Government of **Western Australia**
Department for **Child Protection**
and **Family Support**

Practice guidelines:

Women and Children's Family and Domestic Violence Counselling and Support Programs

Western Australian edition

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1 Introduction

1.1 Background

In Western Australia, government and non-government agencies are working towards integrated responses to family and domestic violence, In this context, 'integrated response' refers to government and non-government agencies working in a coordinated and collaborative manner to provide holistic, safe and accountable responses to victims and perpetrators of family and domestic violence; streamlined pathways through the service sector and seamless service delivery between agencies. Key drivers of this reform are the *WA Strategic Plan for Family and Domestic Violence 2009–2013* and *Western Australia's Family and Domestic Violence Prevention Strategy to 2022* which identify the need to develop a state wide integrated response to ensure early identification of violence, timely access to information and services and coordinated responses between agencies to work towards safety and accountability.

Women's and children's family and domestic violence counselling and support services are a critical part of an integrated response to family and domestic violence. Funded by the Department for Child Protection and Family Support and located across the state, these services provide safety focused support to women and children experiencing family and domestic violence and assistance to find solutions for personal and practical problems that have arisen as a result of the violence.

The target group for these services includes women who are no longer in violent relationships and those who remain in a violent relationship, including those with no prior contact with police or family and domestic violence crisis services. Children are part of the target group, whether as primary or secondary clients.

These guidelines have been developed to support the operation of women's and children's family and domestic violence counselling and support services. They are designed to be used by individual practitioners and organisations to support reflective practice and ongoing quality review and service development. The guidelines form part of the service agreements for relevant services funded by the Department for Child Protection and Family Support.

These practice guidelines should be read and considered in relation to the following supporting documents:

- *Western Australian Family and Domestic Violence Prevention Strategy to 2022.*
- *Western Australian Strategic Plan for Family and Domestic Violence 2009-2013.*
- *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (CRARMF) (2011).*
- *Memorandum of Understanding: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia.*
- *Guidelines for Multi-Agency Case Management.*

1.2 Scope of the guidelines

Although designed for services providing family and domestic violence counselling and support to women and children, these guidelines are relevant for any practitioner working with women and children affected by family and domestic violence, whether in a generalist or specialist service setting.

The guidelines include principles for practice and the legislative context, foundations for practice including professional conduct and integrated responses and guidelines for client work from first point of contact through engagement, assessment, counselling, case work and advocacy.

The guidelines do not encompass crisis responses, nor do they address in detail joint or 'couple' counselling in the context of family and domestic violence. It is recognised that generalist services in particular may be approached with requests for joint counselling, or that family and domestic violence may arise as the key issue after joint or couple counselling has commenced. As discussed in Miller (2007), joint counselling needs to be grounded in feminist concerns for justice and safety; couples counselling may lead to revictimising of women, and risks the person using violence being provided with a platform for self-justification. Joint counselling should be based on zero tolerance for violence and commitment to safety, accountability, and equity, and requires a core distinction between the crime of violence and any notion of 'relationship issues'.

Where practitioners are considering a request for or referral to joint counselling (or family dispute resolution also known as mediation), a thorough assessment, considering the following points at a minimum, should be used to guide decision making:

- the risk to the safety of clients
- the risk that a child may suffer abuse
- the client's ability and capacity to participate on equal terms
- the emotional, psychological and physical health of the clients
- the risk to staff safety.

Information and services regarding client legal rights must also be discussed with the client.

If a service chooses to accept a referral for joint counselling or family dispute resolution where family and domestic violence is or has occurred, risk management strategies must be put in place. For further information about risk management, see the minimum practice standards outlined in the *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* (link provided below):

http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/CRARMF.aspx

2 Context for practice

Family and domestic violence is a widespread, preventable social problem that occurs within the context of broader patterns of social and gender relations and affects people, mainly women and children, in the most personal and intimate areas of their lives. Counselling, advocacy and support provided to women and children who have experienced family and domestic violence must take into consideration both the social dynamics of gendered violence and the specific, individual rights and needs of clients.

Additionally, services providing counselling, advocacy and support to women and children who have experienced family and domestic violence operate within the framework of a multi-agency response to the issue, which has implications for practice and the orientation of services.

2.1 Definition of family and domestic violence

The following definition of family and domestic violence is from the *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework.* A common or 'agreed' definition, including the common use of language and agreed paradigms, is an important feature of an integrated response.

> Family and domestic violence is… behaviour which results in physical, sexual and/or psychological damage, forced social isolation, economic deprivation, or behaviour which causes the victim to live in fear.
>
> The term is usually used where abuse and violence take place in intimate partner relationships including same sex relationships, between siblings, from adolescents to parents, or from family carers to a relative or a relative with a disability. A key characteristic of family and domestic violence is the use of violence or other forms of abuse to control someone with whom the perpetrator has an intimate or family relationship.
>
> The term 'domestic violence' usually refers to abuse against an intimate partner, while family violence is a broader expression encompassing domestic violence and the abuse of children, the elderly and other family members.
>
> Aboriginal and Torres Strait Islander people generally prefer to use the term 'family violence'. This concept describes a matrix of harmful, violent and aggressive behaviours and is considered to be more reflective of an Aboriginal world view of community and family healing. However, the use of this term should not obscure the fact that Aboriginal women and children bear the brunt of family violence.

There are seven broad categories of abuse that are usually referred to when discussing family and domestic violence and these are outlined below. The key characteristics for any kind of behaviour to be characterised as family and domestic violence is the intent to dominate, control and create fear. Any action/behaviour that is conducted with this intent can be included as a form of abuse:

- **Physical assault** — any behaviour that is intended to cause harm e.g. pushing, slapping, punching, choking and kicking.

- **Sexual assault** — forced sexual contact/activity. "Forced" in this context refers to individuals who are physically coerced to participate or who are not in a position to say no as a result of fear, threats or intimidation.
- **Verbal abuse** — threats, put-downs, insults, shouting.
- **Emotional/psychological abuse** — mind games, manipulation, humiliation, making the person feel worthless or no good.
- **Social isolation** — keeping the victim away from friends, family, work and/or other social opportunities.
- **Financial abuse** — controlling the money and decisions around its use, taking or limiting money, stealing.
- **Spiritual abuse** — keeping someone away from places of worship or forcing them to participate in spiritual or religious practice that they do not want to be involved with.

2.2 Incidence of family and domestic violence

2.2.1 Women

Research on family and domestic violence indicates that it is a chronic, under-reported and gendered problem in which women and children are significantly over-represented. While men also report physical violence from women, population-based studies show that most often women are the victims and they experience more frequent and more severe family and domestic violence than men.

The Australian component of the 2004 *International Violence Against Women Survey* (IVAWS) reported that 34 per cent of Australian women have experienced at least one form of violence from a current or former partner (Mouzos & Makkai, 2004). A quarter of women (25 per cent) who identified intimate partner violence through the IVAWS had never before spoken to anyone else about the incident.

This study also found that levels of violence experienced from a former partner (36 per cent) were much higher than from a current partner (10 per cent). Women who experienced violence from former partners were also more likely to sustain injuries and feel that their lives were in danger.

Twenty-nine per cent of women who were surveyed reported that they had experienced physical and/or sexual violence before the age of 16 years. Almost one in five women reported that they had been physically abused as a child by a parent (18 per cent). Fathers were more likely than mothers to physically abuse their child (61 per cent). The levels of violence experienced by women over their lifetime were higher for women who were abused as children compared to women who did not suffer childhood abuse. This pattern held, irrespective of the type of childhood abuse suffered by the women.

Family and domestic violence occurs at even higher rates amongst young women, Aboriginal women, women with disabilities and women from culturally and linguistically diverse (CALD) backgrounds. Aboriginal women are 10 times more likely to be victims of homicide and are 35 times as likely to be hospitalised due to family and domestic violence-related assaults as other Australian females (Ferrante *et al.* 1996; AIHW, 2006). According to Western Australian researchers Hovane and Cox (2011), "Family violence in Aboriginal and Torres Strait Islander communities remains a significant social issue with far-reaching implications for service provision in the health arena, with impacts including: physical injuries; depression, trauma and anxiety; sexually transmitted disease; and substance use."

The Health Costs of Violence study found that intimate partner violence is the leading preventable contributor to death, disability and illness for Victorian women aged 15-44 (VicHealth, 2004: 25). Studies indicate that pregnancy is a time of high vulnerability to family violence, with the first incident often occurring while women were pregnant (ABS, 1996).

2.2.2 Children

Family and domestic violence also has a major impact on the health and wellbeing of children. Recent meta-analyses have shown that children exposed to family and domestic violence exhibit significantly more problems than children not exposed (Edleson, 2011). Children are regularly exposed to the damaging effects of family and domestic violence both as witnesses of violence against mothers and direct victims of assault and emotional abuse.

