NSW Risk, Safety and Support Framework

A guide for responding to men who use domestic and family violence

Part 2: Practice guidance

Version B – for Specialist Male Family Violence Intervention (SMFVI) providers who meet the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* (the *Practice Standards)*

No to Violence
Working together to end men's family violence

October 2020

Acknowledgement of Country

No to Violence acknowledges the Aboriginal and Torres Strait Islander peoples of Australia, the traditional custodians of the lands and waters. We pay respect to all Elders, past and present.

Acknowledgement of victim-survivors of domestic and family violence

No to Violence acknowledges the women, children and men whose lives, safety, wellbeing and liberty have been lost to or harmed by men's use of family violence. We would like to acknowledge the courage of each victim-survivor of family violence, and those who publicly campaign and advocate for a safer Australia for all women, children, men and gender-diverse people.

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> NSW Health Education Centre Against Violence
> NSW Men's Behaviour Change Network representatives:
  – Anglicare, Parramatta and Nowra
  – BaptistCare, Campbelltown and Tuggerah
  – CatholicCare, Fairfield
  – Liberty Domestic and Family Violence Specialist Services, Port Macquarie
  – Lismore Men and Family Centre
  – Mission Australia, Far West
  – Kempsey Families Inc. Specialist Support Services, Kempsey and Coffs Harbour
  – Relationships Australia, Canberra and region, Wagga Wagga
  – Relationships Australia NSW, Sydney

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At a glance

The Risk, Safety and Support Framework (RSSF)

The full Risk, Safety and Support Framework consists of three key components:

Part 1	**Foundations and the key concepts for effective practice**
Part 2	**Practice guidance:** > **version A** – for a wide range of practitioners and services that have contact with men who use domestic and family violence, and/or adult and child victim-survivors of men's violence > **version B** – for Specialist Male Family Violence Intervention (SMFVI) providers who meet the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* (the *Practice Standards)*
Part 3	**Risk assessment tools and companion resources:** **A – Risk assessment tool – user of violence** **B – Structured risk assessment tool** **C – Practical guide to risk domains** **D – Companion resources** Part three is for SMFVI providers who meet the *Practice Standards*.

This document is Part 2 (version B): **Practice guidance.**

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Part 2 (version B): **Practice guidance**

About No to Violence

No to Violence is the largest peak body in Australia representing organisations and individuals working with men to end family violence. No to Violence provides support and advocacy for the work of specialist men's family violence interventions carried out by organisations and individuals. No to Violence plays a central role in the development of evidence to support the work of specialist men's family violence work and provides guidance for best practice, policy and sector development in Victoria, Tasmania and New South Wales. No to Violence also provides a range of training for the specialist men's family violence workforce including a Graduate Certificate in Client Assessment and Case Management (Male Family Violence).

The Men's Referral Service is No to Violence's service arm, which provides telephone and face-to-face counselling and referrals nationally to men who use family violence. Contact the Men's Referral Service on **1300 766 491**.

'National, state and territory definitions of domestic and family violence and criminal codes vary, however control, abuse and violence is never acceptable in any community, family, institution, place or context.'

My Dignity – My body is mine, Insight Exchange, 2020.

A note on terminology

Victim-survivor refers to any person who is exploited/violated/harmed by the perpetrator's use of violence, including children, parents, current intimate partners, previous intimate partners and other family members. In some cases, the term ex/partner is used to refer specifically to action involving a man's current or former partner. Children are acknowledged as victim-survivors in their own right. The term 'victim-survivor' is preferred as it acknowledges that domestic and family violence (DFV) is a process of victimisation and survival, and that women and children are both harmed by, and survive, violence. Use of the term 'victim-survivor' is also intended to be inclusive of the diverse ways a person may connect with their gender, sex and sexuality (Domestic Violence NSW, n.d.).

Men who use violence/user of violence is used interchangeably throughout the document to refer to the person causing DFV harm. There is ongoing debate about use of the term 'perpetrator'. While the term 'perpetrator' is commonly used in NSW practice contexts, including in the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* (the *Practice Standards*), the preference in the NSW Risk, Safety and Support Framework (RSSF) is to use the terms 'men who use violence' or 'user of violence', as the term 'perpetrator' can be experienced as an identity-based term and imply no agency for change. Use of the term 'man who uses violence' is sometimes preferred as it highlights the man's choice to use violence. While the term 'men who use violence' reflects the gendered nature of DFV in heterosexual relationships, 'user of violence' is inclusive of non-heteronormative and non-gender binary identified people.

Men's Behaviour Change Programs/Specialist Male Family Violence Interventions: Men's Behaviour Change Programs (MBCPs) are defined as 'a structured group program that focuses on behavioural change through addressing the drivers of perpetrators' use of violence and abuse' (No to Violence, 2018). Group programs may form part of a Specialist Male Family Violence Intervention (SMFVI), which can also include one-to-one interactions, casework and other tailored interventions that serve to manage risk and keep the family in view. Group programs typically run between 12–36 weeks, meeting at least once per week. The format may be either an open or closed group with a clear underpinning program logic.

Introduction

'There is no vaccine to end domestic and family violence. However, we can (all) eliminate excuses for using violence and remove gaps and opportunities to extend the use of control, abuse and violence in our society.'

– Insight Exchange, 2020.

Introduction

The NSW Risk, Safety and Support Framework for responding to men who use domestic and family violence (hereafter called 'the RSSF' or 'the Framework') establishes a common approach to identifying, assessing and managing risk that users of violence pose, and guidance working towards creating safety and wellbeing for adult and child victim-survivors. The Framework is designed to support practitioners and services to develop a strong foundational understanding of domestic and family violence (DFV); shared language; and a common approach to identifying and responding to DFV risk, through collaborative and shared responsibility.

Purpose of the NSW Risk, Safety and Support Framework

The RSSF is designed ultimately to increase the safety and wellbeing of adult and child victim-survivors. It does this by providing guidance on identifying, assessing and managing the risk posed by users of violence, informed by their unique circumstances and needs, as well as supporting multi-agency risk management, and safety and accountability planning.

Parts one and two of the RSSF **Foundations and key concepts for effective practice** and **Practice guidance** are intended for a wide range of practitioners and services that have contact with men who use DFV, and/or adult and child victim-survivors of men's violence. The RSSF is also intended for use by Specialist Male Family Violence Interventions (SMFVIs) including Men's Behaviour Change Programs (MBCPs), to support their use of the **Risk assessment tools and companion resources** (part three).

The purpose of the Framework is to provide practitioners and organisations with consistent, safe and respectful approaches to engage with men who use DFV to keep them in the view of the service system. The spectrum of responses includes:

- identification of, and engagement with, those who use DFV
- gathering information about the risk the user of violence poses to adult and child victim-survivors in order to assess and manage that risk
- strategies for referral and information sharing as central elements of risk assessment and management
- risk management strategies for specialist DFV intervention providers.

Structure of the NSW Risk, Safety and Support Framework

The RSSF includes three key resources. All resources support the development of safe and effective engagement with men who use violence. They are separated for ease of access by the broad range of practitioners and organisations working with men and other people who use violence in their families and intimate relationships.

Part 1: Foundations and key concepts for effective practice

This section outlines the evidence base and fundamental concepts to guide any practice with men who use DFV. This section underpins the use of the practice guidance and risk assessment tools, which should not be used without consideration of the concepts outlined in this section.

Part 2: Practice guidance

This section provides detailed practice guidance and prompts for each of the 'interventions' with those who use DFV, including identification of the use of DFV, asking about patterns of violent behaviour and gathering information about risk, information sharing, providing referrals, and working within a collaborative, integrated response. For SMFVI providers who meet the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs (*the *Practice Standards),* the **Practice guidance** section also includes practice guidance on structured risk assessment and risk management. Useful references are included to provide links to other resources that can support practice with victim-survivors, as well as information about policy reform in NSW which provides the context for implementation of the RSSF.

Part 3: Risk assessment tools and companion resources

As the **Risk assessment tools and companion resources** are for use by practitioners in MBCPs, they are not available publicly alongside the **Foundations and key concepts for effective practice,** and **Practice guidance**. For more information on the tools contact No to Violence.

The need for the NSW Risk, Safety and Support Framework

In NSW, there are currently no standardised risk assessment tools or guides in use by providers and individuals in government and non-government services, or in private practice who come into contact and work with those who use DFV. The *Towards Safe Families* practice guide (NSW Department of Attorney and Justice, 2012), while containing useful information on MBCP delivery, is currently under review. Current providers and individuals providing therapeutic interventions (psychologists, counsellors, etc.) with those who use DFV use a variety of risk assessment, safety planning, and risk management tools, resulting in a lack of consistency, and a common empirical evidence base.

For MBCP providers, establishing a shared framework will assist in compliance with the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* by offering reliable methods to collect information to inform assessments, and common responses to the management of identified risks. A common framework will ensure programs and practitioners deliver consistent messages and practices that focus on enabling the attitudinal and behavioural change of users of DFV to further the safety of adult and child victim-survivors.

The **safety of adult and child victim-survivors is paramount**, and the protection and enhancement of their safety is given the highest priority in the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* under the first principle. In the context of MBCPs, this is standardised in the form of partner contact with victim-survivors, the provision of referrals to appropriate support services, and risk assessments.

All work in responding to users of violence must consider the **individual and changing needs of adult and child victim-survivors and communities**. Services should aim to be flexible to individuals' specific circumstances and take into consideration the diverse backgrounds and contexts of victim-survivors of family violence.

This Framework is a tool for work with users of violence to make them more visible to the system, and accountable for the risk and harm they pose to victim-survivors. While the voices of adult and child victim-survivors are central to this, the RSSF is not a tool for use specifically with victim-survivors to assess and plan for their safety. It is equally important to have a consistent, evidence-based and victim-centred common risk assessment framework and suite of tools to support adult and child victim-survivors of DFV.

Development of the NSW Risk, Safety and Support Framework

No to Violence established an expert panel in 2018 to investigate what processes are currently being used by providers within the NSW Men's Behaviour Change Network (MBCN, representing current registered MBCP providers). The Expert Panel also included representatives from NSW DFV specialist women's and children's peak bodies, Corrective Services NSW, and NSW Department of Communities and Justice. Program providers shared assessment and management tools, program information and practice wisdom, and identified issues with current practices. A review of national and international research and practice was undertaken by the Panel in the development of this comprehensive RSSF.

NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs*

In 2017 the then NSW Department of Justice released its *Practice Standards for Men's Domestic Violence Behaviour Change Programs*. The *Practice Standards* set out the guidance and expectations for MBCPs to ensure consistent, safe, and effective practice.

The *Practice Standards* are consistent with the *National Outcome Standards for Perpetrator Interventions* (*NOSPI*), endorsed by the Council of Australian Governments in 2015. The purpose of the *NOSPI* is to guide and measure the actions of governments and community partners when intervening with male perpetrators of domestic, family and sexualised violence against women and their children.

In NSW, MBCPs are delivered by non-government or government services, across a range of settings. The *Practice Standards* integrate the **Risk, Needs and Responsivity Model** (Bonta & Andrews, 2007), and 'apply to all programs and services that aim to protect the safety of adult and child victims by working with users of domestic and family violence to change their abusive, coercive and violent behaviour' (Department of Justice, 2018). Refer to Appendix C for detailed information on the *Practice Standards* and to whom they apply.

There are six overarching principles under which the *Practice Standards* are organised. The principles are:

1. the safety of victims, including children, must be given highest priority
2. victim safety and perpetrator accountability are best achieved through an integrated service response
3. effective programs must be informed by a sound evidence base and subject to ongoing evaluation

4. challenging domestic and family violence requires a sustained commitment to professional practice
5. men responsible for domestic and family violence must be held accountable for their behaviour
6. programs should respond to the diverse needs of participants.

The Framework is to be used by any behaviour change program that is registered or seeks to be registered under the *Practice Standards*. The RSSF supports the *Practice Standards* and ideally is an instrument to support MBCP providers to demonstrate their compliance. The *Compliance Framework for Men's Behaviour Change Programs (Compliance Framework)* provides detailed information for program providers on how to register their compliance and understand how their programs will be assessed (refer to Appendix C).

NSW Safer Pathway

The development of Safer Pathway has led to state-wide risk assessment and referral processes that aim to provide a consistent pathway and set of responses for victims of DFV. The provision and use of the Domestic Violence Safety Assessment Tool (DVSAT) with Central and Local Coordination Points ensures that all information is electronically managed, and referrals occur to specialist DFV services via the Women's Domestic Violence Court Advocacy Services (WDVCAS). Serious threat cases are referred to Safety Action Meetings to coordinate an integrated response to the immediate safety needs of women and children (NSW Government Women NSW, 2017). Refer to Appendix C for more information on Safer Pathway.

Practice guidance

'For a person experiencing domestic and family violence, being safe is no simple, single decision or task.'

– *My Safety Kit*, Insight Exchange, 2019.

Practice guidance

Background

The Framework is intended primarily for use by services, agencies and practitioners who engage with men who use family violence. While at a specialist level this would include practitioners working in MBCPs, it is also broadly inclusive of any service, agency, practitioner or case manager who, in the course of their role, becomes aware of a man's use of violence and has the skills and capacity to respond.

MBCPs are erroneously perceived as the main perpetrator intervention when working with men who use family violence. While MBCP interventions are a key specialist service response, this can place the burden on these services alone to keep men in view and support their journey of change. However, contact with a MBCP is rarely the first entry point to the 'system' for most men. More realistically, men's use of family violence comes to light through their engagement with the criminal justice system (for example, via a police callout to an incident, followed by a referral to the Men's Referral Service) or through engagement with other services such as general practitioners, alcohol and other drug services, mental health services, gambling harm reduction services, child protection or other family services (Centre for Innovative Justice, 2016). The broader health and human service sectors play a critical role as part of a system response to men who use family violence through a range of interventions that can 'interrupt violence' safely and effectively, without necessitating direct work with men to stop their violent behaviour, which is the domain of SMFVIs (Twisleton, Coleman & Coorey, 2017).

The *Bringing pathways towards accountability together* report (Centre for Innovative Justice, 2019a) describes a range of different **contexts** (i.e. roles) in which services and agencies can interact with users of violence and/or their families and the interventions used which vary in their intent (i.e. responsibilities), as detailed in Table 1 below. The work of services and agencies can be mapped against these roles and responsibilities to determine how they contribute to the broader system response to perpetrators of DFV.

Table 1: Roles and responsibilities of services and agencies in the perpetrator accountability system

Roles	
One:	Initial engagement with the perpetrator, or on issues of perpetration, during or in the immediate or near aftermath of family violence incidents
Two:	Initial engagement with the perpetrator, or on issues of perpetration, in the aftermath of family violence disclosure or identification
Three:	Bringing the perpetrator into view and adopting a perpetrator pattern-based lens in the context of services directed to victims
Four:	Contact in the context of relationship, family-focused or postseparation interventions
Five:	Opening an appropriate and safe door to intervention and window onto risk, in the days following initial or recontact
Six:	Keeping the door and window open in the first weeks following initial or re-contact
Seven:	Responses to perpetrators over a timeframe of months
Eight:	Longer-term responses
Responsibilities	
A:	Identification of family violence perpetration, or consolidation of identification, through engagement with the perpetrator
B:	Augmenting or contributing to ongoing risk and threat assessments

Table 1: (continued)

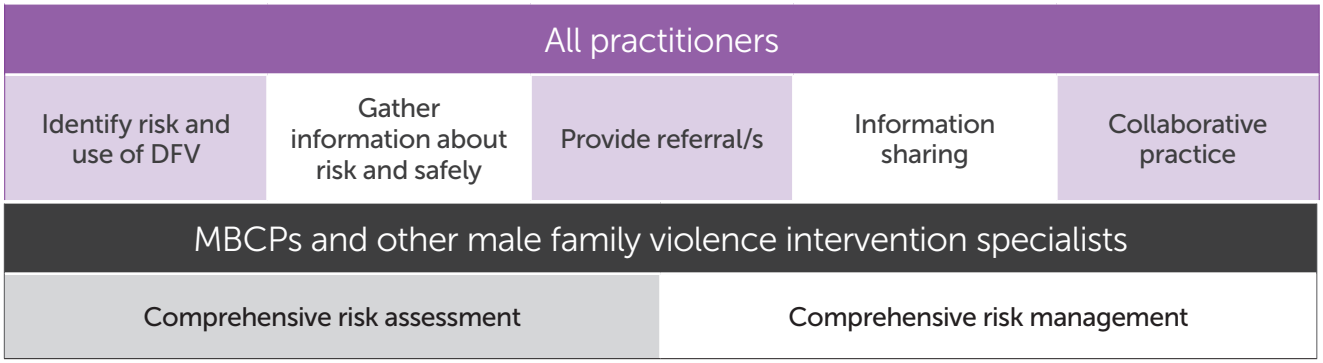
C:	Information sharing regarding perpetrator behavioural and attitudinal patterns, dynamics and risk situations
D:	Risk management through coordinated (multi-agency) actions directed towards or involving perpetrators
E:	Initial specialised perpetrator assessment
F:	Ongoing specialised perpetrator assessment and intervention planning
G:	Referral to services addressing risk
H:	Family violence informed coordinated case management of perpetrators
I:	Scaffolding the perpetrator's participation in services, building the perpetrator's capacity to participate, and strengthening internal motivations to change
J:	Active collaboration with specialist intervention services after referral
K:	Limiting the perpetrator's opportunities or inclinations to use violence
L:	Interventions addressing dynamic risk factors and criminogenic needs
M:	Contributing to behaviour change objectives
N:	Contributing to sustainable behaviour change and secondary desistance from violence

Spectrum of service responses

It is important that when men access any part of the broad service system, service staff are ready and skilled to provide a spectrum of responses or brief interventions to 'interrupt' his use of violence. This includes identifying his use of violence and asking questions to gain a better understanding of his risk and, if appropriate, referring him to a specialist service for comprehensive and ongoing risk assessment and management.

