

NADA Practice Resource

ENGAGING MEN WHO PERPETRATE DOMESTIC AND FAMILY VIOLENCE IN THE ALCOHOL AND OTHER DRUGS TREATMENT CONTEXT

A resource developed by the Network of Alcohol and other Drugs Agencies (NADA) to support best practice when engaging clients who perpetrate domestic and family violence.



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Australian Government

Department of Health

NADA is supported by funding from the Australian Government Department of Health.

Acknowledgement of country

NADA proudly acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the lands and waters throughout Australia. Our office stands on the land of the Gadigal people of the Eora Nation.

We recognise, respect and value the deep and continuing connection of Aboriginal and Torres Strait Islander people to land, water, community and culture.

We look to and celebrate Aboriginal and Torres Strait Islander people for their cultural guidance, leadership and expertise.

We pay our respects to Elders past, present and future.

Suggested citation: Network of Alcohol and other Drugs Agencies (NADA). NADA Practice Resource: Engaging men who perpetrate domestic and family violence in the alcohol and other drugs treatment context. Sydney: NADA; 2021.

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About NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non government alcohol and other drugs services in NSW. We advocate for, strengthen and support the sector. As a member-driven peak body, NADA's decisions and actions are informed by the experiences, knowledge and concerns of its membership.

We represent close to 100 organisational members that provide a broad range of alcohol and other drugs services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Our members are diverse in their structure, philosophy and approach to alcohol and other drugs service delivery.

We provide a range of programs and services that focus on sector and workforce development, data management, governance and management support, research and evaluation, sector representation and advocacy, as well as actively contributing to public health policy.

Together, we work to reduce the harms related to alcohol and other drugs use across the NSW community.

NADA has award level accreditation under the Australian Services Excellence Standards (ASES), a quality framework certified by Quality Innovation and Performance (QIP).

About this resource

This resource aims to support practitioners working in the alcohol and other drugs (AOD) sector to work safely and effectively with clients who perpetrate domestic and family violence (DFV). It is not intended to cover all of the complex and varied factors involved in engaging these clients with respect to their DFV use – this would require a document of much greater length. Rather, this resource provides starting points on how to:

- have safe and non-collusive conversations with clients who cause DFV
- minimise collusion with the attitudes, belief systems and narratives that perpetrators adopt to justify and give themselves permission to use DFV
- discuss referral to appropriate, specialised DFV services.

DFV comes in many forms and can be used and experienced by someone of any gender identity. However, research has shown that men are by far the most common perpetrators of DFV, and cause the most harm.¹ This resource therefore focuses on engaging adult male clients who perpetrate DFV. (However, some of the conversational microskills discussed in this resource may also be relevant to other contexts, such as when working with clients from gender and/or sexuality-diverse backgrounds.)

It is critical to be extremely careful when a female client is identified by police or others as a perpetrator of DFV. Australian and international research consistently demonstrates that a high proportion of women who are charged with DFV-related offences and/or subject to DFV protection orders have in fact used one-off or occasional acts of violence as a means of self-defence or to restore some dignity, within the context of being a victim-survivor of their current or former male partner's use of long-term, widespread, coercive controlling violence.² In these situations the male partner is the predominant aggressor, and viewing these women as perpetrators can result in practitioners and services inadvertently becoming complicit in her partner's efforts to manipulate the system to portray her as the one with the problem.

How this resource relates to broader AOD workforce capabilities

Preventing and reducing AOD-related harm in Australia requires a skilled, effective and adaptable workforce.³ The NSW non-government AOD sector's Workforce Capability Framework (NADA, 2020) establishes a common language and shared understanding of the knowledge, skills and attributes that workers in the sector are expected to have in order to carry out their work efficiently and appropriately.

The framework is organised into six areas of professional responsibility, referred to as domains. Each domain requires specific capabilities – or the knowledge, skills and attributes that a worker in the sector is expected to have in order to carry out their work effectively, efficiently and appropriately within that domain. The six domains are listed and described below.

Each of the six domains identified in the framework is applicable to workers in the sector who are working with men who perpetrate DFV.

1. Australia's National Research Organisation for Women's Safety (2019). *Impacts of family domestic and sexual violence* (2nd ed.). Sydney, NSW: ANROWS. <https://www.anrows.org.au/fast-facts-impacts-of-family-domestic-family-violence>; ANROWS (2018). *Violence against women: Accurate use of key statistics* (ANROWS Insights 05/2018). Sydney, NSW: ANROWS. https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/02/19025810/ANROWS_VAW-Accurate-Use-of-Key-Statistics.1.pdf; Our Watch, ANROWS and VicHealth (2015). *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*. Melbourne.
2. Boxall, H., Dowling, C., & Morgan, A. (2020). Female perpetrated domestic violence: Prevalence of self-defensive and retaliatory violence. *Trends and Issues in Crime and Criminal Justice*, Australian Institute of Criminology. <https://aic.gov.au/publications/tandi/tandi584>; Mansour, J. (2014). *Women defendants of AVOs: What is their experience of the justice system?* Women's Legal Service NSW; Miller, S., & Becker, P. (2019). Are we comparing apples and oranges? Exploring trauma experienced by victims of interpersonal violence and abuse and court-involved women who have used force in relationships. *Journal of Interpersonal Violence*, 88626051882328. doi:10.1177/0886260518823289; Tolmie, J., Smith, R., Short, J., Wilson, D., & Sach, J. (2018). Social entrapment: A realistic understanding of the criminal offending of primary victims of intimate partner violence. *NZ Law Review* 2018, 181-218; Women's Legal Service of Victoria (2018). 'Officer she's psychotic and I need protection': Police misidentification of the 'primary aggressor' in family violence incidents in Victoria. Policy Paper 1.
3. Nicholas, R., Adams, V., Roche, A., White, M., & Battams, S. (2013). *A literature review to support the development of Australia's alcohol and other drug workforce development strategy*. Adelaide: National Centre for Education and Training on Addiction, Flinders University.

NADA Capability Framework

Domain 1: Foundational knowledge and practice

NSW non government AOD workers have, maintain and apply the knowledge required for effective practice.

Domain 2: Communication and engagement

NSW non government AOD workers demonstrate effective communication skills, and are accountable and responsible for the information they collect and maintain in the course of their work.

Domain 3: Access and equity

NSW non government AOD workers promote cultural safety, responsiveness and equity in service delivery and in practice, and actively pursue opportunities to promote social inclusion and to eliminate stigma and discrimination.

Domain 4: Ethical, safe and responsible practice

NSW non government AOD workers meet their ethical, professional, legal and regulatory obligations, and actively contribute to continuous improvement in safety and quality.

Domain 5: Personal and professional development

NSW non government AOD workers make an effective professional contribution and demonstrate active engagement in research and evaluation, continuing professional development, supervision and self-care.

Domain 6: Treatment and interventions

NSW non government AOD workers effectively assess, plan and deliver evidence-based treatment and interventions that are appropriate and responsive to the person's needs, strengths, goals, preferences and resources.

Beyond this resource

For further important considerations relating to engaging DFV perpetrators that are outside the scope of this resource, and for links to other relevant practice guidance designed to assist workforces without specialisation in DFV to develop the knowledge, understanding and skills required to engage DFV perpetrators, see Section 8 of this resource and NADA's online [Resources](#) page.

Acknowledgements

NADA gratefully acknowledges all the people and groups who contributed to the development of this resource, particularly the following:

- Rodney Vlasis, who led the development of this resource. Rodney is a policy consultant, trainer, researcher and supervisor in the area of gender-based violence, including men's use of domestic and family violence
- Simone Tassone, Consultant, specialist DFV responses
- Belinda Volkov, Clinical Coordinator, Sydney Drug Education & Counselling Centre
- Lauren Mullaney, Senior Psychologist, Triple Care Farm, Mission Australia
- Michelle Ridley, Clinical Program Manager, NADA
- Dr Suzie Hudson, Clinical Director, NADA
- NADA Practice Leadership Group
- NADA members who participated in the 2019 consultation workshop Exploring Healthy Relationships in the Context of AOD Service Delivery, including staff from WHOS, Holyoake, St Vincent de Paul Continuing Coordinated Care Program, Sydney Drug Education & Counselling Centre, Haymarket Foundation, Drug and Alcohol Health Services Inc, Mission Australia Triple Care Farm, Community Restorative Centre, Sydney's Women's Counselling Service, One80TC and Kedesh Rehabilitation Services.

How to navigate this resource

This resource has been designed to provide practice guidance on relevant considerations when engaging clients within an AOD treatment setting who are perpetrators of DFV. It is not intended to be a comprehensive guide to addressing behaviour change with people who perpetrate DFV, as it is acknowledged that this is a specialist area of work.

Sections 1 and 2 of this resource provide background understanding of DFV and of perpetrator choices to use DFV. They describe why it is important for AOD services and practitioners to consider issues of DFV perpetration as relevant to core AOD business.

Sections 3 and 4 focus on practitioner roles, responsibilities and parameters for engaging clients who perpetrate DFV on issues related to their violent and controlling behaviour, including actions to consider after or between sessions with the client.

Section 5 describes why and how perpetrators invite practitioners to collude with narratives and belief systems that justify and perpetrate their use of violent and controlling behaviour, and provide guidance and practice tips on how to respond in ways that minimise collusion.

Sections 6 and 7 describe men's behaviour change programs as the preferred intervention option for men who perpetrate DFV, outline why some other types of programs and approaches are not appropriate – and may potentially be dangerous – to refer these men to, and provide guidance on how to motivate and support men to participate in such programs.

Finally, Section 8 lists and briefly annotates further guidance and resources to help build on the material covered in this resource.

GLOSSARY OF TERMS

COERCIVE CONTROL	A pattern of domination of an adult and/or child (known as a victim-survivor) that includes tactics to isolate, degrade, exploit and control them. It affects the victim-survivor's sense of safety, identity and autonomy, and their relationships with and attachments to others.
COLLUSION	Any response of another person (including a practitioner, community leader, family member or friend) to a perpetrator that inadvertently or deliberately, indirectly or directly, indicates agreement with or support for any of the beliefs or thinking that the perpetrator uses to avoid taking responsibility for his violent and/or controlling behaviour. This can include signs of agreement with the narratives the perpetrator uses to deny, minimise or justify his behaviour, to blame the victim-survivor or others, to pathologise the victim-survivor, or to portray himself as the victim; or with the gendered attitudes and beliefs that underpin his choices to use violence.
DOMESTIC AND FAMILY VIOLENCE (DFV)	Any violent, controlling, abusive or intimidating behaviour carried out by an adult to control, dominate or exert power over any adult or child with whom they have or have had an intimate or familial relationship. Behaviours, tactics and acts that constitute DFV include physical, sexual, psychological, emotional, verbal, social and economic abuse, and harassment and stalking. These often occur simultaneously and systematically and have the effect of coercing and controlling the victim-survivor. DFV causes fear, as well as psychological and sometimes physical harm. DFV occurs along a spectrum of risk, ranging from subtle exploitation of power imbalances to escalating patterns over time. It is a deeply gendered issue rooted in structural inequalities and imbalances of power between women and men. Many forms of DFV are offences under the NSW Crimes (Domestic and Personal Violence) Act 2007.
EVIDENCE-BASED RISK INDICATORS	Indicators relating to the perpetrator's behaviour, the victim-survivor's situation or other circumstances, that research has linked to increased DFV risk, including increased risk of the perpetrator using violence that causes serious injury or death.
INTEGRATED DFV RESPONSE SYSTEM	The system of structures, mechanisms and processes through which a range of relevant government and non-government agencies collaborate towards coordinated information sharing, risk assessment and risk management responses aimed at promoting victim-survivor safety and keeping perpetrators within view and accountable to victim-survivor needs. While often not considered part of the 'inner ring' of integrated responses, AOD services have an important role to play in the wider constellation of services that collaborate towards these goals.
INVITATIONAL PRACTICE	A practice approach that uses respectful questioning to provide opportunities for a client to reflect and focus on his own behaviour, keeping open the space when the client attempts to deflect the conversation, blame others or avoid taking responsibility for his behaviour.
LOCAL COORDINATION POINT	A government support agency or non-government support service nominated by the Minister for Justice as a local information sharing hub, which may collect information about an adult victim-survivor, their children and a perpetrator, and provide case coordination towards the goals of victim-survivor safety and perpetrator accountability.
MEN'S BEHAVIOUR CHANGE PROGRAM	A program that works with men who perpetrate DFV, their current or former partners and sometimes their children. These programs typically involve ongoing assessment, group and individual sessions or case management for men aimed at stopping their violent and controlling behaviours; support, information, referral, safety planning and sometimes counselling and case management for victim-survivors; and coordinated and collaborative risk assessment and management in the context of integrated multi-agency responses.

PART 13A	Part 13A of the NSW Crimes (Domestic and Personal Violence) Act 2007, which facilitates the collection, use and disclosure of personal and health information in cases involving DFV.
PERPETRATOR	A person who is using and/or has recently used DFV. Terms such as 'men who use violence' or 'men who perpetrate violence' are sometimes used as alternatives, in order to locate DFV as behaviour that a person (typically a man) chooses to engage in rather than as something inherent in the person.
PERPETRATOR INTERVENTION	Any action, initiative or strategy aimed at promoting the safety of victim-survivors through responses to perpetrators. Perpetrator interventions includes programs conducted by specialist DFV agencies and practitioners as well as responses by those without such specialisation.
PREDOMINANT AGGRESSOR	An alternative to the term perpetrator in situations where a victim-survivor uses an act of force in self-defence or as an assertion of resistance or dignity. The predominant aggressor is the person in the relationship using patterns and multiple tactics of coercive controlling violence.
PRIMARY AGGRESSOR	The person using force in a particular incident, who may or may not be the perpetrator or predominant aggressor in the relationship. Victim-survivors can sometimes be aggressors, their acts of aggression typically carried out in self-defence and/or as assertions of resistance or dignity within the context of their partner's patterned use of coercive controlling violence. Victim-survivors who are aggressors use violence to gain temporary control over an unsafe situation in an attempt to achieve safety for themselves and/or their children, while perpetrators of DFV use patterned tactics in an attempt to gain permanent control over victim-survivors.
RISK ASSESSMENT	The ongoing process of obtaining information from multiple sources in order to determine the likelihood of DFV occurring or continuing, the seriousness of the risk to the victim-survivor(s), and the imminence of any risk. It includes consideration of changes in circumstances, behaviours and events that might be associated with acute spikes in risk. It often involves a structured professional judgement approach that combines the victim-survivor's experience of fear and judgements about risk, the presence of evidence-based risk indicators and the professional judgement of practitioners involved in working with the victim-survivor and/or the perpetrator. Obtaining relevant information about risk from other agencies that have also worked with one or more family members can be critical to risk assessment.
VICTIM-SURVIVOR	An adult or child who is experiencing or has experienced DFV. Victim-survivors are subject to patterned coercive control, and hence usually hold a level of fear and also lack real or felt autonomy.
VIOLENCE-SUPPORTING NARRATIVES	Patterns of thinking that a perpetrator adopts to justify his use of violent and controlling behaviours, generally underpinned by entitlement-based and other gendered beliefs and attitudes. These can include narratives through which the perpetrator erroneously convinces himself and attempts to convince others that he is the victim of the victim-survivor's 'unreasonable' or 'defiant' behaviour towards him.

