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# 'Who's got my back?': Worker safety in the context of domestic abuse

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## Abstract

The safety of practitioners working in the area of domestic abuse is a current subject of research and practice concern, as services endeavour to better understand constantly evolving tactics of violence and abuse and respond appropriately. This paper reports on a subset of findings from a practice-led research project focussed on capacity-building workers and their organizations to address domestic abuse, which highlighted the ongoing concerns expressed by practitioners—particularly female practitioners—about their own physical, emotional, and professional safety. Ethnographic notes were taken of Community of Practice discussions in four regions of New South Wales, Australia, involving 69 senior health practitioners from a range of service streams: specialist domestic abuse, mental health, substance use, and child protection. Themes identified through thematic analysis included the following: a tailored approach to practising safely; attending to physical safety; threats to professional identity; promoting emotional well-being; documentation to support worker safety; and attending to cultural safety. These themes are encapsulated in the practitioner question: *Who's got my back?*—highlighting the importance of legislation, policy, and practices that provide an environment in which safety and support are embedded in a *culture of care* at every organizational level.

**KEYWORDS**
culture of care, domestic abuse, worker safety, workplace violence

## 1 | INTRODUCTION

The safety of practitioners working in the area of domestic abuse (DA) is not a new area of research. It has been an integral part of the specialist DA sector response to safety for women (Littlechild & Burke, 2006). However, worker safety remains a live issue as services endeavour to respond to and better understand tactics of violence and abuse, and their practitioners—and particularly female practitioners—report ongoing concerns about their physical and emotional safety (Murphy, 2023; Tsantefski et al., 2023). As the accountability of the person using violence (usually men) increasingly becomes the focus for practice (Australian Institute of Health and Welfare, 2019), the risks to practitioners increase. A practice-led research project centring the perspectives of practitioners was undertaken (Wagenaar & Cook, 2011) to capacity-build workers and their organizations to address DA. In this process, the safety concerns of participating practitioners were highlighted. While the research was not specifically focussed on this topic, the issues raised suggest that a conceptual and empirical article to update attention to worker safety in the context of DA is needed.

## 2 | BACKGROUND

Worker safety in the context of DA cannot be divorced from the organizational context of the work. Natalier et al. (2021) argue convincingly that a mix of work and organizational factors contributes to practitioners' experiences of verbal, physical, and emotional abuse and intimidation. The impetus to focus on worker safety arises from shifts in DA practice in which practitioners are urged to 'pivot to the perpetrator' (Mandel, 2014), to ensure that the primary source of risk to adult and child survivors is not ignored. The background for the study therefore incorporates the vulnerabilities for practitioners working in the area of DA, alongside the organizational context where legislation and guidance on worker safety is embedded. The preoccupation of the participating practitioners lay with the risks posed by men who use violence and is therefore the focus of this article.

### 2.1 | Vulnerability for DA workers

Violence against workers is a problem internationally (Aeberhard-Hodges & McFerran, 2018) and is not confined only to services targeting the use of violence. Many frontline workers including, for example, those in supermarkets (Cai et al., 2023) and hospitality (Coffey et al., 2023) are increasingly becoming the target of violence and abuse. Interestingly, the research literature about violence towards workers is dominated by its impact on nurses and doctors in hospital settings (Lim et al., 2022; Vento et al., 2020). A search on worker safety and DA features the developing identification and response to victim/survivors of DA in their workplaces, acknowledging that organizations have a duty of care to the safety and well-being of these workers (Adhia et al., 2019; McLindon et al., 2018; Wathen et al., 2015). Violence against social workers provides more specific articles, with quantitative data suggesting that the experience of verbal or physical abuse and intimidation is common for frontline workers (Murphy, 2023), though less so for their managers (Koritsas et al., 2010; Shier et al., 2018). These articles consistently acknowledge that in a feminized workforce, violence and abuse tends to be seen as 'part of the job' and is frequently rendered invisible or minimized (Murphy, 2023; Natalier et al., 2021; Zelnick et al., 2013). Of concern is that the specific issues for minority ethnic workers, and in the Australian context, Aboriginal workers, have been given little attention in the worker safety and DA literature.

In Australia, where our research was based, Natalier et al. (2021) specifically focussed on the experiences of violence for DA and sexual assault workers ($N = 1157$). They noted that the threat, or actual experience, of violence and abuse from both service users and colleagues resulted in emotional strain and intention to resign. As reported in other studies (Enosh & Tzafrir, 2015), men were more likely to experience violence than women, and managers had fewer experiences of violence and abuse. In line with service organizations more generally (Zelnick et al., 2013), the incidence of violence was high. Natalier et al. (2021) found almost half the workers identified an incident in the past year, while many named more than three incidents a year. All studies stressed the importance of organizational context in supporting frontline workers to manage violence, abuse, and stress (Lim et al., 2022; Shier et al., 2016).