Depending on the organisational function, individual role description, and level of competency, practitioners may engage in some, or all, of the responses in the continuum in Figure 1 below. It is critical that for each response the practitioner is clear about the intent and baseline standards for safe practice before they undertake any activities with a person who uses DFV. This practice guidance outlines these standards, providing information and recommendations so that all agencies and relevant staff within the service system can understand the boundaries, scope and limitations of their role and keep the user of DFV in view and accountable for their behaviour.

Figure 1: Overview of RSSF



Implementation considerations

There are a range of considerations for individual practitioners and organisations when implementing the RSSF and embedding it in practice. Part one **(Foundations and key concepts for effective practice)** and two **(Practice guidance)** of the Framework should be read as a unified whole and not extracted or fragmented.

The intention of the RSSF is to meet service providers and practitioners 'where they are at' in their current practice, and to act as a **guide to continuous improvement**. It is based on emerging and current best practice in engaging with men who use violence.

Training and practice development (ideally cross-disciplinary) will be required to support the implementation of the RSSF. The NSW Health Education Centre Against Violence (ECAV) delivers specialist training for staff in male family violence interventions. Please refer to Appendix D for more information regarding specialist training courses.

Services and staff need to be clear on their own service limitations and parameters, knowledge, skills, competency and intent when engaging with men who use violence. It will be important for services to **develop their own context-specific practice guidance** to ensure the Framework is suitable to role and organisational setting.

Critical to an understanding of risk is the awareness that **any intervention with men who use violence, including risk assessment, carries an element of potential risk**. Well-meaning interactions or interventions without current knowledge and competency may contribute to increased reactive harmful behaviours. For example, some men who are contacted to receive an intervention from a worker may assume this has occurred because their partner has disclosed DFV to a service, which may contribute to an escalation of abuse. Therefore, a balance must be met between practitioners being competent and skilled to 'pivot towards' men who use violence and playing a specific role in intervention, without becoming overconfident and stepping beyond their role in what is a challenging, complex and specialised area of practice.

Regular clinical supervision, which provides practitioners with opportunities to review and reflect upon their work and receive support to improve their knowledge and competency, is critical to effectively working with men who use violence (NSW Department of Communities and Justice, 2018). Supervision is also essential for staff wellbeing and retention and to prevent or mitigate vicarious trauma (NSW Health, 2019). Importantly, **critical reflection** and debriefing also helps practitioners to hold a balanced response and prevent them from unintentionally replicating coercive and controlling dynamics towards clients, or colluding with perpetrators by failing to challenge violence-supportive beliefs and attitudes. Unchecked, these coercive or collusive service responses may contribute to men disengaging from a support service.

Reflective Practice enables practitioners to maintain a **balanced response**. Responses to the perpetrator have the potential to generate outcomes on a continuum. At one end, perpetrators may believe that workers agree with them, confirming their view of the world. Alternatively, they may believe that they are being judged and the worker seeks to shame them. Staying in the central region of the continuum, showing curiosity and neutrality, while also being transparent about safety and accountability, is preferred practice. This balanced response can be challenging and is best supported by **Reflective Practice**, examining practitioner responses to power and gender, personal biases in relation to diversity, and one's own position of privilege and power in society. A range of questions to facilitate **Reflective Practice** for practitioners who work with men who use violence are included in RSSF part three (**Companion resources**).

A commitment to accountability

The complexity and risk associated with responding to DFV requires that organisations and individual practitioners are familiar with and adhere to relevant jurisdictional standards and legislation, the *NOSPI,* the ANROWS *National Risk Assessment Principles for domestic and family violence*, and any organisational policies. In addition, organisations delivering MBC work must ensure that staff are competent to practise interventions as outlined in the NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs* (the *Practice Standards*) and the *Compliance Framework for Men's Behaviour Change Programs* (*Compliance Framework*). In summary, at least one of the two group facilitators must have 'significant experience', which is defined as having:

> at least 200 hours of experience in MBC practice,
> at least two years' experience in the DFV sector, and
> a relevant tertiary or vocational qualification (for example, psychology or social work).

The definition of 'significant experience' will change from 1 January 2022 to further professionalise the sector, and will require completion of the NSW Health ECAV National Graduate Certificate in Men's Behaviour Change Individual and Group Work Interventions or equivalent. All facilitators are also required to undertake clinical supervision on a regular basis (NSW Department of Communities and Justice, 2018).

Considerations for diverse communities

While there are similarities in experiences of DFV across all communities, individuals from diverse communities such as First Nations people, LGBTIQ communities, CALD communities or people with a disability can experience unique and compounded forms of DFV.

Victim-survivors may experience several barriers that can prevent reporting violence and accessing appropriate help and support. Practitioners need to be aware of the different ways users of violence may form tactics of abuse to exploit these vulnerabilities, and/or how they may also be experiencing these vulnerabilities themselves.

The *Victorian Royal Commission into Family Violence Report and Recommendations (Vol V)* notes:

> 'while there can be similar dynamics to family violence across all communities, people from these diverse communities can also experience family violence differently
> some people in these diverse communities face barriers to reporting family violence, and in accessing appropriate help and support
> many factors combine to create an individual's identity and experience, with a combination of different factors sometimes being described as 'intersectionality'
> the significance of the multiple and intersecting barriers many victims face cannot be adequately captured in brief summaries
> the importance of:
  – building and ensuring accessible, inclusive and non-discriminatory service delivery
  – expanding understandings of the different forms and complexity of family violence across a range of communities
  – fostering recognition that family violence is a human rights issue and that responses to it must also be consistent with human rights' (State of Victoria, 2016).

Adopting an intersectional lens supports practitioners to explore the impacts of systemic and interpersonal discrimination and disadvantage in diverse groups and with individuals from diverse communities, and the different ways DFV is experienced or perpetrated.

For example, a victim-survivor who is permitted to stay in Australia on a conditional visa may face language barriers to reporting their experience. Inaccurate or limited knowledge of Australian immigration law and legal rights may further disadvantage the victim-survivor and create greater vulnerability to patterns of abuse by the perpetrator. With the knowledge that the victim-survivor doesn't understand their rights, the perpetrator may intentionally misinform them with inaccurate information and make threats to maintain control of the victim-survivor. Supports for the victim-survivor may be limited or non-existent in some areas of Australia, creating extreme isolation and risk.

1.1 Identify risk and use of domestic and family violence

1.1.1 Intent

The intention of identifying risk and the use of DFV is to bring the patterns and tactics of the user of violence into view of the service system. This allows the risks their behaviour poses to be assessed and managed while prioritising the safety of adult and child victim-survivors.

The service system response removes the burden of responsibility from adult and child victim-survivors to manage perpetrator behaviour and risk, and instead places it within a coordinated service response. Opportunities are created for the user of DFV to be referred to specialist services to engage with behaviour change interventions that may manage and reduce the risk of further violence through multi-agency systems of accountability and support.

1.1.2 Introduction

Identifying that a man is using DFV is often the first step in his journey towards taking responsibility for his coercively controlling and violent behaviours. Informed professional judgement is required when assessing how to proceed following the identification of DFV perpetration. Practitioners should be guided by the protocols of their organisation, the scope of their role and service, and their own knowledge and competency in male DFV interventions.

For non-specialist DFV services, depending on the context, it may not be appropriate or safe to ask the perpetrator questions about the violence. Where a practitioner **does not** have the knowledge and competency to safely and strategically ask further about the use of DFV, a practitioner should not persist in this line of enquiry.

There are other responses that can support the safety of adult and child victim-survivors beyond enquiry with the person using violence. These include providing a referral to an MBCP, the Men's Referral Service, or a specialist DFV service seeking a secondary consultation. This Framework provides guidance both where a practitioner determines that it is safe to gather further information from the perpetrator about the violence (section 1.2), and where enquiring further about the violence with the perpetrator would escalate risk (section 1.1.6).

1.1.3 Who should identify risk and use of domestic and family violence

It is likely that, whether or not the service provider's core business is to respond to DFV, practitioners will regularly come into contact and work with people who are experiencing or perpetrating DFV. Knowledge of family violence dynamics, use of tactics by the

perpetrator, current and previous risk factors, and warning signs may assist the effective identification of a person who is using DFV.

Settings in which practitioners may encounter opportunities to identify and respond to perpetrators of DFV include:

> services that work directly with adult victim-survivors, where the user of violence may or may not attend the service (for example, an adult victim-survivor presents to an emergency department or other health service where the user of violence may accompany her)
> services that work either separately with women, or separately with men, in response to other non-DFV issues, and where it becomes apparent that DFV is present and/or may be a significant contributor to their presenting issues (for example, a man attends drug and alcohol counselling and his [ex-]partner does not attend the same service)
> services that work with both parties (for example, a family is referred by child protection to a non-government organisation [NGO] such as Brighter Futures for support with parenting, or a Family Advocacy and Support Service works with a user of violence or adult victim-survivor through the Family Law Court).

Some examples of the types of services that may routinely identify DFV risk include:

> emergency health departments
> primary health services
> general practitioners
> family support services
> employment assistance services
> gambling harm services
> housing and homelessness services
> alcohol and other drug services
> mental health services
> youth services
> settlement services.

1.1.4 When to identify the risk and use of domestic and family violence

Note: A practitioner should never enquire about DFV with a perpetrator when the adult or child victim-survivor/s are present

Identifying DFV may occur at any point throughout interactions with clients, including in one-off interactions, or more likely, through ongoing contact. Informal and unstructured engagement, gradually and over a number of occasions, begin to identify risk factors and confirm suspicion of the presence of DFV. When DFV is suspected or identified, the practitioner should prioritise safety of adult and child victim-survivors and, where possible, maintain service engagement with the user of DFV for the purpose of keeping him, and those affected by his violence, in view of the service system.

There may be opportunities during standardised clinical intake processes to ask a client directly about their current or former relationships. Routinely asking clients about their relationships may provide information for practitioners to identify patterns of behaviour that may be controlling. Red flags include rigid and stereotypical beliefs about gender and dominance in relationships or language that blames, minimises and justifies harmful behaviours.

1.1.5 Identifying risk and use of domestic and family violence

Practitioners are encouraged to remain alert to the use of DFV and identify risks when delivering core services. Being observant to indicators can form part of existing engagement methods used in the course of delivering services (for example, motivational interviewing, active listening, curious respectful questioning, and standard assessment interviewing).

Practitioners must be aware of factors that **indicate a risk of lethality or serious harm**. These include:

> controlling behaviours and intense jealousy or possessiveness
> threats to kill
> non-fatal strangulation and 'choking'
> violence getting more severe and frequent
> sexualised abuse by the user of violence against the victim-survivor
> stalking
> separation from (ex-)partner or relationship breakdown
> pregnancy or recent birth
> violence towards pets/animals.

These behaviours are assessed using the NSW Domestic Violence Safety Assessment Tool (DVSAT) (NSW Government, 2015). Refer to Appendix A for more information on the tool.

Where any of these behaviours are identified, an immediate response must be provided in accordance with your workplace policy and procedures, the Crimes (Domestic and Personal Violence) Act 2007, and the Children and Young Persons (Care and Protection) Act 1998. This may include reports to police, Safer Pathway and child protection.

Direct disclosure

Men who use violence are unlikely to openly and accurately disclose that they are using DFV. Usually defensiveness, denial, minimisation, blame of others, and justification are prominent. Instead of disclosure, men may use language that hints at the use of coercive controlling behaviours.

For example:

> 'I just have an anger management problem'
> 'She knows how to push my buttons'
> 'She's an incompetent mother'
> 'I've always had a short fuse/temper'
> 'I only do (x form of abuse), it's not like I hit her'
> 'We just need to communicate better'.

Observing signs of risk – looking and listening

A perpetrator's use of language, voice, tone and body language may give further clues to underlying beliefs and attitudes, and conformity to patriarchal, gendered and discriminatory norms. These observations can inform professional judgement in risk assessment and accountable decision-making. It is likely that more risk indicators may be present than disclosed by a person who uses DFV.

Perpetrator language often works to intentionally conceal the violence, obscure his responsibilities, conceal victim-survivor responses and resistance to the violence, and blame or pathologise the victim-survivor. The practitioner's role is to reveal the violence, clarify the perpetrator's responsibility, reveal responses and resistance to the violence, and contest blaming and pathologising of the victim-survivor (Insight Exchange, 2019).

Indicators of attitudes, beliefs and cognitions that constitute a risk include:

> use of coercive control (see examples listed in 'Direct disclosure' above)
> use of blame (for example, 'I only get angry when she doesn't back off', or 'She pushes me to the limit')
> motivation to comply with intervention orders for own benefit (rather than be a safe person and cease abuse)
> hostile attitudes towards police, child protection, courts, Apprehended Domestic Violence Orders (ADVOs) and the justice system in general
> expressing or speaking about feeling threatened or attacked (for example, 'Her family keep butting their heads into our business')
> hostile attitudes about women or the adult victim-survivor specifically (for example, 'She'd be lost without me')
> language of ownership and entitlement (including over children, for example, 'What happens in my house is my business')
> justifying use of violence based on a perception of having been wronged (for example, 'I do all the work around the place').

1.1.6 Response/action pathways

When a perpetrator of DFV has been identified or is suspected, it is important to maintain engagement with the perpetrator while pivoting toward the safety of adult and child victim-survivors (whether or not they are a client of the organisation), by working collaboratively to facilitate access to specialist DFV victim-survivor support services.

As outlined above, where a risk factor for lethality or serious harm/threat is identified, the immediate priority is the safety of the adult and child victim-survivor/s. Service providers should initiate a multi-agency service response under part 13A of the Crimes (Domestic and Personal Violence) Act 2007 (Women NSW, n.d.).

If adult and child victim-survivors are clients of your service:

> sensitively, safely and with consent, conduct a DVSAT and offer a referral to the Safer Pathway Central Coordination Point or an alternative appropriate service, and
> follow organisational procedures and make a report to police and/or child protection as appropriate.

If there is no contact with adult or child victim-survivors:

> follow organisational policy (or develop an organisational policy if there is none) whereby contacting victim-survivors to offer support or services may occur if safe to do so
> and it is not possible to contact victim-survivors directly and risk is assessed as high, consider sharing information with a local specialist women's service, such as the WDVCAS and request that they follow-up.

The NSW Health ECAV provides training on responding to DFV – please refer to Appendix D for more information.

Other actions could involve:

> ongoing engagement with the perpetrator in service provision to promote visibility and risk management
> gathering and clearly documenting information to form or contribute to a further assessment of the risk he poses and/or the relevant supports available to adult and child victim-survivors (see section 1.2)
> making an appropriate referral for the user of violence (see section 1.3)
> sharing risk and safety information with other services and the adult victim-survivor (where safe) in accordance with Part 13A of the Crimes (Domestic and Personal Violence) Act 2007, to support safety of adult and child victim-survivors (see section 1.4)
> considering ways to collaborate with other services involved with the user of violence, and seeking secondary consultation from the Men's Referral Service (see section 1.5).

Where there is doubt or concern, service providers are encouraged to contact the Men's Referral Service on **1300 766 491** or a local MBCP for secondary consultation to support decision-making and responses to risk and safety.