The 2005 Personal Safety Survey indicated that 61 per cent of men and women who had experienced violence by a previous partner had children in their care during the relationship. Additionally, 49 per cent of people who reported they had experienced violence by a current partner said they had children in their care at some point during the relationship (ABS, 2006: 11).

During 2012-2013, WA Police attended over 47 000 incidents of domestic violence. It is estimated that in more than 70 per cent of these cases, children were present during the incident or known to reside at the location.

2.3 Impact of family and domestic violence

2.3.1 Women

Women who have experienced family and domestic violence experience a range of consequences including (but not limited to) physical injury, chronic health issues, emotional distress and social isolation (Tually *et al.*, 2008; World Health Organisation, 2000). Family and domestic violence is the leading cause of homelessness for women and children and is a significant contributor to substance misuse and mental health issues for women.

A Victorian study into health costs of violence concluded that intimate partner violence is the leading preventable contributor to death, disability and illness for Victorian women aged 15-44 (VicHealth, 2004: 25).

Despite often horrific experiences of violence, the decision to leave and remain separated from the perpetrator can be complex. One of the biggest challenges in supporting women to leave is overcoming the emotional and traumatic impacts of the abuse (McKinnon, 2008). Most women who have experienced family and domestic violence report that, in hindsight, the emotional abuse that occurred was far more debilitating and destructive than any of the physical assaults that occurred as it causes pervasive feelings of worthlessness, shame, self-blame, fear and helplessness (Arias & Pape, 1999). These emotional consequences can create complex barriers to a woman's escape from violence, including fears about their ability to cope without the perpetrator, their safety if they try to escape, not being believed, exclusion from their social networks or community, and issues related to child custody including presumptions about 'shared care' (Patton, 2003).

2.3.2 Children

Children growing up in homes where there is family and domestic violence experience ongoing and pervasive fear, worry, confusion, self-blame and exposure to multiple insidious forms of violence and abuse.

The impact that this has on children is cumulative and pervasive, affecting all aspects of health and wellbeing from conception through to adulthood. It includes (but is not limited to) insecure attachment to the primary care-giver, high rates of emotional distress, presence of trauma symptoms and social and behavioural issues (Osofsky, 1999; Perry, 2007).

Children growing up in homes where there is family and domestic violence are also vulnerable to other forms of child abuse including physical and sexual abuse and neglect. For example:

- Physical abuse: Approximately 60 per cent of physical abuse occurs in homes where there is family and domestic violence (Moloney *et al.*, 2007). This includes children who are harmed during an assault against the non-abusive adult victim (e.g. if the child is being held or tries to intervene in the violence) and intentional harm of children as a means to punish the adult victim (scape-goating).
- Child sexual abuse: There is a high correlation between child sexual abuse and family and domestic violence. In these instances, the perpetrators use of violence against the non-abusive adult victim contributes to their ability to conceal the child sexual abuse (Brown, *et al.*, 1998; Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, 2007).
- Neglect: Examinations of child deaths associated with neglect in WA revealed that family and domestic violence was a significant contributing factor in over 80 per cent of the cases reviewed (Francis *et al.*, 2008). Neglect is commonly associated with family and domestic violence for a number of reasons including:
    - financial abuse – perpetrator control of household funds may limit access to adequate food and medical needs;
    - control and isolation – perpetrator may limit access to supportive friends or family and/or support services; and

- jealousy – perpetrators of family and domestic violence can see their children as 'competition' for their partner's time. This can lead to undermining the adult victims parenting including actively stopping them from responding to the child's needs through intimidation and violence.

It is important to note that there are individual and familial factors that moderate the impact of violence. For example, age of onset, frequency and severity of violence and the level of support outside of the family can influence the impact of the violence on the child. Similarly, the emotional health and wellbeing of the non-abusive parent is positively related to child outcomes (Department for Child Protection, 2012).

Parenting

Generally speaking, men who use violence see the children as an extension of the adult victim – a means or mechanism through which they can further control or harm. As a result, their parenting style is typically characterised by the following:

- undermining the parenting capacity of the adult victim (usually the children's mother);
- controlling and authoritarian parenting style including the use of fear and intimidation;
- a strong sense of entitlement; and
- treating their partner and children as possessions (Bancroft & Silverman, 2002; Edleson *et al.*, 2003).

The influence of these behaviours on parenting and in turn the children typically include:

- creating a role model that normalises the use of violence in intimate relationships;
- undermining the authority of the mother which can result in the children similarly dismissing or ignoring her attempts to control the children's behaviour;
- retaliating against the mother for her efforts to protect the children. This can cause children to believe that the violence is their fault or in situations where their mother/care-giver ceases these protective behaviours over time, for the children to believe that she no longer cares about them;
- creating divisions within the family including the use of favouritism and manipulation to escalate sibling conflict or familial tensions; and
- using the children as weapons against their mother/care-giver. This can include harming the children or their belongings, threatening to kidnap or take custody of the children, or using the children to monitor and report on the adult victims behaviours. In extreme cases children are actively groomed to participate in the abuse (Bancroft & Silverman 2002; Edleson *et al.*, 2003). (Department for Child Protection 2012).

Family and domestic violence and child protection

The pervasive impacts of family and domestic violence on children, including the effects of cumulative harm, means that practitioners must be attuned to the safety and wellbeing of the child/ren even if they are not the primary client.

This approach is supported by the *Children and Community Services Act 2004* with the central principle that the "best interests of the child" must always be paramount. It sets out the requirement that consideration must always be given to protect the child from harm, protect his or her rights, and promote his or her development.

There will be times when the safety needs and rights of a child or children are not being served by the decisions made by their mother. Practitioners who have traditionally worked with adults will need to be alert to these tensions, familiar with the duty of care obligations which arise, and practised in exercising their duty of care towards the child.

Practitioners are most likely to meet their obligations by utilising a transparent decision making process, such as that described by Burke (1999). In her hierarchy, she addresses both gender and inter-generational power by ranking the safety priorities as follows:

1. The safety and protection of children.
2. The empowerment and safety of women.
3. The responsibility and accountability of perpetrators of the violence.

If there is a dilemma between the principle of child safety and that of the empowerment and safety of women, 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.

2.4 Diversity and experience of violence

While there are commonalities in the experiences of most women and children who have been subject to family and domestic violence, there is also great diversity in the lives and impact of violence on individual women and children. The social position of women and children, including cultural background, sexuality, religion or age can be intimately connected to their experience of violence.

Recognition of the way in which intersections of gender, 'race', class, sexuality, disability and age can contribute to women's experiences of violence have expanded and enriched early feminist analysis of family and domestic violence, which was specifically oriented around gender analysis.

Practitioners should avoid making assumptions about women's or children's experience of family and domestic violence, and be sensitive to the particular cultural and social position of individuals. Services should also recognise that existing family and domestic violence information and programs may be inaccessible or inappropriate for the needs of all women.

Identifiable subgroups of women and children include:

- **Violence within Aboriginal communities**, including family and domestic violence, may be strongly related to a range of factors, including dispossession of land and culture, breakdown of traditional kinships systems, racism and vilification, entrenched poverty, use of alcohol and other drugs, or the loss of traditional Aboriginal social roles for men. Understanding Aboriginal culture is fundamental for effective practice with Aboriginal women and children.

- **Women and children with disabilities** are among the most socially and economically marginalised people in the community. This makes them more vulnerable to abuse and less able to access effective services. Even when they do seek services, women with disabilities may be confronted with negative stereotypes or prejudice.
- **Women and children from culturally and linguistically diverse backgrounds** may face a range of difficulties accessing services, including language barriers, lack of familiarity with the service structure in Australia or social isolation. Their attitudes toward family and their response to family and domestic violence may also be strongly determined by their cultural background, something which needs to be understood by counsellors.
- **Lesbian and bisexual women** are often 'unrecognised' victims/survivors of family and domestic violence. Family and domestic violence services may alienate lesbian women by being oriented toward heterosexual relationships and assuming all clients are heterosexual.
- **Homeless** women and children are particularly vulnerable to violence due to insecure or inadequate living arrangements. They also face a complexity of barriers to changing their situation, including poverty, unemployment and limited access to safe housing options.
- **Age** may be a significant factor that influences women's experience of violence. Older women may be more vulnerable to violence if they are physically or emotionally dependent on their abusers. Young women may also be vulnerable to violence due to lack of experience or confidence in relationships or limited opportunities to gain independence.
- **Women with substance use issues** may face the dual pressure of managing their substance use while also dealing with violence. Substance use may in itself be a reaction to the violence.
- **Women with mental health issues** may already face stigma, discrimination and social isolation. Violence is likely to compound existing mental health issues, and women may fear being disbelieved or blamed if they do disclose violence.
- **Women and children from rural areas face** limited access to services due to geographical isolation. It may also be difficult to disclose violence in a small community where anonymity is difficult and masculine culture is dominant.

It is important to acknowledge that women, young people and children present with a broad range of experiences and complex circumstances. Services and practitioners need to be attuned to the experience of people who are a minority within minorities, and consider these complexities in the design and provision of services.

