COVID-19 and Men's Behaviour Change Programs
PRACTICE UPDATE 3 (30/09/20)

Rationale

Like all jurisdictions nationally and internationally, the COVID-19 situation has caused substantial economic and social disruption to Western Australians' ways of life. However, in relative terms, the public health impact of the pandemic in this state has been 'light'. Community transmission in Western Australia has been very low, if not non-existent during recent months. This has resulted in restrictions to limit the spread of the pandemic being eased much earlier in the state than initially expected.

There is every possibility that Western Australian communities, government organisations and public health authorities will continue to keep the pandemic well under control, without the need to return to stage three (or tighter) restrictions. However, recent events in Victoria, New Zealand, Vietnam and South Korea demonstrate that the situation can change rapidly and unexpectedly – jurisdictions that initially prevented any significant degree of community transmission are now facing notable community outbreaks. The Victorian situation is of course most pertinent here, with the combination of stage three and four restrictions resulting in substantial disruption to FDV and associated services over a period of many months.

Hopefully, Western Australia will remain relatively COVID-free until/if a vaccine is developed and a sufficient proportion of the community becomes immune. However, given that the odds of a community outbreak are not miniscule, Stopping Family Violence believes that it is important for MBCP providers to give some thought and preparation to what a return to stage three (or even tighter) restrictions might mean for their service delivery context.

This update draws upon the current challenges faced by Victorian MBCP providers, to pose priority considerations for how WA agencies might need to adapt should the pandemic re-emerge in this state. Each provider must decide for themselves how much time and resources to put into planning for the possibility of this re-emergence. However, in general terms, Stopping Family Violence believes that it is important for providers not to be 'caught on the hop' given the critical nature of their work, and given the pandemic's impacts on the incidence and severity of FDV.

As such, the update outlines some of the issues that program providers could consider as part of developing organisation-specific COVID-19 response plans.

Managing multiple pressures

As outlined in our first COVID-19 update, a business-as-completely-usual approach is untenable in the context of a COVID-19 pandemic. A re-emergence of the pandemic and associated restrictions will require program providers to establish new, safe procedures and practices, due to the disruption to in-person service delivery and increased risk to victim-survivors. New procedures and practices will be required for:

- Managing new referrals and intake
- Keeping in touch with victim-survivors, and managing increased demand for support
- Providing a differentiated, multi-tiered response to perpetrators
- Meeting the challenges to continue integrated practice
- Considering alternatives to in-person groupwork for change-focused interventions
- OHS for staff working at home
- Building practitioner capacity and skills to respond in a different environment
- Attending to practitioner wellbeing and preventing burn-out.

This update will briefly raise some considerations for program providers in addressing each of these areas of complexity in the context of a return to significant COVID-19 restrictions.

Providers endeavouring to prepare for the possibility of this return should plan for the emergence of at least three inter-related pressures:

- Pressure from perpetrators seeking to complete or commence a change-focused intervention. Some men are of course more patient than others and will accept that like everyone in the community, the COVID-19 situation requires sacrifice and delays to plans and timetables across a range of issues in their

lives. Others, including those with a particularly elevated sense of entitlement, will place considerable pressure on program providers to offer them a program towards meeting the conditions of a child protection or justice system mandate (so that, for example, they can reunite with their family or obtain more access to their children).

- Pressure from referrers. The disruption to in-person services associated with COVID-19 restrictions makes it more difficult for program providers to provide change-focused interventions within the normal timeframes; this creates difficulties for mandated referrers whose own timelines (for example, in relation to the expiry of a Community Corrections Order or child protection order) have not shifted.
- Pressure to provide 'throughput', as the time required for perpetrators to complete programs increases while new referrals continue to enter the system.

There are no magic solutions to addressing these pressures. The extent to which they impact on program providers depend, in part, on the extent and duration of the COVID-19 restrictions imposed. In Victoria these pressures are substantial, given that program providers will face, overall, significant disruption to in-person delivery over a period likely to last at least nine months.[1] However, disruption over a period even half this length would pose significant pressures on WA providers; SFV's view is that at least some level of planning for how to respond to these pressures is required.

Meeting increased costs for service delivery

Contrary to what might first be assumed, providing MBCP services and interventions to perpetrators and their families is *significantly more costly* when COVID-19 restrictions are applied. Although no formal costing analyses have been conducted to SFV's knowledge, anecdotal reports from Victoria and Canada suggest that the overall unit cost of providing MBCP interventions, on average, is unlikely to be less than double the normal cost. The reasons for this include:

- Substantial increase in individual (phone- and videoconference-based) engagement of perpetrators
- Significant increase in intra-team meetings required to re-orient services
- A strengthened risk assessment and risk management focus, given the impacts of the COVID-19 on acute and dynamic risk factors
- The time required to adapt groupwork curriculum for alternative change-focused interventions
- Increased supervision time (including through the use of external clinical supervisors) required to support practitioner adaptions and changes in practice.