ACRONYMS

ADVO Apprehended Domestic Violence Order

AOD Alcohol and Other Drug(s)

DFV Domestic and Family Violence

MBCP Men's Behaviour Change Program

MRS Men's Referral Service

NADA Network of Alcohol and other Drugs Agencies

NGO Non government organisation

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1

NADA Practice Resource

UNDERSTANDING DOMESTIC AND FAMILY VIOLENCE



KEY POINTS AND PRINCIPLES

- Domestic and family violence (DFV) generally takes the form of patterns of coercive controlling behaviour, where the perpetrator uses a range of tactics to control, to varying degrees, the victim-survivor's life.
- We need to shift away from asking "Why doesn't she leave?" towards asking "Why doesn't he stop his violent and controlling behaviour?".
- Victim-survivor decisions and actions that might seem counterproductive on the surface – for example, to stay with an abusive partner, not to disclose the violence to services, to defend him as 'a good man who means well' – can make perfect sense when considered in light of the perpetrator's patterns of behaviour and tactics of coercive control; of the victim-survivor's own assessment of what is safest for herself and her children at any given moment; her past experiences of reaching out for help; and whether she believes that the system is able to protect her.
- Furthermore, within the context of a deep desire to maintain a family and/or be part of a loving relationship, a woman's preference might be for the relationship to continue but for the man's violent and controlling behaviour to stop. Staying in a relationship can be a way of holding on to the expectation that one has a right to be and feel safe with the person they love, without experiencing violence.
- Alcohol and/or other drug (AOD) use does not cause a man to perpetrate DFV; however, it can be implicated in a man's choice to use violence on specific occasions, and in the severity of the violence he chooses to use. Reducing AOD use alone will not address the pattern of behaviours that a man uses to instil fear and maintain power and control over family members. It also will not address the underlying belief systems and attitudes that underpin his choices to use violence. Addressing AOD use can, however, be an important part of a multipronged approach to reducing risk.
- International studies suggest that 30–40 per cent of men participating in AOD interventions are perpetrators of DFV and/or of sexual violence outside of the context of intimate relationships.
- All DFV behaviour is a choice, for which the perpetrator is 100% responsible.
- Men who perpetrate DFV often adopt 'victim-stance thinking', through which they deny, minimise, justify and blame others (typically their partner) for their behaviour. They use this thinking to give themselves permission to use violent and controlling behaviour.
- As practitioners and community members, we can be empathic to some of the difficult situations that some perpetrators have experienced in their lives, while still expecting them to make non-violent choices.

1.1 DFV and coercive control

In recent times, community understanding of domestic and family violence (DFV) has been showing signs of a shift. There is growing awareness of sexual, emotional, social, financial and spiritual abuse, and that these forms of violence can affect victim-survivors at least as much as physical violence. However, DFV is still often misconceived as occurring when the perpetrator 'loses control of his anger'.

The reality is that most perpetrators use a range of tactics to coercively control and entrap their family members. These might include the various forms of violence listed above and/or myriad small actions that to outsiders often seem innocuous in themselves.

Understanding coercive control – the harmful and unwarranted control of one person by another – is critical to understanding the impact that perpetrators have on family members' lives. DFV is about the patterns of behaviour that a perpetrator uses that affect their family members' safety, autonomy, liberty and space for action in their own lives.

Coercive controlling violence has an impact on the whole family. A perpetrator's actions can affect the safety, stability and development of children, including through the numerous ways in which he might directly or indirectly sabotage their mother's parenting of and relationships with them, and the family's access to and connections with appropriate services and cultural supports.

Understanding DFV as patterned behaviour includes being alert to ways in which a man might use services and systems to enhance his coercive control.

A focus on incidents rather than patterns of violence can lead to victim-survivors being unfairly blamed and held partly or wholly responsible for the violence they experience. It is still quite common for services to misunderstand victim-survivor 'messiness' – such as their own AOD use, making and then withdrawing disclosures, inconsistent attendance at appointments, leaving and then returning to the perpetrator, lack of proactivity in making connections with services to address children's needs – as actions that 'fail to protect' their children and that sabotage efforts by service providers to help them.

When we understand the kinds of things a perpetrator might be doing to destroy his partner's worth as a person and as a mother, to limit her freedom and confidence to act in the world and to make her feel responsible for his use of violence, our focus can then shift from 'What does this say about her?' to 'What does this say about him and his behaviour?' Sometimes, an act that might seem nonsensical to an outsider is the exact thing that the victim-survivor needs to do at that moment for her and her children to stay safe from the perpetrator's behaviour.

Understanding DFV as patterned behaviour includes being alert to ways in which a man might use services and systems to enhance his coercive control. Examples include using the child protection, family law or family support services to label a victim-survivor as an incapable and erratic parent; using the mental health system to label her as 'personality disordered' or 'neurotic'; using police to arrest her when she uses force to resist his violence; and using AOD services to pathologise her AOD use.

1.2 DFV and AOD use

International studies suggest that approximately 30–40 per cent of men participating in AOD interventions are perpetrators of DFV and/or of sexual violence outside of the context of intimate relationships.¹ This means that a significant proportion of men presenting to AOD services will currently be using, or have recently used, DFV.

It is also widely recognised that perpetrators of DFV with AOD use problems pose a higher risk of inflicting serious injury.²

AOD use does not cause men to start using DFV in the first place, nor is it a causal factor in a man's choices to continue using DFV over time. In the vast majority of cases, therefore, assisting a DFV perpetrator to bring problematic AOD use under control will not, in and of itself, reduce the risk of his continuing to use violent and controlling behaviour.

DFV generally comprises a pattern of behaviours and, while an AOD-affected perpetrator might be more likely to use certain behaviours as part of this pattern and/or to use them more severely, reducing his AOD use will not address the pattern of behaviours through which he instils fear and maintains power and control over family members, or the underlying belief systems and attitudes that underpin his choices to use violence.

The mechanisms linking AOD use to increased severity in the use of some violent behaviours are not yet well understood. The Victorian Alcohol and Drug Association (VAADA) has suggested that 'the misuse of substances might increase risk for an episode of violence because it acts to heighten men's consciousness and engagement with their violence-supporting narratives, thereby helping to activate the processes by which they give themselves permission to use violence'.³ For example, a man with underlying beliefs such as 'Women can't be trusted' and 'I have a right to know who she's out with' might, when alcohol-affected, increase his rumination on pre-existing unhelpful or dangerous thoughts, such as 'I know she's seeing that guy from work. She's not responding to my texts – she must be in bed with him', which make him feel vindicated to control, surveil and punish her.

Studies of victim-survivor experiences report that perpetrator AOD use can heighten the perpetrator's irritation stemming from highly gendered entitlement-based beliefs and their 'need' to control their partner – for example, when she is not performing household duties to his expectations, or when she does not follow a rule that he has set.⁴ The victim-survivors in these studies viewed and experienced the perpetrator's AOD use as part of a wider pattern of abusive and controlling behaviours, whereas when asked about their own perspectives, the perpetrators focused only on particular incidents of using violence rather than on their wider patterns of behaviour, and clearly attributed the cause to intoxication.

Research also indicates an increased risk of using violent behaviour when a perpetrator is highly irritable while withdrawing from or craving alcohol, heroin or some other substances, or when his partner refuses his demands to engage in legal or criminal activity to procure money or substances to support his use.⁵

1. Radcliffe, P., & Gilchrist, G. (2016). 'You can never work with addictions in isolation': Addressing intimate partner violence perpetration by men in substance misuse treatment, *International Journal of Drug Policy*, 36, 130-140.
2. Vlasis, R., Ridley, S., Green, D., & Chung, D. (2017). Family and domestic violence perpetrator programs: Issues paper of current and emerging trends, developments and expectations. Perth: Stopping Family Violence, p 56. <https://sfv.org.au>; Yates, S. (2019). 'An exercise in careful diplomacy': talking about alcohol, drugs and family violence. *Policy Design & Practice*, 2(3), 258-274.
3. Victorian Alcohol and Drug Association. (2012). Connections: Family violence and AOD. Melbourne: VAADA Position Paper, p 17.
4. Gilchrist, G., Dennis, F., Radcliffe, P., Henderson, J., Howard, L., & Gadd, D. (2019). The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy*, 65, 8–23.
5. *ibid.*

1.2.1 How AOD use can affect a perpetrator's pattern of DFV

There are several ways in which a perpetrator's AOD use might affect the DFV risk he poses to affected family members. These include the following:

- AOD use might have little impact on his ongoing/predetermined choices to use DFV.
- Same-day AOD use might correlate with choices to use particular DFV tactics that day.
- Same-day AOD use might correlate with severity of use of DFV that day.
- AOD use might correlate with frequency of use of DFV.
- The perpetrator might have recruited the victim-survivor into AOD use in order to have someone to drink or use with and/or to help obtain substances, including coercing her into criminal behaviour such as theft, unwanted sex work or drug dealing.
- The perpetrator might have recruited the victim-survivor into AOD use and/or encouraged her to become/remain dependent on substance(s) in order to more easily control her, make/keep her dependent on him and/or to criticise and pathologise her AOD use to social services and family and community networks ("The kids need me at home because she drinks every day...").
- He might use substance(s) to instil fear – for example, he might know that his AOD use will make the victim-survivor feel afraid.
- He might use substance(s) to trigger conflict and thus to provide an excuse to use violent and controlling behaviour – for example, he might deliberately set up a situation where he can punish his partner for impinging on his perceived 'right' to drink when she tries to limit his drinking out of fear that this will increase DFV risk.
- He might use substance(s) as an excuse to use violence – becoming intoxicated might be part of his decision-making chain of steps towards justifying his upcoming use of violence.
- He might blame his violent behaviour on the substance(s) in order to avoid taking responsibility for his behaviour.
- He might use substance(s) at certain times to control his partner's movement, freedom and social connections, such as by making her stay up late to drive him to or from social outings so that he can drink. This can also have the effect of creating embarrassment and discomfort for her when she is forced to stay around while waiting for him to be ready to leave.

1.3 Understanding DFV as a choice

The act of using violent and/or controlling behaviour is always a choice. No matter how intensely a perpetrator feels anger or any other emotion, no matter how aggrieved (rightly or wrongly) he feels, no matter how intoxicated he is, no matter what traumatic situations he has experienced, and no matter how 'out of control' he feels, the use of violence is always a choice.

Perpetrators rarely see their behaviour as a choice. They are usually unaware of the thought processes they use to give themselves permission to use violence. This does not make their violence any less of a choice.

Men who use DFV have often made these choices over a period of many years, literally hundreds of times, to control their partners' actions in small or large ways. When violent and controlling behaviour is chosen over and over again, it becomes a more immediate choice, and it can become more difficult to identify and untangle the steps involved in making that choice. The perpetrator's thoughts that he uses to give himself the 'green light' to use violence, and his deliberate intentions or goals in choosing violence, can become so automatic to him that he experiences himself as 'losing it' and being 'out of control'. He might blame his partner and/or the substance(s) he is using for 'making him lose it', when in fact he is making choices all along the way.

Perpetrators rarely see their behaviour as a choice. They are usually unaware of the thought processes they use to give themselves permission to use violence. This does not make their violence any less of a choice.

What often underpins these choices is a collection of beliefs that many men who use DFV draw on from wider patriarchal cultures and societal influences – beliefs about women, about what it means to be a man, about how men and women should behave in relationships, and about the use of power. When their partner does something that 'contravenes' the rules and expectations that the perpetrator has set regarding what she should or shouldn't do as a woman or as his partner, he might then feel entitled to use violent or controlling behaviour against her.

Men draw these beliefs from multiple sources. Some men are influenced by what they learned from their family of origin. Some are influenced by the ways in which particular peer communities or networks promote or reinforce these beliefs. All men are exposed, to varying degrees, to the numerous subtle and not-so-subtle messages and examples in everyday life that shape our attitudes about gender. Men who perpetrate DFV might commit particularly heavily to some of these beliefs.

For example, some DFV perpetrators have strong beliefs that it is a woman's role to respond to her partner's sexual 'needs'; that men are 'entitled' to sexual gratification from their partner; that women cannot be trusted and therefore need to be 'protected' from other men; and that a man's partner is an 'object' or 'possession' that other men might try to take away from him. These beliefs then heavily influence the choices that man might make when he feels jealous, when his partner moves out and about in the world, and when he perceives a particular man or men in general as a threat.

1.4 Seeing the perpetrator both as someone causing harm and (maybe) someone who has been harmed – but who has a choice not to harm

As practitioners and as community members, we can be empathic to some of the difficult situations that some perpetrators have experienced in their lives, while still expecting them to make non-violent choices in the present.

We can understand the previous and current conditions and cultural and societal influences in a perpetrator’s life that make it easier for him to choose violence, to feel entitled to use power and control and to focus on getting his own way at the expense of his family members. We can be sensitive to his own experiences of marginalisation and discrimination, of what he has come up against in his life – whether that might be homelessness, poverty, racism, childhood experiences of violence and so on.

At the same time, we can still expect him to choose non-violence in the present, and not to use these experiences and circumstances as an excuse for behaviour that causes harm to others. Many people who have experienced highly adverse and traumatic situations do not go on to use DFV. And many perpetrators of DFV have experienced quite privileged lives.

1.5 Understanding the perpetrator’s ‘victim stance’

Perpetrators characteristically adopt a way of thinking about their behaviour, their partners and their intimate relationships that can be termed the ‘victim stance’. This is demonstrated in the following hypothetical scenario involving James and Olivia.