2.5 Outcomes for women and children

Services can be provided in a range of ways. Rather than defining 'counselling' or 'advocacy', it is more useful to think about the outcomes practitioners are aiming to achieve in their interventions.

Outcomes for women and children expected from the counselling, advocacy and support services include:

- improved safety and identification of options to protect future safety;
- a decrease in the effects of trauma and improved emotional and physical health;
- an improved ability to express feelings constructively;
- greater understanding of resources and supports available to them;
- an ability to challenge power, control and gender issues inherent in violent relationships; and
- a reduction in isolation and improved social networks.

Aboriginal communities may include additional outcomes such as recovery and healing for the individual, the family and the community.

- Additional outcomes for children and young people include:
- improved health in attachment relationship with parent/s and carers;
- improved social interaction and behaviour;
- improved resilience; and
- strengthened relationships with caring adults, other children and the community.

Counselling, advocacy and support with children and young people is also likely to involve work with their caregivers to assist them to understand the process the child is going through and to address areas where the rights or needs of a child may be in conflict with those of their adult carers (Gevers 1999:33; Gevers & Goddard-Jones 2003). These outcomes may be achieved through counselling, group work, play therapy, crisis work, safety planning, provided individually and/or as part of a group work program, and preferably in parallel with work with the non-violent parent.

For women and carers, additional outcomes might include:

- self-agency in decisions affecting her own safety and the safety of any children;
- understanding of resources and supports available;
- improved attachment relationship with any children; and
- greater understanding of the impact of violence on any children.

Practitioners may also be involved in case work, either as part of an integrated safety plan with an individual or a family, or as a case manager. This will depend on the practitioner's service, as well as the extent and capacity of the local service system. For this reason, the practice guidelines include reference to case work and case management roles of advocacy, referral and coordination.

3 Principles and frameworks for effective practice

Family and domestic violence counselling, support and advocacy is provided in an explicit socio-political context. A clear statement of the principles and values indicated by this context is important to inform individual practice and the policies and procedures within agencies that are required to support effective practice. This section outlines a range of principles and values that set the context for family and domestic violence practice with women and children.

3.1 Principles

The following principles underpin *Western Australia's Family and Domestic Violence Prevention Strategy to 2022* (Department for Child Protection and Family Support, 2010):

1 Family and domestic violence and abuse is a fundamental violation of human rights and will not be tolerated in any community or culture.

2 Preventing family and domestic violence and abuse is the responsibility of the whole community and requires a shared understanding that it must not be tolerated under any circumstance.

3 The safety and wellbeing of those affected by family and domestic violence and abuse will be the first priority of any response.

4 Perpetrators of family and domestic violence and abuse will be held accountable for their behaviour and acts that constitute a criminal offence will be dealt with accordingly.

5 Responses to family and domestic violence and abuse can be improved through the development of an all-inclusive approach in which responses are integrated and specifically designed to address safety and accountability.

6 An effective system will acknowledge that to achieve substantive equality, partnerships must be developed in consultation with specific communities of interest including people with a disability, people from diverse sexualities and/or gender, people from Aboriginal and Torres Strait Islander communities and people from culturally and linguistically diverse backgrounds.

7 Victims of family and domestic violence and abuse will not be held responsible for the perpetrator's behaviour.

8 Children have unique vulnerabilities in family and domestic violence situations, and all efforts must be made to protect them from short and long term harm.

3.2 An analysis to inform practice

Family and domestic violence has been described as 'both a personal problem and a social issue' (Laing 2001:2). Practitioners working with women who have experienced family and domestic violence work within the context of an interplay between the structural and social dynamics of family and domestic violence and the personal experiences of clients.

Counselling practice risks contributing to the pathologising and individualising of family and domestic violence if it primarily focuses on the psychological symptoms of abuse (anxiety, depression, post-traumatic stress, suicide attempts), the child's behaviour, or the woman's parenting style (Seeley & Plunkett 2002). The social context in which violence occurs can become lost. At its most damaging, an emphasis on the woman's individual characteristics, such as unassertiveness, emotional dependency or other factors which are seen to predispose women to engaging in relationships with violent men, can replicate the patterns of emotional abuse women have already experienced – one in which the woman is blamed for the abuse. Pejorative psychological labels (borderline personality disorder) may also appear to blame the woman and contextualise the violence as occurring because of the specific mental health issues of that client, thus ignoring the social and gendered nature of family and domestic violence and the effects of violence itself (Humphreys & Thiara, 2003). Similarly, children may be diagnosed with conduct disorders or attention deficit disorder when the context of abuse is not acknowledged or the behaviour is not understood as a response to the violence and abuse in which they are living (Deacon-Wood & McIntosh, 2002).

Whatever approach is taken, effective counselling of adult victims of family and domestic violence is underpinned by the strong understanding that the victim is experiencing psychological, emotional and physical difficulties as a result of the intentional choice of the perpetrator to abuse and violate them. This means that opportunities for victims to live safely and develop their life potential as well as parent effectively may well be compromised by living in a state of fear, anxiety and hope.

Victims become highly adept at developing safety strategies and surviving intolerable situations that may include monitoring and surveillance, emotional, verbal abuse as well as the possibility of physical assault. Counsellors are to be mindful of this context and to 'name' the abuse and the perpetrator's choice to use violence as the reason for the above difficulties. This externalises responsibility and reduces victim blaming as well as holds the perpetrator accountable within the counselling environment.

Sociological, women-centred and feminist perspectives of family and domestic violence, which acknowledge the social pattern of inequality in which violence and abuse is perpetrated, provide a social justice framework for counselling practice. Within this context, the gendered pattern of violence can be named and explored (Laing 2001) in all its complexity (see Memmott *et al.* 2006 for a review of good practice in Aboriginal family violence prevention). An exploration of family and domestic violence that is situated within the broader framework of structured inequalities provides opportunities to understand the social nature of gender-based discrimination. It also supports opportunities for women and children to discuss not only the interpersonal experience of violence but other ways in which disability, poverty and other sources of inequality may have created further vulnerability to abuse.

3.3 Supporting frameworks and theories underpinning family and domestic violence practice

Practitioners in the family and domestic violence field come from a range of disciplines and professional backgrounds, using diverse methods and approaches. There is, however, broad agreement about a number of the primary theories and frameworks that are appropriate and effective in working with women and with children. These include the following and are discussed below - empowerment practice, attachment theory, grief and loss, trauma, and systemic/ecological analysis. Regardless of the practice approach taken, fundamental to the effectiveness of the counselling, group work or support is the quality of the relationship between clients and practitioners.

3.3.1 The Signs of Safety Child Protection Practice Framework

Constructive relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective child protection practice. A significant body of thinking and research tells us that best outcomes for vulnerable children arise when constructive relationships exist in both these arenas. The *Signs of Safety* approach to child protection casework seeks to achieve this through the principles, disciplines, tools and processes that assist practitioners both to undertake their statutory role and to do this collaboratively.

The *Signs of Safety* approach is designed to create a shared focus and understanding among all stakeholders in child protection cases, both professional and family, it is designed to help everyone think their way into and through the case from the 'biggest' person (often someone like a director general, ceo, a judge or child psychiatrist) to the 'smallest' person (the child).

Signs of Safety seeks always to bring together the seeming disjunction between a problem and solution focus within its practice framework by utilising a comprehensive approach to risk that:

- Is simultaneously forensic in exploring harm and danger while at the same time eliciting and inquiring into strengths and safety.
- Brings forward clearly articulated professional knowledge while also equally eliciting and drawing upon family knowledge and wisdom.
- Is designed to always undertake the risk assessment process; with the full involvement of all stakeholders, both professional and family; from the judge to the child, from the child protection worker to the protective (non-abusive) caregiver.

At its simplest this framework can be understood as containing four domains for inquiry:

1 What are we worried about? (Past harm, future danger and complicating factors).

2 What's working well? (Existing strengths and safety).

3 What needs to happen next? (Future safety).

4 Where are we on a scale of 0 to 10, where 10 means there is enough safety for child protection authorities to close the case, and 0 means it is certain that the child will be (re) abused (Judgement).

3.3.2 Empowerment in practice

An 'empowerment model' is generally advocated as the most appropriate orientation for counselling practice with women and children who have experienced family and domestic violence (Memmott *et al.*, 2006:23; ODVN, 2003:8; Seeley & Plunkett, 2002:11; Gevers, 1999:25, Domestic Violence Prevention Unit, 1999:19).

The experience of disempowerment (being physically or emotionally prevented from taking action) is a fundamental aspect of physical and emotional violence; therefore rekindling a sense of empowerment may be an important part of recovery and survival for many women. The Ohio Domestic Violence Network (ODVN) defines empowerment as 'the capacity to influence the forces which affect one's life for one's own benefit' (2003:8). Although 'empowerment' as a concept tends to have a broad interpretation across the social services sector, definitions similar to this are adopted by most family and domestic violence service providers.