1.1.7 Practice tips

Practice scenario – Bill is attending an employment service

Bill has told you he was just made redundant and is finding it hard to get another job. He has started drinking in the afternoons. He said his wife is in Australia on a partner visa and must stay home to look after the house and their two children, and now **blames her** for their dire financial situation. Bill says **his wife doesn't know how to discipline the children** and so **he must 'keep them in line'**.

Reflections:

Unemployment and the stress of finding another job is an example of one type of risk factor, known as a dynamic risk factor. If Bill's drinking patterns have changed and he has increased his drinking earlier in the day this could be considered an acute dynamic risk factor (refer to section 1.7.7). Bill's wife is on a partner visa, which could be a vulnerability factor for her. Consider what Bill might mean when he says his wife 'has to stay home' and whether this may indicate adherence to rigid or traditional gender roles. Bill shifts the blame (i.e. shows limited responsibility-taking behaviour) for their dire financial situation onto his wife and talks about himself as the 'real' victim. Bill **criticises his wife's** mothering and indicates that it is **his job to discipline the children**. Consider what '**keeping them in line**' means for Bill's fathering style. In what ways is this potentially dangerous for his children and wife?

(Mis)identifying the predominant aggressor

Sometimes perpetrators of DFV will initially present to a service and identify as the victim. It is not always an easy task to discern from listening to their story who is the predominant aggressor and who is the person most in need of protection (i.e. the victim-survivor). 'Predominant aggressor' refers to the person who is exerting the greatest amount of harm and control over their partner or family member through any number of abusive behaviours, including physical and sexualised violence, threats, intimidation, emotional abuse, stalking and isolation (No to Violence, 2019).

Misidentification occurs when a service:

> incorrectly assumes both parties are equally at risk or equally violent
> incorrectly identifies the person experiencing violence (the victim-survivor) as the aggressor, or
> incorrectly identifies the person using violence as the victim (Government of Western Australia, 2015).

Consequences of misidentifying the predominant aggressor

Misidentifying the predominant aggressor in a relationship can increase the risk of violence to the victim-survivor and increase the perpetrator's ability to assert power and control over the victim-survivor. Other potential consequences include a victim being arrested, having charges laid or ADVOs issued against them, or having children removed from their care.

Where there is uncertainty or ambiguity around identifying the predominant aggressor

If practitioners are hesitant or concerned about definitively identifying the predominant aggressor, they should seek secondary consultation from MBCPs and/or the Men's Referral Service, who have a high degree of skill in determining who is a genuine victim or perpetrator (Twisleton, Coleman & Coorey, 2017).

1.1.8 Related resources and tools

Due to the diversity of practice contexts, skill levels and roles of practitioners, there is no single common perpetrator screening tool at this stage that would be appropriate and applicable across all settings. Ideally, practitioners will operate within the context of their role, being guided by their agency policies and procedures and the RSSF **Practice guidance**. The DVSAT (NSW Government, 2015) is commonly used with victims across services in NSW – please refer to Appendix A for more information. *Predominant Aggressor Identification and Victim Misidentification* may also be a helpful resource (see Appendix A).

1.2 Gather information about risk and safety

1.2.1 Intent

Once a practitioner has identified that a man may be using DFV they should gather more information about any evidence-based risk factors, if appropriate within the scope of their role, knowledge and skillset. This information will initiate or inform an assessment of risk and harm, and crucially, a response to risk. Making an assessment about the risk of harm posed by a perpetrator is a complex, ongoing and evaluative process (Backhouse & Toivonen, 2018).

1.2.2 Introduction

Risk assessment is a process of gathering information about DFV and analysing risk and safety information to assess the severity and impact of coercive controlling violence and the likelihood that it will continue.

Based on broad consensus across national and international literature, **Structured Professional Judgement** is recommended as the best approach to risk assessment and safety management in the context of DFV (Backhouse & Toivonen, 2018). **Structured Professional Judgement** is based on information gathered from a range of sources, including:

> framework of **evidence-based risk factors**
> **victim-survivor's own assessment** of safety, level of fear and perception of risk
> **professional judgement and discretion**, taking into consideration the specific situation and context (State of Victoria, 2018).

The purpose of this section is to provide detailed practice guidance to support **Structured Professional Judgement**, and conversations about risk as part of broader engagement with men. As there is no actuarial or structured tool to assess risk and generate a weighted score, a sound understanding of the nature and dynamics of DFV is important to inform this assessment. Informally gathering information from multiple sources about perpetrator patterns, tactics and behaviour that are controlling, abusive or violent, contributes to forming a professional judgement about the type of risk they may pose to adult and child victim-survivors. This requires observation of men's language and behaviour that demonstrates attitudes, beliefs and assumptions which may point to DFV behaviours and provide information on risk factors. Information about victim-survivor intersectional experiences (for example, cultural identity, sexual orientation, disability, etc.), factors of vulnerability (for example, visa status), and isolation will also inform or contribute further to an assessment of the likelihood and severity of DFV. This information can be gathered via a Part 13A request (Crimes [Domestic and Personal Violence] Act 2007), to exchange information to guard against the system-generated risk of the perpetrator learning about victim-survivor disclosures or system actions to manage his risk. All gathered information is to be recorded and stored securely on client files.

1.2.3 Evidence-based risk factors for domestic and family violence

There is rarely a single cause of DFV. While all risk should be assessed with consideration of each individual's broader circumstances, there is substantial evidence to support common risk factors for DFV.

High-risk factors for severe or lethal violence that can be used to assist in determining level of risk and proportionate action are outlined in the *National Risk Assessment Principles for domestic and family violence*, and include:

> presence of coercive control
> recent or upcoming separation
> non-fatal strangulation i.e. 'choking'
> threats to kill
> history of domestic violence
> stalking
> intimate partner sexualised violence
> escalation in frequency and severity of violence
> perpetrator's access to weapons
> abuse of pets and other animals
> isolation and barriers to help-seeking
> attempted suicide by perpetrator
> non-compliance (breach) of court order
> pregnancy/new birth
> victim-survivors' perception of risk (Backhouse & Toivonen, 2018).

If any of these high-risk factors for severe or lethal violence are identified, the service provider/practitioner must take immediate action (see **Response/action pathways** in section 1.2.8).

The **Practice tips** section (see 1.2.9) includes suggested prompts about how practitioners might elicit information about high-risk factors.

1.2.4 Who should gather information about risk and safety

Any practitioner who is adequately trained, competent and supported to engage with a user of family violence and initiate a risk response, can gather information and make a structured professional assessment and judgement about risk and safety. Practitioners that have an established rapport and engagement with a user of violence are well-placed to undertake risk assessment. Practitioners must be aware that every intervention, including risk assessment, can potentially increase the risk of further violence.

It is critical that practitioners have the skill and capacity to provide a risk response if they are to start gathering information about risk and safety. The **Response/ action pathways** section below (1.2.8) provides guidance on possible risk responses when practitioners or organisations are unable to respond themselves, which will usually involve referral to specialist services. It is critical that service providers develop their own clear response protocols, embedded in organisational policy and procedures, including developing working relationships and Memoranda of Understanding (MOUs) with collaboration partners. Practitioners should be supported at an organisational level to gather information from perpetrators and/or other sources and respond appropriately to risk and safety concerns.

1.2.5 When information about risk and safety should be gathered

Once DFV perpetration is suspected or identified, and where appropriate and safe to do so, the practitioner should gather information about how DFV is used by a perpetrator and/or experienced by a victim-survivor to inform an overall understanding of the level of risk. Information can be gathered during a standard clinical intake process, case management session or other engagement/consultation. Risk is likely to change over time; therefore, when service providers have regular contact with the user of family violence, review and assessment of risk should be ongoing, rather than a one-off static assessment of risk. Every engagement is an opportunity for ongoing risk assessment.

'I know you want to help but if you oversimplify my world so that you can feel you understand, you lose sight of my challenges and my capacities.'

– *Follow My Lead,* Insight Exchange, 2018.

1.2.6 Why gathering information about risk and safety is important

Gathering information supports **Structured Professional Judgement** about the likelihood of future violence by the perpetrator. This information may also be shared to contribute to a specialist service provider's assessment of risk (for example, an MBCP).

Most critically, information gathered can support risk assessment and safety planning for adult and child victim-survivors. Victim-survivor narratives should be prioritised as the best source of information regarding their own safety, particularly when the victim-survivor has received specialist support and information about dynamics and risks. Information gathered from a victim-survivor regarding a perpetrator's pattern of coercive controlling behaviour may offer insight into her current safety and ongoing risk needs. For example, he may hint that he knows her whereabouts, that he is planning to initiate court action, or that he has stopped taking his medication for a diagnosed condition.

1.2.7 How to gather information about risk and safety

Information can be gathered by asking the user of violence direct and indirect questions and inviting responses. Questions may be routine or standardised as part of service intake or clinical assessment; alternatively, an invitational narrative approach may be helpful (Wendt, 2019). Invitational narrative approaches have a strong commitment to women's and children's safety by focusing on responsibility and change. This is achieved by viewing men as inherently capable of engaging in purposeful conversations and using storytelling to encourage men to uncover their beliefs and assumptions around using violence.

Practitioner knowledge and observations contribute to accurate risk assessment. Practitioners should also attend to non-verbal communication and behaviours. Using all available information, a practitioner can draw on their understanding of DFV, including:

> impacts on victim-survivor safety, wellbeing and liberty
> the context and situations in which violence is occurring
> history and patterns of perpetrator behaviours that serve to maintain control
> intersectional factors that may further expose victim-survivors to risk
> barriers to engagement for perpetrator and adult victim-survivors.

People who use DFV are unlikely to share openly about their use of violence – if they answer 'yes' at all to a violence-related enquiry. Denial of, or reluctance to talk about DFV, should not be taken at face value, and

it should not be assumed that there are no risk factors present when met with denial or reluctance.

Instead, where possible, obtain information from other sources including other agencies that the user of violence has currently or previously had contact with, or from victim-survivor reports and narratives. Consent should be obtained from victim-survivors to share information and caution taken to minimise any risk to her safety.

Gathering information about risk and safety should always be followed by some action to manage the risk posed by a perpetrator of DFV. Services should seek secondary consultation from the Men's Referral Service and consider making a referral to a MBCP or the Men's Referral Service, or sharing risk information with a specialist domestic violence service supporting his (ex-)partner.

Ongoing documentation of information gathered, risk assessments undertaken, and action taken in response to risk is vital. Organisation protocols should articulate how information is documented, who has access to such information and how it is used, in alignment with *National Privacy Principles* (Office of the Australian Information Commissioner, 2014). Steps may need to be taken to ensure that information gathered is not shared with the perpetrator or their legal representative, to minimise system-generated risk to victim-survivors and retaliatory violence.

1.2.8 Response/action pathways

Once you have gathered relevant information about risk and safety, it is important to take appropriate action to support the safety of the adult and child victim-survivor(s), which may include:

> making a report to police and/or child protection in response to serious or imminent risk of harm (perpetrator consent is not required to initiate this action; see section 1.4)
> seeking a secondary consultation with the Men's Referral Service for specific guidance on who to share risk-related information with, and how to do it without jeopardising victim-survivor safety
> sharing risk and safety-related information with services involved in risk management (see section 1.4)
> participating in high-risk management referral process for adult victim-survivor as directed by Safer Pathway, via the WDVCAS (refer to Appendix C for more information)
> collaborating with MBCPs or other DFV specialist services in order to keep the perpetrator in view, and support safety for adult and child victim-survivors (see section 1.5)
> referring the perpetrator to an MBCP, the Men's Referral Service or other specialist intervention/s
> maintaining service engagement with the perpetrator, particularly where a referral is not taken up.

1.2.9 Practice tips

Remember: The safety of victim-survivors is always the priority. If high-risk or lethality risk factors are identified (see section 1.2.3), practitioners should report to police and seek secondary consultation from male family violence specialist services (for example, local MBCP or Men's Referral Service).

Questions for practitioners to reflect on their practice

> Have I gathered information from a wide range of sources, including the victim-survivor?
> Am I giving more weight to some sources over others, and is this justified?
> Have I applied my professional judgement to the risk information?

Examples of questions to engage users of violence

Questions asked when gathering information should be kept to a minimum to avoid overly directing the conversation and undermining the broader goal of engagement. The emphasis should be on the relational dynamic between the practitioner and client, and creating a safe space for open conversation. **It is not** anticipated that all the below questions should be asked as a checklist; they are suggestions for the practitioner to explore a risk factor in a conversational style. They should be asked with genuine curiosity, being attentive to any unconscious bias the practitioner may hold.

General introductory questions

> Is it ok if I ask you a bit about what's been going on for you lately? *(Focus on him)*
> You have children? What are their names, what are their ages? Do you get to see them much?
> How are you going, not seeing the kids as often? *(Exploring children at risk)*
> Where can you go when you can't go home? How is that for you? *(Exploring stalking behaviour, patterns, harassing behaviour, non-compliance with orders)*
> When you are using (drug/alcohol) what might I see happening? *(Exploring behaviours)*

1.2.10 Considerations for diverse communities

Engaging men from CALD communities may require understanding and exploring stressors caused by immigration/settlement and the acculturation process, including the possibility of social isolation, low socioeconomic status and racism, and shifts in power dynamics in the family when settling in a new country. Trauma arising from pre-migration experiences may be an additional risk factor for DFV, and there may be

a higher likelihood of multi-perpetrator violence (for example, from in-laws) in some families from CALD backgrounds.

Consideration should be given to using a trained and qualified interpreter when working with people for whom English is a second language. This will promote effective communication and understanding. It is not appropriate to use a person's family or friends, children under 18 years old or untrained volunteers as interpreters.

When using an interpreter:

> speak directly to the client rather than to the interpreter
> speak slowly rather than loudly
> speak at an even pace in short sentences
> pause for the interpreter to interpret
> ask one question at a time
> insist that everything that the practitioner and the client says is interpreted
> be aware that some concepts may not have a linguistic or conceptual equivalent in other languages; the interpreter may have to paint word pictures of some terms you use which may take longer than your original speech
> avoid highly idiomatic speech, complicated sentence structure or changing your idea in the middle of a sentence
> ask the person to repeat back important information so that you can make sure it is understood and provide clarification as required (Refugee Health Technical Assistance Centre, n.d.).

1.2.11 Related resources and tools

Please refer to Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 (see Appendix A) and the *National Risk Assessment Principles for domestic and family violence* (Backhouse & Toivonen, 2018; see Appendix A).

1.3 Provide referral(s) to services addressing risk

1.3.1 Intent

Providing timely and appropriate referral(s) is an integral part of managing risk and safety for both the perpetrator, and adult and child victim-survivors of DFV. The primary purpose of referrals for perpetrators is to encourage them to take responsibility for the violence and begin change work. Coexisting issues, such as homelessness or substance misuse, can be addressed simultaneously where appropriate, and where they are precluding a man from participating in behaviour change interventions (Government of Western Australia, 2015).

Referrals should also be made for adult and child victim-survivors, with their consent, to specialist domestic violence services and/or via the Central Coordination Point through Safer Pathway to support their safety and wellbeing.

1.3.2 Introduction

Referral connects perpetrators, victim-survivors or children to information or services for the purpose of managing risk, responding to or preventing crises and/or harm, and supporting stabilisation and recovery (Victoria State Government, 2018).

Effective referral and information-sharing processes:

> seek informed consent to refer or share information
> prioritise the safety of adult and child victim-survivors
> are guided by risk assessment
> work collaboratively with individuals to facilitate access to appropriate support services.

'Being "safe" is more than being physically safe – it includes all aspects of my wellbeing.'

– *My Safety Kit*, Insight Exchange, 2019.

1.3.3 What referral is

Referral can involve providing information only or can be a more active process. Information referrals where the man is expected to contact a service himself may not be effective if motivation to change is low or he is unwilling to recognise his use of violence as a problem.

Towards Safe Families distinguishes **warm** from **active** referrals (NSW Department of Attorney General and Justice, 2012). A warm referral occurs when 'a referrer outlines the service and program to the man, explains how to access the service, and talks with him about the benefits of his participation', yet requires him to initiate contact himself. An active referral is when contact is made on behalf of the man by a referring practitioner who also follows up with the receiving service on whether the referral was taken up by the perpetrator. This 'feedback loop' between referring and receiving services is an important element of collaborative practice and involves close and ongoing relationships and communication.

Whether or not a perpetrator accepts the referral and engages with the receiving service is important risk-related information. Where there are weak or non-existent feedback loops between services, perpetrators can exploit these gaps in the system to evade detection and re-assert or maintain their power over victim-survivors (Humphreys & Healey, 2017).

1.3.4 Who should provide referrals

All services and practitioners who have identified the presence of DFV have a responsibility to provide referral(s) and work within an integrated service system.