<p>James and his partner Olivia go to a club in the centre of town. James is older than Olivia and considers himself more worldly and tougher than she is. He’s pretty sure she has no idea that guys hit on her all the time because of how she looks.</p> <p>James, who has been drinking steadily, comes back from the toilets to find Olivia chatting with a guy her own age. She appears friendly and chatty.</p>	<p>In some situations, perpetrators might start out with ‘honourable’ intentions, in this case to ‘protect’ their partner. However, these intentions can be influenced by sexism, a sense of male superiority and gender inequality.</p>
<p>James says to himself:</p> <p>“I’ve told her over and over again not to go up and talk to guys she doesn’t know. It’s not safe. I keep telling her, but she just doesn’t listen! She’s doing it to get back at me for that fight about how she cooked the eggs this morning.”</p>	<p>It is common for perpetrators of DFV to feel powerless and to see themselves as victims. They also tend to see themselves as ‘the centre of the world’, and believe that they should be the centre of their partner’s world – and that everything she does is somehow done to hurt, target or undermine them.</p>
<p>James swaggers over to Olivia and puts his arm heavily around her shoulders. When she starts to shrug him off, he tightens his grip. The man she is talking with stiffens and asks Olivia, ‘Is everything alright?’ James snarls at him and steers Olivia away, towards the bar. There, he demands a double vodka and orders Olivia to sit down.</p>	<p>Using AOD can be a way for perpetrators to give themselves a licence for violence. It can also be a tactic used to make family members afraid. AOD use is not a driver or a cause of DFV, but it can increase the risk of the use of more severe forms of violence.</p>
<p>Olivia sits, but then says mildly, ‘That guy was a friend from primary school’.</p> <p>In his head, James says:</p>	

<p>"Bullshit, you wouldn't talk to an old friend like that. He must be an ex. She just talked to him to make me react. But if he's an ex, maybe he's going to try to get back together with her. What if..."</p>	<p>Jealous narratives are an indicator of DFV risk.</p>
<p>The evening is ruined, but James and Olivia spend another hour at the bar while James broods on Olivia's interaction with her 'old friend'. He's pissed off she hasn't apologised for talking to someone else.</p>	<p>It is common for perpetrators to focus on themselves, and to ruminate and feel entitled to enforce their expectations of, and the rules they set for, partners or other family members.</p>
<p>When they leave, James insists on driving home, because, he says aloud: "Even drunk I'm a better driver than you."</p>	<p>Mild insults and disparaging remarks are frequently part of a DFV presentation.</p>
<p>Upon arriving home, James waits again for Olivia to apologise, and when she doesn't, he finally confronts her about 'her behaviour' back at the club:</p>	<p>Perpetrators often build themselves up for violence, brooding on the story of victimhood they tell themselves.</p>
<p>"So what was going on back there? You looked pretty cosy with that guy. Who is he really? Did you arrange to meet him there so I'd get jealous?"</p>	<p>Perpetrators' stories and narratives don't always make sense to outsiders, but provide perpetrators with a 'green light' to use violence.</p>
<p>His voice rises and he clenches his fists: "You knew I'd react, didn't you?"</p>	<p>Given the societal context of men's violence against women, sometimes a gesture is all that's needed to intimate a threat.</p>
<p>Then, more quietly: "You're just a slut. I can't trust you at all. You'll chat with any guy who wanted a piece of you."</p>	
<p>Olivia, quite frightened by now, speaks quietly and deliberately: "I knew him from school. We just bumped into each other. It was really nothing. I won't do it again."</p>	<p>One of the reasons perpetrators use violence is that it works. Olivia is now unlikely to talk to another man at a club again, and James knows that this is the consequence of his actions. The violence has also given James a chance to 'blow off steam', relieving him of his difficult emotions – at least for now.</p>
<p>James is slightly mollified: "Okay. But you know what will happen if you do."</p>	<p>James isn't out of control. He can hear and respond to Olivia's assurances. He expects Olivia to respect his authority.</p>
<p>Over subsequent days, James thinks again about the incident at the club. He continues to harbour suspicions about the 'old friend'. He trawls back through Olivia's Facebook feed to see if the guy is there (he's not) and rechecks her credit card statements to see of anything's out of the ordinary (nothing is).</p>	<p>A perpetrator's sense of entitlement – to monitor, control and regulate the victim's life – is a core feature of DFV. Often this is justified by the perpetrator's belief that he knows better, or that he is acting in the victim's ultimate best interests.</p>
<p>He tells Olivia she won't be going to her friend's hen's night and – just to make sure – he tells the friend that Olivia doesn't want to go. When Olivia finds out from her friend that James has told her friend this, she confronts him, screaming 'What the fuck were you doing talking to my friend like that?' and slaps him hard across the face, breaking his nose and causing him to bleed heavily. James calls the police.</p>	<p>Perpetrators use a range of tactics to reassert control when their victim-survivors do not comply with their entitlement-based expectations. By blaming Olivia for his feelings of jealousy, James sees himself as the victim, and therefore feels entitled to use social violence, financial violence, emotional violence, intimidation and threats to control her behaviour. In these situations, many perpetrators will also use sexualised violence to 'shore up' their claim on their partner. It is this pattern of behaviour that constitutes DFV. James now seizes on a 'gotcha' moment to call the police, and to attempt to portray Olivia as the perpetrator and himself as the victim.</p>

1.5 Understanding the perpetrator's 'victim stance' (continued)

As can be seen in this hypothetical scenario, perpetrators use a range of tactics to reassert control when their victim-survivors do not comply with their entitlement-based expectations.

DFV behaviour like James's becomes entrenched for a number of reasons. Firstly, it 'works'. Many men experience a 'resolution' (albeit often only temporary) of their feelings of anger or jealousy after a violent incident. At the same time, victim-survivors like Olivia – despite doing the best they can to resist the controls placed on them – restrict their behaviour out of fear.

Secondly, perpetrators repeat the same excuses, minimisations and justifications for violence after hundreds if not thousands of incidents, reinforcing their own narratives each time. What's more, when victim-survivors are continually undermined, they often start to doubt their own judgement and make excuses for their partner's behaviour.

For many perpetrators, this 'victim stance' thinking – fuelled by beliefs about men's and women's roles, entitlement-based expectations and self-centred and defensive (sometimes even 'paranoid-like') thinking – is at the core of why they do not take responsibility for their behaviour.

Crucial to understanding perpetrator's self-deception is the concept that while coercive controlling behaviour involves the intentional use of a wide range of tactics to exert power and control, perpetrators often do not think about their behaviour in these ways.

Crucial to understanding perpetrator's self-deception is the concept that while coercive controlling behaviour involves the intentional use of a wide range of tactics to exert power and control, perpetrators often do not think about their behaviour in these ways.

Victim stance thinking, and the 'gender blindness' that comes with male privilege, means that perpetrators generally do not, on their own, reflect on the purpose behind their actions. Indeed, as highlighted earlier, they are more likely to consider their behaviour as justified responses to the 'unfair' behaviour of others.

The strength of this victim stance thinking leads perpetrators not only to justify their use of violence but also to minimise and even deny it. Moreover, the self-deception runs deeper in that the perpetrator does not perceive his expectations and rules about how the other person should and shouldn't behave, nor his focus on exerting his will and getting his own way, as wrong.

Perpetrators draw on broader belief systems and ideas in our society and culture about women's and men's roles, masculinity, and what they should expect and be entitled to, in the process of forming what they see as taken-for-granted, 'natural' rules and expectations. They do not see their behaviour as reflecting particular choices, enacted through male privilege and gender-based conditioning regarding what to believe and expect.

2

NADA Practice Resource

HEALTHY RELATIONSHIPS, DFV AND AOD WORK



KEY POINTS AND PRINCIPLES

- Effective, integrated treatment for AOD issues needs to include support for clients to develop healthy relationships. The use of DFV severely harms the potential for healthy relationships, including for the perpetrator.
- Decisions about whether, when and how to bring a client's use of DFV into conversations with the client are complex. However, while there might be times when a practitioner decides it is not safe (to the client's family and/or to the practitioner) to discuss a client's use of DFV with the client, it is crucial not to ignore or avoid this issue altogether.
- There are several ways in which a client's unaddressed use of DFV can significantly interfere with the effectiveness of AOD intervention.
- Considering a client's use of DFV is an important part of case planning and of offering professional, quality AOD services focused on AOD-related goals.
- We are all part of a broader community responsibility not to tolerate the use of DFV. We all have a role to play – as practitioners and as people – to promote safety for victim-survivors and to provide opportunities for those causing harm to take responsibility for their behaviour.
- AOD services are increasingly working collaboratively with mental health and housing services, due to the interconnectivity of these issues. Similarly, collaboration between AOD and DFV victim-survivor services is starting to build, and this collaboration can extend to DFV services working with perpetrators.
- AOD practitioners also have a duty of care to those who are not in the counselling room – including any adults and/or children affected by a client's use of violence. Keeping in mind their safety can be just as important – if not more so – than the actual work done with the client on his AOD issues.

2.1 How these three issues relate to each other

The health of clients' current and future relationships is an important consideration in AOD work. Effective, integrated treatment for AOD issues needs to include support for clients to develop healthy relationships. Connectedness has been identified as one of the five key processes that support recovery from AOD issues (the others being hope and optimism about the future, identity, meaning in life, and empowerment). Active engagement in the community and supportive social networks have been found to be key to changing problematic AOD issues.¹

AOD practitioners spend considerable time focusing – both directly and indirectly – on clients' relationships with family members and intimate others. A client's ethics, values and goals regarding their relationships can be a motivating factor towards their participation in AOD treatment. Positive, safe and respectful relationships are fundamental to health and wellbeing and can enhance people's lives and build self-esteem, but they don't just happen – they take time to build and need work to keep them healthy.

The use of DFV severely harms the potential for healthy family relationships, including for the perpetrator. It is not possible for a relationship to be healthy while one person feels unsafe, and while their space for action in their life and relationship is tightly controlled by the other. It is similarly not possible for men to have positive relationships with their children while they are using violence against their children's mother.

Helping to create genuine hope and optimism for a client's future, in terms of what might be important to him (for example, a healthy family environment, a positive identity as a good father), requires that AOD service case plans and goals include cessation of his use of DFV. In most situations, this will require his participation in a specialist DFV men's behaviour change program (MBCP).



To encourage this, an AOD practitioner can:

- use their existing motivational interviewing skills to focus on the client's aspirations and hopes for his life and relationships
- work on AOD use reduction goals
- simultaneously introduce the benefits (to the client and to his relationships) of participation in an MBCP, focusing on how it is in the client's best interests in terms of what matters to him about his life to do so.

1. Best, D., & Lubman, D. (2012). The recovery paradigm: A model of hope and change for alcohol and drug addiction. *Australian Family Physician*, vol. 41, no. 8, pp. 593-597.

2.2 Why it is important not to ignore a client's use of DFV

Decisions about whether, when and how to bring a client's use of DFV into conversations with the client are complex. However, while there might be times when a practitioner decides it is not safe (to the client's family and/or to the practitioner) to discuss a client's use of DFV with the client, it is crucial not to ignore or avoid this issue altogether.

Ignoring a client's violent and/or controlling behaviour can result in a missed opportunity to address the safety and wellbeing of the adults and/or children affected by this behaviour. In the most severe cases, this could be a missed opportunity to save a life.

There are also several ways in which a client's unaddressed use of DFV can significantly interfere with the effectiveness of an AOD intervention, including the following:

- Due to the destructive effects on relationships, DFV perpetration breeds isolation and disconnectedness, making it harder for the client to decrease his use of AOD.
- While AOD use does not cause a perpetrator to use violence, many perpetrators choose to use substances as a tactic of control. AOD use can create a climate of fear that the perpetrator uses to enforce his 'rights' (for example, he knows that cracking open a can will make her feel afraid, or will provide an 'excuse' for him to use violence if she tries to limit his drinking). Using substances can therefore be a deliberate part of a pattern of coercive control.
- AOD use can enable perpetrators to 'excuse' their use of violence by blaming it on the substance.
- Some DFV perpetrators deliberately encourage their partner to use AOD (and/or sabotage their partner's efforts to reduce AOD use) as a controlling tactic to create dependency and keep her trapped in the relationship, and/or to pathologise her to wider family networks and the service system.
- Motivational interviewing towards AOD therapeutic goals requires the careful unearthing of dissonance between a client's behaviour and their underlying ethics, goals and hopes for themselves and for their life. For many DFV perpetrators, the continued use of violence requires ongoing suppression of these underlying goals and hopes in order to avoid experiencing this dissonance. It can be very difficult for a perpetrator to live up to his own values while he is perpetrating DFV.
- Perpetrators who want to do something about their behaviour but who are not participating in a specialised MBCP can feel great shame about their behaviour and low self-efficacy about their ability to change. Within this context it can be difficult for them to set and feel confident about meeting substance use reduction goals.

For these and other reasons, considering a client's use of DFV is an important part of case planning and of offering professional, quality AOD services focused on AOD-related goals.

AOD practitioners also have a duty of care to those who are not in the counselling room – including adults and/or children affected by a client's use of violence. Keeping in mind their safety can be as important – if not more so – than the actual work done with the client on his AOD issues.



Imagining the client's partner and children in the room

It can sometimes help, when providing services to a client who is perpetrating DFV, to imagine his partner and children being in the room with you – even if you have never met them – in order to imagine what they would want from you and your service, given what they are experiencing as a result of your client's behaviour.

2.3 Playing our part in a broader community responsibility

We are all part of a broader community responsibility not to tolerate the use of DFV. We all have a role to play – as practitioners and as people – in not ignoring the issue.

Avoiding the issue because we are afraid to upset our client is not acting in his best interests. It also perpetrates the community silence through which victim-survivors continue to suffer, and are sometimes killed.

Enacting this responsibility does not mean that we need to 'go it alone'. Working collaboratively with other relevant services and service sectors is important. Many AOD services and practitioners work closely with other services, including those focusing on mental health, housing and justice, as collaborative and holistic practice best supports clients experiencing AOD issues. Working in partnership with specialist DFV services, including those that work with men who perpetrate DFV, is also important and benefits the client and those affected by his behaviour.

We are all responsible for working together to stop DFV. By doing so we can all play a role in preventing women and children from being killed, seriously injured or traumatised, and their quality of life from being substantially harmed.

3

NADA Practice Resource

OPPORTUNITIES AND PARAMETERS FOR STEPPING IN



KEY POINTS AND PRINCIPLES

- Men's behaviour change work is highly complex, challenging and specialised. There is serious risk of inadvertently causing harm to the safety of victim-survivors if this work is attempted by anyone unqualified to do it.
- All AOD practitioners, across all AOD service contexts, have opportunities to identify clients who are or might be perpetrating DFV, to listen for risk indicators that suggest family members might be facing serious and/or imminent risk, and to appropriately share information with other agencies when there are concerns about safety, in order to contribute towards managing risk.
- All AOD practitioners must attempt to minimise collusion with a perpetrator's excuses, minimisations, 'other-blaming' and justifications used to avoid taking responsibility for his behaviour, and with his violence-supporting narratives and beliefs.
- Many AOD practitioners will have opportunities to provide 'warm referrals' for clients using DFV to specialist MBCPs, and to support their uptake of these referrals.
- Some AOD practitioners, in some circumstances, will have opportunities to engage in more detailed and nuanced conversations with clients about their use of DFV (while stopping short of engaging in specialist men's behaviour change work). These might include conversations to explore risk, to integrate DFV reduction goals into their overall case plan, to conduct immediate and short-term safety planning (i.e. what the client can do to build rather than jeopardise safety for his family members), and to actively support the client's participation in an MBCP. This more nuanced approach can also involve strengthened collaboration with other services to jointly address DFV risk.
- All AOD practitioners – irrespective of what they can or cannot do in any given context – must be guided by the core principles that:
 - the safety of the client's family members, of the client himself and of the practitioner must underlie everything the practitioner does
 - the client is 100 per cent responsible for his use of violence
 - violence is always a choice
 - considering a client's use of DFV is an important part of providing professional, quality services in the best interests of the client and those affected by his use of violence.
- Any AOD practitioner, at any time, can contact the Men's Referral Service on 1300 766 491 to ask for an immediate secondary consultation to guide their approach to a client that they know or suspect is a perpetrator of DFV.

3.1 The role of an AOD practitioner is not to attempt DFV behaviour change work

It is important to be very clear about what is and is not part of an AOD practitioner's role when having conversations with a client about his DFV use.

An AOD practitioner's role will never be to conduct men's behaviour change work with clients, unless that practitioner also happens to be an experienced and qualified specialist men's DFV practitioner and have the service system safeguards to do so. Men's behaviour change work is highly complex, challenging and specialised. There is serious risk of inadvertently causing harm to the safety and wellbeing of victim-survivors if this work is attempted by anyone unqualified to do it.

Men who cause DFV harm generally require active participation in a specialised MBCP to change their behaviour. This is a specific type of program that is part of an integrated DFV response system. Individual counselling is generally not enough, and can even cause harm if the wrong approach is used.

Any AOD practitioner, at any time, can contact the Men's Referral Service on 1300 766 491 to ask for an immediate secondary consultation to guide their approach to a client that they know or suspect is a perpetrator of DFV.

3.2 Opportunities available to AOD practitioners when working with clients who use DFV

All AOD practitioners, across all service contexts, have opportunities and responsibilities to:

- **identify** clients who are or might be perpetrating DFV
- listen for particular **risk indicators** (or 'red flags') that might suggest that a client poses a serious and/or imminent threat to the safety of any family member(s)
- appropriately **share information** with other agencies and services regarding concerns about serious and/or imminent risk to family member safety, to contribute towards multi-agency approaches towards managing risk
- **minimise collusion** with the excuses, minimisations, other-blaming and justifications that perpetrators use to avoid taking responsibility for their use of violence
- **contribute to accountability-focused community responses** that locate responsibility for violent and controlling behaviour with the perpetrator's choices
- (when safe to do so) *name* a client's behaviour as DFV, in ways that respectfully invite him to consider the seriousness of this behaviour and its impacts on others and on himself.

