Case planning for adults who perpetrate domestic and family violence

to reduce risk and harm for adult and child victim-survivors

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Key general takeaways[1]

- Behaviour-focused case planning can be an important part of efforts to interrupt opportunities and inclinations of an adult to continue to make choices to use domestic, family and sexual violence.
- Case planning is best done as part of a multi-agency, collaborative approach towards disrupting these opportunities and inclinations, and providing genuine support for victim-survivors and maximising their choice and control.
- Where possible, case planning with those who cause harm should be informed by the needs and experiences of adults and children experiencing the person's violence, and what will help them to increase their space for action in their lives.
- Case planning has a practitioner-facing component, involving case planning processes and documented case plans that the person using violence often will not see; and a client-facing component, involving violence disruption safety planning with the person using violence.
- The practitioner-facing case plan will guide your direct engagement objectives and goals. Consider carefully which components of the plan are safe to share with the adult, and how you might word these case plan goals.
- Ideally, case planning processes incorporate perpetrator behaviour pattern mapping, behind the scenes DFV risk management, and direct safety planning with the user of violence.
- Sound DFV risk assessment using an evidence-based risk assessment framework and guidance is essential to inform a risk management plan. Serious risk needs to be addressed through a collaborative, multi-agency approach.
- Case plans need to be reviewed and modified on an ongoing basis. For example, anticipate how the adult's achievement of particular case plan goals might result in new stresses and challenges that you'll need to incorporate into the case plan.
- For some adults, case plans will be mostly limited to maintaining or enhancing visibility for purposes of ongoing risk assessment, and to attempting to work towards some degree of preliminary safety planning.
- Consider direct engagement case goals that will help to decrease risk of serious injury or lethal violence, as well as those designed to address aspects of the person's behaviour causing *current* harms. Perpetrator pattern-mapping processes can help you identify case goals that focus on reducing your client's harmful impacts on child and family functioning.
- Proactively share information with other services about the adult's progress (or lack thereof) towards case goals. This includes services engaging with either the victim-survivor(s) or the user of violence who are involved in assessing and managing risk. Consider using proximal behaviour change process indicators to determine if any current reductions in the use of violent and controlling behaviours are likely to be only temporary.
- Bear in mind that reducing risk by addressing complex needs and contributing factors might also increase risk at the same time. This can happen by providing the adult with a more stable platform to resume and expand their use of violent and controlling behaviours.

[1] Written by Rodney Vlais 2023 - 2025. Thank you to Dr Karen Gelb who edited parts of an early draft.

Key takeaways on engaging with shame[2]

- Adult users of domestic and family violence often will go to great lengths to avoid experiencing shame.
- This can include problematic substance use. Adults who use substances can also experience a shame addiction cycle, where the stigma surrounding their substance use further increases their experience of and anxieties around shame.
- Some high risk, high-harm users of DFV can experience *chronic shame* and pervasive shame anxiety. For these adults, chronic shame is not 'just' an intense emotional reaction related to a discrete event or situation. It's when a person has a globally negative self-evaluation, always being on the alert to the possibility that they'll experience shame. Many of these adults have a trauma background.
- Learn how to identify and assess the subtle signs of chronic shame. When it's present, you may need to adopt a gentler approach than when working with other adults who use DFV, being careful not to trigger acute and overwhelming feelings of shame.
- High-risk, high-harm users of DFV can be overwhelmed with acute shame. Intensely activating their shame anxiety can lead to acute escalations in the risk of injury-causing violence to victim-survivors and/or to self-harm. It can also lead to their withdrawal from services and from other supports.
- Shame is not just a psychological phenomenon. Marginalised social groups are often targeted through structural racism, cis-hetero-sexism, and ableism. They are made to feel invisible, which can lead to whole communities feeling devalued, dehumanised, and degraded. This is known as 'collective shame'.
- For some adults who use DFV, shame does not only reflect transgression of one's individual self-identity. Shame can also have a strong cultural and community component.
- A measured approach towards engaging with shame requires an ongoing assessment of each person's shame tolerance, with gentle and gradual pushing up against their shame barrier.
- Shame tolerance varies from person to person. Assessing shame tolerance involves observing nuanced reactions from the individual.
- When working with high-risk, high-harm adult users of violence, it is crucial to build their capacity to experience shame safely, *before* facilitating explorations of how the individual's behaviour isn't aligned with their aspirational self and core values.
- At times this tension-creation strategy might be too shame-provoking for some serious-risk adults. This approach then becomes unsafe. In these situations, attempt to focus initial safety planning strategies in areas that might be less likely to activate intense shame.
- When an adult user of DFV can safely experience a reasonable degree of shame, seek to create a positive emotional space for the adult to productively engage with shame. In effect, this assists them to feel 'good' about feeling bad as they bring more of their harmful behaviour and the impacts on family members into view.

[2] Thank you to Mark Kulkens whose thinking, writing and practice heavily informed parts of the section on engaging with shame.

Key takeaways for case planning and substance use[3]

- The use of alcohol and other drugs (substance use) by adults who use domestic and family violence can be a powerful reinforcer and contributing factor, and influence the risk that these adults pose to adult and child victim-survivors.
- Adult users of violence who are experiencing co-occurring substance use or addiction and mental health issues are at heightened risk of using lethal violence.
- The mechanisms through which substance use increases risk and harm can be varied and complex. Understanding the adult's patterns of substance use and substance use behaviours associated with domestic and family violence tactics will help you to target your case planning and management efforts effectively.
- Consider the behaviours associated with the person's substance use – not only the substance use itself – in contributing to risk and harm. This includes the person's thinking, motivation for use, and behaviours associated with: cravings; acquiring the substance; planning its use; withdrawal; and maintaining connections related to use.
- Multiple aspects of the individual's substance using lifestyle can be associated with patterns of coercive control. The DFV perpetrator might use particular coercive controlling tactics, in part, to maintain aspects of their substance use. Choices around substance use can also be intended to restrict or coerce the victim-survivor's behaviour.
- These tactics can be heightened when the victim-survivor(s) is also using substances. There's also growing evidence that adults who use domestic and family violence can choose relatively more severe forms of physical violence when a victim-survivor uses substances.
- For adult users of violence who also have long-term substance use, it is important to understand the function(s) that substance use has served at different stages of their life, and how this might relate to experiences of complex trauma and/or the use of violence in general.
- Adopt a collaborative approach with AOD service providers so that the AOD practitioner can reinforce some aspects of your work with the individual, and you can reinforce some of theirs. Learn about the range and different types of AOD services in your catchment area, and any common approaches or overlap in your practice models or in how you go about working towards change.
- Men's behaviour change program providers, and other specialist DFV services that engage users of violence, should try where possible not to turn down referrals of adults with heavy substance use. Rejecting these referrals can reinforce the adult's narratives that their use of violence is caused by drugs or alcohol and that they lack choice. If the adult is not suitable for behaviour change group-work, try to keep them engaged and visible through individual sessions and contact.
- A significant proportion of adult users of DFV, and a significant proportion of adults struggling with substance use, have a cognitive impairment or disability. Become informed about how to adjust your work with these adults: there are some highly useful resources to assist you.

[3] Thank you to Joel Palmer who provided feedback and suggestions on an earlier draft of the AOD section in this guide: joelpalmerconsulting.com.au

Key takeaways for case planning and mental health issues[4]

- Like substance use, the mechanisms through which an adult's mental health condition(s) intersects with their use of domestic and family violence are varied. It is important to know how the mental health issue(s) contribute to DFV risk and harm as part of your case planning.
- The use of violent and controlling behaviours is always a choice. There are no excuses for violent and controlling behaviour. 'However', there are a range of ways in which mental health complexities can make it harder for an adult user of violence to choose non-violent behaviours. While not a cause of violence, addressing mental health struggles can be an important part of the case plan.
- Some mental health issues can interact with male entitlement and the operation of core violence-permitting beliefs to intensify the adult's patterns of coercive control.
- Adult perpetrators of violence can use their mental health struggles as an excuse for their harmful behaviour. Some will weaponise their mental health condition to manipulate the victim-survivor and to further reduce her space for action. This can include using children as an age-inappropriate support, sometimes criticising the children's mother in the process, and making children feel that they and their mother are responsible for his poor mental health.
- Treating depression is not likely in and of itself to make the adult much safer for those who experience his violence, but can be a very important part of an overall set of strategies to reduce serious risk.
- Significant depression including a felt sense of hopelessness that the adult user of violence has about their life and future is essential to address.
- Like depression, various forms of anxiety 'disorders' can contribute to the nature and intensity of violent and controlling patterns used against family members.
- Suicide rates are much higher amongst men who use domestic and family violence than amongst men generally. Be equipped with up to date skills in identifying and responding to suicide risk, and learn about risk factors for domestic suicide-homicide and homicide.
- Consider and respond to identity crisis, particularly for high-risk, high-harm perpetrators who experience significant identity loss due to consequences arising from their use of violence. A 'vacuum' of identity, lack of routines / considerable free time, and a fixated grievance towards the victim-survivor is a dangerous combination.
- Many mental health services do not understand the gendered and entitlement-based drivers of domestic and family violence. It is important wherever possible to work collaboratively and to attempt to influence how your client's behaviours are understood, so that mental health issues are responded to without providing excuses for violent and controlling behaviour.
- Conducting a reflective holistic health assessment, and supporting your client to address acute and long neglected health and lifestyle issues, can be a useful part of case planning with high-risk, high-harm users of violence.
- Ongoing risk assessment and risk management is critical, including through information sharing and collaboration between services.

[4] Thank you to Nathan DeGuara for contributing much of the text in this guide on responding to identity crises and the role of reflective holistic health assessments.

Contents

Introduction to this practice guide

This practice guide is written to assist a range of practitioners in case planning responses to adult users of domestic, family and sexual violence. As such, you might be a:

- specialist domestic and family violence behaviour change practitioner who is case planning and case managing responses to perpetrators of violence,
- practitioner or practice lead in an alcohol and other drugs (AOD) or mental health service with a particular focus on engaging adult users of violence, or a
- practitioner in another setting where you have skills, training and organisational support to work with perpetrators of domestic and family violence who have complex needs.

The guide *makes a start* in addressing some of the complex issues involved in case planning with adults who cause harm. Only some intersecting issues with choices to use violence and control are addressed, and in incomplete ways. Consider your own experience and that of your colleagues to build upon the start made in this resource, and to adapt and ground the guidance offered.

This resource focuses on case planning processes, with some areas of overlap into perpetrator-focused *case management* practice. Many important areas of case management practice, however, are not covered by the guide.

Remember that specialist domestic and family violence behaviour change programs or responses are an essential component of case plans.

Your service or organisation might or might not be in a position to offer specialised men's behaviour change programs or interventions that focus directly on the adult's use of violent and controlling behaviours.

Or your client might not be ready to participate in a specialist program or intervention, due to a lack of personal capacity arising from unmet or insufficiently met complex needs, and/or to a lack of readiness to contemplate participation in a specialist program or service.

However, building your client's capacity to do so, and actively linking them into and supporting their participation in a specialist men's behaviour change program that meets minimum standards of practice, is an essential component and goal of case planning with these adults.

This resource does not focus on specialist domestic and family violence behaviour change programs and interventions, **but assumes that they are a critical component of case plans for users of violence**, at least as something to work towards.

Be wary of inappropriate and unsafe interventions for adult users of DFV. Generic 'anger management' programs that are not linked in with services directly supporting victim-survivors can often make things worse (DFV use is not about 'lacking control over anger'), as can relationship counselling and family therapy when the adult is still adopting significant patterns of violence and control (violence is not a mutual responsibility). Most individual psychologists, psychotherapists and counsellors have not had specialist training and support to work safely with adult users of violence, except for those who have been or are specialist practitioners in the field. Consider your referrals for behaviour change work carefully.

Accompanying resources

This practice guide should be read in conjunction with the following resources:

- → *Our Actions* Insight Exchange video (7 mins)[5]
- → *Being Safety* Insight Exchange booklet[6]
- → *Four Considerations in Understanding and Assessing Choices to Use Violent and Controlling Behaviours* practice article[7]
- → *Working with Adult Users of Domestic and Family Violence with a Trauma Background* practice guidance[5]
- → *Safety Planning with Adults who Cause Domestic and Family Violence Harm* practice guidance (detailed slides set)[6]
- → Various written and video demonstration resources on safe and purposeful engagement with adults who perpetrate domestic and family violence[7]

Keeping victim-survivor safety and well-being – for adults and children – firmly in mind

In your work with an adult user of domestic and family violence, you might or might not have information about his behaviours and harm sourced from those who experience his violence. This will depend on whether your service or organisation works directly with victim-survivors, or has information sharing and collaboration arrangements with those who do.

Even if you have no direct or indirect links to those who experience his violence, it is vital to keep victim-survivors in the forefront of your mind as you case plan with the adult causing harm.

Read the Insight Exchange booklet *Being Safety*

- → Use the booklet to reflect on how perpetrators of violence restrict space for action for adult and child victim-survivors to go about their lives and to meet their fundamental human rights and needs.
- → Reflect on what this means for understanding victim-survivor resistance to violence and coercive control, and what they do to attempt to restore dignity and some space for action.
- → Consider how easy it is for society and services to blame victim-survivors (especially when there are children involved) for their decisions and actions if we do not understand the violent and controlling behaviours and patterns they are responding to.
- → Explore how your engagement with clients who use DFV can improve through a nuanced understanding of the lived experience of adult and child victim-survivors in general, even if you do not and will never know the victim-survivors of the client you are working with.

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[5] Scroll down insightexchange.net/animationsvideos/ to locate this video resource.

[6] Download from insightexchange.net/beingsafety/

[7,5,6,7] Accessible for from the Featured section of linkedin.com/in/rodney-vlais/ (a linkedin account is required to access) – scroll through each of the available resources to locate.