1.3.5 When referral(s) should occur

Referral(s) should occur whenever a risk or need is identified for a man who uses DFV. Referral to police and/or child protection should be made as part of an immediate safety plan when high-risk indicators are identified (see section 1.2.3). In these cases, a referral for adult and child victim-survivors to specialist DFV services should also be made as a matter of priority (see section 1.3.8).

1.3.6 Why referrals should be made

Referrals can connect men who use DFV, adult and child victim-survivors and other affected family members with support to address diverse health and welfare needs. Engaging users of violence with one or multiple support services also enables the service system to monitor and hold them accountable.

Practitioners making referrals recognise the boundaries of their expertise and service capacity and connect their clients with other services that are resourced and able to address identified needs. Secondary consultations are an important element of DFV practice, whereby the practitioner contacts the Men's Referral Service or another experienced practitioner to seek advice and feedback to inform collaborative work to support clients.

1.3.7 How to provide referrals

Victim-survivors

Identify what services might be needed for adult and/or child victim-survivors to address their immediate safety and ongoing practical needs.

Understand when, and to which services, referrals can be made with and without the consent of the perpetrator and/or victim-survivor. The RSSF tool **Information exchange template** (part three, **Companion reources**) under Part 13A Crimes (Domestic and Personal Violence) Act 2007 provides further guidance regarding sharing information in the absence of consent, highlighting that information about perpetrators can be shared without their consent if there is a serious and imminent threat to a person's life, health or safety. Information about victims can only be shared if a service obtains their consent to do so, with the only exception being when the victim is at serious threat.

Users of violence

Discuss with the person using violence how other services could help and support them to change. Identify whether there are immediate practical needs that may prevent the person using DFV from engaging in behaviour change work (for example, housing or financial issues, or health concerns).

Motivational interviewing techniques can be used to encourage the person using DFV to see the benefits of taking up referrals and engaging with additional services. Motivational interviewing recognises that different men are at different levels of readiness for change and encourages practitioners to 'roll with resistance' and avoid taking an argumentative stance, as this can strengthen resistance (Murphy & Maiuro, 2009). Instead, practitioners should express empathy, acknowledge the man's current barriers and struggles, and highlight how the man's current behaviour is in opposition to his values and goals. For example: 'You speak about your love for your kids and wanting to be a good dad that has a positive relationship with them, yet you see that your violence leaves them feeling scared. What would you like to do differently to show your love and care for your kids?'

Motivational interviewing aims to increase awareness of the consequences for the user of violence, identifying problems and risks associated with his violence and the benefits of change. Motivational interviewing also supports the development of self-efficacy in men, i.e. the belief that they have capacity to change and reach their goals. This occurs by identifying skills and strengths and celebrating small wins and changes. Professional development in motivational interviewing techniques may be valuable for practitioners working with users of DFV.

1.3.8 Response/action pathways

MBCPs, or other specialist interventions such as the Men's Referral Service, are the referral points of choice to address men's use of violence. The presence of other issues such as drug or alcohol abuse, harmful gambling, or mental health conditions – while not causal factors for DFV – can impact readiness for behaviour change work. Therefore, professionals should refer to services to address these needs.

Examples of **appropriate referrals** to address men's use of violence include:

- local MBCP
- Men's Referral Service: a 24-hour, 7-day-a-week phone counselling service providing risk assessment, engagement and readiness assessment, counselling, information and referral of men who use violence to MBCPs and other specialist services, in addition to secondary consultations for workers (**1300 766 491; ntv.org.au/get-help/**)
- private counsellors or practitioners who are skilled in responding to men who use DFV
- specialist domestic violence fathering programs, such as Caring Dads – a group-based intervention program for fathers who have abused, neglected or

exposed their children to DFV harm.

Examples of **inappropriate referrals** to address men's use of violence include:

> anger management programs
> generalist parenting programs that do not have a focus on fathering in the context of using DFV.

Examples of **appropriate referrals** for adult victim-survivors of DFV include:

> local specialist domestic violence service/s
> state-wide Domestic Violence Line (**1800 656 463**),
> 1800RESPECT (**1800 737 732**)
> WDVCAS (**1800 938 227**)
> Link2home for emergency, temporary and crisis accommodation.

1.3.9 Practice tips

When making a referral to an MBCP:

> develop close working relationships or MOUs with key local agencies
> clearly document referrals and expectations of each service
> provide comprehensive information upfront, including a description of the DFV risk so the referral recipient is aware of the presence of DFV and the extent of known risk, in line with Part 13A of the Crimes (Domestic and Personal Violence) Act 2007
> include any other relevant information to support the referral, such as any barriers to the man taking up a referral
> stay actively involved in the case after referral through contact with the perpetrator (for example, provide supportive messages to enhance his motivation to attend, review goal setting to accommodate his changing life goals, and address barriers that may prevent his participation in the program) (Vlais et al., 2017)
> consult with colleagues or supervisors in the decision process of making a referral; this supports practice by sharing the responsibility for managing and responding to risk across the team rather than with the individual practitioner
> where information about the perpetrator is sourced from victim-survivors, be conscious of the risk of this information becoming public, available or known to the perpetrator or his legal representative, as this may have repercussions for victim-survivors.

1.3.10 Considerations for diverse communities

When referring perpetrators or victim-survivors to other support services, it is important that the service is appropriate and sensitive to their needs. This could include:

> referring to or seeking secondary consultation with specialist services that have expertise and knowledge of best practice in working with certain diverse communities (for example, services for people with disabilities or from culturally diverse backgrounds)
> offering Aboriginal and Torres Strait Islander people choice of referral to an Aboriginal Community Controlled Organisation or a non-Aboriginal service (State of Victoria, 2015)
> having current knowledge of and offering referral to local services specifically for, or inclusive of, LGBTIQ people.

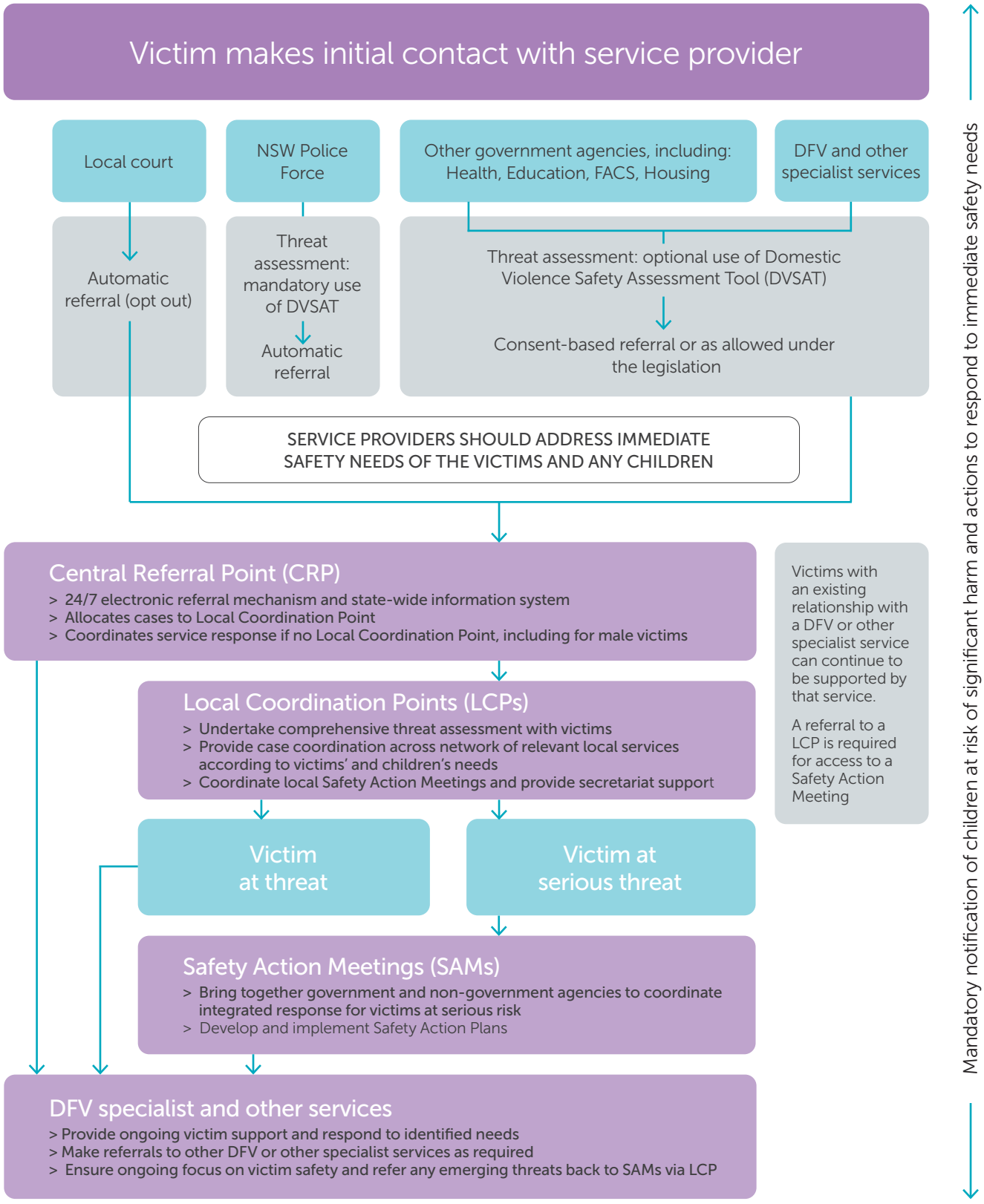
1.3.11 Related resources and tools

> Safer Pathway Service Delivery Map (refer to Figure 2 over the page)
> **Information exchange template** (RSSF part three)
> More information on tools and resources: contact **rssf@ntv.org.au**

'Responses from others are significant and play a part in my safety. When someone is controlling and abusing me my situation is complex. No matter how much I try, no matter what ways I resist and respond, the abuser overcomes my resistance. Just because I cannot stop the abuse doesn't mean I let it happen. I might want to talk to someone about what is going on or to keep thinking about things first. I might want to think about who I want to talk to, and what I will say. If or when I do reach out to someone (a person or a service), I don't have to make any decisions, or all my decisions at once. And no one should be expecting me to. I might want to talk with someone about my experience and all the things I am doing already to stay safe. I might want to talk about where I might need support from others. I might want to talk to someone on the phone, or to talk with someone in person.'

– *My Safety Kit,* Insight Exchange, 2019.

Figure 2: Safer Pathway Service Delivery Map



(Source: *Domestic Violence Information Sharing Protocol,* NSW Government, 2014).

1.4 Information sharing

1.4.1 Intent

The primary intention of sharing or exchanging information about a perpetrator of DFV or a victim-survivor (adult or child) is for the safety and protection of victim-survivors. Sharing relevant information is a central pillar of delivering a coordinated, collaborative system response to keep the perpetrator of DFV in view.

1.4.2 Introduction

There are several legislative frameworks in NSW that allow for information exchange where there are DFV risks, and where children experience DFV in the home:

- Part 13A of the Crimes (Domestic and Personal Violence) Act 2007
- Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998
- *National Privacy Principles* (Office of the Australian Information Commissioner, 2014)
- Health Records and Information Privacy Act 2002.

Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 'facilitates the collection, use and disclosure of personal and health information in cases involving domestic violence' (NSW Department of Communities and Justice, 2014). *The Domestic Violence Information Sharing Protocol* (the *Protocol*; NSW Government, 2014), one in a suite of documents to support the implementation of Safer Pathway, explains how to share information under Part 13A.

This **Practice guidance** should be read alongside the *Domestic Violence Information Sharing Protocol*, such that service providers are familiar with the legislative framework for sharing information in relation to DFV.

Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 allows information to be exchanged between organisations working with children and young people and their families. Information can be shared where there are concerns about their safety, welfare and wellbeing, regardless of whether the children and young persons are assessed as being above or below the statutory reporting threshold. For example, a child or young person below the statutory reporting threshold may need some form of assistance even though they do not need statutory intervention. There is no need for a child or young person to be reported to the Child Protection Helpline for the information-sharing provisions to apply.

Importantly, in the interests of victim-survivor safety, information sharing needs to be supported by strong information management systems and processes for secure storage and transfer of personal and health information (NSW Department of Communities and Justice, 2014). The Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002 contain principles to protect the privacy of individuals' personal and health information in NSW. Part 13A creates some exemptions to these privacy laws which are detailed in the *Domestic Violence Information Sharing Protocol* (chapter 4, page 14). In addition, Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 overrides these privacy laws where the focus of the exchange of information is in respect to safety, welfare and wellbeing, which facilitates the provision of services to these children and their families.

1.4.3 What information sharing is

As defined by the *Domestic Violence Information Sharing Protocol*, information sharing and exchange involves transmitting personal details or health information about a client to another service for a purpose in relation to DFV (NSW Government, 2014).

Service providers may only collect, use and disclose victim-survivors' and perpetrators' personal and health information where there is a domestic violence threat, to make a referral for domestic violence support for a victim-survivor, to provide support services to a victim-survivor or to prevent or lessen a serious threat to a person's life, health or safety.

1.4.4 Who should share information

Part 13A, Crimes (Domestic and Personal Violence) Act 2007

Under Part 13A, all public sector agencies, private organisations, and individual service providers should comply with the *Domestic Violence Information Sharing Protocol*.

Part 13A applies to the following service providers where they provide domestic violence support services:

- any public sector agency, including NSW government agencies and statutory bodies, such as public schools, public hospitals and government departments
- public sector agencies and private sector persons such as medical, hospital and nursing services, general practitioners, community health services, health education services and welfare services
- any organisation funded by NSW Government
- any non-government support service that has agreed to comply with the standards set out in the *Protocol*.

Chapter 16A, Children and Young Persons (Care and Protection) Act 1998

Under Chapter 16A, service providers that are prescribed bodies in the Children and Young Persons (Care and Protection) Act 1998 can exchange information regarding the safety, welfare and wellbeing of a child or young person.

Generally, prescribed bodies under Chapter 16A are:

> NSW Police Force
> a state government department or a public authority
> a government school, registered non-government school or TAFE
> a public health organisation or private health facility
> a children's service or any other organisation which has direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children.

1.4.5 When information sharing should occur

Information sharing and exchange should be an ongoing process that occurs every time new, relevant information is gathered.

When consent is required/not required

Part 13A, Crimes (Domestic and Personal Violence) Act 2007

Obtaining consent is a core element of sharing and managing information and is best practice in terms of privacy protection. Consent can be verbal or written, and must be voluntary, informed, reasonably specific, current, and given by a person who has capacity to consent (NSW Department of Communities and Justice, 2014).

When sharing information about perpetrators, it is preferable to obtain their consent to do so; however, this is not required when:

> the service provider reasonably believes there is a serious and imminent threat to the life, health or safety of a person, or
> there are reasonable grounds to believe that a criminal offence may have been committed.

When cases are assessed as being at serious threat, referral is made to a Safety Action Meeting. The perpetrator is not advised of this referral or any outcomes of the meeting to protect victim-survivors from further harm.

While attempts to gain victim-survivor consent should be made in all circumstances, there are instances as set out in the *Domestic Violence Information Sharing Protocol* (NSW Government, 2014) where the consent of the victim-survivor is not required in order to share relevant information in relation to DFV.
In circumstances where the victim-survivor is at serious threat, sharing information without consent is allowed where:

> it is **unreasonable or impractical to obtain consent** from the victim-survivor (for example, they are in a coma or unconscious, the victim-survivor cannot by contacted despite daily attempts over several days or where there is an urgent need for support and no time to obtain consent), or
> the victim-survivor has refused to give consent but the service provider believes that sharing information will prevent or lessen a serious threat to the victim's life, health or safety, or that of any children or other person; where these conditions are met, **the service provider may override a victim-survivor's refusal to consent** (NSW Department of Justice, 2014).

Service providers should note that if a victim-survivor is assessed as being 'at threat' rather than 'at serious threat', information cannot be shared without their consent.

DFV support service providers that fall under Part 13A include:

> any public sector agency within the meaning of the Privacy and Personal Information Protection Act 1998
> any organisation within the meaning of the Health Records and Information Privacy Act 2002
> any organisation funded by a NSW government agency
> any non-government support service that has agreed to comply with the standards set out in the *Protocol*.

Chapter 16A, Children and Young Persons (Care and Protection) Act 1998

Consent is not necessary for exchange of information under Chapter 16A. However, a child or young person should be given an opportunity to express views on personal matters and consent should be sought where possible. Best practice also recommends that consent is sought from family members before information relating to them is exchanged (NSW Department of Communities and Justice, 2019).