In practice, the principle of empowerment means:

- Operating in a manner that supports women and children to experience a sense of being in charge of their lives – as being the 'expert on their own life' (Domestic Violence Prevention Unit, 1999:19).
- Women and children are encouraged to make choices and decisions about their lives and their autonomy and strengths are emphasised.
- The practitioner provides information and education to assist women and children to understand their options and take action when they choose to. This is different to self-esteem building or counselling approaches which seek to address issues such as passivity or co-dependency in a clinical framework (Laing, 2001:8).

Empowerment focuses on the clients taking a position of power in their lives with the practitioner encouraging clients to trust their own judgment and decision making.

It is important to note, however, that children's real power over their lives is limited, and that they are the most vulnerable to the decisions of others – whether it is the parent/carer using violence, or the decisions of the non-violent parent.

Being conscious of the power within the client-practitioner relationship is also important. Narrative therapy is commonly described as a respectful, non-blaming approach to counselling which centres people as the experts in their own lives. Importantly, it assumes people 'have many skills, competencies, beliefs, values, commitments and abilities that will assist them to change their relationship with problems in their lives' (Morgan, 2000). A narrative approach is often cited as an approach that can increase the client's power:

- through seeing the client as expert in her own life, rather than the practitioner taking an expert position;
- emphasising the client's own agency or control;
- adopting a position of collaboration with the client;
- being transparent in the use of questioning – why certain questions are used and how information will be used (Howard & Wirtz, 1999).

It is also important to assess a client's decisions alongside an evaluation of her safety risk, including the risk to children that may be involved (Seeley & Plunkett, 2002:17). The Western Australian *Family and Domestic Violence Common Risk Assessment and Risk Management Framework* outlines an approach to risk assessment that includes professional judgement, use of an actuarial tool (analysis of key risk indicators) and the inclusion of the victim's assessment of risk. This approach has been designed to assist professionals undertake a well informed and responsive risk assessment that better supports women and children experiencing family and domestic violence.

Other studies have also noted that although the goal of 'empowerment' may be to assist a woman to change and improve her circumstances, it is equally important that clients do not feel judged by their counsellors. Studies have shown that some women felt pressured by their counsellor to make decisions for which they did not feel ready and some women were also concerned about 'letting down' their counsellor by not leaving a violent situation (Seeley & Plunkett, 2002:17). There are many factors that may make it difficult for a woman experiencing abuse to leave or change her situation. This may include lack of access to finances, lack of alternative accommodation, family law issues or fear of retaliation by the abuser, no opportunity to take action, as well as ongoing positive feelings for the person using violence. It is important for counsellors to be aware of these issues and maintain their support for clients even when they make decisions that the counsellor finds illogical or frustrating (Seeley & Plunkett, 2002:16).

The daily experience of living in fear means that victims become highly attuned to safety issues and counsellors are required to incorporate this understanding in their ongoing work with victims of family and domestic violence.

While some counselling, support and group work practices are indicative of an empowerment approach to counselling, such as those mentioned above, the concept of 'empowerment' as a principle to direct practice refers to a broad approach or orientation toward practice. Specialised therapeutic approaches would work within the context of a principle of empowerment, not be replaced by it.

3.3.3 Attachment theory

Attachment theory, in relation to therapeutic practice, rests on the assumption that humans have a basic need to form attachments to people throughout their life. If people are unable to form these attachments, for whatever reason, their longer term emotional and social wellbeing will be compromised. The capacity for attachment is shaped by early experiences with caregivers. The principles of attachment theory would suggest that if a child does not develop a safe and secure bond with their early caregiver(s) then they may find it difficult to form trusting relationships with others later in life. However, if the child has been provided with a secure base in terms of close relationships with their caregivers, they will be more capable of developing close relationships throughout their life. Further, early experiences of loss can affect a child's emotional development. For instance, if a child is too young to cognitively comprehend the loss of a parent, or even a temporary separation from a parent through events such as divorce or long-term hospitalisation, they may experience a fear of abandonment which could influence their relationships throughout their life (McLeod, 2003:100-103).

Attachment theory can be applied to family and domestic violence counselling in several ways, primarily by providing insight into the needs of children who have been affected by family and domestic violence. Violence within the family can impact upon the relationship between a child and their mother. In a situation of family and domestic violence, where violence is being perpetrated against the mother, the mother can become a source of both comfort and inadvertent fear for the child. Babies are particularly attuned to their primary caregiver and will sense their fear and traumatic stress. They will become unsettled and more demanding of an already overwhelmed parent. Insecure, anxious or disorganised attachment behaviour is an impact of the trauma response to family and domestic violence.

The care and comfort of an individual's significant others in the family and community is an important basis for recovery following traumatic events. Violence can isolate and degrade people, and the group is central to rebuilding a sense of belonging and affirmation. In other words, attachment has been shown to be an important part of the process of healing from traumatic events, for both adults and children (Miller, 2007:19).

Key points:

- Engaging non-offending parents, and providing mechanisms for children to begin to feel a more secure attachment to their parent, is an important part of the recovery process (Miller, 2007:20).
- Safety must be the primary consideration of women and children, the focus on stability and attachment must not override risk assessment and safety concerns (Miller, 2007: 20).
- Group work can be integrated into the treatment process to reduce the sense of isolation that comes with family and domestic violence and trauma.

3.3.4 Loss and grief

Feelings of grief and loss, which come with the end of a relationship, are particularly complicated in family and domestic violence situations. Women who have experienced family and domestic violence often grieve the loss of their relationship to the same extent that women experiencing divorce or relationship-loss for other reasons may do. However, this grief and mourning is often not acknowledged. Professionals working in family and domestic violence support services generally emphasise the positive aspects of a woman's decision to leave a violent situation, providing assistance with housing, income and so forth. This, along with the general view that women are better off leaving a violent relationship, may prevent a woman or her caregivers from recognising or acknowledging the sense of grief that accompanies the end of that relationship. Termed by Doka (2002) as 'disenfranchised grief', it is grief that does not fit into accepted cultural and moral patterns of grief (or a grief that cannot be publicly acknowledged). Furthermore, women escaping violent situations may fight against feelings of grief, resisting the need for mourning out of pride. Feelings of anger, or desire for revenge, may also complicate the grieving process. Weisz & Scott (2003) identify a number of issues related to grief and loss that often apply to women who have experienced violence. This includes:

- loss of loved members of the perpetrator's family;
- loss of the dreams and expectations they had for their family;

- loss of trust in others;
- loss of a sense of their own capacity to judge other people (particularly a partner) and keep themselves safe (p.10-12).

Counselling for grief and loss is likely to be an important part of counselling practice for women and children who have experienced violence. As Weisz and Scott (2003: 10) write:

> *"If we consider sexual, physical and emotional abuse as a powerful reason to damage the bonds created by attachment, the consequent grief experienced by the survivor is undoubtedly a loss".*

Indeed, acknowledging the grief that comes with the end of a violent relationship may be an important part of the healing process. However, it is important to acknowledge areas where stages of grieving may be unique to the particular social and cultural context of family and domestic violence.

The experience of loss, grief and trauma has ongoing relevance and impact in the Aboriginal community as a result of their long history of traumatic losses, ongoing dispossession and the constant presence of death in the community. Funerals are a regular occurrence for Aboriginal people and every Aboriginal family has been touched by the Stolen Generations.

Key points:

- A framework of grief and loss therapy may be appropriate for counselling women and children who have experienced violence. However, the way in which the social and cultural context of family and domestic violence is unique to the grieving process must be understood.

3.3.5 Trauma

There is no one central approach to 'trauma therapy' and there are a variety of counselling models that inform trauma counselling practice, the most appropriate model depending on the particular needs of a client. Furthermore, people's response to traumatic events varies considerably. However, the defence strategies many people adopt to cope with trauma can cause ongoing physiological, psychological and social problems.

Hyperarousal responses, such as defiance, resistance and aggression, along with anxiety, panic and hypervigilance, are common responses in women and children exposed to the trauma of family and domestic violence. Also common in young children and women is the dissociative response where a child may be detached, numb and have a low heart rate. A dissociative child is often compliant, displays rhythmic self-soothing or may even faint in extreme distress (Perry 2004). Research has indicated that many women who have experienced physical or sexual violence, exhibit symptoms of possible post-traumatic stress disorder (PTSD) (Stapleton *et al.*, 2007, Laing, 2001:9).

Family and domestic violence is a significant and often ongoing traumatic event for women and children and trauma-based approaches to counselling practice are appropriate for these clients. Models of trauma can provide a framework for exploring the longer-term impact of

abuse 'which describes the woman's reactions as normal and understandable given the trauma to which she has been subjected' (Laing, 2001: 10). Trauma models also equip the counsellor with a range of evidence-based techniques for working with women and children who have experienced family and domestic violence. However, there are factors that may differentiate trauma associated with family and domestic violence from other forms of trauma and may complicate the treatment process. For example, in the family and domestic violence context the emotional attachment to the perpetrator of the violence presents women – and children in particular – with a conflicting image of a person which can be difficult to reconcile.