A systematic review of workplace interventions responding to intimate partner violence reports that the focus is on work with victim/survivors and that no interventions addressed direct work with perpetrators of DA (Adhia et al., 2019). The lack of specific attention to the risks posed by perpetrators of abuse emerges as a gap in the workplace safety response, particularly when more work is directed to ensure that their behaviour is documented and no longer invisible (Humphreys et al., 2020). Practitioners do not pose a significant threat to the person using violence while their work is focussed on victim/survivors (primarily women). It is frequently noted that this has been an active strategy by workers in the child protection and family services area to avoid men and particularly men who use violence (Featherstone, 2003; Humphreys & Absler, 2011). The range of avoidance strategies taken by health and social care workers as perceived by victim/survivors was analysed by Neale (2018). She points to collusion with perpetrators through ignoring, denying, or denigrating women and their experiences of violence and abuse. Neale also highlights the difficulties for practitioners who were motivated to be responsive to clients but who experienced cognitive dissonance when their ability to work effectively was undermined by large workloads, lack of resources, and organizational policies and rules. Strategies of avoidance and denial of women's experiences should be understood within these organizational constraints.

### 2.2 | Occupational health and safety policy

Worker safety is set within the broader context of occupational health and safety. The generic legislation in different jurisdictions pertaining to safety at work highlights the responsibilities of organizations towards their workers (Safe Work Australia, n.d.). These responsibilities tend to be framed in the language of what is 'reasonably practicable' for managing risk to workers. Workers' resilience and their ability to manage their safety in the context of violence is emphasized, rather than responsibility to develop a safe organization (Natalier et al., 2021; Safe Work Australia, n.d.).

Australian guidance for DA workers emphasizes the need to 'maintain a work environment that is without risk to the health and safety of workers' and to 'give workers the necessary information, instruction, training and supervision to do their job safely and without risks to their health' (Safe Work Australia, n.d., p. 2). In the guidance specific for the jurisdiction of our research project, there is less attention to worker safety and more generic advice on training, professional development, and continuous improvement (Domestic Violence NSW, 2022, Principle 11). However, other legislation may also be relevant. For example, New South Wales legislation on information exchange that overrides privacy in situations where there is an imminent threat to victims; protection for workers who do not disclose a serious crime when it affects the safety of others; legislation on civil

protection orders; and stalking legislation (*Crimes (Domestic and Personal Violence) Act, 2007* (NSW) s 8) maybe useful. These are all relevant, though without a central focus on worker safety. More recent legislation has focussed on providing stronger legal protections and leave for victim/survivors of DA in their workplace (Aeberhard-Hodges & McFerran, 2018), rather than the specific safety needs of all DA workers.

In summary, the evidence suggests that violence towards workers in the context of DA is high, and the legislative and policy guidance is often general rather than specific to the risks that practitioners may experience from perpetrators of violence. This article therefore addresses the following questions:

> What are practitioners' experiences of safety and well-being when working in the area of DA?
>
> What practices and/or policies support or undermine practitioners' experience of safety?

## 3 | RESEARCH DESIGN

The findings reported in this paper about practitioner safety concerns form a small part of a larger research project conducted in 2021. The Evidence to Support Safe & Together Implementation and Evaluation (ESTIE) Project investigated and developed practitioner and organizational capacity to assist children and families living with DA where there were co-occurring parental issues of mental health and/or substance use (Kertesz et al., 2022). The recognition of practitioners as knowledge builders draws from the work of Wagenaar and Cook (2011) and their identification of practice-led research as an essential element in understanding practice and practice change. They focus on understanding the micro-practices, organizational culture, and administrative systems that foster specific responses at the frontline of practice. The approach promotes respect for practitioners and their skills and supports an ethnographic methodology to understand the details of frontline practice.

Communities of Practice (Wenger, 1998) were conducted in four regions of New South Wales, Australia, and involved 69 senior health practitioners from a range of service streams: specialist DA, mental health, substance use, and child protection (Table 1). The sample was heavily weighted towards women ($N = 58$; 84%), with a minority of men ($N = 11$; 16%). Invitations to participate focussed on experienced professionals who were in touch with direct practice. Half the participants were frontline workers and a further quarter described themselves as practice or clinical leaders (Table 2).

Prior to participation, participants received training in the Safe & Together™ Model. Discussions from anonymized case examples and associated practice approaches in the Communities of Practice were led by Safe & Together consultants and the research team. The Safe & Together™ Model is a child-focussed practice framework for working with families who live with DA and focusses on perpetrator patterns of behaviour, strengths-based partnering with adult victim/survivors, and keeping children safe (Mandel, 2014). The Model provides helpful language, vision, and practice tools to support collaborative working across diverse statutory and nonstatutory organizations (Kertesz et al., 2022).

