



Interrupting Male Violence with Men who use Domestic and Family Violence

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EXECUTIVE SUMMARY

This paper focuses on brief, safe and effective male family violence intervention (MFVI) practice for generalist Health and human services sector workers to respond, in a range of settings, in a manner that maintains the safety of women and children, whilst increasing responsibility and accountability of men who use domestic and family violence (DFV).

ECAV advocates for a whole of system response with a range of interventions that aim to ‘interrupt violence’, and support better referrals to specialist Men’s Behavior Change Programs (MBCP)³ or to trained Men’s Domestic and Family Violence specialists (MDFVS)⁴. Violence can be ‘interrupted’ in a number of ways without necessitating direct work with men to stop this behavior, which is the domain of specialists (MBCP/MDFVS). These are outlined in this paper and include such interventions as identifying risk factors and sharing information when indicated, and developing safety plans to keep women and children safe; identifying a man’s abusive/controlling tactics and not colluding with him in excuse-making or partner-blaming; focusing on how his parenting and partnering choices affect his family; and keeping men’s use of violence visible when working solely with their partners and children.

It is hoped that this paper will help shape policy and practice for these workers, and will support the NSW Health Education Centre Against Violence (ECAV)’s development of a suite of training modules to increase skills, confidence and the build the necessary competencies to safely work with men on their presenting/identified issue (e.g. mental health, drug and alcohol) whilst effectively recognizing, responding and referring appropriately for DFV related issues. Training programs will focus on men’s use of controlling, coercive and violent behaviors, and assist men to be accountable for the choices they make as fathers and partners. Keeping men and their actions visible, when working with individuals and families experiencing DFV is a key feature for policy development across a broad range of services within Health and the human services sector.

This paper assumes that the workforce (Health and human services sector) should be adequately trained in competent responses to domestic and family violence which prioritise the safety of women and children.

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³ Specialist MBCPs are accredited through the Department of Justice NSW and fully adhere to the NSW Minimum Standards for Men’s Behaviour Change Programs. These specialist programs offer a suite of interventions over an extended period of time towards increasing the safety of women and children, holding the perpetrator responsible and accountable for their abusive/violent behaviour and working towards his engagement in safe and respectful relationships. These programs are integrated into each geographical location, and work collaboratively with other services who may interact with men, women and children in the family violence space.

⁴ This specialist training is being developed by ECAV and will be available in 2018.

This paper will inform a spectrum of brief intervention practices in three settings where workers are:

1. Working directly with women when the man is not in contact with the service but DFV is identified.
2. Working separately with women or separately with men where it becomes apparent that DFV is a key factor in their lives, and may be contributing significantly to their presenting issue in settings such as mental health, drug and alcohol services, child protection services, specialist homelessness services (SHS).
3. Focusing on the impacts the violence has on both partners' parenting in settings such as child protection services (NSW Health, Family and Community Services (FACS) and Child ,Youth and Family support Services), Family Referral Services, Brighter Futures, Intensive Family Preservation, Family Dispute Resolution services.

These practices will assist workers in MFVI to identify and assess risks, with the goal of interrupting DFV, thereby reducing risks to women and children in the short-term. Case-planning/management and appropriate referrals to specialist domestic violence and sexual assault⁵ services for victims, and to MBC Programs⁶ for men and MDFVS are also part of this spectrum.

Key themes, philosophical and theoretical underpinnings will inform evidence-based, best practice educational packages that aim to keep the safety of women and children at the centre of all training. Out of scope of this paper is the more intensive and targeted training that is being developed separately by ECAV to cover specialist MBCPs and MDFVS.

RATIONALE FOR A FOCUS ON WORKING WITH MALES WHO USE VIOLENCE

Based on the Australian Bureau of Statistics' 2012 Personal Safety Survey, the cost of violence against women nationally in 2015-2016 has been estimated at \$22 billion with an additional \$4 billion to be added in consideration of the underrepresentation of vulnerable groups in the survey (KPMG 2016)⁷. NSW has the highest costs compared with other States and territories (\$6.02 billion, *op.cit.*). Whilst the costs to NSW Health are not known definitively, the Department's revised policy, standards and guidelines strongly reflect NSW government priorities of keeping women and children safe, and of making men responsible for their use of violence. This paper focuses on male family violence intervention (MFVI) practice for generalist Health and human services sector workers to respond in a manner that maintains the safety of women and children, whilst increasing responsibility and accountability of men who use domestic and family violence.

ECAV holds the position that gender⁸ is the main driver for violence against women and children (VAWC) with women and children overwhelmingly the victim/survivors of men's violence. International and national research supports this, and clearly indicates that it is predominantly males who perpetrate violence against women and children – and towards other men (ANROWS, 2016; ABS, 2015; NSW Death Review Team, 2015; WHO, 2013; Our Watch, Change the Story 2015).

It is recognised that there are small numbers of men who are genuine victim/survivors of DFV within heterosexual relationships, and within same-sex attracted relationships (ANROWS, 2016: ABS, 2016). This paper however, will

⁵ Sexual assault is often a tool of DV. Almost one-third of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (World Health Organisation 2013).

⁶ Specialist work with men is evidence-based. Programs and practice models are continuously improved through evaluation and research. Staff working for specialist men's behaviour change programs (MBCP) receive an optimal level of training, ongoing regular supervision and professional development opportunities. Programs will adhere to the NSW Minimum Standards for MBCP for organisations and staff working in programs.

⁷ These vulnerable groups include Aboriginal and Torres Strait Islander women, homeless women, pregnant women and those with a disability (KPMG 2016).

⁸ See Appendix for the Australian Human Rights Commission's covenants that underpin ECAV's position on DFV.

use language identifying the perpetrator as male (he/him/his), and women and children as victim/survivors (she/her/children).