Watch the Insight Exchange video *Our Actions*. This powerful resource describes effective responses to domestic and family violence, through:

- → providing genuine support to victim-survivors that follow their lead and that expand their **options**, **choices** and **spaces for action**, and through
- → reducing the **excuses**, **gaps** and **levers** that perpetrators of violence have to continue behaviours that frighten, dominate, isolate, humiliate, punish, degrade, monitor, regulate or subordinate the victim-survivor (and her children).

Keeping victim-survivor lived experience firmly in mind does not mean taking a persecutory approach towards the adult causing harm. See the **accompanying resources** for further guidance.

Practice tip

In your work with an adult user of violence, you might or might not have information about his behaviours and harm sourced from those who experience his violence. This will depend on whether your service or organisation works directly with victim-survivors, or has information sharing and collaboration arrangements with those that do.

Make sure you are aware of the information sharing and privacy guidelines that apply to your jurisdiction. Know under what circumstances you can share information with another service about a perpetrator's current and past behaviour, and about other perpetrator information related to risk, without requiring the client's consent or knowledge that you are sharing this information.

Do not automatically assume that the consent of the person using violence is required to share information about domestic and family violence risk with other services, including services that are working with those who experience the person's violence. You might be covered by legislation enabling you to share information about risk that you learn from engaging with the adult user of violence, without his consent or knowledge.

Adults who use domestic and family violence often deny, minimise and justify their violent and controlling behaviours. You are likely to significantly underestimate risk if you take his minimised disclosures or denials at face value. However, you might discern a range of 'red flags' or important information about risk through your engagement with him, including:

- → evidence-based risk factors for serious risk,
- → hostile, critical or highly grievance-fuelled narratives about family members,
- → attitudes and beliefs that he uses to condone violent and controlling behaviours, and/or
- → current or upcoming situational variables or changes that are unsettling for him and that might be associated with acute spikes in risk.

Sometimes, the most important thing you can do when working with an adult user of domestic and family violence is sharing what you are learning about risk and harm with other services who are working directly with those experiencing his violence. This can assist them in their efforts to support victim-survivors and manage risk.

Practitioner-facing and client-facing case planning documentation

Most case planning documentation is practitioner-facing. While aspects of this documentation might be appropriate to share with the adult (perpetrator-facing case planning documentation), other aspects will not.

Case planning documentation for adult users of DFV should include behaviour change goals, irrespective of whether the behaviour change work is provided by another specialist DFV service or by yourself if your service is set-up for this. It can include:

- succinct statements of the specific risk-related information you'll be seeking to directly or covertly obtain through direct engagement with the adult
- what you're looking to monitor over time about their narratives, mood, etc.
- direct engagement implications of the coordinated multi-agency risk management strategy you're developing in partnership with other services involved in managing risk
- direct engagement goals related to reducing the likelihood of escalation in the use of violence over the near-immediate, short- and/or medium-term, some of which might not have been discussed with the adult
- behaviour change goals that you or another specialist service have discussed with the adult
- behaviour change goals that you or another specialist service has established as a priority to work towards but that haven't been discussed with the adult, or that has been discussed with them only in part
- goals related to addressing (directly or through case management) contributing factors to their use of violent and controlling behaviours, and complex needs.

It's not appropriate to share with your adult user of violence the entire case planning documentation. It can, however, be good practice to share (and collaboratively determine) some behaviour change goals. Together you can identify what he's expected to change and work towards. You can also collaboratively develop a safety plan for him to be safe for others and for himself.

Be careful about creating risk for victim-survivors

Much of this case planning documentation could create risk for victim-survivors if it were shared with the adult user of violence.

To ensure victim-survivor safety, it's crucial that any information they provide to inform responses to the adult user of violence is <u>not documented</u> in the case plan or anywhere that may be shared with the adult.

Case planning is an **ongoing process**. Case plans evolve and mature as we observe how the user of violence responds to our and other attempts to engage him, and the efforts he makes (or does not make) to work towards early case goals.

Initial case plans are important, but they are often based on very incomplete information. It often isn't until about one-quarter or one-third into our and other services' work with an adult user of violence that we might have more of the information that we need. This might include information from other services who have engaged the user of violence, or with those experiencing his violence.

Practice detail

The following are examples of ways to share information from case planning documentation with your client who is using violence:

- Together, complete a form that outlines the goals and agreed steps for your collaborative work.
  - → Highlight what the individual thinks are the biggest risks he presents to his ex/partner and/or to other family members.
  - → Explore what they consider to be situations in which they're at risk of escalating their use of violence. This can sometimes reveal important new risk assessment and case planning information. For example, it's not uncommon during these explorations for an individual to respond with some (variable) degree of honesty.
- To the extent that it doesn't create a safety risk for victim-survivors, the case plan should include your assessment of the greatest risks to victim-survivors and mitigation steps concerning these risks. For example, you could include:

  > "X is very hesitant to attend AOD support and is confident in quitting cold turkey, yet when he has attempted this in the past, he has returned to alcohol use. X identifies that much of his use of physical violence in the past has occurred while intoxicated, and therefore despite his hesitancy to participate in AOD treatment his AOD use is a very important case goal."
- This then becomes an agreement that your client signs. It prepares your client to talk about these risks throughout your work together. This transparency helps avoid later surprises or client feelings of being ambushed or judged by you with sudden revelations of concerns.
- A written agreement also provides the basis for ongoing review of progress and modifications to the plan as additional steps and behaviours to work on are identified.

Always considering changes in risk to victim-survivors

'Upstream' stabilisation and contributing factors – housing, mental health, AOD use and other immediate and complex needs – are often a major focus of case plans and safety planning with adults who pose a particularly serious domestic and family violence risk to victim-survivors. **At all stages, it is crucial to consider how success in addressing these factors might *increase* the person's capacity to cause harm to victim-survivors.**

Outcomes that improve the adult's capacity to engage in services (and make safer choices) can, paradoxically, give them a stronger platform to widen their tactics of coercive control and harm. For example:

- The adult who, due to your case management efforts and collaboration with housing services, now has more stable accommodation might present themselves as the more 'stable parent' in family law matters, especially if their former partner is still facing a long wait for social housing.
- The adult you've helped secure mental health care might now be in a stronger position to weaponise their former partner's mental health struggles – caused in large part by his use of domestic and family violence – to present himself as the 'more fit parent'.
- The adult you've helped with AOD issues might now be better able to adopt particular stalking and online social violence behaviours, given his sobriety and clearer thinking.

These are not necessarily reasons *not* to incorporate into your case plans goals related to contributing factors, complex needs and stabilisation. However, it's critically important to consider, on a case-by-case basis, how doing so might inadvertently contribute to the resumption of prior behaviours (or the incorporation of new ones) that cause domestic and family violence harm.

Once you've anticipated some of the possible inadvertent negative outcomes of stabilisation, you can, in collaboration with victim-survivor-facing and other services, put risk mitigation strategies in place to reduce their likelihood and impact.

Case plan development

Ideally, case plans are informed by the following three casework processes focusing on the adult user of violence:

- The person's (perpetrator-focused, practitioner-facing) **risk management plan** that has *not* been shared with the person.
- **Perpetrator pattern-mapping** that is *not* to be shared with the person.
- The **safety plan** that you've developed collaboratively with the person.

All three of these documents are works in progress, to be updated continuously throughout your direct and indirect engagement with the adult. This means that your case planning documentation will also be updated periodically.

The form and content of case planning documentation

Case planning documentation doesn't need to follow any particular template. Use whatever structure for documenting case goals that works for you and your team.

It is a *succinct description and summary* of case goals for your work with the adult, including the *strategies* or *actions* you plan to take to work towards these goals.

Both the practitioner-facing and client-facing aspects of case planning documentation need to be living documents that are regularly reviewed and modified during your work with the adult user of violence. The practitioner-facing aspects of case planning documentation will change based on your ongoing risk assessment, and how your client responds to your safety planning and behaviour change work.

Case planning documentation is *practitioner-facing*.

It's for use to share with other practitioners in your service, and if appropriate with other agencies and services working with the adult user of violence to ensure you are all on the same page about priority goals.

You'll need to modify the content significantly before including it in case planning documentation presented to your client for signed agreement, so as to prevent risk escalation.

Balance transparency with your client, with the potential for increased risk to the victim-survivor(s) should your client become aware of information that the victim-survivor has disclosed to your or other services.

Below is an example of what your *practitioner-facing* case planning documentation could look like:

Goal	Timelines
Monitor and safety-plan fluctuations in suicidal ideation / risk	Ongoing (and immediate priority)
Monitor narratives about his ex-partner's new relationship, including hostile thoughts about the new partner	Ongoing (and immediate priority)
Monitor presence of shame anxiety when attempting to focus on client's behaviour	Ongoing
Assess degree of criminal pride thinking; lay foundations to focus on values reflecting pride in non-violent behaviour	Upcoming
Support client to adopt a more active lifestyle to distract from obsessive ruminations related to possessive jealousy	Major current priority
Attempt to 'soften' hostile attitudes towards police, given upcoming increase in police presence in client's life (violence disruption tactics)	Coming month; unrealistic to expect major attitude changes, goal is to take edge off usual hostility to authorities
Safety plan preliminary distress tolerance / emotional regulation strategies	Build gradually
Prepare for focus on respectful co-parenting	Medium-term
Develop relapse prevention plan for methamphetamine use	Medium term (currently high motivation not to re-use; isn't *currently* associating with previous friends who used)

It is very unlikely that any one service would be able to work towards each of the above case goals. Different services working collaboratively, each within their own areas of specialisation, would be required. Working towards all of the elements of a case plan such as above is likely to take some time. Each service has a part to play, even if they become involved at different stages.

Practice tip

The adult's achievement of particular case goals can lead to other case goals arising. Case planning is a highly dynamic process.

For example, finding stable housing with the help of a housing provider can result in new stressors, vulnerabilities and challenges for the adult. They'll face a degree of financial management and responsibility that they might not previously have had, or at least not recently. They'll have different routines and requirements of daily living. They might also experience isolation due to disconnection from peers who used to 'look out for each other'.

As another example, achieving sobriety can lead to a range of emotions – including difficult ones – that were previously avoided through the use of substances.

Where possible, anticipate new challenges and difficulties that might arise as case plan goals are successfully met. Doing so will reduce the likelihood of a return to unhelpful behaviours and situations caused by becoming overwhelmed with the 'new reality' of a more stable life.

Creating case planning documentation for sharing with the adult user of violence

In balancing transparency with your client with preventing risk from escalating, the version of the case planning documentation that your client signs will be significantly different from your version. It will address only some of the points in the larger practitioner-facing document. And there will be differences in the wording you use for those aspects of the case plan which you represent in the client-facing plan.

It's important to remember that some adults can be considered to operate largely in 'survival mode'. This is especially true for those who have experienced complex trauma and/or who have a significant history of unmet or poorly met complex needs. They may have had numerous experiences where 'being vulnerable' has been associated with being harmed by others.

In these contexts, the client-facing aspects of the case plan might initially need to be kept relatively simple. They can focus on 'little successes' that your client can achieve in **upstream and midstream safety planning**. They can cover practical aspects of day-to-day life, allowing your client to build some early confidence. After this, you can start to introduce behaviour change goals.

As your work with the adult progresses, they *may* make genuine steps towards addressing goals in the case plan and *may* start taking more responsibility for more of their behaviour. If this occurs, you'll then be able to bring more of your practitioner-facing case planning documentation into view with your client. Over time, the client-facing plan might come to resemble more of the practitioner-facing plan.

Risk management planning

Safety planning and risk management are often conflated, yet they are not exactly the same. Safety planning is one form of risk management, involving direct engagement with a client. Whereas risk management concerns a broader range of actions that might include direct safety planning with a client, *and* additional 'behind the scenes' actions that the client might or might not be aware of.

A risk management plan often involves a combination of direct actions engaging the person causing harm, and behind the scenes actions that they are often not aware of. Managing risk through behind the scenes actions can often be as, if not more important than direct safety planning with the adult.

This is particularly the case when the user of violence poses a serious risk to the safety and wellbeing of victim-survivors, and/or engages in substantial patterns and wide-ranging tactics of coercive control and social entrapment. Managing risk in these situations requires effective collaboration across multiple services.

Risk management responses directed at the person using violence should be informed by the needs and wishes of victim survivors, wherever possible. Obviously, **we have a duty of care to respond to imminent risk**. But in situations where **risk is serious, but not necessarily immanent**, knee jerk or routinised, formulaic reactions that are not informed by the victim-survivor's own risk assessment and wishes can compromise her and her children's safety and well-being.

Risk management is an ongoing process and should be informed by ongoing risk assessment. The information you gather as part of ongoing risk assessment process will inform your risk management approaches directly with the person using violence and indirectly (behind the scenes) through collaborative multi-agency actions. Key action points in a risk management plan should be documented, updated as events transpire, and ideally checked with an experienced co-worker, team leader or practice supervisor/manager.

Practice detail

Behind the scenes risk management actions can include:

- → Collaborating with specialist DFV services, and with any local or regional multi-agency triage or other structures established to respond to escalating DFV risk.
- → Requesting information from other services to develop a shared and up to date understanding of risk, consistent with applicable information sharing and privacy laws.
- → Documenting perpetrator behavioural patterns in case files, so that there is written information concerning the specifics of the adult's behaviour and the impacts on adult and child victim-survivors.
- → Proactively sharing information with other agencies and services engaging with the victim-survivor(s) and/or the perpetrator about the nature, level and changes in risk – consistent with applicable information sharing laws.
- → Providing information to law enforcement, justice system and child protection authorities to assist with statutory responses designed to monitor the perpetrator's behaviour, and to attempt to limit his opportunities to continue to use violent and controlling behaviour. That is, risk management responses that raise the personal costs for him, and that try to limit his options, to continue to use DFV.
- → Participate in multi-agency high-risk team meetings and in other informal/ad hoc and formal multi-agency collaborative processes to address serious risk.
- → **Anticipating the circumstances in which risk might escalate – and sharing your understanding with other services involved in managing risk for the victim-survivor(s).**

In the case of serious risk adult users of domestic and family violence, risk analysis should consider the questions:

What are the potential pathways through which this could end badly?