In each region, a focus group was held, following five Community of Practice meetings, to record participant reflections on their learning and practice development. Focus groups provide a facilitated, semi-structured discussion which supports the exchange of ideas, thoughts,

**TABLE 2** Community of Practice contributing participants role level (attended more than one session).

| Region | R1 | R2 | R3 | R4 | Totals |
|---|---|---|---|---|---|
| Frontline worker[a] | 5 | 3 | 13 | 16 | 37 |
| Team leader | 1 | 3 | 1 | 4 | 9 |
| Senior manager | — | — | — | 2 | 2 |
| Practice/clinical leader | 9 | 4 | 4 | 1 | 18 |
| Other | — | — | 3 | — | 3 |
| Total | 15 | 10 | 21 | 23 | 69 |

[a]Includes caseworkers, clinicians, counsellors, and officers.

**TABLE 1** Community of Practice contributing members' areas of work by region.

| Region | R1 | R2 | R3 | R4 | Totals |
|---|---|---|---|---|---|
| Health violence, abuse and neglect, sexual assault, and social work services | 5 | — | 6 | 5 | 16 |
| Drug and alcohol services | 1 | 1 | 10 | 4 | 16 |
| Mental health services | 3 | 1 | 4 | 1 | 9 |
| Statutory child protection | 1 | — | — | 1 | 2 |
| Health child protection services | 4 | 5 | — | 6 | 15 |
| Non-government child protection services | — | 2 | — | 3 | 5 |
| Other services | 1 | 1 | 1 | 3 | 6 |
| Totals | 15 | 10 | 21 | 23 | 69 |

*Note*: Total number of Community of Practice members contributing to these data was calculated based on having attended more than one session across the Community of Practice series and not having withdrawn data.

and experiences (Luke & Goodrich, 2019). Given the already established trusting relationships developed during the Communities of Practice, these groups proved to be a rich source of practitioner data.

### 3.1 | Data collection and analysis

Members of the research team acted as participant–observers in the 20 Communities of Practices and four focus groups, taking detailed ethnographic notes (Reeves et al., 2008) about practice dilemmas faced by Community of Practice participants and the response of the Safe & Together consultant. It is a method aligned with the practice-led research undertaken by Wagenaar and Cook (2011). While typical ethnographic methodology would involve the researcher observing and noting the actual practice of the worker (Garfinkel, 1967; ten Have, 2002), the note-taking at the Communities of Practice provided indirect access to the work of practitioners through their reporting of and exploration of their frontline experiences. This more discrete focus to the ethnographic study provided fewer opportunities for bias in the data collection process, while still providing rich data about practice experience.

Ethnographic notes were coded in NVivo 2020 (1.0) software and analysed following the thematic analysis framework of Braun and Clarke (2019). A large number of primary codes were developed from the line-by-line initial coding, to then focus on a smaller group of secondary themes, and a conceptual synthesis. To focus on the issues of worker safety, the second author returned to the original primary codes to ensure that data in this coding had not become lost. This process resulted in further analysis to inform the secondary themes relating to worker safety and the emergence of an overarching conceptual code—*Who's got my back?*

## 4 | FINDINGS

One of the five meetings in each Community of Practice series focussed on working safely. However, reflections on this issue arose through all the Community of Practice discussions and it was considered foundational to practice and the implementation of the Safe & Together Model. The concept *Who's got my back?* highlighted the importance of support for workers and the fears arising when they felt obliged to manage their safety on their own. The themes underlying this concept include the following: a tailored approach to practising safely; attending to physical safety; threats to professional identity; promoting emotional well-being; documentation to support worker safety; and attending to cultural safety.

### 4.1 | A tailored approach to practising safely

Practitioners recognized that perpetrators did not all pose the same level of risk to workers. An approach tailored to each circumstance was required to address safety concerns however they presented, that took into consideration a worker's professional judgement and knowledge of violence, substance use, or mental health issues. This included issues such as whether workers had been previously attacked.

Partnering with victim/survivors to map the perpetrator's patterns of abuse was discussed as a central aspect of practice, as this enabled workers to customize their response and case plan. They recognized that when perpetrator threat (or perceived threat) increased safety risks, a common response was to work only with the victim/survivor, placing all the responsibility for safety onto victim/survivors. Such 'paths of least resistance' failed to address the source of risk in the perpetrator.