Under Chapter 16A, information can be shared to make a decision or undertake an assessment or safety plan, initiate or conduct an investigation, provide a service to children and their families, or manage a risk to the child or young person (NSW Department of Communities and Justice, 2019).

Prescribed government agencies and NGOs under Chapter 16A include:

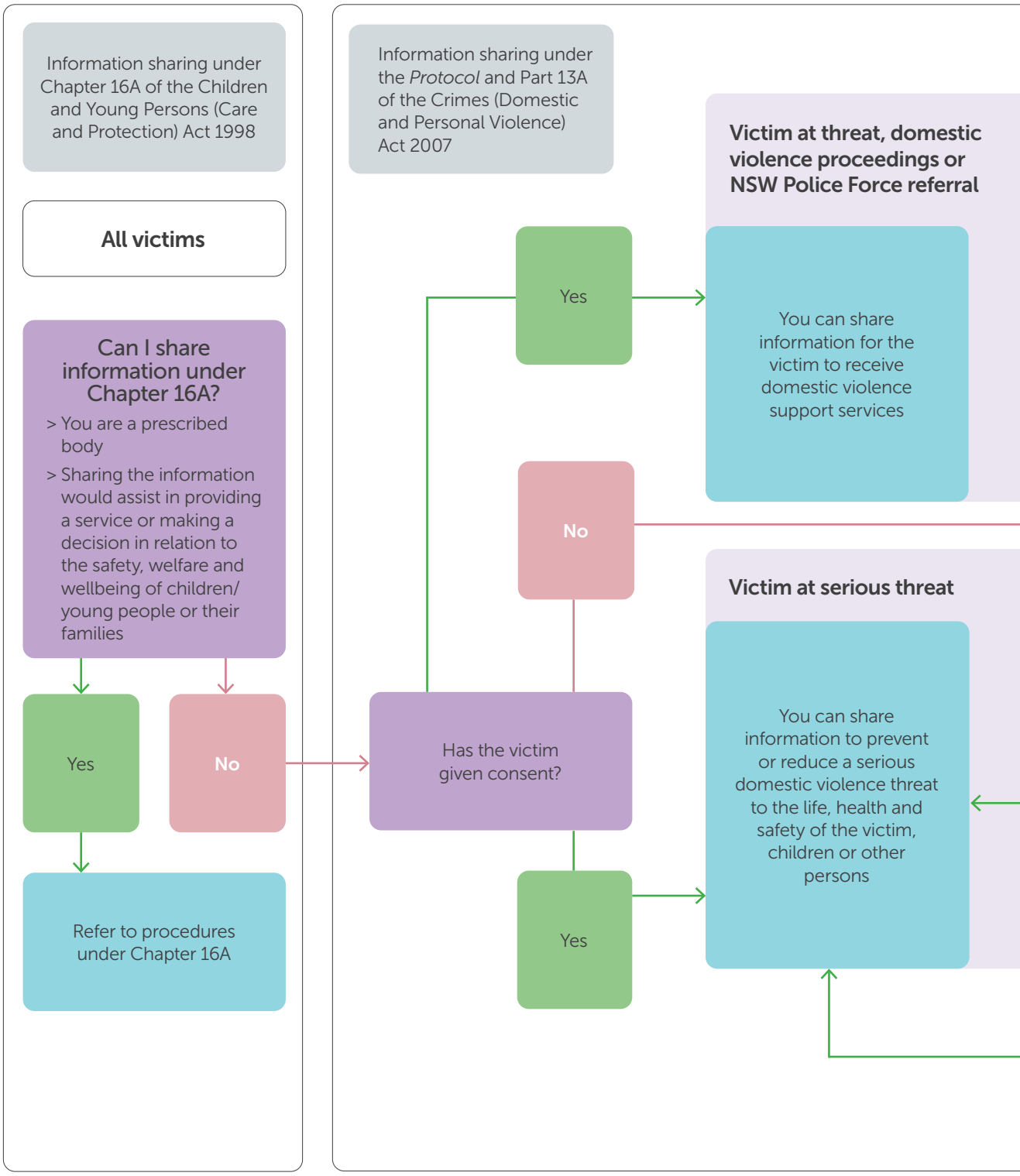
- police
- a public service agency or a public authority
- schools and TAFEs
- public and private health organisations
- the Family Court of Australia and the Federal Circuit Court
- the Department of Immigration and Border Protection
- 'any other organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children'.

Refer to Figures 3 and 4 over the page for flowcharts outlining the information-sharing process and considerations.

'Please remember, there may be much more going on than I care to say – until I know you're safe to share with. If you try to make decisions for me and tell me what to do, I might feel more unsafe than before I shared with you. I may not know what I want you to do, I may want you to do nothing, I may want you to do something. I may want your quiet support alongside me, or I may want you to do something proactive, or a mix of these things. Listen to me and follow my lead.'

– *Follow My Lead*, Insight Exchange, 2018.

*Figure 3: Information-sharing process – Can I share the victim and the perpetrator's information?**



* NSW Police Force and NSW Local Courts refer to Figure 4 over the page.

(Source: *Domestic Violence Information Sharing Protocol*, NSW Government, 2014).

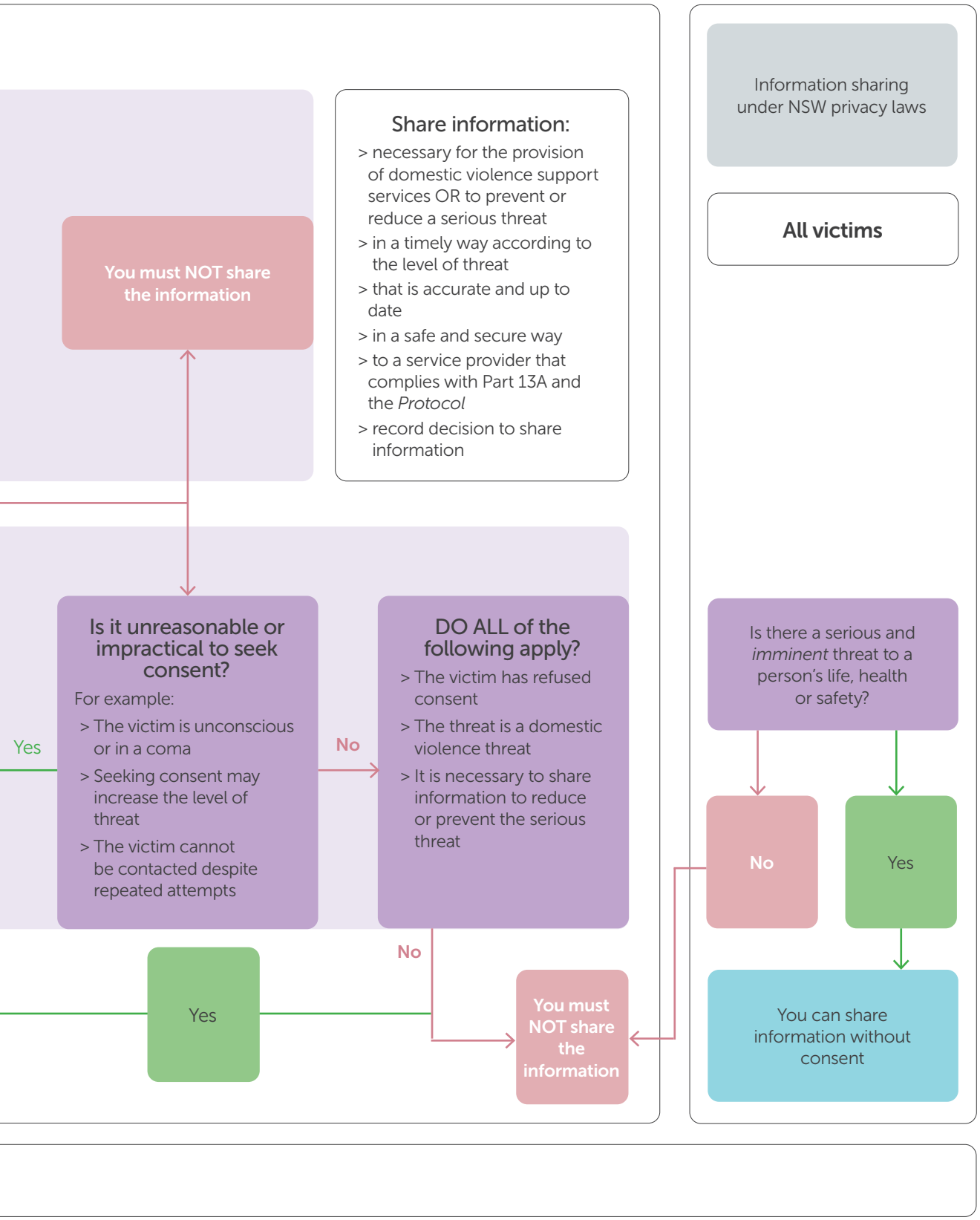
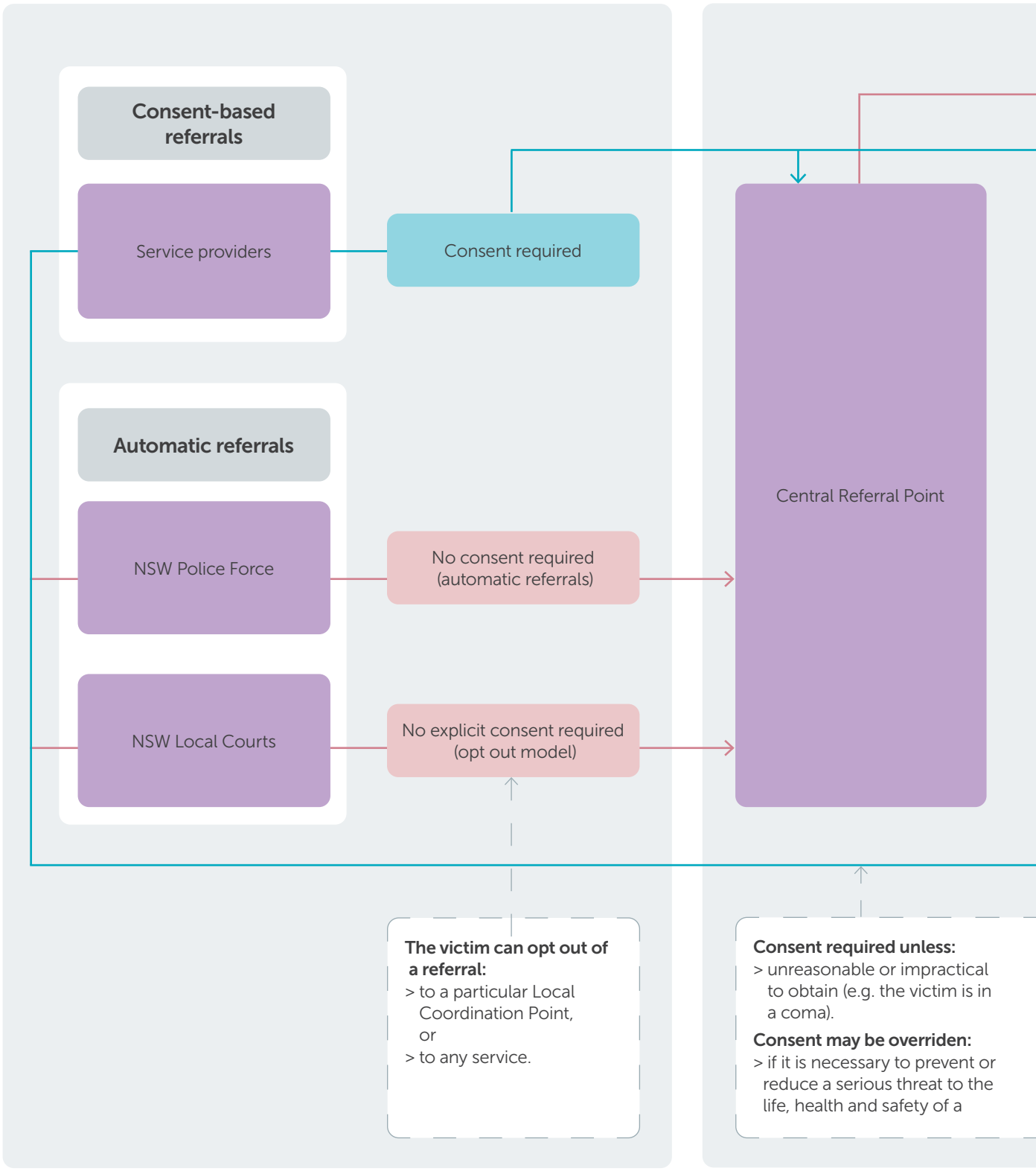
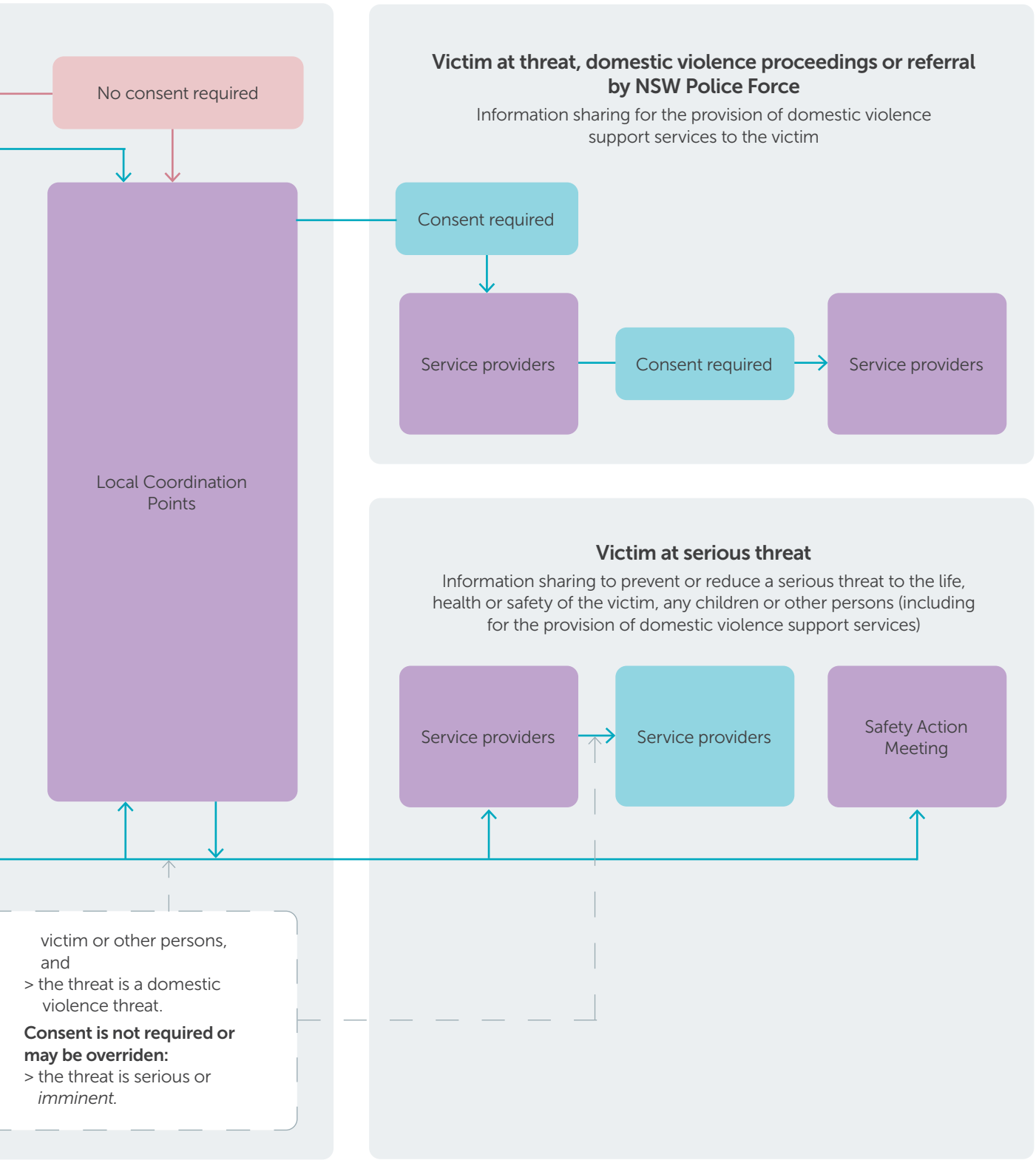

Information sharing under NSW privacy laws
All victims
Share information:
> necessary for the provision of domestic violence support services OR to prevent or reduce a serious threat
> in a timely way according to the level of threat
> that is accurate and up to date
> in a safe and secure way
> to a service provider that complies with Part 13A and the Protocol
> record decision to share information
You must NOT share the information
Is it unreasonable or impractical to seek consent?
For example:
> The victim is unconscious or in a coma
> Seeking consent may increase the level of threat
> The victim cannot be contacted despite repeated attempts
Yes
No
DO ALL of the following apply?
> The victim has refused consent
> The threat is a domestic violence threat
> It is necessary to share information to reduce or prevent the serious threat
No
Yes
You must NOT share the information
Is there a serious and imminent threat to a person's life, health or safety?
No
Yes
You can share information without consent

Figure 4: Information-sharing consent considerations – Do I need consent to share the victim's and the perpetrator's information?



