COVID-19 and Men's Behaviour Change Programs
PRACTICE UPDATE 1 (19/03/20)

Rationale

International experience indicates that the COVID-19 virus will significantly impact on the FDV experiences of adult and child victim-survivors. In addition to this increased risk to victim-survivors, the virus is also likely to have other immediate impacts on MBCPs across Australia, including the dwindling participation in groupwork and closure of physical sites for MBCP activities – possibly for some time. It is critically important that all MBCP providers prepare for these eventualities immediately, both to minimise risks to victim-survivors and to ensure all staff are working – in offices or at home – in safe conditions. This Practice Update provides guidance for managers and program staff associated with intervention and case management responses to perpetrators of FDV.

A changed risk context for victim-survivors

COVID-19 is likely to increase FDV risk for adult and child victim-survivors. For example, they:

1. may need to spend more time with a perpetrator than usual
2. may be more isolated from their supports than usual, including those that might otherwise be protective for example pending school closures, afterschool and sporting activities, community groups and the availability of in-person child support services. which all provide wellbeing support and often key support people.
3. might be at home more or might return to their family of origin, and therefore more easily traced/located if they have been in hiding
4. may have confounding stressors – such as insecure housing, precarious income, poor health, immune conditions or disabilities. The impacts of all these forms of increased risk to victim-survivors will be exacerbated by their experiences of other forms of marginalisation or oppression.

Furthermore, some perpetrators may:

5. use the virus as another way to exert control, for example, 'banning' their partner from certain activities or social contacts, or merely from leaving the house
6. use the virus as an excuse not to attend group sessions
7. become un/under-employed, a known dynamic risk factor for FDV
8. increase their AOD use and/or encourage/exacerbate the victim-survivor's use.

Risk will also be exacerbated by reduced capacity in systems that support accountability and safety, for example:

9. The consistency and timeliness of victim-survivor services may become uncertain, especially as the virus spreads and begins to affect workforce availability.
10. Some courts will physically close, with uncertain implications for acquiring new orders, changing orders or other justice system responses.
11. Family Court services have a high percentage of FDV related cases. Any suspensions or slow-downs are likely to add to pressure on families awaiting meditation to settle matters, living arrangements and contact of children. Wait times are likely to escalate family conflict and unsafe behaviours.
12. Police in some jurisdictions have announced they are no longer breathalysing or drug testing drivers, which some men may see as a licence to drink more and/or use substances (both of which increase risk to victim-survivors).
13. The consistency and timeliness of police responses may become uncertain, especially as the virus spreads and begins to affect workforce availability and/or willingness to intervene/arrest.

Implications for MBCPs

Clearly, a business-as-usual approach is untenable in the current circumstances. Program providers need to establish new, safe procedures and practices in anticipation of the closure of their physical programs *and* this increased risk to victim-survivors. Over page are suggestions for:

- Keeping in touch with perpetrator participants
- Keeping in touch with victim-survivors
- Preparing perpetrators for a changed mode of service
- Triaging interventions
- Managing mandated participants
- Groupwork
- OHS for staff working at home
- Continuing integrated practice during the pandemic.

Keeping in touch with perpetrator participants

With physical sites and/or groupwork closed, other modes of contact will be needed to manage risk.

Virtual MBCP groupwork requires specialist expertise on the part of facilitators, as well as considerable technological capacity on the part of providers and participants. It also raises many questions with regards to safety and confidentiality, for example:

- Who else is in the room during the session?
- How can we guarantee a group session is not being recorded?
- What if a participant is angered during a session and is at home with his partner?
- What if a man asks his partner or children to sit in on the session? (Or vice versa?)

As such, virtual groupwork is not a recommended solution to the current crisis.

In order of preference, modes of individual work with perpetrators as alternatives to groupwork are:

- in person
- via zoom/skype or another video-based platform that enable face-to-face interaction
- via phone.

Email and web-chats are potentially unsafe forms of contact, because they do not allow a practitioner to hear nuance.

It is important to be clear that individualised contact is about **attempting to reduce risk** during the COVID-19 outbreak. It is not possible to deliver the entire or even most program content via individual work under the current circumstances, and this should not be attempted.

Keeping in touch with victim-survivors (i.e. maintaining and enhancing partner/family contact)

Hopefully, in many instances it will be possible to at least maintain existing arrangements for partner contact. Given the increased risks associated with this time, attempts should also be made to extend offers of contact to (ex)partners who have previously declined it or who have not had contact for some time.

Contact practitioners will need to be alert to the ways that this very specific COVID-19 context is increasing risk. Safety plans should be reviewed with all women in anticipation of increased risk to themselves and their children.

Contact practices need to accommodate the possible presence of the perpetrator and/or children during phone calls. With each passing day, more people are working from home or put off work, and increasingly, women will not be able to speak freely. The sooner this is raised with them and planned for, the better.