Particular expressions of gender inequality are pervasive throughout society and are noted to consistently predict higher rates of violence against women. These include:

1. Condoning of violence against women
2. Men's control of decision-making and limits to women's independence in public and private life
3. Rigid gender roles and stereotyped constructions of masculinity and femininity
4. Male peer relations that emphasise aggression and disrespect towards women (Our Watch, Change the Story, 2015)

Whilst for men and women, alcohol and other drug (AOD) misuse, histories of trauma, unattended mental health issues, homelessness, age, attachment issues, physical and/or cognitive ability are all correlates of DFV, and may have a role in exacerbating it, they are not causal factors of DFV. It is important to comprehensively understand the contextual differences in women and men's experiences of these factors, as they present in DFV. Also, exploring 'causes' detracts from timely and evidence-based interventions to increase the safety and well-being of women and children exposed to violence, and detracts from men's purposeful use of violence, whether these factors are present or not.

While it is essential to acknowledge the gendered nature of DFV, it is equally important to consider the other multiple factors of disadvantage that intersect with gender to impact on the differing individual experiences of women, children, and men, which can pose barriers to access much-needed services. These may include cognitive and physical ability⁹, culture, Aboriginality, religion, age, sexual orientation¹⁰, migration status, and living in rural and remote locations. The intersection of disadvantage further marginalises and isolates victims/survivors of violence, leaving them more vulnerable to longer periods of abuse.

Organisations have a responsibility to address the adequacy and appropriateness of services, and the barriers victim/survivors face in accessing them. Knowledge of the nuances of intersectionality needs to inform the practice of generalist and specialist workers in their responses to the diverse and individual experiences of women, children and male partners in same sex relationships, when conducting brief interventions with them. Intersectionality also needs to inform work with the men who use DFV, to ensure the safety of women, children and male partners remains central to frontline service delivery. Thoughtful analysis of the factors of disadvantage that may impact on a man's ability to seek help for his use of violence may in part be ameliorated by taking an authentic, respectful approach that actively acknowledges these nuances.

The most beneficial responses to people with special/diverse needs are provided when there are strong, collaborative, cross-sectoral partnerships which promote a sharing of expertise between specialist and other services to build capacity.

⁹ According to Healey et al (2008) women with disabilities continue to be at risk of being assaulted, raped and abused at least twice the rate of that of non-disabled women, regardless of their age, race, ethnicity, sexual orientation or class and inadequate levels of support of service delivery. Shah et al (2016) cite many studies that support this figure and refer to disabled women's exposure to various forms of systemic as well as individual abuse, specific to their impairment, from more than one perpetrator, including unpaid and paid carers. They experience this abuse across their life span.

Drawing on preliminary evidence from life history interviews with disabled women

¹⁰ Whilst it is acknowledged that DFV exists within the LGBTIQ communities, it is recognized that victims/survivors and those who use violence currently face many barriers to accessing help from police and mainstream DFV agencies, as many services currently are not meeting their unique needs. ACON are in the process of developing policy and best practice guidelines on how to effectively engage and work with LGBTIQ perpetrators of violence.

Intervention Models and Practices are informed by principles of:

1. Safety
2. Responsibility
3. Accountability
4. Education to make healthy, respectful choices
5. Best practice and evidence base

Whilst acknowledging the possible existence of a man's history of trauma, brief MFV interventions and MBC programs do not work directly with trauma¹¹. If required, referral of male clients to other mental health services (e.g. psychologist, drug and alcohol services or psychiatrists) for assessment and support to help a man manage his trauma symptoms is advised when historical or current trauma is identified.

All service providers can support men's pathways towards participating in specialist interventions (MBCP/MDFVS services), and collaboratively contribute towards risk assessment and risk management goals. They can reinforce the work of the MBCP/MDFVS worker by clarifying that a man's trauma, drug and alcohol use, and/or unmanaged mental health are not the reasons that DFV is occurring. Referral to these specialists will assist men who use DFV to identify his underlying beliefs, reasoning and justification for his use of DFV.

Foundation Principals underpinning ECAV's position on domestic and family violence

Women and Children:

- ECAV regards male family violence interventions as opportunities to interrupt men's use of violence in order to increase the safety of women and children. This can be done by bringing his and his partner's attention to it. There is a continuum of practice, from identifying and assessing male violence to therapeutic individual and group work with men, which needs to be done in ways that always enhance the safety of women and children. Safety is paramount and needs to be considered at all stages of engagement with men, in any service setting.
- Every intervention with men who use violence carries risk. All workers (male and female) who engage with men are required to have a sound working knowledge of domestic and family violence and of men's use of violence, including sexual coercion/abuse, and its impact on the physical and psychological health of women and children, to be able to recognise, refer and respond appropriately to risk, in all their professional interventions.
- Attitudinal and behavioural change, the domain of specialist services in MBC Programs and trained MDFVS, is secondary to the strategic objectives of working towards the safety, wellbeing, human rights and dignity of women, children and others affected by men's use of violence (NSW Department of Attorney General and Justice, 2012 as cited by Vlasis 2014).

¹¹ There is also a risk of excusing men's use of violence because of his trauma.