Many AOD practitioners will also have opportunities to:

- provide '**warm referrals**' for clients who use DFV to specialist services that address men's use of DFV (i.e. the Men's Referral Service and/or an MBCP)
- use motivational interviewing and other motivation-enhancement strategies to encourage these clients to **become ready to take up these referrals**
- follow up with clients later about these referrals.

Some AOD practitioners will also have opportunities to:

- engage in **moderately in-depth assessment-based conversations** with clients about their use of DFV – not in order to change their behaviour but in an attempt to understand the risk they pose to family members and how their behaviour relates to their AOD use and AOD-related intervention goals
- bring **clients’ use of DFV directly into their case plan and goal-setting processes** – again, without attempting behaviour change work; where possible this should be guided by secondary consultations with specialist DFV perpetrator intervention expertise or in collaboration with an MBCP provider and/or child protection, community corrections or other involved services
- scaffold **immediate and short-term safety planning with clients** regarding the risk their DFV behaviour poses to family members, to help the client identify and use violence-interruption strategies during situations in which he might be most tempted to use violence; this can include **helping and motivating the client to meet the conditions of any protection order or other court-imposed conditions** designed to keep his family safe
- **support clients as they participate in MBCPs**, check in with them about what they are learning and struggling with throughout the program, and liaise with the MBCP provider so that all services working with a particular client are ‘on the same page’ about both his AOD and DFV use
- contribute to **collaborative and coordinated** risk assessment, safety and accountability planning and other risk-management activities designed to minimise risk and opportunities for further harm.



Important

This resource does not provide guidance on how to engage clients who perpetrate DFV towards some of these more nuanced goals, such as immediate and short-term safety planning and coaching in the use of preliminary violence-interruption strategies. Section 8 outlines some additional resources that may assist you to do so.

All AOD practitioners – irrespective of what they can or cannot do in any given context – must be guided by the core principles that:

- **the safety of the client’s family members, of the client himself and of the practitioner must underlie everything the practitioner does**
- **the client is 100 per cent responsible for his use of violence**
- **violence is always a choice**
- **considering a client’s use of DFV is an important part of providing a professional, quality service in the best interests of the client and of those affected by his use of violence.**

A man’s journey towards reducing and ultimately giving up his use of violence can be very long, nonlinear, interrupted and convoluted. It often takes many actions by a number of services, practitioners and people over time to support this journey. No single practitioner can do it all, but by knowing what is and is not within an AOD practitioner’s role, and what might be helpful in a given situation, all AOD practitioners can play a part.

3.3 Seeking a secondary consultation from the Men's Referral Service

Any AOD practitioner, at any time, can contact the [Men's Referral Service \(MRS\)](#) on 1300 766 491 to ask for an immediate secondary consultation to guide their approach to a client that they know or suspect is a perpetrator of DFV.

The MRS is staffed by qualified and experienced specialists in engaging perpetrators of DFV. As well as taking calls from perpetrators, they assist a wide range of community, social welfare, health and human services practitioners who are unsure of how to engage a perpetrator in a particular situation.

Secondary consultation can provide guidance on:

- how to approach a particular client
- how to 'unpack' aspects of the client's behaviour to understand how it relates to risk
- how to find an 'in' with the client to discuss their use of DFV
- safety planning
- who else to speak with about the client's circumstances and the risk posed to family members.

4

NADA Practice Resource

IMPORTANT CONSIDERATIONS WHEN ENGAGING A CLIENT ABOUT HIS USE OF DFV



KEY POINTS AND PRINCIPLES

- There are a number of indicators that might suggest that a client is using DFV. These can include what the client says and/or how he says it.
- The decision about whether to engage a client about the known or suspected use of DFV depends on several factors.
- Ensuring clarity about the bounds of confidentiality at the beginning of each session allows a practitioner to act appropriately on areas of concern for the safety of others and/or their client.
- Sometimes the most important action a practitioner can take – especially when they are quite concerned about the risk a client poses to family members – is taken after the session. In these situations, it can be crucial to contact and share these concerns with a DFV-focused agency in order to identify what actions can be taken, and by whom, to reach out to the victim-survivor to make a risk assessment and to offer support. Information sharing in these circumstances is covered by Part 13A of the *NSW Crimes (Domestic and Personal Violence) Act 2007*; the perpetrator does not need to be informed and his consent is not required for information sharing and collaboration to take place.
- If an AOD practitioner is concerned about risk of significant harm to a child or children, they must consider their duty of care obligations to make a report to the Child Protection Helpline.
- It is crucial not to disclose to a perpetrator any information provided by his partner or former partner about his use of DFV. It is also crucial not to disclose what services she might be seeking support from. The risk of retaliation against her can be high.
- It is important to avoid seeing the perpetrator and victim-survivor together. Joint work with them, even if focused solely on AOD issues, might not be safe.
- Assessing the nature and degree of risk to family members posed by a client who is known or suspected of using DFV can be very difficult when the only information available is the man's self-reports. It is generally not possible to assess DFV risk based on perpetrator self-reports alone. Many perpetrators greatly minimise or deny their use of DFV.
- If a client discloses that he has participated or is currently participating in an MBCP, do not automatically take this as a sign that he has taken responsibility for his behaviour, has changed his behaviour and/or no longer poses a threat to current or future family members.

4.1 Identifying that a client might be using DFV

There are different circumstances in which an AOD practitioner might come to know or suspect that a particular client is causing DFV harm.

- It might be through information provided by a referrer or by the client himself. For example, a client might disclose that he is subject to a protection order, that police interviewed him due to a 'domestic incident' or that he is attending an MBCP. In this situation, while the client might not consider himself to be using DFV, or might minimise or even deny his use of violence, he is aware that he is considered by a service or a service system to be a user of violence. In some ways this is the 'easiest' situation in which to talk with a client about DFV.
- In other situations, a client might say something that strongly indicates that he might be a user of DFV. For example, statements such as 'I need anger management', 'I have a problem with anger', 'I lost it with her yesterday', 'She left the house at midnight last night and she won't answer my calls' all provide an opening for a conversation about these circumstances and how he chose to respond or act.
- It might also become apparent that a client might be a user of DFV through the way he acts or talks about his partner or his situation, through his 'observable thinking', beliefs and attitudes (see below).

Assessing the nature and degree risk and starting a conversation to explore his behaviour can be trickier in some of these situations than in others.

4.2 Assessing the DFV risk posed by a client

For comprehensive practice guidance on identifying, assessing and managing risk when engaging with clients who are known or suspected to be using or experiencing DFV, see Part 2 of the NSW Risk, Safety and Support Framework: A guide for responding to men who use domestic and family violence (the RSSF). This details an AOD practitioner's responsibilities, in DFV situations, to:

- **identify use and risk of DFV**
- **gather information about risk and safety**
- **provide appropriate referrals**
- **share information to assist multi-agency risk assessment and risk management responses**
- **engage in collaborative practice.**

Assessing the nature and degree of risk to family members posed by a client who is known or suspected to use DFV can be very difficult when the only information available is the man's self-reports. It is generally not possible to assess risk based on perpetrator self-reports alone.

Perpetrators generally greatly minimise or even deny their use of DFV. This is because they often:

- see themselves as a victim rather than as the person causing harm
- see their behaviour as part of normal relationship conflict
- have convinced themselves that they are doing nothing wrong or that their behaviour is justified (for example, that punishing a partner for 'transgressing' his expectations of what makes a 'good wife' is not violence)
- understand DFV only as 'wife beating' and do not think of the range of tactics and behaviours they use as constituting DFV
- want to avoid taking responsibility for their behaviour
- lie about their behaviour because they fear the legal and other consequences of disclosure, or to attempt to manipulate services for their benefit
- do not want to experience the shame that can come from truly acknowledging their behaviour.

In addition, for some perpetrators generalised violence has always been or has become a normal part of their life, with many experiences of seeing other men (including relatives and friends) using violence in various circumstances.

For all of the above reasons, it is extremely important when a client is known or suspected to use DFV not to accept at face value any comments he makes along the lines of, "It was nothing – just an argument that got a bit out of hand", "She only called the cops because ...", "It was just a bit of a shove", "I only lost it with her once, that's all". There is almost always much more to this behaviour than what he reveals. For this reason, it is advisable to rely on evidence-based DFV risk indicators to assess DFV risk.

4.2 Assessing the DFV risk posed by a client (continued)

Identifying DFV risk indicators

While some of the evidence-based DFV risk indicators that focus directly on the perpetrator's use of violence might not be appropriate for practitioners without specialisation in DFV to explore (especially given that perpetrators are likely to respond untruthfully to such questions), there are some indicators that non-specialised practitioners may be able to pick up on relatively unobtrusively.

One way in which indicators of DFV risk may be identified, either directly or indirectly, is from what the perpetrator says and/or how he says it. This can include:

- the way he talks about his partner or former partner – for example, the extent to which he blames, pathologises or criticises her
- being obsessed with her, or consumed with possessive jealousy – for example, bringing her up at various points in the conversation and turning attention back to her, what she is or is not doing, making accusations about her 'infidelity', and so on
- showing signs of being very aggrieved or bitter about her actions (particularly in separating from him), and seeing her as 'ruining' his life and/or 'denying' him access to 'his' children
- being emotionally or otherwise dependent on her – or, in the context of separation or likely separation, feeling depressed, possibly suicidal and/or unable to imagine life without her
- showing agitation or aggression in his voice and/or body language (clenching fists, fidgeting, rubbing hands) when he talks about her and/or their children
- making veiled or indirect threats – for example, sympathising with what other men go through (from his perspective) and the legitimacy of their actions to regain power or 'get back at' their partner.

Indicators of heightened DFV risk may also be identified by asking questions about evidence-based DFV risk indicators that do not focus directly on DFV behaviours or controlling tactics. For example, without directly discussing DFV, but in the course of ordinary assessment and discussion about the client's AOD use, certain evidence-based DFV risk indicators can be assessed, such as whether:

- his partner recently (within the past year or so) separated from him or is currently separating from him
- his partner is pregnant or there is a newborn/infant in the family
- he is experiencing mental health issues (e.g. depression)
- he is experiencing suicidal ideation, and the degree of suicide risk
- he is unemployed and likely to remain so for at least a little while, or has dropped out of formal education
- he and his partner have significant conflict over child custody and/or child contact issues
- he has ever been charged with and/or convicted of any violent offences, or for breaching an ADVO or equivalent DFV protection order
- he has indirect or direct access to firearms or other weapons, such as through his occupation or recreational interests.

While it is very difficult to make a full assessment of DFV risk based solely on engagement with the perpetrator, sometimes 'red flags' will arise that raise serious concerns about the safety and wellbeing of those who might be affected by his use of violence.

For example, it might be possible to unobtrusively obtain information about the degree to which the client's partner is isolated, by asking a few questions about her circumstances (for example, if she is from a newly arrived migrant or refugee community, whether her extended family is in Australia or overseas).

While it is very difficult to make a full assessment of DFV risk based on engagement with the perpetrator alone, sometimes 'red flags' will arise that raise serious concerns about the safety and wellbeing of those who might be affected by his use of violence.

It is also important to note that if a client discloses that he has participated or is currently participating in an MBCP, this should not automatically be taken as a sign that he has accepted responsibility for his behaviour, has changed his behaviour and/or no longer poses a threat to current or future family members. Outcomes of MBCPs vary substantially from participant to participant, with some men making little or no change or making changes that they do not sustain over time. Some men need to participate in an MBCP two or three times before genuinely beginning to take responsibility for their behaviour. Risk to family members can therefore sometimes remain high even during or after the man's participation in the program.

Requesting or sharing risk-related information from or with other agencies as authorised under Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 is another way to contribute to risk assessment and to work with other agencies to help manage risk. (See **Section 4.4 Taking action after a session.**)

A list of indicators that a client might be using DFV is provided overleaf.

Indicators that a client might be using DFV

Client behaviours

- Talks about his (former or current) partner in dehumanising or demeaning ways
- Talks about her with hostility
- Is aggressively or constantly critical of her or her decisions or actions
- Pathologises her or emphasises that she has mental health issues
- Discredits her views or says “No one believes what she’s saying”
- Blames her excessively
- Portrays her as not very capable as a partner and/or a mother
- Says she wouldn’t be able to cope on her own
- Says she shows him “no respect”
- Conveys a sense of ownership of her
- Expresses rigid thinking about gendered roles in family relationships
- Expresses a sense of gendered entitlement to power and control over decision making in the relationship/family
- Is excessively jealous or obsessed with her
- Appears to mistrust women or his partner’s fidelity
- Appears unable to empathise with her, understand her needs or acknowledge her experiences or views
- Has unreasonable or impractical expectations of her and/or their children
- Often accompanies her to appointments or in other ways ‘gatekeeps’ her access to services
- Presents himself as being the ‘real’ victim
- Complains about her being violent to him
- Says he has an ‘anger management’ problem or that ‘she really riles me and makes me lose it’
- Talks about having “big fights” with her or arguments that “get out of hand”

Client’s partner’s behaviours in the presence of the client

- Defers or looks to him before responding to questions asked of her or of both of them

Client behaviours in the presence of his partner

- Speaks for her rather than allowing her to answer questions herself
- Insists on interpreting for her if she has limited English, rather than allowing her to use an interpreter
- Does most of the talking, interrupts or 'corrects' her, or controls the conversation in more subtle ways
- Demonstrates threatening or more subtle nonverbal controlling behaviours towards her
- Talks about her in seemingly well-meaning ways in her presence, but is actually patronising

Practitioner perceptions

- Feeling intimidated by him
- Feeling sexually objectified or demeaned by him (if female)
- Feeling controlled or manipulated by him
- Feeling strong attempts by him to agree with his violence-supporting narratives or beliefs

Client behaviours where he is separated or separating from his partner

- Emphasises how she is preventing him from seeing 'his' children
- Sees family court as a means of restoring 'his right' to have 'his' children
- Wants to limit her access to the children due to her 'inability' to parent
- Disparages her support networks and suggests they are responsible for the relationship ending
- Says his extended family agree with his views about her (and her capacity to parent)
- Feels highly aggrieved about what she has 'done' to him
- Is obsessed with her new life
- Is highly jealous about her new partner

Using 'ecomaps' to unobtrusively assess risk:

Ecomaps are a way of exploring and mapping a range of issues in a client's life that might affect case goals and the client's likelihood of achieving them. Such issues can include the client's:

- financial situation
- food security
- employment
- education
- housing
- culture and identity
- community connections and sense of belonging
- extended family
- friendship networks and peer support groups
- transport options
- access and connection to social welfare and professional services
- telecommunications access
- physical health
- mental health issues and supports.

For a client who is known or suspected to use DFV, an ecomap can be extended to unobtrusively explore some of these issues also in relation to his partner. For example, in terms of housing, if they are living together and renting, is the lease only in his name (thereby indicating a risk of the victim-survivor experiencing homelessness)? Is she experiencing physical health issues or disability that might make her dependent on him? Extending an ecomap in this way can be a means of assessing some aspects of her situation, to identify possible indications of isolation or entrapment.