(Source: *Domestic Violence Information Sharing Protocol*, NSW Government, 2014).


No consent required
Local Coordination Points
victim or other persons, and
> the threat is a domestic violence threat.
Consent is not required or may be overriden:
> the threat is serious or imminent.
Victim at threat, domestic violence proceedings or referral by NSW Police Force
Information sharing for the provision of domestic violence support services to the victim
Consent required
Service providers
Consent required
Service providers
Victim at serious threat
Information sharing to prevent or reduce a serious threat to the life, health or safety of the victim, any children or other persons (including for the provision of domestic violence support services)
Service providers
Service providers
Safety Action Meeting

1.4.6 Why share information

Information sharing allows agencies and services to:

> develop and maintain a web of accountability around the perpetrator to keep his tactics in view and continue to monitor the safety of victim-survivors
> identify the occurrence of DFV
> increase the safety, health and wellbeing of victim-survivors and any children, and prevent domestic violence-related death, disability and injury
> improve victim-survivors' access to support services
> make referrals and allow for coordinated case management to support the person using family violence to engage in behaviour change interventions
> gather a range of professional perspectives to inform a comprehensive approach to risk assessment, risk management and safety and accountability planning
> support timely decision-making about appropriate actions to take (New Zealand Government Ministry of Justice, 2017; NSW Department of Communities and Justice, 2019).

In the context of multi-agency collaboration between specialist domestic violence services and child protection, the focus of information sharing needs to be on perpetrator risk. Caution should be exercised against blanket sharing of private and confidential information about victim-survivors. Trust between practitioners and agencies is a critical element of information sharing, which can be best established through collaborative practices (Humphreys & Healey, 2017).

1.4.7 How to share information

Information sharing can be done through formal and informal pathways, including by talking on the phone, through written templates, and in multi-agency meetings. When sharing information via email or other electronic means, steps should be taken to ensure that data is secure and encrypted. Information sharing and exchange must be carried out within legislative bounds and have utmost respect for client confidentiality. Refer to organisational policy and procedure for guidance on methods for sharing information. Where no formal arrangements exist between organisations, consider establishing protocols and/or MOUs to support practitioners to share information. All agencies have a responsibility to review and maintain their sharing-of-information procedures in accordance with current Safer Pathway protocols and Part 13A of the Crimes (Domestic and Personal Violence) Act 2007.

Use of the RSSF tool **Information exchange template** (part three, **Companion resources**) under Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 should be standard practice for all services working with users of violence and victim-survivors.

This form documents the type and purpose of information sharing and ensures that information shared is protected, under the legislation, from being accessed by the perpetrator or his legal representative.

1.4.8 Response/action pathways

On a regular basis practitioners should:

> make an assessment as to whether they hold risk-related information that needs to be shared with other agencies in order to manage risk or support safety
> make an assessment as to whether they require information to be shared from other sources to better manage risk or support safety
> gain informed consent where possible but understand the limitations to this
> understand when consent is not required to share information.

1.4.9 Practice tips

Where a perpetrator of DFV refuses to consent to the sharing of information, this may be an indicator of potential risk of further violence, and should contribute to professional judgement regarding severity of risk.

Information that the victim-survivor or children have shared should not be accessible by perpetrators or their legal representatives, to protect confidentiality and safety (Government of Western Australia, 2015).

Informing victim-survivors about information sharing and privacy

Practitioners are required to obtain informed consent from victim-survivors before sharing information with or obtaining information from other services (with a few important exceptions outlined in section 1.4.5). This means that victim-survivors are informed of what information will be exchanged, with whom, when and for what purpose; they also give or refuse consent for this to occur. Victim-survivors should be informed of the benefits of sharing information and any potential risks (for example, consequences if there were a data breach).

Informing perpetrators about information sharing and privacy

Practitioners must inform perpetrators that there are limits to the confidentiality that the service can provide and that information regarding the potential risk they pose to women and children will be shared with other services to support safety and prevent further violence or harm. Information may be shared with a range of services including women's support services, police, Probation and Parole, Department of Communities and Justice, and health-related services.

1.4.10 Considerations for diverse communities

People who have experienced past discrimination or negative experiences may have greater reluctance for information to be shared; this may be particularly relevant for members of minority groups. For example, refugees and asylum seekers may be reluctant for information sharing to occur due to fear of deportation. To address this, ensure time is allocated to answer any questions or respond to any concerns that arise regarding information sharing, and inform people that consent to share information can be withdrawn later if circumstances or preferences change.

1.4.11 Related resources and tools

> **Information exchange template** (RSSF part three)
> NSW *Domestic Violence Information Sharing Protocol* – refer to the *Protocol's* Appendix 7 for an MOU template and Appendices 1–3 for quick-reference flowcharts showing the process and thresholds for consent and information sharing (see section 1.3.11 and 1.4.5, also refer to Appendix A for links to further information)
> Safer Pathway *Domestic Violence and Child Protection Guidelines* refer to Appendix A for links to further information).

1.5. Collaborative practice – a multi-agency response

1.5.1 Intent

Establishing an integrated multi-agency response is the central pillar of perpetrator accountability, as this is what enables the whole system to keep the user of violence 'in view', monitor their behaviour and ongoing risk, encourage them to take responsibility for keeping themselves and their family safe, and undertake comprehensive safety planning and support with victim-survivors.

1.5.2 Introduction

There are three core principles or benefits to establishing interagency partnerships and/or integration:

> a focus on improving victim-survivor's emotional, psychological safety
> minimising the secondary victimisation that can occur when women are required to recount their stories to multiple services
> ensuring accountability for the actions of perpetrators (Breckenridge et al., 2016).

There is no silver bullet to make service integration effective; rather, a complex range of factors can facilitate or hamper collaboration (Humphreys & Healey, 2017). Wilcox (2010) conceptualises the ways in which organisations can work together as a continuum ranging from service autonomy on one end to integration on the other (see Table 2 below). The extent of collaboration that is appropriate for an organisation will depend on its mission and goals, and is likely to vary over time or across different parts/projects in the organisation.

Table 2: Continuum of service delivery toward integration

Service autonomy	Collaborative practice	Streamlined referrals	Cooperation	Coordination	Integration
With networking	Formalised networking arrangements and organisational policy development	Incident-based processes, such as police faxbacks	Regular communication around clients and some common goals	Agreed plans and protocols or a separately appointed coordinator	Single system with sub-units and cross-unit accountability

(Source: Wilcox, 2010 in Breckenridge et al., 2015).

1.5.3 What collaborative practice is

Collaborative practice is when different services work together to support families and work towards safety for victim-survivors. Collaborative practice will look different for each family or client and can involve making referrals, sharing information, interagency meetings, case coordination/joint case management, joint-advocacy and sharing learning across sectors.

1.5.4 Who should practise collaboratively

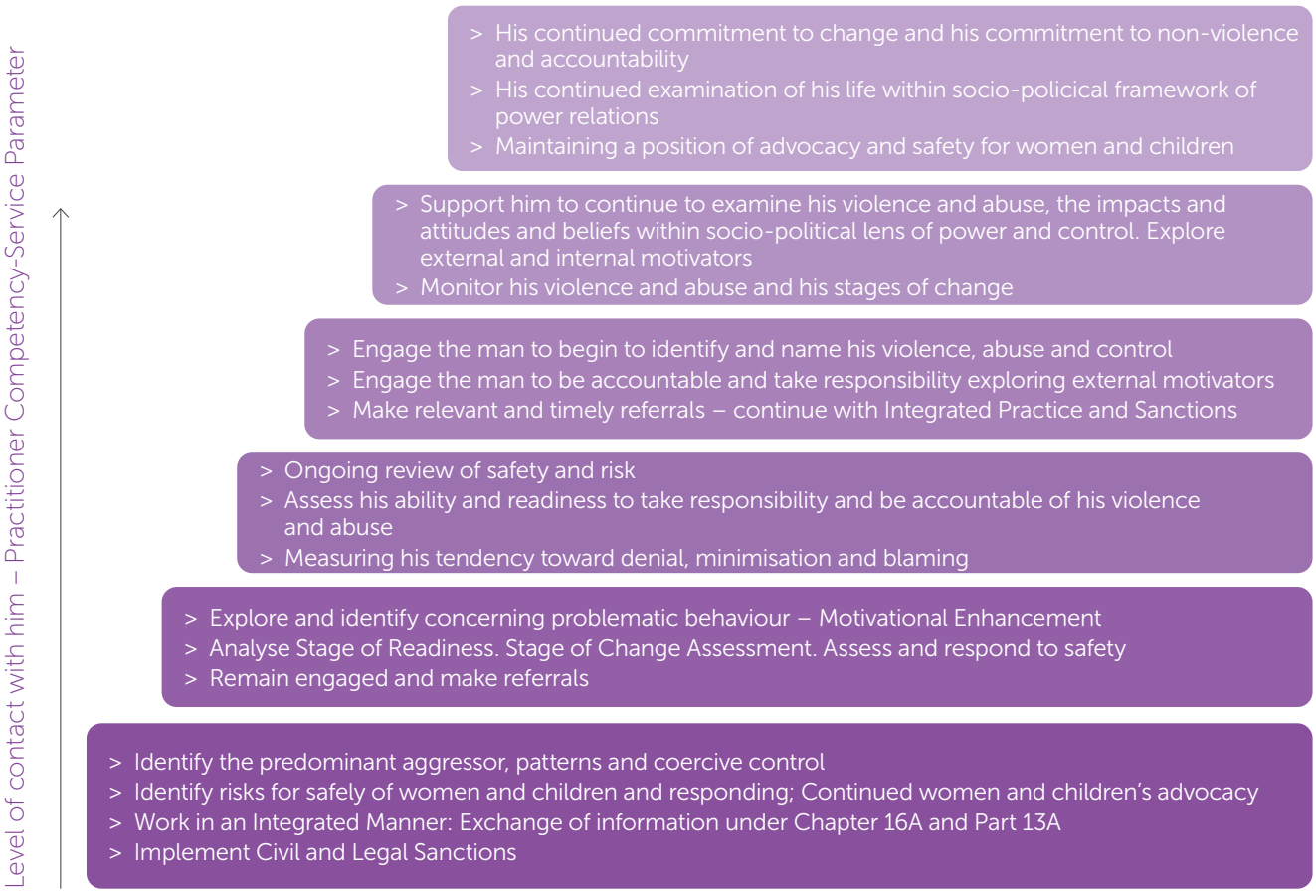
All practitioners should be supported to work within an integrated multi-agency framework. Collaboration operates differently across different levels of an organisation. For example, at a senior level this could include creating and signing agreements or MOUs between organisations, attending interagency meetings, sharing tools or resources and/or participating in Safety Action Meetings. At a practitioner level this could include attending interagency training, making warm referrals, exchanging information and/or providing wrap-around support for clients.

1.5.5 When collaborative practice should occur

Collaboration between services should occur consistently, at the organisation level and in relation to individual cases. Structural barriers such as a lack of time, staff or resources, along with a history of service providers being required to compete for limited funding, can limit collaborative practice. Organisations must work deliberately and strategically to continually improve and create a culture where multi-agency integration is the norm.

The DFV Perpetrator Engagement Matrix below (Figure 5) was developed by NSW Health ECAV in 2019, for its introductory course providing training in basic skills for non-specialist services to respond to perpetrators of DFV. The matrix facilitates practitioner reflection on their role/s, responsibilities, competencies and service scope when responding to men who use violence. The matrix allows practitioners to identify and define their engagement in an integrated response to risk and safety.

Figure 5: DFV Perpetrator Engagement Matrix



Education Centre Against Violence

NSW Government Health

1.5.6 Why collaborative practice is important

Collaborative practice facilitates a joined-up system response which is consistent with best practice. It allows for risk to be held, monitored and managed across the service system, rather than just sitting with one service. This approach is vital as DFV is a complex issue and it is not possible for any one service to meet the diverse support needs of all family members.

Collaboration has a range of benefits:

> increases efficiency by utilising resources, sharing information and minimising duplication
> establishes a shared understanding of violence and risk across agencies
> ensures cohesive and comprehensive responses to victim-survivors
> facilitates responsive and prompt decisions
> offers a broader range of services to families impacted by violence
> provides multiple entry points for people to access support
> improves professional respect, knowledge base and service provider relationships (Brekenridge et al., 2016).

1.5.7 How to practise collaboratively

Although it is the ideal approach, collaborative practice is not easy to achieve. This is because it involves commitment across sectors and within organisations, allocation of resources, development of trust, and sound processes for regular communication and feedback.

A range of challenges can hamper collaborative practice:

> power imbalances between agencies
> lack of common ground between perspectives and disciplines
> communication problems between and across services
> unsustainability due to resource limitations
> loss of specialisation and tailored responses (Breckenridge et al., 2016).

Collaborative practice is most effective when there is an understanding of what other services can and cannot provide, and when trust is built across the sector. The ANROWS-funded PATRICIA Project identifies three domains as critical for collaborative practice between DFV and child protection services. However, these findings can be extrapolated to include collaboration across the broader social services sector:

1) an integrated service focus that involves all key stakeholders, ensures there is a shared language, and that all relevant information sources are available to make good and safe decisions
2) democratising practices that ensure all voices are heard equally within the partnership and that there is meaningful representation of diversity
3) ensuring sustainability of the collaboration by clearly outlining expectations via cross-agency service protocols and having support of leaders, funding and accreditation bodies (Connolly, Humphreys & Healey, 2017).

'Domestic and family violence is in every postcode and community. Preventing violence, understanding violence and improving responses to violence remains a cross cutting national issue and a shared challenge that no community, sector or system can achieve alone. Every response matters. Any time. Every time. Every person and any community.'

– Insight Exchange, 2020.

1.5.8 Response/action pathways

Collaboration is supported at an organisation level via:

> policy and procedures that outline commitment to collaborative practice and how this is supported and resourced across the organisation
> mapping key stakeholders and organisations
> establishing/reviewing/renewing formal and informal relationships with key stakeholders and networks that articulate how collaboration occurs
> embedding collaborative practice in staff position descriptions
> providing staff with time, resources, induction and training to undertake collaborative practice and attend interagency meetings
> participating in Safer Pathway as required
> making referrals and sharing information as required with key stakeholders involved in supporting families
> participating in multi-agency risk management.

The RSSF **Risk assessment tools and companion resources** support services to engage in collaborative practice.

1.5.9 Practice tips

Beginning with the first contact with a victim-survivor or user of violence and continuing throughout the entire service delivery, practitioners should be alert to unmet needs and consider what supports or resources may benefit them.

Practitioners should be guided by feedback from the victim-survivor or person using DFV regarding what they perceive as the most important needs that should be addressed first. In some circumstances, practitioners may need to provide guidance when prioritising needs, particularly if the person's insight or judgement appears to be impacted by trauma, mental health issues, a current crisis or other barriers.

1.5.10 Considerations for diverse communities

Building deliberate relationships with services that specialise in supporting various minority and/or vulnerable groups is an essential component of effective integrated multi-agency DFV responses.

1.5.11 Related resources and tools

> **Information exchange template** (RSSF part three)
> PATRICIA Project – *A Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: Bridging the Research and Practice Divide* (Connolly, Humphreys & Healey, 2017; refer to Appendix D)
> Community Housing Industry Association NSW – *Working with Perpetrators of Domestic and Family Violence* toolkit (refer to Appendix D)
> More information on tools and resources: contact **rssf@ntv.org.au**

'When a person experiencing domestic and family violence reaches out it might be the first, only or last time they seek support.'

– *Workplace Responses*, Insight Exchange, 2020.

2.1 Structured risk assessment

Note: This section applies to SMFVIs, such as MBCPs. It builds on the practice guidance outlined above.