The lives of women who experience violence are often enmeshed with the perpetrator's, through their children and/or their history and relationship together. Children are also likely to be strongly attached to the perpetrator. With other types of trauma or traumatic events, around which trauma therapy has evolved, the victim/survivor will not develop this type of connection with the perpetrator or assailant (if indeed there is one).

Women and children experiencing family and domestic violence are also at risk of subsequent violence, so there are issues of risk assessment, safety and ongoing vulnerability that need to be addressed before a treatment process for trauma can begin. Additionally, as Stapleton *et al.* (2007) point out, women who have experienced family and domestic violence or sexual assault are often likely to feel guilt and shame which isn't a common response to other types of trauma, and something not often addressed in trauma work. It is also important that the clinical individual model of trauma does not divert responsibility away from the perpetrator or from the social context in which family and domestic violence occurs. Clinical models can suggest that the 'problem' lies with the client and reinforce the message that it is she who needs to change or 'fix' herself in relation to the violence (Laing, 2001:11). A return to the foundational work of Herman (1994) reminds us that important steps in the healing process are not only individual but involve re-connecting women to social support and a wider social movement which continues to publicly acknowledge the social problem of violence against women and children. For children this will include the strengthening of their relationships with caring others and acknowledgement that they are not alone in their experience of living with violence and abuse. They need to be safe and given opportunities to integrate and make sense of their traumatic experiences (Miller, 2007).

Key points:

- Risk assessment and risk management must be an ongoing, and central to, practice.
- An appreciation of trauma theory enables counselling professionals to understand the response of women and children to violence. However the nature of family and domestic violence, as different from other sources of trauma, must be considered (Miller, 2007).
- Ensuring the safety of women and children is the primary concern and healing from trauma can only begin as a level of safety becomes established.
- Reconnection to social support is a critical part of healing for women and for children.

3.3.6 Systemic/ecological analysis

Most psychological therapeutic methods have evolved in an individualistic framework – focusing on individual needs and problems. In contrast, a systemic theoretical approach to counselling places the individual within a social and/or environmental context, and draws on systems and constructivist theories rather than psychodynamic theories.

Systemic approaches to counselling practice are often used in family therapy. The basic model of systemic therapy in this context sees the emotions and behaviours of an individual as related to something going wrong at the systemic level, such as poor family communication. The emphasis of counselling practice is 'what goes on between people rather than what takes place inside them' (McLeod, 2003:190-191, emphasis in original).

The benefit of this approach for family and domestic violence counselling is that it places the client within a broader framework. That is, the therapeutic approach rests on the perspective that the family system as a whole needs to be addressed, not simply the individual client. In other words, therapy doesn't attempt to 'solve' the clients' 'problems' in an individualist framework. A systemic approach also recognises that children, as part of the family system, are affected by violence perpetrated against their mother and that a violent family situation affects the whole family.

A major criticism of systemic approaches to counselling practice from a family and domestic violence perspective is that they potentially shift responsibility for the violence away from the perpetrator. Violence can be positioned as occurring because of the nature and structure of the family or the dynamics within that system, placing 'blame' for violence on all members of that unit rather than the perpetrator. While a systemic approach may be useful in terms of understanding violence as something that occurs within the context of a family unit, the unequal power relationships within a family and domestic violence situation can't be ignored. Systems theory must be applied with reference to the basic safety of women and children who are experiencing violence, and in a way that ensures the counselling process does not divert responsibility for the violence from the perpetrator.

A systems perspective can also be incorporated at a service level, understanding that individuals and families affected by violence often become part of a service system. A service system that communicates and functions effectively will provide a more supportive environment for women and children affected by family and domestic violence than a fragmented and complicated system (Miller, 2007: 16).

Systemic approaches are consistent with Aboriginal approaches that seek to heal the whole family (including the perpetrator) and the community.

Key points:

- Individuals affected by family violence should be viewed in a holistic context. Their cultural, environmental and family background impacts on their experience of violence and capacity to recover.
- Coordinated case management with the other agencies and organisations involved with the family is important for working towards safe and accountable responses to family and domestic violence.

4 Legislative context

Practitioners are expected to understand and comply with legislation that imposes duties upon them.

In relation to other key legislation relevant to women and children who have experienced violence (such as family and domestic violence legislation and family law legislation), practitioners are not expected to be experts in this legislation but rather should be able to provide women with general information and referral to appropriate legal advice and assistance.

5 Implementation and use of guidelines

An agency may decide to adopt and implement the guidelines as part of its ongoing commitment to enhancing practice. Alternatively, the adoption and implementation of the guidelines may be required as part of an agency's funding contract.

Adopting and implementing the guidelines is the responsibility of the service as a whole, involving the governance structure of each service formally undertaking to ensure the translation of the guidelines into practice. The process will be an internal one, where services undertake a review to assess the alignment of their current practice, policy and systems, with the practice and service level guidelines set out in this document. This will require thoughtful consideration of each guideline, aided by the reflective questions provided in each section.

The purpose of reviewing the alignment between current practice and the guidelines is to demonstrate internally and externally that the services provided are grounded in the evidence, where it exists, or in consensus-based practice where the evidence is not well established. The Signs of Safety approach should be utilised to determine; what are we worried about? what's working well? and what needs to happen to ensure we are working to increase safety for women and children who are experiencing abuse and holding perpetrators of abuse to account for their violent behaviour.

The review process should not become an end in itself but rather be contextualised as part of the ongoing development of the direct practice and the management practices of the service. It should also be integrated with other quality assurance and improvement processes, including the implementation of other new initiatives and requirements, for example, the *Western Australian Family and Violence Common Risk Assessment and Risk Management Framework* (Department for Child Protection, 2011)

An agency's preferred method of undertaking the review will need to be determined. It may occur over several weeks or several months, depending on the size and complexity of the service and competing demands on key people's time. It may involve considering one area of practice at a time or one client group at a time.

Drawing on the experience of other implementation processes, once an approach is decided, an implementation plan is critical to staying focused, garnering resources and translating the guidelines into practice.

Once implemented, the guidelines become a tool for regular reflection – in supervision, development plans, service review and in the various family and domestic violence networks and forums that support the integrated effort.

Importantly, the whole service, from the frontline staff to the practitioners and managers, has responsibility for the quality and safety of the service provided, and all should be involved in the implementation process.

6 Guidelines for the foundations of practice

6.1 Professional conduct

Professional conduct in this context captures the behaviour, language, use of resources, and practice expected of a person employed to work directly with women and children affected by family and domestic violence. Some practitioners will be guided by a range of mechanisms, including professional standards, codes of practice and codes of ethics. Professional conduct draws on all of these and reflects a consensus-based understanding, built within a workplace.

Practice guidelines

1. Practitioners contribute to work toward a client centred and integrated service response.
2. Practitioners work with colleagues to maintain and improve sub-standard practices, prioritising those that impact on clients of the service.
3. Practitioners work to build an atmosphere of trust, respect and openness while respecting colleagues' rights to hold differing views.
4. Each practitioner encourages colleagues to continually reflect and develop their practice.
5. Practitioners recognise their own position as role models to clients and engage in constructive conflict resolution.

Reflective questions for agencies and practitioners

a. How do I demonstrate and continually develop my commitment to professional conduct?

b. What mechanisms do we have in place within our team to work through contentious and complex practice issues?

c. To what extent does reflection on my professional conduct form a part of my self-reflection, supervision, and professional development planning?

e. How do we understand and model respectful gender relations?

6.2 Inclusive practice

Practitioners' use of language, application of skill and use of resources are all focused on ensuring clients experience respect, empathy and a skilled response. Founded in a rights-based approach to practice, inclusivity refers to the need for all communication – verbal, non-verbal, written - to speak to the full range of client diversity in background, culture and experience. This is a challenge to a system primarily designed and staffed by people from the dominant Australian culture, and requires a concerted effort by services over time.

Practice guidelines

1. Practitioners' language, skills and resources ensure all clients experience respect, empathy and a skilled response. This includes Aboriginal people, people from diverse cultural and language backgrounds; people with disabilities, people who are in same sex relationships.
2. Practitioners can demonstrate their cultural competence to work with specific groups of women and children.
3. Counsellors acknowledge cultural and religious reality for clients.
4. Practitioners are skilled at applying family and domestic violence theory and responses to women in same-sex relationships, for example, practitioners' language does not assume the gender of the person using violence.
5. Practitioners are skilled at recognising and responding to the dual marginalisation experienced by women with complex histories and needs.
6. Practitioners are committed to hearing and respecting the priority women may place on their relationship with the perpetrator, while at the same time engaging women in safety planning.
7. Practitioners demonstrate openness and willingness to learn about a culture without placing clients in the role of cultural advisor.
8. Practitioners are able to access cultural advice in a timely way to seek clarification, test any assumptions and better inform their practice.
9. Practitioners are skilled at using interpreters in counselling practice, including Telephone Interpreter Service, face-to-face and AUSLAN sign interpreters.
10. Agencies have policies regarding the use of qualified interpreters, and under what circumstances family members (especially children) may be used to interpret.