Incoming referrals and intake

During the height of the pandemic – both currently in Victoria and previously in other jurisdictions – program provider practices in relation to new referrals have varied considerably. Some providers ceased taking on new referrals for brief periods. Others continued with normal intake and initial assessment processes (albeit conducted via telephone or videoconferencing), and operated a holding space to actively engage waitlisted men before a place was available for change-focused interventions.

It is highly important that with any re-emergence of the pandemic in Western Australia, both self-referred men and referring agencies do not need to 'shop around' to find a program that is accepting new referrals. It is also highly important that men identified as relatively higher-risk higher-harm perpetrators do not use the 'chaos' associated with the pandemic to slip out of view due to enlarging holes and gaps in the service system. Furthermore, 'closing the books' to new referrals also denies an opportunity for family members to obtain safety planning and other forms of support through partner and family safety contact services.

The COVID-19 situation in Victoria, and to a lesser extent in Queensland and NSW, has required a major rebalance in MBCP focus between the related goals of providing a program and responding to risk. MBCP providers have been required to shift a greater proportion of available practitioner resources to initial *and ongoing* risk assessment, crisis response and risk management, including with men who were new or recent intakes.

This has been part of MBCP providers 'doing their bit' to respond to the potentially increased invisibility of perpetrators associated with COVID-19 restrictions, and to the increased difficulty of providing services to victim-survivors. The traditional approach of 'do we, or don't we, accept him into the program' has been replaced with

[1] Victorian providers had only just returned, or were on the cusp of returning, to in-person service delivery when the pandemic re-emerged in late June / early July.

'how do we keep him [new referral] within view, assess for the risk (including any escalated risk) that he poses to family members, and respond to that risk the best we can within the context of integrated practice, even if that means not providing him with a change-focused intervention at this point of time?'

In this sense, program providers more than ever need to consider how they can operate as part of a collective network, rather than only as individual organisations. Any decision made by an individual program provider has the potential to significantly impact upon others, for example in terms of redirecting referrals or decisions to temporarily tighten eligibility criteria. A re-emergence of the pandemic will require program providers to work closely together, rather than make individual decisions that they then share with each other after the fact.

Planning for increased demand for partner and family contact

Experience both in Australia and the UK indicates that should the pandemic re-emerge in WA, MBCP providers will face an increase in demand for partner and family contact services.

At the same time, maintaining safe and private contact with some partners has been difficult during the pandemic, due to the increased presence of the perpetrator in the family home. SFV recommends that MBCP providers and partner contact workers adopt the following measures in light of the possibility of the re-emergence of the pandemic:

- Planning with each person being provided with partner contact how to accommodate the possible presence of the perpetrator and/or children[2] during phone calls, should the pandemic re-emerge. As a pandemic progresses, and more people are working from home or put off work, increasingly, women will not be able to speak freely. The sooner this is raised with them and planned for, the better, preferably before any signs of a new pandemic emerge.
- Maintaining a strong connection and collaboration with the local CRS / specialist women's FDV response, especially if it seems that responding to the varied needs of all women will be beyond the MBCP program provider's capacity.
- Strengthening collaborative working relationships with local police, including those with a FDV portfolio. The role of police in making proactive visits into family homes can be important in times when the adult victim-survivor is difficult to reach.
- Having an assessment tool with a specific COVID-19 overlay ready for use, in case of re-emergence of the pandemic.[3]

Implementing a multi-tiered response to men

The eastern states' experience of the COVID-19 situation during stage three restrictions earlier this year (and for Victoria, extending into the current re-emergence of the pandemic) revealed the need for a differentiated, multi-tiered response to perpetrators.

Differentiated responses could broadly be separated into three tiers:

1. Perpetrators requiring individual contact (predominantly by phone, but conceivably via videoconference) focusing predominantly on ongoing risk assessment and risk response, at a frequency two or more times per week. These were perpetrators who were assessed as either:
    - high-risk high-harm, and would have been assessed as such even if COVID-19 was not a contextual factor
    - particularly emotionally labile, and/or affected by the economic and social impacts of the pandemic in significant ways potentially related to reduced stability and increased risk.