2.1.1 Intent

Structured risk assessment with men who use violence is advanced practice and should be undertaken by practitioners who have a strong foundational understanding of the causes and context of DFV, and the circumstances that contribute to a person's choice to use violence, as well as the skills to engage safely with men who use violence. Structured risk assessment guides the practitioner to assess the level or 'seriousness' of risk posed by a user of DFV towards an adult or child victim-survivor. This information can inform a risk management strategy to minimise the risk of harm posed by the user of violence, to support their readiness to change and desist from violence, and to inform safety planning with adult and child victim-survivors.

2.1.2 Introduction

The pathways men who use DFV can take to arrive at a MBCP are not linear and can involve many 'stops and starts' (Vlais et al., 2017). Attendance can be 'voluntary' through encouragement from friends/family/(ex-) partner or trusted services, or it can be mandated by the court. Once engaged with a service providing MBCPs, structured risk assessment and management can occur. Structured risk assessment allows for contextual risk analysis and the development of nuanced and targeted risk management responses.

2.1.3 What structured risk assessment is

Structured risk assessment addresses 'all evidence-based risk factors, including serious risk, current and historical experiences of family violence, and other factors relevant to an individual's needs and barriers' (State of Victoria, 2018).

Structured risk assessment identifies risk posed by the perpetrator, via thorough and nuanced analysis of patterns of behaviour and intersectional factors, and underlying thoughts, feelings and beliefs that are known drivers of gendered and patriarchal DFV. It identifies contributing factors and the role they play in exacerbating the likelihood and intensity of potential violence, in order that they be effectively managed.

2.1.4 Who should do a structured risk assessment

Structured risk assessment should be undertaken by specialist practitioners or services, such as:

> registered MBCPs

> Men's Referral Service – when they have access to pertinent risk and safety information to inform the assessment, for example, via the Automatic Referral Pathway

> independent practitioners or mental health and alcohol and other drug services who play a key role in engaging and providing services to men who have used violence. To undertake a structured risk assessment these practitioners must:
  - be trained, competent and qualified in working with perpetrators
  - be familiar with current practice standards and guidance in alignment with the RSSF
  - have sufficient contact and rapport with men to gather information to assess risk
  - be substantially connected to specialist women's DFV support and risk management networks within their local community, and
  - have regular clinical supervision from a supervisor with current knowledge and skills in male family violence intervention or MBC practice.

2.1.5 When a structured risk assessment should occur

Structured risk assessment should occur at the earliest opportunity following disclosure of 'use' of DFV by the service user, or when you become aware of information that confirms the person is using DFV (for example, from another service, the victim-survivor or a Women's and Children's Advocate). Structured risk assessment and management is an ongoing process of monitoring to build a comprehensive picture of risk over time. Risk assessment should be undertaken when new information about the user of violence is gathered and shared, as well as at regular intervals in the program such as during Risk Reviews.

2.1.6 Why do a structured risk assessment

A structured risk assessment should be undertaken to predict the likelihood and severity of future violence and to inform risk management and safety planning. Structured risk assessment contributes to case planning and safety and accountability planning, which are tailored to the individual risk factors, patterns of behaviour, criminogenic needs, other dynamic risk factors and aspects of the man's life that impact motivation, engagement and learning.

Structured risk assessment is the start of what is intended to be a long-term engagement between the service system and the person using DFV to keep him in view and manage his risk, apply systemic accountability measures, and encourage personal responsibility for his behaviour. Structured risk assessment (and risk management), which centralises the wellbeing and safety of victim-survivors, shifts the responsibility for managing perpetrator risk from victim-survivors and places it appropriately within the government and non-government service system.

2.1.7 How to do structured risk assessment

The RSSF includes two risk assessment tools (refer to part three) to be used by MBCP practitioners or practitioners that have the skills outlined in section 2.1.4:

1. **Risk assessment tool – user of violence**
2. **Structured risk assessment tool.**

A word of caution about relying solely on risk assessment tools: Categorical ratings of a person using violence's risk should be made with caution as there are likely to be gaps in the information available to practitioners. Further, risk levels change over time; therefore, any assessment of risk is not a fixed determination. When practitioners receive or obtain information regarding a family impacted by violence, the risk assessment should be reviewed, the case plan adjusted accordingly, and relevant collaboration partners informed in accordance with information sharing protocols.

The **Risk assessment tool – user of violence** is completed based on information gathered from intake and assessment interviews with users of violence.

Structured risk assessment with a user of violence should be predicated on a positive client-worker relationship and rapport. Establishing a relationship with a person is more important than the implementation of any tool and is a key factor in creating an environment conducive to behavioural and attitudinal change (ANROWS, 2020). The risk assessment tools are **not designed to be used as a checklist**. Rather, risk assessment should be conducted using a conversational style, asking curious and open questions, with active follow-up regarding disclosures and identified risk factors, whilst being mindful to avoid collusion. The tools should be used as a scaffold to plan the conversation with the user of violence, including discussing the limits of confidentiality and information sharing policy.

Following an interview (or series of interviews), the practitioner uses the **Risk assessment tool – user of violence** to assess the man's behaviour against a range of evidence-based risk domains, indicating the level of risk and whether that risk is imminent. This produces a Preliminary Risk Rating. Descriptions of each risk domain are included in RSSF part three (**Practical guide to risk domains**), which serve to guide practitioners and are particularly helpful for those who are new to MBCP work.

The **Structured risk assessment tool** is completed soon after the **Risk assessment tool – user of violence** and after any urgent safety actions are completed (see RSSF part three: **Risk action matrix**).

The **Structured risk assessment tool** combines information gathered from the **Risk assessment tool – user of violence**, with information from victim-survivors and/or Women's and Children's Advocates, and other stakeholders (see section 1.4). Once combined, the data is analysed to establish a Comprehensive Risk Rating for future use of violence by the perpetrator and to inform the level of threat to adult and child victim-survivors.

The **Structured risk assessment tool** includes analysis of **Risk, Needs and Responsivity** factors, and supports case planning and program engagement.

An important note about file storage: The Structured risk assessment tool should not be stored in the man's file. It should be saved either as a separate file, or in the victim-survivor's file. This is to protect the information gathered from a range of sources, in particular information from/about the victim-survivor, being shared with a perpetrator or his legal representative. As well as a breach of the victim-survivor's confidence and privacy, if the perpetrator discovers that a victim-survivor has disclosed details of his abuse, he may retaliate.

2.1.8 Considerations for diverse communities

Every person inhabits and is shaped by multiple identities, situations or experiences. Applying an intersectional lens means considering a person's whole multi-layered identity and life circumstances to build a greater contextual understanding of the risk they pose, and appropriate risk management and engagement strategies.

People may experience service barriers or discrimination based on their identity, which may in turn influence how they experience, understand and talk about their use of violence. Service providers engaging, assessing and managing risk of users of DFV and victim-survivors must understand that discrimination and structural inequality create barriers to seeking help and building trust with services.

Furthermore, some intersectional identity factors can create vulnerability for victim-survivors and their children, which may be exploited by users of violence and exacerbate the likelihood, severity, frequency and impact of coercive controlling violence.

2.1.9 Intersection of traumatic brain Injury and use of domestic and family violence

Research has found that significant numbers of men attending treatment clinics in the United States or New Zealand for their use of DFV had a history of traumatic brain injury (TBI; Farrer, Frost & Hedges, 2012).

What is a traumatic brain injury?

A TBI is defined as 'an alteration in brain function… caused by an external force' (Menon et al., 2010). Common causes of TBIs in NSW are road crashes, falls, assaults and sporting injuries. The severity of a TBI can be classified as mild, moderate or severe. Mild TBIs, also referred to as a 'concussion', are the most common. At the other end of the spectrum, in the most severe cases, a small group of people will never regain consciousness. Some people who play sports, or who live in abusive environments, may experience multiple knocks to the head over the course of their lives.

A TBI can result in a range of physical, cognitive and emotional-behavioural impairments. Physically, there may be problems with sight, coordination, or walking. In terms of cognition, problems can be encountered with attention, memory and higher order executive functions such as planning and judgement. Emotional-behavioural changes can include depression, increased irritability and aggression, poor self-awareness and reduced empathy. Depending on the severity and location of the injury, some of these effects resolve over time (usually within the first year post-injury), but in many instances, these impairments are permanent.

In NSW, over 6,000 people are admitted to hospital every year with a TBI (Pozzato et al., 2019). Males are three times more likely to sustain a TBI than females. The highest rates are among people aged between 15 and 29 years, and then after 70 years.

What is the connection between traumatic brain injury and use of domestic and family violence?

If frontal lobe control mechanisms are impaired as the result of a TBI (for example, reducing ability to regulate limbic system impulses), minor everyday provocations can cause aggressive or otherwise socially unacceptable responses. Irritability leading to aggression may be a direct consequence of the damage to the brain, but it may also be the result of an exacerbation of pre-injury aggressive traits (Ylvisaker et al., 2007). In NSW, this impact of TBI on behaviour is illustrated in an assessment of 507 people with a moderate or severe TBI who were community-dwelling outpatients of the NSW Health Brain Injury Rehabilitation Program. Over half the people (53%) were classified as having displayed 'challenging behaviour' over the previous 3 months.

When challenging behaviours occur within the context of the family home, it increases the risk of intimate partner violence and can be worse among clients who have a pre-injury history of alcohol abuse, or other post-injury mental health problems. The consequences are significant and may include relationship breakdown, loss of employment, social isolation and increased contact with police and the criminal justice system.

Screening for a history of traumatic brain injury

The most common way to determine whether someone has a history of TBI is with a screening tool. The Ohio State University TBI-Identification (OSU-TBI ID; Corrigan & Bogner, 2007) is the most commonly used screening tool internationally and has been incorporated into the **Risk assessment tool – user of violence**. The brief version of the OSU TBI-ID includes three questions. The first question determines whether the person has a lifetime history of a TBI. If a participant answers 'No' then a TBI is unlikely (based on their self-report) and there is no need to ask the other screening questions.

For the people who answer 'Yes', there are two additional questions. The second question helps to identify the **most severe TBI** sustained by the person. The severity of the injury is classified by the length of time that the person was knocked out or lost consciousness (less than 30 minutes, a MILD TBI; between 30 minutes and 24 hours, a MODERATE TBI; 24 hours or longer, a SEVERE TBI). The third question determines the age at which someone first sustained a TBI. This is important to know, as people who sustain injuries at a younger age (for example, as a child, adolescent, or in early adulthood), have an increased chance of displaying more challenging behaviours.

Screening for traumatic brain injury

All men should be screened via the OSU TBI-ID when being assessed for eligibility for a MBCP. If it is suspected that a man may have a TBI (i.e. the participant answers yes to the first screening question of the OSU-TBI-ID), then they should be referred to a general practitioner for a more comprehensive assessment. When making this referral, service providers should ask for an assessment of self-reported head injury as well as recommendations to the referring service.

Program responsivity to users of violence with a traumatic brain injury

People with a history of TBI may still be able to take part in an MBCP but may need additional support to engage in the program. The following support strategies (Table 3) are commonly used in the field of TBI (Gallagher, McLeod & McMillan, 2019). Many of these are common sense and are likely to be helpful, particularly for men with moderate to severe injuries.

Table 3: Support strategies for program delivery with people with traumatic brain injury

Impairment	Strategies
Attention Concentration Alertness Fatigue	> Provide breaks for rest during session > Shorten length of session (assume < 50 minutes) > Increase frequency of sessions (more than once per week) > Provide a clear session plan with cues to keep people on track > Alternate between cognitive techniques and physical/behavioural exercises
Communication	> Use clear structured questioning > Limit the use of lengthy, open-ended or multiple questions > Incorporate visual resources into the session to enhance comprehension and draw attention to important points > Interrupt tangential speech and refocus (sometimes this can be an agreed-upon strategy)
Memory Learning	> Spaced retrieval of key concepts (linking back to earlier in the session) > Multimodal presentation – verbal and visual > Writing key points/diagrams/brainstorming on whiteboard, get client to take photo of the results with their phone > Recording session content, for example, using voice memo app on smart phone (suitable for individual intervention only)

In some cases, the man may be deemed unsuitable to participate in a group due to more severe issues with attention, memory and so forth. In these cases, working with men on a one-to-one basis may be more effective.

Intersection of traumatic brain injury and domestic and family violence for victim-survivors

For victim-survivors experiencing DFV, TBI can be caused by physical violence that involves one or more of the following events: assault to the head, neck or airway (involving a weapon or bodily force); vigorously shaking a person; hitting someone with a vehicle; causing someone to fall; drowning; poisoning; suffocation or strangulation (DVSM, 2018b). Non-lethal strangulation/choking is also a high-risk indicator of future lethality and is a powerful method by which perpetrators exert control over victim-survivors (Toivonen & Backhouse, 2018). TBIs can occur acutely at the time of assault or be sustained through cumulative harm over a longer time.

TBIs in victim-survivors can often be misunderstood or overlooked (DVSM, 2018b). It is critical to provide a safety response where physical violence such as that outlined above has been disclosed or is suspected, regardless of whether physical injury is evident. DVSM – Insight Exchange undertook a project aimed at improving awareness about the intersections between TBI and experiences of DFV. This project aimed to improve responses to the safety and wellbeing needs of victim-survivors with a TBI both at the acute stage, and as a long-term health impact of DFV. It includes a map of response and service pathways (in Western Sydney, NSW). Refer to Appendix D for more information about the project.

More information about traumatic brain injury and intimate partner violence

The NSW Health Brain Injury Rehabilitation Program is a network of 12 specialist adult brain injury services located across metropolitan and rural NSW. Refer to Appendix D for links to more information, including where to find your nearest centre for advice about further assessment.

Additional advice and consultation can be sought from:

> Brain Injury Australia – the national peak advocacy organisation representing people living with a brain injury: **(02) 9808 9390**

> Synapse NSW – provides a range of specialist services for people who have a brain injury or disability, carers, family members and organisations: **1800 673 074.**

Refer to Appendix D for links to further information.

2.1.10 Related resources and tools

> **Risk assessment tool – user of violence** (RSSF part three)

> **Structured risk assessment tool** (RSSF part three)

> **Practical guide to risk domains** (RSSF part three)

> **Risk action matrix** (RSSF part three)

> **Information exchange template** (RSSF part three)

> *Compliance Framework for Men's Behaviour Change Programs*

2.1.11 Response/action pathways

When undertaking a structured risk assessment, you may need to initiate an immediate risk response (see **Risk action matrix** – RSSF part three). This may include:

> referring victim-survivor/s to Safer Pathway, in partnership with the Women's and Children's Advocate

> sharing risk-related information with relevant parties in accordance with Part 13A of the Crimes (Domestic and Personal Violence) Act 2007 (see section 1.4)

> following child protection mandatory reporting protocols, in consultation with the Women's and Children's Advocate

> contacting and collaborating with statutory and other relevant parties including police, child protection, specialist women's DFV services, emergency services, Community Corrections, and Women's and Children's Advocates

> working with users of violence towards de-escalation and containment of immediate risk.

The completion of both the **Risk assessment tool – user of violence** and the **Structured risk assessment tool** inform case planning, safety and accountability planning, and collaborative multi-agency case coordination (see section 2.7).

2.1.12 Practice tips

Structured risk assessment should consider:

> the context of structural patriarchy and gender inequality within which DFV occurs, including the importance of an intersectional understanding of DFV, and the impact of historical and ongoing oppression and discrimination on marginalised groups

> a tactic pattern-based understanding of DFV that encompasses historical and ongoing strategies of coercive controlling violence, patterns of service engagement or disengagement, and responses to statutory interventions

> that risk indicators, dangers and threats cannot be accurately assessed without contact with victim-survivors or their advocates

> aspects of adult and children victim-survivors' identity that may also be targeted by the perpetrator to further isolate, dominate and entrap the family

> less overt tactics the perpetrator may be using to enforce control and compliance in adult and child victim-survivors

> the ways that the adult and child victim-survivors resist the violence and take action to restore safety and dignity; this may involve not challenging the user of violence

> contextual understanding of the adult and child victim-survivors' experiences in light of DFV and intersectional identities; seeking to truly understand from a cultural or situational perspective

> how intersectional identities may be drawn on as strengths and mitigating factors for risk.

Structured risk assessment identifies whether the risk of harm is:

> **imminent**, for example, immediate risk of personal harm or significant property damage that requires an emergency response

> **a specific risk situation**, for example, risk of personal harm, property damage, harm to an animal, breach of court orders or bail conditions in the short-term (i.e. the following week); this requires a prompt police and/or child protection response

> **a non-specific risk situation**, for example, risk that a family member's wellbeing will be impacted by the man's use of violence over a longer period (i.e. beyond one week), which may require a child protection or other support system response.

While nuance, 'gut instinct' and what is unsaid are important elements in **Structured Professional Judgement**, they should add to rather than substitute detailed risk assessments based on evidence-based risk factors.

