little evidence to suggest that problematic substance use causes violence. However, use of drugs and alcohol can increase the severity and dangerousness of the violence (Finney 2004). Reports from probation files of 336 men convicted of domestic violence offences indicated that 49% had a history of problematic alcohol use and a further 19% with substance use; 73% reported consuming alcohol prior to the offence (Gilchrist *et al.* 2003). The South Wales evaluation showed that 'Partners with drug problems inflicted significantly more violence and injuries on their partners . . .' (Robinson 2003, p. vii).

A significant minority of offenders also report mental-health problems of either psychosis or depression. A study of 336 convicted domestic violence male offenders showed 22% with a history of depression and 13% with a 'tendency to be paranoid' (Gilchrist *et al.* 2003), while the South Wales analysis of 146 high risk offenders showed 20% with mental-health problems (Robinson 2004).

Separation and child contact

Separation where there is a history of domestic violence heightens the risks of escalation and the chance of homicide and further serious assault (Wilson & Daly 1992). The multi-agency London domestic violence murder reviews showed that 76% of cases involved separation (Richards 2003). Over half the London sexual assaults that were analysed occurred during separation or post separation (116 out of 217; Richards 2004). At least 29 children have been killed in the last decade by their fathers post separation (Saunders 2004). In most of these cases there had been a prior history of domestic violence. Child contact arrangements provide the greatest opportunity for the continuation of post-separation violence (Walby & Allen 2004).

Pregnancy

It is unclear whether pregnancy in itself is a risk factor for domestic violence. However, perpetrators of violence during pregnancy are men who are considered highly dangerous. These attacks represent a form of 'double intentioned violence' (Kelly 1994) as they incorporate both acts of woman abuse and child abuse. One study showed that women subjected to domestic violence in pregnancy were four times more likely to miscarry than women who were not abused (Schornstein 1997). Women reporting attacks in pregnancy are more at risk of moderate to severe violence and homicide (Campbell 1995). The Canadian

national survey showed women abused in pregnancy were four times more likely to report severe violence that included beatings, choking, attacks with weapons and sexual assault (Jameison & Hart 1999).

Escalation including use of weapons and psychological abuse

The escalation of the abuse (psychologically or physically) is consistently noted as a high risk factor (Campbell 1995). The analysis of the South Wales Multi-Agency Risk Assessment Conferences (MARACs) showed that in just of half of cases abuse was becoming worse of more frequent, while the London murder reviews recorded escalation in more than four-fifths of cases. Gilchrist *et al.*'s (2003) study of convicted offenders showed one-fifth used a weapon, while the UK analysis of intimate-partner homicide showed almost a third of victims had been stabbed (Dobash *et al*. 2005).

Attempts/threats to kill

Perpetrators who threaten to kill themselves, their partners or former partners, or others including their children are considered particularly dangerous. In themselves, threats are experienced as psychologically abusive and controlling (Humphreys & Thiara 2003). Although not all threats are carried out, there is a significant relationship between threats and subsequent violence (Brewster 2000). The London murder review observed that in the domestic violence context, 'Offenders who are suicidal can quickly turn homicidal. The two are inextricably linked' (Richards 2003, p. 22).

Actual attempts to kill are difficult to separate from previous serious physical and sexual assaults. In the London domestic homicide review, at least 70% (102) of offenders had a previous criminal history and half had been flagged as high-risk and dangerous on the basis of their re-offending, exhibiting particularly disturbing behaviour when committing the assault in terms of language used, level of violence and/or weapon used (Richards 2004, p. 22). Attempted strangulation is of particular concern given that 33% of intimate-partner homicide occurred through strangulation (Dobash *et al*. 2005).

Child abuse

All domestic violence is a form of child abuse given the evidence that has emerged on the negative effects of children living with domestic violence (Mullender *et al*. 1998; Hester *et al*. 2000). However, it is not always highlighted as an indicator of lethality for women, although it is indicative of lethality for children. There is considerable evidence that as the violence towards the woman increases, the likelihood of direct physical or sexual abuse of children also increases (Ross 1996). Child death reviews consistently report a high proportion of cases where domestic violence is also present (Reder & Duncan 2004) and that children are traumatized by witnessing the murder of their mothers (Hendricks *et al*. 1993). Thirty per cent of the domestic murders in the London review were witnessed by children (Richard 2003).

Isolation and barriers to help-seeking

Increasing isolation is also associated with heightened risk and is also often a form of emotional abuse. Relocation away from friends and family, destruction of relationships and control of friendships, undermining the woman's ability to work (Raphael 2000), all increase the total power of the perpetrator of domestic violence. A significant study of psychological abuse placed domination and isolation together as a risk factor and noted that domination was a particularly strong predictor of repeat violence (Bennett *et al*. 2000). However, there are also barriers to help-seeking that can also increase isolation, particularly for minority ethnic women, disabled women, and gay and lesbians (Humphreys *et al*. 2005).

In short, a number of factors have been highlighted through analyses of serious sexual and physical assaults and domestic homicides, and they draw attention to areas that should raise heightened concerns for adult survivors, children and workers. These factors do not predict future violence, but are consistently associated with increased risks of severe violence and lethality.

THE USEFULNESS OF PERPETRATOR RISK ASSESSMENT

It is worth reiterating that when workers in the child protection arena are undertaking risk and safety assessment, the seriousness of the risk posed by the perpetrator of violence is one of several factors to be considered – an issue raised by Radford *et al*. (2006), who have developed the work in this area. However, significant attention to the risks posed by the perpetrator should clearly be a key factor informing these

assessments and could be important in a number of different ways.

Enhancing multi-agency working

It has been suggested that 'discourses on risk' provide a shared understanding and common language between groups of professionals (Christie & Mittler 1999). This may be less the case in the arena of domestic violence. Separate sets of attitudes, policies and practices inform responses to domestic violence in the criminal justice, child protection and child contact arenas. The different discourses are so marked that Hester (2004) refers to this as child care on different planets.

A pertinent analysis by Blacklock (2005) of the discrepancy between the data on perpetrator risks contained within the police referral forms (S78 forms) to statutory child care teams and the allocation of a social worker highlights the issue. Blacklock undertook a content analysis of 64 of 85 S78 forms that were sent to a local authority assessment team in a 6-month period (forms with little or no information on the referral were not included). Using the South Wales police pro forma of risk assessment factors, he found that the number of risk factors mentioned on the referral form bore no relation to whether a social worker was allocated to the family or not. In fact there was a slight tendency in the opposite direction. The more risk factors about the perpetrator that were identified, the less likely the family was to see a child protection social worker. Clearly, social workers were using criteria other than the information about perpetrators to inform whether the statutory agency was to be involved. Clarification by Blacklock with senior social workers suggested that the numbers of domestic violence referrals were overwhelming and that social worker allocation did not attend to the nature of the violence being experienced, but rather other risk factors in relation to children (Blacklock 2005). It could be suggested that the assessment of the mother rather than the father still continues to be the most significant criteria being used in child protection assessment of risk (Holt 2003).

Further discrepancies arise when some of the risk factors are considered. Separation where there has been a history of domestic violence is one of the highest risk factors for homicide and serious sexual and physical assault (Richards 2003). By contrast, the goal of much child protection intervention is often to insist on separation as the only way to ensure the safety of children (Magen *et al.* 2001). However, when the chances of escalation of abuse are so high, separation needs to be managed and supported by professionals with extreme care. It is the point when women and children need the most support, not the point of withdrawal or a factor that may ensure that women and children do not receive a social work service.

The shift in some areas of the United Kingdom towards multi-agency risk assessment conferences (MARACs) in which professionals from all agencies share information and planning in relation to high risk offenders and their victims has brought to the fore the need to understand the perspectives from which other agencies assess risk and safety. Unfortunately, the limitation in this process is that only small numbers of cases can be addressed. The Cardiff MARAC evaluation showed that only the 'very high risk' (seven or more risk factors) perpetrators came to notice at the monthly MARAC and this involved 20–30 cases for attention. Nevertheless, the evaluation pointed out how important this multi-agency forum was in preventing re-victimization and highlighting the needs of children and women (there were no male victims in the 146 high risk cases; Robinson 2004).

Using perpetrator risk assessment to filter out high risk cases is clearly a mechanism that may increasingly be used by the police and multi-agency forums led by them. It is also obvious that initial assessment teams in the statutory child care sector use 'filtering mechanisms' when they decide which families are referred to other agencies, which families have 'no further action' and which families are allocated to a statutory social worker for further attention. The number of previous referrals, or whether children show up as a source of concern through background welfare checks, may be the principles that guide much of the current filtering (see London Child Protection Committee, n.d.). It is argued here that the level of perpetrator risk could be used much more helpfully to inform these decisions where there is domestic violence. Blacklock (2005) argues that this process could be aided by the police referral forms (S78) containing the police assessment of risk and social workers given prompts for questions about perpetrator risks when taking referrals.

At the very least, it should also be recognized that *future* risk may not be the only concern. Women and children who are affected by sexual assault, stalking, attacks during pregnancy and so on need assistance with the trauma they have experienced. They need *a* service, even if not a statutory one.

Addressing the invisible offender

A consistent theme in the domestic violence and child protection literature is that men are marginalized, whether they are abusive or non-abusive (Featherstone 2001). In the domestic violence arena, where men are frequently the perpetrators of violence, the focus by social workers on mothers and their capacity to protect, or their mental health or substance use problems (often induced by the violence) becomes a source of institutional mother-blaming if there is not equal attention paid to the risks created by the perpetrator and strategies for preventing his further abuse. In the arena of child protection risk assessment, Krane & Davies (2000) point out that the consistent focus on women in these assessments entrench this pattern of mother-blaming, particularly of single mothers in poverty. A focus that explores the risks posed by domestic violence perpetrators and provides professionals with ways to structure their intervention can help to re-orientate practice in ways that rebalance investigations, assessments and case planning.

Interestingly, the risk and safety assessment developed through the Domestic Violence Intervention Project in London assesses for, and where appropriate, identifies a primary aggressor. This counteracts problems with the notion of 'mutual violence', which can distort some assessments within the child protection arena (Radford *et al*. 2006). Assessments with the perpetrator are designed to elicit his perspective on the violence and abuse, its history, his attitudes towards it, his view on the impact on the children, and his motivation to address his behaviour (Radford *et al*. 2006). A respectful and skilful assessment can be the first step towards change and increasing the safety of the survivor and children involved.

Risk and safety planning with women

A frequent source of complaint is that the violence towards the child's mother is not considered an appropriate focus for child protection workers who argue that they must retain a focus on the paramountcy of the child (Holt 2003). Equally, the conflation of the needs of children with those of their mothers where there is domestic violence is also criticized (Featherstone & Trinder 1997). However, it is possible to acknowledge that where there is domestic violence the protection of the child's mother will benefit the child even if they also have separate needs. Lack of attention to the needs of the domestic violence survivor also fails to recognize the extent to which the violence is an attack on the mother–child relationship, not just an issue of woman abuse or child abuse (Humphreys *et al*. 2006).

The key to effective domestic violence intervention is to understand risk assessment and safety planning as interlinked processes. Establishing a dialogue with the survivor that elicits the narrative of violence and abuse is central to this process and potentially provides an important first step in partnership-working and the platform for safety planning for both women and children (Davies *et al*. 1998). There can be problems with the accuracy of victim risk assessments. However, an overview by Robinson (2004) points out that while there may be significant minimization in women's assessments, particularly when they wish to stay with the perpetrator (see Campbell 1995), the research by Weisz *et al*. (2000) showed that the victim's own prediction was the strongest factor to correlate with predicting future violence.

This approach to risk and safety assessment has been developed in the voluntary sector (Davies *et al*. 1998; Healy & Bell 2005) and has some problems being adopted in the statutory sector, where in some situations there is less trust and high levels of anxiety about children being taken into care. However, where a level of trust can be established, a dialogue that asks a woman to assess the range of risks that are associated with increased levels of danger can assist her in naming and acknowledging the violence and abuse she is experiencing.

The evaluation of police risk assessment showed that officers appreciated having a systematic approach to risk assessment which also provided a basis for safety planning (Humphreys *et al*. 2005). Similar advantages may be experienced by child protection workers using perpetrator risk assessments. However, warnings have been raised about making risk assessment an interrogation around a checklist that closes down trust rather than a dialogue that opens up the narrative about abuse (Pense 2004). The Duluth Model developed by Pense and colleagues therefore recommended structuring dialogue around three questions:

- Do you think he will seriously injure you or the children? What makes you think that? If not, why not?
- What was the time you were most frightened or injured by him?
- Are things getting worse? Describe the pattern of the abuse (frequency, type, severity, escalation).

Through establishing a dialogue, the other areas highlighted as significant in understanding the risks posed by the perpetrator may also emerge through

these foundation questions. Establishing the protective strategies which have been used to date can then also flow from this dialogue. In this process perpetrator risk assessment can be used to establish a supportive relationship between child protection workers and survivors of domestic violence, while still maintaining a focus on issues which are of crucial importance in protecting children.

Risk assessment for workers

Domestic violence provides an area of high risk not only for women and their children but also for workers (Stanley & Goddard 2002; Littlechild & Bourke 2006). An understanding of factors that may indicate high risk offenders can helpfully inform the protective strategies that workers may also need to take. Stanley & Goddard (2002) point out that when workers are fearful they make accommodations which may mirror those which can distort the perceptions of survivors in acknowledging the level of danger and abuse they are living with. Minimization, avoidance, rationalization and denial may all feature as responses from workers who lack adequate supervision and are expected to engage in contexts in which their safety is inadequately addressed. It may need to be recognized that if only higher risk families are being allocated to statutory social workers, then by definition worker protection needs to be high priority.

RISK AND SAFETY ASSESSMENT: POSSIBILITIES AND PROBLEMS

It is tempting in a discussion of risk and safety assessment to avoid the difficult epistemological questions about certainty and predictability in exploring the different ways in which risk assessment can be deployed. Weighing both the problems and possibilities of perpetrator risk and safety assessment requires workers to be critically reflective about this question. Even when risk assessment is being used to elicit dialogue and meaning between workers and mothers, it is important to recognize that a background framework is being drawn upon which derives from a first-order understanding of empirical data. Credence is being given to a set of factors that research and analysis suggest are associated with heightened risks of violence and lethality. However, the factors provide associations rather than causal evidence of future harm. There are many false positives as well as highly dangerous situations where few risk factors are present (Sinclair & Bullock 2002). There are therefore possibilities and problems associated with the praxis of using perpetrator risk assessment to inform child welfare practice that need to start with this critical awareness.

Possibilities

A strength of perpetrator risk assessment lies in shifting the child protection discourse to focus more sharply on the perpetrator where there is domestic violence. Moreover, the ways in which it can be also used effectively to heighten the collaboration with the child's mother (sometimes the father), in working to support her assessment of risk, safety and protective factors can also assist in driving forward a more sensitive, less mother-blaming intervention. This does not presume that the interests of mothers and children as survivors of domestic violence are identical, but it does start from a presumption that they are linked and that any work that can support that relationship may well be in the best interests of the child and can begin to be assessed through this process (Kelly 1996). Enhancing inter-agency working through a shared language in relation to risk and safety may also be helpful in providing bridges between the criminal justice and policing agendas and those of child protection and child contact.

Problems

The use of perpetrator risk assessments as a tool for assessing severity and dangerousness as a means of rationing resources, sorting referrals to the statutory agency or deciding which fathers can see their children in the child contact arena is more problematic. The need to engage with these issues including the issue of severity is clear. However, in the arena of child protection and domestic violence, risk assessment needs to be understood as a guide to prevention and safety rather than prediction (Richards 2003). The risk factors have been gleaned from an analysis of lethality and serious physical and sexual assaults. They do not address the broader and important issues of quality of life, recovery and living without fear, and hence are narrowly focused (Radford *et al.* 2006).

Clearly there is value in looking at the accumulation of perpetrator risk factors (and some models work on this basis). For instance, it would be expected that child protection workers should be highly concerned if they are referred a woman with children who has been attacked during pregnancy, whose partner was involved in drug abuse, who had threatened to kill her if she leaves him, and that this was not the first attack.

However, a broader focus provided by the more comprehensive assessment frameworks that include the contexts of the perpetrator, survivor and children is also needed (Calder 2004; Healy & Bell 2005; Radford *et al*. 2006). These frameworks also look more closely at the issue of thresholds and grade the assessment and referral response accordingly. However, they do not provide simple answers to this complex question, which will always need to involve professional judgements. Much will depend not only on the family context but also on the level of community and family support services available.

In conclusion, perpetrator risk assessments are imperfect. They do not provide an 'easy fix' for making decisions about risk and safety. However, obvious as it is, professionals in all areas need to be reminded that without a perpetrator there is no domestic violence. Hence, attention to the risks they pose should at least be a significant issue that informs the assessment and more importantly the intervention that should follow where there are children affected by domestic violence.

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NOTE

1 Given the dominant pattern of male to female violence in cases of most concern to children, gendered terminology will be used, with female survivors and male perpetrators.

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Multi-agency risk assessment and management for children and families experiencing domestic violence

Nicky Stanley [a,*], Cathy Humphreys [b]

[a] School of Social Work, University of Central Lancashire, Preston PR1 2HE, UK
[b] Department of Social Work, University of Melbourne, Parkville, Melbourne, Victoria 3010, Australia

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ABSTRACT

This paper explores risk assessment and management in relation to children and families experiencing domestic violence; in particular, the communication and collaboration between child protection services, the police and independent domestic violence services. Four key themes structure our analysis of the challenges of risk assessment and management in this field: the question of who is the primary client and the focus of risk assessment; the issue of how the information to inform risk assessment is organised, including how it is collected, the tools that are employed, and the context in which information is collected; the position of the child, mother and father and whether risk is assessed and managed with them or to them; and the relationship between risk assessment and risk management, specifically whether risk management is restricted to families where levels of danger are identified as high or whether there are opportunities for support and safety planning for families where the risk is assessed as low. Finally, the paper examines some of the mechanisms that have developed as a means of resolving these issues, describing approaches to multi-agency risk assessment and management in this field that have emerged in both the UK and Australia and drawing on a range of studies undertaken by the authors.

1. Introduction

Established approaches and protocols for risk assessment and management are often challenged at the interface of interagency work. At the level of risk assessment, conflicts emerge between different conceptions of risk and between different approaches to the collection of information used to inform risk assessment. In risk management, some agencies restrict their intervention to high risk cases, while others maintain a focus on those which require lower levels of support. While these conflicts may impede the day-to-day practice of risk assessment and management, they are also valuable in illuminating the varying perspectives which organisations bring to the task of protecting children. Differences which arise in mapping the territory can highlight the need for new structures and the support required for agencies to work collaboratively.

This paper explores risk assessment and management in relation to children and families experiencing domestic violence; in particular, the communication and collaboration between child protection services, the police and independent domestic violence services. This is a field where agencies have struggled to harmonise and co-ordinate their risk assessment procedures, not least because one agency's assessment of risk can result in high workloads for another organisation (Humphreys, 2007; Stanley, Miller, Richardson Foster, & Thomson, 2011a). Relatively recent recognition of the high prevalence of children's exposure to domestic violence (Stanley, 2011) has resulted in agency acknowledgement of a wide arena for intervention but as yet there is limited understanding of how different agencies can contribute to building a response that distinguishes levels of need and provides a calibrated response (Edleson, 2004; Jaffe, Crooks & Wolfe, 2003). In the UK and Australia, this need for a more differentiated service response has been highlighted by key inquiries and reviews into child protection (Cummins, Scott, & Scales, 2012; Munro, 2011).

Domestic violence is a complex phenomenon in families involving different family members in varying roles, evoking different agency models of response (Hester, 2004) and overlapping with a range of other social problems such as substance abuse and mental health needs (Cleaver, Unell, & Aldgate, 2011; Stanley, Cleaver, & Hart, 2009). In this sense it is consistent with Devaney and Spratt's (2009) account of child abuse as a 'wicked problem'. These are problems which:

> *go beyond the capacity of any one organisation to understand and respond to, and* [where] *there is often disagreement about the causes of the problems and the best way to tackle them.* (APSC, 2007, p. 5)

Responding to such problems is likely to involve changing the behaviour of large groups of people across and between organisations, so

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challenging traditional modes of policy making and programme implementation (APSC, 2007; Ison, 2008).

Four key themes structure our analysis of the challenges of risk assessment and management in this field. First, we address the question of who is the primary client and the focus of risk assessment? Second, how is information to inform risk assessment collected and organised; what tools are employed for this purpose; what context is it collected in and when and how does the relationship between the practitioner and the family shape the information available to inform risk assessment? Third, we examine the position of the child and family in risk assessment and management in this field: is risk assessed and managed with them or to them? Fourth, we consider the relationship between risk assessment and risk management: is risk management restricted to families where levels of danger are identified as high or are there opportunities for support and safety planning for families where the risk is assessed as low?

Finally, we explore some of the mechanisms that have developed as a means of resolving these issues, describing approaches to multi-agency risk assessment and management in this field that have emerged in both the UK and Australia and drawing on a range of studies undertaken by the authors.

This paper brings together emerging approaches to risk assessment and management from both the UK and Australia. Since the UK includes four countries and Australia comprises six states and two territories, variations arise between jurisdictions and in what follows we aim to identify broad trends. A number of studies (e.g. Spratt & Devaney, 2009; Spinney, 2012; Munro & Manful, 2012) have sought to compare policy and practice in children's services in these two countries where child welfare systems encounter similar challenges (Sheehan, Rhoades, & Stanley, 2012) but where contextual differences mean that a solution developed in one country may not work for the other. These similarities and differences offer opportunities for explanation and learning (Stafford, Parton, Vincent, & Smith, 2011). In the UK and Australia, policy recognition of the risks domestic violence poses for children has been stimulated in part by the campaigning work of the Women's Movement but also by analysis of child death reviews which have implicated domestic violence in child homicides (Brandon et al., 2009; Connolly & Doolan, 2007). Thus the service response in both countries is informed by both a gender-based feminist analysis of violence to women and children, as well as a child welfare analysis of concepts of risk and danger.

Increasingly, children's experience of domestic violence is conceptualised by policy initiatives in both the UK and Australia as one aspect of multiple problems in 'troubled' families also characterised by substance misuse and mental health problems (Casey, 2012; Hunter, 2008; White, Warrener, Reeves, & La Valle, 2008). Just as in North America (Edleson, 2004; Jaffe, Crooks, & Wolfe, 2003), child protection services in the UK and Australia have been overwhelmed by the large volume of referrals concerning children exposed to domestic violence (Stanley et al., 2011a; Humphreys 2008). Refining and adopting new approaches to risk assessment and management have been a means of controlling that volume. As prevalence studies (e.g. Walby & Allen, 2004; Radford et al., 2012) begin to expose the full extent of children's experience of domestic violence, risk has become a tool for funnelling and rationing the service response to a widespread and complex social problem.

2. Whose risk?

Perhaps the most contentious issue for risk assessment in the field of domestic violence is the co-existence of an adult victim and a child victim, both of whom have linked but separate needs. The intervention system tends to be organised around a strict binary distinction between victim and perpetrator and different organisations do not always concur about who is at risk (Hunter, Nixon, & Parr, 2010). For specialist domestic violence services, the primary focus of risk assessment is frequently the adult victim and the objective of risk assessment is to secure her safety (in this paper we describe adult victims as female since although men can also be victims of domestic violence, men's abuse of women tends to be more severe and have greater impact, see Hester, 2009; Walby & Allen, 2004). Many independent domestic violence services now include children as a primary focus of their work but some may find it hard to distinguish between the needs of children and the adult victim, advocating the view that mother safety is a guarantee of child safety. Children, when consulted, may sometimes express views which differ from those of their mothers (Øverlien, 2011; Stanley, Miller, & Richardson Foster, 2012).

The police also assess risk with a view to securing the victim's safety but additionally they aim to achieve convictions and their assessment therefore has a dual focus addressing the danger posed by the perpetrator as well as the vulnerability of the victim. For child protection services, the primary focus of concern is the child's safety, and while social workers can struggle to maintain a focus on the child (Laming, 2003), where domestic violence is an issue the attention to the woman as victim is frequently overridden by assessment of her as a parent. Child protection social work is all too often only about mothers (Scourfield, 2003) and social workers' engagement with fathers can be limited (Ashley et al., 2011) with the consequence that the risks posed by the perpetrator retreat into the background (Humphreys, 2007). However, recent evidence from a local UK study suggests that social workers are more likely to include fathers in assessments and interventions when they are known to be violent (Baynes & Holland, 2012). These variations in client focus can result in confusion and clashes of perspectives at those points where agencies need to share information or collaborate. Stanley, Miller, Richardson Foster, and Thomson's (2010) study of police notifications of domestic violence incidents to child protection services in England found that risk assessments undertaken by the police focused on the adult victim and perpetrator to the exclusion of the child:

> *…when you communicate with the family you communicate with the adults generally speaking and you don't communicate with the children, the only time that you communicate with the children generally is when they are suspects…or they're witnesses.* (Specialist Supervising Police Officer 1)

Analysis of police incident records and notification forms in this study revealed that the police positioned children involved in domestic violence incidents on the periphery of their gaze: there was limited evidence of police officers talking to children or making even rudimentary direct assessments of the impact of domestic violence on the child (Richardson Foster, Stanley, Miller, & Thomson, 2012). In consequence, the information that the police communicated to child protection services about children's experience of the incident was patchy and sparse; in some cases the information failed to convey the full extent of a child's involvement in an incident. However, children's social workers participating in this study were found to have limited engagement with the perpetrators of domestic violence. While children and mothers were the focus of social work attention in the majority of the 46 cases studied in depth, engagement with fathers was found in less than two-thirds of these cases and some of this engagement was at a minimal level (Stanley, Miller, Richardson Foster, & Thomson, 2011b).

These variations between agencies with regard to their primary client focus and the depth of their engagement with different family members impact on risk assessment processes and outcomes. Shlonsky, Friend, and Lambert (2007) describe how discourses of victimisation differ between agencies and across time and note that 'Conflict in the home has, ironically, created conflict in the provision of services by agencies charged with different yet overlapping missions' (p. 350). Such differences constitute a major challenge for the development of multi-agency risk assessment tools and procedures and, as we argue later in this paper, recognition of these differences is essential if progress is to be made towards these goals.

3. The information underpinning risk assessment

3.1. Context and timing of information gathering

Risk assessments are only as good as the information that informs them, but different agencies collect and rely on different bodies of information; this information is gathered in varying contexts and different tools are used to sort and structure it. Integrating different data-sets and contrasting sources of information is one of the key arguments for interagency collaboration and communication in the field of child protection, but the extent to which different organisations draw on differently constructed and constituted forms of information is often under-recognised in practice.

Risk assessments undertaken by both child protection services and police are likely to happen in the setting of the home. However, while the police usually attend domestic violence incidents in response to a call for help and at a time of crisis, social workers are less likely to have been invited into the home and the process of risk assessment for child protection purposes is underpinned by the threat of the child's removal. Practitioners from independent domestic violence services are less likely to visit the family home although some may do so. In each situation, very different risks will be exposed. This is exemplified in an analysis of risk assessment data taken from a snapshot of data over a two year period drawn from police and specialist domestic violence agencies in Victoria (KPMG, 2008). This research found that only 2% of 886 cases recorded by the police showed six or more risk factors. By contrast, the data on risk factors drawn from the women's specialist family violence organisations in the same time period showed 34% of women with nine or more risk factors. Clearly, the risks identified at the site of a domestic violence incident may differ from those discussed once women are able to talk confidentially with a trusted advocate. The data highlight the need for on-going information sharing given the dramatic differences in risk assessment which can emerge.

The contrasting data held by different organisations points to another issue, namely that of the time-frame within which risk assessment takes place. Social work managers interviewed for Stanley et al.'s (2010) study of notifications of domestic violence incidents noted the immediacy of the police assessment which was rooted in the incident itself:

> *It's more to them about resolving the problem there and then, the immediate problem isn't it? … if a victim is at risk and the children are at risk they will move heaven and earth to get them into a refuge…* (Child Protection Manager 1)

In contrast, children's services were perceived to take a longer term view and to work at a different pace, collecting information to inform risk assessment and acting to contain risk over time; these differing time-frames could lead to clashes:

> *I sometimes feel that the Police are very disenfranchised with children's social services because they are of the opinion that when they say 'jump' we should say 'how high?' and move and do things but the legislative frameworks that we're in, the systems that we're in don't lend itself to moving quickly, now, now, now, now, unless there's imminent danger and, they don't have a great understanding of that.* (Child Protection Manager 2)

3.2. Risk assessment tools

Risk assessment tools in the domestic violence area have been largely developed from an analysis of data available on adult domestic homicides and serious assault cases (Campbell & Glass, 2013; Richards, Letchford, & Stratton, 2008). By contrast, risk assessment tools such as the Structured Decision Making Tool (CRC, 2012) which take child abuse as the focus for understanding risk, are based on the findings of reviews of child abuse cases or serious case reviews that investigate cases where children's lives have been taken or threatened. While there may be points of commonality, the starting points for assessments are different. There are also differences in whether such tools have been developed as actuarial tools to predict and judge future risk, or whether they were conceived as tools to assist decision-making, based on risk factor analysis but not tested, validated or designed to provide measureable risk assessments.

Moreover, the same risk factors may be interpreted differently by different services. For instance, 'separation' is treated as a heightened risk factor for an actuarial domestic violence risk assessment undertaken by the police, but paradoxically (and problematically) is often seen as the goal of intervention in child protection (Stanley et al., 2011b).

Unsurprisingly, when there is both an adult and a child victim, the tools cannot be easily conflated to tackle the range of risks to both adults and child victims. This is particularly the case when domestic violence constitutes an attack on the mother–child relationship (Humphreys, Thiara, & Skamballis, 2011) and the risks are located in the perpetrator's undermining of this relationship. However, most risk assessment tools will collect information about concurrent problems such as mental health needs or substance abuse in either or both mothers and fathers and such factors will heighten the risks for children. Until recently, all child protection services in England and Wales relied on the ecological framework provided by the Government's Framework for Assessment (Department of Health, Department for Education & Employment, & Home Office, 2000) to assess risk in child protection. The Victorian Risk Assessment Framework (VRF) utilised in Victoria, Australia, constitutes a similar model. Such approaches aim to achieve a multi-factor focus on the child's developmental needs, parenting capacity and the environmental and family factors, but can have the reductive effect of producing lists of strengths and weaknesses under a limited range of headings. Turney, Platt, Selwyn, and Farmer's (2011) review of research on social work assessment argued that the process of analysis applied to the information collected through the Framework for Assessment required strengthening.

The Munro Review (2011) encouraged local authorities in England to consider introducing their own individual tools and models for assessment in child protection but the extent to which new models are being adopted is as yet unknown. In some parts of the UK, child protection services have adopted the Barnardo's Risk Matrix (Bell & McGoren, 2003) as a tool to supplement risk assessment in cases where families are known to be experiencing domestic violence. The Barnardo's Matrix provides a good example of a child-focused, domestic violence framework for organising the information available and classifies children's and family's needs at one of four levels indicating the appropriate service response level. The Matrix differs from risk assessment instruments based on actuarial models since it is designed to inform clinical practice and decision making and takes the child as its focus. However, it has not been subjected to rigorous testing. In Australia, risk assessment tools such as the Victorian Common Risk Assessment Framework (CRAF) are now being developed to address the joint concerns for women and children. Again, this tool is designed as an aid to clinical decision making with the specific purpose of providing a framework to assist multi-agency working.

The Domestic Abuse, Stalking and Harassment and Honour-Based Violence (DASH) risk tool kit is widely used in England and Wales and has three stages comprising a risk assessment checklist for frontline police officers, a fuller risk assessment process to be used by trained specialist staff and a risk management plan (Richards et al., 2008). Humphreys et al. (2005) conducted an in-depth evaluation of the police's SPECCS + tool which preceded the DASH and found that the risk assessment checklist was only one element in the complex process of risk assessment and management undertaken by the police. The development of training, supervision, multi-agency collaboration and the administrative arrangements (data inputting, evidence collection processes, and the attention to the management of risk) were needed to

embed the risk assessment and risk management approach. Problems can occur if tools confer an illusion of science and objectivity that is deceptive. Trujillo and Ross (2008) found that risk assessment among police in Victoria, Australia, attending domestic violence incidents was heavily influenced by victims' expressions of fear despite the use of a risk assessment instrument which placed no emphasis on this factor.

3.3. Sharing information?

Information sharing or transfer is a key aspect of multi-agency risk assessment. Problems in multi-agency communication are traditionally attributed to concerns around confidentiality and freedom of information. In domestic violence work, a failure to keep information secure can also compromise the safety of victims and children who have left an abusive household. Stanley et al.'s (2010) research found that the police and child protection staff had different expectations of when and whether families would be asked to give consent to professionals sharing information or even whether they should be told that information was being shared. If family members are to be informed, the question arises as to which family members are told what; as noted earlier, differences in client focus can make for divergent practice between professionals in this respect.

The question of which information gets shared is also relevant for the quality of risk assessments. Stanley et al. (2010) found that while police in one area consistently passed information about the perpetrator's criminal record on to child protection services, this was not established practice in the other area studied. An analysis of risk assessments and on-going feedback loops between police, child protection and perpetrator programmes in Victoria, Australia, showed little on-going information sharing even when risk levels changed, for example, when men failed to attend programmes, new incidents took place, or there were new child protection concerns (Diemer, Humphreys, Laming, & Smith, 2013). The Australian and UK studies both found variation in some of the basic identifying data conveyed in notification forms such as the child's relationship to the adults present at a domestic violence incident and details of the children's school. Where this distinguishing data was absent or misleading, social workers were required to undertake extensive amounts of work to identify and locate children.

The value of information sharing is also determined by the extent to which staff in one agency understand how information they transfer to another agency might be used. When police officers participating in Stanley et al.'s (2010) study were shown typical examples of information on children conveyed by notification forms completed by their colleagues, most officers expressed surprise at the lack of detail they contained. They described the notifications as “a bit basic”, “very vague”, and “a piece of paper with hardly anything on it”. Most were unaware that this was the only information social workers received about the incident and assumed wrongly that social services would have access to the full report contained on police records.

4. Assessing to or with?

The risk assessment undertaken by independent domestic violence agencies is usually described as ‘safety planning’ and focuses on building a picture of the environmental risks for the individual victim and developing strategies to manage these risks. Safety plans are likely to include such elements as identifying a safe place in case of an attack; keeping a safe list of personal contacts or security measures in the home (Davies, Lyon, & Monti-Catania, 1998). Safety planning is conceived as a collaborative process between the victim and worker that is rooted in the victim's own knowledge of her needs and situation. Although there may be disagreements between practitioners and victims about risk management strategies (Hoyle, 2008), it is essentially a process done ‘with’ victims. The extent to which children are involved in these collaborative discussions alongside their mothers is however unknown, although increasingly group interventions delivered directly to children who have been exposed to domestic violence incorporate aspects of safety planning (see for example, Sharp, Jones, Netto, & Humphreys, 2011). Although there is as yet limited evidence of the efficacy of this approach when implemented in the context of group work with children and young people, process evaluations show that it is utilised to discuss ‘what to do in the case of a violent incident’ (Sharp et al., 2011).

Other forms of risk assessment that rely on professional data and which take place in the aftermath of a domestic violence incident or as part of a child protection investigation often position victims and children more as objects to whom risk assessment is ‘done’. When the issue is the impact of domestic violence on children, the gulf in risk perceptions between professionals and parents may be particularly wide. Describing or classifying abusive behaviour as domestic violence is often only achieved by both victim and perpetrator once the abuse has been disclosed and the behaviour is viewed through the prism of professional intervention or through the viewpoint of another. Acknowledging the damaging impact of domestic violence on children can evoke guilt, shame and resistance in parents (Gorin, 2004; Stanley et al., 2012). Risk assessment or management that attempts to impose acknowledgement on either or both parent(s) of the harm for children implicit in domestic violence can be counterproductive, resulting in evasion and denial. Yet recognition of the ways in which domestic violence can impact on children can also be a powerful motivation to end a relationship or change behaviour (Stanley et al., 2012).

Risk assessment needs to engage with mothers and fathers in different ways. The harm to children will need to be addressed through engaging with women as partners in the assessment. The assessment with men in their role as fathers will need to explore and name the harm that domestic violence imposes on children and avoid collusion in claims that the violence is mutual or minimal (Radford, Blacklock, & Iwi, 2006). Using taxonomies such as those developed by Holden (2003) and McGee (1997) that specify the nature and extent of children's exposure to domestic violence with mothers and fathers separately can build a picture of the child's exposure to domestic violence which may assist this process.

Professional risk assessment often fails to engage with children's perspectives. Eriksson's (2009) qualitative study of Swedish children's experience of intervention by social workers appointed to produce a report for the family law court in cases where there had been domestic violence found social workers differed in their capacity to treat children as partners in the process of risk assessment. There was substantial variation in the extent to which children were provided with the information and feedback they needed to participate in decisions about contact. Cossar, Brandon, and Jordan's (2011) study of the views of children involved in the child protection process noted that children and young people identified risk of harm in the wider contexts of school and the community as well as in the family home and argued that practitioners need to validate and start from the child's concerns and worries rather than taking child protection concerns as the starting point for assessment.

A key challenge for interagency assessment of risk is to retain the perspectives of both parents – these are likely to differ between victim and perpetrator – as well as those of children in the process. Increasingly, advocates are being utilised in part to co-ordinate service delivery but also to represent victims' views in formal interagency meetings. In England and Wales, the Independent Domestic Violence Adviser (IDVA) acts as the victim's representative at multi-agency meetings. She is the primary point of contact for the victim and is usually responsible for co-ordinating risk management. An early evaluation of IDVA services, which work with women at high risk from domestic violence, found that the service, while not directly targeting children, was reported by mothers to have a positive impact on children's safety. At cessation of service, conflict around child contact had improved by 45%; victims' fears of harm to their children had improved by 76% and perpetrators threats to kill children had reduced by 44% (Howarth, Stimpson,

Barran, & Robinson, 2009). Some local UK domestic violence agencies have piloted advocates for children experiencing domestic violence and such initiatives may enable children to have a voice in the process of multi-agency risk assessment.

5. Who is risk assessed and managed and when?

Stanley et al.'s (2010) study of police notifications found a high rate of attrition in families' progress towards a risk management response. Only 15% of cases notified to child protection services by the police received social work assessment and intervention (two-thirds of these were already open cases). Sixty percent of the 184 families notified following a domestic violence incident elicited a 'no further action' response. At the level of police intervention, only 25% of incidents resulted in a referral to a specialist police officer, while 12% were referred to a domestic violence service. A more frequent response was the provision of information (31% of incidents) or referral to a health visitor (30% of incidents — standard practice for families with preschool children in one site). Most families were not therefore receiving a risk management response. A similar picture was provided by an Australian study of attrition following a referral to child protection where domestic violence was an issue (Irwin & Waugh, 2007). Cases were less likely to be substantiated than other notifications, but more likely to be re-notified. A further analysis of child protection data from New South Wales, Australia, showed that from 76,000 notifications where domestic violence was a factor, only 5000 (6.5%) were substantiated and this did not necessarily result in the adult and child victims receiving a service (Wood, 2008).