Reflective questions for agencies and practitioners

a. Where language or cultural barriers exist between practitioner and client, how do we ensure a common understanding between clients and practitioners of the service and the work to be undertaken?

b. How do I gain new knowledge about emerging communities where women and children may have experienced high degrees of trauma prior to arriving in Australia and integrate this into my practice?

c. How do we as a service understand the cultural contexts of family relationships? How do we bring this understanding to our family and domestic violence counselling of women and children from diverse cultural groups?

d. What do I know about my region's Aboriginal community?

e. How do we as a service encourage referrals from Aboriginal and culturally and linguistically diverse communities?

F. How do I actively recognise and recover from cultural mistakes?

g. How does my practice encourage women and children to have control over their decisions in a culturally meaningful way?

h. What are the main and emerging population groups in our catchment?

i. To what extent are we seeing women and children from these groups?

j. To what extent does our referral network match the cultural profile of our clients, and the profile of our broader catchment area?

6.3 Integrated effort

Women and children's services are part of the continuum of response for people affected by family and domestic violence, and are most effective when robust networks are in place allowing ease of access between services.

Achieving integration requires effort at the strategic level, the service level, and by practitioners at the operational level. Ideally, integration occurs at all levels because it is part of everyday ways of working and everyday practice – a way of approaching the work to enhance effectiveness. *At the service level* integrated responses may be supported by memoranda of understanding and protocols agreed between services, which set out agreements, common understandings, referral pathways and information sharing agreements.

At the individual level integrated responses can be supported by practitioners liaising with other services and agencies providing responses to women and children experiencing or escaping family and domestic violence; actively contributing to multi-agency case management; and sharing relevant information in a timely manner.

Practice guidelines

1. Practitioners are familiar with, and work within, the *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.

2. Practitioners contribute to multi-agency case management meetings as required this includes *Signs of Safety mappings* and multi-agency case management convened by the Family and Domestic Violence Response Team.

3. Each practitioner is knowledgeable about the family and domestic violence system and is able to refer, link and actively liaise across the system in the interests of women and children's wellbeing and safety.

4. Practitioners are familiar with men's behaviour change programs and actively facilitate accountability protocols.

5. As part of an integrated response, practitioners are able to provide counselling to women and children with complex issues (including those single or multiple barriers to accessing mainstream service, for example, use of alcohol and other drugs, complex disabilities and cultural barriers).

6. All service staff understand the roles and responsibilities of other agencies in the network, including professional or discipline-based differences in use of language and priority setting, and actively promote common understanding in the interests of women and children's safety and wellbeing.
7. Each service understands its place, participates in, and contributes to, a sustainable network of services focused on women and children's safety wellbeing.
8. Memoranda of understanding are in place with key partners in the service system, setting out obligations, responsibilities and the processes to be followed in relation to shared clients, access to resources and information sharing.

Reflective questions for agencies and practitioners

a. How have my agency's partnerships and agreements supported my work with women and children?
b. To what extent does my role contribute to the consistent and linked response that is the aim of the integrated system?
c. How do we evaluate the effectiveness of our networks? What measures do we use?
d. How effectively do I link in with Aboriginal service networks to the benefit of clients?
e. How does this service support the effort to build networks that match the needs of clients?

6.4 Systemic advocacy

Advocacy at the systemic level aims to redress barriers, disadvantage or discrimination experienced by women or children. It is underpinned by the right of all to live free of violence, and it recognises that the systems and bureaucracies in place to deliver justice, economic support and other support are not always responsive to the needs of people at particular times, or with particular experiences.

Practice guidelines

1. Agencies support practitioners to undertake systemic advocacy, bringing to the attention of key points within the system any issues and barriers reported by clients or observed by practitioners.
2. Practitioners participate actively in relevant networks and forums to ensure systemic issues and solutions are identified.
3. Practitioners actively seek to represent the experiences of their clients in seeking policy and legislative reform.
4. Agencies actively seek positive working relationships within and across networks to ensure a forum for resolving barriers for clients and addressing policy and practice issues that may hinder an integrated response.

Reflective questions for agencies and practitioners

1. What are the mechanisms in our service for formal review to identify any barriers encountered by our clients?
2. How well do we use data collection and evaluation findings as evidence to support advocacy efforts?
3. Who are our key partners in advocating with and for people affected by violence? What is the basis of our partnership?
4. How do we resource advocacy efforts in our workloads and recognise the results of these efforts?
5. How do we reflect and prioritise systemic advocacy in our planning agendas?

6.5 Understanding and applying legislation and policy

The legal context for family and domestic violence practice is increasingly complex, with recent changes in both state and federal legislation. The practitioner plays a critical role in the timely provision of information and referral to women and children through the support/counselling/group work period. The practitioner is also subject to legal requirements as well as requirements to adhere to policies of the Government of Western Australia. Practitioners and agencies share responsibility for ensuring legislative and policy requirements are met.

Practice guidelines

1. Practitioners actively seek out up-to-date information about the laws and policies relating to their work and are personally committed to abiding by these.
2. Practitioners understand their duty of care obligations to women and to children, and are proactive in recognising and responding to duty of care issues that arise.
3. Services promote compliance with legal and ethical obligations of practitioners by resourcing staff with information, promoting discussion and ensuring legislation and government policy are reflected in organisational policy and practice.
4. Practitioners are able to articulate and provide relevant information and referrals to women and children about their legal options.

Reflective questions for agencies and practitioners

a. How are we contributing to a stronger justice response to family and domestic violence?
b. How does our service resource staff to remain abreast of changes in legislation, policy and procedural issues?
c. What quality assurance mechanisms are in place to ensure women and children are being referred appropriately and in a timely way?
d. How do we balance the legal interests of different family members, for example when the interests of women and their children may not be aligned?

7 Guidelines for phases of direct practice

7.1 First point of contact

The first point of contact is the beginning of the engagement phase and includes elements of assessment – particularly safety - as well as the provision of timely information about the service or other service options, in a welcoming and inclusive manner. The initial contact made with the service, either directly by the client or by a referring individual or organisation, may be via telephone, face-to-face or electronic communication.

Key message: Make it welcoming and make it easy

'It was such a relief to take the first step.'

Practice guidelines

1. On entering the service, the physical environment and the atmosphere make a clear statement of welcome to the range of age groups and cultures of people likely to attend the service.
2. Staff involved in the first point of contact are able to prioritise safety and action a crisis response if requested/required.
3. The response to a woman or child at their first point of contact includes timely information provision, with a focus on safety.
4. When taking referral information over the telephone or seeking more information about a referral, practitioners/staff ensure privacy is maintained, such as in reception areas.
5. Workers are aware of the risks to safety that may arise for children/women speaking over the telephone.
6. The full range of available options is offered. This could include other children's services, specialist mental health, alcohol and other drugs, or men's services.
7. When asking for information from an Aboriginal person use appropriate language, ensure it is welcoming and show interest in the person, their family and where they have come from.
8. Information collected at the first point of contact includes a history of orders including family law, child protection and violence restraining orders.

Reflective questions

a. How is safety included in all first contact interactions?

b. Following the first point of contact, do we know how to make safe contact with this client?

c. How is the safety of children prioritised at this early phase?

d. How is privacy maintained in our reception area?

e. How is potentially identifying information protected, for example, in data entry, to maintain client privacy?

f. What training and support is provided to reception staff to ensure the best possible response at the first point of contact?

g. How do people of diverse ages experience first contact with my service? What advice have we sought about this?

h. How do we know how women or children with a range of disabilities experience entry to our service?

i. To what extent is our information provided in a range of formats matched to clients' developmental stage, language and literacy? How do we know our information is useful to clients?

j. How confident and skilled are our frontline staff members in asking people about Aboriginality?

k. How do we ensure Aboriginal clients know the reason for asking a question about Aboriginality and how the information is used?

l. What is our written procedure in the event of a violent incident and to what extent is it understood by frontline staff?

7.2 Engagement

Engagement refers to the development of rapport and trust between the practitioner and the client. It is paced to enable clients to become familiar with the service and gain a better understanding of the role of the service as well as their rights as a client of the service. Pacing is led by the client and may take numerous contacts before formal assessment can begin.

Risk and safety assessment for women and any children will form a part of this phase and may also include addressing practical issues that are priorities for clients. Activity and approaches in this phase will be tailored to the needs of each client and will be informed by the client's culture, their expressed preferences, their developmental stage, history of service use and so on. At the conclusion of the engagement phase, clients should know their rights as well as the expectations of the service (for example, limits to confidentiality, appointment cancellation), and be on the way to building a trust-based relationship with the practitioner.