Ideally, program provider capacity for partner contact would be increased – or at least maintained at current levels – for the duration of the COVID-19 epidemic, so that the program can better understand and respond to the risks and concerns that women have. It will be critically important to liaise with women's services, especially if it seems that responding to the varied needs of all women will be beyond the program's capacity.

Preparing perpetrators for a changed mode of service

Ideally, all perpetrators who are currently receiving a service from the program (including men being case-managed) would:

- have a COVID-19 management and safety plan
- continue to be engaged by the program in some way.

At minimum, a COVID-19 management plan might contain:

- information about the man's intended accommodation during self-isolation
- identification of situations and times where the man might be at relatively higher risk of using violence
- strategies for the man to choose respectful and non-violent behaviours during these situations
- strategies and reminders about positive lifestyle habits, ways to keep occupied (and therefore provide his partner with some breathing space) and to avoid unhelpful habits
- strategies specifically regarding alcohol and other drug use and mental health
- constructive supports outside of his immediate family that he can utilise
- specific actions he is willing to take that will promote safety and wellbeing for his partner/family/ children, particularly during the COVID-19 crisis period
- goals for the duration of the one-on-one work.

If another agency is also supporting a man and has capacity for contact him during this time, it will be helpful to co-ordinate contact so that it is spread evenly across a given time period, rather than there being long gaps in which he is not being called to account for his behaviour by people other than family.

Triaging interventions

Working one-on-one with program participants will inevitably create a resource challenge; it requires significantly more hours than groupwork, both in terms of face-time and note-taking. Where program capacity is limited, it might be necessary to triage levels of intervention. For safety, it is important that the criteria for this are set by the program provider and applied systematically, rather than priority men being arbitrarily decided by individual staff.

Programs should prioritise work with men who:

- are currently at higher risk of inflicting harm/are having the most impact on family members through their current or recent use of FDV; and/or
- are likely to increase their use of FDV / increase the impact of their behaviour during the upcoming social distancing measures / family isolation; and/or
- are likely to be living with family members over the coming few months, even if they do not fit either of the two categories immediately above.

It is very likely that a significant proportion of men in any given program will fall into the categories above.

New and waitlisted participants

Given the likelihood that groupwork programs and/or physical sites will be closed for some time, providers should give thought now to how and when new or waitlisted participants might be offered services. Given that COVID-19 is associated with increased FDV risk and that it is important to take advantage of opportunities to engage men, if capacity allows, it would be preferable to admit men and commence individual work as soon as possible.

Managing mandated participants

A conversation with the referrer is required for each and every mandated participant. Do not assume that the referrer's own mechanisms (e.g. for checking on participation) will continue unchanged. For each individual man, ensure that the referrer is aware of his plan. Ideally, they would speak with him directly, to set a clear expectation that he will participate through individualised contact.

It is important that referrers understand that individualised contact is not a substitute for participation in a MBCP, but rather a risk management intervention to address the unique circumstances of this time. Mandated participants will still need to engage in a full MBCP when this becomes possible.

Wrapping up face-to-face groupwork

In many jurisdictions, there may only be one or two sessions of groupwork remaining (at best) until they no longer become viable. The focus of groupwork should be on:

- what pressures families might experience at this time and how best to manage them
- practical strategies the men can use to interrupt often-made choices to use violence
- being the parent they want to be during these difficult times
- what individual contact will look like
- the importance of returning to groupwork when it resumes.

Occupational Health and Safety for workers

The intensity of work during this period may necessitate additional supervision for all staff.

If work is to be done from home, staff will need:

- a private, quiet space from which to make phone calls (due to the nature of the work, from a mental-wellbeing perspective, it is inappropriate that this be a bedroom)
- direct or indirect access to client database systems
- a place to lock away notes
- a process to back up hand-written and electronic files
- clearly documented and understood processes for responding to specific instances of elevated risk and/or crisis
- processes for information sharing
- provisions for supervision.

It is recommended that work towards these be given priority over all other work.

Continuing integrated practice during the pandemic

It is critical that managers and practitioners are talking *now* with partner agencies in integrated response systems – police, courts, child protection, corrections, specialist women's FDV services, intensive family support services and others – about:

- how risk-related information will be shared between agencies during the pandemic period
- how and when practitioners across agencies will 'meet' to discuss responses to high risk cases
- what is reasonable to expect of police, child protection and courts.

It will be important to know, for example, if police will follow-up on reported breaches of orders, and how child protection might investigate new cases.

Of course, the work of all parts of the service system will change as the virus progresses through a community; but it is critical that all program providers have a way to keep abreast of these changes and have ways to adapt as developments unfold at the local level. It is sensible to have a person within the team delegated to keep the lines of communication open between the key agencies involved in an integrated response; and for this person to have a back-up in case they become ill. This person needs a reasonable level of delegated authority; however, this is not a substitute for line managers being aware of needs and issues as they arise.