The question of who receives a risk management response is determined in part by where in the process risk assessment takes place. Multi-Agency Risk Assessment Conferences (MARACs) have been introduced in England and Wales as a means of improving interagency risk assessment and risk management for victims of domestic violence. Representatives from the police, probation, housing, health, child protection and domestic violence services meet to pool information, assess and manage risk. MARACs appear to have been successful at achieving information sharing but these interagency forums for risk assessment are restricted to high-risk victims of domestic violence with most referrals coming from the police (Steel, Blakeborough, & Nicholas, 2011). The focus is the adult victim's safety although they have provided a setting where information about children living with domestic violence can be identified and discussed (Robinson, 2004).

In England and Wales, recognition of the large numbers of families who encounter statutory services but fail to receive any form of intervention has resulted in the development of mechanisms designed to promote intervention at an earlier stage — early intervention in the true sense rather than that which is confined to families with young children. The Common Assessment Framework (CAF) (CWDC, 2009) was introduced in England and Wales to allow a wide range of practitioners including education professionals, community nurses and voluntary sector staff to share information and develop plans of action for children about whom there are concerns but who have not reached the threshold for child protection assessment. The CAF therefore offers an interagency mechanism for assessing risk at a lower level although it adopts the same binary structure of listing strengths and needs across three key domains used in higher level child protection assessments (White, Hall, & Peckover, 2009). Early evaluation of the CAF in Wales found that domestic violence featured regularly in CAF referrals (Pithouse, 2006). Easton, Morris, and Gee's (2010) evaluation across 29 local authorities found that use of the CAF was producing some positive outcomes; these seemed particularly evident in the field of education. Buy-in to the CAF process was variable, perhaps because of the CAF's identity as 'a single, neutral and universally used system that is not 'owned' by one sector or service' (Easton et al., 2010, p. vii). Oliver, Mooney, and Statham's (2010) review of the evidence on integrated working found that the CAF was strengthening and speeding up multi-agency work and was improving the quality and quantity of information collected. In Australia, a small number of pilot programmes have been developed to provide an early response to domestic violence. These programmes focus on the ante-natal period and use a set of risk factors which identify vulnerability to domestic violence: these contrast with risk factors developed from domestic homicide reviews in that they assess for conflict in the relationship, early parenting vulnerability and issues of control emerging in the relationship (Just Families, 2011).

In both the US and Australia, progress has been made in designing online safety assessment tools for women experiencing domestic violence (Glass, Eden, Bloom, & Perrin, 2010). These tools are still in the process of development and testing. Their development is informed by the knowledge that many abused women never access formal services (PSS, 2005) and that early support accessed privately can be helpful. Early results appear promising (Glass et al., 2010).

6. New models of interagency risk assessment

New models of multi-agency risk assessment are emerging that seek to address some of the gaps and dilemmas outlined above. As is often the case with research on multi-agency initiatives, the evidence available on these new approaches is usually in the form of process evaluations rather than outcomes for children and families. However, these new models throw some light on what makes for successful implementation of multi-agency risk assessment.

Multi-Agency Safeguarding Hubs (MASH) are a screening mechanism currently being introduced in many local authorities in England. The MASH model involves the establishment of a multi-agency team usually involving practitioners and administrative staff from child protection services, the police and health, although other agencies such as housing and youth offending services may also contribute staff (King, 2012). Team members have the capacity to collate information from their respective agencies to inform the screening of all referrals of children and families from professionals and the public, so replacing child protection services' previous mono-agency intake systems. Interagency information sharing is freed from concerns about confidentiality and data protection by designating the multi-agency team as a 'sealed intelligence hub' (Golden, Aston, & Durbin, 2011, p 2) where information can be released from different agencies' databases and used to inform risk assessment with protocols covering its dissemination outside the hub. An initial traffic light rating determines the speed at which a referral will be processed. Co-location is a significant feature of this model and of a number of other such models. Early feedback (Home Office, 2013) suggests that the introduction of the MASH has contributed to risk assessment that is sensitive and dynamic with decisions based on information that is timely as well as extensive.

While the MASH model is being introduced as a screening mechanism for all referrals, triage approaches which aim to filter and direct domestic violence referrals, particularly the large volume of notifications received from the police, are developing simultaneously in some local authorities in England. These usually involve practitioners from child protection services, the police and domestic violence agencies with, in some cases, health involvement, pooling information on individuals and families to determine the level of service response required. The Triage model is also being piloted in Victoria, Australia, although the evaluation is currently at an early stage.

The risks posed by abusive fathers are an alternative focus for interagency risk assessment. In Hackney, London, the Domestic Violence Intervention Project (DVIP) has co-located staff in child protection services with the aim of situating specialist expertise in the assessment of domestic violence perpetrators within child protection teams. This represents a move to integrate risk assessment of perpetrators which was previously contracted out to DVIP as a separate agency (see Radford et al., 2006) with child protection assessment of parenting and offers opportunities for building child protection staff's skills and confidence in work with perpetrators through joint work, consultation

and training (Ostrowski & Phillips, 2013). An early process evaluation (Phillips, 2012) indicated that the skills and knowledge acquired through consultation were permeating into other aspects of social workers' practice.

7. Emerging solutions

In this concluding section we draw together the ideas and initiatives discussed above to identify emerging solutions in interagency risk assessment and management of domestic violence. As noted, there are a number of challenges to be overcome, and some of these can be attributed to the funnel effect that occurs when a universal service such as the police generates a high volume of referrals of children exposed to domestic violence for a highly targeted service such as child protection.

In England, Wales and Australia, *multi-agency systems* or structures are increasingly being introduced. These bring professionals from different agencies together to perform risk assessments with the aim of routing children and families to the appropriate level of intervention. While some of these interagency structures, such as MARACs, only assess and manage those cases already identified as 'high risk', others assess and filter referrals at an earlier stage. The MASH teams assess children and families at the child protection threshold while the CAF provides a structure for assessment of need at the level of 'concern' or early intervention. These interagency groups and structures can require considerable resourcing (Holmes, McDermid, Padley, & Soper, 2012) but this may be justifiable if the accuracy of assessments improves as a consequence of the increased amount and spread of information available to inform decisions and if more families receive appropriate, high quality interventions. While there is some evidence of positive outcomes from such systems (Easton et al., 2010), we might be concerned that risk assessment is being prioritised at the expense of risk management since on its own risk assessment does not support families, achieve change or provide interventions for children.

One of the challenges for multi-agency risk assessment lies in developing a *common assessment tool*. Problems arise about whether children's risks are addressed alongside adult risks and the extent to which only the risk of domestic violence is addressed, or whether a broader suite of risks is taken into account. The Barnardo's Risk Assessment Matrix is potentially one of the most promising common risk assessment tools to date with its inclusion of both risks to women and children and attention to a range of thresholds for different forms of risk management and intervention (Bell and McGoran, 2003). However, it has not as yet been rigorously evaluated. The implementation of common risk assessment tools is usually accompanied by *multi-agency training* and this permits learning and development aimed at implementation of the tool as well as appreciation of the rationale for the inclusion of different elements in the assessment fields (Humphreys, 2007).

Community based specialist domestic violence services appear more able to maintain *a balance between the assessment of risk and the delivery of support and advocacy services* to children and families experiencing domestic violence. This is in part because they are not shackled by statutory child protection responsibilities that require all referrals to be screened for risk but also because, to date, the independent domestic violence sector has resisted being co-opted into over-complex assessment frameworks that demand a heavy bureaucracy. As public services shrink, interagency partnerships are developing and extending to embrace the specialist domestic violence sector; the sector will need to decide whether it wishes to retain its own assessment tools and models or adopt those of the statutory sector. Pressure is also mounting for the introduction of 'one door' approaches which emphasise the responsibility of adult services (particularly domestic violence, mental health, housing, and drug and alcohol services) to provide assessment and intervention which is inclusive of children. This family-sensitive approach recognises that many adults accessing services are parents and that their children's needs should not be ignored (Arney & Scott, 2013).

Co-location is increasingly being used as a mechanism for embedding the specialist skills and knowledge of the independent domestic violence sector in statutory services. Banks, Dutch, and Wang's (2008) evaluation of the 'Green Book' initiative implemented in five US states between 2000 and 2005 found that co-location of domestic violence advocates in child welfare teams acted to bridge gaps between systems. Banks et al. (2008) also highlight the value of 'institutional empathy' as an outcome of co-location initiatives and interagency training. 'Institutional empathy' entails an appreciation of the context shaping the work of another agency — in other words, an understanding of professional and agency difference. Professionals need to spend time together working on joint tasks in order to understand the nature of these differences and so bridge them. At the level of interprofessional communication, a recognition that professionals and organisations differ in their client focus and goals is required for practitioners to appreciate how their information will be used by another organisation and to recognise the need to check that the meaning of their communication is received and understood (Reder & Duncan, 2003).

However, strengthening interprofessional collaboration and communication should not exclude the aim *of involving children and women* who experience domestic violence in the process of risk assessment and management. Within the specialist domestic violence sector, safety planning has been a means of developing collaborative conversations about risk. These conversations occur with both women (Pennell & Francis, 2005) and children (Sharp et al., 2011), although there are clearly questions to be asked about the extent to which children are included in safety planning and whether this 'parentifies' children inappropriately. Nevertheless, those who deliver group work for children who have experienced domestic violence (Sharp et al., 2011) have argued that this is a form of preventative and protective behaviour which children who live in situations of adversity appreciate. It chimes with the findings from other research with children living with domestic violence who stated clearly that they wanted to be included in the information and decisions that were being made around them in relation to the violence that they experienced (Stanley et al., 2012).

In conclusion, there is evidence that services in the UK and Australia are beginning to generate solutions to the challenges posed by domestic violence at the interface of child protection services, the police and the independent domestic violence sector. The drive towards multi-agency risk assessment and management has been prompted by an acknowledgement of the scale of the problem that domestic violence represents for children and families, by the recognition that disclosure of domestic violence often takes place outside the child protection arena and by a need to ensure that risk assessment is informed by all available information. Some key obstacles remain to be navigated: these include developing common risk assessment tools, finding means of involving children and victims as partners in the assessment and management of risk and ensuring that a focus on risk assessment does not obscure the need to deliver supportive services to children and families living with domestic violence.

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Melbourne Research Alliance to End Violence Against Women and their Children

Briefing Paper No. 2 on 'Accountability for perpetrators of family violence'

Authors: Cathy Humphreys, Lucy Healey, Kristin Diemer, David Gallant

Accountability for perpetrators of family violence

Relevant to Royal Commission into Family Violence Issues Paper Question 14 & 16

Introduction

This briefing paper addresses a number of issues after outlining some of the overall challenges in developing accountability for perpetrators of family violence. It examines the challenges in gathering evidence and evaluating for perpetrator accountability; it highlights the importance of Women's Support Programs as equal and integral to men's group programs; and it explores specific issues of accountability for Aboriginal perpetrators of family violence (FV) and recommendations relating to these.

We draw from a number of projects in which we have been involved and which are relevant to perpetrator accountability: The *SAFER ARC Linkage project* strand on men who use violence; the *Evaluation of the Family Violence Court Intervention Program, Summary Report*; the PhD by Dr Joanie Smith titled, *Experiences of consequences, accountability and responsibility by men for their violence against women and children*; and the *Fathering Challenges ARC linkage project* which includes a strand on Indigenous programs.

The routes to accountability for perpetrators of family violence are varied and require a wide range of integrated policy and practice developments. Victoria has an advantage over many other states in having comparatively well-developed men's behaviour change programs and partner support services (MBC programs) as well as a peak body (NTV) which provides recognised standards, guidance, resources and training. The courts, child protection and family relationship services are reliant upon these programs to provide a response to men who use violence. The child protection response is also shifting towards focusing on the perpetrator of family violence.

Key Issue

A key issue is that the system of accountability in which men's behaviour change programs and other interventions with men who use violence should be imbedded has few consistent and predictable feedback loops to provide consequences for men who use violence. A second issue concerns the essential role of the Women's Support Service or Partner programs provided within a MBC Program but have often been inappropriately marginalised.

Challenges

- In Victoria, men's behaviour change programs grew out of the community health sector which provided a voluntary route to services. With the development of the Victorian Integrated Family Violence Reform, there has been a greater development of men mandated to attend a MBC program, usually through conditions on intervention orders. Connecting the accountability and consequences for men on MBC programs to the broader intervention system (police, courts, child protection, corrections and women's services) so that they are 'held' within the broader system is critical to the effectiveness of programs.

- Many men are referred to MBC programs from relationship counselling services in the Family Law area and from Child Protection in relation to issues involving their children. At this stage, the programs are only minimally addressing the issues of fathering for men who use violence.

- The MBC programs are overwhelmed with referrals. An immediate and timely response is critical to engage men in a crisis. Not all men are suitable for MBC programs. Exploration of a differentiated response is needed.

- There is no consistency in the consequences of non-attendance/drop out from MBC programs where attendance is mandated by courts or as a condition on an intervention order.

- Drug and alcohol intervention is inappropriately siloed for a large group of men who use violence and who also have problematic drug and alcohol use (see accompanying submission on Alcohol and other drugs).

- The Women's Support Service (Partner Support Program) is an essential feature of MBC programs. Programs are ineffective without this service. The Women's Support Service in Victoria has not been closely connected to the other specialist support services for women living with domestic violence. This siloing is inappropriate and leaves women adrift if their partners or ex-partners withdraw from the MBC program.

- Work with children whose fathers are engaged with MBC programs is undeveloped.

- The evidence base about the effectiveness of MBC programs is limited and still developing. However, the conditions for evaluation (common tools for assessment at commencement and exit of programs; agreement by men to participate in evaluation; availability of follow up data re recidivism; data on attrition; common feedback criteria from women on the women's support service) are not in place for a comprehensive evaluation to occur.

- The role of the informal (friends, relatives, neighbours, community and church/religious) networks which offer support and accountability to women, men and children have been undeveloped and unacknowledged as important aspects of accountability. The development of a web of accountability that includes the formal and informal system is critical to an effective and sustained response to FV.

- The Family Law issues particularly in relation to child contact with perpetrators of abuse have been inappropriately and destructively siloed from the family violence intervention and specifically perpetrator accountability (see accompanying submission on Family Law).

- Intervention with perpetrators of FV should not be only the domain of MBC programs. The development of Child Protection and Family Support workers to intervene and respond to perpetrators of family violence is at an early stage but must be enhanced and sustained. The guidance for child protection workers is available, however training and development is required to support the new guidance and the specialisation of workers in this area. The specific assessment and skills required to work with some (but not all!) men who use violence who are still living with their partners and children is also at an early stage (see accompanying submission on 'responding to children living with FV').

Evidence and Evaluation Issues

Men's Behaviour Change programs (MBC programs)

The Victorian Government and voluntary sector organisations make a considerable investment in MBC programs in Victoria. A problem lies in the difficulty of evaluating these programs to ensure that they respond appropriately and effectively to men referred to these programs as well as to the women referred to partner support (Women's support) programs. Measurement of the success of a program is usually undertaken through process and outcome evaluation.
There have been a number of significant outcome evaluations, both single site evaluations and meta-analyses on the efficacy of MBC Programs (Buttell and Carney, 2008; Cissner and Puffett, 2006; Costello, 2006; Gondolf, 2002; Murray and Graybeal, 2007; Parmar, 2007; Kelly and Westmarland, 2015). These evaluations investigate the impact of attendance, full program completion versus partial completion, program length, counsellor qualities, mandatory attendance, female partner involvement, women's assessment of good outcomes, completion rates and percentages, as well as the efficacy of differing program approaches such as cognitive behavioral approach, ecological community based accountability (Douglass, 2008), Restorative Strengths Perspective (Van Wormer & Bednar, 2002), Narrative approaches (Jenkins, 1990) and Constructivist Approaches (Laming, 2005).

There are a number of important considerations when assessing the merit of the research into MBC programs. Many of the studies have no control group so results cannot be definitively attributed to this intervention (Silvergleid, 2006). There is little agreement regarding how perpetrator characteristics, typologies and demographics impact on program effectiveness (Buttell and Carney, 2008; Huss, 2008). Most studies are plagued by low response rates. Many have short-term follow up with high and selective attrition. These issues distort findings as those who are most likely to drop out are also those who are least likely to change their behaviour (Gondolf, 1997; Laing, 2002).

The major point of agreement in the evaluation field is that robust outcome evaluation is administratively onerous and resource intensive, dependent on access to victims, perpetrators and comprehensive police and court data sets. A number of issues are relevant for setting the ground work for robust evaluation in Victoria. The government in its commissioning would need to support these evaluation requirements through resources, monitoring and regulation.

History of offending and intervention order conditions

The man's previous history of offending, the conditions of the intervention order and the police risk assessment are essential information for both evaluation and counselling intervention purposes. It is recommended that this information is systematically available to program facilitators when men enter a MBC program (Paymar 2002). It is an issue for evaluation (to provide a benchmark about the change process for the man) as well as a program issue of assessment, worker safety, and intervention effectiveness. It is an issue which is more difficult to ensure when a man self-refers but should be available when police, child protection or the courts make a referral.

Non-compliance with court ordered attendance at MBC program

Men ordered to attend MBC programs can miss a number of sessions due to reasonable circumstances, including work and family commitments. However, reasons for non-attendance are self-reported and men are not systematically required to re-attend subsequent programs to make up the sessions previously missed. Accurate monitoring of non-attendance and sanctions is a key element in the evaluation of this

aspect of MBC programs. It is also recommended that breaches or non-compliance with court orders to men's behaviour change programs and the sanction as a result of the breach are systematically recorded and available to evaluators. Men's self-report is not accurate as an evaluation measure in this area.

Compulsory participation in the evaluation

Accurate evaluation data will never be available while the participation in program evaluation is optional for MBC programs or the men participating. Program evaluation is important for ensuring good practice is maintained and encourages a dialogue for program and practice improvement (Partnerships Against Domestic Violence, 2001). It is suggested that the limited confidentiality waiver that participants sign when entering the program is extended to require them to participate in the review of their progress across the program. No effective evaluation of outcomes can occur if only a small proportion of men agree to participate: the data is immediately skewed toward those who are more 'compliant' and presents a distorted view of program outcomes (Day et al, 2009). Voluntary evaluation participation data is largely unusable in providing meaningful evaluation of the effectiveness of program intervention.

Evaluators to be given unencumbered access to monitor programs

The program model is important in terms of safety and accountability and therefore the ability of evaluators to observe the model of MBC group or individual work is an important aspect of evaluation. Previous research (Chung et al 2003 and O'Leary et al 2004 cited in Chung and O'Leary, 2009 p20) points to potential disjuncture between philosophy, explanations and group program practice, which is only illuminated through program observation by the evaluators. It is a standard explicitly written into the UK guidelines in this area that state that monitoring, taping and observation of sessions by evaluators is an accreditation requirement. The men on the program allow access to evaluators as part of the confidentiality waiver that they sign (Respect Accreditation Standard, 2008, B3.4). It is recommended that the Victorian MBC programs also adopt this model.

Partner (former Partner) Follow Up

The proactive engagement of partners and ex-partners in evaluating their experiences of safety and the impact on them of the men's behaviour change program provides significant data on program effectiveness or otherwise. It is only possible when there are close links with, and a well developed partner/ex-partner support program (Gondolf, 2002; Kelly and Westmarland, 2015). The information from women provides an important complement to the police data and men's self report. It is therefore recommended that systematic data be kept on all partner contacts made and attempted and that this information is available to evaluators.

Tracking further offending

Evaluators (or police data analysts) need the ability to track individual cases of men who were participants in men's behaviour change programs to ascertain whether further offending occurred. While arrest and/or intervention orders or police call-outs to domestic violence incidents are a crude measure of recidivism, it has also been established internationally as a standard and objective measure against which program effectiveness can be gauged (Gondolf 2002). Men's self report in this area is not a reliable measure of their desistance or continuance of violence and abuse. Consideration of the process for gaining police data is critical to future evaluation of program outcomes.

Review program changes

The area of intervention with men who use violence is continually changing (Laing and Humphreys, 2013). It is important that Victorian programs keep up to date with new developments in the field and are able to review the impact of changes on their programs. Examples lie with:

- Programs such as the Caledonia Project in Scotland, which provide 'pre-group' 6-8 week sessions to manage both the 'readiness to change' and the long, wait list for groups.
- The development of fathering modules during or following the MBC program) e.g. Caring Dads programs (Scott and Crooks, 2007)
- The development of children's groups
- The development of the work in relation to alcohol and other drugs (see Communicare WA or DVIP, London)
- The developments within Aboriginal healing programs
- Stronger oversight from the Court with reporting of progress (or not) to a judge or magistrate – a model of therapeutic jurisprudence.
- The development of programs that specifically address the response to women who use violence. For this minority group, there are both commonalities and differences with men who use violence.

Women's Support Program (Partner Support)

In this submission, the Women's Support Programs are highlighted to ensure that MBC programs are understood as equal to the men's group program.

The rationale for men's behaviour change programs is consistently cited in the literature as holding a dual focus: the safety of women and children (victims); and increased accountability of men who use violence and desistance of their controlling tactics and violence. Creating a victim focus in men's behaviour change programs requires that (former) partner contact and support is a crucial element of a men's behaviour change program (Gondolf, 2002; Day et al, 2009; Burton and Mullender, 2001). The evaluators of these programs often acknowledge that supporting this involvement may not be straightforward and that while there is a group of women who will not want contact with a family violence intervention service, there is another group who are in transition and crisis, but with helpful persistence will be engaged and highly responsive to support (Chung et al, 2009; Gondolf, 2002; Kelly and Westmarland, 2015). Significantly, research on whether women stay or leave their abusive partners shows that this decision can be highly dependent upon whether the man agreed to attend a men's behaviour change program (Gondolf, 2002). Knowledge and understanding of the MBC and its possibilities and limitations is therefore critical knowledge for women.

An initial analysis of Australian Perpetrator Programs (Keys Young, 1999) found significant variation in partner contact programs. They found that many programs ran the partner contact service poorly and in a perfunctory way. They found that many women were left with little knowledge of their partner's activities and that the man could potentially use his new knowledge against the woman (p. 158). The research by Smith (2013) confirmed many of these findings in the more recent Victorian research.

A number of strategies would address the currently marginalised nature of many partner support programs:

- Governance arrangements that ensure that the Partner Support Program is seen as an equal stakeholder in the MBC program and fully represented at strategic planning meetings.
- Consideration is given to a name change for the 'Partner Support Program'. 'The Women's Safety and Information Service', or 'Women's Safety Program', or 'Women's Support Program' are

suggested. The engagement of women in relation to their needs following an incident of family violence is critical. Most women will not want to be engaged on the basis of their partner's attendance at the MBC program but rather in terms of their own needs – one of which may be knowledge and limitations of the MBC program. The terminology/naming of the program may therefore be a consideration.

- A wider range of engagement strategies for current/former partners could be considered. These could include: active support to the partner contact program by the Applicant Worker or other referrers; on court ordered referrals, the magistrate could provide a stronger context to encourage women to take up the opportunities provided by a 'women's support and information' service.; the Intervention Order application forms could include a statement such as: 'A family violence specialist service will contact you to offer assistance for yourself or your children'.
- Greater flexibility in the service model may be needed. Flexible models for (former) partner support work could be explored and include individual counselling, outreach and group work.
- There is little information regarding the safety of women during and after program completion. Given that the priority for MBC programs is the safety of women and children, further development of this aspect of the Women's Support Program is needed.
- Children's Support at this stage does not reflect the impact of family violence on children in the MBC service delivery and it is recommended that this aspect of MBC programs is explored with a view to further service development.
- The current resourcing of the partner support program does not appear to reflect the significance of support for women's and children's safety.
- The research by Dr Joanie Smith demonstrated that women were much more able to assert themselves and to hold men accountable for abuse or 'slippage' in their behaviour when there was a 'web of accountability' provided by both informal and formal support. More attention needs to be paid to the informal systems of support which can bolster the woman's confidence and provide a much stronger sense of empowerment (Smith, Humphreys and Laming, 2013).

Connections to the wider intervention system

A finding from an interesting strand of research within the MBC literature suggests that programs appear to be more effective, the more tightly they are aligned and supported by other parts of the domestic violence and justice intervention systems (Edleson, 2012; Gondolf, 2002, 2012). To illustrate this point, Gondolf (2002) has coined a phrase "*the system matters*," meaning that program participant retention and accountability increases as MBC programs become more integrated within the wider system involving the police, courts, child protection, women's services, and drug and alcohol counseling. This approach draws from the Duluth approach which consistently emphasizes that MBC programs need to be part of a coordinated community response (Pence & Shepard, 1999) contributing not only to men's accountability but also to community building and safety more generally (Gondolf, 2011).

In response to this injunction to strengthen the effectiveness of MBC programs through tighter collaborative working between organisations involved with the FV intervention (courts, police, child protection, corrections), the SAFER research team used the Community Partnerships and Collaboration Matrix (O'Leary et al, 2004) to survey the extent of tight collaborative working and accountability between MBC programs and referring organisations. The survey indicated that those aspects of collaborative working which were mandated were well developed, while most other areas which were voluntary or relied on 'good practice'

(e.g. feeding back to the referrer about attendance and progress) were poorly developed (see attached paper, Diemer et al, 2015).

Aboriginal specific issues of accountability

For more than two decades it has been widely acknowledged that Australian Aboriginal men are over represented as perpetrators of family violence (Atkinson, 1990; Memmott, Passi, Go-Sam, Thomson, & Sheppard, 2009). Despite this recognition there is still a dearth of research literature that has focused on 'what works' in engaging Aboriginal males in sustainable behavioural change. However, it must be strongly stipulated that whilst this is true in the context of the literature, Aboriginal communities have long added a voice to how 'healing practices' should take place.

Within the literature it is argued that to date, government policy and NGO responses to family violence have had little impact in Aboriginal communities because many initiatives continue to be based on western constructs of family violence and models of intervention (Cheers et al., 2006; Cripps, 2007; Taylor, Cheers, Weetra, & Gentle, 2004). Cox, Young, and Bairnsfather-Scott (2009) state that to provide equitable services, Aboriginal culture must be valued and respected as much as western culture.

Whilst it is beyond the scope of this response to reproduce in depth the stipulated causal reasons for high rates of family violence within Aboriginal communities, it is however important to be reminded and recognise these complexities in the context of engaging Aboriginal men in behavioural change;

- Dispossession of land and traditional culture
- Breakdown of community kinship systems and Aboriginal Law
- Racism and vilification
- Economic exclusion and entrenched poverty
- Alcohol and drug abuse
- The effects of institutionalisation and child removal policies
- Inherent grief and traumas and loss of traditional Aboriginal male roles and stature. (Victorian Indigenous Family Violence Task Force, 2003, p. 11)

Within the growing body of grey literature, there is some evidence to suggest that healing centres and the practice of 'healing' can be a sustainable vehicle to engaging Aboriginal men in behavioural change and taking greater accountability for their actions (Aboriginal Healing Foundation, 2008; Caruana, 2010).

It is argued that "healing is an important concept and practice for Aboriginal and Torres Strait Islander People (KPMG, 2012, p. 4). KPMG (2012) state that "healing is a holistic response to both the causes and symptoms of trauma… healing involves the application of existing cultural knowledge, and the development of new ways to practice this in a contemporary context" (p.6).

Despite the limited published research on Aboriginal men and behavioural change programs there are examples that can be cited (Mals, Howells, Day, & Hall, 2000; Zellerer, 2003). Mals et al. (2000) examined how violence rehabilitation programs in prison could be effectively adapted to meet the needs of incarcerated Australia Aboriginal men. Mals et al. (2000) stated that whilst their findings were largely anecdotal they did provide insight into how programs could be better tailored to overcome barriers to engagement of Aboriginal men in therapeutic programs (Mals et al., 2000). Some of the key themes included:

- The use of all-Aboriginal treatment groups and Aboriginal facilitators or co-facilitators

- Utilise an Aboriginal liaison officer as the first point of contact between the offender and program staff
- Seek consultancy from Aboriginal service providers at the case formulation stage (intake)
- Programs need to be evaluated including collecting feedback from participants.

(Mals et al., 2000, p. 133)

Zellerer (2003) investigated the first Canadian Aboriginal specific family violence program for male prisoners. Several of the key themes highlighted in the research included:

- Aboriginal people believe in an holistic approach that focuses upon healing rather than punishment
- Policies and programs should have a dual focus on accountability and safety within an overall framework of cultural competence
- Programs should combine mainstream or contemporary methods with traditional Aboriginal approaches
- Aboriginal people must be involved in all levels of program development, implementation, and evaluation.

(Zellerer, 2003, p. 187)

Both Mals et al. (2000) and Zellerer (2003) argue that an enhanced knowledge base was required to inform how behavioural change programs can be better targeted to Aboriginal men and their behavioural change needs.

Recommendations relating to Aboriginal specific issues

Adequate funding

- Long term financial commitment from governments is required to support the communities approach to healing and increasing the accountability of Aboriginal men.
- Increased funding is required to support organisations to meet the current and future demand for behavioural change programs for Aboriginal men.

Workforce needs

- A strengthened Aboriginal workforce is required to better inform the design and delivery of programs aimed at changing the behaviour of Aboriginal men.

Program needs

- Increased cultural competency is required in mainstream programs to better meet the needs of Aboriginal men in their behavioural change journey.
- Programs need to be designed to address the impact of personal histories of trauma and abuse.
- An integrated approach to behavioural change is required to promote the engagement of perpetrators across different stages of their change journey. Often programs operate in silos and there is no clear pathway for perpetrators to stay engaged in sustainable behavioural change.
- Attention to drug and alcohol issues and their role in family violence needs to be integrated into the programs.
- Accountability to community and extended family including elders, women and children is a significant practice development which is cultural sensitive and prevents 'men's business' becoming siloed from community and family responsibility (Richardson and Wade, 2010).

Increased collaborative partnerships

- More equitable collaborative partnerships between government agencies, NGO's, and community will promote more informed approaches to increasing accountability and engagement of offenders.

Research

- There is a clear need for independently funded research focused on investigating 'what works' in engaging aboriginal men in sustainable behavioural change.
- Independent program evaluations are required to gain a greater understanding of what works in intervention with Aboriginal men who use violence towards their families.

Opportunities for Policy and Practice

This submission has outlined a range of areas in which policy and practice can be developed to enhance the accountability for men who use violence. The submission has focused on the role of MBC programs and highlighted the following areas for attention:

- The development of the framework for process and outcome evaluation of programs.
- The development of the women's (partner) support programs as services of equal significance to the men's group work program.
- The attention to strategies which 'tighten' the connections between MBC programs and the wider FV intervention system.
- The development of programs which are responsive to the specific circumstances of Aboriginal men.
- The need to continue to flexibly respond to new developments in the field in recognition that the evidence base in this area remains at an early stage.

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Researching collaborative processes in domestic violence perpetrator programs: Benchmarking for situation improvement

Kristin Diemer
School of Social Work, University of Melbourne, Australia

Cathy Humphreys
School of Social Work, University of Melbourne, Australia

Chris Laming
School of Applied Media and Social Sciences, Monash University, Australia

Joanie Smith
School of Applied Media and Social Sciences, Monash University, Australia

Abstract

• *Summary:* This article reports on research undertaken in Victoria, Australia with workers from men's behavior change programs (perpetrator programs) to explore the extent of the collaborative processes established with police, child protection, and other human service organizations. It poses the question: how do regional collaborative arrangements and the pathways to referral reflect the responsiveness of men's behavior change programs to domestic violence service integration? It builds on a strand of research highlighting the significance of the wider domestic violence intervention system in holding men who use violence accountable.

• *Findings:* A research tool was designed around a Practice Matrix to outline different dimensions against which expectations of collaboration could be benchmarked in men's behavior change programs. It was found that at this early stage within the domestic violence reform process in Victoria that the integration of programs within the wider

Corresponding author:
Kristin Diemer, School of Social Work, University of Melbourne, Parkville, Victoria 3010, Australia.
Email: [redacted]

domestic violence sector was relatively undeveloped. The feedback loops between agencies, which enable reporting on attendance, breaches of intervention orders, changes to the risk assessment, and progress at formal review points were relatively undeveloped. However, the formal engagement within domestic violence regional committees and with police was more developed.

• *Application:* Social workers, particularly in the vulnerable children's area provide referrals to men's behavior change programs. Active involvement in feedback, risk assessment review, monitoring for change support the accountability and collaborative effort required to strengthen the effectiveness of men's behavior change and enhance the safety of women and their children.

Keywords
Social work, collaboration, domestic violence, integration, perpetrator programs, reflective practice, social work practice

Introduction

Domestic violence intervention has become an increasing preoccupation of social workers as the links in areas such as child abuse (Överlien & Hydén, 2009; Stanley, Miller, Foster, & Thomson, 2011), mental health (Humphreys & Thiara, 2003), and substance use (Galvani, 2006) come to light. Within this arena, the role of men's behavior change (MBC; perpetrator programs) holds a specific but contested place. It is frequently pointed out that social workers, particularly in the children's area, are reluctant to work with men who use violence (Baynes & Holland, 2012). In addition, there is little investment in the skills development and safety context required for effective work. Group work programs for perpetrators of domestic violence are slowly developing and to some extent, respond to this gap. In particular, programs which accept community referrals (rather than court-ordered) provide a referral avenue for assessment and intervention where there are concerns about the safety of women and their children (Coy, Kelly, & Foord, 2009; Saunders, 2008).

This article reports on a project researching MBC programs in Victoria, Australia which had been provided with new funds to enhance their programs and improve collaboration and accountability with the wider domestic violence sector. The project is applied research that has been designed to provide evidence of strengthened collaboration to support practice change. It has the dual purpose of both researching the MBC programs to provide a benchmark against which they can measure situation improvement, as well as providing both the funders and the programs with a tool through which they can distill the dimensions of collaborative work.

The article begins with a discussion of terminology given the different language used internationally, before turning to the relevant literature on MBC programs. The methodology sets out the context and research design prior to the analysis and

discussion of two dimensions of a matrix against which collaborative developments were benchmarked.

Terminology issues

The language in the domestic violence area varies across discourses and between countries. We have chosen to use the term ''domestic violence'' rather than ''intimate partner violence,'' ''domestic abuse,'' or ''family violence.'' In writing for an international audience, the term ''domestic violence'' is more commonly used, particularly by those who hold a gendered understanding of the patterns of violence in domestic relationships. When talking about perpetrators of domestic violence, we therefore refer to ''men'' to reflect the gendered pattern, but recognize that some women are also perpetrators of violence and abuse (Diemer, 2012; Laming, 2008).

There are similar issues when referring to ''batterer programs,'' ''perpetrator programs,'' or ''men's behavior change programs.'' We have mostly used the latter given that it is the terminology used in Australia and we think, helpfully focuses on the behavior, extending it beyond physical battering without disregarding the abusive beliefs and attitudes that inform it (Wheeler, 2005).

Relevant literature

The contested nature of the effectiveness of MBC programs is a possible reason for the slow development of this intervention. Men's behavior change programs have burgeoned in Australia and internationally (Day, O'Leary, Chung, & Justo, 2009; Gondolf, 2002). These programs aim to educate men in their responsibility for their violence and change their abusive behavior toward women (Gondolf, 2002, 2012; Laming, 2008; Silvergleid & Mankowski, 2006). Victim and child safety is regarded as the cornerstone of MBC programs, particularly those which draw from the Duluth models of intervention (Gondolf, 2011; Wheeler, 2005). Concurrent with the rise in these programs has been a plethora of literature about the effectiveness of MBC programs.

However, program evaluations highlight the complexity of measuring program effectiveness (Gondolf, 2002, 2012). The success of any MBC program evaluation relies on documenting both the *process* (context, key practices, performance standards, and collaboration between the criminal, civil justice systems, and the human service systems (Strategic Partners, 2004) in relation to program *outcomes* (Gondolf, 2008; Wheeler, 2005). A process evaluation can effectively illustrate system processes including the effectiveness of agencies working together to establish a coherent, accountable, and safe program (Chung & O'Leary, 2009). It can be the precursor to an outcome evaluation when programs are in the early stage of development and when the high level of resources and cooperation between organizations about data systems and permission needed to measure issues such as

recidivism and re-referral are still being negotiated (Gondolf, 2002; Hendricks, Werner, Shipway, & Turinetti, 2006; Morran, 2011).

A finding from an interesting strand of research within the MBC literature suggests that programs appear to be more effective, the more tightly they are aligned and supported by other parts of the domestic violence and justice intervention systems (Edleson, 2012; Gondolf, 2002, 2012). To illustrate this point, Gondolf (2002) has coined a phrase ''the system matters,'' meaning that program participant retention and accountability increases as MBC programs become more integrated within the wider system involving the police, courts, child protection, women's services, and drug and alcohol counseling. This approach draws from the Duluth approach which consistently emphasizes that MBC programs need to be part of a coordinated community response (Pence & Shepard, 1999) contributing not only to men's accountability but also to community building and safety more generally (Gondolf, 2011). In England, the development of multiagency risk assessment panels (MARACS) has provided a different, but related initiative in drawing together tighter multiagency networks to which perpetrator programs contribute (Robinson, 2006). This line of argument also concludes a major summary of research and effectiveness of ''batterer programs'':

> . . .the integration of abuser, survivor, and criminal justice interventions within each community may provide the key to the most effective interventions. (Saunders, 2008, p. 166)

Evaluating the effectiveness of coordinated responses through multiagency partnerships has been mixed and fraught with methodological difficulties (Gondolf, 2012; Javdani, Allen, Todd, & Anderson, 2011). Studies in the United Kingdom of multiagency forums (Hague, 1999) and of Domestic Violence Coordinating Councils in a Mid-Western state in the US (Allen, 2006; Javdani et al., 2011) show that effectiveness needs to be measured across different dimensions and, not surprisingly, there is a significant variation between the regional coordinating bodies. This too applies to MBC programs. Following a major Australia wide audit and process evaluation of MBC programs which also showed significant (and concerning) variation between states and individual programs, a matrix to guide collaborative practice was developed (O'Leary, Chung, & Zannettino, 2004). It was clear that in spite of the development of practice standards (Respect, 2012; Wheeler, 2005), many programs paid little attention to collaborative practice development. The researchers (O'Leary et al., 2004) argued strongly that without strategic, regional level partnerships, it is difficult to situate a coordinated, operational response to men who use violence. This analysis is supported by examples of multiagency working in which policy and practice to support survivors appear to be strengthened by multiagency partnerships (Hester & Westmarland, 2005; Robinson, 2006).