Key message: Building trust means showing that you know each woman and each child is unique

'I went away feeling we were going to get help.'

'Speaking to her made me realise we were not alone. Finally I began to see the reality of what was happening.'

Practice guidelines

1. Practitioners understand the importance of establishing trust and pace the process to maximise the development of rapport.
2. Engagement is culturally respectful with methods tailored to the needs of the individual, for example, the cultural norms of the client may lead to an advocate attending and speaking on their behalf; it may involve the practitioner meeting with a client's family members who are supporting her help-seeking.
3. Clients are provided with explanations of their rights as clients of the service, appropriate to their age and intellectual capability.
4. Clients are provided with age and language appropriate information about service complaints procedures.

Reflective questions

a. How do I decide the most effective method of beginning work with each client?

b. How does our service demonstrate respect for culturally-based preferences in this early phase of work?

c. Do our service policies work against client-led pacing of the engagement phase?

d. How do I check that women and children have understood what we have offered and all the options available to them?

e. How do I show trust and use language that is focused on hearing and listening to the client's story?

f. Are there aspects of our model we consider non-negotiable, for example, number of sessions of counselling? How do these aspects support or hinder offering a service that is paced to suit the client?

g. What do we know about the help-seeking patterns amongst different groups we work with, and the differences in help-seeking at different points in recovery?

h. While drawing on what we know about the general experiences of women and children, how do we ensure we are not stereotyping in our responses?

7.3 Risk Assessment

Services and practitioners' risk assessment practices must meet the minimum standards as outlined in the *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework.*

Risk assessment is a dynamic process and must be reviewed and discussed as part of any ongoing work with women and children. Any assessment of risk to victims of family and domestic violence must be structured and informed by:

- The victims own assessment of their safety and risk levels.
- A sound evidence base, which identifies factors that indicate an increased risk of reoccurrence of family and domestic violence.
- The professional judgement of the person making the assessment, which takes into account the above and includes all other risk relevant information known about the victim and their situation.

Risk assessment begins at the first point of contact and must be continually revisited throughout the period of work with the client. The risk assessment will directly inform the intervention and response of the practitioner.

Critically, practitioners need to ensure the cultural validity of any assessment tools and only use these appropriately. It is important to understand that how questions are asked and how the conversation is entered into will directly affect the willingness and comfort of the woman or child in disclosing their experiences of family and domestic violence and sharing their information.

Key messages:

Risk assessment and the analysis of risk include the consideration safety, options and choices that are appropriate to age, developmental stage, gender and culture

A child's' subjective experience is central to assessment and analysis – put them at the centre of your assessment.

A woman's lived experience needs validation, careful listening and explanation of your role and the assessment process.

Adult voice: *'They told me why they asked all these questions about my children – I realised then they knew what they were doing.'*

Child voice: *'There was a toy box in the room and we played in a sandpit.'*

Practice guidelines

1. Practitioners are guided by the minimum standards outlined in the *Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework*.
2. Risk assessment and safety planning for women and children, limits on confidentiality, and information sharing requirements are explained to clients. (Information sharing is permitted under several Acts and formal arrangements such as relevant 'memoranda of understanding.')
3. Assessment of children is informed by up-to-date theoretical and practice knowledge about how developmental stages, gender and culture can affect the impact and recovery from family and domestic violence.

4. Assessment takes a holistic view of the client – their cultural, environmental and family background - as a means of understanding the possible impact of violence and their recovery from it.
5. The assessment process is explained to each woman and child, along with age and culturally appropriate written information.
6. Assessment includes questions about the strengths and vulnerabilities of the relationship between child/ren and their mother and father.
7. Practitioners avoid any undue influence of parents/carers and other adults in their assessment of children, basing their assessment on knowledge and understanding gained about the individual child.
8. Assessment includes questions about previous or current family law, Children's Court orders and/or violence restraining orders.
9. Assessment includes a focus on the individual's strengths as well as resilience factors in a client's broader family or social context.
10. Practitioners use their knowledge of the symptoms of trauma to ensure comprehensive assessment of need.
11. Assessment includes identifying legal, financial and other practical requirements, providing information and connecting women and children to services.
12. Based on any concerns identified, practitioners actively discuss with women and children what other assessments might be useful, for example, a comprehensive physical and psychological assessment of children.
13. Proactive referrals are made for any needs identified that are beyond the scope of the service/practitioner.
14. Clients are given a choice of referral options (where these are available) to culturally specific or mainstream services, and are offered support in taking up the referral.
15. Group work assessment includes current safety status, recognising safety is variable particularly in the post separation period.
16. Assessment for group work includes consideration of the risk of re-traumatisation for participants through sharing their own experience or listening to the experience of others.
17. Assessment results in a written plan reflecting the goals that have been developed and including referrals to be made and the actions planned.

Reflective questions

a. How do I remain up-to-date about emerging issues and practice approaches?

b. How and when is safety reviewed as part of working with women and with children?

c. What form of safety planning do we recommend within our service?

d. How do I make sure I am referring appropriately to Aboriginal services?

e. When seeking information from my clients how do I tailor my method to their strengths.

f. How does my assessment of children promote their rights to protection from harm, to stability?

g. How do I understand my duty of care to women and to children? How do I explain this to women and to children as part of the engagement/assessment phase?

h. What referral pathways do I have to specialist assessment for children and for women?

i. What are our service protocols for seeking and disclosing information from other agencies as part of the assessment phase?

j. What is our mechanism for remaining up-to-date with current legal and family law information?

7.4 Counselling, case work and advocacy

Work with women and children can involve a range of therapeutic approaches and methods. In this section guidelines are provided for counselling women and children – whether individually or together, and for group work with women and with children. It is important to note that counselling is not a necessary precursor to group work; either or both may be useful to women and to children, and should be agreed with the client as a purposeful intervention based on assessed need and preferences.

Key message: Safety, validation and the parent child relationship

'We're not alone in this – and that helps.'

'I was a bit scared at first and I didn't want to talk – but the lady gave me a puppet to play with and then it was easier than I thought.'

7.4.1 Counselling

Counselling is focused on supporting women and children to move beyond their experience of family and domestic violence. One-on-one counselling is often defined as a developmental process in which the counsellor encourages and assists the client to:

- determine their own issues and goals;
- decrease the effects of trauma;
- gain self-agency in decisions affecting safety and their future plans.

Typically, individual counselling is conducted over an extended period of time and/or involves a set number of sessions as determined by the counsellor, client or service. In some cases, individual counselling may only involve one session. In the context of family and domestic violence, the counsellor will also consider the needs of the client's children within the counselling process and counselling may form part of a range of interventions to support the client and her children.

'Joint counselling' for couples in the family and domestic violence context is a highly specialised area of practice which is, to some extent, still contested in terms of its impact on safety, accountability and efficacy where family and domestic violence is present and, as such, is outside the scope of the integrated family and domestic violence counselling service model (see discussion in section 1.2 Scope of the guidelines).

> *Last month I went to counselling with my mum. She organised it. The counsellor was nice, she asked me to tell mum how I felt about everything. I asked mum why she didn't leave my step-dad earlier? She got upset and said she wanted to leave him but was worried about what he would do if she did. It was good because we got to hear how each other feels. (Bursting the Bubble, Stories from Young People DVIRC http://www.burstingthebubble.com/)*

Practice guidelines

1. Practitioners recognise the importance of a proactive approach in family and domestic violence counselling and undertake to:
    - proactively name the violence
    - use the definition of family and domestic violence included in these guidelines
    - locate the responsibility with the person using violence
    - provide information and referral assistance to address the full range of issues arising for women and for children as part of a comprehensive response.
2. Counselling is informed by mutually constructed goals led and informed by clients' needs and includes ongoing attendance to safety.
3. Practitioners are skilled at recognising and responding to the attachment children may feel toward the person using violence.
4. Where concerns for the safety of children or young people arise through the counselling process, these are documented, discussed and actioned to privilege children and young people's safety, in line with counsellors' duty of care obligations.
5. Practitioners are knowledgeable and skilled in key practice theories, including empowerment practice; attachment theory including Aboriginal parenting approaches; trauma; loss and grief; and the use of systemic or ecological understandings of the client in their context.

6. Where there are children as primary or secondary clients, practitioners attend to the strength of the mother-child relationship and offer specific support and/or referral to support the recovery of this relationship.
7. Practitioners focus on building a stable and consistent relationship with women and with children, with an understanding of the importance of the alliance between practitioner and clients.
8. Practitioners are aware of the range of responses to violence within the family and domestic violence dynamic and pace counselling to promote safety and avoid re-traumatising.
9. Practitioners are clinically skilled or have access to clinicians to assess and respond to symptoms such as depression and anxiety.
10. Practitioners build into the work with women and with children the development of social skills to promote confidence and competence where there is a need to re-establish and maintain effective interpersonal relationships.
11. Tracking of progress toward client goals is monitored, using the client's own perspective, observations by the practitioner and, for children, takes into account the views of the parent/carers.
12. Practitioners use planned closure of counselling with women and with children, promoting independence from the service, celebrating accomplishments and promoting connection to ongoing supports.