4.3 Deciding whether to engage a client about his DFV use

The decision about whether to engage a client about his known or suspected use of DFV depends on several factors. If a client knows that a particular practitioner knows he has been identified as a user of DFV, then not discussing this at all can lead him to think that the practitioner doesn't see DFV as an important issue. Similarly, if he provides a strong indication of his behaviour, then not exploring this can signal that the unspoken behaviour is acceptable. Not discussing or exploring a client's use of DFV in either of these situations often amounts to collusive practice.

There might be times, however, when a practitioner decides not to raise the issue at a particular time. These times might include when:

- there is significant risk of the client assuming that the issue is being raised because his partner has 'dobbed him in', raising the risk of him 'retaliating' against her; he might be more likely to make this assumption if the same agency also provides a service to her
- the client appears agitated, distressed or emotionally labile, and there may be implications for his partner's safety when he leaves the session if the issue is raised with him
- there is risk to the practitioner's safety, given the client's level of agitation
- it is more appropriate to indirectly obtain a sense of the risk to his partner, in order to determine what actions should be taken to support his partner.



An important note about practitioner feelings of discomfort

It can feel uncomfortable for AOD practitioners to raise and discuss DFV. It is important for all AOD practitioners to be aware of their own level of discomfort in this situation. This awareness can help them to know, when they are feeling uncomfortable or anxious about raising the issue with a particular client in a particular situation, whether this feeling indicates that it might not be safe to raise the issue at this time, or whether it reflects the practitioner's general discomfort about discussing DFV.

If the latter applies, then it is important to reflect on the reasons for this general discomfort and work on strategies to overcome it – for example, by discussing it in clinical supervision or with a manager or colleagues working for specialist DFV services.

4.4 Taking action after a session

Sometimes the most important contribution an AOD practitioner can make – especially when concerned about the risk a client might pose to family members (see **Section 4.2 Assessing the DFV risk posed by a client**) – is not necessarily to engage him about his use of DFV but to take action after the session.

Of course, if a client directly threatens someone or in other ways indicates his intention to cause physical harm, police must be contacted immediately. In other situations, however, there might not be any indication that a victim-survivor is at imminent risk but a practitioner might still be concerned for her and/or her children's safety and wellbeing.

In these situations, it can be crucial to contact and share these concerns with a DFV-focused agency in order to identify what actions can be taken, and by whom, to reach out to the victim-survivor to make a risk assessment and to offer support. It will often be best to contact the nearest DFV Local Coordination Point (this might be the local Women's Domestic Violence Court Advocacy Service or another agency) to have this discussion.

Most AOD service providers and other community-sector agencies in NSW are covered by Part 13A of the NSW *Crimes (Domestic and Personal Violence) Act 2007*. This enables these agencies to share information, under particular circumstances, with other agencies (such as DFV Local Coordination Points, other specialist DFV service providers and other relevant government and non-government services) for the purposes of helping to identify, assess and/or manage DFV risk. Eligible information can be shared between these agencies without the perpetrator's knowledge or consent.

Of course, if an AOD practitioner is concerned about risk of significant harm to a child or children, they must consider their duty of care obligations to make a report to the Child Protection Helpline. Mandatory Reporters can use the Mandatory Reporter Guide to assist in deciding whether to make a child protection report.



Actions that AOD practitioners might consider taking after a session include:

- considering what risk-related information needs to be shared, and with whom
- discussing with team leaders how the service should address the client and the situation, including how to respond to the risk that the client poses to family members
- re-evaluating the practitioner's approach to engaging the client, if required
- re-evaluating the practitioner's goals and the client's case plan
- obtaining a secondary consultation from the Men's Referral Service or an MBCP provider regarding how to keep him engaged and monitored in a safe way
- obtaining supervision and debriefing from within the agency, if necessary.

4.5 Handling information obtained about a client's behaviour from his partner

Sometimes an AOD practitioner might have information about a client's use of DFV from his partner or others affected by his behaviour. This might occur if the agency is also providing a service to the client's current or former partner, or if it has obtained this information from another agency.

It is crucial not to disclose to a perpetrator any information provided by his partner or former partner about his use of DFV. It is also crucial not to disclose what services she might be seeking support from. If information shared by a victim-survivor finds its way into questions that a practitioner asks a perpetrator, he might realise that the victim-survivor has been disclosing his behaviour, and the risk of him retaliating against her can be high. He might also use his new awareness of what she has disclosed as a 'reason' to further control and monitor her movements, and to try to prevent her from accessing any services or supports.

It is crucial not to disclose to a perpetrator any information provided by his partner or former partner about his use of DFV.

Perpetrators of DFV can be highly suspicious. Even if a practitioner has done their very best not to disclose any information obtained either directly or indirectly from a victim-survivor – even if that practitioner has never spoken to her, or knows nothing about her – the perpetrator might still believe that she has spoken to that practitioner or to another service and retaliate against her in some way.

For this and other reasons, while AOD and other community-sector agencies sometimes find themselves in a situation where they are providing services both to a perpetrator and to their victim-survivor(s), it is important that no practitioner sees them both. Separate practitioners working with each client will minimise the risk of a practitioner inadvertently revealing to the perpetrator what the victim-survivor has disclosed, and will also maximise the agency's opportunity to conduct ongoing risk assessment and contribute to the victim-survivor's safety.

More generally, **it is important to avoid seeing the perpetrator and victim-survivor together in any context.** Joint work, even if focused solely on AOD issues, might not be safe with the perpetrator and victim-survivor together. Perpetrators have a substantial power imbalance over their partner, and can manipulate any joint work to their advantage in ways the practitioner might not realise.

5

NADA Practice Resource

MINIMISING COLLUSION TO PROMOTE ACCOUNTABILITY FOR DFV USE



KEY POINTS AND PRINCIPLES

- It is easy to inadvertently collude with a perpetrator's violence-supporting narratives and beliefs and with his efforts to deflect responsibility for his use of violent and controlling behaviour.
- It is important for all practitioners to consider what ideas they, their organisation and/or their community might have about perpetrators and/or DFV that might influence them to collude with a perpetrator's violence-supporting narratives.
- A client who is using DFV can in a variety of ways invite a practitioner to collude with these narratives and efforts to deflect responsibility. However, it is possible to minimise collusion by respectfully expressing dissent with the narratives, while still building and maintaining rapport with the client, being respectful and empathic, and taking the approach that the client is capable of adopting different attitudes, beliefs and behaviours. It is not necessary to 'lock horns' with a client to minimise collusion.
- Minimising collusion is not about attempting to change a client's violence-supporting attitudes or beliefs – that is the work of men's behaviour change specialists over many months. Rather, it is not about not giving him the impression of agreement with his attitudes, beliefs and behaviours.
- It is important for practitioners to be aware of their own body language when a client invites them to collude with a violence-supporting narrative – monitoring and adjusting the use of automatic smiling, nodding and other gestures that could be taken as signs of agreement.
- Any conversation with a perpetrator about his behaviour is likely to feel difficult. If it doesn't, the practitioner is possibly being too collusive with him. The practitioner and/or the client feeling some discomfort during the conversation is a good sign.

5.1 Understanding collusion

Collusion, within the context of DFV, occurs when a practitioner, agency or system excuses, minimises or justifies a perpetrator's violence towards family members.

Collusion can take many forms. At practitioner level it can be expressed through a nod of agreement or a sympathetic smile (whether inadvertent or deliberate) when a man expresses a violence-supporting attitude or belief, or through not raising the issue of a client's use of DFV when the client knows the practitioner is aware of his behaviour.

At agency level it can take the form of policies that approach DFV as a mental health issue and/or as a by-product of adverse childhood or other traumatic experiences.

At system level collusion can occur when a father's rights are elevated over what is in the best interests of their child, or when the mere fact of attending and completing an MBCP is automatically seen as a sign of change, irrespective of whether the man has actually demonstrated any change.



Collusion is problematic because it can:

- reinforce the violence-supporting narratives that a perpetrator adopts to give himself permission to use violence
- reinforce the ways in which a perpetrator avoids taking responsibility for his behaviour
- enable a perpetrator to cast blame on to the victim-survivor and/or to make her feel responsible (e.g. "My counsellor says you need to go easy on me as I'm going through a pretty hard time at the moment").
- signal to him that services and the service system are taking his side (and signal to her that she will not be listened to or believed).

Colluding with perpetrators' violence-supporting narratives and with their efforts to deflect responsibility for their use of violence is common. Many of the attitudes and beliefs that perpetrators draw on to maintain their victim stance are adopted more widely in society. Beliefs about women being 'too emotional' or 'indecisive', about 'the gender wars' having 'turned things too far against men', and about men's violence being 'triggered' by their own experiences of trauma or psychological problems are all common messages that practitioners, as individuals in our society, have absorbed throughout their lives. In a patriarchal society we have learned to elevate men's voices and not to give the same legitimacy to women's.

It is also easy to collude because discussing a client's use of DFV can be challenging or uncomfortable for practitioners, due to anxiety or anticipation of the client's reactions – including of the client escalating or becoming agitated – and of risk to practitioner safety. It may also be difficult because practitioners can worry about how having these conversations might affect the client's future engagement with them and with the service. These concerns can cause practitioners to downplay or ignore the likely impacts of the client's behaviour on victim-survivors.

It is important to reflect and consider the impact on victim-survivors of *not* having these conversations with clients who are causing them harm. Supervision can be an important avenue to explore discomfort in having these conversations with clients.

5.2 Identifying invitations to collude



Colluding is easy to do because many men who use DFV actively invite practitioners to collude with them, such as by:

- presenting as calm, likeable and persuasive
- presenting his partner as 'hysterical' or affected by mental health issues
- selectively presenting the facts of a situation and/or lying to make his partner look bad or to blame
- suggesting that the police, courts and other services "never listen to the man's side of the story"
- suggesting that the violence runs both ways ("It takes two to tango")
- appealing to sexist stereotypes, perhaps more so if the practitioner is male ("You know what women are like")
- blaming his DFV on his AOD use ("I just lose it when I've had too much to drink – I can never remember afterwards what happened", "Everyone will tell you I'm a nice guy except when I get on the piss").

It can be particularly challenging to resist such invitations to collude while trying to build rapport with a client, but it can also be difficult when a practitioner knows a client well and does not identify his use of DFV until some time into the working relationship.

It can also be difficult when advocating for a client who has experienced discrimination, marginalisation or oppression, such as by virtue of mental illness, poverty, ethnicity, sexual orientation or gender identity. In such cases it is important to address the discrimination, marginalisation or oppression while also clearly articulating that the violence is not caused by these things.

This can take time and skill to do well, but it can be done by setting and varying an appropriate tone across each contact with the client.

5.3 Knowing when a practitioner might be more likely to collude

As individuals and as practitioners, we all hold ideas, beliefs and assumptions about gender that reflect our culture's social norms, our own performance of gender and the presence or absence of gender-based privilege. Regardless of how hard we try to bring these into our awareness, there will always be unconscious bias. It is critical for practitioners to be as aware as possible of the personal values that underpin their practice, to recognise their own biases and assumptions and to identify how and when these might affect their practice, such as through choice of tone, responses and assessment of risk.

What ideas might you, your organisation or your community have about perpetrators and/or DFV that you might inadvertently draw from to collude with a perpetrator's violence-supporting narratives?

There are also situations in which a practitioner might be more likely to collude than in others. It might be with a man who has been intermittently homeless due to a combination of mental illness, AOD abuse and an acquired brain injury. It might be with a man who, after being removed from the family home by police and subject to protection order conditions by the courts due to his use of DFV, talks about how much he misses his kids, and how unfair it is to him and to them that he can't see them. Or it might be when a situation involves some of the attitudes and beliefs that a practitioner has absorbed due to their gender-based or other forms of privilege.

Knowing the particular situations and circumstances in which one might be more likely to collude can help practitioners to prepare and resist.

It is important to remember that collusion involves not only explicitly or implicitly agreeing with what a perpetrator says but also signalling agreement with his underlying thinking and violence-supporting narratives, such as that "a boy needs his father", "men use violence because they can't regulate their emotions", or "some women will manipulate a man to such an extent that he just snaps".

A practitioner might also notice collusion among other professionals, or feel drawn into engaging in collusive discussions with them. For example, the way a practitioner responds to a family counsellor or a police officer who implies that a client's DFV behaviour is caused by his AOD use can influence whether the broader system and the community as a whole maintains such myths about DFV.

5.4 Finding the 'midpoint'

In their highly useful 2015 book *Engaging with perpetrators of domestic violence: Practical techniques for early intervention*, Kate Iwi and Chris Newman suggest that when engaging clients who are perpetrating DFV, practitioners should adopt a 'midpoint' in their approach between being collusive and being persecutory. This approach can be represented as follows.¹

Find the 'mid-point'

Collusive	Mid-point	Persecutory
You prioritise the relationship with the client above everything else Become matey with the man	Respectful	Oppositional
Empathise with his victim stance or criticism of her	Empathise selectively (not with violence-supporting narratives)	Butting horns
Signal agreement with sexist comments, even if subtle	Adopt an invitational approach	No empathy
You blame his violence on his upbringing, mental health issues, substance use or trauma that he has experienced	Tone based on curiosity, not moralising	No interest in his life or his circumstances
You see him as the more 'stable' or 'capable' parent	Sympathetic to and sensitively find out about the oppression and traumatic experiences he might have faced / be facing, but not see these an excuse for his behaviour	No interest in the oppression he might have faced, or the traumatic experiences he has encountered
Client feels validated about his behaviour, and doesn't have to take responsibility for his behaviour or think differently	Focus on safety of those affected by his violence, his responsibility for his behaviour, that violence is a choice, and that he is accountable for the impacts of his behaviour	You do not manage your own internal reactions
You avoid tension/ anxiety about raising difficult issues		Client can stay defensive, focusing on 'pushing back' or doubling down, and thereby avoids the need to think differently about his behaviour
		You might feel better by 'making the perpetrator accountable' (but the highly challenging and moralising approach actually does the opposite)

Where the 'midpoint' falls exactly will vary from situation to situation. In contexts where a practitioner and a client have a significant rapport and on ongoing working relationship, the practitioner might be able to hold a stronger focus on the client's behaviour and push their invitations for him to think differently a bit further. In situations when a client is emotionally labile or escalating, however, the practitioner might need to pull back and use less forthright ways to minimise collusion.

1. Adapted from Iwi, K. and Newman, C. (2015) *Engaging with perpetrators of domestic violence: Practical techniques for early intervention*. Jessica Kingsley Publishers.

5.5 Practice considerations for minimising collusion

Avoiding collusion completely is impossible. Challenging every violence-supporting belief or attitude a perpetrator expresses can result in a conversation being too combative and rapport quickly eroded. The goal is to minimise collusion as much as possible.

Minimising collusion need not mean locking horns with a client. Refusing an invitation to collude can be more subtle, such as leaving a pause before responding rather than nodding, or saying ‘No, I don’t know what women are like’ and then moving the conversation on.

Below are some practice considerations to keep in mind when trying to minimise collusion.