> The challenge of actually … having some of those really important conversations in the context of crisis, around what is actually happening for that family, and often because there's a really limited understanding of that. So there's a critical incident, but there's not actually an understanding of things like the perpetrator's tactics, and the history of coercive control, and the level of risk at that point. Or the extent of the perpetrator's experience of mental health or drug and alcohol issues.
>
> (Health Social Worker)

> The culture's changing around it, and the way we're thinking about it is changing. The focus on the women as having to be the big protectors is changing. The gaps in the information that we seek or are provided with around the perpetrator behaviour and his impact, that's all starting to change so I think that's really good.
>
> (Health Child Protection Worker)

Shared information from other organizations was also critical to risk assessment and planning interventions with the person using violence. It was an area where collaboration across DA, mental health, and substance use services was vital to understanding the risks posed by perpetrators.

> … it's incremental, what we get to know about people, and each service, if we can all talk to each other, we get that information and we're not all starting on the ground again … we're in this small community up here, all working quite closely with quite stable teams.
>
> (Health Child Protection Worker)

Participants explored how feelings of being unsafe or under threat significantly impacted their ability to conduct ethical and non-collusive work with families. Their fears could be based on direct physical threats or other forms of intimidation from a perpetrator.

> … we noticed ourselves and we pointed this out, that idea of parallel processes, we were behaving like the family members. Each time we had to make a call we

> had to brace ourselves and think what will he say? Each visit as well.
>
> (Non-Government Child Protection Worker)

Workers also discussed how to ensure worker safety without closing down help-seeking and increasing the fears for victim/survivors, particularly if they were already socially or culturally marginalized. For example, requiring male workers to accompany female workers to conduct home visits for assessment in case a perpetrator was present is a common practice, but it also sets a particular tone for engagement which can be intimidating for the victim/survivor.

> For a client who is already under threat, and is operating at that level of everyone is threat, we are [a threat] too. And when there is two of us that's even more. When we're sending the big burly manager, that's more imbalance of power, more threat for them. Thinking about how to approach our safety in a way that doesn't increase clients perceiving us as threat too.
>
> (Health Child Protection Worker)

Finding ways to practise as individuals with unique constellations of safety concerns was a particularly salient topic throughout all the Communities of Practice. Individual worker characteristics and circumstances connect to broader discussions of gender, parenthood, discipline-specific challenges, and geography (e.g., rural/regional vs. metropolitan). Community of Practice members described doing their best to navigate these individualized challenges. Female workers felt more physically vulnerable to perpetrator threat but also were more likely to face challenges around perpetrators' use of charm and grooming behaviours (and the associated invitation to collude), alongside physical intimidation of women.

> I think there was some implied threat around gender in the interview space.
>
> (Health Child Protection Worker)

> The perpetrator will often use similar tactics and strategies with me and the therapist working with them, and how scary that can be. Knowing how to engage with them, also me being a female, having female co-clinicians, and this powerful male - it can re-enact the [DA] process again.
>
> (Health Child Protection Worker)

## 4.2 | Attending to physical safety

Most Community of Practice participants reported feeling physically safe in their place of work—health headquarters, office buildings, community centres, clinics, and other organizationally run workplaces. Established protocols, with good assessment, understanding, and attention to risks, all contributed to this sense of physical safety and were for the most part already in place.

> We have coded locks for the staff, screens and more of a security presence … When we've got fathers walking into our waiting room demanding to speak to the person who's counselling their kids, we make sure that there's two of us, and we actually make sure that it's part and parcel of … our policy. This is how we work, give them information, try to placate them, but there's always that awareness of who's going to pay for this. … We've also got video cameras, and signs saying we've got video cameras. We don't see anyone we're worried about, we've got duress alarms, all that sort of stuff. So physically, yes, we're okay.
>
> (Health Social Worker)

Some disturbing exceptions related to threats to physical safety not being taken seriously by organizational management. Workers emphasized the importance of managers paying attention to worker concerns regarding clients, considering the impact on them as individuals and holding the person using violence accountable, rather than expecting workers as professionals to be able to individually keep themselves safe. An example of a disappointing response from management involved a substance use worker's experience with a male client known to have a history of using violence. The worker was not supported to pursue legal avenues to increase their safety when the client used stalking behaviours against them. Instead, they were directed to alter their own behaviour. Following a physical attack by the client in the workplace, the line manager focussed on deficits in how the worker had handled the situation. The worker was required to repeat safety training, amendments were made to their workplan, and restrictions on the types of clients they engaged with were put in place by management.

> Sometimes the response to critical incidents where workers are assaulted or something, we can be blamed for not preventing it somehow, or not looking after ourselves, and a similar approach to vicarious trauma as well.
>
> (Specialist DA Worker)

Workers felt much less protected by their organizations outside their formal place of work, in settings such as external consultations, home visits to clients, and in their personal lives outside work hours. Home visits where perpetrators were physically present were described as less worrying than those where perpetrators might be present but unseen.