    The aim of these frequent contacts has been to ensure that the perpetrator is kept within regular view, to assess and respond to risk on an ongoing basis, and to help him manage day-to-day stressors and adjustments caused by the COVID-19 situation. For men in a significant degree of crisis due to COVID-19, this might necessitate brief, almost-daily contacts, in addition to one more substantial engagement each week. Many of these men are considered not suitable for change-focused interventions, at least not in the form of videoconference groupwork, due to their emotional lability and potential to

[2] Due to lack of childcare options or school aged children engaging in remote learning.
[3] See, for example, the Victorian COVID-19 risk assessment resources at https://www.vic.gov.au/maram-practice-guides-and-resources

undermine the process. A significant degree of coordinated and collaborative practice is required across agencies to manage the risk they pose to family members. Some of these men have required a case management approach to address complex needs that arose either before or as a result of the pandemic.

2. Perpetrators requiring an approach that actively 'holds' them while they wait for an available space in an appropriate change-focused intervention. These men might require individual contact weekly or fortnightly (again phone- or videoconference-based), through an approach involving motivational interviewing and some preliminary behaviour change work focusing on short-term safety planning and violence interruption strategies.
3. Perpetrators participating in change-focused interventions, either through individual phone-based or videoconference sessions, or through videoconference groupwork.

It is important to stress that *for all three tiers*, offering partner and family contact to affected victim-survivors is an essential parallel to the work with the men.

Working one-on-one with significant volumes of men 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. It might be important, for example, to give some priority to men living with their family members, especially if they are spending substantial amounts of time at home due to unemployment or the restrictions.

This multi-tiered response has required program staff to be somewhat flexible in their role. As few MBCP providers have dedicated case managers or staff whose main role is to engage with men through individual sessions, groupwork facilitators have often needed to step into providing a risk response and holding intervention for many of the men..

Continuing integrated practice

Integrated practice can suffer during COVID-19 lockdowns, depending on the extent of restrictions. Child protection, courts, corrections and police all have to adapt their services, as do NGO and community sector organisations. Yet with some perpetrators being able to fall more easily out of view, and with outreach to women and families more difficult, integrated practice is required more than ever in this context.

To prepare for any re-emergence of the pandemic in Western Australia, managers and practitioners can talk *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, including those that the MBCP provider is struggling to keep within view (for example, due to perpetrator evasiveness)
- what is reasonable to expect of police, child protection and courts
- what is required for perpetrators to clearly understand FDV-related police and court orders, if the normal processes through which police and court staff explain these orders are disrupted.[4]

Of course, the work of all parts of the service system 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. As part of a COVID-19 response plan, it is sensible to have a person within the MBCP 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.

MBCP providers need to be prepared to have a conversation with the referrer for each and every mandated participant. Referrers will need to understand the difference between perpetrators receiving a service based predominantly on a risk response, and those who are engaging in change-focused interventions. MBCP providers

[4] There is anecdotal evidence in Victoria, for example, that with the move towards virtual hearings for some matters, respondents to a FDV protection order have not been having the conditions of the order sufficiently explained to them.

will need a clear communication strategy to ensure that referrers understand that men might need to be engaged with the MBCP provider for longer periods of time than usual, and that it might not be possible for some men to complete the intervention until a return to in-person groupwork becomes feasible.

MBCP providers will also need mandated referrers to communicate clear expectations to perpetrators that they are required to participate in individual risk response sessions with the provider, even if they are not offered a change-focused intervention at that point in time.

Carefully considering alternatives to in-person groupwork

Due to the reintroduced and extended restrictions in Victoria, MBCP providers have been forced to consider alternatives to in-person groupwork so that change-focused interventions can be offered to at least some perpetrators. In all cases, these alternatives have been developed quite rapidly, with opinions divided on which types of alternatives – phone- or videoconference-based individual sessions, groupwork videoconference sessions, or some combination of both – offer the safest and best opportunities to approximate the potential behaviour change gains that can arise through in-person groupwork.

The rapid experimentation of these alternatives has raised a number of questions and issues, including:

- Which perpetrators these interventions are safe and appropriate for, and which, and in what situations, should perpetrators be screened out
- How to assess the likelihood/risks of inadvertent negative consequences if perpetrators participate in videoconference-based groupwork sessions from the family home, while their partner (and children) are also present in the home – and furthermore, how to assess this if partner contact is proving difficult in any particular case (e.g. because the perpetrator is gatekeeping her access to services, or because she has no private and safe opportunities to respond)
- How to set up videoconferencing groupwork sessions in ways that maximise participation, including the development of a productive group culture
- What aspects of a program's groupwork curriculum, and underlying theory of change, can be adapted for videoconferencing groupwork sessions? What aspects or change processes are unrealistic (or even unsafe) to attempt?
- Whose responsibility is it to address technical / IT infrastructure barriers that might prevent or limit a perpetrator's participation in videoconference sessions? What if the man's access to NBN/internet connection is not sufficient, or if he does not have a private space? What if the only device he has access to is his phone, rather than a tablet or laptop more conducive to a 'gallery view' and for engaging in content that's portrayed visually? Is it the responsibility of the program provider, or the mandated referrer, to support him with the equipment and environment required to participate?
- How might program practitioners who might never have engaged in individual change-focused sessions with men build their capability to adapt groupwork curriculum, in non-collusive ways, for individual intervention contexts?
- How is the question of 'equivalency' addressed? Should a videoconference groupwork session be dubbed as equivalent to an in-person session?[5]

Addressing these questions is leaving many program providers with needing to offer a larger 'suite' of change-focused interventions than usual, with this suite having been broadened, or being broadened, quite rapidly. Some providers are offering a combination of highly intensive individual risk response monitoring and engagement of high-risk high-harm perpetrators, and of perpetrators who are not suited for videoconference based interventions; with some combination of alternatives to in-person change-focused interventions. The diversification of intervention is proving highly challenging both at an agency and individual practitioner level.

A further challenge concerns how to meet built-up demand generated through a lockdown period, where referrals keep coming in at the same time as fewer men are able to complete programs. This has resulted in a backlog of men waiting to start a program, that need to be cleared once it is possible to return to some form of

[5] In Victoria, according to Family Safety Victoria guidelines, each videoconference groupwork session can count towards 0.5 equivalent of an in-person groupwork session, and as a whole, can make up no more than one-quarter of the minimum requirements for program completion (i.e. no more than the equivalent of 5 of 20 sessions). Individual phone or videoconference sessions are equivalent on a 1-1 basis, however, provided they are of a minimum length.

in-person groupwork delivery. At this *recovery* stage in the pandemic, it becomes safe to provide in-person groupwork provided that group-rooms are sufficiently large to enable the minimum physical distancing requirements. This has been a challenge for some program providers, whose own group-rooms are not of sufficient size, and who do not want to require staff to work in hired community venues at night if they will be the only staff onsite at that time.

It is essential that an agency-level COVID-19 response plan considers the above and other issues involved in developing, providing and transitioning away from alternatives to in-person groupwork, including agency capacity and capability requirements to offer a more differentiated and flexible range of interventions than what is ordinarily the case.

Occupational Health and Safety for workers

The intensity of work during any re-emergence of the pandemic might necessitate additional supervision for all staff. The adoption of alternative change-focused interventions to in-person groupwork will be a new and challenging experience for most staff; as will providing individual interventions predominantly through a risk response lens.

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, and 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.

The eastern states experience has identified that some organisational infrastructure has not been conducive to supporting significant numbers of clinical staff working from home. Unanticipated problems have arisen in some circumstances, such as client database systems being slow to access remotely, or an insufficient number of videoconference accounts to support the numbers of staff who might seek to videoconference at any point in time. A COVID-19 response plan would identify technological and infrastructure barriers and issues, and propose (or even road-test) solutions.

Build practitioner capacity to work differently

Responding to perpetrators in a COVID-19 pandemic context requires practitioners to work in new ways. Only a (small) minority of the MBCP workforce in Australia, for example, has experience in adapting group-based programs for individual intervention contexts – irrespective of whether sessions are provided in-person or through phone or videoconference mediums. A significant proportion of the workforce, with experience predominantly or solely in groupwork co-facilitation, have been or are being called upon to provide individual risk response focused contact with perpetrators for the first time. Equipping practitioners to be prepared to make such adjustments can be an important part of a COVID-19 response plan; and even if the pandemic does not re-emerge, can provide staff with useful skills they can use to assist the program provider to operate in more flexible ways.

Sandbag against impacts on practitioner wellbeing

Current Victorian and Queensland research into FDV practitioner experiences during the COVID-19 situation is finding major negative impacts on health and well-being.[6] The combination of physical isolation from colleagues and supports; of bringing the clinical imperatives of responding to highly traumatic, sometimes life-and-death issues directly into the family home; and of the potential large number of individual engagements with victim-survivors or perpetrators over the course of a day – can all contribute to adverse mental and physical health outcomes and potential for burn-out.

A COVID-19 response plan would anticipate and incorporate strategies to ameliorate against these and other potential threats to practitioner wellbeing.

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[6] https://theconversation.com/we-are-in-a-bubble-that-is-set-to-burst-why-urgent-support-must-be-given-to-domestic-violence-workers-141600