Men who use violence:

- Men's use of violent and controlling behaviours often follows highly complex and firmly entrenched patterns, and involves a range of tactics to create a climate of fear and control, and to bend family functioning to focus predominantly on their own 'needs' and wishes. These patterns and tactics are very resistant to change, as many perpetrators are heavily invested in maintaining these behaviours, attitudes and belief systems, including their privileged positions as males which they occupy, develop, and seek to retain, despite the best efforts of others and services to change them (Vlais 2017).
- Perpetrators can use these efforts to address their use of violence as justification for the behaviour, as a reason to exacerbate their controlling and violent tactics, minimize the impact of their use of violence and to further disadvantage victims, and to enlist others into their view of the behaviour. This can occur for example, when an inadequately trained worker colludes with the perpetrator's narratives and beliefs used to justify their violence.
- Efforts to change men's violent and controlling behaviours should generally be conducted by specialist perpetrator intervention services and programs, run by practitioners with specialist training and skills in male family violence interventions (e.g. MBCP, Caring Dads and other DFV-specialist fathering programs, and men's DFV case management). Health and other human service sector workers have a role in engaging perpetrators to support their pathways towards participating in these specialist services and programs¹².
- Responsibility and accountability lies with the person who uses DFV in all of its forms.
- Often men will initially present to a service and identify as a victim. Generalist Health and human services sector workers need to consult with a specialist MBCP or MDFVS provider about this presentation, and about how it will impact on their work with the man on other issues if present, such as drug and alcohol or mental health. They need to share relevant information about male violence to specialist services but make no definitive assessments around their use of violence. There is a high degree of skill required for primary aggressor recognition to determine whether a man is a genuine victim or perpetrator, and this currently lies with accredited MBC Programs and the Men's Referral Service (Victoria).
- Some men live in fear of their partner and should be afforded support via identified programs and services.
- Some men report that they experience emotional abuse by their partners and feel controlled around access to their children during separation. Once again, this requires consultation with and effective referral to specialist MBCP or MDFVS providers who can skillfully engage these men to assess and put appropriate interventions in place, if he is identified as the primary aggressor or victim.
- Whilst men can be and are victims of violence and coercive control, the majority of these are in the context of male colleagues/friendships, extended family context, or same sex relationships. Determining who the primary aggressor is fraught, due to men who use coercive control and violence nearly always claiming they are victims of their partner (usually women's) behaviour (Coleman 2017). Toxic forms of masculinity including self-schemas of male privilege and hyper-masculinity can masquerade as caring concern for women through re-directing attention away from the men's own actions, and reframing them as concern for the safety, well-being and mental health of their partners. Such caring concern is in reality a 'Trojan horse', which can easily ensnare unwary workers in colluding with the perpetrator where the worker becomes co-opted into his world view without realising what has occurred (op.cit.). When this occurs, women and children's safety and well-being are compromised, and women's belief that the service system (e.g. mental health, drug and alcohol) sees them as the problem entrenches their isolation and fear.

¹² The role of Health and other human service sector workers will involve using motivational interviewing skills to assist with effective referral to these specialist services in a way that is likely to be accepted and acted upon.

- When an Aboriginal or Torres Strait Islander man has been identified as using DFV, workers need to acknowledge the historical and current impacts of colonisation he experiences as an Aboriginal or Torres Strait Islander, and the barriers he may experience in accessing services and supports, in relation to his DFV.
- DFV shares commonalities in every relationship whether non-LGBTIQ or LGBTIQ, especially with respect to the issue of power and coercive control. Where a man identifies as part of the GBTIQ community, practice and language needs to be inclusive of his unique needs, in order to meaningfully and respectfully engage with him in a manner that supports his access to specialist MBC Programs and trained MDFVS, and which ensures his partner and children are safe.

Service Delivery:

- Organisations have a responsibility to address the adequacy and appropriateness of services provided and the barriers victim/survivors and men who use violence face in accessing them, giving consideration to the individual experiences and needs of all.
- The degree to which Health, Child Protection and other human services sector workers can enact particular responsibilities in perpetrator engagement depends on three key essential elements:
 1. They have participated in base-level training in domestic and family violence, and in essential skills in male family violence interventions¹³
 2. They have access to trained specialist perpetrator intervention providers to enable secondary consultations and advice to help them apply these skills in complex situations
 3. Their agency or service has developed clearly defined policies and procedures for engaging perpetrators, sharing information (including to help keep the perpetrator's victims safe), and working with other agencies/services as part of multi-agency responses to perpetrators (Vlais 2017).
- Health and other human services sector workers are responsible for identifying risk factors and sharing information when indicated. It is dangerous to engage perpetrators in ways that are disconnected from services supporting his family, as it can result in this work being blind to the level and nature of risk he poses to family members (Vlais 2017). At times, the high risk may stand out as obvious (from the way he speaks about his partner, explicit threats to harm her or their pets etc.). However it is also easy to under-estimate risk, based on the man's self-reports and disclosures alone. It is important to be part of co-ordinated or integrated responses that include partner contact, and which involve specialist women's and children's DFV and Child Protection services, police courts, corrections and other services. This approach enables the most accurate and reliable information about the risk the perpetrator poses to family members, to be obtained (op.cit.).
- Organisations are to undertake regular cultural competency training to ensure their workers are able to respectfully engage with Aboriginal and Torres Strait Islander families, keeping local Aboriginal culture, and historical and current impacts of colonisation at the forefront of their MFV interventions.
- Organisations need to ensure staff have completed diversity training¹⁴ that encourages a more nuanced analysis of diversity, and includes an element on understanding how attitudes that reflect gender-based

¹³ See section, *Recommendations regarding training for different levels of engagement, assessment and referral with men who use intimate partner and family violence*, page 9.