Practice consideration	Possible response	Reasoning
<p>Minimising collusion is not about attempting to change a client’s violence-supporting attitudes or beliefs.</p> <p>Attempting to do so is the work of men’s behaviour change specialists. What an AOD practitioner can do, however, is not leave him with the impression that he agrees with him.</p> <p>Minimising collusion is also not about being robotic, non-empathic or never using warmth or engaging facial expressions. Nor is it about being moralistic, judgemental or disrespectful of a client. Rather, it is about deciding how to be respectful and empathic without reinforcing the client’s violence-supporting attitudes and beliefs.</p>	<p>If a client says:</p> <p>“She’s the one who drives me to drink. I just don’t get a break when I get home – she’s at me as soon as I walk through the door.”</p> <p>A possible response:</p> <p>“My guess is that you work hard and are very tired when you arrive home, and would like some space. I’m also guessing that Jenny has been working hard all day too, juggling the kids, caring for her Mum and working at her part-time job, so she’s also pretty tired. What do you think Jenny looks forward to when you come home?”</p>	<p>This response acknowledges and expresses some empathy for how the client is feeling when he gets home, but also invites him to consider his partner’s experience. In this way the practitioner minimises collusion without directly ‘challenging’ the client, while also centralising the experience of those who are affected by his use of DFV.</p>
<p>It is important to see the person using violence as more than simply their behaviours or attitudes, while focusing on the effects of these.</p> <p>When responding to a client’s invitation to collude, a practitioner can express disagreement with the attitude, belief or behaviour while taking the approach that the client is capable of adopting different attitudes and beliefs.</p>	<p>If a client says:</p> <p>“I’m not a wife-basher. I just lose it a bit when I’m drunk.”</p> <p>A possible response:</p> <p>“I can see when you say you’re not a wife-basher that you’re telling me you don’t want to cause harm to others. You’re telling me you don’t want to be a man who harms his family. I wonder, though, what Jenny and the children see you doing when you decide to lose it, and what effect that has on them.”</p>	<p>This type of response (familiar to many practitioners in the AOD sector) draws a contrast between the client’s values and the effects of his choices with respect to AOD use, violence and how he treats others. The added layer is inviting him to consider the effects of his choices on family members, and how this takes him away from the partner, parent or person he wants to be.</p>

Practice consideration	Possible response	Reasoning
<p>It is likely to be a difficult conversation.</p> <p>Any conversation with a client about his DFV behaviour is likely to become difficult. If it isn't, the practitioner is possibly being too collusive with him. Either or both parties feeling some discomfort during the conversation is a good sign.</p> <p>Iwi and Newman advise practitioners to pre-empt this discomfort with clients.</p>	<p>"I'm going to ask you a few questions that might be uncomfortable to talk about. I have some concerns about how things are going at home, and it's important for our work together to have an honest conversation about this. Sometimes when I talk about these things with clients, they feel the need to take a break. If you feel that way, could you let me know?"</p>	<p>Taking a pre-emptive approach indicates to the client that he can take some responsibility for how he is feeling (Iwi and Newman 2015). The indirect message is 'If you are becoming agitated, please let me know rather than becoming abusive or aggressive towards me.'</p> <p>However, while discomfort is to be expected, it is important for the safety of the client's family members not to antagonise him. Working towards behaviour change is the role of specialist DFV services, not AOD practitioners.</p>

While a practitioner might offer an alternative perspective and invite the client to consider it, if he wants to argue the point it is best not to get into an argument. It is important to remember that men who perpetrate DFV often feel powerless and not in control. They do not realise that they are making deliberate choices to use male privilege, male entitlement and other forms of power and control. Within this context, while an AOD practitioner might be able to plant seeds towards the client viewing his behaviour differently, he is not likely to make major shifts no matter what is said to him.

These examples are based on an invitational approach, which uses respectful questioning to provide opportunities for the client to focus on his own behaviour within the context of values of safety and responsibility. Invitational practice keeps open the space of respectful curiosity when the client attempts to deflect the conversation (for example, by blaming his partner or using other 'smokescreens') to avoid taking responsibility for his behaviour.

Ultimately, however, it is the client's choice whether he enters this space. No practitioner can make him do so. Invitational practice is the opposite of taking a moralistic approach or 'locking horns' with a client, which will often only increase his resistance.

5.5 Practice considerations for minimising collusion (continued)

Summary practice principles	Possible response	Reasoning
Letting some things go to the keeper	It can be difficult and counterproductive to challenge all of a client's concerning statements, attitudes and beliefs. Challenging everything is too much and can lead to 'locking horns'. Express your disagreement by not showing signs of agreement. If appropriate, find a way to discuss his statement/belief later in the session, if it doesn't come up again.	
Forming a bridge to a possible conversation about DFV	<i>"If it's OK, I'd like to focus on this a bit. While it's not the focus of our work together, understanding a bit about your life and relationships, support people and the situation, will help us to work together on your drinking. Did you say there was an argument of some kind?"</i>	It is important to explain to the client why focusing on his relationships, and the choices he makes in how he responds to situations and to intense feelings in that relationship, is important for your work together and for what he hopes to achieve through participating in your service.
Respectful interrupting when necessary	<i>"She was right up in my face, literally screaming at me. I tried to calm her down, but once she gets in a state like that, nothing can stop her..."</i>	Respectfully limit the space he takes to criticise, pathologise or otherwise blame his partner, especially when repetitive.
Expressing empathy while minimising collusion with violence-supporting narratives	<i>"If I can interrupt you there. It sounds like a really difficult situation. I can see that in retelling this you're becoming agitated, you've raised your tone a bit and you've gone a bit red. What is it that you're feeling in your body?"</i>	Build rapport without agreeing with his interpretation of the victim-survivor's behaviour, nor with his violence-supporting beliefs and attitudes. Find ways so that he can feel heard, while minimising collusion. Take him through a grounding strategy if required to bring down his level of agitation.
Inviting awareness of the victim-survivor's experiences	<i>"She said she'd call the police if I didn't let her go! These days women call the police at the drop of a hat..."</i> <i>"It sounds like it was very stressful for you, and also I imagine for her, if she was considering calling the police."</i>	Acknowledge his experience while minimising collusion with his violence-supporting narratives. Invite him to consider the victim-survivor's experiences, needs and reasons for taking protective action.
Respectful challenging		There are often opportunities to respectfully challenge sexist and violence-supporting attitudes and beliefs without making the client feel targeted or putting him on the defensive.

Summary practice principles	Possible response	Reasoning
<p>Focusing on the effects of the client's behaviour on the victim-survivor</p>	<p>"How did you try to stop her* from leaving? What did she see you say or do? How might she have been feeling at that moment?"</p> <p>"I wonder if it's possible that she was feeling frightened?"</p> <p>"Assuming this has happened more than once, could this be making her feel unsafe in the family home?"</p>	<p>The client might not want, at least initially, to consider the effects of his behaviour – he is likely to deny, minimise or justify his behaviour or portray himself as the victim. However, asking questions that focus on his choices, and the effects of those choices, can 'plant seeds'.</p>
<p>Naming the behaviour as DFV</p>	<p>"Look, I've got a bit physical with her from time to time, but she gives as good as she gets, and she knows I'm a bit of a hothead."</p> <p>"When you say that you get 'a bit physical' with her, I wonder how she experiences that. I'm not going to beat around the bush: we're all learning as a society now to be more open in talking about domestic violence. Sweeping it under the carpet doesn't do any good to anyone, including you."</p> <p>"I wonder what effect you're getting physical with her is having on her, and on your relationship?"</p> <p>"What do you think she would say to you about how she feels about you getting physical with her?"</p> <p>"I wonder if that behaviour is making things unsafe for her?"</p> <p>"I wonder how getting physical with her might be affecting the children. Can we spend some time now considering this?"</p>	<p>While it can be important not to 'beat around the bush', sometimes it is best initially to stay with the language he uses to describe his behaviour – but only if that language doesn't minimise the behaviour too much. Mirroring language such as 'We have fights/arguments' is too collusive, as it mutualises responsibility for his violence. However, you might choose to use other language that he uses, such as 'getting physical' or 'getting angry' to begin with, even though that language is still not ideal.</p> <p>If you have little rapport with the client, and he is disclosing something about his behaviour for the first time, it can be preferable to stick with his language (again, provided this is not too collusive) and leave naming his behaviour as DFV until later in the session if/when he has told you more.</p> <p>You might also choose not to name his behaviour as DFV if the main source of information you have about his behaviour is from his partner, as this might place his partner at risk of retaliation.</p>

* It is better where possible to use the name of the client's partner in these conversations, rather than 'she' or 'her'. Using the partner's name humanises her rather than an approach of talking about 'the missus'.

5.5 Practice considerations for minimising collusion (continued)

Summary practice principles	Possible response	Reasoning
Using directed, open questioning	<p>“How did you try to stop Louise from leaving? What did Louise see you say or do?”</p> <p>“When you were feeling angry, what did Louise see or experience you doing?”</p>	<p>An open question that also directs the client to think about his behaviour and discourages vague or evasive responses. Adopting a curious approach, neither collusive/matey nor overly challenging/accusatory, focuses the conversation on the client’s choices and the effects of these choices, in an invitational way.</p>
Emphasising the difference between the feeling and the behaviour		<p>These questions, by nature of their wording, communicate that emotion does not drive behaviour, and that the client has a choice regarding how to respond to that emotion or to the situation. Anger, jealousy, felt-humiliation and so on are not the same as violence.</p>
Emphasising that the client has a choice about how he responds to a feeling or situation		
Reframing	<p>“She was hysterical, she was just going off at me.”</p> <p>“Sounds like she was feeling very upset. What did you do at that point?”</p>	<p>This approach reframes the client’s statement away from the loaded, sexist, demeaning language that the client used to portray himself as the victim. Instead it uses words that still acknowledge his experience but move closer towards empathy and understanding of how the other person might experience his behaviour. In this way you can move the conversation along and minimise collusion, without needing to directly challenge him.</p>
Centralising safety	<p>“Have there been other times that she might have felt afraid, or not safe, around you?”</p> <p>“My sense is that there are things you can do differently to be a safer man for your family, to be a man who is safe for them no matter what.”</p> <p>“What effect do you think this is having on your children? What would be your best guess about this?”</p>	<p>Using the language of safety means stating clearly that everyone’s safety is a core concern of your work and that of the service, including the safety of those affected by his behaviour. Contextualise the benefits of your client working towards being a safer man as an important part of his AOD case plan and as highly relevant to his AOD goals.</p>

Summary practice principles	Possible response	Reasoning
Centralising safety (cont.)	“Although our focus is on your drinking, being a safe man for other people to be around is important. It will be harder for you to achieve your goals in reducing drinking if there are times when others are afraid of what you might do.”	Invite him to consider what being a safe family man means to him, how important being a safe man is for him and for his family. Invite him to talk about how important it is for him to be a safe man and a safe father <i>irrespective</i> of what he might be feeling or thinking at any given moment, and <i>irrespective</i> of whatever the circumstances might be. Create a space for him to explore how much he wants to be a safe man <i>no matter what</i> .*
Focusing back on his behaviour	“Is it OK if I interrupt you? Talking about what she did or didn’t do isn’t going to help me understand how I can help you. She isn’t here to discuss her behaviour, but we can focus on you and your responses.”	Men who use DFV will often try to draw the conversation back to their partner. Redirect him back onto focusing on himself and his behaviour.
Inviting him to consider, rather than moralising	“I wonder if whether ...” “Could it be possible that ...” “I’d like to explore something together with you. I’m going to draw something on the board for you to look at, and see if it fits.”	The client might be more resistant if he feels moralised at or shamed. You do not need to hide your concerns or make light of the situation, but the journey towards taking responsibility for one’s own violent and abusive behaviour is often very long. You are inviting him to take some very early first steps.
Normalising the conversation	“Many of my clients, when they make behaviour choices that make their family afraid, find these conversations difficult. My guess is that you haven’t talked about this with anyone before?”	While being careful not to normalise the violence, normalising the conversation and letting him know there are others in his situation might help him to feel less targeted and therefore less defensive.

* This is a positive, invitational approach towards exploring with the client that there is never any excuse for the use of DFV, in a way that is less likely to leave him feeling ‘moralised at’ or ‘lectured to’, and which encourages him to think and articulate his own reasons for becoming a safer man.

5.6 The importance of body language

It is important for practitioners to be aware of their own body language when a client invites them to collude with a violence-supporting narrative, attitude or belief. Practitioners should monitor and adjust their use of automatic smiling, nodding and other gestures that could be taken as signs of agreement; however, they should try not to stiffen or become unresponsive.

Appropriate body language when having these conversations includes maintaining 'soft eyes' and a relaxed but professional posture, leaving pauses and becoming stiller when he says something problematic.

Adopting body language that is respectful but minimises collusion can be challenging for practitioners who are used to showing unconditional positive regard for their clients under all circumstances. However, the reality is that perpetrators of DFV often lie to themselves and to others, and the risks their violent behaviour poses to family members needs to take centre stage in the practitioner's thinking.

6

NADA Practice Resource

APPROPRIATE INTERVENTION OPTIONS FOR MEN WHO USE DFV



KEY POINTS AND PRINCIPLES

- DFV is not an 'anger management problem'. Most perpetrators of DFV use a range of tactics of control and coercion, including when they are not angry. How one behaves when experiencing an intense emotion is a choice.
- Men who perpetrate DFV should not participate in relationship counselling or family therapy before they reach a point of completely and sustainably stopping their use of violent and controlling behaviour, as verified by the victim-survivor.
- Engaging men in relationship counselling or family therapy while they are still using violence carries significant risk of making things worse for their partners in the short and longer term.
- Anger management programs are not an appropriate referral option for men who perpetrate DFV, as they do not address coercive control or the perpetrator's patterns of behaviour.
- MBCPs are the referral option of choice for DFV perpetrators. In NSW, MBCP providers are registered by the NSW Government.
- Most private practitioners are not equipped to work with men on changing DFV behaviour, and are likely to employ approaches that are ineffective at best or collusive at worst. There are, however, a small number of private practitioners who are experienced MBCP practitioners in the DFV field, having worked previously within an MBCP provider setting. Local Coordination Points can also help to determine whether the victim-survivor can be offered parallel support.

6.1 Interventions that aren't appropriate for men who use DFV

Anger management programs

DFV is not an 'anger management' problem. Most perpetrators of DFV use a range of tactics of control and coercion, including when they are not angry. DFV is generally about power and control, and is not caused by emotions. Anger, jealousy and/or humiliation are sometimes present when men choose to use violent and controlling behaviour; however, the emotion is not the behaviour, and the emotion does not cause the behaviour. How one behaves when experiencing an intense emotion is a choice.

Anger management programs are inappropriate and unsafe interventions for men who perpetrate DFV, and can even make their violent and controlling behaviour worse.

Anger management programs assume that the expression of anger is at the root of men's use of violence. It is very unhelpful to conceptualise DFV in this way, as it ignores the motivations and intentions men have when they use violent and controlling behaviour towards family members. These programs also generally have poor DFV risk assessment and risk management approaches, and offer no contact or support to the victim-survivors affected by these men's use of violence. Not only are they unlikely to be effective in changing men's behaviour, they can also be blind to the risks to family members.

Anger management programs are inappropriate and unsafe interventions for men who perpetrate DFV, and can even make their violent and controlling behaviour worse.

Relationship or family counselling or mediation

DFV is not a relationship problem. DFV is a pattern of coercive control by one person over another. It is different from relationship conflict, in which each partner has relatively equal power. Individuals can have difficulties communicating, relating and understanding each other without there being an abuse of power.

Relationship counselling and family therapy are generally not appropriate interventions for men who use DFV, in part because they ascribe responsibility for the violence to all parties and assume they are all responsible for making changes towards a common goal. This operates against a fundamental principle of DFV work – the need for the perpetrator to take 100 per cent responsibility for his behaviour.