A further hotly contested issue within the MBC literature lies in the ''voluntary'' versus mandated referral into programs. Arguments abound about whether MBC

programs which are not within a criminal justice system, where men are mandated to attend programs, can still be feminist informed (Flood & Pease, 2009). There are, on the one hand, a number of arguments that have led to the continuation of nonmandated programs (Rees & Rivett, 2005). These arguments include: support for an earlier intervention model where men attend programs prior to justice involvement; requests from women who do not wish to pursue (or are not supported well enough to pursue) criminal charges; concern for mandated systems where the consequences for noncompliance are poorly policed and inadequately supported (California State Auditor, 2006); a view that acceptance of responsibility for violence and subsequent rehabilitation is better supported through ''voluntary'' engagement; ambiguous evidence of the effectiveness of mandated programs (Smedslund, Dalsbø, Steiro, Winsvold, & Clench-Aas, 2007); and the view that any opportunity to expose men, within groups, to gendered perspectives on their violence and abuse toward women and children is useful for engaging men who otherwise are not challenged about their behavior and values (Gregory & Erez, 2002; Silvergleid & Mankowski, 2006).

On the other hand, there are many who have great concerns about whether a coordinated community response, as developed within the Duluth model (Pence & Shepard, 1999), can be effective in a service system where domestic violence may not lead to a criminal conviction and where men are not mandated to attend a MBC program (Chung, O'Leary, & Zannettino, 2003; Holder, 1999; O'Leary et al., 2004).

This debate about voluntary versus court mandated referrals into programs lies as a backdrop to this article as referral practice frames the collaborative processes and information sharing protocols. Victoria has adopted a ''hybrid'' model where some men ''self-refer'' (including social pressure) into MBC programs; others are referred as a condition to a court order; and there are two specialist mandated court programs.

Methodology

A research design, cognizant of the complexities outlined in the literature review was developed by the authors with attention to the specific context and setting, the research participants, the issues for data collection, ethical approval, and data analysis.

Research setting and context

Internationally and nationally in Australia, domestic violence is pervasive and a clearly identified gendered social issue (Walby & Allen, 2004). In response, all Australian States and Territories have sought to reform government funded domestic violence strategies to introduce cross-departmental, integrated service system approaches to better meet the demands and needs of victims and perpetrators (Commonwealth of Australia, 2009; Murray & Powell, 2011). In Victoria,

a whole of government domestic violence reform was established to make a concerted effort to tighten the coordination and intervention between Victoria Police; the Departments of Human Services, Justice, and Planning; and Community Development (Victoria Police, 2010; Wilcox, 2010).

As part of the overall state-wide plan (Office of Women's Policy, 2005), community services in receipt of government funds were expected to become part of an integrated, whole of government, response defined as requiring:

> . . . agencies to decide on and articulate common goals and agree on ways to pursue those goals. Integration of services is more than co-ordinated service delivery – it is a whole new service. Co-location of agencies, agreed protocols and codes of practice, joint service delivery, agencies reconstituting or realigning their core business to confront the challenges posed by a broadened conception of the problem: these are the key indicators of an integrated response. (Domestic Violence Resource Centre Victoria as cited in Office of Women's Policy, 2005, p. 18)

For MBC programs, integration into the wider domestic violence service sector began with an offer of new government funds to programs forming partnership agreements with a range of organizations enabling greater safety for women and tighter accountability for perpetrators. The expectation was that the current Victorian MBC programs, evolving from a varied collection of models and practitioner experience broadly concerned with helping men to stop using violence, could develop a more integrated response in conjunction with courts, police and domestic violence services.

Framing the MBC program models in Victoria is the *No To Violence* (NTV) peak body providing feminist informed minimum standards for programs working with violent men (Wheeler, 2005). A condition of the new funding was that MBC programs would adhere to NTV minimum standards. It is a model which has elements in common with UK accreditation model (Respect, 2012).

In developing this project within overarching research into the Victorian domestic violence reform program, a stance was taken that most of the MBC projects were too early in their development and too diverse in their approach to provide meaningful outcome data, particularly given the requirements needed for an accurate evaluation (Gondolf, 2012). Instead, appreciative inquiry principles were broadly adopted (Bellinger & Elliott, 2011; Carter, Cummings, & Cooper, 2007) to examine the processes through which collaborative relationships were developing between MBC programs and the wider domestic violence sector. The appreciative inquiry principles include a shared acknowledgement of strengths which can be used to build situation improvement in an area where change is needed. The literature suggests that system processes are a significant part of the framework for establishing an effective collaborative approach to multiagency working with MBC programs (Horwath & Morrison, 2007; Wilcox, 2010).

The guiding question for the research was: Where and how are MBC programs involved within their regional integrated domestic violence service system?

Specifically, how do the regional collaborative arrangements and the pathways to referral reflect the responsiveness of MBC programs to domestic violence service integration? This research provides a benchmark for an early stage of the reform process from the perspective of MBC program workers and is part of a larger project examining different aspects of the Victorian integrated domestic violence reform.

A Continuum Matrix of structures, processes, and practices for developing integrated responses to domestic violence for Moving Good Practice Forward (O'Leary et al., 2004) was used as a framework to structure an online questionnaire for surveying all 29 MBC programs funded under the reform initiative. The final questionnaire was developed with a project reference group and MBC program managers.

While the *Continuum Matrix* (the Matrix) was not used to formulate Victorian government policy or the NTV minimum standards, the core principles of both are reflected within the Matrix. The full Matrix contains seven key areas guiding good practice (O'Leary et al., 2004) and this article focuses on the two areas surrounding the steps for building an integrative service program:

1. Community partnerships/collaboration and organizational structure.
2. Pathways to programs.

Building on the premise that a framework of good practice principles provides a structure for building collaborative practice, the Matrix provides three column headings including: ''Unacceptable form'' (potentially unsafe practices), ''Minimum form,'' and ''Optimal form.'' The ideal program practices are presented in the ''Optimal form'' column and identified as something to aim for over time. While called ''a continuum,'' this tends to be a heuristic device through which a number of practices which are ''unacceptable,'' ''minimum,'' or ''optimal'' are listed in each column. ''Unacceptable form'' and ''Minimum form'' identify practices which could be enhanced by deeper cross-sector links. In the absence of standardized practices guidelines for collaboration, the Matrix was seen as a useful model in which to locate MBC programs at the early stages of integration and provide a baseline for comparison as the programs evolve.

Participants and data collection

A survey of the 29 MBC programs funded under the state reform initiative was designed as a two-part process: once at an early stage of integrative processes, followed by a second round when collaborative practices had the opportunity to be embedded. Questions were developed to elicit information about where an agency would sit in relation to the elements within the Matrix and in line with NTV minimum standards for practice.

Information was gathered quantitatively through an online questionnaire containing both closed- and open-ended questions with ample space for participants to qualify their responses. The first survey was undertaken at the end of 2008 (the second year of targeted state government funding) and a follow-up survey planned to provide later comparative data against which situation improvement could be measured. This article reports the results of the first-stage questionnaire.

Access to the survey was delivered through an email link to the nominated managers or coordinators of the MBC programs. The survey was designed so that one form was completed for each program, and multiple workers in the program could contribute. The methodology replicates the collaborative practice espoused by MBC programs whereby the program managers, group facilitators, and partner contact workers regularly share information in relation to practice principles, safety, and accountability issues. The data collection process also meant that the operational questions could be appropriately answered by front line workers, while the strategic questions could be responded to by the managers. Confidentiality was maintained in that agency responses were only visible to practitioners from the same agency and involvement was facilitated by program managers.

At the end of the survey period, individual agencies received a report of their own responses but not those of other agencies. An overall summary report (de-identified) was provided back to the participating MBC programs and government, as well as the wider domestic violence sector through regional workshops. Through this dissemination process, a tool (the Matrix) plus evidence was provided to MBC programs with a view to building a continuous improvement model for coordinated, collaborative processes.

Data analysis

Data from the questionnaires were downloaded into Excel for the purpose of generating simple graphs and tables portraying the results. Qualitative comments were also extracted from the questionnaires. This mixed-method approach (Tashakkori & Teddlie, 2003) provided a picture of both patterns and meaning in the data which was used to highlight important details and differences between programs. The qualitative data provided evidence of the way in which different programs interpreted and positioned themselves on the Matrix.

Results

Across the 29 agencies eligible to participate, 26 were actively delivering programs and could fully participate in the survey. Programs had been in existence for between one to 23 years with an average of 10 years in operation; however, the funding and contractual arrangements with government under the Victorian Domestic Violence Integrated Reform were recent. There was a 100% response from those programs eligible to be involved.

Community partnerships and collaboration

The first dimension analyzed was the extent of community partnerships and collaboration, with a specific focus on police and human service organizations. A matrix against which organizational responses could be plotted is outlined in Table 1. Elements illustrating clear partnerships and collaborative processes are listed in the right column and those where partnerships are yet to be developed in the left column. The number of programs identifying practices within a particular domain are identified by asterisks (*) in each table cell. Three asterisks (***) indicate that more than half of the programs had implemented a process and a single asterisk (*) represents fewer than five programs.

A number of issues stand out when analyzing Table 1. It is clear that collaborative work between MBC programs and other organizations is at an early stage and that development is uneven. Some individual programs have developed wider community partnerships ahead of others and readily identify practices in the Minimum and Optimal columns. Additionally, some collaborative processes (both general and specific to MBC programs) were imposed on the sector by government, including establishment of cross-sector regional interdepartmental domestic violence committees; multiagency representation on cross-sector regional interdepartmental domestic violence committees; and formalized processes for police referrals to service providers in cases of domestic violence. These initiatives push service providers actively to liaise with one another and are reflected in Table 1 where greater progress has been made. At the time of the survey, more than half of the MBC programs did have formal links with police for referrals into the program, including Memorandums of Understanding (MoUs) (17 programs; Table 1, column 3), thus leading Police to become a primary referral point into many MBC programs.

While few MBC programs had *formal links with other service sectors* (Table 1, columns 1 and 2), nearly all programs were represented on a *domestic violence multi-agency steering committee* (Table 1, column 3). These committees were imposed upon the sector at the initial stages of state-wide system reform. Therefore, most MBC programs are able to report that senior management is represented on a domestic violence multiagency steering committee.

A further, obvious step for MBC programs would be to formalize links and referral processes with local services supporting women and children, in addition to courts and police. These external formalized links across the service sector have not evolved into actual practice for most agencies (Table 1, particularly column 1). Although specifically funded to provide services for (ex)partners, few programs had established formal links with women's or children's services, health services, child protection, or corrections; each of which could enable accountability checks on the men's circumstances, assist with (ex)partner contact support, and enhance the safety of women and children. Only one in 10 (12%) programs identified that they *regularly* consulted with programs external to the MBC program and

Table 1. Community partnerships and collaboration (O'Leary et al., 2004).

Unacceptable form Column 1	Minimum form Column 2	Optimum form Column 3
No formal links with women's services.***	Memorandum of Understanding for referral and accountability process with key women's services.*	Senior management participation on a representative steering committee that guides the program as one component of a community response to domestic violence.***
No formal links with child protection, corrections, or health services. Use of ad hoc referral processes with no formal processes for follow-up or evaluation.***	Formal protocols for referring clients from other agencies (limited confidentiality).** Established relationship for referral of clients to other agencies.*	Memorandum of Understanding for referral of clients from statutory authorities (corrections, courts, child protection).*
No formal links with police and use of ad hoc referral processes without formal processes for follow-up or evaluation.**	Protocols established for mandatory notifications and reports of breaches to statutory authority.**	Memorandum of Understanding for referral of clients from Police.***
No designated staff member for leadership of men's domestic violence program (problem at two rural agencies unable to recruit qualified staff).*	Designated coordinator of men's domestic violence program.***	Coordinator of men's domestic violence program as part of the management structure.*

***:14 or more programs (more than half); **: more than five programs but less than 14 programs; *: five or fewer programs; X: not measured.

(ex)partner contact workers although over half (56%) indicated that external consultation *sometimes* occurred.

Another avenue for building collaborative relationships lies within the organization where the MBC programs are situated as they often provide a range of social and health services. Involving the MBC coordinator within the internal management structure of the organization (Table 1, column 3) may increase understanding of domestic violence within co-located services, encourage other services to refer men into the MBC program, and better support men who might be presenting across services (e.g., drug and alcohol, relationship or generalist counseling, and financial planning). At the time of the survey, few MBC programs reported that they were represented within the host organization's management structure and cross referral was a rare occurrence.

In order to maintain and further develop on-going collaboration, agencies are encouraged to formalize their relationships and agreements through Memorandums of Understanding (MoUs), an important initiative arising from the original Duluth models of community collaboration (Table 1, column 2). Pence and Shephard (1999) emphasized the value of written policies and procedures in establishing minimum standards to reduce individualized ad hoc practice. Formal MoUs are generally achieved in one of two ways, either through state mandate, which may bring agencies together who have not previously worked together, and which "force" relationship building; or through gradual, informal relationship building leading to more formal collaboration over time. Victoria has chosen the second route. That is, structural forms such as regional domestic violence committees are mandated while formalizing relationships through MoUs is encouraged but not mandated. Across the MBC programs, at the time surveyed, most of the formal MoUs were between MBC programs and the police and applied to referring men into MBC programs. Fewer than five programs had formalized agreements with other agencies/services.

Pathways to programs

The most controversial element in the current framework and funding for MBC programs in Victoria lies in the ways in which men enter the program. The Matrix in Table 2 outlines processes by which men come to be involved in the programs including referral pathways, assessment, screening, procedures for (ex)partner contact, and some elements of program structure (which may limit attendance). Program structure was not analyzed in this project, so elements such as details of contractual processes and group size were not measured, nor was there an audit of domestic violence-related history through court and police records.

From the summary provided in Table 2, it is immediately obvious that most programs receive men into the program through self-referral or social mandate (Table 2, Column 1) which is considered *unacceptable form*: an issue addressed in the later discussion. As mentioned earlier, historically the Victorian MBC programs have relied on a *voluntary* referral system working with a method of change built on willing engagement rather than coercion. At the time of survey, two

Table 2. Pathways to programs (O'Leary et al., 2004).

Unacceptable form Column 1	Minimum form Column 2	Optimum form Column 3
No established referral and assessment pathway. Clients are recorded as self-referral which includes clients who seek involvement in a program due to social pressure or social mandate.***	Direct formalized process of referral from statutory agencies (e.g., police courts, corrections, child protection) which does not rely on the man deciding the appropriateness of referral. Police = ***; other agencies = *	Referrals from all agencies (statutory and nonstatutory) have formalized processes of follow-up, monitoring and evaluation. (ensures agencies actively engage with the program when referring)*
No individual assessment prior to group entry.*	Established assessment process for men entering ongoing group programs to ensure basic understanding of core concepts.***	
No written contract with the man about program requirements.*	Written contract detailing program requirements such as (ex)partner contact, limited confidentiality, attendance, nonintoxication, behavior, no use of violence, consequences for noncompliance X	Contact with (ex)partner as appropriate for the assessment process.*** Audit of man's domestic violence-related civil and criminal history, through man's consent to release of such information. X
No formal limit to maximum number of participants. X	Group programs limited to 12 participants – Maximum. X	

***: 14 or more programs (more than half); **: more than five programs but less than 14 programs; *: five or fewer programs; X: not measured.

programs were piloting mandated court ordered attendance and subject to their own evaluation and hence are not included in this data set. However, some magistrates in courts outside those associated with the mandated court programs list attendance in a MBC program as a condition of a civil protection, or community-based order (Table 2, Column 2). In these situations "court directed" participants can attend MBC programs alongside self-referred participants.

With primary referral practices being self-referral or social mandate, most programs implement screening processes and contracts with the men to ensure clear understanding of the program and intended outcomes, as well as screening out clients deemed to be inappropriate referrals (Table 2 columns 1 and 2). Screening out potential clients is another contentious issue, but part of what was deemed safe practice at the time of the survey.

In a voluntary/socially mandated system of MBC programs, it is often fear of losing a partner or access to children which is the driver of self-referral (see discussion below). Therefore, it also makes sense that the (ex)partner is provided with feedback on his progress and can be a monitoring point for his on-going behavior change if she chooses to engage in this process. A Duluth-based system of MBC programs identifies that the (ex)partner is the primary point for follow-up, feedback, and accountability (Paymar, 2000). In the results from this survey, it was the case that more than half of the programs ensured they made reasonable attempts to contact the (ex)partner in order to give her the opportunity to provide feedback (Table 2, Column 3). Conversely, when men were more formally referred into a program, few had established follow-up and feedback processes with the referring agency, usually being the police and court (Table 2, Column 3).

Formalized collaborative processes for follow-up, monitoring and evaluation

As evidenced above, a system of on-going collaboration between the MBC program and the referring agency is in early stages of development across the sector (Table 2, Column 3) and yet, has been identified as essential for supporting effective long-term intervention with men who use violence against women and children (Gondolf, 2002). Taking active referrals, providing feedback to the referrer on the back of obtaining authorization for release of information are all part of a system's network which consistently builds accountability for men who use violence.

The next element to measure, when assessing practice improvement in agency collaboration, is to examine information sharing processes. Programs were asked specifically about the information and level of feedback with the civil and criminal justice system separate to social services.

As illustrated in Figure 1, a majority of programs provide regular feedback from the MBC programs to courts and community corrections offices, but this primarily centers on administrative details of attendance. Feedback to the police occurs less often and on an ad hoc basis, but is more likely to focus on safety risks rather than program attendance. A detailed risk assessment is rarely provided to any of the justice-based referring bodies (Figure 1). Some survey participants further explained their feedback process as follows:

> *The letter to court is usually requested by the client [and] would cover a brief description of issues identified by the client, engagement in treatment and agency level of commitment to continue working with the client*. (agency id 10)

> *[We provide feedback] when asked directly from police officers on Duty*. (agency id 15)

> *[T]he referrals from police are voluntary, and feedback to police made with clients' consent*. (agency id 6)

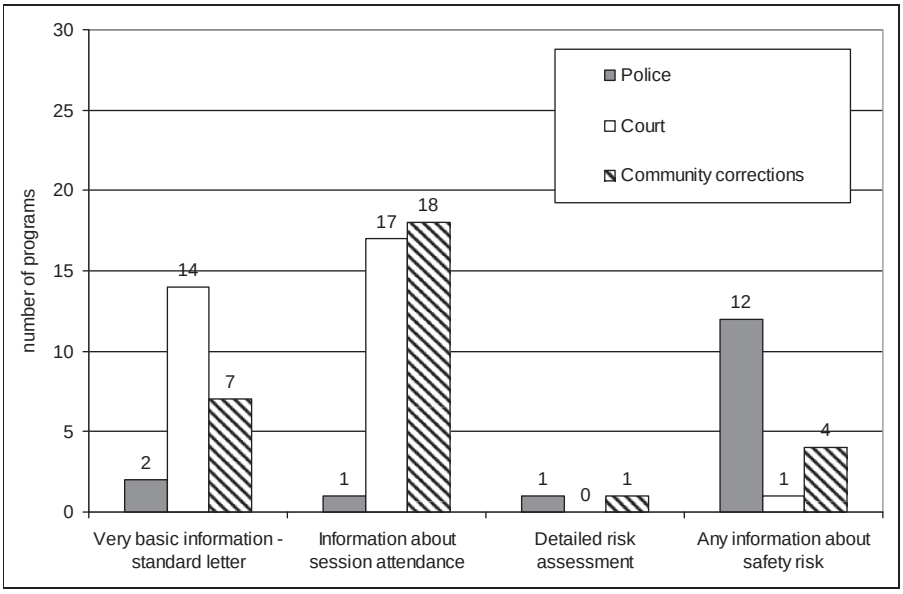

Figure 1. Formalized feedback processes in place with police, courts, and corrections (based on 26 agencies, multiple responses accepted).

Enhancing the feedback process may readily improve justice system referral as identified in a local evaluation of domestic violence networks where police officers reported they were more engaged when informed about referral outcomes (Crinall & Laming, 2005).

MBC programs are less likely to provide feedback to noncorrectional-based social services such as the Department of Human Services (DHS), women's domestic violence agencies, and child protection (Figure 2). The information on session attendance is more often provided to DHS and child protection in relation to compliance with child protection orders, but not generally to women's services. However, when Domestic Violence agencies did receive information it was usually related to risk and safety rather than program attendance.

About one-third of programs routinely provide risk-related information to all agencies and while workers spoke about a willingness to share information they indicated it would only occur if the client of the MBC program signed an agreement to share the information as explained by some workers below:

> *At times it can be difficult to work cooperatively with other agencies whilst being restricted by the man's right of confidentiality*. (agency id 7)

> *Information is provided where there are risk issues, where joint work is occurring on a case, [and] where it benefits all clients at risk to do this*. (agency id 23)

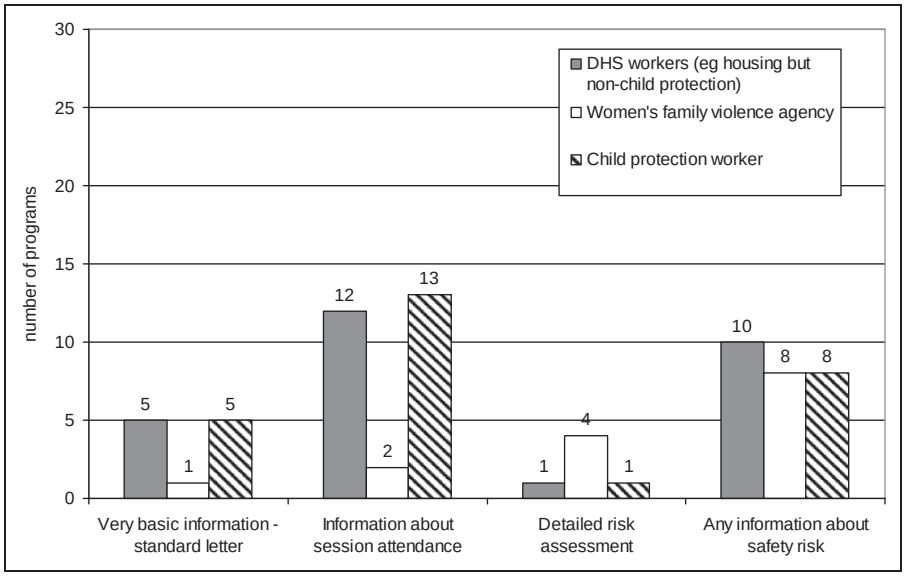

Figure 2. Formalized feedback processes in place with the Department of Human Services, women's DV agencies, and child protection (based on 26 agencies, multiple responses accepted).

Collaborative practice and (ex)partner contact

The guidelines for practice under the Victorian funding model and NTV standards identify regular (ex)partner contact as a minimum standard; however, survey responses demonstrate variability of practice in this area.

Most of the programs meet the basic requirements expected internationally for women's support (partner) services. This is namely that a man entering a MBC program is informed that his (ex)partner will be contacted and signs an agreement both acknowledging this and providing appropriate contact details (Figure 3).

A primary weakness of the women's support program, and subsequently the effectiveness of this measure of accountability, and ultimately a primary risk to her safety is the variability in regularity and frequency of contact across the programs. For example: two of the 26 programs reported that men were encouraged to provide (ex)partner contact details, but it was not required prior to commencing the program and in more than two-fifths of the programs (46%), it was not mandatory for participants to report new relationships while participating in the MBC program (Figure 3).

Additionally, two-thirds (n=17) of programs did not have formalized procedures in place for group facilitators or women's support workers who become aware that a man in the program had breached an intervention order or committed another crime. For those programs that did have formal agreements to

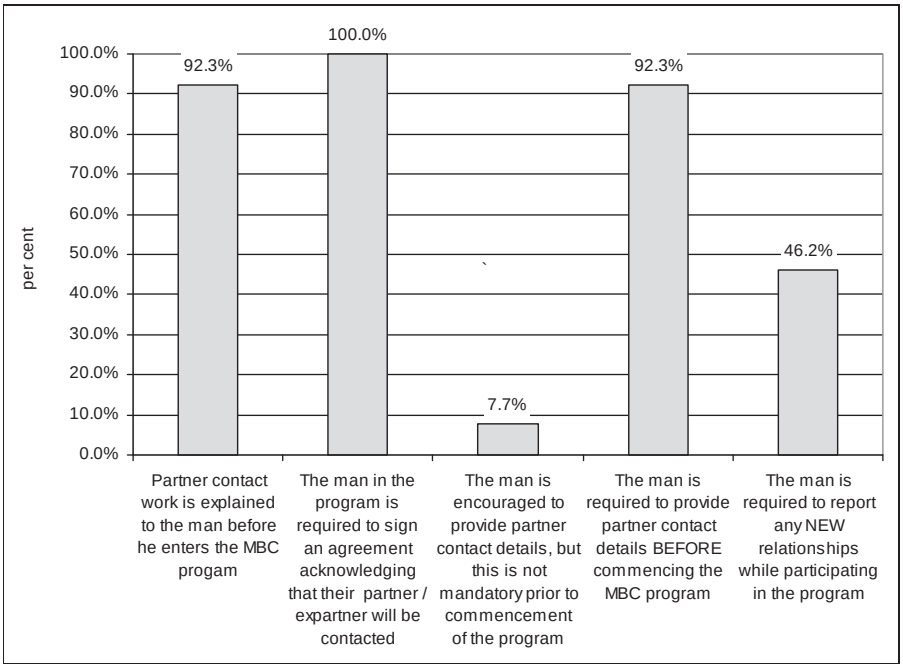

Figure 3. Is there an established process to ensure basic understanding of (ex)partner contact work prior to a man entering the MBC program? (based on 26 agencies, multiple responses accepted).

report breaches, but not MoUs, it was usually through a voluntary compliance agreement.

> *Men sign a participation consent form that states they agree to limited confidentiality and that breaches are expected to be reported by themselves or otherwise by program staff.* (agency id 07)

In short, the results from this initial survey indicate that there are some positive collaborative practices developing in the early stages of the funded program, however where collaboration and feedback mechanisms are weakest there exists potentially large gaps in accountability and consequences for men who use violence with increased risk of continuation of abusive behaviors.

Discussion

The orientating question for the research demanded an exploration of the extent to which MBC programs in this sample are integrated into the domestic violence intervention system. The exploration goes beyond "participation at regional forums" to look more closely at two dimensions of collaborative practice which

create a tighter system of accountability for men who use violence and abuse toward their (ex)partners and their children. The Continuum Matrix for Practice Improvement was used to provide a framework for research and a benchmark against which MBC programs and their regional forums could measure their collaborative development, as well as a guide to services about the different dimensions expected in a more intensive collaborative effort.

Initial results show early stage development, yet relatively poor collaborative processes between MBC programs and other sectors. This situation might be expected in the early reform stages and where funding has only recently been provided to programs, many of which have evolved separately from the wider domestic violence intervention system, often from a different philosophical basis. It can be argued that it is not necessarily lack of willingness which precludes collaborative practice development but a system lacking mentoring opportunity, resourcing, and advanced understanding of the expectations of good practice models which demand tight system and community accountability. Significant debate occurs about the level of funding required for tighter case management and referral feedback. However, the minimum practice guidelines, to which most programs subscribe, and which pre-date recent funding agreements, support, and expect collaborative working.

While the number of responses which currently fall into ''unacceptable practice'' as defined by O'Leary et al. (2004) gives rise to considerable concern, there are some indications that stronger collaborative models are being developed. Often inhibiting collaboration is a lack of understanding of legitimate information sharing protocols in the face of privacy legislation mixed with the need to protect vulnerable populations: an issue for which the Victorian Privacy Commissioner has now created clearer guidelines (Office of Women's Policy, 2010).

The results of the survey also invite a discussion about whether self-referral to a program is an acceptable practice. The Matrix firmly denotes this as an unacceptable practice (O'Leary et al., 2004) though it does not necessarily mean that all programs must involve men mandated by the court. A strong social mandate can be provided through the consequences of abuse, namely a partner's threat to leave, or restricted child contact (Laming & Fontana, 2008; O'Leary et al., 2004). This social mandate can be supported through the development of formal referral processes to include reciprocal information sharing between police, child protection, women's services, or probation. This would ensure greater accountability and strengthened risk management processes. Feedback loops between agencies enable reporting on attendance, breaches of intervention orders, changes to the risk assessment, and progress at formal review points on such dimensions as the man's acknowledgement of responsibility and empathy. Essentially, it means that there is a witness to the man's change (or lack of change) process. Information sharing at this level, outside court ordered processes, will often require formal agreements and consent at the point of intake. At this stage in the evolution of collaborative practice, there were only isolated cases where tight feedback loops had been developed.

While not minimizing contact with (ex)partners as vital for documenting the behavior change process, lack of other formal sources of information leave the majority of responsibility for feedback about men's behavior with the (ex)partner who is also the victim. Many (ex)partners do not want to participate in providing feedback, and a notable proportion of men attend programs after a partner has left, or may meet a new partner while in the program and she is unable to measure his behavior from before entering the program (Day, Carson, & Saebel, 2010; Gondolf, 2002; Mullender & Burton, 2001). Therefore, many men will not have (ex)partner contact as a ''check-in'' reference point. A more formal process further validates a woman's experience, thereby assisting her to make decisions about her safety and risk (Macrae, 1998).

Taken together, the processes of creating more formalized and more tightly responsive processes between MBC programs and those organizations (justice, child protection and human service organizations) that refer and respond to men who use violence and abuse toward their (ex)partners and children are critical. It could be argued that ''the proof is in the pudding'' and that only outcome research will provide the necessary feedback about the effectiveness of these programs and particularly about the value of ''voluntary'' programs. This is certainly a limitation of this research. On the other hand, a poorly implemented outcome evaluation is of little value, and potentially distorts the value, or otherwise, of MBC programs. The choice of the MBC Matrix developed by O'Leary et al. (2004) provides a process evaluation through which benchmarking, information, and constructive feedback as the basis for continuous improvement could be provided (Blagg, 2001; Gondolf, 2008).

While the results of the MBC program matrix survey are specific to Victoria, the process may have broader application. In the field of MBC, bedevilled with poor outcome evaluations and where many programs have neither the numbers nor resources to undertake comprehensive evaluations, the MBC Matrix provides an accessible and informative guide for both practitioners and policy makers. It highlights the significance of the wider context in which MBC programs are situated and provides a mechanism for benchmarking which can be used productively, not only by a specific program but also by the regional committees which guide strategic and operational development.

Limitations of the research

The MBC programs included in this project continue to undergo transition and the discussion is applicable to a process of monitoring development of programs aligned with the Duluth model of MBC rather than specific program methods and techniques. The findings here illustrate a point in time, early in a transition period, and most programs will have evolved beyond the position as illustrated above.

Social survey analysis is sometimes criticized for classifying responses into predefined and subjective scales (DeVaus, 2002) and in this case, practices are

classified across a scale from ''optimal'' to ''poor,'' which are subjective measures and researcher allocation of practices into categories is also subjective. Criticism can be made that analysis of results attempts to unify the programs when in reality each will be very different.

Conclusion

This research was designed to work constructively within the policy and practice constraints in which it is situated. MBC is a contentious area, all the more so because many stakeholders (police, child protection workers, women's support workers, women survivors, policy workers, politicians, and magistrates) want to know whether MBC programs ''work.'' Often this question is asked with little attention to the diversity of programs and their contexts, and the question of what works, under what conditions, and for whom (Gondolf, 2012; Pawson & Tilley, 1997). It has been argued in his article that when the specifics of these outcome questions are unable to be fully addressed, a framework to guide greater collaboration to support accountability and safety can provide a useful and constructive way forward.

Ethics

This project received research ethics committee approval from the University of Melbourne (id 0828131), Department of Justice (id 08/15566), Anglicare (id 2010-03) and Relationships Australia (id RAVREC102008).

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Melbourne Research Alliance to End Violence Against Women and their Children:

Briefing Paper No. 3 on 'Alcohol and other Drugs'

Authors: Cathy Humphreys, Lucy Healey, Kristin Diemer

Reducing the severity of family violence: the need to address the Alcohol or Other Drugs gap in current responses to family violence

Relevant to Royal Commission into Family Violence Issues Paper question: 7

Introduction

I would like to address Question 7 by examining the links between family violence and the problematic use of alcohol use by changing the question to 'conditions associated with **the reduced severity** of family violence'. My primary focus is the role of alcohol in domestic and family violence (DFV), however discussions with service providers in the Alcohol or Other Drugs (AoD) area point to the poly-drug use of a very large number of their clients; hence it is inappropriate to always silo alcohol from other drugs. This is particularly pertinent with the escalation of the use of ice which is one drug associated with a direct causal link to violence.

I developed an interest in the connections between domestic violence and alcohol and drug use from working in the UK on a project called the Stella project, a London based service integrating domestic violence and drug and alcohol services (http://www.avaproject.org.uk/our-projects/stella-project.aspx). My research team was involved with a two year project researching the links between domestic violence and substance use (Humphreys et al, 2005a & b) which was followed later by a research overview of services for women experiencing DFV and substance use problems (Galvani and Humphreys, 2007). The research work with Dr Menka Tsanfeski further highlighted the links particularly for substance using mothers with infants (Humphreys & Tsanfeski, 2014). I continue to be concerned about the profound division between the two sectors, a chasm which belies the evidence base and where there is strong potential to make greater inroads into the reduction of harm from family violence.

Key message: The critical question is 'why the gap between interventions for AOD and DFV?' when women and their children are so severely impacted and perpetrator programs have the potential to increase their effectiveness if they intervene on drug and alcohol issues.

Challenges

- There are a number of issues which contribute to siloing the sectors (Humphreys et al, 2005a). These include: the concerns about 'causality' (that perpetrator responsibility will be minimised if alcohol can be 'blamed' for the domestic violence); a 'cultural clash' between services (primarily that AoD services are often gender neutral and that some explanations for addiction refer to a disease and do not hold the person fully responsible for their actions); the politics of a 'single issue' focus which simplify the intervention and expertise required; the problems of resourcing projects which address dual or complex needs; lack of evidence of successful programs which address the dual issues; lack of knowledge and training across sectors; fragmentation at government level which prevents co-resourcing of intervention programs (See Humphreys et al, 2005a).
- The problematic use of alcohol and other drugs is a contributing rather than a cause of family violence (Humphreys et al, 2005a).
- When alcohol use co-occurs with attitudes and behaviours supportive of violence against women, abuse is more likely to escalate (Braaf, 2012).

- Severity of family violence is increased by the use of alcohol and some drugs by both the perpetrator and victim. Some victims may have turned to alcohol and drugs as a way of coping with the violence and its repercussions. Hence the reduction of the use of alcohol is a significant harm reduction strategy for DFV and the wellbeing of children.
- The connection between the severity of violence and alcohol use has been known about for more than 30 years; however the DFV and AoD sector services are strongly siloed with few service links between the sectors.
- Alcohol was consumed in 44% of domestic homicides (Dearden, 2006), and 87% of Aboriginal domestic homicides (Virueda, 2010). Data on police reported incidents of domestic violence suggest alcohol is present in approximately 50% of incidents (Victoria Police Corporate Statistics Division, 2014; NSW BCSR, 2014).
- The lives of children are at increased risk of harm when both family violence and alcohol issues are present (Lassett et al, 2015).
- The evidence to support stronger integration of service responses is compelling. The severity and risk of injury is increased; women's rehabilitation from drug and alcohol problems is directly related to whether they are able to escape domestic violence (Swan, 2001); perpetrators use their substance use as a 'tactic of abuse' to increase fear and control (Humphreys et al, 2005; Room, 1980).
- A number of examples of good practice are emerging in the drug and alcohol and DFV sectors though work is generally under-developed and resources often do not go beyond pilot programs

Evidence of the connection between alcohol and family violence

Alcohol does not cause domestic violence. A substantial number of DFV incidents do not involve alcohol. Many women report that they have been physically attacked both when their partners or ex-partners have used alcohol and when they have not (Galvani and Humphreys, 2007). Many perpetrators of physical and sexual violence do not use alcohol, and the regime of power and control which can involve financial and emotional abuse is frequently ubiquitous and does not involve alcohol.

However, there is compelling evidence that alcohol increases the severity of violent incidents. Where injuries are sustained, the DFV incidents are more serious and more numerous compared to non-alcohol related DFV (Laslett et al, 2010). The Australian part of the International VAW Survey found that for women whose partners got drunk two or more times per month that the risk for physical violence increased by a factor of 3 (Mouzos &Makkai, 2004). A comparative study from thirteen countries reported significantly higher numbers of physically violent incidents when one or both partners had been drinking, compared to incidents in which neither partner had been drinking (Graham et al, 2010). The analysis of the PSS indicated that approximately 50% of all DFV incidents involved domestic violence and that 73% of cases where there was physical assault (Laslett et al, 2010, p. 80). The homicide data is particularly compelling with an Australian study over a 6 year period showing 44% of domestic homicides involving alcohol (Deardon & Payne, 2009), and when Aboriginal domestic violence homicide data was examined, 87% involved alcohol.

The data is inherently unstable (FARE, 2014). An interesting study based at an alcohol rehabilitation centre by key DFV researchers showed that the rate of co-occurring violence and alcohol misuse depended upon

who was asked (Gondolf and Foster 1991): clinical reports by workers showed 20% of men reported DFV alongside alcohol misuse; men's self-reports showed 52% reported domestic violence; while partner reports showed 82% women reported DFV co-occurring with alcohol consumption.

The research evidence on DFV and alcohol use highlights the gendered nature of both DFV and alcohol misuse (White and Chen, 2002). The research and practice divides into three broad areas: victims of DFV (mainly but not only women); perpetrators of DFV (mainly but not only men); and children living with DFV and substance using mothers and/or fathers.

The higher risk of alcohol and drug problems for women living with domestic violence has been noted across all areas of the service system (drug and alcohol services, midwifery, primary care, police DFV units, child protection). Substance use agencies show particularly high rates of women experiencing DFV (Berman et al, 1989). Victims more likely to have alcohol problems, with data suggesting 2 to 9 times the rate of those not living with domestic violence (Loxton, 2006; Quinliven 2001). They are also more likely to suffer injuries; less likely to be believed and supported; and also more likely to be involved in perpetrating abuse, even if that is in self –defence (Call & Nelson, 2007). A well recognised explanation for the strong association between women living with DFV and problematic substance use lies in the anaesthetizing effects of alcohol and other drugs in managing the physical and emotional pain of DFV (Zubretsky, 2002).

The lives of children are significantly and detrimentally impacted when they are exposed to both DFV violence and substance misuse (Humphreys and Tsanfeski, 2013). There are heightened rates of children entering out of home care when these issues co-occur.