¹⁴ ACON provide this diversity training in relation to working with the LGBTIQ community. They are Australia's largest not-for-profit lesbian, gay, bisexual, transgender and intersex (LGBTI) health organisation based in NSW and Australia's largest and most recognised

discrimination, homophobia and transphobia are abusive, and heighten the risk of any gender identity that does not match the traditional cisgender¹⁵, heterosexual, or masculine identity being oppressed, through the use of violence (Langenderfer-Magruder et al., 2016, pp. 860-861)

- Organisations need to ensure staff are sensitive to the migration and refugee experiences of CALD women, children and men, and adopt appropriate communication strategies that include effective engagement of Interpreters.
- Organisations are required to establish a working relationship with Aboriginal and Torres Strait Islander, disability, LGBTIQ and Culturally and Linguistically Diverse (CALD) services to build strong referral pathways into these communities.
- An integrated multi-agency response, including moving beyond case management to case coordination, is essential whereby government and non-government services work collaboratively for the safety of all parties. Organisations need to commit time for workers to develop cross-sectoral partnerships and build capacity relationships with other agencies, including Sexual Assault Services.
- Information-sharing is consent-based unless risk of significant harm exists (children and adults). Organisations need to have policies and protocols in place to guide sharing of high risk-related information.
- Female victim/survivors should preferably be referred to Women's Specialist DV services which utilise strengths-based and trauma-informed approaches, empowerment and assistance with long term recovery. Women should be supported to make informed choices. For example, she may choose to remain in the relationship and/or to continue to reside at the family home. These choices need to be honoured through the provision of non-judgmental support and advocacy.
- As DFV harms children, sound child protection assessments and reporting processes are to be followed. Children's experiences of DFV are to be kept at the centre of child focused trauma-informed service responses.
- Crucial to any work with men who use DFV are comprehensive ongoing risk assessments, safety planning (acute and dynamic to changing life circumstances and risk), and case coordination for victim/survivors and children. These same processes need to be used with the man when assessing ongoing risks around his use of violence e.g. how is he going to work towards maintaining the safety of his current/former partner and children? How is he going to abide by the conditions of his Apprehended Domestic Violence Order (ADVO)? This is highly complex work and involves assessment of the levels of his risks, and integrating this into his safety plan and case plan. These processes are currently being developed by ECAV.
- Where current and former partners of men are engaged in services within specialist Behaviour Change Programs, it is essential that MBC workers have a comprehensive understanding of victim/survivor experiences and a commitment to keeping this at the forefront of their practice. This also applies to trained MDFVS. Strong, informed and collaborative case management and information-sharing between MBC/trained MDFVS and Health and human services sector workers is essential for best outcomes for all family members.
- Couple counselling or mediation is considered dangerous where DFV exists and may seriously endanger the safety of women and children following these sessions. A woman may feel safe enough to discuss something

national provider for LGBTI inclusion, operating across all states. Their Pride in Diversity Training Stream offers this general training which includes components on discrimination, phobias and heteronormativity. See link to training:

<http://www.prideinclusionprograms.com.au/health/>

¹⁵ Cisgender is a person whose gender identity matches the gender assigned to them at birth and not transgender or gender-diverse.

in the presence of a counsellor/mediator, only to experience backlash from her partner afterwards. Counsellors/mediators may not be aware of the unseen power dynamics in the room, and unknowingly collude with the man as he tells his version of the story. This may make it difficult for the counsellor/mediator to challenge or question him about his behaviour. In addition, challenging the man's actions in couple counselling can further increase the level of danger as he recognises that his abusive behaviours are being named and questioned, and that his partner has been disclosing his use of violence towards her and any children. The level of danger may also be increased when a man is aware that services his partner is accessing are collaboratively sharing information with his MBCP/MDFVS provider, and safety plans for women, children and the man using violence need to take this into consideration.

- Clear policy and procedures must be in place when working with families, particularly for staff who may be conducting initial and ongoing engagement through home visits or in the workplace where the primary aggressor remains with the family or has ongoing contact (see assessing and managing dynamic risk).
- Staff must have significant training regarding their own and client safety concerning the perpetrator's potential use of recruitment tactics to co-opt workers to support his views, and to undermine workers' attempts to work with the women and children.
- In the context of individual work and in the best interests of safety and client engagement, best practice is for female staff to work with female clients. However when seeking to engage men, the gender of the practitioner can be as effective whether male or female (Vlais, 2017)¹⁶. Currently most of the human services sector workforce (government, NGO and agencies) are female and increasingly are coming into contact with males as the primary aggressor within their work context.
- There is a potential risk of breaching confidentiality when the same worker works with both victim/survivor and perpetrator. This work requires highly skilled workers who are provided with regular debriefing and specialist supervision to undertake work with both parties. Best practice supports this work to be carried out by a third party or subcontracted to a specialist DFV women's service.

RECOMMENDATIONS REGARDING TRAINING FOR DIFFERENT LEVELS OF ENGAGEMENT, ASSESSMENT and REFERRAL WITH MEN WHO USE INTIMATE PARTNER AND FAMILY VIOLENCE

All interventions with perpetrators involve some degree of risk, more so in some situations than others (Vlais 2017) and requires careful consideration to the extent of specialist training and levels of expertise of workers. It has to be remembered that these men can hold deeply entrenched beliefs concerning the 'rightness' of their behaviour and justify their use of violence, abuse and coercive control through their heavily filtered lens of minimization, denial and blame.

In determining what level of engagement and service delivery workers can have with men who use intimate partner and family violence, the following ECAV courses are recommended as a minimum requirement:

1. Working directly with women when the man is not in contact with the service, but DFV is identified.
 - a. Practical Skills in responding to people who experience domestic and family violence
 - b. DV for Health workers
 - c. DV for Drug and Alcohol and Mental Health workers
 - d. DV and child protection for Maternity and Early Childhood nurses
 - e. Domestic Violence in the Workplace

¹⁶ In line with NSW Minimum Standards for Men's Behaviour Change work, MBC group programs should be co-facilitated by male and female workers to demonstrate healthy respectful relationships.