Relationship counselling and family therapy with DFV perpetrators are inappropriate because they can:

- exacerbate risk by potentially exposing a victim-survivor to retaliation for talking about the violence
- worsen the perpetrator's use of controlling behaviour, because his goal in using violence is to control the relationship and the victim-survivor's actions, so any intervention by a relationship counsellor or family therapist to try to rebalance power can result in him increasing and widening his use of controlling tactics at home
- limit an accurate assessment of risk, due to the victim-survivor not being willing to disclose information for fear of retaliation

- substantially collude with the perpetrator’s denial, minimisation and justification for his use of violence, due to:
 - the commitment of the relationship counsellor or family therapist not to ‘take sides’, and to attribute the cause of violence to relationship or family dynamics rather than the perpetrator’s choices
 - the focus on multiple issues (not just the perpetrator’s behaviour), resulting in messages that his behaviour is not the priority issue to address
- lead the victim-survivor to blame herself for his use of violence (something she might already tend to do, in part due to his tactics to make her feel responsible for his behaviour)
- further disempower the victim-survivor by placing her in a situation where she needs to remain silent due to fear of retaliation and is therefore unable to advocate for herself safely
- send the victim-survivor (and the perpetrator) the message that violence is normal and acceptable in family relationships; and that if she were to disclose it, nothing would be done about it.

Before other issues in the relationship can be effectively addressed, the abusive behaviour must end. This is akin to couples counselling where one or both parties are active alcoholics – until they are sober, such interventions will have little effect. Similarly, until the abuse has stopped, other interventions will have limited effect.¹

Individual counselling with a private practitioner

Most private practitioners – whether psychologists, counsellors or psychotherapists – are not equipped to work with perpetrators of DFV. They generally have had no specialist training in DFV behaviour change work and, as a result, are likely to employ approaches that are ineffective at best or collusive at worst. There is also generally no capacity for private practice work with DFV perpetrators to connect with parallel work by a separate women’s practitioner reaching out to offer risk assessment, support and safety planning to those affected by the man’s use of violence.

There are, however, a very small number of private practitioners who are experienced MBCP practitioners in the DFV field, having worked previously within an MBCP provider setting. When considering whether to refer a client who is perpetrating DFV to a private practitioner due to a lack of specialist MBCP options, it is important to check with the Men’s Referral Service to clarify if the practitioner has MBCP provider experience. Local Coordination Points can also help to determine whether the victim-survivor can be offered parallel support, and can check whether the private practitioner’s work with the man is making things better or worse for her and the family.

1. Allies in Change Counselling Centre: 12 reasons why couples counselling is not recommended when domestic violence is present. https://www.dhs.state.or.us/caf/dv/desktops/couples_counseling_12_reaso.pdf

6.2 Men's Behaviour Change Programs

Men's behaviour change programs (MBCPs) do assist men to develop the skills to make non-violent choices when they experience anger. However, they do far more than this, and are generally (and necessarily) longer and more intense than anger management programs.

MBCPs operate within the context of integrated DFV response systems, and work closely with other agencies towards the joint goals of victim-survivor safety and perpetrator change and accountability. Many Australian jurisdictions, including NSW, have minimum standards to guide how MBCPs operate, including their approach to identifying, assessing and managing risk, and in offering support to victim-survivors.

Internationally, specialist group-based DFV perpetrator programs (called MBCPs in Australia) are considered the most appropriate intervention for men who use DFV. Research suggests that these interventions provide the greatest potential to address men's violent behaviour and to reduce risk.¹

MBCPs vary in their intervention models and approaches, but they all focus on working with men to help them take responsibility for their behaviour.

MBCPs involve:

- one or more individual assessment sessions, to ensure that the man is suitable for the program, to build on existing risk assessment information, to discuss the requirements of program participation and to start building internal motivation for change
- group work, typically over three to six months, generally in the form of one 2–3 hour session per week
- (sometimes, depending on the risk posed by the man and the complexity of issues in his life) a few individual sessions parallel to participation in the group work component of the program.

MBCPs vary in their intervention models and approaches, but they all focus on working with men to help them take responsibility for their behaviour; to identify their existing values and ethics that support pathways to non-violence and respect for family members; to make non-violent choices irrespective of their emotions and 'triggers'; to identify and change underlying beliefs that support the use of violence, control and abuse; and to understand and consider the experiences and needs of adult and child family members affected by their behaviour.

1. Gondolf, E. (2012). *The Future of batterer programs: Reassessing evidence-based practice*. Boston: Northeastern University Press. See also <http://respect.uk.net>

MBCPs are designed specifically to work with men towards changing their violent and controlling behaviour. They are run by psychologists, social workers and other practitioners with specialised training and experience in working with DFV perpetrators. The quality of this work is supported by NSW Government–endorsed professional practice standards to which MBCP providers need to adhere in order to receive NSW Government funding for this work.² These guidelines are essential to promoting safe and appropriate practice because, due to the highly complex and difficult nature of the work, programs that do not meet the standards can inadvertently do harm.

Men aged 18 or over who are using DFV are eligible to participate in MBCPs. MBCP providers accept referrals from a wide range of sources – some men are mandated or semi-mandated to attend through the justice or child protection systems, others attend voluntarily. However, MBCP providers expect that most, if not all, men who enter an MBCP – irrespective of whether their attendance is mandated or voluntary – will begin with a high level of denial about their behaviour and with relatively low motivation to change.

Providers will generally accept referrals for men who are experiencing AOD use and/or mental health issues, provided they have the capacity to attend group or individual sessions and that these issues are being managed through appropriate services.

An essential component of MBCPs is partner contact and support. All current partners of participants are offered support by a partner contact worker for the duration of the man's participation in the program (and in some cases for longer). Previous partners might also be offered support, particularly if the man spends time with their children. Partner contact assists with risk assessment and can support women with safety planning, provide information about the program, and provide a listening ear as the woman explores what the changes he might or might not be making mean for her.



Finding an MBCP for a client

To find out about the MBCPs in your area, contact a provider directly or contact the Men's Referral Service. In some circumstances the Men's Referral Service can engage in short-term, phone-based introductory behaviour change work with men who need to wait before a place becomes available to participate in a local MBCP.

ACON runs specific programs for people from gender- and sexuality-diverse communities who use DFV, including those who do not identify as male.

A small number of Aboriginal Community Controlled Organisations in NSW offer specific programs for Aboriginal men who use DFV.

There are also currently a small number of trials of MBCPs in NSW of in-language, in-culture programs for particular ethnocultural communities; however, most mainstream MBCPs have a significant proportion of men from migrant, refugee and other culturally and linguistically diverse backgrounds.

2. See <http://www.crimeprevention.nsw.gov.au/domesticviolence/>

6.3 Specialist DFV fathering programs

It is widely known that men's use of DFV can have significant effects on their children. There is also a growing body of evidence of the negative effects a man's use of DFV can have on family functioning as a whole. Many DFV perpetrators deliberately target the adult victim-survivor's capacity to parent and her relationship with her children. Many DFV-perpetrating fathers also display problematic parenting practices and do not relate to their children in child-centred ways.¹

Generic parenting programs that have not been developed specifically for fathers who perpetrate DFV are often not suitable referral options for these men. These programs do not address the belief systems or dynamics through which DFV-perpetrating fathers come to parent in harmful ways, nor through which they directly or indirectly sabotage the parenting capacity and confidence of the children's mother.

A small number of DFV-specific fathering programs are now being established in Australia, including the Caring Dads program, adapted from Canada. Caring Dads is not an alternative to MBCPs, and it is important for DFV perpetrators who use significant levels of violent and controlling behaviour to participate in an MBCP first. However, Caring Dads is an option for men who need a second stage of work to become more child-centred and child-focused fathers.

1. Callaghan, J., Alexander, J., Sixsmith, J., & Fellin L. (2018). Beyond 'witnessing': Children's experiences of coercive control in domestic violence and abuse. Beyond the physical incident model. *Journal of Interpersonal Violence*, 33(1), 1551-1581; Fish, E., McKenzie, M., & MacDonald, H. (2009). *Bad mothers and invisible fathers: Parenting in the context of domestic violence*. Domestic Violence Resource Centre Victoria; Heward-Belle, S. (2016). *The diverse fathering practices of men who perpetrate domestic violence*. *Australian Social Work*, 69(3), 323-337; Katz, E. (2019). *Coercive control, domestic violence, and a five-factor framework: five factors that influence closeness, distance, and strain in mother-child relationships*. *Violence Against Women*, 25(15), 1829-1853; Lamb, K. (2017). *Seen and heard: embedding the voices of children and young people who have experienced family violence in programs for fathers*. PhD thesis. University of Melbourne; Lapierre, S., Cote, I., Lambert, A., Buetti, D., Lavergne, C., Damandt, D., & Couturier, V., (2017). *Difficult but close relationships: Perspectives on their relationships with their mothers in the context of domestic violence*, *Violence Against Women*, 24(9), 1023-1038.

7

NADA Practice Resource

MOTIVATING A REFERRAL TO AN MBCP OR OTHER APPROPRIATE INTERVENTION



KEY POINTS AND PRINCIPLES

- Investigating local MBCPs in advance and knowing how they work can make a referral more persuasive.
- Men who use DFV will often agree to participate in an MBCP mostly due to external motivations, such as to save a relationship or a to meet the requirements of the child protection or justice system. MBCP providers are accustomed to men having relatively little internal motivation to change at the start of the program.
- It is best to refer a client directly to an MBCP. However, drawing on existing motivational interviewing skills will help to create an invitational conversation that encourages the client to consider the referral, by linking the referral with his goals, what he hopes for himself and for his future, and what type of man/partner/father he wants to be.
- It is important not to imply that taking this step will guarantee that he will be able to save his relationship or 'get his partner back' – this will also depend on the victim-survivor's choices and what will be safe.
- Many men who perpetrate DFV do not realise how their behaviour is harming their children. It might be possible for an AOD practitioner to 'plant some seeds' that one of the most important things he can do as a father is to contribute to a family environment in which everyone feels safe, and that it is therefore hard to be a good father while using violent and controlling behaviour against the child(ren)'s other parent. A referral to an MBCP can then be reframed in this way.
- There should be follow-up in the next session about whether he has acted on the referral – not to shame him if he hasn't but to reaffirm the importance (to him and to those affected by his behaviour) of taking this step.
- AOD practitioners can phone the Men's Referral Service to obtain an on-the-spot secondary consultation on how best to approach a conversation with a client about his use of DFV, and how best to attempt to motivate him to accept a referral either to MRS or directly to an MBCP.
- The mere fact that a man has completed or is completing an MBCP is by no means a guarantee that he has made shifts in his behaviour or that he poses any less risk to those affected by his behaviour. Outcomes vary substantially from man to man.
- Motivating a client to accept a referral to an MBCP or to call the Men's Referral Service is not the only goal of an AOD practitioner in considering a client's use of DFV. In cases where risk and/or harm being caused to victim-survivors appears serious, the most important actions an AOD practitioner can take might not involve engagement with the client at all about his use of DFV, but rather sharing information with a DFV Local Coordination Point or other agencies so that they can reach out to the victim-survivor(s).

7.1 How to approach referral

Men who use DFV do not need to be highly motivated to change their behaviour in order to commence an MBCP. MBCP practitioners are used to working with men with relatively little internal motivation for change – developing this motivation is part of the work of the program.

However, while MBCPs do not require men to be ‘change ready’ at the start, their work can be more effective if participants have already begun to think about how participation in the program might benefit them.

Many men begin an MBCP because of an external mandate or external pressure of some kind, such as a referral from child protection or the courts. Other men voluntarily decide to participate because of a different kind of external motivation – they might believe, for example, that by doing so they can persuade their recently separated partner to return to them, or that it will ‘look good’ in an upcoming family law hearing.

Developing an internal motivation to change can be a long process for a perpetrator of DFV, but an AOD practitioner can ‘plant some seeds’ and, by doing so, encourage the client to at least consider participating in an MBCP.

It is best to refer a client directly to an MBCP. However, if a client is particularly hesitant to accept a referral to an MBCP, he can instead be encouraged to phone the Men’s Referral Service (MRS) as a first step.

A possible conversation might begin as follows:

“Phil, I’d like to provide you with some information about a service for men that I talk about with many of my clients. It’s called the Men’s Referral Service.

It’s a service for men who have noticed or have concerns that their behaviour is affecting the people they care about or is making their life harder. It’s a phone-based service, but it’s also possible to chat with them online, at least initially. You can speak to someone who’ll listen, who speaks with many men in a similar situation to yours, and who will also give you some advice on what steps you can take to start to make things work better.

They receive hundreds of calls a month from men. Can I give you their details?”

This approach normalises the referral (“that I talk about with many of my clients”, “They receive hundreds of calls a month”). It does not sugar-coat the referral, because if Phil looks up the website he will see that the service focuses on DFV. The language of ‘giving advice’ rather than ‘getting help’ can also be beneficial, as sometimes men can be more receptive to the former (although the need for men to reach out for help is becoming more socially acceptable).

Developing an internal motivation to change can be a long process for a perpetrator of DFV, but an AOD practitioner can ‘plant some seeds’ and, by doing so, encourage the client to at least consider participating in an MBCP.

This approach also attempts to appeal to Phil’s own interests (“what you can do to start to make things work better”), although of course there is a fine line here in terms of collusion. If Phil appears to be accepting a little bit of responsibility for his behaviour, this language could be changed to “and who will also give you some advice on what steps you can take to be a safer man”.

A man might be motivated to phone the MRS or participate in an MBCP in order to persuade his recently separated or separating partner to return to the relationship, but a practitioner should never imply that this result will be more likely if he takes this action. His partner might prefer not to return to the relationship due to concerns about her safety or for other reasons. Separation is already a time of heightened DFV risk – if a client believes that by participating in a program his partner will be obliged to return to him and she in fact chooses to remain separated, then this can increase DFV risk even further. Linking the client’s participation in a program to the possibility of relationship reunification also makes victim-survivors responsible for his change, and denies their own experiences and choices.

7.2 Using existing motivational interviewing skills

To build a client's motivation towards phoning the MRS or contacting an MBCP, it can be helpful to explore what matters to him and what he would like in the future for himself and for those he cares about.

This approach will largely be informed by the extent to which the client is willing to disclose and talk about his use of violence. However, perpetrators who are reluctant to discuss their violent behaviour might still be drawn to the idea of using a men's DFV service to become the best father they can be or to 'stay out of trouble'.

The motivational interviewing techniques that AOD practitioners use to talk with clients about their substance use can also be applied to their use of violent and controlling behaviour. If a client is willing to discuss at least something about his behaviour, then he might also be willing to explore the dissonance between his hopes for himself and his family, and his current behaviour.

A possible conversation might begin as follows:

"Phil, you said earlier that you want to reduce your alcohol use because you said you can be 'a bit unreliable' and 'a bit all over the place' [the client's words] when you drink? What's a positive quality that you'd like to be known for by other people, if you were less unreliable and less – can I say less erratic, is that the right word?"

"Yeah, erratic is probably right. Ah, um, I guess I'd like to be known as a calm, easy going guy – someone who's dependable."

"OK. What difference would being a calmer, more dependable man make to your life?"

and/or

"How would you being calmer and more dependable benefit other people?"

and/or

"On a scale of 0 to 10, how important is it to you to be a calmer, more dependable man?"

This initial exploration of the importance of the value to the client's life could then be followed with:

"I can hear, Phil, that becoming a calmer, more dependable man is really important to you. You've mentioned how you can become 'all over the place' and unreliable when you drink – that it takes you away from being the type of calm, easy going person you'd like to be. Is that right?"

"Yeah."

"I wonder, when you get physical with Louise, does that also take you away from being that calm, dependable man you want to be?"

"Look, I only got physical with her once – it was just that time when she..."