The links between the perpetration of DFV and alcohol use is not new. A study by Collins in 1981 undertook a meta-analysis of 15 studies and showed alcohol was significant in 60-70% of cases. Similarly Hotaling and Sugarman in 1986 examined 52 studies and showed alcohol use as one of four consistent risk factors across research studies. The same evidence continues to emerge (Wilson et al, 2014; Braaf, 2012; FARE, 2014), and one could argue continues to have minimal effect on service intervention. A range of explanations are available to explain the link between the two social problems, few suggest a causal relationship. Most explanations argue a link between social context and attitudes (Bennett and Williams, 2003). These include: a belief (supported by the Australian National Community Attitudes towards Violence Against Women Survey, 2014) that violence is excused when a person is intoxicated; that violence supportive attitudes are more dangerous when fuelled by alcohol or other drugs (Johnson, 2001); and that drinking is a defining and acceptable aspect of masculinity (Gondolf, 1995).

Opportunities for policy and practice

In spite of the strong association between substance misuse (particularly alcohol) and DFV, and the finding that problematic alcohol use increases the severity of violence, the intervention strategies to address the co-occurring problems are under-developed and not well evaluated. A substantial study by Wilson et al (2014) which searched the international literature identified 11 studies that met strict evaluative criteria. These were studies at both community and individual levels. Their conclusion was that the potential for alcohol interventions to reduce intimate partner violence has not been adequately tested.

There were nevertheless some promising directions for intervention which could occur at the community (primary prevention) or at the level of the individual (tertiary prevention) through individual and group work. The WHO recognises that there are no simple, quick answers to lowering either the rate of DFV or the rate of alcohol misuse (Laslett et al, 2015). Instead, a complex array of interventions is required through a socio-ecological approach to both DFV and alcohol misuse; for example:

a) The studies on the impact of increased prices and taxes shows weak evidence for the effectiveness of this intervention when strict evidence criteria are used (Wilson et al, 2014). However, the lowering of the level of binge drinking particularly by students and teenagers in the UK has had a number of different explanations. The UK Office of National Statistics which identified the significance of the decrease from 2005-2013 suggests that pricing of alcohol combined with unemployment levels rising may have been one of several explanations.

b) Studies of community-level policies do show some impact. The longitudinal study by Livingstone (2011) of alcohol outlet density and DFV in Victoria from 1996 to 2005 showed a stronger association between DFV and the density of off-licence (take-away) liquor outlets in an area than on-premise licenses during the same period. The off-license showed that an increase in one off-premise license per 1,000 residents was associated with a 28.6 per cent increase in the mean domestic violence rate. The FARE research organisation also draws attention to the concentration of alcohol outlets in low socio-economic areas in ways which potentially exacerbate the pressures in more vulnerable populations.

c) At the level of individual intervention there is some evidence of the effectiveness of short-term brief drug and alcohol interventions in the context of Men's Behaviour Change (MBC) programs (Wilson et al, 2014). Unsurprisingly, the effects of the intervention were not sustained. The studies, even though they reached the strict research criteria for research selection would not have met the criteria from practice – no AoD sector workers would suggest that a 90 minute intervention would sustain harm reduction or abstinence. In many ways, the research evidence points to the lack of development of complex and integrated interventions.

   There are nevertheless interesting and important practice developments which have occurred with MBC programs. For example, Communicare in WA were funded for a 3 year pilot program which integrated the MBC program with a drug and alcohol intervention. Groups to support cessation of drug and alcohol consumption ran parallel to the MBC groups. Each man had a drug and alcohol worker as well as engagement in the MBC program. A manual was developed and substantial training of workers occurred. Interestingly, the program found it more effective to train MBC workers in addiction work than to train the drug and alcohol workers. The latter found much more difficulty in engaging men on the issues of accountability and responsibility.

   In the UK, the Domestic Violence Intervention Program (DFVIP) is developing innovative work with selected substance use organisations to address both substance use and domestic violence perpetration http://www.DFVip.org/assets/files/downloads/Substance%20use%20%20aggression%20programme.pdf

Several MBC programs in Victoria initially refer men to a substance use program before they are eligible for working in a group with other men on their DFV issues. However the impact of this approach has not been evaluated. The approach arises from a pragmatic stance that men need to be beyond chaotic substance use before they can actively engage with their other problematic issues.

d) Monashlink Community Health Service has an AoD practitioner to specifically work with victims and perpetrators at the interface with DFV. This is a promising example of integration between the service systems.

e) The STELLA project in London has developed a range of resources to support greater integration across sectors http://www.avaproject.org.uk/our-projects/stella-project.aspx

Our research (as part of the Stella project) suggested that it was the women's drug workers who were the most attuned to a response to women which addressed both their substance use issues as well as the issues of violence and abuse that they faced. They had a holistic practice in which they were trained and knowledgeable about both DFV and substance use. From their perspective, they were unable to see the divisions between the service systems and wondered how anyone could work effectively in the area without the skills and knowledge base to support an holistic approach (Humphreys et al, 2005b).

f) The FARE monograph, Hidden Harm (Laslett et al, 2015) highlights the issues for children living with alcohol affected mothers and fathers. It also raises some issues about the overlap with DFV for these children. It is clear however that more work is required to develop the practices which effectively work across both sectors for children.

In summary, the Royal Commission provides a very important opportunity and possible circuit breaker to address the problematic siloing between the substance use and DFV sectors. The use of alcohol and other drugs increases the severity of injury and impact from domestic and family violence. This in itself is a compelling reason to engage in innovative prevention practices to gauge the impact of intervention in this area. For perpetrators of DFV, violence supportive attitudes in conjunction with alcohol other substances provides heightened risks of dangerousness.

See the following relevant documents (* means supplied)

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Contact: Cathy Humphreys; & [redacted]

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Contact: Cathy Humphreys; [redacted]

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Domestic Violence and Substance Use: Tackling Complexity

Cathy Humphreys, Linda Regan, Dawn River and Ravi K. Thiara

Correspondence to Dr Cathy Humphreys, School of Health and Social Studies, University of Warwick, Coventry CV4 7AL, UK. E-mail: [redacted]

Summary

Domestic violence and substance use are issues which pervade social work practice, yet are often on the margins of the knowledge base for practitioners and their managers. This article provides an overview of the literature on substance use and domestic violence, highlighting the problems with the separation of both practice and policy in these areas. Research on substance use and the needs of women survivors of domestic violence are explored, alongside the more substantial literature on perpetrators of domestic violence and patterns of substance use. The problems of a simplistic analysis which suggest that there is a causal link between substance use and domestic violence are highlighted. Using data from an on-going research project, the sources of the continuing and dysfunctional separation of work in these areas are explored.

Keywords: domestic violence, substance misuse, alcohol misuse, drug misuse.

Domestic violence and substance use: tackling complexity

> It's never made sense to me that we haven't done more work about this area. Lots of women that we've engaged with have actually, at some point in time come out and spoken about their experience of misusing alcohol mainly, but lots and lots of women have also spoken about kind of using crack and heroin as well (Manager of a women's refuge service, London).

Making sense of the research and the divisions which continue to shape service provision for both survivors and perpetrators of domestic violence who also have problems with substance use[1] provides the impetus for this article. The

[1] The term 'substance use' is used in this article as the least stigmatizing term for men and women with problematic drug and alcohol use.

separation highlights the extent to which distinct discourses develop within a particular sphere, creating deep divisions in policy and practice between different sectors. In this process, those people who do not fit within the sector's dominant policy and practice framework become invisible, their needs remain unacknowledged and aspects of their lives discounted and subjugated. While refuges and outreach services, perpetrator programmes and alcohol and drug services are not always in the mainstream of social work practice, they employ a significant number of social workers and provide services which constitute an important aspect of the multi-agency environment in which assessment and referral occur, particularly in relation to child abuse and mental health. Thus, it is an issue of profound relevance for social workers (Galvani, 2001).

This article is primarily a literature review which outlines the extent of overlap between substance use and domestic violence. It also draws on a current research project for explanations which account for the 'a silo' mentality which pervades these areas of work and creates barriers to a more holistic approach to service provision. The article concludes with a brief discussion of the ways forward.

Literature review

Within the research literature, the overlap between substance use and domestic violence has been noted and explored for more than 30 years. Plant *et al.* (2002) describe the copious literature on substance use and domestic violence as 'extensive, flawed and often contradictory' (p. 207). The shear weight of research evidence in this area is initially daunting, particularly in relation to male perpetrators of violence and substance use. Nevertheless, 'the bulk' of evidence in this area highlights the puzzle about how and why it is that this research has had such minimal impact on policy and practice. There are few perpetrator programmes or services for survivors which address substance use in any systematic way, and just as scarce are drug or alcohol services which explore the issues of domestic violence for either perpetrators or survivors. In the process of referral and help-seeking, one or the other issue becomes lost.

The literature can be broadly divided into two areas: those issues pertaining to substance use by survivors; and those related to substance use by perpetrators of violence and abuse. The problems for children which arise from living with substance-misusing mothers and fathers and domestic violence are not addressed in this article, and are the subject of a significant and emerging literature in the area (Kroll, 2004; Cleaver *et al.*, 1999; Harwin and Forrester, 2002). The research literature tends to identify the extent of the overlap and then explore explanations for this overlap.

Survivors of domestic violence

The relationship between domestic violence and patterns of drinking and drug abuse for survivors is undoubtedly complex. Almost all the literature pertains

to women survivors and draws from women using both substance use agencies and women's contact with police, refuges and outreach projects. Little attention has been given to the problematic use of prescription medication. Research is hampered further by issues of invisibility and access. The stigma associated with substance use problems for women is exacerbated for some by religious and cultural issues (Taylor, 2003), and the fact that substance use may be part of the criteria which exclude women from refuges and mean that samples in this area may be particularly skewed.

There is nevertheless significant evidence of the vulnerability of survivors of domestic violence to substance use. Most of the studies explore alcohol use, though there is an emerging literature on drug use and, of course, the dual use of alcohol and a range of drugs together.

The higher risk of alcohol and drug problems for domestic violence survivors has been noted across a range of settings, including: specialist midwife services (Sims and Iphofen, 2003); substance use agencies (El-Bassel *et al.*, 2000; Gil-Rivas *et al.*, 1996; Stringer, 1998); police domestic violence units (Hutchinson, 2003); primary health care settings (McCauley *et al.*, 1995); refuges and outreach services (Khan *et al.*, 1993; Gleason, 1993) and hospital accident and emergency units (Berman *et al.*, 1989; Stark *et al.*, 1979). The extent of the overlap reported varies with the research site and with the research tools.

Substance use agencies are showing particularly high rates of service users reporting domestic violence. A Swedish study (Berman *et al.*, 1989) showed that 65 per cent of 49 women treated for alcoholism reported being beaten at least once and 81 per cent of these had been in relationships of chronic domestic violence. Thirty-two per cent of women being treated for alcoholism were also injecting drugs. US studies show similar high rates. Swan *et al.* (2001), in a study involving 360 women across eight substance use agencies, reported 60 per cent of clients disclosing either current or past domestic violence and 47 per cent reporting current domestic violence at intake. Rates of domestic violence were higher amongst users of crack cocaine compared to women who used alcohol and other drugs. Similarly, Downs *et al.* (1993), working through substance use agencies, showed that 60–70 per cent of women experienced violence or abuse in the previous six months.

When experiences of abuse include experiences of child physical, sexual abuse and neglect as well as domestic violence, the number of abused women increases substantially. Finkelstein's overview of research studies (1993) showed more than 50–90 per cent of women using substance use programmes experienced current or past physical, emotional or sexual abuse.

Studies in the United Kingdom of women with drug problems, again, show a worrying overlap with domestic violence. A study of 60 women using crack cocaine (Bury *et al.*, 1999) found that 40 per cent reported being regularly physically assaulted by a current partner and 75 per cent assaulted by a current or past partner. Much of this abuse was at the severe end of the continuum, with approximately 50 per cent needing hospital treatment in the past year as a result of partner violence. Other violence from acquaintances, dealers, relatives

and friends was also reported. A further study of 66 women opiate users showed that 30 per cent reported physical violence from a current partner and 44 per cent reported high conflict (Powis *et al.*, 2000). This rate is similar to an Israeli study by El-Bassel *et al.* (2000) in which it was found that women who combined crack and alcohol were five times more likely to report current partner violence.

Samples drawn from refuges, accident and emergency departments and police reports of domestic violence incidents show very significant, though lower, rates of overlap between women's substance use and domestic violence. Hutchinson (1999) found that 24 per cent of 419 women who called the police reported high to moderate drinking. A similar rate of 24 per cent of alcohol dependence was reported by women being treated at the hospital for domestic violence-related injuries, and 16 per cent injected intravenous drugs (Berman *et al.*, 1989). A small US refuge-based study reported 29 per cent of residents with substance use problems (Khan *et al.*, 1993). Comparable rates of 23 per cent of 30 residents with alcohol use and 10 per cent with drug use were found in another refuge (Gleason, 1993), but, as expected (due to lack of exclusion criteria), higher rates of 44 per cent alcohol use and 25 per cent drug use for the 32 women receiving outreach support.

Taken together, these studies indicate that there is a significant group of women suffering domestic violence who have problematic use of alcohol or drugs. Several explanations for this link have been explored. The most commonly cited theory, and one supported by both qualitative and quantitative data, is that women who are subjected to domestic violence use alcohol or drugs to cope with the attacks they experience. For example, Barnett and Fagan (1993) showed different patterns of drinking between men and women. Men drank twice as much as women during an incident (30 versus 17.8 per cent), but women's drinking was twice as common following the abusive attack (48 versus 24 per cent). Other smaller studies have reported a similar pattern of women's drinking (Stringer, 1998) and point to the ways in which women use alcohol and drugs to cope with the trauma of abuse (Zubretsky, 2002; Downs *et al.*, 1993), highlighting again the links between women's mental health and domestic violence (Humphreys and Thiara, 2003).

Other explanations explore the extent to which women's substance use increases the likelihood of their victimization. The research in this area is equivocal, though a substantial review is made by Hutchinson (2003). Some studies, such as Miller *et al.*, (1989) and Telch and Lindquist (1984), suggest that women are much more likely to be subjected to violence because of their drinking. They are seen more negatively and their male partners rationalize their violence on the basis 'that they deserve to be hit'. Other studies, however, have suggested that the woman's drinking in itself is either not a significant risk factor (Van Hasselt *et al.*, 1985), or inconsistent as a risk factor, though where there is drug use as well, the risk of victimization is increased (Hotaling and Sugarman, 1990). One of the most quoted studies is that of Kantor and Straus (1987), which, on the basis of a very large population survey, found that when

women were drinking, they were more likely to experience 'minor' domestic violence incidents, but that their drinking or drug taking bore no relation to severe violence from perpetrators. There is now some suggestion of a cyclical pattern, whereby women cope with the assaults and 'block out their feelings' (Stringer, 1998) by increasing their drinking and drug taking, and that this, in turn, may lead some abusers to rationalize and escalate their violence and abuse of the woman when she is drinking or using drugs (Kilpatrick *et al.*, 1997). The review by Kaufmann Kantor and Asidgian (1997) also suggests that risk factors for women increase because if they have problems with alcohol and drug abuse, they are more likely to also have partners who are heavy drinkers or drug users and that the women themselves may also be more aggressive when drinking.

Whatever the *explanation* for the link between women's substance use and domestic violence, the overlap is more than sufficient to suggest that there is a need for services to be developed which respond to both women's need for safety and their issues of substance use. The question arises as to why such interventions have been so slow to develop when the need has been identified for so long.

Perpetrators of violence

The overlap between domestic violence and substance use is not only relevant to the survivors of abuse. The research literature on substance use and perpetrators of violence is substantial. The issue of causality and the question of the relationship between the amount of drinking and severity of violence have been given particular attention. The issue of drug use has emerged more recently and there is, therefore, less literature in this area to date.

The fact that there is a significant overlap between the problematic use of alcohol and drugs by a substantial number of perpetrators of domestic violence is now uncontested (Straus and Gelles, 1990; Brown *et al.*, 1998; Hutchinson, 2003; Mirrlees-Black, 1999). The rate of overlap depends on how the substance use and domestic violence are assessed and recorded, and the research site. For example, Gondolf and Foster (1991) undertook research at an alcohol and rehabilitation clinic. They found that clinical reports showed 20 per cent of clients perpetrated domestic violence, while self-report by the same men, when asked directly, showed 52 per cent as perpetrators; and that spousal reports showed 82 per cent of the rehabilitation clients perpetrated violence.

The reports of women survivors about their partners' substance use show some variation. This is often a function of how questions about substance use are asked. There is a difference between asking whether the perpetrator of violence has a substance use problem and whether he was using at the time of the incident. In some cases, men who are chemically dependent may be more dangerous when they are sober, particularly if they are in the process of withdrawal (Bennett and Williams, 2003). A US study of 4,000 reports from women

using a domestic violence helpline found 35 per cent reported their abusive partner as a 'problem alcoholic' (Roy, 1982). Another victim report survey, the British Crime Survey (Budd, 2003), indicated that 44 per cent of domestic violence offenders were under the influence of alcohol and 12 per cent affected by drugs during the domestic violence incident. The substantial Canadian and US population studies of violence against women showed alcohol abuse by their partners to be one of the consistent and predictive risk factors for injury (Thompson *et al.*, 2001, 2003).

More detailed research, such as that by Hutchinson (2003) based on 419 police callouts to domestic violence incidents, reported that 50 per cent of perpetrators were high to moderate drinkers (compared with a national average of 21 per cent), and 14 per cent were binge drinkers (compared with a national average of 7 per cent). There was also a significant amount of dual alcohol and drug abuse, with 36 per cent having used alcohol and cocaine in the previous six months. Amongst cocaine users, 40 per cent had used cocaine three times per week during the month preceding the police callout incident. The heaviest drinkers were also the heaviest drug-using group.

While women's reports about their partner's drinking and abuse are said to be relatively accurate (Lindquist *et al.*, 1997; Hasselt *et al.*, 1985), the high rates they report are also consistently confirmed elsewhere. Fifteen studies of husband to wife abuse published between 1974 and 1979 show that alcohol was present in 60–70 per cent of cases (Collins, 1981). A further overview of 52 studies (Hotaling and Sugarman, 1986) of husband to wife violence found that alcohol abuse emerged as one of four consistent risk factors (p. 573). Within this literature, there is also some indication that binge drinkers were more abusive than those who drank consistently and heavily (Leonard *et al.*, 1985), though there is some evidence that the heavier the drinking pattern, the higher the likelihood of increased physical violence (Brown *et al.*, 1998; Brecklin, 2002). Some of this evidence is unclear. For example, a Canadian study found higher levels of injury where the perpetrator had been drinking, but not necessarily higher levels of drinking (Pernanen, 1991), and one study showed that the heaviest drinkers were actually less dangerous than those drinking moderately (Coleman and Straus, 1983). Substance use by men participating in perpetrator programmes appears to be particularly high, with reported rates of 63 per cent (Brown *et al.*, 1999) and 70 per cent (Feinerman, 2000) and an average rate across studies of 50 per cent (Gondolf, 1999).

The emerging literature on drug use and domestic violence suggests that perpetrators who use drugs and alcohol together are more likely to be dangerous than single drug users (McCormick and Smith, 1995; Denison *et al.*, 1997; Schafer and Fals-Stewart, 1997). For example, in a study of domestic violence incidents, Brookhoff *et al.* (1997) found that family members reported that two-thirds of the male perpetrators had used a combination of cocaine and alcohol on the day of the incident, while a San Francisco study of 20 domestic violence homicides found alcohol or drug involvement in all cases, including 20 per cent where both alcohol and cocaine were used by the perpetrator (Slade *et al.*, 1991).

Taken together, there is no doubt that a significant group of perpetrators of violence also have substance use problems. However, while the research and literature point to an association between substance use and domestic violence, amongst this myriad of studies are very few (Bushman and Cooper, 1990; O'Farrell and Choquette, 1991) that suggest that the disinhibiting effects of alcohol or drug use actually *cause* domestic violence.

The old chestnut of causality

It is worth pausing on the issue of causality. The way in which it is perceived that agencies respond to this relationship between domestic violence and substance use has been one of the most contentious issues and continues to have implications for inter-agency working.

A number of issues confound a causal relationship. In spite of a link between substance use and violence, several population-based studies show less than half of domestic violence incidents directly involve drugs and/or alcohol (Leonard, 1999; Mirrlees-Black, 1999). Other studies indicate that although the abuser may have alcohol problems, incidents of abuse were often unconnected to their drinking (Frieze and Browne, 1989). In smaller studies, while women report that there is often drinking at the time of the incident, most women also report being beaten when the man was sober (Galvani, 2001; Sonkin, 1985; Eberle, 1982). One study, however, suggested they were more likely to call the police when their partner was drinking or using drugs (Hutchinson, 2003). In a critical discussion of the literature, Gelles (1993) argues that on the basis of cross-cultural evidence (Levinson 1983, MacAndrew and Edgerton 1969), laboratory experiments to test aggression (Lang *et al.*, 1975), blood tests of men arrested for wife beating (Bard and Zacker, 1974) and the result of national surveys (Kantor and Straus, 1987), there is no evidence to support a causal relationship between substance use and domestic violence.

Other factors are consistently shown to be of more importance, or it is argued that the relationship between substance use and domestic violence is complex and involves a range of both personal and social factors. Unsurprisingly, there are a number of theories on this subject, outlined by different authors (Plant *et al.*, 2002; Bennett and Williams, 2003). In most theories, some emphasis is given to the role of social context and attitudes.

There are several different permutations on the significance of attitudes and beliefs. First, it is argued that it is not the chemically induced disinhibiting effects of alcohol which are key, but rather the *belief* that it is disinhibiting and, hence, in many cultures, it allows an individual (particularly men) 'time out' from the normal rules of social responsibility (MacAndrew and Edgerton, 1969; Coleman and Straus, 1983). It thus serves as an excuse for what is normally seen to be unacceptable behaviour, as an external agent (drugs or alcohol) can be blamed, particularly when, within the culture, the substance is perceived

to cause the aggression. In this process, perpetrators who wish to be violent can get themselves drunk in order to be violent (Gelles, 1993).

Second, it is theorized that the drug or alcohol use needs to be set alongside beliefs and attitudes about violence and abuse, namely that it is sometimes justified to physically abuse and control your partner. It is this belief system about violence which differentiates those who will be violent and those who will not. For example, data taken from national probability samples find a high correlation between domestic violence and substance use. However, the rates of violence were consistently higher amongst those couples where the man held the belief that 'slapping your wife' under some circumstances was acceptable (Kaufman Kantor and Straus, 1987) or where they held strong beliefs about the rightness of male dominance (Johnson, 2001).

Third, it has been suggested that attitudes to drinking and masculinity are significant and that those men who drink and are also perpetrators of intimate violence hold some or all of the following beliefs: that drinking is a defining and acceptable aspect of masculinity; that the man's traditional role as head of the family and other patriarchal attitudes are central; and that aggression and power are increased by alcohol consumption (Leonard and Blane, 1988; Leonard, 1990). In this sense, the use of alcohol becomes yet another part of the wide array of strategies used for domination and control within male–female relationships (Room, 1980; Gondolf, 1995).

While attitudes and beliefs are clearly significant, the research on women's attitudes to the notion that alcohol and drugs excuse the man's violence are interesting. A superficial reading of the research would suggest that some women, particularly in the early part of a relationship, might support the notion of alcohol and drugs excusing the behaviour (Leonard and Senchak, 1995) and, in fact, that it is psychologically protective to 'blame the booze'. However, an in-depth study by Galvani (2001) suggests that while many women say that they experienced violence when the man was drunk, they nevertheless were quite categorical that this did not excuse the behaviour.

In summary, the issue of causality has been, and continues to remain, contentious. There is little or no evidence to support a direct link between alcohol, drug abuse and domestic violence. Rather, the relationship is complex. Similar sets of personal circumstances may lead to quite different outcomes, whilst quite different circumstances may also lead to a similar outcome of both substance and interpersonal abuse. The interaction of personal and cultural beliefs about substance use (particularly alcohol use) and abuse of power within intimate relationships are crucial interacting factors, but ones which will always require individual assessment to comprehend their significance for effective intervention.

Key informants consultation

Some explanations need to be provided for the lack of attention to this evidence base by agencies working with domestic violence survivors—mainly refuges

and outreach services; programmes run for perpetrators; and agencies providing drug and alcohol services.

A research project funded by the Home Office Drugs Directorate and the Greater London Authority has been drawn upon to understand some of the problems associated with working together across these different sectors (see Humphreys *et al.*, 2004). The first stage of this on-going research project, which explores the links between substance use and domestic violence, involved semi-structured interviews with 48 key informants in the area. These informants were professionals working in either policy or practice who discussed with the researchers the knowledge base which informed their work; the barriers to progressing policy and practice and the possibilities for future intervention with service users which could meet their needs in relation to both domestic violence and substance use. They represented workers who had a particular interest and experience in the development of this area of work and hence were interested enough to volunteer to be interviewed. Interviews were taped and key themes identified. It is these data from the first phase of the project which are drawn upon in the next section.

Inter-agency working: another old chestnut

Workers who were interviewed were well aware of the dual nature of the problems of substance use and domestic violence. They also had no problem in acknowledging that service provision was inappropriately separated. A range of reasons was given for the barriers to inter-agency working or the inability of agencies to address the dual issues. In general, the barriers are very familiar to any other area of health and social care where workers attempt to work across professions and organizations (Farmakopoulou, 2002; Barr, 2002), though specific issues related to the nature of work in the substance use and domestic violence arenas. Undoubtedly, urging hard-pressed front line workers to engage in more extensive inter-agency working to meet the needs of their service users is a further 'old chestnut' which is depressingly familiar and does little to make a real difference to entrenched patterns and relationships between workers and organizations. Nevertheless, without understanding some of the specific issues, steps to ameliorate the situation cannot be made. We have chosen five themes which highlight both the generality and the particularity of inter-agency working in this area.

Cultural clash

The reason quoted by more than half of the informants for the separation of services can be described as 'cultural differences'. This related to three primary areas: contrasting practice models and knowledge bases; splits between statutory and voluntary sector services; and the significance of a gendered perspective. At its most stereotyped, this was explained as substance use services working

primarily with a medical model focused on the individual, often linked to a crime agenda, with many services based in the statutory sector. In contrast, domestic violence services were described as working from a social/feminist model with an advocacy/empowerment approach and based in the voluntary sector. While this is an overly simplistic description of the two sectors, it does describe how perceptions may create barriers:

> . . . they come from different cultures, so often domestic violence services come from within the voluntary sector and drug services come from medical models of working so therefore there's inevitably splits there (women's substance use worker).

The differences in gender politics were commented upon by a significant minority of informants. Several mentioned that alcohol services have historically developed to work with men, leading to both a lack of services for female alcohol abusers and a lack of understanding of the relationship between alcohol abuse and domestic violence. A gender neutral analysis was common and contrasted with the significance of a gendered understanding held by most workers in the domestic violence sector.

A single issue focus and concerns about causality

An issue highlighted by several informants was the politics associated with keeping a single issue focus:

> There's a lot of stigma attached to it (substance use). And if you're suffering domestic violence as well that means that you've got double the stigma. So I think that's why they've always been kept separate issues. I may be wrong, but I think it's the same with all areas of diversity . . . it's just much easier to deal with one problem. . . . So I think that people try and put people in silos and say, 'Well, we can deal with this problem and let's hope everything else gets sorted out' (female senior policy worker).

At the heart of many workers' concerns lay the previously raised issue of causality. The single issue focus was seen as a way of not 'muddying the waters' and letting any suggestion through that treating the issue of substance use would cure the problem of violence. Interestingly, all informants, bar one, were clear that it was *not* the cause of domestic violence. However, more than half the informants noted that within some agencies still, substance use was seen as an excuse for domestic violence.

The problems of resourcing men, women and children with complex needs

The issue of resourcing was raised by all informants and viewed as a constraint which kept agencies focused on a single issue:

> The facilities which have existed for a long time have been fairly limited. Particularly refuges have not been well staffed or they've not had sufficient cover and so have always felt that they've had limited ability to cope with women with additional substance use issues. It has been a heated problem I have encountered where they feel they can cope with one issue, but they can't cope with additional issues (Women's Services, Drug Action Team Worker).

While several areas have identified a need, and actively sought funding for a refuge with 24-hour staffing and self-contained units, at this stage, no funding has been forthcoming for this level of support (see Sen, 1998).

The need for resources was not only mentioned in relation to accommodation. Scattered throughout the informant interviews were references to other aspects of work which would need resourcing if the entrenched separation between the sectors was to be overcome. Such areas included: training, multi-agency working, policy development and increased staffing to cope with the longer time it takes to work with women and men with complex needs.

Differences in resources between the two sectors were noted by three informants, emphasizing the large amounts of funding that have been channelled into services countering illegal drug use. Unevenness in resourcing, whether due to one agency being comparatively well resourced and hence having little motivation to co-operate, or under-resourcing, where there is not the capacity to engage in inter-agency work, have both been highlighted as constraints to inter-agency collaboration (Birchall and Hallett, 1995).

The lack of knowledge and training across substance use and domestic violence

In relation to individual agencies, lack of knowledge and training were seen by all informants as a major barrier to the development of more appropriate holistic responses by staff:

> It's difficult for them to see it and name it for what it is because they don't feel confident or capable to kind of get into beginning to look at what her needs are, because they haven't been trained (female drug and alcohol assessment team worker).

A small number of informants pointed out that there were very few people currently whose skills and knowledge base spanned both sectors. Workers were either trained in substance use or domestic violence, and rarely had experience or training across both. It was noted that foundational training in professional courses such as social work did not comprehensively address both issues. The level of specialism required suggests that this is a rich area of post-qualifying development and specialist training (Stella Project, 2004).

Fragmentation at government level

It was interesting that few workers mentioned the fragmentation of response at government level. However, national policy workers did point out that they were actively working to bridge the 'departmental silos'. An holistic approach is not assisted by the policy and dominant funding for each sector being separated. Drugs issues are based within the Home Office, due to the links with the crime and disorder agenda; alcohol issues are the responsibility of the Department of Health, emphasizing the connection with health and the medical model; domestic violence services for survivors are largely funded through the voluntary sector and accommodation needs through housing based within the Office of the Deputy Prime Minister, while the voluntary sector and probation services fund programmes for perpetrators:

> It has all been very separated across government. . . . There is a need for a much more strategic focus and approach to this issue as well . . . it would mean a lot of government departments getting together to agree something. . . . No one has ever sat down properly and sorted out approaching it more strategically (female senior policy worker).

The complexity of service user needs are reflected in these equally complex departmental arrangements and point to the amount of work which will need to be undertaken to create a shared agenda.

Mainstreaming or specialism?

Interviews were characterized by ambivalence about the issue of mainstreaming versus specialization. The first model is to mainstream the work in this area through further support and funding to currently operating services. This requires a range of different measures to develop capacity within both refuges and substance use organizations. It recognizes that services need to be extended so that those with substance use problems *currently excluded* from services have greater access, while the high numbers of perpetrators and survivors *currently using* services need to have their issues acknowledged and appropriately supported with a more holistic intervention.

The second model is to develop specialist services which cater for the specific needs of survivors or perpetrators who have the dual issues of domestic violence and substance use. Both models would need to address the diverse needs of service users from black and minority ethnic backgrounds, the specific issues for disabled people and the access issues for gay and lesbian service users. The needs of children and young people and the way in which services may also need to address mental health issues were also raised.

Informants were generally fluid in their attitudes to these issues. It was recognized that service development in this area is in its infancy and little evaluation

has been undertaken of 'what works?'. A number of informants pointed out that the development of specialist services as the primary response to those with substance use problems and domestic violence would be one way of ensuring that there would never be enough services. In that sense, while informants recognized the need for some specialist services, developing the capacity of already established local services to respond more appropriately to their service user group with dual problems was the recognized priority and has now been tackled in a number of recent reports in the area (Carter, 2003; Taylor, 2003; Barron, 2004).

Conclusion

A small number of projects are now developing in the United Kingdom to explore ways of addressing the issues of substance use and domestic violence (see Taylor, 2003; Humphreys *et al.*, 2004). They stand in contrast to the separated provision which has traditionally occurred in the United Kingdom and which flies in the face of the evidence base which points to an extensive overlap between substance use and domestic violence.

The effective 'siloing' of provision suggests that the barriers may be higher than in some other areas of work, particularly when one considers that domestic violence multi-agency forums have been in existence in many areas of the United Kingdom for ten years or more (Hague and Malos, 1998). While some forums are far more successful than others in drawing together a comprehensive provision for children, women and men, there has nevertheless been general recognition that joint working will be more effective than working alone. The lack of representation of substance use agencies on these multi-agency forums, or the representation of domestic violence workers on the drug action teams, therefore, stand as anomalies.

The five themes which have been drawn out from interviews with workers across the sectors indicate where some of the barriers to joint provision lie and provide some explanation for this division of services. Underpinning these themes lies a failure in the mechanisms of social exchange which provide the motivation for *voluntary* inter-agency and inter-disciplinary co-operation whereby workers actively perceive mutual benefit in co-operation (Farmakopoulou, 2002). However, there are also few *external injunctions* to co-operate provided by legislation or administrative guidelines which enforce linkages between organizations such as we see in the area of child protection (Birchall and Hallett, 1995) and some areas of community care (Preston-Shoot and Wigley, 2002).

Awareness raising across the arenas of substance use and domestic violence will therefore be a necessary first step in gaining voluntary collaborative partnerships at local level, as well as developing the necessary policy context to promote a more holistic approach to service users. Such an approach will ensure that wherever men and women are presenting with substance use,

either as survivors or perpetrators of abuse, appropriate interventions can be forthcoming.

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Infant risk and safety in the context of maternal substance use

Menka Tsantefski *, Cathy Humphreys, Alun C. Jackson

The University of Melbourne, Australia

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ABSTRACT

Substance-exposed infants are extremely vulnerable due to biological, environmental and systemic risk factors that commence in pregnancy and are compounded by the postnatal caregiving environment. Substance-dependent mothers face unique challenges in caring for an infant while managing drug use or pharmacotherapy. The vulnerability of infancy therefore requires thorough assessment of risk and a prompt response from service providers. Drawing upon a prospective case-study of twenty women accessing a specialist alcohol and other drug obstetric service, this article explores the factors which contributed to infant risk or safety from the perinatal period to the end of the infant's first year. Data sources included structured interviews with counsellors and child protection workers and semi-structured interviews with mothers. The findings demonstrate continuing exposure to risk identified in pregnancy, including substance use and domestic violence, and inadequate follow-up of infants after discharge from hospital. The ability of an obstetric provider to conduct accurate risk assessment was evident. In addition, a sub-group of infants at higher risk of removal from maternal care was identified. The argument is made for a differential response by the service system to ensure women in greatest need are provided with extensive support when infants are most vulnerable and mothers most open to help.

1. Introduction

All infants, due to total dependence on a caregiver to meet their needs, are vulnerable. Substance-dependent infants are extremely vulnerable due to biological, environmental, economic and systemic risk factors often beginning in pregnancy and compounded by the postnatal care-giving environment (VCDRC, 2000). Substance-dependent mothers face unique challenges in caring for infants while managing drug use or pharmacotherapy. This complexity in the mother/infant dyad requires thorough assessment of risk and a prompt response from service providers. Consequently, many substance-exposed infants are brought to the attention of child protection services in the perinatal period, particularly prior to discharge from hospital when vulnerability is heightened. Once they enter the child protection system, infant cases are more likely to be substantiated and to result in placement in out-of-home care where they tend to remain longer than other children (Zhou & Chilvers, 2010).

While perception of risk is ubiquitous in child protection practice, few studies report how risk is experienced and enacted (Stanford, 2010 p. 1067–1068). Equally, limited attention has been given to the subjective experience of substance-dependent women involved with child protection services (Davies & Krane, 2006). This article draws upon a prospective case-study of twenty women accessing a specialist alcohol and other drug (AOD) obstetric service. Two perspectives are presented: those of service providers and mothers to demonstrate the need for a differential response to risk when problematic parental substance use has been identified in the perinatal period.

2. Literature review

Data from the U.S. (Havens, Simmons, Shannon, & Hansen, 2009), the U.K. (Crome & Kumar, 2007) and Australia (Bartu, Sharp, Ludlow, & Doherty, 2006) indicate that approximately 5% of women use substances during pregnancy; although underreporting by women, and limited screening by hospitals, suggests these estimates are likely to be lower than actual rates (Anthony, Austin, & Cormier, 2010). Substance-use frequently continues in the postnatal period, and together with mental health problems and domestic violence, is present in the majority of notifications to child protection services in Australia (Council of Australian Governments, 2009), the U.K. (Forrester & Harwin, 2008) and the U.S. (Blythe, Heffernan, & Walters, 2010). Annual reviews of the deaths of children known to Child Protection conducted in the state of Victoria, Australia, repeatedly demonstrate that infants under twelve months of age are most likely to come to harm (VCDRC, 2000, 2012). While they vary in scope and approach, particularly in relation to mandatory reporting of unborn infants, where differences are found across and between countries, child protection systems generally seek to intervene early when in-utero substance use has been identified; the response, however, can vary greatly. For example, U.S. federal law mandates notification of infants exposed to in-utero substance use. Although the intent is to support pregnant women, there is potential in some states for prosecution on the grounds of child abuse (Drescher Burke, 2007). Child

* Corresponding author at: Department of Social Work, School of Health Sciences, The University of Melbourne, Parkville, Victoria, Australia, 3[redacted]
E-mail address: [redacted]u (M. Tsantefski).

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protection systems in Australia are also operated by individual states and territories, with differences in mandatory reporting requirements; child protection policy nevertheless reflects an underpinning philosophy of harm reduction. The aim is to improve pregnancy outcomes, prevent or ameliorate the severity of parenting difficulties, assist mothers in recovery and reduce the need for involvement with statutory child protection services (Anthony et al., 2010). This approach is also evident in the U.K. where the policy response is to promote access to alcohol and other drug treatment, mental health services and parenting education for mothers (Gilchrist & Taylor, 2009). Obstetric services therefore play a critical role in the identification of at-risk infants and in initial decision-making to activate the formal service system, either through notification to statutory child protection, or through referral to child and family welfare services (Campbell, Jackson, Cameron, Smith, & Goodman, 2000). However, questions have been raised regarding the requisite skill and knowledge of professionals other than child protection workers in conducting risk assessment (VCDRC, 2000).