> It's really … scary. I've lost count of the amount of times the perpetrator is under the house, in the garage, in the bedroom, on the roof. And the client talking, the woman speaking softly. That experience there, it can

be scarier that they aren't seen, rather than if they are sitting in the lounge room. You think, who is in that room? We have ice users, dealers under houses in our home visits. You can just see the pressure the client is under.

(Non-Government Child Protection Worker)

In regional areas and small communities, where personal community networks and the client groups practitioners served were more likely to overlap, this was reported to be an ever-present concern. Regional workers gave examples of feeling particularly vulnerable when working with perpetrators, who they then encountered outside work, even if no overt threats had been made towards their safety.

My experience of that directly was interviewing a violent father who tried to groom me, in prison, on remand. Not long after, [I] wound up sitting with him and family at a Christmas school event. The vulnerability I had, made me concerned that he may know my kids.

(Health Child Protection Worker)

Participants from regional and remote areas discussed a variety of safety strategies, which underlined the vulnerability that they felt. One worker spoke of never ordering home delivery pizza as she could not predict who would come to the door. Another worker said:

We do practise within small communities, … people [practitioners] talking about stopping shopping in this town, etc, external factors in our lives to the structures we can implement in work. Predictability in work, even in face of AOD and MH, but unpredictability in external circumstances.

(Health Child Protection Worker)

## 4.3 | Threats to professional identity

Threats to professional identity emerged as a key theme throughout the Community of Practice discussions on worker safety. Perpetrator complaints against professionals, actual or threatened, were a major concern for participants who reported that the impact extended beyond their own well-being and safety, to that of their families and of the clients they were working with. In one instance, a perpetrator was reported to have threatened to accuse a health worker's husband of child sexual abuse, and the impact of this threat was also felt by professionals who subsequently worked with the family.

In contrast to issues of physical safety and risk assessment, workers described feeling underprepared and unsupported regarding threats to their professional identity.

I feel more of a threat to my professional reputation and standing, because the way psychology works as a profession, psychologists are registered. It's a big deal to be registered, and complaints are taken seriously, with a lot of processes. … I feel less supported by my organisation to deal with it, than a physical threat. Workplaces are set up … for physical threats. Trouble-making complaints are dealt with in the same way as real ones. It's a threat to worker safety, I find it quite significant.

(Sexual Assault Worker)

Other organizational practices also undermined professional safety more generally. The obligatory investigation when a perpetrator made (often false) allegations against a partner or ex-partner as part of their tactics of control could undermine the safety of the relationship between workers and victim/survivors and increase victim/survivors' perception of the control that perpetrators have over systems and service providers.

## 4.4 | Promoting emotional well-being

Community of Practice participants consistently advocated for increased attention to emotional well-being, going beyond a focus on physical safety, and described shared experiences of a wide range of stresses.

All of us work at capacity at the best of times. I find when I work at capacity, I have to prioritise which issues I address with clients or how much of a holistic approach I can afford to have. … We are time limited. Just the level of frustration, or the missed opportunities for real satisfaction I'm finding tricky. I talk about it in supervision all the time.

(Substance Use Worker)

Challenges to worker well-being included fear of collusion with perpetrators, concerns that service involvement could increase risks to adult and child victim/survivors, pressure to manage significant workloads with limited resources, and navigating complex systems not aligned with DA-informed principles.

One of the pathways I think for vicarious trauma for a lot of people is bumping up against the challenges, especially when there are ethical or moral kinds of challenges you have to hold, and you are fighting against the system. … you're doing the best you can absolutely, but you're seeing it not necessarily impacting the system right now. And having to hold that, I think is a really big impact.

(Sexual Assault Worker)

Workers often minimized their needs and felt unable to discuss the impacts of the work.

> As a workforce, we're kind of rewarded for our martyrdom, and also that we kind of downplay our needs, because we do deal with horrific stories and a lot of trauma.
>
> (Substance Use Worker)

The notion of a *culture of care* recurred throughout the Community of Practice discussions, to reduce workers' feelings of individual responsibility for their safety and instead foster organizational responsibility, collaboration, and mutual support. The opportunities provided by this study of a shared conceptual model, and the opportunity for regular practice reflection in the company of colleagues, were commonly referenced as reducing workers' feelings of isolation.

> It makes such a difference communicating with other workers. … After every visit we contact each other, there is so much going on, need to know the plan each week. And if I need help or they need help with something, we do rely on each other. It's fantastic to have that working relationship for services but also for the clients.
>
> (Health Child Protection Worker)

Meaningful, DA-informed supervision and support and training provided by line management were identified as crucial but separate elements of a *culture of care*.