Reflective questions

a. How do I understand and seek consent in counselling children? How does our service understand and manage consent with children?
b. What mechanisms are in place to prompt the setting and review of goals? How is the client involved in these stages?
c. How do I pace counselling to promote safety and not re traumatise?
d. How do I ensure the limits to confidentiality are clearly understood by women and by children of different ages?
e. How does knowledge of the impact of family and domestic violence on child/parent attachment and the likely negative impact on the child's development inform my work with children and their mothers?
f. How does my knowledge about developmental ages and stages guide my counselling with children?
g. Who can I seek consultation from in regard to the needs of children across different ages and stages?
h. How do I effectively use my understanding of the symptoms of trauma in working with women and with children?

i. How do I speak with women about the potential cumulative harm of family and domestic violence on the physical, behavioural, psychological and social development of children?

j. What protocol do we have in place to ensure child safety concerns are dealt with appropriately?

k. How do I understand and manage the complexities within my duty of care obligations?

7.4.2 Case work and advocacy

Case work is a critical component of the response to family and domestic violence. While it is anticipated that counselling and group work would not be part of the crisis response, the nature of family and domestic violence and the resulting upheaval means there will be instances when practitioners will be the best placed people to support their client with the practical assistance generally associated with case work. Where practitioners may be the case manager for a particular client, they are more likely to be part of a case management plan, coordinated elsewhere in the service or by an external service. Case management is intended to assist the client to better negotiate multiple services, while enhancing outcomes by adopting a planned and collaborative approach to meeting client needs. A case manager coordinates access to each of these services from a centralised position, while working collaboratively with other professionals who are involved with the client.

Advocacy is about advancing the rights of women and children affected by family and domestic violence, and may be part of a case work response or provided on a time-to-time basis. Advocacy may involve working with, and on behalf of, individual women and children to ensure their needs are appropriately and adequately met by services or systems. On other occasions when a client is confronted with a barrier to service or support or information to which they are entitled, the practitioner may be best placed to advocate alongside or on their behalf. Advocacy in the family and domestic violence context requires specialised knowledge of the service system; an understanding of how to consider and resolve tensions that may arise when the rights of children and their mothers differ; a commitment to empowerment practice; and professional relationships and contacts to negotiate access or address other concerns of clients.

Key message: Children's needs and rights come first

Adult voice: *'They worked with me on what they said they would, and together we helped my kids.'*

Child voice: *'It was important the worker stayed in touch – they're nice and they help you and they talk to you – that's what they're here for.'*

Practice guidelines

1. Practitioners assist women and children to identify their needs and rights, and advocate for these rights.

2. Practitioners skilfully apply their specialist knowledge of the service system to assist clients to navigate and access information and services required.

3. Practitioners understand their greater duty of care to children than to adults and are informed by this hierarchy in understanding and advocating with and for children.
4. Where there are barriers to self-advocacy, practitioners advocate in the interests of their client/s, keeping in mind their duty of care obligations.
5. Practitioners identify systemic issues experienced by women and by children and refer these through their service to be addressed at the appropriate level.
6. Where counselling forms part of a broader service to a client, practitioners participate in the case management arrangements required to support their client, whether the case management is provided internally or by an external service.
7. Agencies have in place policies and practices to guide practitioners in relation to their role and obligations as part of a case management framework.
8. Practitioners maintain client notes for each client, including separate notes when working with parents and children.

Reflective questions

a. How does our service ensure that our team is kept up-to-date about changes in key service systems including the courts, police, Centrelink?
b. How does our service prioritise advocacy?
c. How do we pass on the experience of our clients into the policy agenda at a regional and state level?
d. How do we ensure the barriers encountered by children and other vulnerable groups in accessing services feeds into systemic advocacy?
e. How do we work in with case management plans coordinated through external agencies?
f. How do our procedures and policies support collaboration?
g. How do we resource participation in the relevant networks and demonstrate the worth of networking?
h. How do we participate in reviews, evaluations and other relevant projects to ensure the voices of our clients feed into policy and review processes?
i. What key partnerships are in place and operating well in the interests of women and children? What are the priority areas for new partnerships, knowledge and advice?

7.4.3 Group work

Groups can help reduce the sense of isolation that often comes with the experience of family and domestic violence, and provide women and children with positive, affirmative feedback from others as well as a chance to reconnect with others. Groups should be a space in which

participants feel safe, where their experience is validated. A range of therapeutic methods and approaches is used in group work and groups for women and for children can take many forms, including:

- Networking and information groups – open, ongoing, supportive and resource orientated groups to provide opportunities for women and children to meet others who have had similar experiences of family and domestic violence in a supportive environment. They focus on empowerment, social support and safety.
- Support/educational – closed and time limited groups to address the impact of the violence and provide an educational component on its causes, complexity and consequences with a focus on victim safety.
- Therapeutic groups – closed, more directed to specific therapeutic goals, provide opportunities for women and for children to support each other through the therapeutic process.

The micro skills described here apply to group work practice, as does the proactive approach to naming and defining family and domestic violence and locating responsibility with the person using violence.

Key message: Safety, ownership and rebuilding connection

Adult voice: *'Spending time with other women, talking about ourselves, and also our kids – it was the best and the hardest thing to do.'*

Child voice: *'This is mainly an activity place – you come here to have a good time.'*

Practice guidelines

1. Group work is offered to women and to children in response to the assessed need and preference of clients.
2. Prerequisites for facilitators of family and domestic violence groups, in addition to the theory and framework outlined above, include:
    - understanding and skills of group work as a practice method;
    - understanding and skills in the role of facilitator;
    - understanding of the risks of re-traumatisation;
    - understanding of importance of strengths-based methods, including approaches that attend to stories of women and children's resilience;
    - skill in showing respect through body language, listening and understanding to engage with people from cultures other than their own;
    - clearly defined roles with an established framework for co-facilitation.

3. Children's groups include:
    - pre-group assessment sessions with child only and the child with their mother;
    - a range and balance of age appropriate activities that engage on a number of levels – talking, activity, reflection, sharing, listening;
    - mothers as active participants in supporting their children's recovery and rebuilding the mother-child relationship;
    - a minimum of two facilitators with a preference for three to ensure responsiveness to individual needs that may arise;
    - an age appropriate, soundproof space that allows ease of entry and exit
    - complementary sessions for parents, siblings and or individual sessions.

4 Depending on the objective of the group, groups with children may include a focus on: responsibility for the violence lying with the perpetrator
    - feelings about the violence and their parents/carers, including potential for confusion about and loyalty to perpetrator;
    - problem solving, negotiating and social skills;
    - focus on feelings about themselves;
    - exploring assumptions about gender roles
    - strengthening of their personal support network.

5. The type of group (open, closed, ongoing, time limited) is explored in terms of both need and the resources available.

6. Practitioners ensure that commonly agreed good practice approaches are in place, including group composition in terms of similarity of age/stage/cultural background/experience of violence.

7. Participants are actively engaged in establishing boundaries regarding confidentiality, safety and setting ground rules for the group.

8. Planning for groups with women from small communities include consideration of the particular challenges in this context in terms of confidentiality; gender roles within a particular community; lack of alternate supports.

9. Groups are adequately resourced to ensure the purpose, focus, content and process of each session is documented and reviewed.

10. Participants are actively engaged in evaluating the group – process, content, outcomes (immediate and on follow up basis).

Reflective questions

a. How do I articulate my theoretical understanding of group work? How does this apply to the group I am running?

b. How do I establish guidelines with women and with children that attend to individual and group safety and confidentiality?

c. How do we optimise our referral pathways across service networks to promote our groups and engage suitable numbers of participants?

d. How do we ensure workers across the referral system understand the benefits of groups and are equipped to promote group work to clients?

e. How do I balance needs of individuals and needs of the group?

f. How am I using the dynamic of the group to achieve group aims?

g. How do I understand and incorporate cultural communication, for example, avoidance and diversion, into my group work practice?

h. What measures am I using to evaluate whether the group is meeting its objectives?

i. What aspects of the program/approach are contributing most/least to this?

j. How are we managing/helping women and children to manage safe disclosure?

k. How are we resourcing effective debriefing and supervision?

l. How is the client's voice heard in the evaluation?

m. How does our process for setting group norms build women's ownership of group?

n. How do I effectively contain situations that arise in the group, for example, redirect dominant discussion/individual?

o. How do we balance the pressure/tension between getting adequate numbers to run a group, and screening/referring of participants who aren't ready or suitable?

p. What range of developmentally appropriate group work can we provide?

q. To what extent are we collaborating through our service network to offer clients a choice of options?

r. What additional advice, support and expertise could we be bringing in to support our work?

s. What qualifications and skills do we have in house to build our group work program, for example, infant/toddler and mother/carer groups?

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