What would be the steps towards the adult engaging in severe or lethal violence?

Given what we know about the severity of his violence-supporting beliefs, the depth of his grievance, and what he believes has been 'taken away' from him that he strongly feels entitled to, what current or upcoming circumstances might he make particularly hostile meaning about? How might he respond to any police, courts, corrections or child protection attempts to 'hold him accountable'?

What can we put into place in a risk management strategy that would make pathways towards causing (further) severe harm less likely?

Sound DFV risk assessment is crucial. Know your options for your service to become skilled in an evidence-based domestic and family violence risk assessment framework and approach.

See the **Homicide Timeline** homicidetimeline.co.uk and the **Pathways to Intimate Partner Homicide** report and resources anrows.org.au/project/pathways-to-intimate-partner-homicide to help you understand what to look out for.

Perpetrator pattern mapping

Perpetrator pattern mapping is often used in child and family-focused services that work with domestic and family violence issues. Drawing on tools such as the Safe and Together Model perpetrator pattern mapping tool,[8] this process helps services and practitioners to identify:

- patterns of coercive control used by the person causing harm
- the impacts of these patterns on child and family functioning
- resistance to the behaviours (and other strengths) exhibited by adult and child victim-survivors.

The mapping processes support analysis of *current harm*. They also provide useful information to assist with assessing the risk of the adult using lethal or serious-injury violence in the future.

Perpetrator pattern mapping is particularly useful to identify behaviours that affect family functioning and children's social, emotional and physical development and wellbeing. It should also focus on other aspects of a child's 'developmental ecology', including:

- the family's connections to health, educational, community sector and other services
- extended family, cultural and informal supports.

Perpetrator pattern mapping also assesses violent and controlling behaviours that affect the adult victim-survivor's parenting capacity and bond with their children.

In developing case goals for your work with an adult using violence, consider goals that help decrease the risk of serious injury or lethal violence *and* goals that address aspects of the person's behaviour causing current harm.

Keep in mind, however, that your work with the adult might only go a small way towards addressing patterns of behaviour that have the greatest impact on child and family functioning. For example, the adult might be using a pattern of behaviour that includes attacking an adult victim-survivor's dignity through tactics intended to humiliate and degrade. The opportunity for greatest impact might lie in rebuilding her sense of confidence to withstand these attacks. This could be achieved by supporting the victim-survivor to have more safe options to embark on new creative pursuits. It might or might not be possible to work with the adult towards reducing his use of behaviours that aim to humiliate and degrade; at the very least, however, understanding his patterns of behaviour can inform work with the victim-survivor.

Safety planning with the adult user of violence

Safety planning involves direct work with the adult user of violence to support him to take steps that might help to prevent, or interrupt, some of his choices to use violent and controlling behaviours.

In safety planning with the adult using violence, you are likely to be able to only bring in the 'tip of the iceberg' of his use of violent and controlling behaviours into view. Particularly in the early stages, he is not likely to disclose or admit to much about his behaviour, and you might know details sourced from the victim-survivor that you cannot raise in discussions with him.

You might start with small, realistic goals, that if achieved might at least reduce a bit of the risk faced by those experiencing his violence. Or that might result in these victim-survivors having a little more space for action or choice in their lives, or experiencing a bit less harm in a significant way.

[8] https://safeandtogetherinstitute.com/tools-for-systems-change/practice-toolkits/mapping-tool/

Safety planning occurs at three levels:

→ **Upstream:** Changes to the person's lifestyle, habits, related behaviours or complex needs that might make it (somewhat) less likely that they will continue to choose to use certain forms of violent behaviour.

→ **Midstream:** Strategies the person can use to interrupt common pathways towards choosing to use violence, when they notice early warning signs. This includes supports to interrupt build-up towards choices to use violence, or safe distractions.

→ **Downstream:** Strategies to adopt when the choice to use violent or controlling behaviour is close, or when this behaviour has begun.

Safety planning resources designed for adult users of DFV

See ***Safety Planning with Adults who Cause Domestic and Family Violence Harm***[9] for more detailed guidance, and for links to additional highly useful resources.

These resources are particularly suited to safety planning with adults who are at a very early stage of accepting responsibility for their violent and controlling behaviour, and who greatly deny, minimise and justify their harmful behaviour.

For those users of violence who progress towards more meaningful acceptance of responsibility, more advanced safety planning tools are required, drawn from specialised men's behaviour change program work.

Sharing information with other services about progress towards case goals

Keep other services informed about the adult's progress (or lack thereof) towards case goals.

This is particularly critical when the adult isn't genuinely participating in active safety planning measures or isn't stepping into core elements of a behaviour change process.

In some cases it's crucial to be proactive in sharing information about a lack of progress. This should include information on implications for the continued risk to victim-survivors. Such cases include those where the adult:

- doesn't turn up to most sessions of your service
- is continuously lying about their behaviour and circumstances
- is continuing to use violent and controlling behaviours.

In such cases, the continued danger presented by the adult is clear. You might also need to make explicit that this lack of engagement means you've not been able to maintain visibility of the person.

In other situations, the adult's lack of progress might be more subtle. If so, consider the use of *proximal indicators* to judge whether they're stepping into some of the necessary elements of a behaviour change process.

[9] This resource is a PDF set of detailed powerpoint slides, accessible from the Featured section of linkedin.com/in/rodney-vlais/ (a linkedin account is required to access)

Practice detail

After several months of working with you and other services, a hypothetical adult has stopped using many of their patterned violent and controlling behaviours. But they're still denying ever having used most of these behaviours – or are still blaming their ex/partner or external factors for those behaviours they do admit to. In such a case, it's likely that the current pause in violent and controlling behaviours is due to *temporary* factors that will change, such as:

- a temporary separation from their partner
- the motivation to remain out of prison in the context of current criminal matters
- the realisation that their behaviour is currently quite visible to statutory authorities
- the need to be on their 'best behaviour' to win back support from family or friends, or to 'prove' to the family court that they are the most 'capable' parent.

Once these external conditions change (for example, an order ends or they're reunited with their partner), it's very likely that their use of high-harm domestic and family violence will resume. This is because there are clear indicators that the individual has not stepped into the necessary elements of a productive behaviour change process.

Behaviour change – beyond choosing to be on one's 'best behaviour' while being watched by the system – is unlikely to occur when the adult continues to deny or justify most of their violent and controlling behaviour, and/or appears unwilling or uninterested in exploring the impacts of their behaviour. Genuine behaviour change work requires the adult to sit in considerable discomfort, and to reflect on their beliefs, attitudes and ways of seeing and being in the world that give rise to their choices to use violence. They will need to be open to new possibilities for themselves, and work actively to 'de-commission' their entitlement-based grievances. **This is a gradual process that takes time – proximal indicators concern whether the adult is stepping into the journey.**

When an adult is *not demonstrating proximal indicators* of genuinely stepping into required elements of a behaviour change process, **it is critical to notify other services that they remain a significant risk for resuming their high-harm domestic and family violence behaviours**. This has to be done *even if* they're attending your sessions and not currently engaging in their usual patterns of violent and controlling behaviour.

Be careful about using proximal indicators as signposts

Using proximal indicators as signposts is complex. Doing it in a superficial or ill-considered way can result in wrong conclusions being drawn and communicated to other services involved in collaborative assessment and management of risk. See https://cij.org.au/news-and-views/signposts-to-perpetrator-change/ for further guidance.

Proximal indicators are easiest to use to observe and document when an adult user of DFV is not embarking on a concerted change process. They are much more difficult to use to affirm positives when an adult might appear to be stepping into the necessary elements of a change process.

This is because there are numerous instances of users of violence appearing to say the right things, and appearing to demonstrate the right things, who are being manipulative or who know what to say or do to make it seem as though they are changing, when they have little or no genuine intent to do so. Some users of violence make poor and obvious attempts at 'faking change', but others are much more highly skilled at this.

Engaging with shame

Shame occurs when there is a discrepancy between a positive self-evaluation that an adult would *like* to make (an aspect of their 'aspirational self') and a negative self-evaluation they've made of their behaviour. That is, when there is misalignment between a person's aspirational self and their behavioural self.

Shame can be associated with negative self-evaluations akin to "I am bad", or at least that "Given what I've done, I'm not the good person that I thought I was / would like to be."

Adults who use domestic and family violence often deal with their shame by trying not to think about it – effectively denying their shame and its cause. This may take many forms:[10]

- Denial of fact (e.g., "I didn't do it" or "I wasn't there")
- Denial of culpability (also called blame; e.g., "I did it but she made me do it" or "If he hadn't [done X] then I wouldn't have [done Y]")
- Denial of responsibility (also called justification; e.g., "I did it but it's not my fault" or "everyone has a blue now and then")
- Denial of harm (also called minimisation; e.g., "I did it but it wasn't that bad" or "at least I didn't...").

Shame isn't the only reason that adults who use DFV deny their behaviour. Other reasons can include:

- The desire to manage how the practitioner and others view them (as a deliberate impression management strategy).
- The perceived need to withhold information that might incriminate them (in the context of criminal matters) or that might affect family law outcomes.
- The belief that certain aspects of their behaviour are justified ("there's nothing to feel shame about").

Adults who use DFV may deny their violence repeatedly. They may acknowledge their violence at one point, only to retreat back into denial at a later point. They may also admit to single instances of violence but deny it's part of a broader pattern of using power and control. They will acknowledge their violence *to the extent that they can manage the private and public shame they feel for their behaviour*.

But while a sufficient degree of 'shame tolerance' or 'shame resilience' is a *necessary* condition for an individual to be able to acknowledge their violence in an ongoing way, it's not a *sufficient* condition. **They might still deny most aspects of their violent and controlling behaviour for other reasons that are unrelated to shame**.

When working with high-risk, high-harm users of domestic and family violence, it's especially important to:

- allow their denial, to an extent, to serve the protective function for which it's designed
- be aware that their engagement in the process of change need not be wholly confrontational or threatening to their sense of 'self'

[10] Kulkens, M & Wheeler, E, 2013, 'Shame and denial: Engaging mandated men', *Ending men's violence against women and children: The No to Violence Journal*, Spring, Vol 1, p. 91.

- be aware that confronting or threatening their sense of self can lead to shame overwhelm and the experience of humiliation
- be mindful that experiences of shame overwhelm and humiliation can increase risk to victim-survivors and/or of the risk of self-harm.

There are important differences in the way shame is experienced across adults who use domestic and family violence:

- For many adults who use DFV, their shame manifests as 'feeling bad' about their behaviour (to some degree), and then attempting to repair the relationship (though often towards a distorted notion of what a healthy relationship should be).
- For some adult users of DFV who have a lack of empathy and grandiose or superior self-view or self-worth, there will be little in the way of remorse. **Instead, their drive to protect themselves from experiencing shame is so intense that they relentlessly target victim-survivors.**

When working with individuals whose biggest source of shame is their use of domestic and family violence, practitioners can focus specifically on this violence-related shame. The individual might feel very uncomfortable experiencing this shame and might have a strong shame barrier. Nonetheless, there's potential to push against their shame barrier gently and progressively over repeated sessions to expand their ability to experience shame. This can then be used as motivation for behaviour change.

Be careful about exploring shame too soon

Adults using DFV who have a fragile sense of self often have very low shame tolerances. Significant care is therefore needed when pushing up against their shame barrier. For these individuals, it's not just shame about their behaviour that they're defending against. They're also defending themselves from feeling overwhelmingly bad, feeling like a failure, and potentially feeling self-hatred. Many of these adults have a trauma background.

High-risk, high-harming adults can strongly hold onto justifications for their violent and controlling behaviour. Sometimes they hold onto these justifications so strongly that they believe their behaviour is not something to feel shameful about. When they do feel shame, it's often an impending, overwhelming sense of shame that may have been generated through a history of trauma or experiences of social marginalisation and structural oppression, and is not necessarily tied to their behaviour.

When a high-risk, high-harm perpetrator of violence is overwhelmed with this feeling of shame – and when that shame is witnessed – the resulting humiliation can lead to a major increase in the risk of escalating severe violence or may result in the adult disengaging from the program or other services.

When working with high-risk high-harming adults, **it is crucial to build their capacity to experience shame safely, *before* facilitating explorations of how the individual's behaviour isn't aligned with their aspirational self**. For some high-risk, high-harm users of DFV, it will **never be safe** for you to lead them to a state where they feel 'bad'. For others, you might need to spend considerable time first laying the foundations so that you can safely focus on shame.

Felt experiences of humiliation can make it very difficult to build rapport with a client. While transparency and directness can be important aspects of your engagement style with many high-risk, high-harming adults, be mindful of the potential for them to feel humiliated if you challenge their denial too strongly.

AOD use and shame

Shame experienced by adult users of DFV can be accentuated if they are a heavy user of substances. Not only might the adult use substances as a way to cope with, and avoid experiencing, shame arising from their use of violent behaviour. The heavy use of substances can in itself induce further experiences of shame, due to the social stigma, lack of personal dignity & self-respect, and the secrecy and isolation associated with substance use in some contexts.

Some adults who struggle with substance use enter a 'shame addiction spiral', with shame and substance use feeding off each other. Add the use of DFV, and the adult can experience a 'double whammy' of shame.

While you might or might not work directly with the adult user of violence on issues of shame, it is very important to understand how your client might experience shame, and how this might influence their choices related to DFV and substance use.

Understanding chronic shame and shame anxiety

For most adults who use DFV, the shame they experience can be acute but then subsides. They might still feel overwhelmed by their experience of shame, and this overwhelm still might not be safe if they disengage from the service, stop disclosing their behaviour, or harm others they hold responsible for 'exposing them' to this shame. In these circumstances, practitioners need to take a careful approach, so as not to trigger acute and overwhelming feelings of shame.