2. Working separately with women or separately with men where the worker/or client recognises that DFV is a key factor in their lives
 - a. Practical Skills in responding to people who experience domestic and family violence
 - b. Violence against women in CALD communities
 - c. Violence against women in refugee communities
 - d. Domestic Violence in the Workplace
 - e. Essential Skills in Male Domestic and Family Violence Interventions (4 days)¹⁷.

3. Workers engaging in service provision to either/both partners in a ‘family’ setting where children and their needs are included in the focus.
 - a. Practical Skills in responding to people who experience domestic and family violence
 - b. Domestic Violence and Child Protection: developing good practice responses to a complex problem
 - c. Domestic Violence in the Workplace
 - d. Essential Skills in Male Domestic and Family Violence Interventions (4 days).

4. Specialist MBCP workers and Male Domestic and Family Violence Intervention Specialist Workers
 - a. Practical Skills in responding to people who experience domestic and family violence
 - b. Domestic Violence in the Workplace
 - c. Essential Skills in Male Domestic and Family Violence Interventions (5 days).
 - d. Graduate Certificate Male Domestic and Family Violence Interventions (2018)

ADDRESSING VIOLENCE DYNAMICS

Generalist Health and human service sector workers are not expected to work with a man on his violence as this is specialist work. However this section is written to provide a window into a continuum of interventions that workers can use in response to violence. ‘Not seeing or addressing the man’s use of DFV’ can inadvertently collude with him in his excuse-making, increase blame on his partner and children, and disempower them from seeking assistance for themselves (Coleman 2017).

ECAV’S position is to promote best practice in the Health and human services sectors through training to ensure that safe and respectful environments for women and children are maintained by assisting men to:

- Cease violent and abusive behaviour
- Cease coercive and controlling behaviour
- Accept full responsibility for their own actions
- Develop and practice respectful ways of relating

Interventions with men will vary depending on where they present e.g. an Emergency Department, a child protection service, a Drug and Alcohol service, a MBC Program or to a trained MDFVS. Intervention and the training programs developed to support workers need to address the following:

¹⁷ This 4-day workshop will be a modification of the currently offered 5-day ESMFVI training and will have a different title to distinguish the two courses.

Collusion

A fundamental skill required for workers is how to balance respectful, authentic engagement with a man, while remaining aware of any recruitment and collusion strategies he may be using. He may present himself as the victim, minimising his behaviour, leaving sections of the story out, and blame the victim/survivor (partner and children). If workers are not aware of the risks they are generating if colluding with the narratives and beliefs that perpetrators use to justify their violence, or providing the wrong interventions at the wrong time, or in the wrong contexts, the stakes for other family members can be extremely high and even fatal.

It is important that the man using violence is held accountable for the impacts his behaviours have on his family, and that interventions, however brief, stay focused on how his parenting and partnering choices are affecting his family.

Training and supervision are essential for workers in how they manage their own responses to a man's very real sense of distress during these interactions to avoid colluding with him. Knowledge and practice skills that keep women and children's experiences at the centre of engagement with men assist workers to listen to his account of the situation and refrain from being recruited into his story. This is an essential topic for supervision. Supervisors are required to have expertise in this area and provide regular sessions to workers e.g. monthly at a minimum.

Recruitment

Recruitment strategies of men who use violence, which include invitations to collude and a range of other tactics are key areas for practice and ongoing professional development. Training supports knowledge of the tactics a man may use, and the necessary skills to keep these visible, when engaging with men within a wide range of service settings can mitigate risk. Safety of women and children is the desired outcome of the efficacy (or lack of) of recruitment to collude with his story.

Stopping Violence, not Anger Management

The perpetrator's decision to use violence is different to his failure to manage his own anger. Training will clearly establish the drivers of DFV and the range of behaviours, including identifying coercive control, where anger is not necessarily a factor. While the ability to regulate strong emotions is a component of specialist behaviour change work, themes and topics in all training are much broader. These may include: identifying risk factors; that DFV is a crime; awareness of the range of coercive controlling and intimidating behaviours that constitute DFV; impacts of this behaviour on women and children and on men as parents and partners; safety and risk planning; socialisation stereotypic societal attitudes; gender drivers and communication skills.

Accountability

It is recognised that as a family engages with Health and/or the human services sector, a number of opportunities for a man to become visible, to be held accountable for his behaviour and engage with services and programs that can support him will arise. Staff in these settings should not engage therapeutically with the man about his use of DFV unless they have received training and it is specifically within their role to do so. MBCP practitioners are clear that where therapeutic work is required to address a man's history of trauma and other issues¹⁸, this needs to happen through one-to-one sessions with qualified practitioners, psychologists or counsellors trained in specialist MDFVI, whilst additionally working to end his coercive control and violence towards his family members.

¹⁸ Whilst acknowledging that some 'therapy' happens for men in group settings, the focus of MBCP groups is to address men's use of DFV, not to address other issues in men's lives.

Focus on the Man's Choice to Use Specific Actions and Behaviours

When Health or human services sector staff engage with men who use family violence, they are provided with training, backed by policy and practice documentation on how to keep the focus of respectful engagement with the man around accountability for his choices to use DFV. As Alan Jenkins, notes:

'Collaborative practice with men who abuse relies on an understanding that men can change, and that their reluctance to engage is not proof of a preference for unequal and unsafe relationships. A man may be simultaneously invested in a sense of entitlement, control, and justification while desiring a safer more respectful relationship with women and children (Jenkins, 2009).

Staff should be able to build rapport and provide referrals to appropriate specialist services and practitioners who will work further to elicit ethics, values and belief systems that will support behavioural change.