> Management are on the same page as myself and the one other counsellor we have, in making sure we are clearly documenting behaviours of the perpetrator and using that wrap-around approach, and that's been clearly articulated not so much in supervision but in conversations around practice.
>
> (Specialist DA Worker)

> … as an organisation we've come so far with those structures, supporting us as clinicians to not feel like [we're] wading into croc infested waters, when compelled to go into those environments …. We've got a privacy policy, subpoena, responding guides, but they don't hold complexity and the nuance that clinicians are grappling with.
>
> (Specialist DA Worker)

Participants noted that poor practice not addressed by managers could parallel the abuse dynamics experienced by their clients.

> When workers have bad management experience, it means they won't trust in the future. Just like DV disclosures, same in this situation.
>
> (Specialist DA Worker)

Another area of discussion was the need for organizations to be aware of, and provide support for, the significant proportion of workers with their own lived experiences of violence and the associated expertise and professional skills. The impact of current and past experiences on workers was identified as an area as yet largely unaddressed.

> If we are in a workplace where I can actually explore that, we can use that experience to inform part of our assessment for what it's like for her and how we can be creative to still offer service.
>
> (Non-Government Child Protection Worker)

Overall, participants believed that a *culture of care* was crucial for workers to feel they could achieve practice change. This encompassed support at both organizational and individual levels for workers to be vulnerable; have and discuss emotional needs; have time to plan, reflect, and debrief; and to be trusted to use professional judgement.

### 4.5 | Documentation to support working safely

Participants spoke of using documentation to support their safety as workers in the face of spurious or egregious complaints made by perpetrators who sought to intimidate or threaten workers. They emphasized that this constant need for documentation took its toll on their sense of safety and well-being.

> I guess, my approach has been about making sure I documented an alternative narrative, notes, conversations with supervisors, managers. It's preparing for a fight right, when actually, it would be nice to feel safer than that.
>
> (Sexual Assault Worker)

Other workers highlighted the importance of the document trail regarding perpetrator harm, not only for themselves as workers but also the survivors they worked with.

> As reports are legal documents, other services will contact and ask for them. Documentation is important. Not a great deal I can effectively do in the time, but I could plant the seed. … It is useful to make a homework list, or things to address in future, hopefully near future. Other services can pick that up.
>
> (Substance Use Worker)

Documentation of perpetrator patterns, including any apparent willingness to use complaints or service system mechanisms against professionals, can support workers and provide an effective counter-narrative. Participants emphasized that explicit documented attention to coercive control was particularly important for safety.

> I used to just write the notes for whoever might be interested. Now I write for other services who will be reading the notes, to give them a context of what I know and what I have learnt in the time the client is with us. It might be mental health, it might be [service name], whoever, I know they might read those notes. And I want them to be informative.
>
> (Substance Use Worker)

### 4.6 | Attending to cultural safety

Cultural safety is a critical component across all work and applies not only just to Aboriginal and ethnic minority families involved with services but also to professionals. Creating cultural safety for families and for workers engaging with mainstream services was a key area of discussion throughout the Communities of Practices, particularly in relation to Aboriginal workers and families.

> I just think moving forward for Indigenous and non-Indigenous workers, more training on how understanding our culture can improve working relationships between Indigenous and non-Indigenous workers. It can improve just by understanding. We don't expect a non-Indigenous worker to understand our culture but to be learning, just be open minded, and expect the unexpected in a good way.
>
> (Non-Government Child Protection Worker)

Strategies to support both Aboriginal clients and workers, and non-Aboriginal clients and workers, were the subject of many Community of Practice discussions, such as reports that Aboriginal clients often felt culturally safer when Aboriginal Health Liaison workers accompanied non-Aboriginal workers on visits.

> I could settle mum quite quickly when I was around … I was there to support the family, let them know I was an Indigenous caseworker, and then her mood would go from slamming the door, it changed completely, she was completely calm.
>
> (Aboriginal Non-Government Child Protection Worker)

Mainstream and non-Aboriginal workers actively prioritizing the development of their own cultural competency and learning also promotes safety for minority ethnic and Aboriginal workers within mainstream organizations. Discussion and case examples included reports of Aboriginal workers constantly feeling they were pulled in a multitude of directions through requests for case consultations, home visit collaborations, training, and supervision. It was acknowledged that expecting cultural competence to be the responsibility of every worker lessens the burden on Aboriginal workers and promotes their physical and psychological safety.