But the experience of *chronic shame* complicates this. High-risk, high-harming adults can be more likely to experience chronic shame. Chronic shame is not 'just' an intense emotional reaction related to a discrete event or situation. It's when a person has a **globally negative self-evaluation, always being on the alert to the possibility that they'll experience shame.** This can lead to powerful feelings of unworthiness, despair, powerlessness, and self-hatred.[11] When shame is this intense, it's hard to use it productively in working towards behaviour change.

Adults who experience chronic shame will do whatever they can to avoid it. In other words, **they frequently experience 'shame anxiety' – anxiety that 'at any moment' they'll be judged, ridiculed, humiliated, or rejected by others**.

Shame anxiety may be understood in the following ways:

- People with shame anxiety aim to steer clear of relationships, circumstances, events, and conversations that might induce shameful experiences.
- It's not necessarily or always shame that they experience, but fear, worry and dread.
- It creates a desire to escape or hide, along with intense feelings of inadequacy.
- It can be particularly pronounced when the person fears that others have social standing or positions of power to judge them (and therefore belittle, ridicule, or reject them).

[11] Dolezal, L, & Gibson, M, 2022, 'Beyond a trauma-informed approach and towards shame-sensitive practice', *Humanities and Social Sciences Communications*, Vol. 9, pp. 1-10.

High-risk, high-harm users of DFV may attempt to avoid experiencing shame anxiety by:

- lashing out to attack others, and/or self-harming
- isolating themselves or withdrawing from social connections, sometimes to the extent of hiding and disappearing or placing themselves in 'exile'
- withdrawing and disconnecting from services so their deficiencies (such as coping behaviours or past decisions) aren't exposed to a helping professional who has the power to judge, ridicule or reject them
- staying emotionally flat or numb (hypo-arousal)
- avoiding taking up new responsibilities or fulfilling current responsibilities.

Attempts to avoid shame anxiety may be more common among people who have experienced complex trauma. Connecting with others raises the prospect of experiencing shame and humiliation if 'defective' aspects of their selves are exposed. They fear that others will judge or ridicule them. There is a strong association between complex trauma and chronic shame.

Some adults may put so much energy into avoidance that they might not identify with describing their experiences as shame. That is, they aren't necessarily *aware* that what they're doing is avoiding shame anxiety.

Cultural dimensions of shame

Shame is not just a psychological phenomenon. Marginalised social groups are often targeted through structural racism, cis-hetero-sexism, and ableism. They are made to feel invisible, which can lead to whole communities feeling devalued, dehumanised, and degraded. This is known as 'collective shame'.

For some adults who use DFV, shame doesn't only reflect transgression of one's individual self-identity. Shame can also have a strong cultural and community component.

Much of the guidance in this resource is based on the cultural assumption of an individualistic, 'bounded' sense of self. It assumes that one feels shame in relation to feeling bad about this 'independent self'. But shame may be experienced in more complex ways across different communities and cultures. **Be aware of your own assumptions and biases so you can be open to these different understandings of shame**.

Some communities and cultures may view the 'self' not purely in individualistic terms, but as more inter-dependent. Identity may be defined in terms of community and be far more relational – both a collective identity and an individual identity. In these communities and cultures, shame can be experienced in different ways:

- Shame goes beyond an individual feeling bad about themselves or letting themselves down.
- It's brought on by behaviours that are inconsistent with mutual responsibilities for one another.
- It's experienced as letting down one's family or community, as people collectively feel shame for the actions of others with whom they're connected.

Shame can play a powerful role in these communities and cultures. It regulates people's behaviour, so they comply with accepted roles and responsibilities. The fear of shaming their whole family or community acts to inhibit behaviour that sits outside the norm.

Sometimes adult users of domestic and family violence will experience this inter-dependent sense of shame and use it to fuel their victim stance. For example, they may accuse their partner of bringing shame on to the family by going to the police, or even bringing shame on to the whole community by opening it up to scrutiny about a perceived cultural or religious 'sanctioning' of violence. The norm that the victim survivor(s) has supposedly transgressed will also be influenced by the perpetrating adult's interpretations of their culture (for example, a patriarchal interpretation that ascribes certain attributes or roles to women). The resulting shame may be used as an excuse to use violent and controlling behaviour.

Practice tip

The ways in which shame is experienced across different communities and cultures can be complex. If you're working with an adult user of DFV with a background that is different to your own, **consult with a DFV service that specialises in working with culturally and linguistically diverse communities or a bicultural DFV worker** if possible. This will help you to understand how shame manifests in ways that might be different from your own community or culture, and will help you to challenge some cultural assumptions that you may make about the adult's use of family violence.

Be careful to avoid seeing an individual's community or culture as an 'either/or' concept

The adult users of DFV you are working with are not subject *solely* to their particular community and cultural norms, or to their interpretations of these norms. They're also living in a westernised society that often frames identity in terms of the individual.

Try not to see them *only* through the eyes of their particular ethno-culture. Be open to understanding its influence but be aware that they may also have a strong individual sense of self that they feel deep shame about.

Also remember that identity can be complex and multifaceted. Ethnocultural associations might not be the most powerful influence on the serious-risk adult using family violence's identity. Different aspects of their identity might be associated with particular (and not always complementary) sets of values and norms.

Taking a measured approach towards addressing shame

Shame can be debilitating when the gap between the person the adult wishes to be and the person they see themselves to have been (as evidenced by their behaviour) becomes too large. Flooding adult users of DFV with shame by being too confrontational can be counterproductive. This can happen when attempts to 'force' the individual to 'face up' to or become accountable for their violent and controlling behaviours push up too firmly against their shame barrier. How far and how fast (or how gradually) you can push up against shame barriers will vary from person to person.

See the demonstration video associated with the post "Here is a video of some skills when engaging men who use domestic, family and sexual violence…" located in the Featured section of https://www.linkedin.com/in/rodney-vlais/ (you will need to create a linkedin account to view) for practice tips on engaging with shame and denial.

It is very important **not to overwhelm** high-risk, high-harm perpetrators of DFV with experiences of shame.[12] The experience of shame overwhelm can lead individuals to:

- Harm those they blame for causing them to feel shame (e.g., their partner for, in their view, directly or indirectly 'making them' participate in a program). In some instances, overwhelming shame can cause the adult to feel what is known as 'humiliated fury', which can lead to their choices to use injury-causing physical violence.[13] **Some DFV perpetrators will use severe violence when they feel that the victim-survivor has humiliated them, even though the perception of humiliation arises out of the perpetrator's distorted view of the victim-survivor's actions based on a highly entitled and righteous lens.**
- Harm themselves, due to the shame activating feelings of low self-worth (sometimes self-hatred). Shame can also create or intensify a loss of hope for the future.
- Increase their level of denial, minimisation, and justification for their behaviour, while also closing down those aspects of their harmful behaviour they've been willing to disclose and discuss.
- Withdraw from engaging with programs and services due to the 'felt humiliation' created when the practitioner witnesses their experience of shame. People with intense shame reactions often prefer to 'hide themselves' from others when they are experiencing shame.
- Adopt harmful behaviours to protect themselves from chronic shame.

Behaviour change work aims to help adult users of DFV to identify their values and aspirations that are consistent with non-violence and to make better behavioural choices that are aligned with these values. Emerging values, growing self-awareness, and changing self-identity means that they may evaluate their prior violent and controlling behaviours in an increasingly negative light.

Over time, the adult might come to recognise and acknowledge more of their violent and controlling behaviours, including intimate partner sexual violence. As the process of behaviour change and their focus on their behaviours and its impacts on others deepens, the experience of shame can substantially increase.

Be careful when exploring values with those experiencing chronic shame

Extra care needs to be taken when exploring values and aspirations with some high-risk, high-harm users of DFV who experience chronic shame:

- tread gently in early explorations of values and aspirations
- sometimes even an initial positive focus on values can trigger shame anxiety, if the individual feels a loss of hope about being able to live up to these values
- in the beginning stages of your work, consider focusing on values or modest aspirations that appear within reach for the adult, that might operate as a guide in the near-term, rather than a long-term 'becoming a new me' aspiration that might seem to the client to be out of reach
- monitor for the experience of shame throughout your work with the client

[12] Kulkens, M & Wheeler, E, 2013, 'Shame and denial: Engaging mandated men', *Ending men's violence against women and children*, Spring, Vol 1, p. 95.

[13] Watch this video for a definition of 'humiliated fury', also known as 'shame-rage'.

A major challenge in behaviour change work with adult users of DFV is to avoid overwhelming the individual with shame while *at the same time* scaffolding journeys of accountability and supporting the safety of victim-survivors. **This requires a *measured approach* – one that gently pushes up against the adult's shame barrier, while also attempting to expand their shame tolerance**.

Practice detail – considerations when taking a measured approach

Skirting around behaviour or going too 'softly' can be collusive. But if adult user of DFV feels flooded with shame their main focus can become protecting their sense of self from attack (e.g., "I am not a wife bashing monster!"). This can distract them from the behaviour change process, and from other components of your practitioner-facing case plan.

Take a measured, gradual approach towards addressing shame by considering the following:

- Work with what the adult is willing to reflect on at the time. The adult will not acknowledge most of their use of violence to begin with, and perhaps never will. Push gently and progressively against their shame barrier towards discussing more.
- Shattering their sense of self can be counterproductive. Build a solid foundation from which they discuss more details of their behaviour over time. Go at the pace that they can manage. Regularly assess their current shame tolerance. Identify supports and processes available to increase their capacity to tolerate greater degrees of shame.
- While scaffolding them to expand their shame tolerance, there remains the need to engage in safety planning to build safety and interrupt their current and future choices to use violence.
- If they're experiencing chronic shame, taking a measured approach can be more challenging at first. This is because there's less room to focus on accountability goals and to bring the person's behaviour into view without overwhelming them with shame.

See various written resources and demonstration videos located in the Featured section of https://www.linkedin.com/in/rodney-vlais/ (you will need a linkedin account to view) for practice suggestions in taking a measured approach, including the use of mid-point and conversational container skills. Begin with *Concepts, Models and Skills in Engaging Adult users of DFV*.

Assessing shame tolerance

Shame tolerance varies from person to person. Assessing shame tolerance involves observing nuanced reactions from the individual, including:[14]

- physical cues (e.g., covering their face, blushing, downcast eyes)
- using synonyms for shame (e.g., 'self-conscious', 'embarrassed', 'foolish', 'worthless', 'inept')
- paralinguistic cues (e.g., stammering, silence, long pauses)
- shame avoidance behaviours demonstrating 'bypassed shame' (see 'the compass of shame').

[14] Dolezal, L, & Gibson, M, 2022, 'Beyond a trauma-informed approach and towards shame-sensitive practice', *Humanities and Social Sciences Communications*, Vol. 9, p. 7.

Practice tip

Be aware of your language, behaviour, demeanour, questioning style and interpersonal dynamics, as they may inadvertently be shame-inducing. Choose your language carefully when working with the adult (e.g., use 'feeling judged', 'feeling self-conscious' or 'feeling embarrassed' rather than the term 'shame').

Restoring dignity

Some adult users of DFV might have experienced major attacks on their dignity. These might have arisen in the context of:

- experiencing structural oppression/violence focusing on issues of race, gender, or sexuality
- a history of struggling with mental health and/or AOD issues.

In these circumstances, a measured approach involves working to create a dignified environment for the individual, while not losing sight of the degradation and loss of dignity their behaviour has caused for victim-survivors. This can include:

- acknowledging and supporting the individual's efforts to resist and counter the impacts of structural oppression and marginalisation on their and their community's lives
- taking time to understand how they work towards restoring dignity for themselves and their community in the face of oppression and marginalisation
- understanding your own privilege and biases that might make it difficult for you to see and appreciate important aspects of the individual's experience.

In some circumstances, you might be able to help the adult to draw parallels between their own struggles for dignity and the loss of dignity experienced by family members due to their use of domestic and family violence.

If the adult has significantly expanded their capacity to experience shame safely

Adults who use DFV may feel somewhat ambivalent about their use of violence. They might feel entitled to use violent and controlling behaviour in their families, while also feeling ashamed by it.

Expressions of shame and remorse can be evidence of an individual who's pre-occupied with their own pain and with avoiding responsibility. But they can also be potential opportunities to invite the individual to distinguish between:

- irresponsible expressions of remorse, such as repeated 'hollow promises and apologies' for the violence, and
- responsible expressions of shame that may lead to sincere apologies and genuine steps towards stopping the violence.

Practice tip

Throughout engagement with the adult user of DFV – and **when it's safe to do so** – look for opportunities to make space for the second type of expressions of shame and remorse.

This can be done by asking questions to draw these experiences of shame and remorse forward, to have them more richly described in the conversation, and by exploring together what is 'absent but implicit' in these expressions of shame. For example, you can ask a question such as: “What does the fact that you feel really bad about your behaviour say about what you actually prefer and value?”

In this way, expressions of shame become entry points to conversations about the individual's preferences for their life and for their intimate and familial relationships.

Assist the adult user of DFV to reflect on their feelings of shame and remorse. Do this in ways that support them to take a stand against the violent and controlling behaviour that caused them to experience these feelings. Explore with them that experiencing these feelings means they:

- know that they – or at least a strong part of them – want to behave in different ways
- can take action to face their violence
- can take action to reduce the likelihood of further harm.

These explorations can assist the individual to work towards the self-respect and respect for others that comes from bringing their behaviour into line with their values. Indeed, the intensity of the shame can come to be equated with the intensity of their commitment to wanting loving, non-violent relationships.

The following types of questions can be useful in efforts to help the adult develop self-respect through responsible expressions of shame:

> “I wonder, would you have more respect for yourself if you were addressing the violence, rather than avoiding it?”
>
> “What courage and strength does it take to face these issues rather than run away from them and pretend they don't exist?”

In some ways, a focus on shame and remorse can create a conversational space with two simultaneous components:

- one in which the individual feels increasingly 'bad' – for gradually facing up to their violent behaviour
- another in which the individual feels increasingly 'good' – both for feeling 'bad' and for connecting with their self-respect as they work to end their violence.