FOCUS ON VICTIMS/SURVIVORS

Generally, it is victims/survivors of DFV who present via a range of service settings for multiple reasons. Often the burden of responsibility is placed on them to keep themselves and their children safe, whilst the men who use DFV remain largely invisible. Policy and practice requires a shift to hold men accountable and responsible for their use of DFV, and for the impacts it has on their family (current and/or former). Good governance and appropriate training are required to reflect this, which includes an intersectional approach, to uphold the safety of workers and clients.

BEST PRACTICE AND ORGANISATIONAL RECOMMENDATIONS

The following section offers some practice tips to guide government agencies and NGOs to develop policy and practice that will interrupt male violence, and support better referrals to specialist MBC programs or to trained MDFVS.

1. Working directly with women when the man is not in contact with the service, but DFV is identified.

- Build strategic networks to work collaboratively with other specialist services, including child protection and the police, who can safely engage the man who is using violence in his family and/or intimate relationship.
- Provide team leaders, supervisors and frontline workers with essential accredited training in practical skills that equip them to respond to people who experience DFV. Training must reflect current legislation, updated policy, best practice standards and guidelines, which include the nuances of intersectionality in response to the diverse and individual experiences of women and children.
- Ensure all Non-Aboriginal workers attend Aboriginal cultural competency training around the historical impacts and influences of colonisation on Aboriginal and Torres Strait Islander peoples. Awareness of the dimensions of these impacts are critical elements for understanding how DFV is experienced in their communities.
- Ensure staff have completed diversity training that encourages a more nuanced analysis of diversity, and includes an element on understanding how attitudes that reflect gender-based discrimination, homophobia, and transphobia are abusive, and are a part of the same attitudes that account for men's violence against women. Respectful engagement could entail, for example, letting an individual from the LGBTIQ community determine how they want to be identified and addressed.
- Ensure staff have completed cultural competency training that promotes sensitivity to the migration and refugee experiences of CALD women, children and men affected by domestic and family violence, and appropriate communication strategies that include effective engagement of interpreters.

- Ensure workers keep the man who uses DFV visible in their case management plans and engagement with the woman, so that she does not bear the burden of responsibility for his use of DFV. Questions that elicit how his behaviour is impacting upon her and how that impacts on her ability to be the mother she would like to be help maintain a focus on his behaviour, rather than on her inability to protect herself or her children.
- Support women with children to understand how the man using violence is making parenting choices when using DFV in the family.
- Refrain from giving advice about leaving and remain respectful of the woman's choice to stay in a relationship and/or close to her extended family and community. Instead focus on safety planning that applies to whatever situation she chooses to be in.
- Ensure older children are involved in safety planning, as they will already have strategies, some which are helpful and useful, but others which might be taking more responsibility than they should. Some children develop rituals they believe may prevent DFV, or try to intervene rather than going to a neighbour, for example.
- Ensure staff are trained in understanding how children may bear some responsibility for their father's use of DFV, and how to respond to this appropriately. Children's experience of violence needs to be heard and acknowledged, and incorporated into both case and safety planning.
- Ensure staff are trained in understanding the impact of their father's use of DFV on their relationship with him, on their relationship with their mother and their siblings. Children may appear to not be impacted by this behaviour and may in fact appear to be more 'attached' to their father than to their mother and/or siblings.
- Be proactive and respectful when a child or young person is at risk of significant harm as there may be times when a report has to be made to FACS. Where possible, do this with the woman's knowledge, and empower her in the process. In situations where a child's safety could be compromised, reporting may have to be done without her knowledge.

2. Working separately with women or separately with men, where it becomes apparent that DFV is a key factor in their lives, and may be contributing significantly to their presenting issue in settings such as mental health, drug and alcohol services, child protection services, specialist homelessness services (SHS).

Ensure detailed procedures and organisational policies are in place for the safety of women, children and workers.

- Provide team leaders, supervisors and frontline workers with essential accredited training in practical skills that equip them to respond to people who experience DFV, which reflects current legislation, updated policy, best practice standards and guidelines, an intersectional approach, and foundations skills in engaging men who use violence.
- Ensure all Non-Aboriginal workers attend cultural competency training around the historical impacts and influences of colonisation on Aboriginal and Torres Strait Islander peoples. Awareness of the dimensions of these impacts are critical elements for understanding how DFV is experienced in their communities.
- Organisations need to provide their staff with LGBTIQ diversity training and re-train regularly.
- Ensure staff have completed cultural competency training that promotes sensitivity to the migration and refugee experiences of CALD women, children and men affected by domestic and family violence, and appropriate communication strategies that include effective engagement of interpreters.

- Develop policy that requires initial engagement with the victim/survivor only, to hear her understanding of the situation, conduct a risk assessment and undertake the required safety planning. It is important to preference women's stories unless reliable evidence states otherwise.
- While it is important to address the immediate issues a man presents with (alcohol and drug use, homelessness, mental health concerns), note that these factors are not the cause of his controlling and/or violent behaviours.
- Ensure practice promotes a man's responsibility to make safe and healthy choices, and incorporates an awareness that while childhood and ongoing trauma may be factors in his use of violence, they are not an excuse for behaviour.
- Provide training to workers on the range of recruitment tactics and invitations to collude, as many men will present as 'victims' in their relationships and of the wider service system.
- Ensure workers name the violence with victims, and reinforce to victim/survivor that DFV is a crime, but do not engage the man in conversations about his use of violence, unless essential training has been undertaken to do this in a safe manner that does not jeopardise his partner's safety.
- Minimally, workers need to complete an initial risk assessment (formal/informal) to determine whether naming the violence with the man will lead to increase physical violence or coercive control towards his partner and risk her disengaging from services being offered to her, out of fear.
- Actively encourage self and peer reflective practices, along with regular supervision where recruitment and collusion can be identified and managed. This applies to all workers engaged with men who use DFV and is integral to maintaining the safety of workers, women and children.