Concern with the reliability of risk-assessment has resulted in widespread use of risk assessment instruments to guide decision-making. Yet, even with the use of standardised instruments which have become central to child protection practice (Gillingham, 2006), variability in the appraisal of risk and confidence in performing assessments have been noted amongst child protection workers. Regehr, Bogo, Shlonsky, and LeBlanc's (2010) study of 96 Canadian child protection workers found that worker variables including age, level of stress and ability to engage family members correlated with confidence in performing assessments rather than the level of risk assessed. This finding has significant implications for infant practice in the context of maternal substance use. Concern for vulnerable infants is likely to increase worker anxiety and drive risk-averse practice, particularly after high profile media events of serious harm to infants or children (Connolly & Smith, 2010). Substance-dependent parents in the U.K. have been noted to resent child protection intervention if they perceive it to be based on judgement rather than evidence about parenting practices and to be more likely to respond with antagonism (Buchanan & Corby, 2005). Faced with confrontational behaviour, workers are more likely to assess child risk as higher, as noted amongst participants in LeBlanc, Regehr, Shlonsky, and Bogo's (2012) Canadian study. The association between substance use and violence noted in U.K. child protection samples (Stanley, Miller, & Richardson Foster, 2012) is likely to further contribute to a 'culture of fear' pervading practice (Davies & Krane, 2006) leading to a spiral of mutual mistrust between parents and workers that may paradoxically leave the most vulnerable infants and children most exposed to risk. Studies conducted in the U.K. indicate that when domestic violence combines with the secrecy, resistance, denial and hostility that often characterises interactions between substance-dependent parents and service providers, workers may be more inclined to avoid contact with families (Forrester & Harwin, 2008) or to direct attention to mothers rather than the perpetrator of violence (Stanley, Miller, Richardson Foster, & Thomson, 2011). For their part, mothers experiencing domestic violence may be reluctant to ask for help for fear of being directed to separate from partners as noted in the U.K. (Stanley et al., 2012) and Australia (Walsh, 2002). It has been proposed that the concept of 'readiness to change' understood in relation to alcohol and other drug use may be applicable in situations of family violence (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008; Humphreys, Thiara, & Skamballis, 2011); the process of intervention may, therefore, be an important factor in outcomes in relation to both substance use and family violence.

Various approaches to managing risk in child welfare have been recommended including improved engagement with parents (Darlington, Healy, & Feeney, 2010; Davies & Krane, 2006) and increased interagency collaboration in infant practice when maternal substance use has been identified (McGlade, Ware, & Crawford, 2012). The perinatal period has been referred to as 'a window of opportunity' in which women re-evaluate domestic violence (Pulido, 2001); many strive to become abstinent or, at the very least, to change their drug habits, as reported in Mayet, Groshkova, Morgan, MacCormack, and Strang (2008) and Radcliffe's (2011) U.K. studies. It is also a time when preparedness by mothers to be honest with health care providers, in the best interests of the infant, has been noted by Australian obstetric services (Phillips et al., 2005). The perinatal period may, therefore, be an ideal time to engage substance-dependent women in working towards an improved trajectory for themselves and their infants.

3. Method

3.1. The policy and practice context

There is no legal mandate in Australian legislation to support intervention with unborn babies but duty of care is considered imperative. Some child protection systems are able to receive reports for the purpose of support to expectant women but concern must be for the infant's wellbeing in the postnatal period (Mathews, 2008). Despite potential to intervene early in the development of problems, the Australian practice response to substance use in pregnancy is inconsistent with some hospitals notifying all newborn infants and others using discretionary powers. Child protection responses to infants deemed at risk prior to birth are similarly inconsistent (Wickham, 2009).

The present study was conducted in the State of Victoria which has mandatory reporting requirements for specific professional groups including the medical profession. Alternatively, reports can be made to community-based intake for vulnerable families not requiring a statutory response. Since the enactment of new legislation in 2007, Victoria has been able to formally receive notifications of unborn infants. In the absence of other concerns, substance is not considered sufficient grounds for notification in the pre or postnatal period. Victorian policy guidelines encourage health care providers to notify the statutory Child Protection service when women who have lost the care of previous children present at an obstetric service as this is considered a significant risk factor in child maltreatment. Case-planning meetings are generally held for all neonates considered at risk prior to discharge from hospital. Family Group Conferences are not mandated and are held at the discretion of Child Protection workers. The study was located at the Women's Alcohol and Drug Service (Women's ADS) at the Royal Women's Hospital, the state's largest provider of health services to pregnant women and newborn infants. Approximately 60 women access the service each year, half of whom who are brought to the attention of Child Protection in the pre or postnatal period on a case-by-case basis.

3.2. Research design

The overall aim of the study was to understand the trajectory for substance using women and their infants in the first 12 months of the infant's life and the role of the service system in responding to their needs. The research question addressed in this paper is: What risk and protective factors influenced outcomes among substance-exposed infants at infant age 12 months and how did the service sector, particularly the statutory child protection service, respond? The study was a mixed-method prospective case-study with two units of analysis: communication and collaboration between the Women's ADS and CP in the perinatal period and a twelve-month follow-up of individual women accessing the Women's ADS.

Data sources were:

1) The Women's ADS Client Assessment Tool which lists client demographics, psychosocial and risk assessment conducted by staff as routine intake procedure and case notes made after each contact with women accessing the service.
2) Structured interviews with Women's ADS counsellors to understand assessment of risk in infancy and corresponding referral pathways for each participating woman and her infant.
3) Structured interviews with CP workers to ascertain infant progress through the child protection system from notification to the making

of Court Orders in cases of substantiated abuse/neglect and referrals made on behalf of each family. Both services were asked to report on the extent and quality of their mutual collaboration in the perinatal period.

4) Semi-structured interviews were held with service users. Women were asked about their experiences of a specialist AOD obstetric service and any other services they used, including CP. Women were also asked about their experiences of caring for a substance-exposed infant, their social network, substance use and the availability and helpfulness of formal and informal support.

Data were collected in three phases. Women's ADS staff members were interviewed at infant age six weeks. CP workers and participating mothers were interviewed at infant age six weeks, six months and twelve months. The study generated 54 interviews with mothers. Twenty interviews were conducted with Women's ADS counsellors. Twenty interviews were also conducted with CP workers ranging from three interviews regarding each participating mother/infant dyad to one only for one mother and her infant. Notes were taken during structured-interviews with Women's ADS and CP workers and presented in the form of answers to questions that guided the study. Semi-structured interviews with mothers were tape-recorded and thematically analysed manually. Emerging patterns were sought to draw out similarities and differences in experiences (Ryan & Bernard, 2000). Ethics approval for the study was provided by the University of Melbourne Human Research Ethics Committee (Approval No: 030702.1).

3.3. Participant description

There were three categories of participants: Women's ADS staff ($n = 2$), CP staff ($n = 18$) and service users ($n = 20$). A total of 51 women accessed the Women's ADS during the six month recruitment phase of the study. Twenty-two women agreed to take part in the study. Two women were lost to follow-up prior to the first interview. Among the remaining 20 women, eighteen participated in phase 2 interviews and 16 at phase 3.

With the exception of one woman who reported heroin use exclusively, all women were polydrug users. Pregnancies were largely unplanned; ten women were having their first baby. Among the remaining women, the majority had lost the care of older children. Half of the women reported depression during pregnancy and half had attempted suicide at some stage of their lives. Eight women were single. A third of the women reported domestic violence during pregnancy. Approximately half of the women disclosed past physical, sexual, emotional and verbal abuse. Their partner's drug use was problematic for approximately half of the women. Five women had involvement with child protection in their own childhood. Educational attainment was generally very low and all but one woman relied on social security payments. Housing instability or transience was high. Approximately half of the women faced legal charges; a third had been incarcerated at some stage, three during the pregnancy that resulted in the birth of the infant who was the subject of the current study. The mean age was thirty years. Sixteen women were non-Indigenous Australian, one woman was Australian Indigenous, three women were European and two were Asian. Comparison of demographics and descriptive variables with previous research (Kelly, Davis, & Henschke, 2000) indicates that the women in the present study were highly representative of mothers accessing the Women's ADS.

4. Findings

The following section reports the reasons for and the number of notifications made by the Women's ADS to CP in the perinatal period and outlines individual women's involvement with CP at each study phase.

4.1. Identification of risk in the perinatal period and ensuing CP involvement

Two women came to the Women's ADS with pre-existing CP involvement. Ten notifications were made by the Women's ADS in the perinatal period, four prior to the birth of the infant (Table 1). Two to eight risk factors per mother/infant dyad were identified by Women's ADS counsellors, these were: continuing maternal substance use ($n = 10$); older children out of maternal care ($n = 6$); intimate partner violence ($n = 9$); and unstable accommodation associated with domestic violence ($n = 9$). While continuing maternal substance use was the most frequently cited reason for notification, no woman was notified for substance use in the absence of other concerns. One notification was investigated and closed; the remainder resulted in further protective investigation and intervention. Amongst four mother/infant dyads, CP involvement ended by the second phase of the study (infant age six months). The remaining women had CP involvement until the conclusion of the study. At phase 2, one further infant was notified. An additional infant was notified at phase 3. In all, 14 of the 20 women who participated in the study beyond initial recruitment were involved with CP in their infant's first year: just over half lost the legal care of their infant ($n = 8$). Three of these mothers retained daily or regular care by residing with the infant's grandparents who had legal care of the infant; the remaining five infants were lost to maternal and familial care.

At the conclusion of the study, no woman unknown to CP in the perinatal period was subsequently notified (some were known to the service through involvement with older children). This finding could be read in one of two ways. Either, accessing a specialist AOD obstetric service predisposes women to notification to CP or that the Women's ADS conducted comprehensive, differential and accurate risk assessment. Consideration of the circumstances of infant removal suggests the latter interpretation is correct. With the exception of one infant who remained in his grandmother's legal care throughout the study time-frame, all infants separated from mothers were removed following police activity in relation to family violence or conflict, crime committed by mothers, or in one instance, a road accident in which both parents were substance-affected with children in the car.

4.2. Intersectoral collaboration in response to risk in the perinatal period

While the assessment of risk and protective factors in the perinatal period is generally a process focused on the mother (and her partner), the management of risk includes engagement with the service system. A strong engagement with the service system can be a protective factor, while lack of engagement and a poor service system response constitutes a risk. The ability of the Women's ADS to identify risk in the perinatal period and to begin the process of addressing protective concerns

Table 1
Notification and involvement with Child Protection by study phase.

Participant	Phase 1	Phase 2	Phase 3
K[redacted]	Open	Closed	Closed
A[redacted]	Not notified	Not notified	Open
I[redacted]	Open	Closed	Unknown
J[redacted]	Open	Open	Open
S[redacted]	Open	Open	Open
E[redacted]	Open	Open	Open
B[redacted]	Open	Open	Open
D[redacted]	Open	Open	Open
T[redacted]	Not notified	Open	Open
Ja[redacted]	Open	Closed	Closed
A[redacted]	Open	Closed	Closed
R[redacted]	Open	Open	Open
N[redacted]	Open	Open	Open
S[redacted]	Open	Open	Open
TOTAL	12	9	10

through engaging mothers prior to notification was highly valued by CP. As reported by a CP Manager:

> We really have got a very good practice model with the Women's ADS and the work that needs to be done with substance-using mothers, so the Women's ADS very clearly spell out and articulate for the mother, their concerns, their desire or need to notify to protect are discussed upfront with the mothers…It's an excellent model of practice and it has worked very, very well.

From the perspective of CP workers, collaboration was helpful in engaging mothers and their partners in the development of safety plans or in devising alternative case-plans in the event of parental non-compliance. Planning meetings were held prior to infant discharge from hospital for all infants brought to the attention of CP, except one. These meetings did not have the structure of formal Family Group Conferences and inclusion of fathers, extended family or community-based organizations was minimal. Early identification of risk did, nevertheless, contribute to case-planning including decisions to initiate Children's Court action and to activate referral pathways. As one CP worker noted:

> Given the crux of the information, this was vital at the beginning. The richness in information provided enough detail to proceed with the case.

There was almost unanimous agreement among CP staff and Women's ADS counsellors that timely referrals and service links resulted from intersectoral collaboration. From a Women's ADS counsellor:

> CP put really good supports in place. They really tailored the action-plan to the woman's needs.

While professional communication and collaboration was highly valued by both CP and the Women's ADS, contact between services was limited to the period between notification and infant discharge from hospital. In addition to service links initiated by CP, the Women's ADS made 96 referrals for 18 women. In some instances, several referrals were made to different agencies for the same type of service. CP also actively referred women to mental health, alcohol and other drug treatment and domestic violence and family support services across each phase of the study. The following section reports women's use of services throughout the infants' first year and their perspective of intersectoral collaboration.

4.3. The response of the wider service sector and parental engagement

While the Women's ADS was able to accurately identify which women needed further support, service mapping in interviews with mothers revealed a fragmented and uncoordinated response to substance-use and early parenting post discharge from hospital. Women concurred that the Women's ADS and CP worked well together but generally noted poor communication and collaboration with the wider service sector and between service providers and service users. Ava described her experience:

> The level of communication that went on between CP when we went for an assessment at (residential parenting assessment and skill development service), they, the lady that was doing the assessment said, "Oh, so, what? You are coming in tomorrow or something?" We'd been waiting ages for this placement and we thought, Oh my God, they haven't done anything yet. They weren't communicating with us at all.

Good professional collaboration, which was largely limited to the perinatal period, was valued by women but was experienced as alienating, threatening, even conspiratorial if they felt excluded from discussions.

> It's a bit scary because I've heard her talking on the phone, and yeah, she's like a spy for CP, so I don't trust her. (N)

Despite extensive activity by the Women's ADS in the perinatal period, engagement with services tended to be superficial and not well sustained: Women were reluctant to keep appointments made on their behalf and service providers failed to provide assertive outreach. Support to women with neonates at imminent risk of removal was largely confined to residential parenting assessment and skill development services which provided minimal long-term support. Service use was slightly higher among women with CP involvement which, as noted above, continued throughout the infant's first year for some mother/infant dyads. However, with the exception of two women attending the same family support programme, CP referrals to a range of services including domestic violence counselling and alcohol and other drug treatment for mothers, and men's behaviour change programmes for fathers, also failed to result in meaningful engagement to help either parent overcome barriers to effective and safe parenting. Some women actively resisted services they believed to be closely aligned to CP. R noted her partner's lack of compliance with a Children's Court directive to attend what she referred to as an "anger management" course:

> He went for two goes and then he stopped. It hasn't looked good on his behalf.

The overall pattern of service use was characterised by some use of housing and crisis support services, particularly during pregnancy and the perinatal period to address immediate needs for safety and accommodation; there was variable but continuous engagement with General Practitioners and the Maternal and Child Health Service, both of which are universal, medically-oriented providers; and little engagement in AOD treatment, domestic violence counselling, mental health or family support services. Not one of the four men directed to men's behaviour change programmes engaged with a service. Among women, fear of infant removal was the most significant barrier to help-seeking or honest engagement with CP and the wider service sector. S, among the most socially isolated women in the study, expressed reluctance to ask for assistance:

> I'd love to say to somebody, "I need help in this or that regard", but they're going to think that I'm not coping and that I can't look after her.

4.4. Women's perspectives on risk in the perinatal period

The perinatal period was a time of optimism and concerted effort by mothers and service providers. At this time, women were likely to share the professional perception of risk and to address risk factors which could jeopardise care of the infant: drug use and domestic violence. While some disputed the need for mandated intervention, women involved with CP theoretically acknowledged the important role the service plays in protecting women and infants, generally accepted the presence of significant family problems and understood why notifications were made. Most women reduced or ceased drug use, and, as directed by CP, five women agreed to separate from, or not to return to, relationships with violent men. Early interviews focused largely on initial assessment and monitoring by CP. Mothers expressed preference for pre-natal notifications and called for more active involvement before birth to prepare for the infant's discharge from hospital, engage men, and support both parents, particularly in situations of domestic violence.

> They could have started a little bit earlier, like three months earlier, or something, to get a bit more prepared and that in case people

need counselling for drugs and alcohol. They should get more supports for fathers, and that, some detox or something for them. (N[redacted])

Women's expectations of and response to CP in the early days of the infant's life were largely determined by prior involvement: those without experience of a statutory service were generally more positive; parents with CP involvement in the lives of older children described heightened anxiety, learning to work collaboratively or knowing how to maintain a level of control over unwanted involvement through feigned cooperation. The requirement to 'prove' one-self featured in many early interviews. Mothers who remained in relationships with men who had used violence held high hopes for change in their partner in direct relation to fatherhood and were able to articulate benefits from involvement with both the Women's ADS and CP. D[redacted] commented:

I'm willing to give him a go and he hasn't stuffed up so far but the second he does, I'm not going to put up with shit anymore.

4.5. Managing risk in the context of continuing maternal substance use and domestic violence

All women retained infants in their care in the perinatal period while protective investigation was initiated; albeit, some infants were discharged from hospital to residential services while their mothers were assessed for parenting capacity and others were placed in the legal care of grandmothers. Despite good intentions and successful reduction, cessation, or changes in drug use patterns during pregnancy, and commitment to remain free of domestic violence in the perinatal period, 'the window of opportunity' slammed shut for many women by infant age six months. As the intervention unfolded, dichotomous perspectives between mothers eager to retain infants in their care, and CP workers charged with protecting infants and ensuring their wellbeing, emerged and resulted in mounting tensions and parental disengagement. In the tussle to protect, paradoxically, risk amongst some infants increased: all five women directed by CP to leave or not return to their partners in the perinatal period remained in, returned to, or formed new relationships with violent men; and several women attempted to conceal the resumption of illicit substance use. E[redacted], who had lost the care of older children, described learning how to "play their game". She successfully avoided Children's Court action for a year by stating preparedness to comply with CP directives without real intent. As reported in interview:

Now this week I'm supposed to provide three clean urines and they'll leave me alone but I haven't…so I will be lying to them and telling them I have to go somewhere.

Poor assessment by CP was seen to result in disruptive outcomes including unnecessary removal of infants and separation of couples which reduced the availability of support to mothers, strained relations between parents, and between parents and the wider family when called upon to care for infants. Several mothers considered CP a barrier to the creation or continuation of a family. J[redacted], who eagerly worked with the service in the perinatal period while her partner was incarcerated for assaulting her, later noted:

It (domestic violence) happened once and that was it. He's never shown any violent tendencies for a long time. He just wants his family; that's what he wants. He realizes that now, you know.

For their part, CP workers noted women's failure to provide urine screens, the presence of men who came to their attention following acts of violence against mothers, parental failure to comply with directives and maternal recidivism to crime. CP workers also observed that among infants with older siblings no longer in maternal care, the reason for removal of infants in the present study was strikingly similar to those that resulted in prior child loss: maternal drug use, exposure to domestic violence and crime, a finding confirmed in interviews with mothers. Notably, only D[redacted], who retained the care of her infant throughout the study time-frame, described her infant as at risk of exposure to domestic violence. A highly-experienced CP manager assumed responsibility for case-management due to worker safety concerns regarding a man with an extensive history of violence towards women. D[redacted]'s quote illustrates the benefits of CP involvement when engagement with mothers has been established:

They kept her safe, at least for now…Knowing that CP is still helping me and, you know, need be, they'd get me out of there like that (clicks fingers), which they've got to do.

Although women were acutely aware of being monitored by CP and other service providers, they did not resent this intrusion in their lives, as such: involvement with the service system, including CP, was experienced as both a risk and an opportunity for assistance. What they did resent was monitoring without encouragement or support; monitoring without children in parental care; or monitoring that focused exclusively on mothers. It is noteworthy that all four 'first-time' mothers with CP involvement commented on the discrepancy between the level and type of support they anticipated and what they received. When support did not match expectation, they became disillusioned and less willing to accept the service. While they argued for support for their partners, women also described repeated unsuccessful attempts at engagement with fathers by CP and minimal or outward compliance by men. The approach by individual workers was considered an important factor in engagement. Efforts by older and more experienced CP workers were particularly valued. These workers were more likely to attempt to work with both parents, including those where there was domestic violence, and to be proactive in linking women with services. As a result, women were more prepared to accept monitoring. J[redacted] reported:

She (older worker) was the one who helped me. She was always coming down, and you know, checking on me and all that.

By the end of the study several women described resignation to an outcome predetermined by CP, outward compliance with, and resistance to, a range of directions including referral to services, or biding time until Children's Court Orders expired and CP withdrew, leaving the situation, essentially, unchanged. R[redacted] explained:

Well, the Protection Order ran out and there wasn't much they could do about it…they've got nothing new to go on.

Women called for inclusive, family-centred practice, improved collaboration among service providers and support for parents for reunification of infants and children to their care. Perhaps paradoxically, increased monitoring, on the condition it came with support, including counselling for alcohol and other drug use and domestic violence for both parents, was proposed as a viable alternative to infant removal.

4.6. Differences in outcome among individual women and their infants

Outcomes among this group of mothers need to be understood on an individual basis. Retaining or losing care of the infant in the first year postpartum was not determined solely by whether a woman was subjected to domestic violence or used substances; the interplay between factors related to the woman, her partner, the wider family and the service response were critical. As mentioned above, of the twenty-women participating in the study beyond initial recruitment, fourteen experienced CP involvement in their infant's first year, eight lost the legal care of the infant, and among this eight, five infants were lost to the

family. A 'good' outcome was operationalized as continuous maternal care of the infant, drug use that was manageable or had ceased, and absence of domestic violence. The term 'mixed' accounts for women who lost legal but maintained daily care by residing with the infant's grandparents. There is little doubt that without the availability of familial support these infants would have been among those placed in foster care and outcome would therefore have been considered poor. Approximately half of the women did well with their infant, six did poorly, and outcomes among the remaining three women for whom there is data were mixed. Although E[redacted] maintained the care of her infant until infant age 12 months, the outcome was considered poor due to an escalation in drug use and the formation of another relationship marred by domestic violence. Table 2 lists the key descriptive variables in this study and outcomes for individual women and their infants.

Among the women with good outcomes, seven were first time mothers; the remaining three were able to demonstrate ability to provide adequate care of the infant under changed circumstances. Overall, women who did well were those who: were able to significantly alter their substance-use patterns, either by ceasing to use, reducing frequency or changing their drug of choice; were not subjected to or managed to escape domestic violence; felt well-supported; and did not experience child protection involvement in their own childhoods. Women who did well tended to have partners for whom drug use was either not problematic or less problematic than their own or to have left their partners during the time-frame of the study.

Conversely, women who did poorly were more likely to be in relationships characterised by domestic violence and to not have been able to control their drug use. Some of the latter group of women lived with men with problematic substance use and others did not. By far, the variable most likely to be associated with poor outcome was the mother having experienced out-of-home care in her own childhood. Four of the five women who lost daily care of their infant by the conclusion of the study had experienced childhood sexual assault and had been removed from parental care as adolescents. These women remained in high risk situations; during adversity, they lacked sufficient familial support to buffer them from circumstances leading to loss of the infant. Current practice intervention was also insufficient in helping them overcome barriers to effective and safe parenting.

5. Discussion

This study documents a productive partnership between CP and the Women's ADS at a time of heightened infant vulnerability prior to discharge to home or to alternative care. The study demonstrates capacity by a specialist AOD obstetric provider to conduct accurate risk assessment operationalized as consensus with CP and by examination of the outcomes of a twelve-month follow-up which revealed that no woman unknown to CP was brought to the attention of the service within this time-frame. The findings therefore confirm that 'there appear to be fairly good systems for identifying concerns around babies born to drug-using mothers' (Forrester & Harwin, 2006 p. 331). Decisions made by the Women's ADS in the perinatal period were important in determining pathways to service provision but did not adequately impact on the effectiveness of the child protection system as a whole. Despite accurate identification of risk in infancy, referrals without assertive outreach, poor collaboration between service providers beyond the Women's ADS and CP and lack of follow-up of vulnerable infants in the community were evident: the same gaps in communication and collaboration among professionals are repeatedly identified as contributing factors in the deaths of children known to CP in Victoria (VCDRC, 2000, 2006, 2008, 2012).

The ability of the Women's ADS to engage a population of women who typically have low-levels of trust in service providers created opportunity for early intervention. However, the call by women, including those notified prenatally, for even earlier intervention suggests the response is still largely crisis-driven and reactive (VCDRC, 2008 p. 32). Rather than being risk-averse, CP 'took a stand for their clients' (Stanford, 2010 p. 1074) and initially gave all women, including those who had lost care of older children, an opportunity to parent the new infant. However, the initial response, referral to parenting assessment and skill development and other services, led to monitoring of mothers (Zhou & Chilvers, 2010) without translating into increased long-term support for families. Fear of infant removal and women's attempts to protect the relationship with the fathers of their infants overrode engagement (VCDRC, 2006). Service use by men was largely non-existent, even when mandated. As the 2006 Victorian Child Death Review notes, referral is not of itself an intervention (VCDRC, 2006). Without CP involvement there was little long-term case-management

Table 2
Key descriptive variables in who did well and why.

Participant	Out-of-care in own childhood	Primi-gravida	Older children out of maternal care	Drug use in study time-frame	History of domestic violence	Domestic violence in study time-frame	Sole parent at end of study	Infant in maternal care at end of study	Outcome (mother retaining care)
B[redacted]		✓			✓	✓	✓	✓	Good
K[redacted]			✓	✓	✓		✓	✓	Good
A[redacted]			✓	✓	✓			✗ ✓	Mixed
L[redacted]		✓						✓	Good
L[redacted]				?	✓	?	?	?	Unknown
J[redacted]		✓		✓	✓			✗	Poor
Si[redacted]	✓		✓	✓	✓		✓	✗	Poor
L[redacted]		✓		✓				✓	Good
M[redacted]		✓					✓	✓	Good
E[redacted]			✓	✓	✓	✓		✓	Poor
B[redacted]			✓				✓	✓	Good
C[redacted]		✓		✓				✓	Good
D[redacted]		✓		✓	✓	✓		✗✓	Mixed
T[redacted]	✓		✓	✓	✓	✓	✓	✗	Poor
Ja[redacted]				✓				✓	Good
A[redacted]		✓		✓			✓	✓	Good
Ru[redacted]		✓		✓	✓	✓		✗✓	Mixed
Na[redacted]	✓		✓	✓	✓		✓	✗	Poor
M[redacted]		✓					✓	✓	Good
S[redacted]	✓		✓	✓				✗	Poor

Legend: ✓ = Yes; ✗ = No; ? = Uncertain; and ✗✓ = Mixed.

to coordinate service delivery or to assist women address the psychosocial issues discussed during pregnancy with Women's ADS counsellors, which could be interpreted as indicative of the need for notification, a conclusion based on a potentially erroneous assumption that substance-dependent women must be mandated to ensure service use. Universal use of the Maternal and Child Health Service and General Practitioners indicates willingness to access non-stigmatizing services directed to the wellbeing of infants.

The women in this study were a heterogeneous group who presented at the Women's ADS with different psychosocial profiles that elevate risk of disruption to caregiving: a history of childhood trauma, depression, social isolation, domestic violence, poverty and poor or unstable housing. By six months postpartum it was evident that not all women were willing or able to give up drug use. Similarly, not all women in situations of domestic violence wanted to leave their relationship (Stanley et al., 2011) and directing parents to separate largely proved ineffective (Stanley et al., 2012). This was a critical time for loss of infants to maternal care. It is highly likely that a longer study-time frame would have recorded greater numbers of infants entering the child protection and out-of-home care system (Forrester & Harwin, 2008). The finding that women most likely to lose the care of the infant were those who had experienced placement in out-of-home care in their own childhood confirms research conducted with substance-dependent women in the U.K. (Gilchrist & Taylor, 2009). Without familial support, or appropriate service provision, this sub-group of women was unable to safely retain infants in their care. As it is not possible to fully eliminate risk (Gambrill & Shlonsky in Shlonsky & Friend, 2007), the harm reduction approach underpinning the AOD sector has been proposed as a means of working with families where there is domestic violence (Shlonsky & Friend, 2007). Both are long-term problems (Stanley et al., 2011); in combination, they are serious cause for concern.

The harm reduction approach accepts that recovery from addiction is typically a non-linear process involving cycles of change with likelihood of relapse (Prochaska, DiClemente, & Norcoss, 1992). The concept of 'readiness to change' has recently been considered in relation to women experiencing intimate partner violence. Hegarty et al. (2008) report that returning to a violent relationship, or to an earlier stage of readiness, is part of the process of leaving abusive partners and that most women only slowly come to the realization that their partner will not change. It is now understood that organizational cultures and contexts also facilitate or impede external elements associated with the change process for women and children subjected to family violence (Humphreys et al., 2011).

There is no doubt the infant was a catalyst for change in the perinatal period. The 'window of opportunity' in which women re-evaluate substance use and violent relationships (Pulido, 2001) may have remained open longer with continuity of care (Phillips et al., 2005). According to the women in this study, protective intervention needed to commence earlier (Wickham, 2009) and to continue well beyond the perinatal period. CP was considered potentially helpful, but without engagement of mothers as clients in their own right, professional collaboration was seen to exacerbate parenting difficulties (Davies & Krane, 2006) and to undermine relationships between parents, between fathers and infants and between parents and the wider family. Women with prior experience of child protection were able to negotiate their way through the child welfare system (Radcliffe, 2011). The findings lend support to Darlington et al.'s (2010) contention that women with histories of child protection involvement are more likely to respond with caution or outright hostility which seriously hampers the ability to conduct a thorough assessment and to intervene effectively. The present study also demonstrates that, depending on the extent of trust generated between service provider and mother, experience can also lead to acknowledgement of the need for change and positive help-seeking behaviour and improved infant safety or, just as readily, in greater ability and willingness to conceal problem behaviours including uncontrolled substance use and domestic violence, thereby increasing risk to the infant. Organizational factors, including readiness to work with parents, are therefore of critical importance if harm reduction is to be safely applied in relation to parenting of vulnerable infants. Consideration also needs to be given to the wider social context in which substance use and domestic violence occur.

External intervention helped to prompt insight (Hegarty et al., 2008) in the perinatal period, but the women most vulnerable to losing care of their infants, those with histories of trauma in childhood and adolescence (Gilchrist & Taylor, 2009), resumed substance use and returned to, remained in, or formed new relationships with violent men, all of whom, with one exception, were problematic substance-users. Leaving an abusive relationship and overcoming substance-dependence require more than motivation; much is dependent upon the availability of resources within the informal network and the service sector. As an alternative to infant removal, the mothers in this study recommended increased monitoring of infants provided it occurred with support to whole families, including services to help men address violence and substance-use, and called for improved collaboration between services and between services and parents. These recommendations, and the finding that most referrals by the Women's ADS were not actively followed up by women or service providers, suggests the need for assertive outreach to bridge the gap between obstetric and community-based services.

A differential response in child protection practice needs to do more than determine referral pathways: it needs to be transformative; this could only occur with genuine engagement which relies on establishment of a trusting relationship. A trusted key professional could monitor infant safety and wellbeing, coordinate services (McGlade et al., 2012) and provide advocacy for parents involved with child protection (Darlington et al., 2010). This may help alleviate some of the hostility directed towards child protection workers by parents anxious about child removal (Buchanan & Corby, 2005), reduce the anxiety experienced by child protection workers in high-risk situations (Connolly & Smith, 2010) and enable more accurate risk assessment (LeBlanc et al., 2012) including perpetrator risk assessment to allow for a more nuanced intervention (Humphreys, 2007) with options beyond separation of couples (Stanley et al., 2012). Conversely, increased support to mothers may enable some to parent alone rather than resorting to relationships with men who are violent. As substance-dependent parents are often resistant to service involvement, a comprehensive model of care with home visits and interventions focused on substance-use and domestic violence would be required (Forrester & Harwin, 2006). The key worker would need understanding of addiction and requisite skills for effective intervention in domestic violence. Appropriate service provision would need to be intensive and of sufficient duration to address the needs of all family members. It would, therefore, be comparatively expensive but it may help to break intergenerational cycles of involvement with statutory services and removal of infants and children from parental care through improved, timely and appropriate support.

6. Conclusion

The present study demonstrates accurate assessment of at-risk substance-exposed infants by a specialist AOD obstetric provider and supports research identifying a sub-group of infants at increased risk of separation from mothers. The longitudinal method illustrates that practice is hamstrung by reliance on statutory services to monitor and intervene and that the current response does not lead to resolution of the issues that bring infants to the attention of child protection. If we are to restore the client's place in human service intervention, and uphold parental rights to care for infants and the rights of infants to remain safely with parents, scarce resources need to be targeted to the most vulnerable mother/infant dyads, men need to be engaged as fathers and a relationship with a trusted professional needs to be established to ensure effective child welfare practice.

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Melbourne Research Alliance to End Violence Against Women and their Children:

Briefing Paper No. 4 on 'Responding to children: Strengthening statutory (child protection) and non-statutory work with victims (women and children) and perpetrators in the context of family and domestic violence'

Authors: Cathy Humphreys, Lucy Healey, Kristin Diemer

Responding to Children: Strengthening statutory (Child Protection) and non-statutory work with victims (women and children) and perpetrators in the context of domestic and family violence

Relevant to Royal Commission into Family Violence Issues Paper questions: 8 -11, 20

Introduction

The negative impact of domestic and family violence (DFV) on children is now well established. The heightened risks of physical and sexual abuse are recognised, and the impact on the relationship between women and their children is beginning to be acknowledged. Attention is also being given to the long-term effects on the emotional (Holt et al, 2008) and physical wellbeing (Riviara et al, 2007) of children and the ways in which children living with family violence are also more vulnerable to other forms of abuse, outside as well as inside the home. In short, the needs of children of all ages from infants to adolescents who are living with family violence are now well articulated. However, effective ways of responding to their needs are far less developed. The response to the needs of children living with DFV rather than the knowledge base about children and DFDV is the focus of this paper.

This submission draws from 20 years of training, writing, researching in the area of children and domestic violence. Relevant research includes: '*Talking to My Mum: An action research program to strengthen the mother-child relationship in the aftermath of domestic violence*; a UK project contracted by the Lord Chancellor's Department, *Identifying thresholds: arrangements for contact in the context of domestic violence and child welfare concerns*; *The L17 Triage demonstration project*; the ARC linkage grant: *Fathering Challenges: Promoting responsive, reparative, responsible fathering in the context of domestic and family violence*. Three articles are attached.

Key messages:

Many children are currently referred to child protection as the pathway for the assessment of risk and access to services. The majority receive neither an investigation nor a service. A differential pathway which routes most children and their mothers to community based services is required, with child protection as a referral in only the more complex cases. The pathway to children's safety through separation is currently marred by the Family Law response which is frequently unresponsive to the on-going dangers and threats to the well-being of children who are continuing to live with post-separation violence.

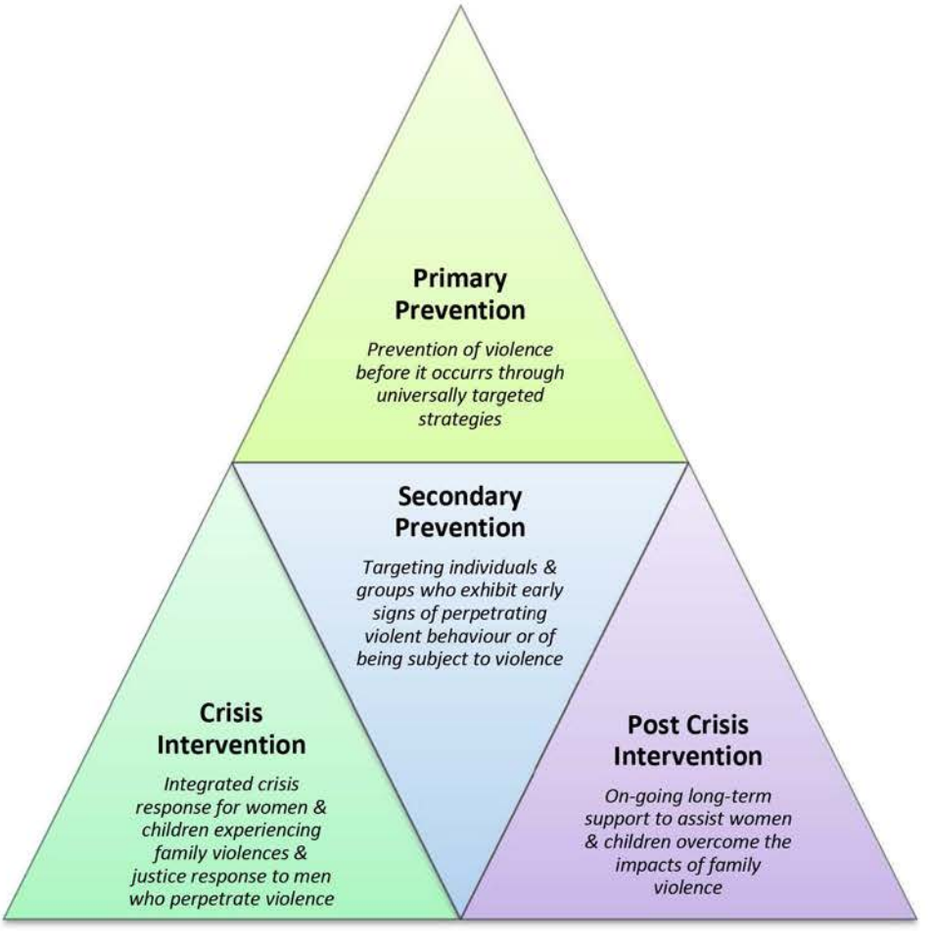
Challenges include:

- Ensuring that FDV intervention addresses primary, secondary prevention as well as providing crisis and post-crisis services for children living with FDV.
- Responding to the volume of children in families involved in FDV and providing a differential response to Child Protection intervention.
- Responding to both adult and child victims: not only responding to the woman survivor as a mother but also addressing her needs as a victim.
- Engaging children in relation to their individual issues but also strengthening the mother-child relationship.
- An ability to focus intervention on the perpetrator of violence, usually (though not exclusively) the child's father or step-father.

- Recognition of FDV as a primary issue and not only as background to other adult issues such as substance use and mental health problems.
- Reaching out to minority ethnic and indigenous families, and mothers with disabilities in ways that leave them with a sense of empowerment rather than fear.
- Addressing the problems which occur when the Family Law response is disconnected from the family violence intervention for children, women and men.

Addressing both prevention and the response to children living with DFV is an essential framing for intervention. A model specific to the DFV sector has been developed by a group of community service organisations to illustrate the different levels at which service provision is needed (Desmond, 2011).

Figure 1: Family Violence Intervention Pyramid (Desmond, 2011 p.7)



Primary Prevention

Currently, most of the resources for children living with DFV are directed to crisis intervention. While important, the long term answers to the 'wicked problem' of DFV lie in the primary prevention area. In relation to children and young people, child care centres, youth clubs, primary and secondary schools are critical to the development and the implementation of respectful relationship programs. These programs need to be part of curriculum and programing across these organisations. At this stage, programs are ad hoc and not necessarily a mainstream aspect of the curriculum. At the secondary school level, they need to

address the issues of sex education in the context of respectful relationships, addressing the issues of pornography, sexting and internet bullying.