Seek to develop both components of this conversational space simultaneously. **Doing so creates a *positive emotional space* for the user of violence to engage productively with the shame and discomfort of acknowledging their harmful behaviour and its impacts.**

With a user of violence who has (developed) sufficient shame tolerance, a direct focus on feelings of remorse, regret or shame can be very beneficial in working towards change. However, do so in a way that supports them to draw *positive meaning* from the fact that they’re experiencing these feelings. Frame them as *signposts* of efforts towards self-respect and behaviour change.

This simultaneous exploration reduces the chance of leaving the individual feeling negative and without hope. It allows the feelings to act as entry points for further exploration of their hopes and wishes for their relationships and for their life, and to develop and strengthen commitments towards choosing behaviours based on safety, non-violence, kindness and respect.

Case planning and substance use

Understanding the interplay between substance use and the perpetration of coercive and controlling behaviours is highly important for case planning.

There is substantial evidence that substance use can be associated with increased frequency and severity of domestic and family violence tactics.[15] There's also growing evidence that individuals who have co-occurring addiction and mental health complexities are at heightened risk of using lethal violence.[16] This combination of factors, as well as significant substance use alone, are implicated in the *persistent disorderly* pathway towards domestic homicide.[17]

Addressing substance use alone will rarely, if ever, be sufficient to substantially reduce domestic and family violence risk and harm. However, several studies suggest that specialist AOD treatment with adults who use DFV can result in significant reductions in physical violence. Conversely, relapses in substance use are associated with a renewed increase in risk.[18]

Be careful not to adopt a judgmental or moralistic tone when talking about substance use with your clients.

Use person-centred language, rather than stigmatising language that reinforces negative stereotypes. Read the Alcohol and Drug Foundation's Power of Words language guide and the Network of Alcohol and Other Drugs Agencies (NADA)'s Language Matters language guide for guidance on how to use non-stigmatising language.

It is important to ask the adult user of violence about their patterns of substance use, so you can understand when best to engage with them. Try to negotiate session times based on the individual's availability (such as late afternoon after they usually wake up) or negotiate for the individual not to use substances within a particular window of time before a session (depending on how long the effects of the substance usually last). There might be other nuance to negotiations, depending on the individual's preferred substance and their patterns of use.

Practice tip

Try to develop an understanding of what the pattern of substance use looks like for your adult client using DFV. This will help you to assess why and when they engage in substance use, and how different stages of their substance use may contribute to the use and escalation of violence and controlling behaviours. Some considerations might include:

- What type of substance(s) is used and how is it used (the modality of use)?
- What quantity of the substance(s) is used and how often is it used?

[15] Mayshak, R, Curtis, A, Coomber, K, Tonner, L, Walker, A, Hyder, S, Liknaitzky, P & Miller, P, 2020, 'Alcohol-Involved Family and Domestic Violence Reported to Police in Australia', *Journal of Interpersonal Violence*, Vol. 37, No. 3–4.

[16] Oliver CL & Jaffe PG, 2021, 'Comorbid Depression and Substance Abuse in Domestic Homicide: Missed Opportunities in the Assessment and Management of Mental Illness in Perpetrators', *Journal of Interpersonal Violence,* Vol. 36, No. 11-12.

[17] See anrows.org.au/project/pathways-to-intimate-partner-homicide

[18] Gilchrist, G, Potts, L, & Radcliffe, P et al., 2021, 'ADVANCE integrated group intervention to address both substance use and intimate partner abuse perpetration by men in substance use treatment: a feasibility randomised controlled trial', *BMC Public Health,* 21,980.

- Who is the substance(s) used with (alone or with friends and/or family)?
- How is the substance(s) procured, how much money is spent on it, and has a debt been incurred?
- What is the cycle of use and withdrawal (e.g., sleeping day 2,3, agitated on day 4)?

Note that many DFV perpetrators many use multiple substances. Poly-substance use is common among people who use drugs. They might use one substance (e.g., alcohol) to manage come-down after the use of another (e.g., methamphetamine). Poly-substance use is a risk factor for overdose.

Assessing the mechanisms by which substance use contributes to DFV use

There are different mechanisms by which substance use can increase the likelihood and/or severity of domestic and family violence. These must be assessed on a case-by-case basis.

It is important to assess both the *function* that substance use performs in the person's life, and how their substance use *contributes to and is a part of* their patterns of abusive and controlling behaviours.

Some relevant considerations for this assessment include:

- What is the motivation behind the substance use (e.g., to maintain use, reduce, access withdrawal)?
- What function does substance use serve in terms of self-soothing, emotional regulation and/or supporting mental health? How does it impact on feelings of self-worth and power?
- Does substance use correlate with choices to use – and severity of – violent and controlling tactics?
- How do behaviours associated with substance use (i.e., patterns of physical, psychological, and emotional behaviours related to craving, planning to use, acquiring the substance, intoxication, after-effects and attempts at withdrawal) impact particular tactics of coercive control?
- Are substances used with the victim-survivor(s)? Have attempts been made to pressure the victim survivor(s) in substance use (e.g., keep them dependent on substances or to interfere with their efforts to seek counselling or treatment?)
- Are substance(s) used around children and young people?
- If such attempts have been made, are they designed to entrap the victim-survivor(s)? Or as part of systems abuse tactics to make them out as unreliable or as an unfit parent? Or 'simply' so that the adult perpetrating DFV has someone to use substances with?
- How are substance(s) used to instil fear in the victim-survivor(s)?
- How are substance(s) used to trigger conflict and provide a justification to use abusive and controlling behaviour? Or used as a justification to use DFV in other ways?
- Does substance use result in an increase in particular types of obsessive thinking and rumination of negative thoughts?

Understanding the individual's current patterns of substance use can help us develop a plan for positive engagement as well as analyse risk. Any number of these considerations might also be relevant to the role that substance use plays in patterns of violent and controlling behaviours. By assessing which mechanisms are involved in any given case, you'll be in a stronger position to case and risk manage and address the individual's substance use.

Assessing the adult's DFV behaviours associated with substance use

A DFV perpetrator's substance use or withdrawals can be associated with increased risk for adult and child victim-survivors. Substance use or addiction can lead to the adult's misidentification or misreading of environmental cues, resulting in them attributing threat to another person's intentions or behaviour where no actual threat exists. Considerations that in other circumstances might inhibit abuse, such as the presence of onlookers, might not come to mind when intoxicated. All this can result in conditions that are conducive to the adult's choice to escalate their violent behaviour.

But it's not only intoxication that increases risk for victim-survivors. **It's vital to consider the whole spectrum of behaviours associated with the perpetrator's substance use** – not only substance use itself – in terms of the dynamics associated with risk and harm. Substance use behaviours include thinking, restricted focus, obsessions, and other behaviours associated with:

- dependence on and cravings for the substance(s)
- accessing and acquiring the substance
- connections and relationships with others in relation to securing access
- planning substance use
- actual use of the substance (intoxication)
- connections and relationships with others who use the substance with them
- coming down from the substance – immediate after-effects
- any attempts at withdrawal from the substance, or in moderating its use.

There are multiple ways in which an individual's substance use might be implicated in their patterns of controlling and violent behaviour.[19] For example, an adult user of violence might:

- express increased irritability and have lowered distress tolerance during intense periods of withdrawal, increasing their likelihood of choosing to use domestic and family violence when feeling 'annoyed' by victim-survivors
- use threats, intimidation, and other coercive controlling behaviours to force victim-survivors to acquire substances for them, including through illegal activity and sex work
- engage in sexualised violence, including forcing their partner to do unwanted sexual acts during periods of hyper-sexuality that can be associated with some substances
- use financial violence to ensure that their partner contributes financially to their substance use, or to control finances in other ways that enable them to fund their use
- adopt secretive behaviours to fund and maintain their substance use

[19] Gilchrist G, Dennis F, Radcliffe P, Henderson J, Howard LM & Gadd D, 2019, 'The interplay between substance use and intimate partner violence perpetration: A meta-ethnography', *International Journal of Drug Policy*, Vol. 65, pp. 8-23.

- escalate their use of physical and other forms of family violence in 'retaliation' when the victim survivor(s):
    - refuses to engage in actions that support the individual's substance use (e.g., refuses to hand over money or cover for the adult when too intoxicated to follow through with a commitment)
    - pushes back against the individual's expectations that the victim(s) survivor puts their, and their family's needs, second to the individual's substance use
    - attempts to directly limit the individual's substance use.
- behave unpredictably when using substances and/or intoxicated, leading the victim-survivor(s) to need to monitor constantly the adult's moods for signs of impending violence
- create an unsafe environment for the victim-survivor(s) by exposing them to situations where they are in the same space as the user of violence and his friends who are very intoxicated, where they have contact with people with links to drug-related organised crime, or where they are around drug paraphernalia which the adult could use as a weapon.
- be extremely irritable and lack emotional regulation during periods of withdrawal – some victim-survivors report that periods of withdrawal can be the highest-risk times that they experience.

Practice tip

It is important to assess and map the constellation of lifestyle factors and behaviours linked to the perpetrating adult's substance use. This will help you, and any AOD services that also work with the individual, to understand how particular factors and behaviours are implicated in the adult's patterns of coercive control.

When the victim-survivor is also using substances

Coercive controlling tactics used by the adult perpetrator of violence can be heightened when the victim-survivor(s) is also using substances. There's growing evidence that DFV perpetrators choose relatively more severe forms of physical violence when the victim-survivor(s) uses substances.[20] Many adults who use DFV adopt tactics to interfere with efforts by victim-survivors to reduce or recover from substance use,[21] an example of broader patterns of **substance use coercion**.[22]

When their partner is also using substances, the adult causing DFV harm might:

- use domestic and family violence to create unequal access to the substances they both use, and various tactics to control their household's drug supply
- control their partner's access to the substance such that the DFV perpetrator becomes the only feasible option for supply, effectively trapping their partner in the relationship
- further entrap their partner by trying to sabotage attempts to withdraw or obtain treatment

[20] Coomber K, Mayshak R, Liknaitzky P, Curtis A, Walker A, Hyder S & Miller P, 2021, 'The Role of Illicit Drug Use in Family and Domestic Violence in Australia', *Journal of Interpersonal Violence*, Vol. 36, No. 15-16.

[21] Gilchrist G, Dennis F, Radcliffe P, Henderson J, Howard LM & Gadd D, 2019, 'The interplay between substance use and intimate partner violence perpetration: A meta-ethnography', *International Journal of Drug Policy*, Vol. 65, pp. 8-23.

[22] theconversation.com/how-perpetrators-of-domestic-violence-use-drugs-and-alcohol-to-control-their-victims-236865

- force their partner into degrading behaviours in return for providing them with substances (e.g., coerced sexual activity as an 'exchange' for drugs)
- threaten to report her to authorities for illegal activities used to fund/obtain substances
- combine coerced sexual activity with emotional abuse to make their partner feel degraded and humiliated for engaging in these activities, and coerce her into using substances to heighten her sexual activity against her will
- use social violence ostensibly to 'protect' her from 'unscrupulous' peers with whom she wants to use, but motivated in reality by feelings of jealousy and obsessive behaviour.

Victim-survivor resistance to the adult's use of domestic and family violence can increase when the victim survivor(s) is intoxicated. Perpetrators are likely to meet this resistance with an increase in physical and/or other forms of violence in order to supress it. This is due to the hostile meaning the adult user of violence makes of acts of resistance based on their **victim-stance thinking**.[23]

Victim-survivor success in overcoming their substance use can be a time of increased risk, if this provides her with more choices, options and 'independence' that the perpetrator finds threatening to his control. Some users of DFV would prefer that their partner remains substance dependent so that they can be more easily controlled, and if she has children, more easily demeaned as an unfit parent.

Taking a lifespan approach

For adults who have been using substances for a period of time, it is important to understand the function(s) that their substance use has served at different stages of their life, and how this might relate to experiences of complex trauma and/or the use of and experience of generalised violence.

Recent research has identified two different lifespan pathways relevant to understanding how an individual's substance use relates to their violent and controlling behaviours.[24] While both pathways relate to the impact of trauma on an individual's use of substances, it's important to note that not all people who use substances have experienced trauma in their lives.

Rule breaking pathway

The *rule breaking pathway* is where the individual, as a young person, begins engaging in substance misuse and generalised violent behaviour (both within and outside family contexts) as a response to childhood trauma such as parental physical and emotional abuse. Significant substance use may have begun early in childhood, not so much as a means to cope with experiencing trauma, but more to obtain a 'buzz', and in the context of engaging in antisocial and rule breaking behaviours.

The violence of these individuals is sometimes very severe, characterised by motives of entitlement, power and control, male dominance, disrespect of women and sexual jealousy. These individuals also appear to have little empathy for people whom they consider have 'allowed themselves to be victims, and to be vulnerable'. Their substance use can intensify in certain situations, such as during relationship breakdowns.

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[23] See *Responding to perpetrator "I'm the victim here!" thinking* at linkedin.com/in/rodney-vlais/ (from the Featured section – a linkedin account is required to access)

[24] Gilchrist, E, Johnson, A, Thomson, K et al., 2023, 'Substance Use and Intimate Partner Abuse (IPA): A Descriptive Model of the Pathways Between Substance Use and IPA Perpetration for Men' *Journal of Family Violence*, Vol. 38, pp. 855-868.

Sometimes the substance use is associated with the use of domestic and family violence. On other occasions, power, and control motives and highly sexist (often misogynist) beliefs manifest in DFV in the absence of any substance use. **Individuals in this pathway are likely to be violent and controlling even without the use of substances.**

The recent and rapid growth of the online 'manosphere' can perform an important reinforcing function here. Entitlement-based beliefs can become accentuated when young men become engrossed in a sense of collective grievance fuelled by online influencers.

Individuals who exhibit a rule breaking pathway towards substance use and domestic and family violence might require intervention components that aim to:

- identify unhelpful beliefs and patterns of thinking and behaving arising from how the client has processed childhood experiences
- enhance distress tolerance and self-regulation
- address cognitions stemming from male entitlement and a need to control.