## 5 | DISCUSSION

Practitioner experiences and the policies and practices that support or undermine their safety and well-being are two interrelated questions. Discussion about worker safety when working with DA across services within four regions in New South Wales highlighted a wide range of practices. Taken together, the practitioner experience was either of an overarching sense of safety and well-being in which they felt that their colleagues and managers 'had their back' or alternatively a sense of fear and anxiety (in 'croc infested waters') if they felt alone and unsupported. While lack of support, abuse, and anxiety about the pressures of work are generic issues which many health and social service organizations and workers grapple with (Lim et al., 2022; Vento et al., 2020), the concept is magnified for practitioners working daily with issues of violence and abuse (Koritsas et al., 2010).

The significance of creating a *culture of care* within the work environment is mentioned in other research about worker safety (Shier et al., 2016). It is a term that encompasses peer support as well as management practices and policies. At the operational level, it was noteworthy that practitioners spoke about the sense of well-being engendered by regular Communities of Practice, the ability to debrief and discuss their work with families, and consistent checking with colleagues following visits outside the office. It can also refer to the sense of cultural safety that workers from Aboriginal (Crooks et al., 2022) and ethnic minority communities can experience if they feel well supported and respected within their workplace. While a *culture of care* is a generic work-based concept, it has potentially greater relevance when working in the area of violence where safety concerns are high (Kim, 2011; Lim et al., 2022).

The study practitioners were introduced to a practice model (the Safe & Together Model) that provided a shared conceptual language, practice approaches, and principles they could implement between and across services (Heward-Belle et al., 2022). The positive stimulation of implementing practice changes, which were supported by both peers and senior management, also contributed to a dynamic *culture of care* for study participants. While involvement in a practice-led research project (Wagenaar & Cook, 2011) provided a very specific context, working together with other professionals towards a common goal is an important ingredient in a *culture of care*. This is highlighted in the systematic review by Herkes et al. (2019) who found that workers' well-being was highly correlated with their sense of 'fit' with their work, shared collegiate values, and the culture of the wider organization. Alternatively, when workers were unsupported or constantly exposed to violence, many chose to leave, creating 'churn' in the workplace (Horejsi & Garthwait, 1994; Murphy, 2023).

Information sharing between services about the risks posed by the perpetrator of violence is recognized as an essential element of accurate risk assessment (Dheensa & Feder, 2022). Most risk assessment tools focus on the risks to victim/survivors, with a presumption (rarely expressed) that such an assessment is also accurate for

workers. Practitioners noted this as a gap as they attempted to understand whether a person using violence posed too great a risk for workers to engage with them (Tsantefski et al., 2023). Documenting this information was noted as a practice development foundational to current and future safety for victim/survivors and workers. Information sharing about the perpetrator is supported in many jurisdictions, through legislation to overcome privacy laws that may have previously ensured information was confidential to one organization. Nevertheless, much of this legislation is complex and ambiguous, requires training, and, in some jurisdictions, remains restricted to 'imminent and serious risk' (Dheensa & Feder, 2022). Such barriers may currently undermine the safety of professionals within an organization. In some areas, the practice of mapping the perpetrator's patterns of violence into one shared document counters the fragmentation of information that can undermine accurate risk assessment and management (Tsantefski et al., 2023).

Threats to physical safety proved to be an area of ongoing discussion in the Communities of Practice. Interestingly, with some exceptions, practitioners felt physically safe within their formal places of work as a result of organizational policy on worker safety. This was a heartening example of the ways in which the policies on safety were found by this study to be being implemented consistently. There was a sense in which the organization 'had their back' within the office context.

It was outside the building that workers felt much more vulnerable. Home visits were a concern, particularly if stretched resources meant workers visited on their own. Rural workers reported particular concerns when there were long journeys, isolated properties, and lack of connection to colleagues. These are concerns raised elsewhere (Wendt, 2010). However, there was also thoughtful reflection about how to counter perceived heavy threats from workers to families who experienced themselves as marginalized and disempowered. This was particularly relevant for Aboriginal families where statutory and other mainstream services have a history of discriminatory practices (Krakouer et al., 2022).

Regional and rural workers also consistently raised the issue of their vulnerability to the perpetrator of violence when they lived in the same small town or rural area. While many took steps to protect themselves and their families, personal and professional boundaries inevitably blurred in these locations, particularly when children attended the same schools or sporting clubs. The focus on safe DA practice in rural areas is one which continues to challenge practitioners, managers, and policy workers as current urban-based models are recognized as inadequate to meet the needs of victim/survivors (Owen & Carrington, 2015; Wendt & Hornosty, 2014). The focus on collaborative relationships in Community of Practice and focus group discussions reflects strategies for challenging isolation, fragmentation, and lack of support for practitioners (Wendt, 2010).