3. Working with services where the focus is on the impact on the violence on parenting in such settings as child protection services (NSW Health and FACS), Child ,Youth and Family Support Services, Family Referral Services, Brighter Futures, Intensive Family Preservation, Family Dispute Resolution Services

- Ensure detailed procedures and organisational policies are in place to ensure safety for women, children and workers. This includes guidelines for workers to exercise responsibility to exchange information for the safety and well-being of children (Chapter 16A), and make mandatory reports to Child Protection authorities in cases where there is risk of significant harm to children and young people (ROSH).
- Provide team leaders, supervisors and frontline workers with essential accredited training in practical skills that equip them to respond to people who experience DFV, which reflects current legislation, updated policy, best practice standards and guidelines, an intersectional approach, and foundations skills in engaging men who use violence.
- Ensure all Non-Aboriginal workers attend cultural competency training around the historical impacts and influences on parenting as a result of colonizing policies and practices such as removal of children (stolen generation), removal from traditional land, and intergenerational trauma on Aboriginal and Torres Strait Islander peoples. The dimensions of these impacts on the interruption to child rearing, breakdown of kinship systems, and on the loss of cultural responsibilities and roles are critical elements when focusing on the impact of DFV on parenting.
- Organisations need to provide their staff with LGBTIQ diversity training and re-train regularly.
- Ensure staff have completed cultural competency training that promotes sensitivity to the migration and refugee experiences of CALD women, children and men affected by domestic and family violence, and appropriate communication strategies that include effective engagement of Interpreters.

- Ensure practice acknowledges how DFV harms children, and ultimately harms everyone, including the man who chooses to use violence against his children’s mother and possibly his children, or his partner’s children.
- Ensure child protection and family services workers keep safe conditions for children and their mothers and care-givers central to engagement with the family, and specifically with the man who is using violence. For example, consider:
 - Is there a reduction in the man’s active attempts to sabotage the mother’s parenting? Alternately, is the man maintaining or even increasing tactics to undermine her parenting?
 - Is he becoming more supportive of the mother, are her children receiving appropriate social and health services, rather than attempting to isolate them from services?
 - Is he working towards providing a safer parenting environment for the children? (Vlais 2014)
 - Can he see the impact of his violence on his children? What can he do to address this?
- Ensure staff are trained in how to interrupt male violence by developing safety plans for women and children, and where it is within their role, to engage, assess and provide interventions that include his fathering practices, whether for his own or her children, whilst prioritising the safety of his current (or former) partner and all children. These interventions for men who use family violence relate to ‘being a safe father’ and ‘being a safe and respectful partner’ (or former partner) e.g. how is he going to manage his responses to differing opinions on how to parent? How will he remain safe and respectful during handover and pick-up times with the mother and their children now that they are recently separated?
- Ensure recognised training for staff that equips them to engage a man to explore how his use of DFV is harming his family. This may involve the use of motivational interviewing skills, while inviting the man to explore his ethics and values of being a father, and to take responsibility for his parenting choices.
- Ensure workers name the violence and reinforce to the victim/survivor that DFV is a crime, and that they are not to blame for his use of DFV, only if it is safe to do this in the situation. Workers are not to engage the man in specialist MBCP work, but should refer on to a MBC program or trained MDFVS. NSW Health Policy states it is not the role of Health Workers to engage therapeutically with men about their use of DFV (NSW Health 2003 [rep.2006]).
- Provide training to front line workers on the range of recruitment tactics and invitations to collude, and on how to assist the man to maintain a stance of responsibility for his parenting choices. A man who is using DFV cannot be a ‘great dad’. He is making parenting choices that greatly impact on his children’s safety and wellbeing.
- Provide training to staff to utilise the Mandel¹⁹ *Safe and Together* model where the focus is on actions the man can take to create safety, holding him responsible for his family’s wellbeing. This approach focuses the work with him about the impact his use of DFV has on his parenting, while not necessarily focusing on the DFV itself.
- Provide training on how to engage with men to accept referrals to a specialist MBC Intervention and other specialist services such as mental health and drug and alcohol services.

4. Generalist Health and Human Services Sector Workers engage men to make suitable referrals to Primary appropriate services only

¹⁹ See link to this Model: <http://endingviolence.com/our-programs/safe-together/safe-together-overview/>

- Ensure existence of detailed and culturally appropriate organisational policies and procedures on safe referral processes and pathways for women, children and men. This includes guidelines for workers to exercise responsibility to exchange information for the safety and well-being of children (Chapter 16A) and make mandatory reports to Child Protection authorities in cases where there is risk of significant harm to children and young people (ROSH).
- Provide team leaders, supervisors and frontline workers with essential accredited training in practical skills that equip them to respond to people who experience DFV, which reflects current legislation, updated policy, best practice standards and guidelines, an intersectional approach, and foundations skills in engaging men who use violence.
- Ensure all Non-Aboriginal workers attend cultural competency training and understanding, of the historical impacts and influences on Aboriginal and Torres Strait Islander peoples, to understand the interruption to child rearing and breakdown of kinship systems, loss of cultural responsibilities and roles when working to address DFV.
- Organisations need to provide their staff with LGBTIQ diversity training and re-train regularly.
- Ensure staff have completed cultural competency training that promotes sensitivity to the migration and refugee experiences of CALD women, children and men affected by domestic and family violence, and appropriate communication strategies that include effective engagement of interpreters.
- Ensure workers have a sound knowledge of, and can facilitate referral to local specialist DFV services for victim/survivors, and to MBCP's or trained MDFVS for men who use violence, including State and national numbers and websites. Provide this information in various languages when required.
- Ensure workers do not engage in behaviour change work or therapy unless they have specialist skills in this area and it is a requirement of their role.
- Provide Essential skills training to workers to respectfully²⁰ engage with a man to explore how his use of DFV violence is harming his family. The priority in any intervention or case planning is for the safety of his partner and children. Workers need to use motivational interviewing skills to assist with effective referral to relevant specialist services to address men's use of DFV in a way that makes the referral likely to be accepted and acted upon in conjunction with other support services relevant to his needs eg. to mental health, drug and alcohol services, and GPs.