Entrenched substance use pathway

Individuals who follow an *entrenched substance use pathway* also experience traumatic childhoods, but typically involving *sexual* abuse. For these individuals, the trauma is more severe, degrading and humiliating. Their substance use begins at a very early age as a way to cope with their experiences of trauma. A chaotic and unstable lifestyle emerges based on drug and/or alcohol dependence.

These individuals may have poor coping skills, significant mental health problems, cognitive disability or impairment, and multiple struggles in life. These might include:

- poor physical health or chronic illness
- involvement with the criminal justice system
- housing instability
- experiences of physical violence

In this context, substance use is their primary coping mechanism. It becomes a way of self-medicating intense emotions arising from traumatic backgrounds and poor mental health.

Individuals in this pathway don't necessarily engage in antisocial or criminal activity before their drug dependence. But once entrenched in heavy substance use, some engage in criminal activity to fund their use. **Individuals in this pathway are more likely to be in relationships with a partner who's also using substances, and to feel trapped within their entrenched use of substances.**

Practice tip

These individuals need a strong focus on interventions designed to improve their mental health, as well as treatment for their substance use.

They also need sustained efforts to strengthen their distress tolerance and emotional regulation skills. Without these, treatment to address their substance use might fail.

Adopting the principles of *trauma and violence informed practice* are particularly crucial for these adults.

Read the practice resource ***Working with Adult Users of Domestic and Family Violence with a Trauma Background*** for guidance on addressing trauma in ways that are consistent with intersectional feminist understandings of DFV.[25]

The resource explains how trauma and violence informed practice builds upon trauma informed care, and explores the nuanced interplay of trauma backgrounds and (male) entitlement in creating pathways for DFV use.

Case managing an adult perpetrator of DFV who uses substances

Adults who cause domestic and family violence harm may blame their violent behaviour on their substance use. Some claim they become a 'different person' or they 'black out and can't remember' when under the influence – that in other circumstances they're not violent. There's always a tricky balance between the need to take substance use very seriously as a major contributing risk factor, while not colluding with this narrative.

Consider building your own capability to understand substance use directly with adult users of violence. Often, you'll still need to refer them to a specialist AOD service. But there might be situations where you can work directly on substance use-related issues with the individual, with the help of secondary consultations from an AOD specialist.

Practice tip

Some adults who cause DFV harm might not have a current acute substance use issue but might have in the past. Due to the discomfort and heightened experience of shame that can arise through a DFV behaviour change process, an adult who has overcome their substance use might be at risk of returning to it to cope with these feelings and experiences.

It is important that you work towards defending against this risk of relapse. Explore the strategies the adult uses to prevent themselves returning to substance use, when they face challenging situations and intense emotions in their life. If they've engaged in treatment for addiction in the past, they might have a relapse prevention plan that you can remind them of. If they were receiving substance use treatment relatively recently, you can use, if possible and appropriate, information sharing powers provided by your jurisdiction's information sharing and privacy legislation to request a copy of this plan from the treatment provider.

In some situations, you might not need to have experience or specialisation in providing substance use treatment to work with DFV perpetrators on substance use relapse prevention strategies. Obtain a secondary consultation from an AOD service to assist you. Take a strengths-based approach focusing on the individual's existing strategies and be guided through secondary consultation in how you might be able to bolster these strategies.

[25] Downloadable from the Featured section of linkedin.com/in/rodney-vlais/ (accessible with a linkedin account).

There are a wide variety of different types of AOD services – the sector is very diverse. These include drop-in services, addictions medicine and pharmacological support, day programs, non-residential rehabilitation support, residential rehabilitation centres, care and recovery / addictions counselling, and therapeutic communities. Explore how you can support each other's work, given the intersect between DFV and AOD use.

Work closely with the AOD services to which you refer adult users of violence. Explain your analysis to them of how the individual's substance use is implicated in their violent behaviours and coercive controlling tactics. Adopt a collaborative approach so that the AOD practitioner can reinforce some aspects of your work with the client, and you can reinforce some of theirs.

Learn how the AOD service works towards goals (such as building capacity to emotionally regulate, prevent relapse, and develop harm reduction strategies), and towards assessing and managing risks (such as overdose and relapse).

There might be strategies that can be used by both you and the AOD practitioner in their respective work with the client, such as cognitive-behavioural therapy (CBT) distress tolerance, emotional regulation techniques, or specific motivation-building approaches (e.g., Motivational Interviewing). Find the commonalities, overlap or theories that intersect, so that both your service and the AOD service provide opportunities for the individual to practice and refine some similar skills.

Men's behaviour change program providers, and other specialist DFV services that engage users of violence, should try where possible not to turn down referrals of adults with heavy substance use. Rejecting these referrals can reinforce the adult's narratives that their use of violence is caused by drugs or alcohol and that they lack choice. If the adult is not suitable for behaviour change group-work, try to keep them engaged and visible through individual sessions and contact.

Practice tip

For some adults using violence, the 'hooks' to motivate change are most likely to focus on their enlightened self-interest, at least to begin with. Help the individual realise that **safety planning their substance use and reducing their behaviours associated with domestic and family violence can both support working towards similar goals**, including improved physical and mental health, fewer life crises and the potential at least for healthier relationships.

For others, the impacts of DFV and AOD use on their children can be a motivating factor. If the adult is a parent, you could test out whether focusing their attention on some of these impacts might increase their motivation to take steps towards change. Do so carefully, mindful of the adult's tolerance to experience the shame that might arise if they allow themselves to sit with these impacts.

Where possible, be informed by the victim-survivor's situation and the ways in which they resist violence and work towards safety, when case planning substance use goals with the adult causing harm. It is not uncommon, for example, for some victim-survivors to, in certain situations, encourage the adult's substance use as a means to sedate or incapacitate them during periods of escalating risk.

Following the victim-survivor's lead means interrogating your automatic assumptions regarding what will, or will not, make things safer.

Substance use and cognitive impairment and disability

A significant minority proportion of adult users of DFV have a cognitive disability or impairment, most notably an ABI/TBI or the cumulative impacts of a childhood developmental delay; others might have neurocognitive deficits due to long-term substance use or other causes, mild intellectual disability or Foetal Alcohol Syndrome Disorder. Many adults struggling with substance use also have a cognitive impairment, even more so amongst long-term substance users.

Co-occurring impacts of substance use and cognitive impairment can include lowered impulse control, impaired flexibility of thought, lower distress tolerance, and reduced ability to solve problems through verbalisation. The use of violence and aggression can become an attractive choice for adults with these limitations.

Practice tip

Neuropsychological assessments can be highly helpful when working with users of domestic and family violence who have cognitive disability or impairment. A neuropsychological report (and subsequent engagement with the neuropsychologist who conducted the assessment) can provide concrete and specific strategies regarding how best to engage the person. Neuropsychological assessments delineate aspects of a person's cognitive functioning (for example, attention, new learning and memory, information processing speed, verbal skills and executive functioning), and outlines how the cognitive impairment affects the way they think, act and deal with the demands of everyday life.

Resources for engaging clients with cognitive impairment or disability

Responses to adult users of domestic and family violence with cognitive disability or impairment are becoming more specialised. There are several innovation trials in Australia (Victoria, NSW and Queensland) of men's behaviour change programs being adapted specifically for men with a cognitive impairment.

The Victorian MARAM (Multi Agency Risk Assessment and Management framework) contains a number of sub-sections and a tool focusing on the intersect of DFV use and cognitive impairment or disability. The tool focuses on screening criteria to help detect the presence of an impairment if not already identified upon referral.[26]

The Alcohol and Drug Cognitive Enhancement (ACE) program,[27] produced by the NSW Government Agency for Clinical Innovation, provides a range of program screening and assessment tools for working with people with cognitive impairment and disability, and includes a brief intervention and cognitive remediation program to support case planning and clinical intervention goals. These are highly useful for working with adult users of DFV with a cognitive impairment or disability.

[26] See https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence/responsibility-3 - specifically 3.3.1 *Practice considerations for people with cognitive disability and impairment, when assessing and managing risk*; and Appendix 5 *Screening questions for cognitive disability and acquired brain injury* which can be used to help detect the presence of cognitive disability when suspected but not verified.

[27] aci.health.nsw.gov.au/projects/ace-program

Case planning and mental health

Like substance use, mental health issues can be interwoven through some of the violent and controlling behavioural patterns of an adult user of DFV. Mental health issues and challenges generally aren't a cause of violent and controlling behaviour, but can contribute significantly to risk and to harm.

When a person using violence is experiencing mental health issues or complexities, it is important to try to assess the mechanisms or processes through which they impact upon choices to use violence. Understanding these will assist you in developing and evolving your case plan, and in collaborating with mental health services so that you aren't working in opposing directions.

Mechanisms through which mental health complexities contribute to risk and harm

→ Mental health issues can make the adult's 'task' to choose non-violence more difficult. Violence is always a choice, and we need, 100% of the time, to expect the adult to not use violent and controlling behaviours, irrespective of the circumstances, irrespective of his trauma background, and irrespective of what he is experiencing in the moment.

'However', it is not a 'level playing field' across users of violence in terms of how 'easy' it is to make non-violent choices. Backgrounds of trauma, substance use and/or mental health challenges can make this task more difficult for a user of violence, even though we need to assume that they are always capable of making safe and non-controlling choices.

Mental health complexities can make this task more difficult in a number of ways. For example:

- depression can result in reduced care for self and for others, and increased irritability
- anxiety patterns can intensify the adult's focus on violence-facilitating ruminations
- 'disorders' associated with *under*-control can make emotional regulation more difficult (in a range of situations, not only with intimate partners and family members)
- 'disorders' or generalised patterns associated with *over*-control and limited cognitive flexibility can become tied into coercive controlling patterns, for example to force family members to comply with the adult's rules that he sets in various domains of day-to-day life; generalised patterns of over-control can also interact with male entitlement to lead the adult to feel particularly threatened when he believes that his ex/partner or family member is accusing him of wrongful behaviour or of making a mistake[28]
- chronic shame and shame anxiety associated with trauma backgrounds can combine with entitlement-based beliefs to 'overwhelm' the adult user of violence and lead him to feel convinced that his partner is 'victimising' him.[29]

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[28] Generalised patterns of over-control can include the adult habitually avoiding realisations that they have made mistakes, and avoiding or not responding well to feedback. This can be associated with limited cognitive flexibility and openness. For men with highly entitled gender-based beliefs, generalised patterns of over-control can accentuate existing choices that the adult makes to escalate violence when they feel 'threatened' by feedback or criticism.

[29] For further information, see *Working with Adult Users of Domestic and Family Violence with a Trauma Background* accessible with a linkedin account through the Featured section of linkedin.com/in/rodney-vlais/ - scroll through each of the available resources to locate.

→ In some cases, mental health complexities can result in significant disorganisation in the adult's daily living, associated with marked fluctuations in thinking and mood. They can also result in periods of homelessness or housing insecurity. These forms of instability in the perpetrator's life can contribute to heightened risk for victim-survivors, and make it more difficult for the adult user of violence to focus on behaviour change work.

→ General agitation and/or emotional lability due to mental health issues can create additional fear and distress for victim-survivors (e.g., leaves them 'walking on eggshells'). **Knowing this, some adult users of violence with mental health complexities make deliberate choices to alter their mood in the presence of family members as a controlling tactic**. This can be through portraying 'moodiness' as well as choosing to make their agitation more visible.

→ Mental health issues can intensify violence-supporting narratives and 'thought stacking'. Depression and/or anxiety can serve a similar function to substance use in this respect, narrowing the adult's attention, removing his ability to notice cues in his environment, and intensifying his ruminations. Due to their entitlement-based and other core beliefs, these adults often exhibit rapid thought processes focusing on what their ex/partner or other family member has 'done unfairly to them'. They then habitually dwell, stew and invest in this "I'm the victim here!" thinking, and in doing so give themselves permission to use violent and controlling behaviour to shut down the victim-survivor's options and spaces to continue the behaviour that the adult perceives is 'harmful', 'unfair' or that interferes with his entitlements or rights.[30]

  Some mental health complexities, in some circumstances, can intensify this process. For example, as jealousy can be experienced as agitated, anxious worry, an adult who struggles with an anxiety 'disorder' and who therefore has a highly tuned antennae towards any (small) possibility of a catastrophic outcome might ruminate more intensely on jealous thoughts.

→ The adult user of violence might genuinely have limited self-efficacy due to their mental health struggles, and have little confidence that they can make things work for their own life or for their families. This might limit their efforts to work towards behaviour change, especially if they feel that they don't have the ability to make changes to their behaviour, or that they are not able to become the man or father/parent they really want to be.

  If the adult has identity aspirations or values consistent with non-violent, non-controlling ways of being, but has little confidence that they can put these values into practice and take steps towards this 'new me', motivational enhancement and behaviour change strategies based on carefully stimulating cognitive dissonance between the adult's behavioural self (his violent and controlling behaviours) and aspirational self (who he really wants to be as a man or father/parent) might have limited impact.

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[30] Victim stance thinking, or victim stance orientation, refers to the beliefs and thinking adopted by adults who cause DFV harm through which they give themselves the 'green light' to use violence. Paradoxically, many adult users of violence perceive that rather than themselves doing wrong, that they have been wronged. In large part, this is due to the adult's adoption of entitlement-based belief systems drawn from patriarchal culture – he sets highly unreasonable and entitled expectations of his (ex)partner, based on gendered belief systems. When she understandably fails or refuses to meet the full extent of these expectations, he believes that he has been untreated unfairly and that he is the 'victim' of her unreasonable behaviour. Based on this thinking, he therefore believes that she 'deserves' to be punished and controlled. Victim stance thinking enables men to avoid the shame involved in owning up to their behaviour. However, for many men, victim stance thinking in part evolves from violence and abuse suffered at an earlier point in their lives (often family of origin). **Crucially, for men from minoritised communities, their victim stance orientation is also reinforced from everyday experiences of structural and systemic oppression.**

Adults perpetrating DFV might use their mental health history and current struggles as excuses for their behaviour, and to expand their repertoire of coercive controlling tactics. They might:

Play upon having 'poor self-esteem' as a reason why they need to focus on 'self-care' with 'limited capacity' to attend to the needs of their family members.