Countering invitations to collude with the perpetrator can take many forms, and practices are also outlined by Neale (2018). Fearful workers can be dangerous workers if their anxiety leads to avoidance, alignment with the perpetrator's account of events, and minimization of the significance of abuse. However, skill development and supervision are also required to mitigate against grooming and charm, tactics also used by many perpetrators. These are tactics that may not induce fear but may nevertheless undermine the safety of victim/survivors and practitioners. While working with perpetrators of violence has largely been the territory of specialist men's behaviour change workers to date (Day et al., 2009), the perpetrator's pattern of behaviour demands attention in all DA work. The skillset required to focus on the perpetrator as a source of risk is emerging as a priority area for training. It is an area where the demand for visibility and accountability may increase the risks to worker safety as the perpetrator's tactics of control are challenged (Smith & Humphreys, 2019).

The tactics perpetrators use to attack the professional identity and credibility of practitioners, and therefore their safety, have received less attention. Strategies often used by men who use violence to threaten victim/survivors were reported to be also used against practitioners. These tactics included vexatious or fictitious complaints to authorities and professional organizations about practitioner conduct. This was the area where practitioners in this study felt their organizations were least prepared, reporting a lack of policies that specifically addressed this issue. In fact, existing policies could be used to actively undermine practitioners, as all complaints were required to be investigated, regardless of the abusive history of the perpetrator. Practitioners noted that their whole career and reputation could hang in the balance. In rural areas, at a more informal level, gossip and rumour spreading can also seriously undermine not only victim/survivors (Owen & Carrington, 2015) but also practitioners as well, unless they have strong networks of support.

Support for workers with lived experience of DA is an issue which has galvanized workplaces (Aeberhard-Hodges & McFerran, 2018; McLindon et al., 2018) and was a minor but important theme in the discussions within this study. For those workers impacted by past DA experiences, levels of support were mixed. More training may be required for managers to respond appropriately to new policies that are now in place (McLindon et al., 2018). Practitioners reported some very poor experiences of management responses to threats and harm towards them. The occupational health and safety legislation which places an onus on workers to manage the risk themselves was experienced as unhelpful and destructive. Such incidents of poor management practice can reverberate throughout an organization, leading workers to talk about the dynamics of abuse by perpetrators being replicated by management (Neale, 2018). Practitioners aware of these vulnerabilities took care to document carefully incidents and risks to ensure that they were 'covering their own backs'. These were practices that some practitioners reported as adding stress to already difficult jobs.

Much of the literature refers to workers' dissatisfaction with their employment when workloads are experienced as unmanageable (Vento et al., 2020); leadership is authoritarian; and supervision is inadequate (Lozano et al., 2021). In the area of DA, these issues may lead to avoidance of difficult situations and poor practices such as ignoring perpetrators and blaming victims (Neale, 2018). Policies and protocols cannot cover all the nuances of working safely in the DA context, and a significant aspect of an organizational *culture of care* is

the provision of clinical supervision separate from line management oversight (Kim, 2011). Studies have shown that strong supervision creates greater safety for service users (Natalier et al., 2021) and, in turn, for practitioners.

A limitation of the study lies in the lack of gender diversity in the research, with a minority of male voices contributing to the findings presented in this article. While women were vocal on this subject, men's experiences of abuse and safety were discussed and documented in this study with significantly less frequency and nuance than those of the participating women. This is a limitation of the study and suggests the need for a study that attends to men's experiences of safety, abuse, and violence. The broader literature suggests that men report higher levels of violence towards them than women (Enosh & Tzafrir, 2015). However, the literature and research are also replete with references to the vulnerabilities of a female-dominated workforce in the face of the gendered nature of DA in which violent men predominate as the aggressors (Littlechild & Burke, 2006; Neale, 2018). It lies as an area for further exploration.

## 6 | CONCLUSION

The establishment of a *culture of care* requires an interplay between peer and organizational support. In an area where violence and abuse are the central focus of the work, the attention to safety and well-being for the employees comes into sharp focus. Threats to physical, emotional, and professional well-being are foreground rather than background issues and require proactive attention. Policies and guidance that delineate appropriate support for workers need to be enacted. Practitioners in this study raised concerns that current guidance and legislation are not sufficiently developed to ensure their backs are covered when perpetrator tactics of control and abuse are deployed against them. This issue goes well beyond this study. In a female-dominated workforce, the notion that abusive behaviours are part of the job is one that needs to be challenged (Baines & Cunningham, 2011; Weatherall et al., 2021). It requires the enactment of policy and practices that provide an environment in which safety and support are embedded in a *culture of care* at every level in the organization. When practitioners ask, 'Who's got my back?', they want the answer to be my colleagues, my organization, and the legislative framework in which I work.

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### CONFLICT OF INTEREST STATEMENT

The authors declare that there are no conflicts of interest with respect to this research.

### DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

### ETHICS STATEMENT

This research received ethics approval from the University of Melbourne Human Research Ethics Committee (Ethics ID: 20554).

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