Given the devastating impact of DFV on health, well being, the economy and the ability to learn, it cannot be argued that this aspect of curriculum is marginal and should be the domain of parents and families. The fact is that one in four children (Indermaur, 2001) will be exposed to FDV across their childhood and they therefore require strong value messages about relationships which are respectful of women and which eschew violence supportive attitudes and behaviour. Our Watch is leading the way in this area and the programs and priorities suggested by that organisation will need to be resourced and supported.

Secondary Prevention: pregnant women and women with infants

Many groups within the community have been identified as more vulnerable than others and hence could be the subject of targeted resourcing. I have chosen to raise concerns for pregnant women and women with infants. In a secondary prevention strategy, this also would engage with men in their role as fathers.

The risks for infants living with family violence are critical. Fear and trauma directly affect the infant's brain development and the mother's fear of violence may affect her ability to tune in appropriately to the needs of her baby (Jordan and Sketchley, 2009). The more comprehensive research studies show that children of mothers with a history of DFV have significantly greater use of mental health, primary care, specialty care, pharmaceutical services than those who do not live with family violence – including children where the violence ended before the child was born (Rivara et al 2007). Intervention early in the child's life course has measurable cost benefits (National Research Council and Institute for Medicine, 2000), not only in terms of dollars invested early but in terms of the long term well-being of children. Evidence suggests that the prime time for engagement lies in pregnancy and following the birth of the baby (Wulczyn, and Barth, 2005).

Victoria has developed the Cradle to Kinder program (http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/children,-youth-and-family-services/cradle-to-kinder-program) targeted at vulnerable pregnant women under 25. Vulnerability specifically includes young women with disabilities, teenage mothers, aboriginal women and those women with an out of home care background. Many of these women will be living with DFV. This has been an important development and one which needs to be retained as an integrated and long term aspect of the service system. It has taken Victoria beyond short term pilots into the provision of an infrastructure of support provided through the Child First Catchments and Family Alliances, and driven by multi-agency advisory groups, quality standards and detailed guidance.

The provision is still in the process of being 'rolled out' across Victoria. My view is that this is the infrastructure for work with vulnerable pregnant women and their infants and that further services in this area need to be linked or embedded in this program of work. To address the issues for pregnant women living with FDV further developments will be required. These could include:

- Further funding to allow services to be provided for pregnant women and women with infants who are subject to DFV, but who do not currently meet the specific criteria for this program. This would include women referred from Maternal and Child Health where DFV has been identified.
- Funding to support co-working between Cradle to Kinder and the specialist DFV service in the area to ensure that the women's needs in relation to DFV are addressed alongside her needs as a mother (housing, financial, legal, medical).
- The provision of specialist DFV support programs which have been trialled or evaluated and which provide intensive support for those women living with DFV. For example: a) The MOVE

project to support maternal and child health nurses to identify and respond to family violence based developed by Professor Angela Taft (Taft et al, 2012; Hooker et al, 2015); b) The Mentoring Mums project provided by Children's Protection Society (Mitchell, Absler and Humphreys, 2015) and the MOSAIC project, a mentoring program developed for pregnant women and young mothers; c) The 'Peek a Boo' program for infants and their mothers affected by family violence developed by Wendy Bunston http://www.waimh.org/Files/Signal/Signal_2006_14_1.pdf

- The development of alcohol and drug programs which support pregnant and new mothers to engage closely with the FDV sector through support workers with specific community liaison roles (e.g. the Women's Alcohol and Drug Service). Currently, this program confines its service to the women while in hospital. However, research indicated that the critical referrals to community sector organisations (including DFV organisations) which followed discharge from hospital needed much greater support and liaison to be effective. Only those women referred to statutory child protection continued to be connected to the service system (Tsanfeski, Humphreys & Jackson, 2014).

The work with new fathers is under-developed in Victoria. Even the universal service system is named 'Maternal and Child Health', a name which immediately excludes fathers as central to the lives of their infants. Emerging research on the effectiveness of using fatherhood to engage men in preventing violence indicates that engaging men as fathers through parenting programs shows some promise in preventing child maltreatment (see Pfitzner, Humphreys and Hegarty forthcoming 2015). This mirrors work on interventions for male perpetrators of domestic violence that highlights the effectiveness of strategies that engage men as fathers in motivating behaviour change and preventing further acts of violence (Featherstone & Fraser, 2012; Stanley, Graham-Kevan, & Borthwick, 2012). This approach is now being explored in domestic violence primary prevention (; Flynn, 2011; Tiwari, 2012).

Early intervention programs such as 'Baby Makes 3' are being trialled in specific regions of Victoria and the issues of engaging men as an early intervention strategy are being explored (Pfitzner, Humphreys & Hegarty forthcoming, 2015). While this is an important step, three group work sessions directed towards fathers within a 'respectful and equal relationship' model provides only one spoke in what should be a complex wheel of inter-connected parenting services. This is a specific area for further service development in Victoria.

Responding to children living with DFV

The challenges listed at the front of this submission point to a range of issues that need to be solved to strengthen the family violence intervention for children living with DFV. The issues are particularly relevant for the statutory child protection response but apply more broadly to other services engaged in responding to women and their children.

- *The development of a differential response to children living with DFV*

A particularly difficult issue to grapple with in family violence intervention is the need for a differential response to children and their mothers (see Humphreys, 2007). Not all children are equally affected by the violence and abuse they live with. At the extreme end, we have the tragic deaths of a number of children who were living with domestic violence. However at least a third of children do as well as those not identified as living with family violence (Laing and Humphreys, 2013). Protective factors will be in place. Family violence, while debilitating and destructive, varies in severity and impact (both physical and

emotional). Separation is not necessarily a panacea as so many children are exposed to ongoing post-separation violence via child contact arrangements and the process of separation holds heightened dangers (Stanley et al, 2011; Thiara and Humphreys, 2015).

The default position in Australia, the United Kingdom (UK) and North America has tended to be to refer all children living with family violence to statutory child protection. Sometimes this is through legislation on mandatory notification, at other times through practice guidance. Hitching children who are living with family violence to 'the child protection juggernaut' (Featherstone and Trinder, 1997) fails to acknowledge the differential response that may be needed and more appropriate.

While some children undoubtedly are at risk of significant harm and require a referral to child protection, there are problems with routing *all* affected children through this pathway. Evidence from our research on the L17 Triage Project in Melbourne's northern metropolitan area drawing on data collected from November 2012 to November 2013 (total cases vary according to collecting agency's data) showed the following:

- The rate of closure of police family violence incident referrals at CP intake requiring no further action was 79% (L17 Triage Project).
- Of 1,960 police referrals to CP, only 13.9% resulted in a CP investigation (L17 Triage Project).

The data mirrors that of a case tracking study in the UK of cases referred by police to child protection (Stanley et al., 2011). Their study concluded that of 251 cases only a small percentage resulted in an investigation and only 5% of children were assessed for a service to provide for their needs. Interestingly, more than 50% of referrals involved post-separation violence much of this around child contact. The statutory net was widened but little effective action taken. A similar picture emerged in NSW. Data generated for the Wood Inquiry in NSW (Wood, 2008, p699) showed that of 76,000 reports where a risk of harm from domestic violence was the primary reported issue, only 5000 (6.5%) cases were substantiated and this did not necessarily result in the family receiving a service. NSW and WA have now moved towards a differential response which diverts most cases of children living with DFV to community sector organisations.

Infrastructure is needed to support a differential response. In NSW this has been provided by an electronic structured decision-making tool across the whole system of statutory child protection; in WA triage teams which include child protection, police and the specialist family violence sector provide the initial confidential information sharing and decisions about service pathways. In Victoria, initial work has been undertaken in the North Metro Region and the basis for the development of a confidential triage between police, child protection and specialist domestic violence services is in place. An agreed risk assessment is in the process of development but further work is required to agree the thresholds for child protection intervention. Funding is required to support a demonstration project.

A further infrastructure measure needs to be an increase in funding to ensure that many children diverted from child protection gain some form of service; and that workers in either women's services or family support services are trained to intervene with women and their children.

- *Addressing the issues of children living with post-separation violence*

Currently, the child protection system is not designed to intervene effectively where there is a protective mother (or father), but the child and often the mother are continuing to be subjected to post-separation violence and stalking. Much of the abuse occurs when the child moves from time with their father to time with their mother (see Briefing Paper 5). Under these circumstances, children are not safer and their well

being not protected when abuse occurs at 'handover'. However, on-going stalking and on-going control through texting, threats and the use of social media means that the child's mother can continue to be abused and her mothering undermined. The absent presence of the perpetrator of violence and abuse is often experienced many years after separation (Thiara and Humphreys, 2015).

In the past, 'separation' from an abusive relationship has been used as a marker of 'the protective parent'. However, separation is a time of heightened risk, danger and fear for women and their children. While all Intimate Partner Violence risk assessments recognise that separation creates a heightening of risk, the child protection intervention has been slow to consistently recognise this fact (Humphreys and Absler, 2011; Douglas and Walsh, 2010). Women are still urged to separate but without the necessary supports to keep themselves and their children safe. Support would need to include: extensive discussion to assess 'readiness', potentially including motivational interviewing; the evidence to demonstrate that the child's father is a danger to the child; proactive links to the family violence support services; and leverage provided with housing services, Centrelink and legal proceedings to ensure that there is accommodation (beyond a couple of nights in a refuge), money to live on and legal protection which is enforceable. Children are no safer if they are homeless and immediately subject to contact arrangements with an abusive father. This is an area for practice development and more effective working between Family Court services (including organisations providing Family Dispute Resolution services), and child protection, RAMPS, and the family violence sector.

- *Focusing on the perpetrator of DFV*

A particular source of criticism of child protection intervention, but one which also relates to other services has been the tendency to focus on the adult victim (usually mother) and her ability to protect her children, rather than intervention which effectively targets the perpetrator of the abuse who is the source of the risk (Stanley et al, 2011; Laing and Humphreys, 2013).

There are significant policy and practice developments which are attempting to shift the focus on child protection workers and their practice. These developments need to be fully supported and enhanced. DHS in Victoria published a specialist practice resource, *Working with families where an adult is violent* (DHS, 2014) and provided training across the state to support the launch of the new resource in 2014. This is an excellent start, but a rolling program of training and development is needed.

Several state child protection departments and No To Violence (Victoria) have engaged David Mandel from the US who has developed work with child protection which focusses on the perpetrator of violence and support for both adult and child victims through the use of the 'Safe and Together' resources. http://endingviolence.com/ Subsequent training with No To Violence has capacity built the child protection response (http://ntv.org.au/resources/ Continuing to support this professional development will begin to address the shift in 'culture' which is required to change the focus of child protection work.

Other states have developed work within the family violence and family services areas to work with perpetrators of domestic violence. For example, Burnside Uniting Care in conjunction with the Parenting Resource Centre and NSW Department of Family and Community Services are developing practice and resources to work with a 'harm reduction model' of domestic violence focused on those families where the

perpetrator is currently remaining in the home http://www.parentingrc.org.au/index.php/sharing-knowledge/advancing-the-science-and-practice-of-implementation/unitingcare-burnside-supporting-the-implementation-of-a-domestic-violence-practice-framework The work is at a relatively early stage. However, it is an important development for family services working where there is DFV. Many women are unable to leave (no residency status; remaining committed to the perpetrator of abuse; no available housing; unfavourable Parenting Orders which provide the perpetrator of abuse with extensive time, unsupervised with the children; a desire to stay in their own home, but ineffective FV Intervention Orders etc.). In these circumstances it is important to develop strategies for working with some (not all!) perpetrators of abuse and their families. It is an important area for exploration.

It may also present greater clarity for the service pathways where there is DFV. The specialist DFV organisations are primarily women's services which are also developing skills in working with children. Their core business is not with men. On the other hand, the family support services are designed to work with families with complex needs, including where there is DFV. The work with perpetrators of DFV is currently under-developed. Potential lies in the work being developed by the Parenting Research Centre, closer alignment with MBC programs (including tight feedback loops), and the development of work with perpetrators through David Mandel's *Safe and Together* resources. NTV is advocating that each perpetrator of abuse have a customised individual plan which provides the basis of intervention with the Courts, MBC programs, Corrections, Child Protection, mental health services and family services. This is a recommendation which should be supported.

- *Strengthening the mother-child relationship*

Strengthening the mother-child relationship in the aftermath of family violence is a key point of intervention. A significant aspect of family violence is the systematic attack on the mother-child relationship as one of the major tactics of abuse. This may be a direct attack – coercing children to insult their mothers, undermining the woman's mothering through criticism and actions which make it difficult for her to parent, ensuring that women are 'punished' for spending time with children particularly if it takes attention away from the man's needs. It also can be an indirect attack which disables the mother physically or emotionally so that she is unable to parent appropriately. Interventions which work to actively strengthen the mother-child relationship in the aftermath of abuse are still in the early stages of development, although it is an area gaining traction (See Special Edition of *Child Abuse Review*, September, 2015). The *Talking to My Mum* activities developed through an action research project with women and their children (Humphreys et al, 2006 a & b) are but one of a number of supports for this work.

Evidence is emerging that the most effective intervention response in the post-crisis period for both women and children is for them to work together, either in parallel children's and women's groups (see Bunston, 2008; Humphreys et al, 2015) and joint mother-child rather than individual counselling (Liebermann et al, 2006).

Currently, the post-crisis work for women and their children is marginalised in the DFV intervention. An audit of different programs for children living with FV in 2011 undertaken by Tracy Castellino and myself showed a wide range of group work and individual programs throughout Victoria. However, none of these programs had on-going funding and by the end of 2012 most programs had either been de-funded, were projected not

to move beyond the pilot phase or were under threat. The sector clearly sees the need for this work with children, but long term funding streams have not been forthcoming.

Opportunities for policy and/or practice

- The development of DFV prevention programs (respectful relationships programs) which are part of mainstream activities within schools, child care centres and youth facilities are an essential arm of the DFV strategy. Recommendations derived from Our Watch consultations will require resourcing and support.
- The value of early intervention programs for infants is recognised and effective programs are provided with ongoing funding and the potential for further extension of programs to develop work with fathers and with a wider range of new, but vulnerable mothers.
- Developing the policy to manage a differential response that diverts most children and their families to community-based services rather than into child protection intervention where most are never provided with a service. Initial rapid risk screening (triage) of all police family violence incident reports (L17 reports) for victims (adults and victims) and perpetrators needs to be developed. This would take place within defined geographic areas and maximise referral pathways.
- Developing nuanced risk assessment and risk management tools, which are agreed across the multi-agencies and support a differential response. This includes police, judges and magistrates (particularly in the family law and children's court jurisdictions) alongside CP and FDV agencies.
- Responding to post-separation violence and specifically developing an alignment between concerns for the harm to children identified through child protection, family support services the specialist family violence sector and decisions made in the Family Law arena. This is currently the weakest point in family violence intervention.
- Recognising that FDV represents an attack on the mother-child relationship, and that it is crucial to look at the *perpetrator's behaviour* (not the relationship or the survivor's behaviour as the source of the risks to the child). This means ensuring CP with the requisite skills and knowledge to work with perpetrator-fathers as well as professional development work with family support services. The development of individual plans for perpetrators of DFV which can be used to align work across organisations and courts.
- Training workers in the foundational concepts relevant to children living with FDV, including their important role in documentation of the violence and abuse. This means CP workers documenting what the mother is doing to support her child and accurately documenting the harm the father is doing and has done to the family.
- Providing resourcing for the post-crisis response for children and their mothers living with and separating from family violence.

Summary

To date, we have been better at identifying than resourcing and responding appropriately to the needs of children living with family violence. The area has been characterised by innovation but problems lie in sustaining a strong and ongoing response in all parts of the service system from primary prevention to post-crisis services. The issues for children living with DFV are critical but frequently marginalised in our current response.

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Contact: Cathy Humphreys; [redacted]

AUSTRALIAN DOMESTIC AND FAMILY VIOLENCE CLEARINGHOUSE

DOMESTIC VIOLENCE AND CHILD PROTECTION: CHALLENGING DIRECTIONS FOR PRACTICE

CATHY HUMPHREYS[1]

School of Social Work, University of Melbourne

INTRODUCTION

This discussion is framed by a concern, fuelled by growing evidence, that the statutory child protection system in a number of Australian jurisdictions is in danger of being overwhelmed by referrals of children affected by domestic violence. At one level, this reflects a positive recognition, evident in legislation, policy and practice, that children can be profoundly affected by living with domestic violence. It is a testament to the active work undertaken in Australia (Breckenridge and Laing, 1999; Gevers, 1999) and elsewhere (Mullender and Morley, 1994; Jaffe *et al.*, 1990), to highlight the needs of children affected by domestic violence and which, it could be argued, has been successfully translated into mainstream service provision (Fraser, 1989).

However, this achievement has brought with it some unintended consequences. There are indications that without intervention the statutory child protection system in some states will be pushed towards systemic failure. Critical thinking about the current response is timely and is occurring in different ways in all states (see Jacob and Fanning, 2006; DoCS, NSW, 2006a). This paper is written as a 'think piece' and contribution to these discussions. It raises some difficult questions about the directions of current practice around child protection and domestic violence.

In its first section, this paper contends that 'grafting' domestic violence onto the extant child protection system can push an already vulnerable situation towards system failure, when judged against the criteria for a functional system (Checkland and Poulter, 2006). It argues that issues specific to domestic violence need to be addressed if a more effective intervention is to occur for children affected by domestic violence[2]. In this first section four issues are explored, along with negative and unintended consequences that have arisen. They invite the re-consideration of the referral or notification[3] to statutory child protection

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[1] Cathy Humphreys is the Alfred Felton Chair in Child and Family Welfare at University of Melbourne.

[2] Parallels can be drawn with the response to child sexual abuse in the eighties when it was realised that key issues, particularly in relation to criminal justice, were not addressed by a system focused on physical abuse and neglect.

[3] There is a difference between states about whether a call of concern about a child is recorded as a notification or a referral.

agencies of all children affected by domestic violence often, although not always, due to the requirements of mandatory notification.[4]

In section two, the discussion explores directions for a more functional system to respond to children's safety and well-being. It specifically considers whether fewer children affected by domestic violence could be referred to statutory child protection and a greater use made of other services for children and their families, which support their safety and well being. In the first instance this involves an examination of the research evidence in relation to the impact of domestic violence on children. The paper explores whether there are clues for future policy and practice that take into account more nuanced understandings of the evidence base and deal with the complex and difficult issues of severity, risk management and safety. Alternative pathways for referral, the essential development of services and interventions to respond to children, women and men, and a system based on high levels of multi-agency co-operation (if not integration), are then discussed.

Through the paper, arguments are made for a functional statutory child protection system, in which the notification of children affected by domestic violence can be judged in relation to:

- efficacy (does it produce its intended outcome – a satisfactory management of the intake and intervention for children affected by domestic violence?)
- efficiency (does it do this with the best use of resources?)
- effectiveness (does it achieve a higher-level or longer term aim – the safety and protection of children?) and
- ethicality (are the purposes of the system met in ways which are congruent with principles and values which promote respect and justice for children and others affected by domestic violence (usually women)

These criteria for performance are raised to trigger reflection and dialogue amongst stakeholders in policy and practice about the difficulties in responding to children affected by domestic violence. While specific questions are raised about the complexities of notification, the discussion raises broader issues about the response of child protection services to children affected by domestic violence. This is a complex area in which there are multiple perspectives and understandings of different terms and language. The discussion begins with a clarification of terminology.

Clarifying the terminology

The Australian Domestic and Family Violence Clearinghouse favours a definition of 'domestic violence' adopted by the Commonwealth Partnerships Against Domestic Violence program in 1997:

[4] This discussion does not explore the referral or notification of other categories of child abuse, such as child sexual abuse, even though it is recognised that there is an overlap between domestic violence and child sexual abuse.

> *Domestic violence is an abuse of power perpetrated mainly (but not only) by men against women both in relationships and after separation. It occurs when one partner attempts physically or psychologically to dominate and control the other. Domestic violence takes a number of forms. The most commonly acknowledged forms are physical and sexual violence, threats and intimidation, emotional and social abuse and economic deprivation. Many forms of domestic violence are against the law. For many Indigenous people the term family violence is preferred as it encompasses all forms of violence in intimate, family and other relationships of mutual obligation and support.*

'Domestic violence' is used as the preferred term for this paper, as it provides a closer reflection of the data gathered in the different states, particularly by the police.[5] Gendered terminology is also used throughout the paper to reflect the dominant patterns of violence and abuse, namely that women are the primary victims and men the primary perpetrators of domestic violence. This is not to deny minority patterns of same sex violence and women perpetrating violence against men.

The terminology 'children affected by domestic violence' is used to overcome the problematic divisions sometimes made between 'children witnessing domestic violence', 'children exposed to domestic violence', 'children directly abused in the context of domestic violence', 'children living with domestic violence' and 'children drawn into domestic violence'. 'Children affected by domestic violence' covers all these overlapping groups, including those where healing from trauma and disruption in the aftermath of domestic violence is an issue.

'Integration' is another term requiring clarification. It is a term now often used loosely to describe almost any form of, or aspiration for inter-agency co-operation. In this discussion, integration is more tightly defined than co-operation and refers to agencies forming shared governance arrangements at a strategic level and intensive case management, based on shared protocols and data sharing arrangements at operational level for front line workers (O'Brian *et al.*, 2006). A continuum of multi-agency working occurs from relatively minimal co-operative relationships, via co-ordination of work towards a common goal, through to active collaboration and finally to integrated services.

SECTION 1: PROBLEMS 'GRAFTING' DOMESTIC VIOLENCE ONTO CHILD PROTECTION

It could be argued that currently a relatively simplistic response to the safety and well-being of children has been taken across many states in Australia. This response suggests that, given many children are harmed or at risk of significant harm as a result of living with domestic violence, then all children known to be affected by domestic violence should be referred to a statutory child protection system. Some states build this into Codes of Practice for major referrers, such as the police; others have it written into legislation. Some states explicitly name domestic violence as an aspect of child abuse and require

[5] Other Australian articles make very cogent arguments for adopting alternative definitions of family violence and intimate partner violence respectively and provide excellent discussions on language and conceptualisation (Hegarty and Roberts, 1998; Tomison, 2000).

any adult or a wide range of specified professionals to report to the statutory child protection authority.[6] While the intention is laudable, serious problems arise when a child protection system is not structured to manage either the extent or the implications of the issues for these children and their families. This section explores four issues which create limitations to the statutory child protection response.

Issue 1: Domestic violence - a chronic social problem

This issue concerns the statutory child protection system response to domestic violence; a wide spread and chronic social problem. The extent of domestic violence and the level of notification to state child protection systems, alongside the implications for resourcing, raise serious questions about the effectiveness of the current response.

Three Australian population surveys show very significant rates of violence against women by current or former partners. These are:

- the *Personal Safety Survey* (*PSS*) (ABS, 2006)
- the *International Violence Against Women Survey* (*IVAWS*) (Mouzos & Makkai, 2004) and
- the *Women's Safety, Australia* survey (*WSS*) (ABS, 1996).[7]

The Australian component of the *IVAWS* surveyed over 6000 Australian women and found of women who had ever had an intimate partner, 34% reported experiencing at least one form of violence from a current or former partner (Mouzos & Makkai, 2004, p. 44). The *WSS* (ABS, 1996) had previously showed 23% of Australian women who were currently in or had previously been in an intimate relationship, had experienced physical or sexual violence from a partner. The *PSS* (ABS, 2006) showed that of women who were physically assaulted in the 12 months prior to the survey, 31% were assaulted by their current or former partner (p. 9). An important finding from the *PSS* has been a notable increase in women reporting physical assault by a male perpetrator to the police in the 12 months prior to the survey, from 19% of incidents in 1996 to 36% of incidents in 2006. This, nevertheless, leaves around two-thirds of incidents unreported to the police.

The data from the prevalence studies in Australia and elsewhere suggests domestic violence covers a wide range of abusive behaviours that may vary in both severity and frequency (Statistics Canada, 2006; Walby and Allen, 2004). In Australia, the *PSS* (ABS, 2006) reported that 50% of women reported one incident, while for other women the violence and abuse was chronic and severe, and led to living with high levels of fear.

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[6] It is recognised that there are substantial differences between states but it is not considered appropriate in this discussion to document and make comparisons between them, particularly when both legislation and policy is changing so rapidly but see AIHW (2006) and Bromfield and Higgins (2005).

[7] Problems of under-reporting apply to these population surveys: e.g. they tend to be incident based whereas domestic violence refers to a wide range of strategies of power and control; in the *PSS* the representation of men was low relative to the representation of women; remote communities where there are high levels of domestic violence reported elsewhere were not surveyed; a UK survey found that using confidential self-completion computerised questionnaires significantly increased the amount of reporting compared with interview techniques, such as those used in the Australian surveys (Walby and Allen, 2004).

Violence and abuse occur in all communities, though there is an increase in vulnerability for women living in poverty and where other issues of inequality surface due to social exclusion (Walby and Allen, 2004), disability (Baldry *et al.*, 2006) and compounding forms of discrimination. These issues are exemplified by the high levels of violence experienced by Indigenous women (Blagg 2000; Ferrante *et al.*, 1996).

Children and young people can rarely be protected from the knowledge that domestic violence is occurring. The *PSS* reports that 61% (822,500) of men and women who had experienced violence by a previous partner had children in their care during the relationship, while 49% (111,700) of people who reported experiencing violence by a current partner said they had children living with them (ABS, 2006, p. 11).[8] A further study of 5000 young Australians showed that one quarter reported witnessing violence against a parent (Indermaur, 2001). These are profoundly concerning figures which point to a chronic and pervasive social problem affecting high numbers of children and women, and undermining both individual and community safety and well-being. This problem is also reflected in the referral of children to statutory child protection services, though inferences need to be made as domestic violence is subsumed under the standard categories of neglect, emotional, physical and sexual abuse (AIHW, 2006).

Throughout Australia, the child protection notification rate has more than doubled in seven years from 107,134 in 1999/00 to 266,745 in 2005/06 (AIHW, 2007a). The rate varies between states and different recording processes make comparisons impossible[9]. Some of the rise reflects changes in recording practices. Victoria remains the exception in the state systems, holding a steady rate of approximately 37,000 notifications. All other states have seen significant rises. For example, Queensland, NSW and the ACT doubled or more than doubled the number of notifications in this period.

The Australian Institute Health and Welfare (AIHWR) report (2006) suggests the shift in notification rate reflects an increase in media attention due to high profile reports into child abuse in different states, which has increased the number of people reporting to child protection services. They also cite a change in the characteristics of families where notification occurs and particularly the proportion where domestic violence is an issue. New domestic violence legislation in Tasmania and Western Australia is also noted as a contributing factor, particularly with the strengthening of the requirements for mandatory reporting where there are children affected by domestic violence.[10] State co-ordinators who were consulted for this paper confirm the significant increase in notifications due to domestic violence.

Two examples are taken to highlight the notification issues, though several other states could also be chosen. In both NSW and Tasmania referral is to a centralised intake point

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[8] Interestingly, police data on attendance at family violence incidents (representing only a minority of actual incidents) show similar patterns to the prevalence data. Victorian police attended 28,000 incidents in 2005, of which children were present in 48% of cases (*Family Violence Reform Initiative,* 2005).

[9] For example, some states count all referrals to intake as a notification, others only those which are investigated.

[10] See Bromfield and Higgins (2005) for a more detailed outline of the similarities and differences across Australian states in mandatory reporting.

and mandated for most workers. In NSW this includes people who deliver health care, welfare, education, children's services, residential services or law enforcement to children. In NSW it is the subject of a considerable fine for those who do not report (*NSW Children and Young Persons (Care and Protection) Act 1998*). In 2004-05, domestic violence was the most common primary reported issue to the central NSW Helpline, constituting 27.2% (58,758 reports) of the total of 216,386 reports[11]. This is an average rate of more than 1000 reports a week (DoCS, NSW, 2006). *The Report on Child Protection Services in Tasmania* (2006) notes that mandatory reporting under the *Children, Young Persons and Their Families Act* (1997), combined with the *Family Violence Act* (2004) has substantially lifted the rate of notifications, though the actual percentage of the 10,788 notifications which involve domestic violence is unspecified. The Report does provide an estimate that 80% of the 2,678 police notifications involve domestic violence.

Major implications are arising as a result of the over-extension of the child protection system across Australia to manage this increase in demand. It raises general issues, as well as ones specific to children affected by domestic violence, due to the proportion of the increase related to these children. The exponential rise in notifications shown in some states has also seen a substantial lowering of the proportion of investigations[12]. The substantiation rate remains relatively steady although the point is made very clearly that a very large proportion of investigations are not substantiated and the proportion of notifications which are investigated varies from 100% (in states which only name cases as notifications if they are to be investigated) to 29% (AIHW, 2006). While noting that there are differences in reporting, notification and substantiation patterns between states, it is nevertheless worth commenting on the fact that of the quarter of a million notifications Australia wide in 2006, only 21% were substantiated, with some states showing particularly low rates of both investigations and substantiations.

Many politicians, policy workers and researchers are highly committed to the value of mandatory reporting by a wide range of professionals and for any form of child abuse including domestic violence (Liddell *et al.*, 2006). It is seen as an appropriate recognition of the seriousness of child abuse, and of the problems, if not the dangers of professional discretion, and a process through which a hidden problem becomes visible. In some states, particular efforts have been made to bring children affected by domestic violence to attention through this process so that the extent of their needs can be recognised. Legitimate concerns arise about whether children affected by domestic violence would be sidelined if there was not the expectation to report all children.

While recognising these benefits, the problems of the inundation of the statutory child care system is now leading to a serious questioning of this policy more generally (Scott, D. 2006). The significant 'net widening' of the child protection system means that it now includes many more families but with a high proportion for whom a worker is not allocated, where there is no investigation, and where the threshold for significant harm and the substantiation of abuse does not occur (Scott, E. 2006). Re-notification and re-substantiation remains an issue (AIHW, 2007b). In this discussion, the particular concern

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[11] Referrals of concern to the central helpline are screened and classified. 152,806 children went forward as a notification under the AIHW data (2007a).

[12] Notification data is very dependent on the different criteria used by states to record a notification.

is raised with regard to the net-widening caused by the increase in referrals of children affected by domestic violence.

Research by Irwin *et al.* (2002), and the Tasmanian Report on Child Protection Services (Jacob and Fanning, 2006) point out that the designation of a category of 'domestic violence' and mandatory notification has not necessarily improved services for women and children living with domestic violence. The Tasmanian Report raises a paradoxical and concerning situation:

> *While introduced in Tasmania and elsewhere to increase the referral net for child protection referrals and improve child safety, mandatory reporting has had the unintended negative consequences of overloading the statutory system without necessarily improving child safety* (p.59).

The study by Irwin *et al.* (2002) also notes that domestic violence-related referrals were less likely to result in an investigation. Where investigation occurred it was more likely to result in referral or closure, and there was little follow up of cases referred to other agencies. A further concern was that re-referral was commonly associated with domestic violence, even if not noted as the primary reason for re-referral. Moreover police were experiencing an unintended consequence, namely that some women were no longer calling the police due to the fear of the mandated child protection referral (Irwin *et al.*, 2002). Others have noted that children who are at high risk may not be able to be found amongst the huge number of referrals which are currently swamping the system (Scott, D. 2006).

The costs of this shift in reporting have been raised both in Australia (Mendes, 1996; Ainsworth and Hansen, 2006), and in the United States (Edleson, 2004). The thought provoking article by Edleson (2004) draws on Minnesota as a case example. He points out that the changes to the *Minnesota Reporting Act 1999* resulted in a 50%-100% increase in child protection reports for domestic violence exposure. He goes on to state:

> *This seemingly simple and unfunded change in the law created the need for over $30 million in expanded services to newly identified families. The experience was so overwhelming for child protection agencies that the Minnesota Legislature repealed the change in April 2000* (p.8).

The view of this eminent researcher was that the lack of resourcing to child protection agencies meant that only high risk cases were provided with further services, and that screening and investigation did not help to strengthen these families (Edleson, 2004). Similar points are made by Ainsworth and Hansen (2006) about the child protection system more generally. They highlight the estimated 38.8% increase in costs of child protection over five years (p.37) and this was prior to the more substantial increases in notifications since their 2003 analysis. In an analysis of the impact of changes to mandatory reporting criteria in Victoria in 1993, Mendes (1996) points out that unless there is the political will to resource the change, the major effect is that welfare resources from the family support and prevention services are simply diverted into the statutory sector.

This issue has re-ignited discussions about the balance between family support and statutory investigation both here and in the UK (Parton, 1997). Statutory intervention shifts the emphasis of work from services *for* families to investigation *of* families (Scott, D. 2006). While each state has increased its provision for family support services (AIHW,

2006, 2007a) this provision has to be weighed against the policy and legislated demands associated with the increasing level of notifications.

In short, managing this highly prevalent social problem through increasing the notification of children affected by domestic violence to the statutory child protection system raises serious questions about efficacy (can the system manage the notifications appropriately?), efficiency (is this the best use of resources?), effectiveness (are children safer?) and ethics (is 'net widening' ethically defensible when such a high proportion of these families are not investigated or abuse substantiated). It seriously questions whether the problems of referring all children affected by domestic violence to statutory child protection are now outweighing the gains of this strategy.

Issue 2: The interface between specialist domestic violence services[13] and statutory child protection services

The ethics of net-widening, the cost, and the effectiveness of notification and investigation are not the only contentious issues when the statutory response to children affected by domestic violence is considered. Other issues also create difficulties in developing a sensitive child protection response. Perhaps the most significant limitation is highlighted through exploring the difference between two systems: one conceptualised as women-centred, voluntary[14] domestic violence services; the other, a child focused, statutory and involuntary child protection system. Each has their own history, values, policies and practice focus. Unsurprisingly, the interface between these services is not always straightforward (Laing, 2003; Zannettino, 2006; Findlater and Kelly, 1999).

Specialist services developed to respond to women and children living with and escaping from domestic violence are voluntary services. They originated with the second wave of feminism that bought a particular focus to the values of self-determination and empowerment for women experiencing domestic violence. Their development was tied closely to women's refuges and, later, to legal and specialist counselling services (McGregor and Hopkins, 1991). Attention to children's needs in relation to domestic violence was slower to emerge but eventually led from within this sector (Mullender and Morley, 1994; Breckenridge and Laing, 1999). Recent policy and practice development now emphasises the importance of separate but linked services for women and children, that recognise that the safety and well-being of children is tied closely to the safety and well-being of their mothers (Radford and Hester, 2006; Irwin *et al.*, 2003). A core value developed through 30 years of work involves supporting women in their decision-making and ability to reclaim their lives following the abuse of power by their partners or ex-partners. Evaluations by women and children consistently show high levels of reported satisfaction with these services (Chung *et al.*, 2004; Zannettino, 2006; Irwin *et al.*, 2006).

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[13] There are problems in defining the specialist domestic violence sector across different states and funding regimes. Many (but not all) are based in non-government, community sector organisations, they all have a specific remit in relation to providing services for women and children affected by domestic violence.

[14] Women and children can choose and are not compelled to attend

By contrast, the statutory child protection system has a far more ambiguous and often coercive history. The wider community concern to protect children from harm, particularly harm perpetrated by family members, has been recognised since the second half of the nineteenth century (Scott and Swain, 2002). It has spawned legislation that allows the state to intrude into family life to protect children from abuse and neglect. Such legislation provides a structured and often contested interface between the state and the family, in which there is constant tension between the care and control functions of the state: the fine line drawn between support and authority (Parton, 1991).

In Australia, this includes the history of the eugenics discourse in the first half of the twentieth century that rationalised the role of the state intruding into Aboriginal communities to take children from their families and communities, for the purpose of assimilation rather than protection from abuse (HREOC, 2003). This provides a graphic (and shameful) example of the power of the state in family life and serves as a constant reminder that although the eugenics discourse is no longer pervasive, that this state legislative power allowing the removal of children is one that is always open to contestation and a level of mistrust within the community.

While the number of children taken into out of home care remains very small relative to the number of children notified, it nevertheless remains a deeply held and constantly mentioned fear for many women experiencing domestic violence (Radford and Hester, 2006; Irwin *et al.* 2002). It is particularly a concern for Indigenous women (Kaye *et al.*, 2003) given both the past history of child removal and the current over-representation of Indigenous children in out of home care (AIHW, 2006). It is, of course, compounded by the tactics of abuse by the perpetrator who may constantly instil in the woman fear that he will report her to the authorities for neglecting the children (Mullender *et al.*, 2002; Findlater and Kelly, 1999).

Parallel to this story of the authoritative role of statutory child protection in family life runs a story of the statutory system as supportive to vulnerable families. This latter story shifts across time and is strengthened when child protection workers have resources to provide counselling support, significant practical and financial help, and a role in community prevention strategies. A trend towards an increasingly minimalist welfare state has seen child protection workers often confined to case co-ordination and case management (Healy, 2000) and investigations and legal procedures related to reported abuse (Mendes, 1996) rather than providing direct services for children and their mothers and fathers. McIntosh and Deacon-Wood (2002) refer to this as protection without healing. In the last couple of years, a counter-trend has been reported, with some states now re-investing in family support services (AIHW, 2007a).

In spite of this more recent shift, evaluations of child protection services particularly in relation to domestic violence are far less positive than that shown in the specialist domestic violence sector (Irwin *et al.*, 2003; Zannettino, 2006). Women and children rarely choose statutory child protection as their front line service. In fact, it is noticeable how marginal child protection intervention is in any evaluation or discussion of services for either women or children (Chung *et al.*, 2004; Bagshaw *et al.*, 2000; Irwin *et al.*, 2006). These evaluations suggest that the re-investment in support services may be best achieved for children affected by domestic violence through funding the community based sector rather than necessarily directing all resources into the statutory sector.

Clearly, these two very different intervention systems (statutory child protection and specialist, community based domestic violence services) have needed to find ways of working together, as have the other services involved in domestic violence intervention. One significant aspect of this work has been to develop a set of over-arching principles to provide a transparent basis for work across agencies in the field. These have been set out coherently by Burke (1999, p.264) based on her work in a community service organisation, that worked explicitly with families where there were frequently issues of both child abuse and domestic violence. They reflect and address the hierarchies of both gender and inter-generational power. These are:

1. Safety and protection of children

2. Empowerment and safety for women

3. Responsibility and accountability of perpetrators of violence

Helpfully, Burke (1999) has suggested that these principles form a hierarchy when there is a conflict of interest. For example, should there be a dilemma between the principle of child safety and that of the empowerment and safety of women, which even after high level support is unable to be addressed, then the safety of children remains paramount due to their level of vulnerability. Similarly, if there is a conflict of interest or resourcing pressures, the safety and empowerment of women needs to be placed as a priority over potential work with men. In the first instance, however, it is attendant upon agencies to develop complex working practices which respect and work with all principles, whether from within their own organisation or through multi-agency working.