“Phil, if I can interrupt here – sorry to speak over you – but you mentioned before that Louise was close to calling the police. And you agreed that there is a possibility that Louise was feeling quite afraid. We don’t know for sure – Louise isn’t here to share her perspective – maybe there have been other times when Louise has felt unsafe around you, maybe not. [The practitioner uses Louise’s name rather than ‘she’ as much as possible, in order to humanise her as a person with her own needs and experiences.] But say your behaviour has made Louise feel unsafe, at least from time to time. How does that affect you wanting to be a calm, dependable man?”

“I guess she might feel a bit wary around me. If I was calmer she wouldn’t probably feel that way. She probably wouldn’t end up wanting to call the cops.”

If Phil and Louise have children, and Phil considers himself part of a family, the practitioner might also ask questions like:

“What’s important to you in being a husband/father?”

“What’s important to you about family?”

“What does family safety mean to you? On a scale of 0 to 10, how important is it to you for your family to feel safe?”

“Why is it that important to you?”

“How is ‘getting physical’ with Louise getting in the way of your family feeling safe, and being happy?”

Many perpetrators have little awareness of how their use of DFV affects their children. They might believe that their children have not seen or heard the violence, and therefore assume that they have not been affected at all. This issue is discussed further below.

7.3 Drawing on motivations linked to parenting

There is ample research showing the substantial negative effects of DFV on children. This research clearly demonstrates that it is not possible to be a 'good father' and perpetrate DFV. Men who express great love for their children – and who profess to care for them deeply – still greatly harm those children when they perpetrate violent and controlling behaviour against the children's other parent.

The narrative of 'but he's a good father' runs deep in our society. Most perpetrators believe it, and it is a myth that is still widely accepted in the broader community.

It might be possible to use motivational interviewing techniques, if a client is a father, to explore the dissonance between his self-identity as a good father and his actual behaviour. For some men who use DFV, starting to see the effects of their violence on their children, and/or how this behaviour takes them away from being the parent they want to be (or think they are), can be a powerful motivator to change. For others, this is too much to confront early on, and might instead result in them retreating.

The safest way to frame a discussion of parenting-related motivations is to raise the idea of 'being the best father you can be'. Using this idea, it might be possible to explore the client's hopes for his children and the ways in which his current behaviour might affect those hopes.

Nobody wants to be told they're a bad parent, so any information an AOD practitioner provides about the effects of DFV on children should be framed gently. For example:

"Sometimes we think we do things that people – particularly children – won't notice or be aware of. But children in particular can be acutely aware of the atmosphere around them. They pick up on all sorts of behaviours, feelings or vibes, just by noticing their surroundings. Children, like adults, notice their surroundings to try to get a sense of what's safe and what's not – to help protect themselves.

It can be hard to believe and to hear, but it's very likely that your children are being affected by your behaviour in ways that you aren't aware of."

When planning to explore parenting as a motivation, beginning by asking general questions about the client's children can be a neutral way to warm up to more motivational questions. For example:

"Could you tell me a bit about each of your children? What do they like doing? What makes them happy? What surprises you about them? What do they find difficult? What things does each of them struggle with?"

Moving on, some early motivational questions might include:

“What do you hope for as a parent?”

“How do you think your behaviour affects your hopes as a parent? And your wishes for your children?”

“What is your son learning from you about how to treat girls and women?”

“What is your daughter learning from you about how women should be treated in a relationship – about what’s acceptable?”

“What will happen if they take these learnings into their first relationships?”

“How might your children see you in ten years’ time, if they continue to experience the behaviour you are using at home?”

“How do you think relating to their mother with respect rather than violence might benefit your kids?”

“How do you think your children would like you to treat [name of their mother]?”

“How important is it for you to be the best father you can be?”

“Are you ready to start looking at how your behaviour is getting in the way of that?”

Of course, some of these questions might be beyond the scope of what’s possible to explore in any given situation, depending on the strength of the working relationship and what the client is willing to disclose about his behaviour.

7.4 Exploring enablers and barriers to acting on a referral

A motivational approach would also involve exploring factors that might help or hinder the client acting on a referral.

A possible conversation might include some of the following:

“Phil, that’s great that you’ve agreed to give the Men’s Referral Service a call. As we’ve discussed, it’s going to be easier for us to work together on your drinking if you take steps towards becoming a calmer, more dependable man for other people to be around.”

“Giving the Men’s Referral Service a call is a big step. When you leave today’s session, what sorts of things might go through your mind to talk yourself out of making the call?”

“This would be a big step to give them a call. Do you think you’re ready?”

“What would help you to be ready to take this step?”

“What would taking this step say about your commitment to being the best partner/father you can be?”

“What might make you hesitate to take this step? What can you tell yourself if you do start to hesitate in making the call?”

“What might come up for you that would get in the way of you making this call?”

“What do you need to remind yourself to take this step?”

“What other things might you need to do to feel able to make this call?”

7.5 Seeking a secondary consultation

When referring a client directly to an MBCP, it can be helpful to have a secondary consultation with the program provider first, as this will help to formulate how best to introduce and talk about referral.

Remember that AOD practitioners can phone the MRS to obtain an on-the-spot secondary consultation on how best to approach a conversation with a client about his use of DFV, and how best to attempt to motivate him to accept a referral either to the MRS or directly to an MBCP.

Given that perpetrators’ motivations to act on a referral are often ambivalent, most MBCPs will accept a ‘warm referral’, in which an AOD practitioner books an intake or assessment time on behalf of a client while he is in the room with them. If he is not ready for this step, he might be encouraged instead to phone the MRS immediately after the session, maybe using a room at the AOD agency if there is one available.

7.6 Following up on a referral

It is important to follow up in the next session regarding whether the client has acted on the referral. Providing information about the referral once and never mentioning it again signals to the client that the referral, and his use of DFV, is not a priority issue.

Many clients will choose not to act on the referral, despite a practitioner's best attempts to motivate him to do so. This is consistent with victim stance thinking and the associated hesitancy to take responsibility for his own behaviour. It is therefore common to need to come back to conversations about why it is in the client's best interests to act on the referral.

It is important to do this in a way that does not shame the client for not acting on the referral. It is much more helpful to maintain an invitational approach towards how taking the step to contact the MRS or an MBCP can help him to be the type of man, partner or parent he wants to be.

If he still does not act on the referral, at least the practitioner might have planted some seeds. It might take several conversations and approaches from different practitioners and people in his life over months or even years before he takes this step.

Motivating a client to accept a referral to an MBCP or to call the Men's Referral Service is not the only goal of an AOD practitioner in considering a client's use of DFV. In cases where risk and/or harm being caused to victim-survivors appears serious, the most important actions an AOD practitioner can take might not involve engagement with the client at all about his use of DFV, but rather sharing information with a DFV Local Coordination Point or other agencies so that they can reach out to the victim-survivor(s).

7.7 Supporting the client's participation in the program

Helping him navigate any waiting period

The 'windows' during which a man will accept a referral to an MBCP can be narrow. They may arise during or following a crisis in which he has something important to lose if he does not change his behaviour. During this window, there might be some potential starting points of the man accepting some responsibility for some of his behaviour.

These windows close quickly, however. His customary habits of blaming others and feeling like the 'victim', which he has used for years to minimise and excuse his behaviour, can quickly bury any inklings of self-awareness that his behaviour needs to change.

As a result, if a practitioner is not able to find quick access for a client into an MBCP due to program waiting lists, staying involved with the client and providing follow-up contact during the waiting period is crucial.

This can take the form of motivational interviewing to encourage him to think about the reasons participating in the program would benefit him and what he wants for his life. Without this, his motivations to participate can rapidly decline, and the opportunity can be lost.

If a man is informed by the only available MBCP in his area that he must wait months before he can start a program, and if the MBCP provider is not able to do any one-to-one work with him during the waiting period, then the MRS might be able to provide some phone-based bridging sessions during this period. The AOD practitioner can phone the MRS to discuss.

Supporting his participation in the program and adopting consistent messaging

If an AOD practitioner is likely to have continuing contact with a client while he participates in an MBCP, the AOD practitioner should talk with the MBCP provider about how best to encourage and support the man's participation in the program. Staying involved, and talking to the program provider about how continued engagement with the man can support what the program is attempting to achieve can lead to better outcomes.

It is crucial for the AOD practitioner and the MBCP provider to adopt consistent messaging about the client's responsibility and accountability for his behaviour. If the client receives messages from an AOD practitioner that attributes responsibility for his violence to his AOD use, mental health issues, poor self-esteem, adverse childhood experiences or other traumatic experiences, his work with the MBCP will be undermined.

Of course, addressing such issues in counselling or psychotherapy parallel to his participation in the MBCP can be of tremendous help, but it is important to do so in ways that do not leave him blaming factors such as these for his behaviour. Men who use DFV are very adept at avoiding responsibility for their violence by blaming other things and other people.

Not assuming he is making shifts in his behaviour by mere virtue of program participation

Men's behaviour change work is difficult, and outcomes differ significantly from man to man. The underlying attitudes and beliefs that drive men's DFV behaviour can be deeply embedded and difficult to shift.

There is no doubt that some men make significant shifts due to participation in an MBCP, and become much safer for current or future family members to be around. However, often such change is incremental.

In addition, some men make only modest changes to their behaviour, or changes that they do not sustain. Some men make shifts in some aspects of their behaviour but not others. Other men change little and remain a significant risk to family members despite their participation in a program.

It is important therefore to remember that the mere fact of a man completing an MBCP is by no means a guarantee that he has made shifts in his behaviour, and that he poses less of a risk to those affected by his behaviour.

8

NADA Practice Resource

FURTHER RESOURCES AND GUIDANCE

8.1 DFV perpetrator intervention peak body websites

These contain valuable information and practice guidance on engaging perpetrators of DFV.

[No to Violence](#) (includes Men's Referral Service)

[Stopping Family Violence](#)

[SPEAQ](#) (Services and Practitioners for the Elimination of Abuse Queensland)

[Respect](#) (UK)

[European Network for the Work with Perpetrators of Domestic Violence](#)

8.2 AOD sector resources on engaging men who cause DFV harm

A framework for working safely and effectively with men who perpetrate intimate partner violence in substance use treatment settings

Kings College London (Hughes, Fitzgerald, Radcliffe & Gilchrist), 2015

This framework outlines the key capabilities required to work with men who use substances and who perpetrate DFV. It is primarily for practitioners who work within AOD treatment services but is also relevant to those who plan and lead service developments within the AOD sector, including managers and funders.

Complicated matters: A toolkit and e-learning programme addressing domestic and sexual violence, problematic substance use and mental ill-health

Stella Project (2013)

This resource is designed to raise professional awareness of how these three issues relate to each other, and to encourage reflective practice on the most effective ways to engage with individuals and families affected by these issues. It includes information on the links between experiences of domestic and sexual violence, problematic AOD use and mental ill-health; how to encourage victim-survivors to engage with services and how to meet their needs; how to increase safety for victim-survivors and their children; how to hold perpetrators accountable for their behaviour; how to develop a holistic approach based on partnerships and integrated work across agencies; and practical tools that enable organisations to improve policy and practice.

8.3 Resources for practitioners to use with clients

Better Man online interactive resource

Safer Families (2019)

This is a brief online healthy relationships tool designed to motivate men to seek help for DFV. It comprises three modules: Better Values, Better Relationship and Better Communication. Practitioners from a range of settings, workforces and sectors can use the tool with clients to provide them with awareness and motivation to seek help for their violent behaviour.

Choose to Change: Your Behaviour, Your Choice

Safe and Together Institute (2020)

This is a resource that practitioners can use to help men who use violence to develop a support network to interrupt their violence and increase safety for their family members. It guides men through a four-step process to take an active role in developing a Choose to Change Network. It also provides information and guidance for those who agree to be part of a man's support network, as well as guidance for practitioners on how to use the resource with their clients, and information for partners of the men.

8.4 Other resources and guidance

NSW Risk, Safety and Support Framework: A guide for responding to men who use domestic and family violence (the RSSF)

No to Violence (2020)

The RSSF is highly useful for guiding AOD practitioners and services (among others) towards addressing DFV, and is a more comprehensive guide covering a wider range of issues and considerations than the NADA resource you are reading now. While written in part for practitioners working in the specialist male DFV sector, both Part 1 (Foundations and key concepts for effective practice in engaging men) and Part 2 (Practice guide) are highly relevant to a broader range of practitioners and service sectors working with clients who use DFV. The framework is designed to increase the safety of victim-survivors by establishing a shared understanding of DFV risk across the system and a common approach to identifying and responding to DFV risk through collaboration and shared responsibility.

Engage: Roadmap for frontline professionals interacting with male perpetrators of domestic violence and abuse

Work with Perpetrators – European Network (2019)

This is an excellent set of resources for practitioners without specialisation in DFV on engaging perpetrators, based on a four-step roadmap. It includes a helpful practice resource containing relevant micro-practice strategies and tips and a set of training guidelines. While produced in Europe, most of the guide is highly applicable to Australian contexts.

Engaging with perpetrators of domestic violence: Practical techniques for early intervention

Kate Iwi and Chris Newman, Jessica Kingsley Publishers (2015)

While written for child protection social workers, this book provides detailed practice suggestions on a range of issues relating to engaging men who use DFV that are relevant to many workforces. It includes practice tips on working with clients causing DFV harm on preliminary violence interruption strategies as a bridge before their participation in a specialist MBCP. It is highly recommended for AOD practitioners who want some more advanced practice strategies in their toolkit.

Working with perpetrators of domestic and family violence: A toolkit to support community housing providers

Community Housing Industry Association NSW (2018)

This toolkit offers community housing providers practical resources, strategies and information to support engagement with perpetrators of DFV. It is accompanied by a series of supporting resources that practitioners can adapt to suit their needs.

Victorian Multi-Agency Risk Assessment and Management Framework: Guidance on risk assessment and risk management with family violence perpetrators, MARAM Family Safety Victoria (forthcoming)

This framework provides practice guidance on roles, responsibilities and engagement strategies in relation to clients who pose DFV risk. While focusing primarily on specialist DFV practitioners and services, it is also highly relevant to practitioners in other service sectors without such specialisation. At the time of this NADA resource's publishing, most available MARAM resources focus on engaging victim-survivors; additional resources focusing on engaging perpetrators are due to be published in 2021. This will include a tool that can assist these workforce to identify clients who are, or who are highly likely to be, perpetrating DFV, based on sets of observable indicators across several domains.

Practice Guide: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues

ANROWS (2020)

Based on the [Safe and Together](#) model, which focuses on perpetrator accountability by mapping patterns of perpetrator DFV behaviour and drawing links to the effects on child and family functioning, this guide focuses on six themes relating to working with intersecting DFV, parental AOD use and mental health issues: partnering with women (victim-survivors), working with men, focusing on children and young people, working collaboratively with other services and agencies, working safely, and influencing organisational practice change and capacity building.

Invisible Practices: Working with fathers who use violence (Practice Guide)

ANROWS (2018)

Based on the [Safe and Together](#) model, this resource provides useful examples of conversations with clients about their use of DFV, and suggestions for how to think about men's role as fathers and the intersection with DFV.

8.5 Training on engaging DFV perpetrators

In addition to professional development sessions and activities organised through NADA, the NSW Health Education Centre Against Violence offers both face-to-face and online training opportunities for practitioners who wish to develop their skills in engaging men who perpetrate DFV.

Currently available courses include:

- Engaging Perpetrators of Domestic and Family Violence: Health Workers Responding in Non-Collusive Ways
- Skills in Working with Male Family Violence
- Essential Skills in Men's Behaviour Change Programs
- National Graduate Certificate in Men's Behaviour Change Individual and Group Work Interventions.