Make their partner feel sorry for them due to mental health struggles, in a way that limits her ability to raise issues about their behaviour or to negotiate having more say or control ("Oh, I can't talk about that now, I'm too depressed").

Blame their mental health issue on things they want the victim-survivor to stop doing.

Use their mental health struggles to do little or none of the emotional heavy lifting in the family, absolving almost all responsibilities to their partner and other family members (while still vehemently defending his 'rights' and perceived entitlements).

Use their mental health struggles as an excuse for social isolation tactics, making it difficult for their partner to bring friends and her family into the home, and interrupting her attempts at social connections through requesting her help to 'care for him'.

Attempt to coerce her into engaging in behaviours against her will to help him cope with or alleviate feelings of depression or anxiety.

Threaten not to take his medication for a mental health issue as a means of making her comply with a demand or rule that he sets.

Make inferences or threats in relation to attempting suicide.

Deliberately play upon their partner's goodwill and values of care and love, to elicit ongoing feelings and an overall narrative of sympathy for the adult.

Confide in one of their children (perhaps most likely a daughter) and share their mental health struggles and vulnerabilities in ways that are inappropriate for the age of the child. In some situations, this can be a deliberate tactic to alienate the child against their mother/parent, and to place a wedge in their relationship ("Your Mommy shouldn't get me upset like that, she knows I feel really bad inside of myself"). It can also make the children feel responsible for the perpetrator's mental health.

Depression

Depression is highly important to include in a case plan when working with an adult user of domestic and family violence. Perpetrator depression is an evidence-based risk factor for the lethal use of violence, particularly when co-occurring with substance use and/or with 'personality' characteristics such as jealousy, possessiveness, paranoia, irritability, impulsivity, rigidity, low trust in others and avoidance.[31]

For some high-risk, high-harm adult users of violence, depression can be experienced with a significant degree of hopelessness about the future, associated with one or more of the following:

- the adult sees little reason to adopt non-violent and respectful ways of relating as part of making a better life for themselves and others

[31] Lawler, S., Boxall, H., & Dowling, C. (2023). The role of depression in intimate partner homicide perpetrated by men against women: An analysis of sentencing remarks. *Trends and issues in crime and criminal justice*, (672), 1-16.

- has a *deteriorating life situation* (e.g., in terms of employment prospects, relationships and social connections, physical health, housing stability, AOD use)
- has an increasing sense of desperation
- experiences (and might express) substantial resentment and bitterness towards their (ex)partner or other family member(s) (e.g., perceiving that she has 'won' and her life is going well while his is deteriorating).

This type of depression and hopelessness about the future can signal very serious risk. It can be associated with the adult user of violence changing the intent behind their harmful behaviour from attempting to control the victim-survivor(s) they feel aggrieved towards, to attempting to punish or destroy them through severe actions.

Collaborating with mental health services so that the adult's depression can be treated needs to be a very high and urgent priority for these adults. Some high-risk, high-harm adults will avoid mental health services, so you might need to be gently yet proactively persistent.

Practice tip

It is crucial that you **obtain secondary consultations from mental health specialists** for guidance on how to approach your conversations with the adult as part of encouraging and supporting him to engage with an appropriate mental health service.

Active outreach and warm referral processes might be required, including accompanying the adult to the service and building in other scaffolds to support his attendance. *This is not the time to adopt the approach that the adult needs to take full responsibility for accessing and following through with services himself*. When risk is this high, do what you can (within reason) to scaffold his participation in appropriate mental health services. Lowering serious risk to victim-survivor safety is the paramount priority.

Of course, in many situations the adult's depression will not be as strong. It might be possible to reduce its effects through a combination of GP management and a contained focus on mental health self-care and supports through your work with the adult.

In doing so, **always be mindful of how the adult might be using depression and mental health issues as an excuse or smokescreen for his violent and controlling behaviours**. Try to work with him in ways that avoids strengthening these excuses, and that does not inadvertently expand his options to control his ex/partner and family members.

You cannot control how the adult might manipulate or misrepresent your work with him in ways that disadvantage family members. But you can try to minimise these possibilities by being mindful of how you frame your work with him on things that he can do to keep the depression at bay.

You might, for example, try to link work with him on mental health self-care with how this can help him to adopt more responsibilities to notice the needs of, and to care for, others. Or on how this can place less pressure on his partner to care for him, and role model taking responsibility for one's health to his son(s).

Anxiety patterns

Depression can often co-occur with significant levels of anxiety; however, there are also of course specific anxiety 'disorders'. There is less research about intense patterns of anxiety as a risk factor for adult users of domestic and family violence, compared to depression or mental illness in general. Certainly, some adult users of violence have been, or are diagnosed with anxiety conditions such as generalised anxiety, panic disorder, social phobia or OCD.

A feature of many anxiety conditions is the desire of the person experiencing the anxiety to attempt to make 100% certain that the circumstances or events they are worried about will never happen. This constant search for 100% certainty paradoxically feeds their anxiety. The more the person attempts to achieve 100% reassurance, the more the anxiety builds. Overcoming anxiety requires the adult to live with the uncertainty that the feared outcome could conceivably happen (though in many instances, might be very or extremely unlikely).

In this case of sexual jealousy, for example, this need for certainty can form part of what the adult user of violence can experience as 'driven behaviour' to ensure that their fears about their partner's 'infidelity' never eventuate. This need for certainty can be a central characteristic of anxious, agitated worry associated with jealousy; anxiety in general is fuelled, in part, by actions to attempt to make certain that the feared outcomes at the centre of the anxiety have no chance of occurring. Choices to use social violence and associated controlling tactics can be made with the intent to *make 100% sure* that the man's partner has *no opportunity* to 'cheat' on him. Obtaining 100% certainty however is not possible (unless he chooses intimate partner homicide); attempts to obtain absolute uncertainty only fuels the man's anxiety further.

A perpetrator's struggles with anxiety, therefore, can increase their risk of using controlling and violent behaviours to attempt to 'make sure' that their partner does not engage in a behaviour they are highly anxious about. **Male entitlement much more than anxiety is the cause of this behaviour; however, the two can combine to increase risk even further**.

OCD is a case in point. It is not uncommon for adults who experience OCD to attempt to influence the actions and choices of family members. A certain degree of compliance might be 'required' for family members not to engage in actions that interfere with the adult's compulsions or 'need' to have things arranged in particular ways. If the adult who experiences OCD is using domestic and family violence, however, they might choose to cross the line into using patterns of violent and controlling behaviours to ensure family member compliance.

Recognising and responding to identity loss and identity crises

Adult users of DFV will often have experienced significant stressors in their lives. Many of these are a consequence of their violence and others' responses to their behaviour. These stressors might include relationship breakdown, financial troubles, problems at work and breaking the law. Such consequences tend to build over time.

As the violence and its consequences become more visible, the way others view the adult may change. This can then lead to feelings of shame and tension in how they define themselves as a man. These may all combine to create a sense of loss of identity.

Feelings of loss of identity – as husband, father, provider – are common among adult users of DFV. When combined with other significant life stressors, an identity crisis might set in. This might be even more so if they are beginning to acknowledge at least some aspects of their use of violence and come to see themselves as some version of a 'woman beater'.

Such a profound realisation and its impact on one's sense of self can make a person more vulnerable to pre-existing, recurrent or new mental health or substance use problems. These can include problems that the adult previously had under control but are now at risk of resurfacing.

Recognising identity loss and identity crisis

The effects of an identity crisis may become evident during initial presentation or assessment. They may manifest in 'catastrophic' or 'all-or-nothing' thinking, with no middle ground. Common examples include:

"I'll never see my kids again"
"I have nothing left to live for"
"I have nothing left to lose"

These types of responses to identity crisis can indicate very serious risk.

Responding to identity loss and identity crisis

It can be helpful to raise the question of identity crisis explicitly with the adult user of violence. Discussion of the impacts of this crisis can focus on ways to reduce its negative effects. Sometimes this discussion will be necessary to allow meaningful engagement around the use of violence.

In these situations, particularly when risk is serious, it can be useful to conduct a **holistic health assessment** to support the adult in making choices that will improve overall well-being. Other responses to identity loss can include:

- linking back to existing or previous psychological support
- recommending a GP visit for referral to psychological support
- identifying current supports who may have been forgotten, such as family, friends or colleagues.

Be aware of the positive and negative aspects of further identity loss and crisis

It's not uncommon for adult users of violence to express feelings of loss slowly, over the course of many sessions.

If positive shifts in behaviour take place, the adult may realise that they need to end some friendships that are having a bad influence. They may also realise that they need to change their employment situation / job to make a fresh start.

Together, these major shifts can trigger further experiences of identity loss. They can also deepen identity loss to the point of becoming an identity crisis.

This may be expressed in terms of 'becoming a new person' who 'doesn't recognise himself anymore'

These changes can result in profound experiences of disconnection, confusion, vulnerability and loss. Support and scaffolding are needed to enable the adult to navigate them safely, as distinct from spiralling down into depression and a lack of care about how his actions impact others or himself.

These changes can also be positive. They can be important in re-shaping an identity to one that has no place for the continued use of violence. They can support finding new connections and social supports who value the 'new person' who is emerging.

In these scenarios, it can be helpful to create healthy 'replacements' for the adult user of violence, particularly when he poses a serious risk to those who experience his violence, and/or to himself. An effective option is to facilitate an interview with an agency that links people with volunteer jobs. Such work can offer a positive, self-affirming activity that increases social ties.

Another option is to provide information for activities they can join in the local area. These could be practical endeavours like sporting/hobby clubs. They could be groups associated with the man's cultural or other links to community, or involve local cooking or language courses. This can help increase the breadth of social ties and replace a lost sense of identity with new connections.

Some users of violence will attempt to fill the vacuum of identity loss in unhealthy ways. Relapse into substance use, or new substance use, can be a significant risk.

If identity loss is related to separation by their recent/former partner, not only might they escalate their violent and controlling tactics to attempt to coerce or manipulate her to return, they might also rapidly seek out a new partner.

Some of these adults **feel that they cannot survive** without a partner – emotionally, psychologically, financially and/or practically. Some feel that they cannot survive without the particular partner who has separated from them – others need a relationship in general to feel 'okay' within themselves, and possibly also because they lack fundamental life skills.

Some high-risk, high-harm users of violence have a pattern of starting new relationships soon after their former partner has separated. This does not mean, however, that the risk to their former partner has necessarily reduced. Some perpetrators maintain a strong grievance against their former partner(s) for years, and continue to use behaviours to punish, control and limit their space for action. This can of course have major consequences for both the former partner and her children.

Some high-risk, high-harming adults have privilege levers that they can use to 'protect' themselves from identity loss, and to isolate and marginalise victim-survivors. These might include high-profile leadership positions, positive reputation in the community, connections with people of influence, or holding occupational roles with access to resources.

These adults are able to protect themselves from experiencing many of the public-facing and legal system consequences stemming from their use of violence that others with less privilege might find harder to avoid.

Some adult users of violence with significant privilege levers might escalate their use of violent and controlling behaviours if they feel that their identity, status and positive reputation is at threat.

Follow the victim-survivor's lead regarding what risk management responses might be safe or unsafe to enact, including under what circumstances, if the user of violence is likely to experience identity, status and reputation threat as a result.

Identity threat can be particularly dangerous if the user of violence feels that they will experience humiliation through the loss of status or reputation. **High-risk, high-harming adults can sometimes choose severe forms of violence when they experience humiliation or the threat of humiliation.**

Responding to identity loss might not be a component of case plans with many adult users of domestic and family violence. But particularly for those who pose a serious risk to victim-survivors, the vacuum created by identity loss can be filled with an increasing sense of grievance fuelled by "I'm the victim here!" narratives. Leaving him in this vacuum is not safe, even more so if he lacks routines and has a lot of time on his hands.

Suicide risk amongst DFV perpetrators

There is growing research demonstrating that men who use domestic and family violence are at a substantially higher risk of suicide than general populations of men. A UK study, focusing on high-risk, high-harm users of violence, found the rate to be over 20 times higher.[32]

There is also evidence that DFV perpetrators who have a history of suicidality are at increased risk of committing intimate partner homicide.[33]

Threats and inferences of suicide are significant evidence-based risk factors for serious outcomes of domestic and family violence, including serious injury and homicide. A threat or inference of suicide can reflect a genuine intent to suicide or self-harm. At the same time, it can also be used by perpetrators as a deliberate tactic of coercive control.

Regardless of the underlying intent, threats or inferences of suicide should always be taken seriously. This is particularly true if there is an escalation in the individual's threats or attempts to suicide, or greater specificity in the threats they make.

If a high-risk, high-harm user of violence feels that the threat of suicide and/or other coercive controlling tactics have not been sufficient to control the victim-survivor's behaviour, they may use their successful suicide as a way to punish and control the victim-survivor through ongoing guilt and grief even after they have died. In a context where the adult perceives their life as unravelling, suicide can be a 'last ditch' act to maintain power over the victim-survivor.

Suicide can also reflect the individual's loss of hope for the future and the extent of their emotional pain, depression, and anxiety. Some adult users of violence who feel an intense loss of hope may conclude that death is a better alternative than living a life in which they believe there is no prospect of a positive future. This negative view on life can be a significant risk factor for suicidal behaviour.

Practice tip

As some adults who perpetrate DFV can use threats and inferences of suicide as a coercive controlling tactic, it can be tempting to assume that the risk of suicide is not real. This can be a dangerous assumption.

Some adults who cause DFV harm use threats and inferences of suicide as a controlling tactic *and at the same time* are at genuine risk of suicide, or even of suicide-homicide. They might engage in suicidal behaviour to manipulate or punish their partner or former partner *and* be in a genuine state of feeling hopeless about themselves and their future.