A problem with the reporting of all children to the statutory child protection system is immediately revealed. This practice ensures that the first principle is always allowed to over-ride the second principle. Most women would not choose to refer their children to statutory child protection services. It is not considered a benign or voluntary system. Yet where notification/referral is mandated or expected, this step must be taken by professionals regardless of the woman's view on the subject, or the protective factors which may be in place. In effect, in many states each time a woman calls for help in a crisis she is also referring her children to statutory child protection services. A more appropriate employment of Burke's approach would see the over-riding of one principle by another only in a minority of contentious situations.

That said, there are points when such a referral will be entirely appropriate due either to her wishes, or the danger to the children. However, when tens of thousands of referrals are being made, and when it is an early response rather than a selective, tertiary response, questions need to be raised. Is this response congruent with the principles outlined? In this sense, has the 'hitching of domestic violence to the child protection juggernaut' (Featherstone and Trinder, 1997) been allowed to over-ride strongly held values of empowerment and self-determination developed in the specialist domestic violence sector, as effective and respectful ways of working with women and children? This questions the ethicality of current arrangements as well as their long term effectiveness.

Issue 3: Culpable women and invisible men - problems in the child protection response

A structural problem lies at the heart of the statutory child protection response to children affected by domestic violence. This is namely that there is both an adult and child victim, with the adult victim more often than not the child's mother. Child protection services have generally not been set up to manage this complexity (Davies and Krane, 2006). Indeed, it is written into much child protection legislation that there needs to be a 'parent able and willing to protect the child from significant harm'. The sensitive implementation of such legislation requires recognition (as already mentioned) that frequently when children are affected by domestic violence that their protection is linked to the protection of their mother. Some models suggest that ideally this requires a worker focused on the child's needs and a worker or an advocate to address the needs of the adult victim of violence (Bragg, 2003).

This is a difficult issue to discuss. While emphasizing that this is a structural problem, it is easy for it to be read as criticism of individual workers. As we know, many will be working over-time to think of, and act in creative ways to support the dual child and adult victims. It also can be read as not taking into account the policy work (for example, DoF Queensland, 2002; DHS, Victoria, 2005) and pilots (DART project NSW, Sykes, 2004; Onkaparinga, South Australia; Chung *et al.*, 2004) that have been funded and developed in an attempt to address this complexity. This discussion recognises and should not be read as minimising these important developments. However, this work is generally at the project stages of implementation and dominant patterns elsewhere in the child protection organisation remain hard to shift.

From Gordon's historical research in Boston (1989) through to the research by Irwin *et al.* (2002) and Zannettino (2006) in Australia, a number of issues are named with monotonous regularity, particularly in relation to 'mother blaming' and lack of focus on men as perpetrators of violence. This marked pattern points to structural issues, such as the underlying focus of child protection legislation, policy, resource limitations and the incident focused nature of intervention.

Without fail, child protection research on domestic violence both in Australia and elsewhere mentions the way in which child protection workers focus on women as mothers and their 'failure to protect' their children from domestic abuse at the expense of addressing the perpetrator and his violence (Humphreys, 1999; Krane and Davies, 2000; Irwin *et al.*, 2002; Findlater and Kelly, 1999; Zannettino, 2006). In this process, the lack of attention to the dangers of separation (which too often is construed as the only possible safety strategy), and the responsibility to co-ordinate a high quality response from professionals across the multi-agency setting to support safety for both women and children are frequently missing.

A compounding problem lies in the lack of development of the interface with other specialist adult services that can effectively manage serious problems of substance use (Kroll, 2004) and emotional well being manifested in depression and trauma (Darlington *et al.*, 2005). These problems are often directly related to the impact of violence and abuse and need to be addressed as part of child protection planning for both children and their mothers – highlighting again the relationship between children's experiences of abuse and their mothers' abuse.

An issue inter-connected to mother-blaming is the 'invisible man syndrome' (Burke, 1999) that casts a long shadow over the child protection response. It is stating the obvious to mention that there is no domestic violence without a perpetrator. Hence, attention to this issue should lie at the centre of child protection work. Paradoxically, the impact of the perpetrator is ever-present but frequently not addressed (Tomison, 2000). The pattern is so pronounced that Stanley and Goddard (2002) suggest that child protection workers become gripped with the same fear that immobilises women and children, leading to a distortion of their response to the situation, including either avoiding or colluding with the perpetrator.

A UK child protection case file analysis (Humphreys, 1999) showed a range of micro-practices that led to the perpetrator becoming invisible and the domestic violence minimised. These included: formal reports which failed to mention domestic violence in spite of this being the reason for referral or part of the investigation; serious domestic violence reported but named as something else such as 'family conflict' or 'marital argument'; other issues, such as mental health, neglect or substance use named as the problem; the woman's abuse construed as equal or greater than the man's, in spite of other evidence in the file that suggested this was not the case; and the man's lack of involvement in assessment, making his actions invisible.

The challenge to address these intervention problems has been increased with the emergence of domestic violence as one of the most common reasons for notification to statutory child protection services (AIHW, 2006; Irwin *et al.*, 2002) alongside its prevalence in on-going child protection case loads (Humphreys and Stanley, 2006; Callister, 2002). Again, it raises the concern about 'grafting' domestic violence onto the child protection system without making the necessary accommodations to adequately address the issue. This in turn raises the question of whether it is efficient, effective, efficacious or ethical to refer thousands of children and their families into a system that is neither designed to meet the needs of both a child and adult victim, nor has a history of an appropriate response to male perpetrators of violence?

Issue 4: Managing the interface with the family law system

The differences between the values and operation of state statutory child protection services and the community-based domestic violence services are significant. However, the interface with the traditions and decision-making of the Family Court is equally, or more problematic (Kaye *et al.*, 2003).

Statutory child protection work with children affected by domestic violence has been premised on safety for children being provided by women separating from the perpetrator of violence (Zannettino, 2006; Davies and Krane, 2006). This strategy is significantly less effective if, upon separation there is shared parental responsibility and extensive child contact (*Family Law Amendment [Shared Parental Responsibility] Act, 2006).* In spite of provisions in the *Act* to not award equal shared time or substantial and significant time to both parents in cases of child abuse or domestic violence, the shift in emphasis in the *Act* is likely to see most fathers awarded contact, a trend that is already evident (Kaye *et al.*, 2003; Brown, Thea and Alexander, 2007). There is a serious contradiction in the intervention strategy if women in one context are challenged about their 'failure to protect' for not separating from the perpetrator of violence, yet are then immediately faced with

making child contact arrangements with the same perpetrator of violence, and are criticised for 'implacable hostility' should they raise objections (Radford and Hester, 2006), or not demonstrate a 'willingness to facilitate a relationship' between the child and other parent. This can result in a negative court decision (Brown, Thea and Alexander, 2007).

In some states, pilot projects have attempted to overcome this contradiction through closely linking child protection and Family Court cases in the Magellan and Columbus projects (Brown, Thea, 2006; Hay, 2003). Western Australia has developed specific strategies and legislation to address this issue. The Family Court itself has also produced a *Family Law Violence Strategy* (2006). However, the presumption that contact will almost always occur and the reported difficulties with the new Family Relationship Centres - specifically the lack of attention to the risks and safety issues for victims of domestic violence - highlight an emerging difference between policy and practice (Brown, Toni, 2006). Moreover, the pervasive belief that men are disadvantaged in the Family Court arena, and that 'women going through custody battles make up claims of domestic violence to improve their case' was evidenced in a community based survey that showed that 46% believed this statement to be true (VicHealth, 2006). Such widespread attitudes (not supported by evidence (Brown, Thea and Alexander, 2007), provide the backdrop against which contact arrangements for children affected by domestic violence are made.

These institutionalised inconsistencies highlight again the problems of 'grafting' domestic violence onto the child protection system, without the major changes to policy and practice that are then required: in this instance at the interface with the Family Court. A very strong response at one end of the system (the referral of all children affected by domestic violence to statutory child protection) is contradicted by a response that then supports child contact (and opportunities for post-separation violence) at the other end when separation occurs. Integration of the investigation of child abuse between child protection and Family Law is providing one way forward. The other may be that child protection intervention needs to continue after partner separation by providing support for evidence gathering and advocacy within the Family Court processes. This issue has a direct impact on the effectiveness of the whole system in its response to children affected by domestic violence.

SECTION 2: DIRECTIONS FOR A MORE FUNCTIONAL SYSTEM FOR CHILDREN'S SAFETY AND WELL BEING

The first section of the discussion has raised serious questions about the functionality of the statutory child protection system's response to children affected by domestic violence. Questions were raised in relation to four issues: the problems of overwhelming the child protection system with referrals/notifications; the difficulties of balancing the women centred values of the voluntary domestic violence sector with the child centred values of an involuntary, statutory child protection system; the long standing problems of addressing male perpetrators of violence and abuse, and the concomitant focus on women's failure to protect; and the contradictions in goals and practice between the statutory child protection system and the Family Court. In particular, questions have been raised about whether too many children and their families are being notified/referred to the statutory child protection system. While there are differences between states, the increased reporting of children affected by domestic violence raises issues which are common to all jurisdictions.

These issues arise against the backdrop of major changes to domestic violence intervention in which every state has embarked on programmes to create a more integrated or co-ordinated response to domestic violence.[15] Determining the most appropriate pathway for the protection of children is proving to be one of the most significant challenges. Some states show dramatic progress in the outcomes of integrated criminal justice but are simultaneously struggling with an overwhelmed child protection system.

The second part of this discussion begins to address the implications for policy and practice of the unintended consequences raised in the first section. Three issues are discussed: aspects of the evidence base relevant to the complex issues of severity, harm and protection of children affected by domestic violence; the directions for diverting children from the statutory child protection system; and the essential development of community-based services for children, women and men alongside effective perpetrator intervention within a framework of interagency co-operation.

Issue 1: Relevant evidence on severity, harm and protection

The research evidence on the impact of domestic violence on children provides a helpful starting point for considering appropriate intervention to support children's safety and well-being. Points in the substantial overviews already undertaken in this area in Australia (Laing, 2001; Gevers, 1999), the UK (Hester *et al.*, 2006) and Canada (Ministry of Children and Family Development, 2004) are not reiterated here. Instead the discussion focuses on two central themes.

- Firstly, is there evidence to support the notification of all children affected by domestic violence for statutory child protection intervention on the basis of risk of harm or actual harm?

- Secondly, if this is not the case, is there evidence to suggest which children and their families should be notified to the statutory child protection system and which children can be effectively supported within the community based specialist services or universal services in the health and education sector?

This latter question highlights the need to engage with the contentious issue of severity of the impact of violence and what this means in the child protection context. It should be reiterated that this discussion is not about minimising the need to provide services for children affected by domestic violence. It is rather, that while all children affected by domestic violence require a response, is this most effectively provided by notification to the statutory system?

[15] See the Australian Domestic and Family Violence Clearinghouse website for a summary of state programmes: http://www.austdvclearinghouse.unsw.edu.au/states.htm

Evidence of the balance between harm and protective factors

An initial exploration of the research on the impact of domestic violence on children shows widely diverging experiences. The research overviews consistently show that children living with domestic violence have higher rates of depression and anxiety (McCloskey *et al.*, 1995), trauma symptoms (Graham-Bermann and Levendosky 1998), and behavioural and cognitive problems (O'Keefe 1995) than do children not living with these issues. On the basis of the evidence, there is growing concern about the interaction between the environment and the neurological development of babies in utero and infants where there is violence and abuse (Teicher, 2002; Perry, 1997). Child death reviews also highlight the frequency with which fatalities occur against a backdrop of domestic violence (NSW Child Death Review Team, 2002; O'Hara, 1994).

This body of knowledge generally highlights the serious and negative impact of domestic violence on the lives of very significant numbers of children. However, within the evidence base studies are emerging that equally highlight children who are doing as well as other children, in spite of living with the serious childhood adversity created by domestic violence. Sometimes this is referred to as 'resilience' (Margolin and Gordis, 2004). Such terminology suggests an individual trait and hides rather than elucidates the fact that children live in different contexts of both severity and protection. Laing (2001) in her overview of research draws particular attention to the incomplete state of our knowledge of protective contexts for children. Higher rates of distress shown across a range of clinical measures should not be conflated with the notion that *all* children show these elevated levels of emotional distress and behavioural disturbance. It highlights the maxim that 'correlation is not causation' (Magen, 1999).

The point is exemplified by research that shows that in any sample of children there are generally about 50% who do as well as the control group (Magen, 1999; Edleson 2004). This is a slightly different proportion from Kizmann *et al.* (2003) who, in a meta analysis of 118 studies showed 63% of children witnessing violence doing worse than those who do not witness violence, but 37% whose well-being is comparable or better than other children. The study by Hughes and Luke (1998) of 58 mothers living in a refuge showed 26% of children with few behavioural problems, high levels of self-esteem and no anxiety recorded. There was also a group (36%) who had mild anxiety symptoms and above average self-esteem. Other research studies point to similar findings (Margolin and Gordis, 2004; Sullivan *et al.* 2000a; Hughes *et al.* 2001; Jaffe *et al.*, 1990).

This research data seriously challenges over-pathologising all children living with domestic violence. There is a substantial proportion of children who are managing in a situation of adversity. This *must not be read* to mean that children do not have a right to live free from violence or need a service in these circumstances. However, it does raise questions about whether all children need a statutory referral.

Evidence for the assessment of children's experiences

Understanding children's different responses to living with domestic violence is not straightforward. Some trends are observable within the evidence base, but are not definitive. There is clearly an interplay between issues that create heightened vulnerability and issues which increase protection in relation to perpetrators, survivors (usually the

child's mother) and children. The evidence base is explored in relation to aspects of these three areas that are currently shaping decision making in this area.

This discussion, therefore, does not attempt to pursue the evidence associated with all aspects of a comprehensive assessment for children affected by domestic violence (Radford *et al.*, 2006; Calder 2004; Healy and Bell, 2005). The framework provided by Healy and Bell (2005), for example, names nine areas for assessment: the nature of the abuse; the risk to the children posed by the perpetrator; risks of lethality; perpetrators' pattern of assault and coercive behaviours; impact of the abuse on the woman; impact of abuse on the children; impact of the abuse on parenting roles; protective factors; and the outcomes of women's past help-seeking. Exploring all these dimensions is beyond the scope of this discussion, that has a more specific focus.

One of the most contentious areas in relation to assessing children's experience lies in whether *children who witness domestic violence and abuse* are less at risk than those who experience direct physical abuse within a context of domestic violence. The Australian studies by Irwin *et al.*, (2002) and Zannettino (2006), like those elsewhere (Brandon and Lewis, 1996), suggest that many child protection workers make decisions about severity and those situations to be investigated and those which fall into categories of 'no further action' or referral on this basis.

The evidence on this issue initially appears contradictory. A significant group of children living with domestic violence are also directly physically abused. An overview of 31 studies by Edleson (1999) showed that between 30 and 66% of children who suffer physical abuse are living with domestic violence. Some studies indicate that children who are directly physically abused in the context of adult violence are more likely to show severe impacts on their health and well-being (Edleson 1999; Hughes *et al.*, 2001; Crockenberg and Langrock, 2001), and are more likely to replicate patterns of violence in their later adult relationships (Ehrenshaft *et al.*, 2003).

However, other research shows little difference in relation to the impact on children between witnessing domestic violence and actual abuse. Mertin and Mohr (2002) in their study of 56 children living with domestic violence divided them according to children witnessing violence; being involved in the violence; and being a target of the violence. Little differentiation was found. Further evidence is provided by the meta-analysis of 118 studies by Kitzmann *et al.*, (2003), that evaluated the psychosocial outcomes of children living with domestic violence. It showed significantly poorer outcomes on 21 developmental and behavioural dimensions for children witnessing domestic violence than those living without violence. However, the witness outcomes were similar to those where children were also directly physically abused.

It would seem that issues such as age, severity and definitions of 'witnessing' may be intervening variables that can shed light on these contradictions. For instance, the impact of *developmental stage* has been consistently reported as relevant. Pre-school children tend to be the group who show the most behavioural disturbance (Hughes 1988) and are particularly vulnerable to blaming themselves for adult anger when living with domestic violence (Jaffe *et al.*, 1990). This is supported by evidence from the 'LONGSCAN' longitudinal studies in the US which suggest that for children under 8 (as against the older group of children), witnessing violence towards their primary care giver may be particularly traumatic. Psychological tests indicated this was more disturbing than the effects of direct physical maltreatment (Runyan, 2006). What is not so clear from these studies are the

protective factors that may be also present, that may account for the fact that in each of these studies are groups of children who are not so affected.

Concerns about the impact on babies are also growing in the light of the vulnerability of this group to fatalities (NSW Child Death Review Team, 2002), as well as the emerging evidence on the interference with their neurological development (Perry, 1997; Schore, 2003). Babies also show their distress in other ways with high levels of ill health, poor sleeping habits, excessive screaming (Jaffe *et al.* 1990) and disrupted attachment patterns (Quinlivan and Evans, 2005).

One model supports a conceptualisation of cumulative harm. It suggests that the problems for children can compound over time as they live with the multiple difficulties associated with the effects of domestic violence. A summary is provided by Rossman who states:

> *Exposure at any age can create disruptions that can interfere with the accomplishment of developmental tasks, and early exposure may create more severe disruptions by affecting the subsequent chain of developmental tasks* (Rossman 2001, p.58).

Another range of factors need to be considered, including the *severity* of violence. Those studies mentioned earlier that showed more serious cognitive and behavioural problems where children are directly abused in the context of domestic violence may be demonstrating a disturbing interaction between the physical abuse of children and the fact that the most violent perpetrators towards women are frequently the most abusive towards children. The study by Ross (1996) found that in a US study of 3,363 parents that the most violent men to women[16] were virtually all also physically abusing the children in the household.

Other findings at the extreme exemplify the issue of severity that may have more general application. There is no doubt that children who witness the homicide of their mothers will be traumatised (Hendricks *et al.* 1993), as will the disturbing number of children who witness the sexual assault of their mothers (10% of children in two qualitative samples Mullender *et al.*, 2002; McGee, 2000). However, interviews with children and young people also draw attention to how distressing it is to hear screams, the noise of the destruction of their home and seeing assault with weapons. These children often believe their mothers are on the point of being killed (Mullender *et al.*, 2002).

Such research draws attention to the myriad of ways children experience domestic violence. They may be used as hostages (Ganley and Schechter, 1996); they may be in their mother's arms when an assault occurs (Mullender *et al.*, 2002); they may be involved in defending their mothers (Edleson *et al.*, 2003). Stanley and Goddard (1993) and Kotch, (2006) also refer to violence within the community of people surrounding the family which may also instil fear and may contribute directly to the abuse of the child. Describing this range of violent experiences as 'witnessing' fails to capture the extent to which children may become embroiled in domestic violence (Irwin *et al.*, 2006).

[16] The criteria for severity based on the revised conflict tactics scale.

The compounding factors associated with *diversity* also highlight the inadequacy of current categorisation into witnessing and direct abuse. The problems are writ large in relation to Indigenous children and are such that Memmott *et al.* (2001) developed a more ecological model through which the complex interplay between precipitating causes (events which trigger a particular violent episode), underlying factors (historical circumstances, including the legacy of colonialism and racial oppression) and situational factors (alcohol abuse, unemployment and welfare dependency) are identified. This model highlights the complexity of the ways in which domestic violence, child abuse and disadvantage create a major social problem (SNAICC, 2005) that is poorly captured through thinking about severity in relation to witnessing violence or direct abuse in the context of violence. A different range of issues also surface for children with disabilities (Baldrey *et al.*, forthcoming) and children from culturally and linguistically diverse (CALD) communities (Baghsaw *et al.*, 2000) where there is increased vulnerability and hence the tactics which can used to exert power and control are increased without there necessarily being direct physical or sexual abuse.

In summary, the distinction between witnessing and direct abuse may be a false one and should not be the principal criterion for understanding the severity of the impact on children and their need for protection. Children's age, stage of development, proximity, and severity of violence set alongside the complex range of ways children are drawn into domestic violence are intervening variables that need consideration. It is an area where further research clearly is needed to understand the interplay between protective factors and harm, and one in which there has been little Australian development to date (Higgins *et al.*, 2005).

Evidence for the assessment of the domestic violence perpetrator

A second and 'live' issue lies in the assessment of the perpetrator and his current and future risk of harm to the child. The problems of 'the invisible man' highlighted in the first section are compounded if child protection assessments marginalise the evidence of the extent and severity of perpetrator violence. Such practice fails to take account of the relationship between women abuse and child abuse and the link between the protection of women and the protection of her children (Tomison, 2000; Waugh and Bonner, 2002).

Significant (though controversial) work has seen the development of perpetrator risk assessment models based on an analysis of factors associated with domestic homicide (Campbell, 1995) and serious domestic sexual and physical assault incidents (Richards, 2004). Some assessments focus on the risk of homicide, others on the risk of re-offending posed by different perpetrators. To date there has been little use of perpetrator risk assessment to inform child protection practice in the area of domestic violence. An exception lies in Wales where evaluation has shown that the multi-agency attention and action focussed on the most serious perpetrators identified through the use of a perpetrator risk assessment tool has shown very positive results in protecting the most vulnerable women and children (Robinson, 2004). By contrast, a London study (Blacklock, cited in Humphreys, 2007) undertook a documentary analysis of the referral information to child protection social workers where there was domestic violence. The study found no relationship between the risks and severity of perpetrator violence (judged by the Welsh scale of risk factors) and decisions made by child protection social workers about whether a case should be investigated and a social worker allocated. There was in fact a slight

trend in the opposite directions (the higher the number of risks from the perpetrator, the less likely the child was to be allocated a social worker).

Some states have adopted standardised risk assessment tools based on factors associated with dangerousness and lethality (for example RAST in Tasmania; SPECCS+ and risk assessment for multi-agency working in Victoria). However, the assessment of the perpetrator does not have to occur through standardised tools. A continuous theme through the risk assessment and risk management literature is that risk factors are only one element of assessment that should also include the victims assessment of their own level of risk combined with the practitioner's professional judgement (KPMG, 2006; Radford *et al.*, 2006). Problems also arise if risk assessment is used to predict future violence rather than as a means of informing safety planning and prevention (Richards, 2003; Humphreys, 2007). The Clearinghouse Topic Paper on *Risk Assessment in Domestic Violence* (Laing, 2004) provides more detail and draws attention to the fact that some evidence suggests that the most chronic and dangerous perpetrators are not the ones where lethality indicators are present. Rather they are those men who continually 'get away with it' and become emboldened by the inability of the system to respond to their offending with any meaningful consequences (Gondolf, 2004). This suggests that an aspect of risk assessment needs to include the extent and success of the system's response to the perpetrator.

There are a relatively common set of factors used to assess the severity of risk posed by the perpetrator.[17] Any of the factors is relevant to the assessment of child protection and it is notable that most factors do not refer to physical violence but take into account the tactics of isolation, evidence of controlling behaviour, harassment and obsessive jealously. In this context, two factors are worthy of consideration to highlight the relevance of the evidence base in relation to perpetrators: firstly the dangers of separation; and secondly, violence and abuse during pregnancy.

Undoubtedly, *separation* where there is a history of domestic violence heightens the risks of escalation and the chance of homicide and further serious assault (Campbell, 1995). The multi-agency London domestic violence murder reviews showed that 76% involved separation (Richards, 2003). Moreover, a study of sexual assault in the context of domestic violence showed that over half (116/217) occurred during separation or post separation (Richards, 2004). Child contact arrangements provide the greatest opportunity for the continuation of post-separation violence (Walby and Allen, 2004; Kaye *et al.*, 2003). This evidence, that tends to put separation at the top of the risk factors for policing domestic violence shows a contradiction with child protection practice that tends to construct separation as a safety strategy. This highlights the importance of holding a nuanced understanding of the evidence base. Risk factors are not predictions. Many women and children will find separation provides a safer environment, however, there are also a group of women and children for whom this is a dangerous and potentially lethal

[17] The SPECCCS+ model (Richards, 2003) uses the following factors: separation (child contact), pregnancy (new birth), escalation, culture (community isolation and barriers to reporting), stalking and sexual assault. A further six additional factors are also included as prompts for police officers to consider (abuse of children, abuse of pets, access to weapons, either victim or perpetrator being suicidal, drug and alcohol problems, jealous and controlling behaviour, threats to kill, and mental health problems).

strategy. All separation where there is domestic violence will therefore require high levels of safety planning and support.

Violence during *pregnancy* highlights the blurring of distinctions between domestic violence and child abuse: a form of 'double intentioned violence' (Kelly, 1994). The *PSS* (ABS, 2006) shows 41% of women who experienced domestic violence reported violence during pregnancy, and that 20% of women who experienced domestic violence reported that their first experience of violence was during pregnancy. This concurs with the study by Taft *et al.* (2003) and other studies (Campbell 2002; Schornstein 1997) that show that pregnancy is a time of increased risk of abuse with a significant association between miscarriage and physical or sexual violence. In this sense, violence during pregnancy can be construed as the most serious form of child abuse. When this evidence is combined with studies such as the one by Jameison and Hart (1999) that show women attacked when pregnant were three times more likely than other women suffering domestic abuse to report serious violence (attack with weapons, strangulation and hospitalisation) it suggests that the risks posed by these perpetrators to both women and children need to be taken extremely seriously. This includes when decisions are being made in the Family Court.

This brief exploration of the evidence base in relation to the severity of perpetrator violence highlights its relevance to the child protection context and suggests that it is not an issue that should be ignored. In fact, it can be used to helpfully re-orientate practice to focus on the perpetrator.

The significance of the interconnections between women and children

The extent to which the focus of children's safety and well-being is linked to their mother's raises the most contentious issues when thinking about harm, safety and the contexts for children's protection. Protective factors when present become vulnerabilities when absent. It needs to be emphasised that vulnerabilities are often a consequence of the perpetrator's violence and abuse and, therefore, cannot be separated from that context, hence, the attention to perpetrator assessment prior to this discussion of women and children. The discussion, needs to be prefaced with the strongest assertion that this evidence demonstrates the essential need to support women if issues in relation to children are to be addressed. Their needs are linked but separate and intervention needs to focus on strengthening *both* the woman and the child and their relationship.

Research evidence on children surviving the adversity of living with domestic violence suggests a number of factors that are linked very positively to their mothers. These include the ability of women to maintain their mothering capacities under such adverse conditions and to model assertive and non-violent responses to abuse (Peled, 1998). Mothers who are perceived by their children to be positively supportive are particularly important moderators of the abuse impact (Cox *et al.* 2003). Children who experience high levels of extended family and community support, also show the positive impact of this support, a factor particularly, though not exclusively evident for minority ethnic children (Mullender *et al.* 2002) and Indigenous children (Blagg, 2000). Unsurprising, undermining these relationships with the child's mother or extended family is a central abuser tactic (Zannettino, 2006; Irwin *et al.*, 2002; Radford and Hester, 2006; Mullender *et al.*, 2002) and one that workers will need to address (Humphreys *et al.*, 2006).

Other studies point to the mother's positive mental health as a source of resilience for children (Moore and Pepler 1998). For example, an overview of three studies of the context for children's resilience when living with domestic violence showed that the children of women who did not experience moderate or severe depressive symptoms showed fewer emotional problems (Hughes *et al.*, 2001). However, depression is highly correlated with women's experience of violence and abuse (Golding, 1999). Major ethical problems, therefore, arise in any intervention that dissociates women's experiences of mental health problems from their abuse experiences and does not intervene to address these issues as part of the 'symptoms of abuse' (Humphreys and Thiara, 2003). It highlights the link that needs to be made between the intervention to support children and the intervention to support women affected by domestic violence. Similar issues can also be identified in relation to women's problematic substance use in the context of domestic violence and the effect on their children (Kroll, 2004). Few studies have attended to the father-child relationship when the father uses violence. Sullivan's study (2000b) is an exception and showed a direct negative effect of the man's abuse not mediated by the mother's well-being.

A further factor promoting a context for children's protection lies in strategies taken by women and others that seek to curtail the violence and support children's well-being. Such strategies can include applying for protection orders; seeking counselling and other support services; separation; supporting criminal charges; gathering support from within a community to challenge the perpetrator's violence; and active engagement with safety planning (Davies *et al.*, 1998).

A final point needs to be made. The issues of adversity for both women and children need to be placed in the context of research that demonstrates that parenting can improve significantly in the first six months following separation if the abuser's violence is curtailed. Like their mothers, many children will recover their competence and behavioural functioning once they are in a safer more secure environment (Holden *et al.* 1998; Radford and Hester, 2006) and with support, have even proved to be effective social and political actors in securing resources for similarly affected children and young people (Houghton, 2006). In particular, children who are not continually subjected to post-separation violence (Mertin 1995; Wolfe *et al.*, 1986) and protracted court cases over child contact (Buchanan *et al.* 2001) show a stronger pattern of recovery.

This exploration of some of the more contentious areas of the evidence base in relation to severity, risk and protection finds no straightforward answers. There is an interaction between issues of violence and abuse with issues of protection that requires both an understanding of the relevance of these factors, as well as professional judgement. Some children are living in situations in which there are few protective factors and high levels of danger and harm indicated through the impact on children's emotional and behavioural responses, the risks posed by the perpetrator, and the effect of violence and abuse on their mothers. However, the evidence suggests that there is not a clear cut distinction to be drawn between children where safety is an issue and those whose well-being can be managed through community based support services (Platt, 2006). It is clear that it may take time and trust for the complexity of the issues to emerge.

Major political questions then arise that go beyond the research evidence base. They are firstly whether other workers, besides child protection workers, should or can be involved in judgements about the services that are most appropriate to children and their mothers

and fathers where there is domestic violence? Secondly, whether public health models (Scott, D. 2006) [18] that recommend early intervention and connecting children to universal and community based services as the front-line response, are also appropriate for children affected by domestic violence? Thirdly, whether 'a whole-of-government approach' to domestic violence will be resourced to provide the necessary high levels of co-ordination and training needed to respond and make a difference to the lives of children living with domestic violence?

Issue 2: Diverting children affected by domestic violence from statutory services

The pressures on the statutory child protection system have given impetus to creative developments to divert children from the statutory system both in Australia and elsewhere. Much of the work is at an early stage with some states now actively pursuing this strategy. However, many of the policy and legislative issues are still to be addressed if pilot projects are to be 'scaled up' and potentially replace initial notifications to statutory services. Some directions for practice are developing.

A common element in several of the projects lies in the diversion of referrals to small multi-disciplinary initial assessment teams. The Domestic Violence Action Teams in Queensland, the Pathfinder projects in Scotland, and the Warwickshire Initial Assessment Teams in the UK provide examples on this model. In some cases this involves domestic violence referrals 'sifted' by the multi-disciplinary team and decisions made about appropriate pathways and interventions. In other cases it involves undertaking initial assessment work, intervention and in high risk situations intensive, offender-focused case management (e.g. the DART project, DoCS, NSW, 2006). The advantage of small multi-disciplinary teams lies in their recognition of expertise and knowledge of the range of interventions required to support children and their families. The team usually includes police, statutory child protection worker and a worker from the specialist domestic violence sector. The most appropriate pathway for effective intervention can then be agreed, the decision-making is shared and an effective brake can be placed on notifications of all children to the child protection system. It also provides a central point for recording and monitoring that a child is in a vulnerable situation.

These models are not a resource neutral option but require investment in the multi-disciplinary team particularly where intensive case management is involved. Nevertheless, the evaluated success of a project, such as the DART project suggests the benefits of effective policing and child protection worker support to the family will show positive cost benefits and efficiency of early intervention (Sykes, 2004). Feedback from several projects also indicates that it requires consistency in the workers from each agency to allow the development of trust, as well as workers who have some training and expertise in domestic violence. The development of consent procedures with women seeking help has also been important.

[18] See DoCS, (2006) for a critique.

Other approaches to early intervention are not domestic violence specific. Child FIRST in Victoria (Kolasa, 2006) for instance is being flagged as a development that may assist in early diversion of vulnerable children and families to community based services. At this early stage it has not been developed as a specialist domestic violence project but rather as a point where vulnerable families in each region can be referred to community based services through a multi-agency, family support service intake point. Further training and resourcing to take up the numbers of domestic violence referrals would need to occur to make this a real option for the sector. A statutory child protection worker is allocated to liaise with each Child FIRST service to provide expertise when required about the appropriateness, or not, of a notification to child protection. Other services such as the 'Child First Framework' in Western Australia and 'Referral for Active Intervention' in Queensland are also developing approaches to co-ordinating delivery of family support and children's services (AIHW, 2007a).

These specialist projects point to the involvement of workers from police, the voluntary sector and other community based or universal services (health and education). All draw on the resource of a child protection worker supporting this work to assist in identifying those children most at risk who need to be notified for statutory child protection intervention. They exemplify some likely future directions for policy and practice development.

Other questions arise about whether specialist initial assessment teams are the only option, even if they are emerging as the preferred option. Potentially they will also be subject to inundation. They are also resource intensive. Other alternatives require grappling with the capacity of the community and universal services to respond to domestic violence prior to any child protection involvement. The Scottish policy for instance starts with a statement that:

> *..agencies and professionals need to exercise greater levels of judgement, in consultation with others, about the best approach to securing a child's welfare and recognise that protecting the mother may be the best way to protect the child/ren. A more comprehensive and unified approach to meeting the children's needs should remove the need for automatic referrals to the reporter*[19] *of cases of domestic violence*…..' (Scottish Executive, 2006 p.3).

The Scottish example raises the question of whether the default position is to respond to children affected by domestic violence wherever they come to notice of the services through a co-ordinated community and police response, and to refer to statutory child protection when avenues for protecting children in the community are not effective (Scott, D. 2006). Community based support rather than authoritative statutory intervention is the start point of referral and work with women and children (Jacob and Fanning, 2006). The statutory, criminal and civil justice response is reserved for perpetrators in the first instance.

[19] The reporter role is specific to statutory child welfare practice in Scotland but is essentially a statutory referral.

Such a stance allows a substantial level of professional discretion in relation to children affected by domestic violence[20]. However, there are strong arguments that such discretion needs to be adopted and supported as a specific strategy (discussed in more detail later). Suffice to say that again, it is not cost neutral and needs substantial resources. It requires widespread and on-going training of front line workers across disciplines, as well as the development of protocols and guidance about the dimensions of risk, protection and harm which need to be taken into account in relation to notification (Pense and Shepard, 1999). It also requires thinking about how 'cause for concern' is logged at a central point, and the development of the infrastructure to support multi-agency working with children affected by domestic violence. In Scotland, for instance pilot projects focused on developing high levels of multi-agency co-ordination for children affected by domestic violence are being trialled. However, there is an expectation that they will be 'scaled up' once the infrastructure and protocols for co-operation are developed, and will operate within existing (although enhanced) resources. Potentially, this model contributes to a more functional statutory child protection system in which high risk children are notified by workers who have initially seen or worked with the children and family at an earlier point in the intervention.

The directions for change are not clear cut. Different states are developing alternative pathways dependent on local conditions and the extent to which they are prepared to consider strategies for keeping children and their families out of the system, rather than net-widening to pull in more and more children and families living with this major social problem. In spite of inter-state differences two broad areas are common across all change strategies and are addressed in the next part of the discussion.

Issue 3: Development of, and co-operation between services and intervention for children, women and men

The backdrop to any shift in child protection practice is dependent on strategic development. No change is possible without the development of community based, specialist services for women and children, the increased responsiveness of health and education services alongside effective interventions with perpetrators. Furthermore, intensive co-operation (though not necessarily integration) between different service systems responding to domestic violence is essential and requires strategic planning and implementation. The breadth, depth and nature of co-operation between domestic violence service providers is a full discussion in itself. A few points that are particularly pertinent to issues raised in the earlier part of the discussion are highlighted.

Service provision: women and children

There is no argument that children and their families affected by domestic violence need a service. In spite of all the problems and limitations already outlined, where no other service exists, the statutory service will be used as the service to provide for the

[20] In some states this is already the case for a number of professional groups (see Bromfield and Higgins, 2005)

monitoring, safety, protection and well-being of children affected by domestic violence. This may particularly be the case in rural areas. Such a scenario highlights the imperative to invest in community based services, develop the capacity of health and education services, and recognises the inter-dependence of statutory child protection with other services responding to children affected by domestic violence. Some would argue that the state should simply re-invest in their own family support services and perpetrator intervention. This first section of this discussion paper argued that it is not only a resource issue but one of history, ethics, values and specialist knowledge that suggest that early intervention services for women and children affected by domestic violence are ideally based within the community sector.

On paper at least, there appears to be a significant injection of funds in all states of Australia into community based services for women and children affected by domestic violence. Several states have designated budgets of more than $30 million to develop services under the umbrella of integrated domestic violence services (see for example, *Safe at Home* [2004] in Tasmania and *Family Violence Reform Initiative* [2005] in Victoria, though every state or territory has a resourced action plan or strategy)[21] and NSW has made announcements of $150 million for early intervention services in 2008 (though these are not specific to domestic violence) (AIHW, 2007a). It is yet to be seen whether this will make inroads into the finding from the PADV meta-analysis of the needs of children and young people (undated), that shows only 14% of children accompanying women using SAAP services were provided with counselling, child care, kindergarten, and/or assistance with access arrangements. A similar picture is painted by an audit of 1244 agencies Australia wide that showed only 36 (3%) organisations operating 65 individual programs for children exposed to domestic violence (Kovacs and Tomison, 2003).

At this stage, the full leverage from the development of services is yet to be realised in ways that impact positively on the child protection system. Defensive child protection practice in many states necessitates a dual track system in which all children are referred to statutory child protection even when receiving and responding to a community based service. This leads to an increase in services in some states alongside an inundation of the statutory child protection system. Such a strategy fails to take advantage of the fact that services to women and children provide a significant contribution to child protection work.

Moreover, in spite of investment in services for women and children there has been little 'scaling up' of these services. In the area of women's services, countering violence and abuse requires services that provide support, information and advocacy across a continuum which includes early intervention, early referral, crisis responses, first responses and medium and long term support (Chung *et al.*, 2004). Currently, most interventions are focused in the area of crisis and first responses. There is an impressive array of good practice examples from every state that are documented on the Clearinghouse website and through evaluations of women with women in multi-agency settings (Chung *et al.*, 2004). Likewise the creative development of services to children, or services that address the relationships between women and children are also numerous, but again, not comprehensively available across regions or diverse communities (Bunston

[21] Some questions have been raised about the extent to which some of these allocations are new money, or old money 'rebranded' (Women's Services Network Annual Report, 2005-06).

and Heynatz, 2006; Kids and Domestic Violence Program, Lismore City Council (Boardman and Willis, undated; SNAICC, 2005; PADV undated). These are being supported by the development of practice standards and evaluation guidance for children's work (Gevers, 1999).