In conclusion, this paper aims to shape a dialogue that can influence policy and the work of those who come into contact with women and children who may be victims/survivors, and with men who may be using violence across a range of settings. Best practice and organisational recommendations are offered for government agencies and NGOs that are at the core of good governance, clinically sound policy and practice guidelines. This supports the creation of a skilled workforce that can safely interrupt male violence, effectively maintain the safety of women and children, while increasing male responsibility and accountability for their violence and parenting choices. It also acknowledges that referral to specialist MBC programs or trained MDFVS is paramount to fully address men's violence.

²⁰ Reynolds (2014) talks of '*holding the dignity and safety of women and children at the centre of working to hold men responsible for their violence, while maintaining the dignity and humanity of these men*'.

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APPENDIX A

Core philosophical underpinnings

- DFV is a crime in Australia and a violation of human rights.

'There is a consensus in the international research that examining the way in which gender relations are structured is a key to understanding violence against women. Studies by the United Nations, European Commission, World Bank and World health all locate the underlying cause or necessary conditions for violence against women in the social context of gender inequity' (Change the Story, p. 22). Freedom from violence (whether sexual, mental, emotional, financial or physical) is a fundamental human right. The right to protection from violence and to security and liberty of person is recognised in the major human rights agreements including the:

- *International Covenant on Civil and Political Rights*
 - *Convention on the Rights of the Child*
 - *Convention on the Elimination of all Forms of Discrimination against Women*
 - *Convention on the Elimination of All Forms of Racial Discrimination*
 - *Convention on the Rights of Persons with Disabilities*
 - *Declaration on the Rights of Indigenous Peoples*
- *Domestic and family violence violates a wide range of human rights including:*
 - *The right to life.*
 - *The highest attainable standard of physical and mental health.*
 - *The right to decent work.*
 - *Freedom of expression and the right to hold opinions without interference.*
 - *A child or young person's right to leisure and play.*
 - *The right to education.*
 - *The right to be free from torture and other cruel, inhuman or degrading treatment or punishment (Australian Human Rights Commission).*

The above covenants underpin ECAV's position on domestic and family violence. ECAV believes that gender inequality and exploitation of assigned male privilege generate the environment in which men are socialised to choose to use violence, power, and coercive control, and thereby violate human rights of women, children and other men. There is an inherent understanding that because men make choices to become violent partners and/or violent fathers, they can change this. Specialist MBCP and MDFVS providers can assist men to be accountable for their choice to use violence, and to take responsibility for stopping this behaviour.

APPENDIX B²¹

NSW Minimum Standard Accredited MBC Programs²²

BaptistCare

Bankstown
1300 130 225 or 02 8713 4333
Media enquiries 0403 879 913
[Click here](#) for website

BaptistCare

Campbelltown
1300 130 225 or 02 4624 8700
Media enquiries 0403 879 913
[Click here](#) for website

BaptistCare

Tuggerah
1300 130 225 or 02 4352 7900
Media enquiries 0403 879 913
[Click here](#) for website

CatholicCare Sydney

Fairfield
02 8723 2222
[Click here](#) for website

Port Macquarie Hastings Domestic and Family Violence Specialist Service

Port Macquarie
02 6583 2155
[Click here](#) for website

Kempsey Family Support Service

Kempsey
02 6563 1588
[Click here](#) for website

Kempsey Family Support Service

Coffs Harbour
02 6568 7657
0437 737 818
[Click here](#) for website

Men and Family Centre

Lismore
02 6622 6116
[Click here](#) for website

Men and Family Centre

Tweed Heads
07 5536 8868
[Click here](#) for website

Relationships Australia

Broadmeadow / Maitland
02 4940 1500 or 1300 364 277
[Click here](#) for website

Relationships Australia

Macquarie Park
02 9418 8800 or 1300 364 277
[Click here](#) for website

Relationships Australia

Sydney CBD
02 8362 2888 or 1300 364 277
[Click here](#) for website

Relationships Australia

Wollongong
02 4221 2000 or 1300 364 277
[Click here](#) for website

Relationships Australia

Westmead
9806 3299 or 1300 364 277
[Click here](#) for website

Relationships Australia

Penrith
02 4728 4800 or 1300 364 277
[Click here](#) for website

Relationships Australia Canberra and Regions

Wagga Wagga
02 6923 9100
[Click here](#) for website

Corrective Services and Anglicare

Parramatta
02 9895 8144
[Click here](#) for website

Corrective Services and Mission Australia

Dubbo
0437 962 615

USEFUL LINKS:

The **Men's Referral Service 1300 766 491** may be able to assist men with family and domestic violence matters which include issues such as Apprehended Domestic Violence Order (ADVO), behaviour change, anger management, parental plans or parental access.

No To Violence incorporating the Men's Referral Service's Head Office is located in Victoria

Contact details:

Phone: 03 9487 4500
Address: PO Box 277, Flinders Lane VIC 8009

²¹ Please note that the MBCN cannot guarantee that the details above are current.

Please call the Project Officer of the MBCN on 02 8713 4312 if you cannot reach a member organisation listed above.

²² Source: <https://www.mbcn-nsw.net/life-coaching>