[32] Knipe, D., Vallis, E., Kendall, L., Snow, M., Kirkpatrick, K., Jarvis, R., ... & Bickham, V. (2023). Suicide rates in high-risk high-harm perpetrators of domestic abuse in England and Wales. *Crisis*.

[33] Fitz-Gibbon, K., Walklate, S., Maher, J., McCulloch, J. & McGowan, J. (2024) Securing women's lives: examining system interactions and perpetrator risk in intimate femicide sentencing judgments over a decade in Australia. Monash University and University of Liverpool.

Check in with yourself about how open you are to acknowledging the intense psychological pain that the user of violence might be experiencing, associated with suicidal ideation. Obtain supervision and secondary consultations with mental health and/or DFV specialists to support your ability to respond genuinely to a perpetrator's suicide risk, in ways that do not collude with his intense grievance against his partner or former partner, or with his entitlement-based beliefs.

It might not be safe to 'challenge' his grievance (e.g., that 'she is ruining his life') or entitlement-based beliefs (e.g., that 'she is keeping my kids away from me'). Without colluding, you might be able to help him understand **how being dominated and controlled by this grievance or beliefs is harming him**. That there are practical things he can do to gradually push the grievance or beliefs away from always being in the centre of his thinking and view.

By doing so, you and other services can offer him a pathway towards reducing his psychological pain, in ways other than harming the victim-survivor and/or himself. And you might be able to sow some seeds for any later behaviour change work, that might attempt to help him explore how his sense of grievance and underlying/core beliefs (fed by entitlement and/or a trauma background) are the enemy, not his ex/partner.

Watch the highly informative Work with Perpetrators – European Network webinar on identifying, understanding and responding to suicide risk amongst high-risk, high-harm users of domestic and family violence. The whole webinar is valuable; however, the final half zeroes in on suicide risk safety planning with adult users of DFV.

Google WWP EN Annual Conference 2023 and scroll down to the workshop 6 YouTube video: **Suicide Prevention in high-risk, high-harm domestic abuse perpetrators**.

Practice tip

Periodically screen for whether an assessment of suicide risk is required. This will be especially important if there are significant changes in the perpetrator's circumstances, presentation, and/or evidence-based risk factors common to DFV and suicide risk (for guidance on these commonalities, see Appendix 6: Recognising suicide risk in the context of adult people using violence at vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence/responsibility-3). A suicide risk assessment is also strongly recommended if you become aware that the user of violence has been making threats to suicide.

Collaborating with mental health services

Your adult client using DFV with mental health needs might or might not have a formal diagnosis. When you have a formal diagnosis, there might be a psychologist, psychiatrist or other specialists already involved with client, either in the private or public system.

When this is the case, prioritise obtaining consent from your client to speak with them, and pursue a collaborative relationship to proceed alongside your work with the client. Remember however that depending on your jurisdiction's information sharing and privacy laws, in some situations, and with some mental health services, you might not need your client's consent to share information related to collaborating with the mental health service to assess and manage DFV risk.

Where someone is not involved or no longer involved with an appropriate mental health service, it may be important to facilitate the client to re-establish contact, or to obtain a referral from their/a GP to establish a new appropriate support for their mental health.

Many mental health services do not understand the gendered and entitlement-based drivers of domestic and family violence. It is important wherever possible to work collaboratively and to attempt to influence how your client's behaviours are understood, so that mental health issues are responded to in a way that does not provide excuses for violent and controlling behaviour.

Some specialist mental health supports can be difficult to get in regular contact with due to time constraints. Some might have quite a different view of domestic and family violence, not seeing it as a gendered issue, or adopting a mostly forensic view of violence and inadvertently colluding with some of the problematic belief systems held by the adult user of violence.

In these situations, the client may be inclined to 'side' with the mental health professional, diluting the power of any discussions you or specialist behaviour change services might have with the client.

When this occurs, it is useful to draw upon or bring in other DFV-informed services into the case mix, where possible and appropriate. This can help to increase the strength of a consistent counter-narrative that the client (with support) is capable of making – and is expected to make – safer choices for their family and for themselves.

Practice tip

It can often be important to explore and keep tabs on medication compliance and any other potential barriers to engagement or causes of concern for escalated risk; for example, AOD use may have been or become a complicating factor. Situational changes can have an intensified impact on someone already facing multiple challenges; practical case management can sometimes take priority to mitigate these influences. This can include a focus on housing, pending criminal charges, new life stressors, financial crises, and basic needs such as access to food and healthcare.

When multiple services are involved, it can be tempting to assume that someone else is attending to these case management needs. Or there might be two or three services focusing on different complex needs of the adult user of violence, with each doing 'bits' of broader case management. Service coordination meetings can be highly important here, to ensure that important needs of the adult that contribute to the risk they pose to victim-survivors (and to themselves) do not fall between the cracks.

If your service has brokerage funding, and if there are indicators that something is present in your client's cognitive functioning that is impacting their ability to work productively with you, consider arranging a neuropsychological assessment. This process can generate valuable recommendations for how to adjust your work with the adult. Note that some mental health conditions can become associated with changes in cognitive functioning that your client might not know how to describe. For example, an ABI, drug-induced cognitive disability or even a random aneurysm can have very specific effects that might have a substantial impact on functioning but might not have been noticed in other settings. Sometimes impairments such as these can remain unidentified or undiagnosed for years.

Conducting a reflective holistic health assessment

Addressing the health needs of an adult user of DFV will not always, or even often, be a high priority. However, for some, including those who pose a serious risk to victim-survivors, doing so can be a part of **upstream safety planning strategies**.

Men are less likely than women to seek help for physical or mental health issues. This tends to be even more common in men who use violence. Over time this can have a wide range of impacts that can reduce a person's ability to concentrate, to reflect, to regulate their emotions and to self-monitor. These issues can also inhibit memory.

For example, the experience of chronic pain is not entirely uncommon amongst men who use domestic and family violence. This might have arisen from a workplace injury, with the adult dependent upon long-term use of pain killers.

Men who have recently separated/divorced are even less likely to be looking after themselves properly. This is partly due to having relied on their partner to look after many of their health needs.

Addressing health issues can ultimately increase engagement with services focusing on behaviour change.

Health status is generally a non-confrontational topic. Discussing it can position the practitioner as providing welcomed support. It can therefore help develop rapport and trust.

Be wary of attempts by the client to frame a health narrative as an excuse for violence, or attempts to blame their ex/partner as causing or exacerbating their health issue.

Breaking down health challenges into manageable steps creates an opportunity to obtain some 'quick wins on the board'. This can then help increase the adult's confidence in their ability to make changes. And it can increase trust in the practitioner's ability to help them do this.

The health assessment process can create opportunities to bring in additional professionals such as a GP, psychiatrist, psychologist or counsellor. They can then (potentially) provide reinforcing messaging in their work.

Practice tip

There are many ways to go about conducting a reflective health assessment. It's useful to incorporate visual messages. One easy way is to draw a large picture of scales. Helpful behaviours and choices are written on the right scale and unhelpful behaviours and choices are written on the left.

This can help your client to gain a quick visual representation of how out of balance their lifestyle is. As they make changes to replace unhealthy and destructive choices with more self- and other-respecting ones, they can see how the scale rebalances.

Topics to include in the health assessment

There is no real limit to which aspects of health you might want to include. **But remember: you are probably not a health professional specialising in any or all of these areas.** This process is about using common sense and, where relevant, referring to health professionals. A practical range of subjects might include:

- **Sleep**: Does your client feel like they're getting enough sleep? If yes, write it in the right side of the scales. If the answer is no, write down about how much sleep they're getting on average. It's worth asking for thoughts about why this is happening, but don't get distracted. If your client says he's spending hours on pornography sites, for example, acknowledge that this will be useful to discuss later and move on.
- **Diet**: Does your client feel like they're eating well? Relying on junk food and drive-thru is common in the weeks and months after separation or divorce.
- **Exercise**: Does your client do any exercise, and has that changed recently? It's very common to hear that they used to exercise but have stopped. Merely asking the question can inspire some people to take action. There are many benefits of exercise, and it will support improved engagement.
- **Alcohol**: How much does your client drink on average? Are there particular patterns such as a six-pack or two per day or binge drinking every weekend?
- **Drugs** (either illicit drugs or prescription medication abuse): How much does your client use on average? Are there particular patterns?

Practice tip

Adults who use domestic and family violence are likely to 'play down' their alcohol and/or drug use. This is especially likely during an initial assessment, when questions about their violence can make them feel defensive. In the context of a general health discussion, though, they're more likely to be honest.

- During initial assessment of factors contributing to their use of domestic and family violence, it can be helpful to flag that you'll revisit some issues:
  - → *"I'm going to ask you a few initial questions about some health-related issues. We'll just make a start on these now, then come back to explore them in more detail later on."*
  - → Discussion of the issues can then be extended one or two sessions later via the reflective health assessment.
  - → Taking this two-step approach means that your client is more likely to give honest responses.
- A reflective health assessment is **a chance to have a second go at assessing these sorts of important issues.**

- **Medications**: When did your client last have a medication review?
  - → It's not uncommon to have been prescribed a relatively high dose of something years ago, and they've been taking it ever since.
  - → Ask if there are medications they've stopped taking, especially recently. It's not uncommon for the use of important medication to drop off following separation or other major stressful events or life changes.
- **Gaming**: How much time does your client spend gaming in an average week? Are there particular patterns? Which device do they use? (using a phone in bed can disrupt sleep).

This can take some prodding, as there's often an element of shame about the real amount of time spent gaming. It's not uncommon to hear 30 or more hours per week: gaming can be a significant addiction for some adult users of violence, but it's often overlooked. A substantial gaming addiction has significant health impacts, and like other addictions, can be a contributing factor to their use of violence when this excessive, at least indirectly.

- **Gambling**: How much time and money does your client spend gambling in an average week? Are there particular patterns? What % of their income do they spend? What have the impacts been?
- **Financial stress**: Does your client have major debts hanging over their head?
- **Recuperative activities:** Recuperative activities help the brain move into an alpha state. They offer genuine relaxation. These might include:
  - → meditation/mindfulness
  - → reading a novel
  - → playing a familiar musical instrument
  - → listening to music
  - → playing with pets
  - → gardening
  - → being in/looking at nature
  - → watching a flickering candle or fireplace

  Non-recuperative or 'comfort' activities are not necessarily bad – they are just not helpful in terms of genuine relaxation. These might include watching TV, drinking energy drinks, and gaming. You should be working with your client to replace at least some comfort activities with recuperative ones. This can be done visually using the scales, adding helpful recuperative activities to the right scale and unhelpful 'comfort' activities to the left.
- **Mental health**: Has your client been diagnosed with a mental health condition? Are there suspected but undiagnosed issues, such as hallucinations, paranoia, unpredictable mood swings, self-harm ideation, depression or anxiety? Are they seeing a counsellor or any other supports? Have there been recent changes in their mental health?
- **Physical health**: Are there known or suspected physical health problems, such as diabetes, disabilities, chronic pain, obesity, immune diseases or other vulnerabilities? Have there been any recent changes in physical health?
- **Social supports**: Does your client have anyone whom they can call at 2am if they're in trouble? Are they involved in any clubs or other social networks? Do they see their friends or family?

Practice tip

Once you've run through the health assessment and added helpful and unhelpful behaviours to the scales, invite your client to share any thoughts they have. Ask them to consider the steps they could take to move some of the items from the unhelpful to the helpful side. Some of these steps might be quite simple, others more complex.

Support your client to **choose one or two things to make a start on.** Trying to address everything at once would be overwhelming and is more likely to fail. A small beginning, like cutting down ecstasy use while returning to playing basketball (or something else they used to love or enjoy), can be measured and built upon.

You should also conduct short reviews with your client, coming back to the scales diagram for a few minutes every couple of sessions.

The impact of a health assessment on the use of violence

Addressing health issues such as these can be an important part of an overall risk management approach for adult users of violence, particularly for those posing a serious risk. Addressing these issues can make it easier for the adult to choose non-violent behaviours in situations and circumstances when they've previously chosen violent and controlling behaviour.

Conducting a reflective health assessment and working with your client to improve their physical and mental health can help to achieve these aims, as an upstream safety planning strategy. While helpful in the early stages, it isn't, of course, sufficient in itself as a risk management strategy.

Improving physical and mental health routines can also benefit safety planning and violence-interruption strategies. For example, a high-risk, high-harming adult who is constantly tired and preoccupied due to a gaming addiction will find it harder to apply the violence-interruption strategies you've worked on together, or that they've learnt from other services. They'll also find it harder to self-monitor or notice physiological and cognitive signs of build-up.

Focusing on lifestyle habits can help generate some initial small 'wins'. Building up a 'bank of confidence' can support clients as they undertake more challenging behaviour change work. This can be particularly important for adult users of violence who have limited self-efficacy about making changes in their life.

Behaviours related to physical and mental health are highly gendered. Working with male users of DFV on their health goals can sow the seeds for later work on men and masculinities.

This can happen through the male client taking responsibility for identifying and managing self-care and health-related behaviours, and through obtaining the necessary healthcare supports to do so. Efforts that a man makes to take responsibility for his life more generally, including his health, can, *in some circumstances*, help to step him slightly/moderately forward towards taking responsibility for his violent and controlling behaviour.

Improvements in how the man takes responsibility for his health-related behaviours can be steppingstones towards exploring unhelpful masculinities. It can help him to identify the gendered beliefs that underpin his choices to use violence.

Be careful: don't assume this work will always reduce risk

Supporting the physical and mental health of an adult user of domestic and family violence won't reduce risk in all cases. In some situations, it might have both helpful and unhelpful impacts.

Sometimes an adult user of violence will use their improved physical and mental energy to extend controlling behaviours, to isolate, degrade and/or punish the victim-survivor.

Other times, a focus on physical and mental health self-care might inadvertently serve to reinforce the adult's modus operandi that 'you have to look out for number one!' (irrespective of the impact on others).

As always, whether and how much you focus on particular strategies depends on the specifics of your ongoing risk assessment and analysis.