The development of services that quite specifically tackle the relationship between women's emotional well-being in relation to depression and trauma, and/or problematic substance use and the violence they experience have been slower to develop. Addressing this service deficit and the protocols between child protection and these other adult services are crucial for the well-being of not only women but also their children. It is a primary area in which child protection services need to commission the development of specialist services in the community sector and exert influence on state policy makers to harness the contributions of other adult services: health, disability, drug and alcohol.

There has been less development of work that brings a specialist domestic violence worker directly into the frame of child protection to support and respond to the needs of the mother while other workers undertake a child abuse investigation and assessment. This model has been developed in the US with marked success in programs such as AWAKE at Boston Hospital (Bragg, 2003), though the strongest development of this model has occurred in Sweden through the 'women's peace' reform package sanctioned through an amendment to the *Social Services Act 2002* that explicitly states that the social service agencies have a responsibility to support abused women when there are child protection issues (Humphreys and Carter, 2005 p. 28). Other models rely on close co-operation (not a co-located, integrated service) between the specialist domestic violence sector and child protection workers. Without the development of this work to support the adult victim of domestic violence, the difficulties of providing a sensitive and supportive child protection service will always be problematic. Given this is resource intensive, it highlights again the need to have a functional and selective intervention, rather than one which is inundated by more cases than can be managed.

Service provision and intervention: working with men who use violence

The most effective form of child protection involves strategies that stop the violence of the perpetrator. In most states, this requires a shift in child protection practice and particularly its interface with the civil and criminal justice sector. A raft of intervention is required which involves child protection as well as the police, courts and community sector workers.

Strategies to consider address safety for children, empowerment of women and challenge the perpetrator and can include:

- Development of the use of exclusion conditions attached to protection orders that allow women and children to stay in their own homes and require the perpetrator of violence to leave. Such orders prevent some of the potential harm created through constantly disrupting the lives of children including their schools, peer support and family networks. However, they require very significant support and monitoring of the perpetrator to ensure compliance and safety (Edwards 2003 p.7).

- Underpinning child protection intervention with a civil protection order provides leverage and safety, not only for women and children but also for child protection

workers. It is a strategy used very effectively by Burke (1999) as the first stage in contracting with families where child abuse and domestic violence is an issue. It is also strongly supported in some state child protection guidance (see DHS, Victoria, 2005) and legislation (e.g Western Australia *The Acts Amendment (Family and Domestic Violence) Act,* 2004). This can draw on the strategic use of third parties such as police (and in some states, child protection workers) to take intervention orders on behalf of the woman and/or child (Humphreys and Kaye, 1997). This is not a power available in other countries and is a significant prevention strategy. In Victoria, police have increased their use of civil protection orders very significantly (6018 orders from 28,301 incidents attended in 2005) in a strategy to increase the protection of women and children.[22]

- The apprehension of the perpetrator and a consequence for violent and abusive behaviour. This involves high quality policing, consistent prosecution, appropriate judgements, and strong support for adult victims within the justice process (see Holder 2001). In other words a scaled up, integrated criminal justice response to which child protection workers, particularly through evidence gathering can provide specific support.

- The development of men's behaviour change programs under quite specific conditions that address the current highly varied quality of these programs (REUGV, 2004) and their outcomes (Laing, 2002). The programs with more positive evaluations are integrated with the civil and criminal justice system and provide consistent consequences for men who continue violence and abuse (Gondolf, 2004). They need to employ a gendered understanding of violence and provide close liaison with services for women and children (REUGV, 2004). It is also essential that the issues and consequences of violence for men as fathers are addressed (Rakiil, 2006). The Family Court provisions currently ensure that most men who use violence will continue to have contact with their children[23]. This is an area in which significant work needs to be developed in the Australian context to address the issue not just of parenting, but the impact of men's violence on their children (Bennett and Williams, 2001 cited in Laing, 2002).

- Potentially, the development of agreed risk assessment, risk management and safety planning across domestic violence intervention to assist in the development of high levels of multi-agency co-operation focused on the perpetrator (see KPMG, 2006, Victoria; RAST, Tasmania).

- Addressing worker safety issues to underpin all intervention with men who use violence (Stanley and Goddard, 2002). The situation is seen most starkly in both Australian and UK child death enquiries where a continuous theme is that child protection workers avoided situations in which they were afraid of a violent man in

[22] It should be noted that this action did not appear to be at the expense of charging for criminal actions which also showed an increase in the first year of the operation of the new Code of Practice.

[23] While the ethics and safety of this policy need to be continually questioned and challenged, the reality of men in their continuing fathering role cannot be ignored.

> the child's household (Pahl, 1999). An overview of enquiries in the UK led O'Hagan and Dillenburger (1995) to make the following statements:
>
> *Violent men consistently dominate the 35 inquiry reports produced since 1974, and have, with few exceptions, been responsible for the deaths of the children in those reports* (p.145)
>
> and that,
>
> *It is obvious ... how the avoidance of men can and often does constitute an abuse of women, but avoidance also seriously exacerbates the paramount task of protecting the child* (p.146).

Such data highlight the centrality of worker safety to addressing the safety of children where there is domestic violence.

The point is clearly made that effective child protection work for children affected by domestic violence requires carefully co-ordinated intervention which focuses on the perpetrator of abuse. It is a central not a peripheral aspect of the work.

Co-ordination between child protection and other services

A more discrete use of statutory intervention also requires high levels of co-ordination and sometimes integration of services (Child Abuse Review Special Edition, 2006). This recognises that protecting children and responding to their safety and well-being is not a sole agency responsibility. It also recognises that the structured weaknesses in the child protection response require engagement with other services and interventions. A few points are made in relation to this complex issue[24].

Firstly, a major shift is occurring across most Australian states to bring domestic violence into a 'whole-of-government' integrated strategy driven at senior level by inter-departmental committees (see, for example, *Safe at Home* in Tasmania, although every state or territory has an action plan or strategy). Successful programs are usually rolled out at a local community level where multi-agency leadership, local characteristics and resourcing shape the response (for example, Gold Coast Integrated Response, Queensland; Okaparinga, South Australia, Chung *et al.*, 2004).

However, consistent 'health warnings' have been raised about integrated working (Humphreys and Stanley, 2006; Mulroney, 2003; Pence and Shepard, 1999). In itself it is not a goal. Rather it is a useful strategy to enhance victim safety, reduce secondary victimisation and ensure that abusers are held accountable for their violence (Mulroney, 2003). Within the domestic violence area there is significant evidence provided through the Duluth model that a highly co-ordinated response to domestic violence can bring effective results (Pence and Shepard, 1999). Jurisdictions, such as Tasmania and the ACT where there has been a systematic attempt to work with careful integration of a complex criminal justice response has shown some highly significant results (Holder,

[24] See Mulroney, 2003 for a more detailed discussion.

2001)[25]. Other states, such as Western Australia have undertaken a 'safety audit' with the help of Ellen Pense to discern the extent to which each service contributed to, or alternatively created barriers to safety for victims of domestic violence.

The discussion in this paper, however, has highlighted the difficulty of working with service systems with very different remits, histories and values. Warnings have also been provided about conflating the statutory and voluntary sector work with women and children (Krane and Davies, 2006). High level co-operation rather than integration is potentially a more ethical and realisable goal. Moreover, at this stage, most of the focus towards integration or co-operation focuses on state based services. This effectively leaves out the Family Court. Within the response to the protection for women and children affected by domestic violence such an over-sight is unacceptable. While recognising that work in this area is underway, this discussion paper highlights the urgency of this project.

Secondly, it needs to be recognised that effective co-ordination (or integration in some circumstances) is a major project that requires significant time, resources and development. It is the consistent message about successful multi-agency working (Katz and Hetheringon, 2006). An outline of key principles provided under the Duluth model highlights the extent of work required:

- Develop a common philosophical framework
- Create consistent policies and procedures which coordinate and standardise the intervention actions of practitioners involved in a community response
- Monitor/track cases from initial contact to case disposition to ensure practitioner and offender accountability
- Coordinate the exchange of information, interagency communication on a need-to-know basis, and interagency decisions on individual cases
- Provide resources and services to victims and at risk family members to protect them from further abuse
- Utilise a combination of sanctions, restrictions and rehabilitation services to hold the offender accountable and to protect victims from further abuse
- Work to undo the harm to children
- Evaluate the coordinated community response from the standpoint of victim safety and the goals of the intervening agencies (Pense and Shepard, 1999 cited in Malroney 2003).

The extent to which domestic violence has been 'grafted' onto the child protection response is revealed when there is a lack of co-ordination between the domestic violence strategy and the children's services strategy. Given that 50 to 66% of statutory child

[25] The term integration is not used lightly, but refers to intensive case management through the criminal justice system.

protection cases involve domestic violence, such a separation needs to be addressed (Humphreys and Stanley, 2006; Callister, 2002). At the most basic level, it requires significant representation by workers from the domestic violence and children's services sector on both strategic planning forums.

CONCLUDING COMMENTS

This discussion paper has raised questions about the current directions of child protection practice and policy for children affected by domestic violence. It queries the capacity of the child protection system to respond effectively, efficiently, ethically and with efficacy to this chronic social problem through practice that involves the notification/referral of all children.

The alternatives are not straightforward. An exploration of the evidence base suggests that there are factors associated with children, their mothers and perpetrators that create environments of high vulnerability or alternatively contexts of protection. Identifying pathways for referral requires both skill and guidance and may be most effectively met through multi-disciplinary initial assessment teams. There remain concerns about whether the inundation of one system will be simply replaced with the inundation of another, though without the same ethical dilemmas posed by statutory referral. Alternatively, creating more rigorous criteria for notification and supporting increased professional discretion in the context of higher levels of training, co-ordination and guidance may allow the child protection system to be used in a more judicious and selective way. This would weave child protection intervention much more thoughtfully into the emergent domestic violence strategies.

At the heart of this discussion is a concern with the deployment of precious resources for children and their families affected by domestic violence. Advocacy, support, accommodation and counselling for women and children, and effective strategies to respond to perpetrators of violence and abuse from diverse backgrounds are essential services that require further development. Major concerns arise if the inundation of the statutory system with notifications and investigations requires the diversion of resources for children affected by domestic violence into the investigatory and court processes of the statutory child protection system at the expense of the development of other services. A functional system for children's safety and well-being requires a substantial array of community based and universal services (Mendes, 1996; Scott, D. 2006).

Finally, some, but not all answers lie in the development of multi-agency co-ordination and collaboration. This paper has argued that the differences in history, values and focus suggest that co-ordination and collaboration needs to be disentangled from integration when planning services and intervention. However, it will only be through the development of the complex processes of multi-agency working that a more functional approach to children affected by domestic violence will emerge. In particular the current marginalisation of the Family Court from these developments is problematic and needs addressing, if child protection intervention for children affected by domestic violence is to be coherent.

A guiding question in all domestic violence intervention is always: Are women and children safer as a result of this intervention? An over-extended child protection system does not

produce a positive answer to this question. Unintended consequences can swamp people's good intentions. This paper has argued that it is timely to challenge the current direction for child protection practice where children are affected by domestic violence and ask whether alternative pathways are available.

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http://www.unisanet.unisa.edu.au/staff/homepage.asp?Name=Lana.Zannettino

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Australian Domestic & Family Violence Clearinghouse
UNSW NSW 2052
Ph: (02) 9385 2990 Fx: (02) 9385 2993
Email: clearinghouse@unsw.edu.au
Website: http://www.austdvclearinghouse.unsw.edu.au

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Absent presence: the ongoing impact of men's violence on the mother–child relationship

Ravi K. Thiara* and Cathy Humphreys†

*Principal Research Fellow, University of Warwick, Coventry, UK and †Professor, Department of Social Work, University of Melbourne, Melbourne, Victoria, Australia

Correspondence:
Cathy Humphreys,
Department of Social Work,
University of Melbourne,
Parkville,
Vic. 3010,
Australia
E-mail: [redacted]

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ABSTRACT

This paper draws from interviews with 45 mothers and 52 children who participated in an action research project to develop activities to support women and children in the aftermath of domestic violence. A thematic analysis was used to analyse the data and explore the question: In what ways does the perpetrator of abuse remain present in the lives of women and children following separation? The paper invites workers to recognize the distortions created by domestic violence that may need to be identified and addressed in the aftermath of violence. The ways in which past trauma, erosion of self-esteem and the undermining of the mother–child relationship continues to create a shadow across the present relationship are identified. The continued presence of the perpetrator of abuse through child contact arrangements and ongoing harassment is also highlighted. The 'absent presence' of the abusive partner is posited as a concept to assist workers with a framework through which to understand problems in the mother–child relationship which emerge when living with and separating from a violent partner. The paper has implications for social workers orientating practice to focus on perpetrator accountability and support strengthening the mother–child relationship.

INTRODUCTION

> . . . you notice things, like he was wearing his socks and pants in bed and I thought I ain't seen his toes for ages, why is he wearing socks now. I spoke to him the next morning and that killed me, that really made me realise what that boy had been through. To be waiting to run and not go to sleep. (Fam 40, mother living in a refuge)

This paper explores the ways in which men's violence and abuse against their partners and children impacts on the relationship between mothers and children in the aftermath of domestic violence. By drawing on interviews with women and children, it is argued that the damaging presence of the abuser remains even in his absence, casting a continuing shadow over the relationship between mothers and children. This 'absent presence' of the abusive partner is posited as a concept to assist workers with a framework through which to understand problems in the mother–child relationship that emerge when living with and separating from a violent partner.

CONCEPTUALIZING ABSENT PRESENCE

The concept of absent presence has a long and rich philosophical tradition, which dates back to Aristotle and Plato. Latterly, Heidegger and Derrida have taken up the mantle to unpack the relationship between presence and absence and the role of speech, writing and representation in mediating this relationship. Central to this discussion is the binary notion that absence and presence can only be understood in relation to the absence of the other. Thus, a person or an object is either absent or present. The philosophical tradition, however, has constantly questioned and placed this binary under scrutiny. An example lies in

the role of the photograph as an image, which denotes a presence in the absence of the actual person or scene (Barthes 1981) or text (defined broadly) as always mediating the presence of a person through speech, writing and images while these representations of a person exist, a person is continuously present even in their absence.

Although the philosophical debate should not be ignored, the application of the concept of absent presence also has traditions within social work and therapeutic work more generally. 'Ghosts in the Nursery', the evocative title of a paper by Fraiberg *et al.* (1975), graphically illustrates the ways in which trauma and emotional pain may be carried across generations. The events and people creating pain may be in the past, but the impact of their invisible presence continues. In fact, in reading across the applied literature on absent presence, the heterogeneity of the concept is striking. The area of loss and grief is particularly well represented (Cody 1991). The presence of the dead or absent person is constantly acknowledged by both practitioners and the grieving person. In other areas also, the ways in which subjugated knowledge is surfaced uses the terminology of absent presence. Brown (2008), for example, uses the metaphor of the absent presence of ghosts to refer to the marginalization of the colonized 'other' in Canadian multicultural discourse. Perhaps most common of all is the usage of absent presence to refer to the distraction of people in the communication realm. People may be present, but lost to the other person through their engagement with books, mobile phones and other electronic devices:

> We are present but simultaneously rendered absent; we have been erased by an absent presence. (Gergen undated, p. 1)

The use of absent presence in this paper invites practitioners to look beyond the immediate behaviour that confronts them when assessing and responding to women and their children separated from domestic violence. Instead, to recognize the ways in which the perpetrator of violence, either through the legacy of violence or through actual and continuing contact, remains present. Thus, we argue that both absence and presence exist simultaneously.

RESPONDING TO THE IMPACT OF DOMESTIC VIOLENCE

The heightened risks to the emotional and physical well-being of children living with domestic violence have been well established (Kitzmann *et al.* 2003; Holt *et al.* 2008). Hearing and seeing their mothers attacked, becoming caught in the violence themselves, and living in an atmosphere of fear and unpredictability where there may be little attention to their needs, particularly (but not only) during violent incidents, undermines children's development, their mental health and well-being (Mullender *et al.* 2002) and physical health (Rivara *et al.* 2007). Although the concerns for children are now better identified, attention to women living with domestic violence also needs to remain in focus. Research shows consistently heightened vulnerability to mental health problems such as depression, trauma and suicidality (McLaughlin *et al.* 2012).

It is unsurprising that given these negative impacts on both women and children, an emerging area for attention lies in the different ways in which domestic violence undermines the mother–child relationship (Radford & Hester 2006; Humphreys *et al.* 2011). A complex picture emerges of women who are systematically physically and emotionally disabled becoming poorly placed to respond consistently to their children's needs. This may include criticizing and humiliating the woman in front of her children and manipulating children in ways that undermine her parenting (Mullender *et al.* 2002). Morris (2009) refers to these tactics of abuse as the abusive household gender regime to highlight the pervasive and gendered nature of the abuse. A 'conspiracy of silence' may develop between mothers and their children in which each believes they are protecting the other by not disclosing (or debriefing) about their fears. Only a minority of women and children have talked together about the domestic violence they are both experiencing (McGee 2000). While acknowledging the damaging impact of domestic violence on the mother–child relationship, the resilience of that relationship should also not be underestimated. Casanueva *et al.* (2008) in a large US study of a child protection population showed that most women took active steps to compensate for their partner's violence and that their parenting behaviours were comparable or more positive than those for a national sample of disadvantaged families (Bradley *et al.* 2001).

Although the impact of domestic violence on women, children and their relationships has been increasingly identified, effective intervention responses are less developed (Stanley *et al.* 2011). This is particularly marked in the attention given to strengthening the mother–child relationship in the aftermath of violence (Radford & Hester 2006; Humphreys *et al.* 2011). The statutory response often

appears to dominate the intervention, yet the history of statutory child protection services in responding effectively to both an adult and child victim (as occurs where there is domestic violence); engaging men as the perpetrators of abuse; and overcoming the fear that women hold that their children will be taken into care remain barriers to supportive interventions (Coy *et al.* 2011; Humphreys & Absler 2011). These barriers may be particularly strong for women who already experience themselves as marginalized (Thiara *et al.* 2012; Nixon & Cripps 2013). It remains an area where the gaps in professional practice continue to emerge in spite of programmes to address these lacunae (Munro 2011) and shift from continuing to hold women responsible for all aspects of their children's welfare to more accountable interventions for fathers who perpetrate domestic violence (Devaney 2009).

The response to women and their children escaping from a violent partner through divorce and separation has been particularly criticized (Douglas & Walsh 2010). Although statutory child protection responses have continued to pressure or support women to leave violent relationships for the sake of the children, in the area of private or family law, the requirement for children to have ongoing contact with their fathers remains a source of concern. High levels of continuing post-separation violence (Stanley *et al.* 2011; Thiara & Gill 2012) leave women and children vulnerable to ongoing fear and the continued undermining of the mother's relationship with her children (Scott & Crooks 2007).

In short, effective intervention in the domestic violence area remains problematic particularly in understanding the dynamics and the strategies that undermine the mother–child relationship.

METHODOLOGY

The semi-structured interviews, which provide the empirical data for this paper, are one part of a broader action research study (Humphreys *et al.* 2011). Action research is a combined strategy for enquiry (research) and development (practice/action) (Ison 2008). The approach is based on repeated cycles of planning, action and reflection in which the process of reflecting on what has been achieved in any one phase of activity leads to planned improvements that form the beginning of the next cycle. University of Warwick provided the ethical clearance for the research, which was funded by the Big Lottery Community Fund, and involved a partnership with a domestic violence organization.

The aims of the project were to research aspects of the mother–child relationship and develop activities to support the communication and relationship building between mothers and their children who had lived with domestic violence (Humphreys *et al.* 2006a & b). The project was based on three cycles of implementation and feedback, followed by reflection and incorporation of feedback into the developing materials. The project worked with children aged from 5 to 16 years and their mothers and included research sites in 10 refuges, two NSPCC teams and two voluntary sector women's services. A limitation of the project lies in the predominance of the families from a refuge population where the experiences of abuse and need for safety may be higher than for the other survivors and their children living in the community.

A total of 45 mothers and 52 children participated in the research. Of the participating children, 27 were boys and 25 were girls; their age ranged from 5 to 16 years, with the largest being the 5- to 7-year-olds (n = 15) and 8- to 10-year-olds (n = 19), seven were 11- to 12-year-olds and 11 were teenagers. Twelve of the families were Asian. Children, young people and their mothers were interviewed individually. The interviews provided an opportunity for participants to act as research consultants. Similar to other research in this area, both women and children said they were motivated to engage with the research in the hope that it would help other women and children (Morris *et al.* 2012). In the process of these interviews, a range of issues about current and past experiences were also explored.

All interviews were taped and transcribed. As with any action research project, questions arose as the project developed. The researchers noticed strong patterns in the themes emerging and the particular intensity around issues related to the perpetrator of the abuse. These led to an exploration of the focus question for this paper:

> In what ways does the perpetrator of abuse remain present in the lives of women and children following separation?

The exploration of this question led to a thematic analysis (Thomas & Harden 2008) across all interviews, ignoring the different cycles and focusing instead on the ways in which children and their mothers talked about the effects of abuse and the past and present impact of their fathers or stepfathers who perpetrated the abuse. Mother and child transcripts were placed together and numbered by family to support the analysis of relationship issues and experiences. The three stages of thematic analysis (line-by-

line coding, the development of descriptive or primary themes, and the generation of analytical themes) provided the structure through which the interview data were approached (Thomas & Harden 2008, p. 45). The descriptive themes remain 'close' to the original data and are reported in the findings section of the paper. An analytic theme is used to organize the reporting of the findings and represents an interpretation by the researchers, which 'goes beyond' the descriptive themes and generates new interpretations or constructs.

Analysis was manual but systematic, building the *descriptive* themes from line-by-line analysis of the interviews with mothers and their children. Researcher inter-relatability was gained by three of the researchers sampling transcripts and checking the theme analysis and 'coding tree' (Bazeley 2009). The *analytic* themes were developed through intensive researcher discussion and checking back to the descriptive themes. The concept emerged much more strongly from the women's transcripts. They were able to talk more explicitly about the past and present impact of domestic violence on their mothering. Children were asked less about the abuse and in fact were much more inclined to talk about the immediate positive effects of 'spending time with mum' rather than the nightmares or anger that their mothers were still managing. The findings therefore draw more from women's transcripts than those of their children.

In the *reporting* for this paper, the process of descriptive and thematic analysis is reversed. The final analytic concept, the absent presence opens the findings section and the descriptive themes are then organized to identify the different aspects of this overarching concept. In itself, it is an interesting aspect of qualitative data analysis where the analytic concept once identified reorganizes or 'unscrambles' the themes that built its original identification. As with a jigsaw, we felt that the 'audience' needs to see the whole picture and then the different pieces are more easily understood.

FINDINGS

The absent presence of the abusive man on both his ex-partner and children marked the stories of the interviewed women and children. Arguably, most aspects of the ongoing effects on women and children from their experiences of domestic violence could be highlighted as absent presence, a part of past trauma that is relived in the present for both women and their children, especially if they have received little or no supportive interventions for their experiences. However, we have chosen to focus on those aspects that women and some children reported directly impact on their relationship. It is here possibly more than any other area that the perpetrator continues to cast a shadow over the mother–child relationship in the post-separation period.

The past surfacing in the present

An interesting and pervasive issue is that there was slippage in the language about the present and the past. Even though women were separated, they often spoke as though the past experience of domestic violence was ongoing:

> It's like a mask, you wear it for so long that it sticks to your face and you can't take it off. Because it's what everybody knows. So you're never you. Even with people that you care about, you're never you. Because you can't be. Because if you take the mask off it means that you might slip up when you put it back on. . . . Because if the secret gets out you just know from this churning feeling inside you, something awful is going to happen. You just know. And it's going to hurt and you're going to be the fall guy. (Fam 44, woman living in a refuge)

This woman was talking about a time when she was in the relationship fearing that she would disclose the violence she was experiencing. However, there is a strong sense in this narrative that this learnt behaviour is still present.

Erosion of confidence in their mothering

The undermining of women's mothering appeared to be a deliberate strategy used by abusive men and reported by the majority of women in the study. Alongside eroding their self-confidence more generally, the attempted psychological manipulation resulted in women questioning their ability to parent:

> He basically destroyed all my confidence in me and my confidence in being a mum too. I just thought I'm just a shit mum. (Fam 37)

The manipulative games and the psychological impact this had on women were regularly mentioned:

> . . . it wasn't so much the physical, it was the mental abuse that was the worse. He manipulated my mind all the time and he'd twist everything and he did things that made me feel like I was going mad . . . I'd think well I'm sure I did that, no you haven't. But I had done it. But he'd . . . make me think that way . . . so he could control me. (Fam 37)

Additional issues were raised in several cases by South Asian women, who described how they were

forced, sometimes through rape, to have children and were then prevented from forming a mothering relationship with them; a role assumed by members of men's families:

> They didn't used to leave the baby with me, his sisters used to take him out all the time, I never had much time with him. I was like their servant. They had a shop at home, the house full of boxes, so they made me work there. I was forced to have the children, I didn't want to go near him, all three were forced. There was no love between us. (Fam 28)

Others were isolated and prevented from normal mothering activities:

> We used to live in a council flat on the top floor of a tower block. I couldn't leave the house or take the kids out. My son was four years old and I had never taken him out. I knew nothing about looking after kids. He prevented me from taking him to play groups. . . . I knew nothing when I came to the refuge. I didn't even know how to cross the road with them. . . . I was not confident. (Fam 31)

In short, women's narratives were replete with examples of ways in which their confidence as mothers was undermined *in* the relationship, but where they were left with a confidence and skills deficit in the present: the long shadow of the impact of the perpetrator of violence.

Undermining the mother–child relationship

The erosion of women's sense of self, their confidence in their mothering and the undermining of the mother–child relationship are all closely linked and form part of a continuum for women in the pre- and post-separation periods. Women in the study talked about a range of overt and covert ways in which their relationship with their children was undermined both in the past and stretching into the present. Although now separated, most women wanted to talk at length about the different ways in which their relationship with their children was undermined while they were still living with the abusive man.

A group of women could name ways in which men deliberately attacked the mother–child relationship:

> He never wanted me to show love towards my son. He wouldn't let me breastfeed which I wanted to do. . . .When my son started to speak he didn't want him to call me mummy. When he started school and if he hugged me he hit him. If he tried to stop me from crying he would hit him. (Fam 49)

Sometimes children were also able to speak of this impact on the relationship with their mothers:

> I never used to get to talk to my mum . . . because he had big ears . . . he was like Dumbo because he could hear everything . . . I could never like get to talk to mum unless we were out or anything. (child, Fam 40)

Women reported having to prioritize men's needs at the expense of the children, which they perceived had a negative impact on their relationship in the post-separation period:

> Oh he was very jealous about it, very, very jealous . . . he was always there trying to come between us . . . if he wanted a meal, he had to come first. So it was hard, really hard to juggle . . . It really did affect her . . . she obviously realised that I'd got no respect. So she learnt not to respect me. And when we got out of the relationship she had no respect for me at all. (Fam 21)

In some South Asian families, women were undermined by men and other family members who attempted to deliberately turn children against their mothers:

> I used to listen to his dad telling him not to listen to me, he used to tell him, 'Your mummy is thick, she doesn't know anything, she is mad, uneducated'. They all used to tell him that. (Fam 28)

Alongside undermining women in front of children, men also used children to undermine women, leaving women to counteract the negative effects:

> My husband used to swear at me and he used to try and teach my son to swear at me as well. He used to tell him negative things about me . . . I used to sit and talk to him and say 'What daddy is saying isn't right and you shouldn't do that'. (Fam 30)

The impact of such negative messages about the child's mother do not disappear upon leaving, although women were in a better position to counteract such 'brainwashing' once men were more absent than present. Women also talked extensively about tactics and the legacy of abuse continuing in the post-separation period.

> He'd belittle me, call me names and all sorts of things and laughs about it in front of her as he was handing her over. . . . He did his absolute level best, level best to destroy through manipulation. (Fam 52)

The women's confrontation with poverty and needing to rebuild their lives was a challenge for women, but one which also impacts on their children and their mothering.

> I was a wreck coming out. An absolute wreck and sometimes I can understand why people go back because they know what to expect. I came out, I lost my house, my job, I had a huge debt because of him and I thought, 'God what can I do?' (Fam 37)

Sometimes, women were unaware of the extent to which their own experiences of domestic violence distracted them from the needs of their children.

> And I thought it wasn't really that bad. I didn't suffer that much and I'm out of it now so it doesn't matter. But I came into the room and we (women in the refuge) sat down and they started talking and I just felt 'God that happened to me' . . . It's like actually it was horrific what I went through and I'd blocked it all out. I went back and I thought I'm not being a good mum to my daughter because I'm not talking to her and she's crying out to talk to me. (Fam 44)

Women who were aware of the impact on children of men's deliberate undermining recognized that children needed time and support to overcome this so that the presence of the perpetrator was diluted over time:

> I knew he was affected and I know it will take time but he's changing. He was taught a lot of negative things and it will take time. (Fam 28)

In particular, re-establishing authority and control over children, where this had been chronically eroded by the abuser, was cited as a significant challenge by women, some of whom overcompensated because of guilt about what they had put children through. Many said they struggled to get into the driving seat to appropriately discipline children:

> That's why I think I've lost a little bit because I'm trying to be the mum and dad . . . the discipline bit you see was always the dad . . . and it isn't quite working because I'm not firm enough and I give in. (Fam 42)

All women in the study could cite ways in which their relationship with their children had been undermined by the tactics of the abuser, and for many the early post-separation period was particularly challenging.

Child contact problems

Child contact was an area in which the absent presence of the abuser was clearly evident and an issue for about a third of the women and children in the sample. Child contact formed a link between men's undermining of relationships between women and their children before separation and the continuation of this after separation occurred. Men's abuse through contact arrangements greatly impacted on children and their relationship with their mothers:

> She's scared of him . . . he comes and takes her out on Sunday and she doesn't want to go in the first place, but she daren't not go. She daren't say boo and then she takes it out on me when she comes back. It's like all that frustration that's built up during the day, I get it thrown in my face. It's awful. (Fam 42)

In many cases where child contact was an issue, this provided a site not only for men to further harass women but also to continue undermining women to children.

> He's discussing things that are going on in Court with her . . . and he's saying to her 'look you know next time I go to Court the Judge is going to make a decision because he's sick of your mum messing me around'. . . . he shouldn't be discussing the Court case with her. She's nine years of age . . . it's times like that that the relationship becomes difficult between me and her. (Fam 33)

Sometimes, the undermining of the mother–child relationship became worse after separation. Given the separation between child contact and child protection processes, professionals encountered by women often took little cognisance of the ongoing abuse. When voicing their concerns about the negative effects on their children, a number of women reported being disbelieved, sometimes leaving them blaming themselves for being a 'bad mum':

> Everything and everybody I used to go to for help were . . . just didn't want to know. And I was just, 'is it just me? I'm a bad mother?' . . . Nobody wanted to know . . . I fought and fought and fought and eventually I managed to have the access stopped because she was terrified of him. . . . She'd wet herself in front of the mediator as soon as he walked in through the door and then they blamed me . . . for a child to come back and behave the way she was for so long . . . there was one particular night where she literally destroyed her bedroom. She was five years old. (Fam 52)

In these cases, the ongoing abuse was not seen by professionals and was therefore 'absent', even though the presence was clearly a reality in the lives of the women and their children.

Post-separation harassment/violence

Post-separation harassment often, although not always linked to child contact, prevented women and children from moving on with their lives:

> He basically wouldn't leave it alone. I had a year and a half of harassment from him. I had to go to Court and he basically got off with a smack on the hand and had to pay a fine. (Fam 37)

The absent presence especially prevented women who had insecure immigration status from moving on. In such situations, upon separation, women and children were frequently left in a state of limbo for long periods as they attempted to secure their immigration status:

> I have been living in the refuge for one year; I am waiting for my passport from the Home Office as he didn't give me my passport. It's hard to live in the refuge for so long with four kids. (Fam 31)

In these cases, the actual presence of post-separation violence or the legacy of dealing with abuse tactics meant that the abuser continued to cast a shadow over mothers and their children.

Issues for children

> That was how he ruled it, because he made sure that every time I had a holiday he booked the six weeks off and then he'd just sleep through the holidays. So I couldn't have any friends round or anything . . . every holiday . . . claimed that it was my fault that he was drunk. (Child in Fam 44)

The majority of women reported that their children had been exposed to a range of abusive situations, which created trauma for them and continued to affect their lives after separation – a reality that provided many challenges for mother–child relationships. Almost all of the children were aware of the domestic violence and a large number had seen extreme violence, where some had intervened by calling the police. Fear about their situation was sometimes outweighed by fear for their mother's safety. Some had been subjected to physical and emotional abuse, something which had ongoing consequences for children:

> His dad used to say 'you're thick as shit you are, you've got a fucking problem' . . . so that boy has no self-esteem. 'I am thick, I can't do anything at school, I'm rubbish'. And I say to him 'you're none of those things'. . . . (Fam 38)

Growing up with domestic violence, where they had either seen and heard or been directly targeted, resulted in various effects on children. Women in our study widely reported behavioural issues for children, not only while living with domestic violence but just as commonly after they had left, and especially if child contact was in place. Sometimes women only realized the extent of the impact on children once they were out of the abusive situation as reported by the mother in the opening quote for the paper.

Leaving their home was often unsettling for children and created a sense of displacement that manifested in their behaviour after separation; however, for others separation created the space for their recovery:

> He started speaking very late, only when he was five years. He understood but didn't speak. He was very withdrawn, my husband used to hit me in front of my son. . . .When I left and he went to nursery he started to talk. He made friends in the refuge and we started to go out. (Fam 31)

Most women with more than one child reported that domestic violence affected children differently in the same family. Anger issues for children were reported by many of the mothers and this was something that women were left to manage, sometimes becoming the target of their children's anger. This was one area where the legacy of the abuser and his violence especially brought his presence into the mother–child relationship. Some children were able to talk about their anger:

> He's hurt my whole family in the heart so I'm not happy with him. One day he's getting his comeuppance. I hope . . . If you give it away, if you do that you expect it to come back to you . . . So I hate him for doing what he's done to my mum and all that. (Child in Fam 41)

In this quote from the child, there is a strong sense in which the child's feelings towards their father are configured by the past but remain strongly present. It is also noteworthy that it is the perpetrator's actions towards the child's mother, rather than the child herself, which lie at the heart of the emotion.

DISCUSSION

The findings from the interviews with women and children in the aftermath of domestic violence highlight the many ways in which their lives have been marked by abuse. Low self-esteem and self-confidence and the ongoing impact of fear manifested in symptoms of trauma for many women and children (Holt *et al.* 2008).

As seen in other studies, the relationship between women and children bears the brunt of the continuing effects of domestic violence and the tactics of abuse (Mullender *et al.* 2002; Morris 2009). Re-establishing the mother as parent away from fear and the controlling behaviours of the domestic violence perpetrator is new territory for both women and children. Most importantly, while women and children may be separated from the perpetrator, the abuse may be ongoing through child contact arrangements, stalking, harassment and financial abuse.

Using the accounts from women and some children, we have conceptualized these ongoing effects of abuse as the absent presence of the perpetrator. This terminology represents a helpful reminder to practitioners to explore, understand and to be curious about the things they may not be seeing directly, yet may be profoundly affecting the lives of those with whom they are working. This language stands in stark contrast to conceptualizations that focus on the deficits in mothering and the mother–child relationship and

which fail to grapple with the ways in which the domestic violence perpetrator continues to cast a shadow over that relationship. Although most social work practitioners would argue that their practice is no longer so narrowly focused, there are a number of indicators which suggest that 'the invisible man' or the invisibility of the effects of abuse remain problematic (Lapierre 2010; Humphreys & Absler 2011).

A particular problem highlighted by women in the study was the need for ongoing support. The domestic violence abuser had targeted not only the woman but also her relationship with her children leaving a legacy of ongoing mother–child issues; a problem Morris (2009) refers to as 'maternal alienation'. The implications of this for practice post-separation are obvious. Women's narratives revealed a need for support to help them to build their capacity to mother/parent. Unfortunately, services remain concentrated at the crisis and assessment stages of intervention, with work to strengthen the relationships between women and children in the aftermath of abuse marginalized and underfunded (Humphreys *et al*. 2011). Interestingly, evidence now suggests that parallel group interventions (Graham-Bermann *et al*. 2007) or mother–child interventions (Lieberman *et al*. 2005) in the post-crisis period show stronger effects than child-only or woman-only interventions.

Women in this study also highlighted the problems of ongoing child contact with domestic violence perpetrators. Within family or private law proceedings, women are still urged to become 'future focused' and to place the experiences for themselves and their children behind them and to focus on the child's need for their fathers (however violent and abusive). The denial of direct contact to abusive fathers remains an exception in spite of high reported rates of post-separation violence (Stanley *et al*. 2011; Thiara & Gill 2012). Guidance such as that developed by Sturge & Glaser (2000) to inform the Court of Appeal about the need to restrict contact that could be re-traumatising unless specific changes had occurred in those responsible for the perpetration of domestic abuse were outside the experience of the women in this study.

The findings from the study have implications not only for practice with women and their children. The development of programmes for fathers that tackle the issues of their abusive behaviour is an emerging area of practice. The circumstances under which these interventions are effective are still in the early stages (Scott & Crooks 2007; Coy *et al*. 2011). Nevertheless it is now clear that most men, no matter how abusive, will live with or have contact with children (Alderson *et al*. 2013). An opportunity lies in making the presence of the perpetrator of abuse and his tactics overt rather than absent.

CONCLUSION

Derrida contributed to understanding a world in which absence and presence are not binary positions in which presence is 'truth' and absence a negation. Rather, he reminds us that every word, every textual representation has both a presence and a meaning which is open to construction and interpretation (Derrida 1997). It is in this 'space', where difference (differance) is determined (Derrida 1997), where absence can be made visible and where opportunities lie for practice.

Social work practitioners and particularly statutory workers hold significant power to interpret the behaviour and the meaning of the relationships with which they are confronted. We have argued in this paper that the shadow that the perpetrator of abuse continues to cast across the relationship between women and their children may not be fully understood and interrogated in practice. Instead women, who themselves may be struggling, may be held responsible for both the problems and the solutions to those problems in the relationship with their children following separation from an abusive partner.

Strengthening the mother–child relationship through joint work, debriefing the violence and abuse they have both experienced and building on the strengths and protective actions that were needed to survive the experience of domestic violence are not common practitioner models. Without proactive strength-based work with mothers and their children in the aftermath of violence, it is all too easy for women to be left struggling with the absent presence of the perpetrator that can continue to undermine rather than rebuild the relationship between women and their children.

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