Dignity-driven practice acknowledges:

- that users of violence engage in **patterns of coercive control** to dominate and entrap adult and child victim-survivors;
- that users of violence anticipate resistance and take deliberate actions to oppress such resistance, exposing the **intentional nature of each act of violence**; and
- therefore, an **incident-based interpretation of DFV increases risk for victim-survivors** as it fails to account for the frequency, forms and severity of the violence. Viewing DFV as one-off incidents rather than an ongoing pattern of behaviour allows the perpetrator to subvert or avoid a system response and maintain or accelerate other, threatening and potentially high-risk controlling tactics towards victim-survivors (DVSM, 2018a; Department of Communities and Justice, 2017).

While victim-survivors are generally in the best position to know what is likely to compromise their safety, they can sometimes be unrealistic or overly optimistic about the likely impact of a MBCP on men's behaviour, or underestimate the perpetrator's dangerousness or risk of using violence. Furthermore, love, loyalty, fear of retaliation and self-blame might also result in victim-survivors' reluctance to disclose violence or reveal their level of fear (Department of Attorney General and Justice, 2012).

Engaging a user of violence in structured risk assessment

All interventions with the user of DFV carry risk and have the potential to generate outcomes along a continuum. On one end, the man may believe that you agree with him, confirming his worldview. On the other end, he may perceive judgement and feel shame and anger. Both ends of the intervention continuum can impede engagement and influence risk. Consideration must be given to holding a safe intervention position with a perpetrator, where the practitioner is careful to hold a balanced approach between **accountability** and **compassion**, being strategic and mindful not to **collude** or use **coercion**. Occupying a central and balanced approach on the continuum requires **maintaining curiosity and neutrality**, whilst being **transparent about safety and accountability**.

Some users of violence invite practitioners to **collude with their narrative** and description of their needs and circumstances, by agreeing with their **minimisation, denial, or justification of their use of violence and coercive control**. Observing narratives and behaviours of denial, minimisation, justification and blame is an important aspect of risk identification and assessment. It provides some insight into the user of violence's readiness to acknowledge their use of violence and willingness to start accepting responsibility and working towards behaviour change.

Practitioners must remain alert to the potential for system-generated risks like collusion, coercive practice, and any retaliatory action that perpetrators take towards victim-survivors in response to being held to account by the service system. Remaining centred on the continuum can be challenging and should be supported by supervision and reflective practice, examining practitioner experiences of and responses to power and gender, one's own position of power and privilege in society, and personal biases in relation to diversity.

Centring adult and child victim-survivors' experiences in risk assessment

Practitioners must also remain alert to their own unconscious biases that may create blind spots or influence how adult and child victim-survivors respond to service responses. For example, a blind spot that may impact or exacerbate risk is the perception of the family's situation as relationship conflict rather than identifying perpetrator patterns of power and coercive control. Practitioners must consider how their responses **build trust**, how they hold victim-survivor experiences close in the work, and how they **participate in building confidence in a system that doesn't collude with the user of violence and acts to keep victim-survivors and their children safe**.

'Perpetrators of violence anticipate, suppress and overpower resistance. Whenever people are subjected to violence, they resist. People resist violence and abuse overtly and covertly in creative, resourceful, careful, clever, cautious ways to uphold their dignity and stay safe. And to protect the people they love.'

– *My Dignity – My body is mine*, Insight Exchange, 2020.

2.2 Risk management

2.2.1 Intent

The primary purpose of risk management is to increase safety for adult and children victim-survivors, by closely monitoring the risk level of users of violence and implementing measures tailored to their specific risk profile. Risk management that is coordinated and collaborative across the service system can remove the burden from the adult victim-survivor to be the only one monitoring his risk levels, which allows space for her to reclaim freedom and dignity, and sends the message to the user of violence that he and his behaviour are visible to the service system.

2.2.2 Introduction

The ANROWS *National Risk Assessment Principles for domestic and family violence* identify an integrated, systemic response to risk assessment and management as critical to the safety of victim-survivors (Backhouse & Toivonen, 2018). The aim of risk management is to, at best, support the user of violence to stop their violence and coercive controlling behaviour. At a minimum, the aim is to minimise opportunities for them to use violence or coercive control without detection or consequences. Risk management requires a collaborative approach whereby service providers working with family members share information and respond in ways that weave together to create a safer environment.

2.2.3 What risk management is

Risk management is any action or intervention taken to reduce the level of risk posed to adult or child victim-survivor/s by the person using DFV. It is a coordinated set of strategies and actions aimed at enhancing the safety of those experiencing DFV and reducing the likelihood of further harm being perpetrated. Risk management with the person using DFV provides an opportunity to engage and ensure personal responsibility for ending the violence is located with the person using violence, and not with the victim-survivor.

Risk management includes:

- responding to the specific risks identified through the risk assessment tools, including immediate responses to risk (see **Risk action matrix** – RSSF part three), and spikes in acute dynamic risk (for example, impending Family Court hearing)
- working with the user of violence to develop risk mitigation and safety planning strategies, and updating these plans if the risk has changed or escalated (see **Companion resources** – RSSF part three)
- where safe and appropriate to do so, engaging with adult victim-survivors, or collaborating with Women's and Children's Advocates, to ensure safety and wellbeing is supported
- coordinating or contributing to a multi-agency response, including collaborating with other services to share relevant information and provide active referrals.

Risk management for adult victim-survivors

In NSW, Safer Pathway is a state-wide platform for risk assessment and referral that provides a consistent pathway and set of responses for victim-survivors of DFV. The key components of Safer Pathway are: a DVSAT to better and consistently identify the level of domestic violence threat to victims; a Central Referral Point to electronically manage and monitor referrals; and a state-wide network of Local Coordination Points that facilitate local responses and provide victims with case coordination and support. Serious threat and high-risk cases are referred to Safety Action Meetings to coordinate an integrated response to the immediate safety needs of victim-survivors (NSW Government, Women NSW, 2017).

When risk to victim-survivors is assessed as 'at threat' and the threshold for a Safety Action Meeting is not reached, a collaborative, multi-agency response is nonetheless required to respond appropriately to DFV. Victim-survivors receive support from a range of services to meet their needs; these services work collaboratively, sharing information with the consent of victim-survivors to guide appropriate safety responses.

Safer Pathway is victim-survivor-focused and managed by WDVCAS.

Collective responsibility for risk management

As MBCPs are often involved with a user of violence for many weeks or months and come to know his ways of thinking, patterns of behaviour, life and contextual circumstances, they are in a unique position to take a leadership role in coordinating and driving multi-agency risk management processes. However, they alone do not hold the responsibility for risk management. A multi-agency response involves collaborators in managing risk, including, for example, Men's Referral Service, law enforcement, child protection, mental health and alcohol and other drug services, and specialist DFV services.

'Robust information-sharing processes and multi-agency risk management approaches, which include the central involvement of victim services, are required when the decision about how to address the spike in risk cannot or should not be made by any single service alone' (Centre for Innovative Justice, 2019a).

Identifying and responding to spikes in risk due to acute dynamic risk factors, such as a recent separation, an impending court hearing, or escalation in substance misuse, requires a coordinated multi-agency response. MBCPs can lead this response, in partnership with specialist women's and children's services, to place a 'protective bubble' around the adult and child victim-survivors, including safety planning and any other interventions required (Centre for Innovative Justice, 2019a).

A crucial element of risk management is **containment** of users of violence via strong and consistent accountability measures, which are often legal sanctions. Civil and criminal legal interventions include criminal charges and convictions, ADVOs, Community Corrections orders, supervision, and imprisonment.

In NSW, the Automatic Referral Pathway is a risk management intervention where police automatically refer men who use violence to Men's Referral Service. Men's Referral Service makes three attempts to contact him to offer a single-session counselling and referral service within 48 hours following a DFV 'incident' attended by police.

Risk management strategies within MBCPs

MBCPs have developed the dual function of supporting the user of violence on a journey of behaviour change, and responding to and managing the risk they pose to those harmed by their use of violence and coercive control. The function of risk management can be fulfilled by MBCPs through strategies such as:

> safety planning (in response to immediate and ongoing risk)
> case planning (in line with **Risk, Needs and Responsivity** principles)
> safety and accountability planning (also known as an 'exit plan')
> risk reviews
> participating in or leading multi-agency collaboration including information sharing and active referrals.

See section 2.2.7 below for more information.

2.2.4 Who should participate in risk management

As with all interventions with men who use DFV, risk management is a collective responsibility shared by services engaged with the user of violence, or adult and child victim-survivors harmed by the user of violence. A range of services participate in risk management, including those services who have referred to the MBCP or are working alongside the MBCP, police, corrections, child protection, and other family services. Any service who holds the user of violence 'in view' has a role to play in contributing to risk management.

As identified by the Centre for Innovative Justice (2019a), the extent to which services are involved in risk management varies, from contributing information, scaffolding readiness to participate in programs, or leading multi-agency processes.

This practice guidance is for SMFVIs who can play a leadership role in managing risk and providing a coordinated response, with specialist DFV services and/or Women's and Children's Advocates at the centre.

2.2.5 When risk management should occur

Risk management is an ongoing process continuously informed by structured risk assessment. Risk management involves planning, coordinating, documenting and implementing a broad range of strategies that together, help to reduce the risk of harm posed by the user of DFV, whilst increasing safety for adult and child victim-survivors.

A multi-agency risk and safety response should be initiated following the completion of a structured risk assessment. The appropriate response will vary according to the level and type of risk (see section 2.2.7 on **Risk, Needs and Responsivity**).

2.2.6 Why undertaking risk management is important

In line with NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs*, victim-survivor safety is the core priority of all risk identification, assessment and management frameworks, removing the burden of responsibility from victim-survivors to manage the risk that the user of DFV poses to their safety. Men must be held accountable for their use of violence through an integrated service response.

Risk management aims to:

> enhance victim-survivor safety by managing risk through multi-agency collaborative practice
> develop safety plans with adult and child victim-survivors, or support their development with specialist women's services/Women's and Children's Advocates
> support accountability measures to prevent future use of violence, including reporting crimes or threats of crimes, and child protection mandatory reporting
> recognise and respond to individuals' diverse needs and backgrounds, which heighten the likelihood, impact or severity of violence and create additional barriers to seeking and obtaining support
> remove barriers for families to participate in services
> enhance motivation to desist in the use of violence and increase internal motivation towards long-term behaviour change.

2.2.7 How to undertake risk management

Risk, Needs and Responsivity is the framework used in NSW for MBCPs and is the foundation for managing risk by providing differentiating responses to individual users of violence. Rather than a one-size-fits-all approach that focuses on a man attending a minimum number of group sessions, the **Risk, Needs and Responsivity Model** is based on tailored interventions. The model asks programs to deliver different levels of intervention according to the identified level of **risk** (low, medium and high) and not to mix risk-level participants within the same program or cohort of participants.

The aim is to support engagement with the program by addressing his specific **needs** (for example, alcohol and other drugs, mental health, acquired brain injury, and social and peer identities) while providing program delivery that will enhance engagement and learning **responses** (for example, consider language or cultural needs, diverse abilities and literacy).

Criminogenic needs are either static or dynamic risk factors that increase the risk of criminal behaviour. These include anti-social personality traits, pro-criminal attitudes, substance abuse, poor family/intimate-partner relationships, social supports for crime, low satisfaction or poor performance at work/school, and a lack of pro-social activities (NSW Department of Justice, 2018a). Criminogenic needs inform risk assessment, MBCP design and delivery, and the development of individual case plans and safety and accountability plans that respond to the user of violence's specific needs and aim to decrease barriers to engagement with the MBCP.

Programs are tailored based on a structured risk assessment that includes an inventory of stable dynamic risk factors (attitudes/beliefs, alcohol and other drug and gambling use), the dynamic variables (loss of job, pregnancy, separation) and intersectional factors that can contribute to future use of violence. If not addressed, these risk factors and variables may limit his capacity to change his violent behaviour (Colorado Domestic Violence Offenders Management Board, 2016). Intersectional factors may require secondary consultation with or inclusion of a specialist service in a multi-agency risk and safety response.

Risk assessment and management with men who use violence that uses a **Risk, Needs and Responsivity** approach considers a broad range of information, including:

- **static risk factors** (for example, history of violence or age of perpetrator)
- **stable dynamic risk factors** (for example, substance abuse, attitudes towards women, sense of entitlement and other violence-supporting narratives)
- **dynamic variables** (for example, loss of job and housing, Family Law Court rulings, and abuse of alcohol and other drugs)
- **patterns of coercive controlling behaviour** (for example, multiple repeated behaviours that intentionally instil fear, guilt and intimidation, ensuring victim-survivor compliance with perpetrator demands, and physical, emotional, verbal, sexual or financial abuse)
- **conditions of vulnerability** (for example, socio-economic disadvantage and discrimination).

Over time and changing circumstances, program flexibility allows for adjustment to each case plan based on individual risk indicators. For example, a man who initially presents and is categorised as low risk may have a case plan that states he is to complete a core group program. It is then discovered that in a previous relationship he attempted to strangle a former partner. A risk review is conducted, placing him in a high-risk category. In addition to a multi-agency risk management response, his case plan is amended so that he repeats modules that examine ownership of and responsibility for behaviours and attitudes, and the impacts of violence on victim-survivors. His safety and accountability plan is also reviewed to incorporate in-depth understanding of victim-survivor experiences and strategies to ensure future responsibility and accountability.

The process is not always linear; however, the diagram below (Figure 6) outlines the steps featured in a flexible and tailored response. **Risk monitoring occurs at all stages of the process and through every engagement**.

Figure 6: Risk management response

A tailored response to a user of violence can have a range of features. Examples include:

> phone-based contact for immediate responses to users of violence assessed as high risk and/or those in remote areas
> modulated group program as a core component of the overall behaviour change intervention
> option to repeat all or some of the group modules as assessed, to respond to individual risk factors, risk categorisation and needs
> low-risk users of DFV **not** mixed in groups with medium- and high-risk clients
> flexibility to re-classify perpetrators into a higher risk category as required
> ongoing and nuanced risk review and adaptation of risk responses to match risk and safety concerns at all stages of the program
> individual sessions preceding and/or during group program in response to individual needs
> specialist services (internal or external referral) for issues such as alcohol and other drugs, mental health, homelessness or gambling
> flexible and targeted responses to the unique needs of individuals from diverse communities such as First Nations communities, people with disabilities, CALD groups, and those in LGBTIQ relationships
> individual response to needs relating to literacy, languages other than English, learning styles, disability and community-oriented healing work
> case planning and flexibility regarding practical issues affecting his attendance such as transport issues, learning and literacy needs.

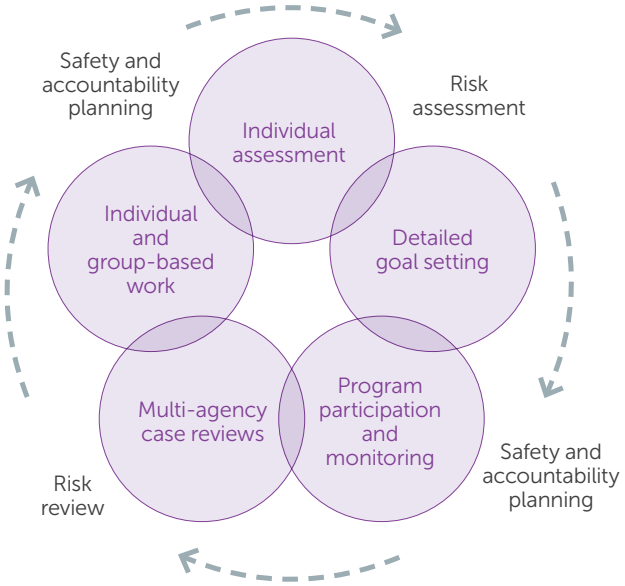
2.2.7.1 Case formulation, planning and monitoring

Case formulation and planning are core elements of tailoring programs to each individual perpetrator in alignment with the **Risk, Needs and Responsivity** approach. This work is vital for ongoing risk monitoring and multi-agency risk and safety responses. However, unpacking specific behavioural patterns and events focusing on how they impact on family functioning can require significant practitioner time and service resources, which are not always available. Practice in the NSW context is still developing in line with a growing knowledge and evidence base, and resourcing of the MBCP sector.

The **Case plan template** (RSSF part three) supports service providers to work with men who use violence to develop goals; address dynamic risk factors that contribute to the severity, frequency and intensity of violence and coercive controlling behaviour; and address barriers to engagement with services. The case plan is informed by the structured risk assessment.

The diagram below (Figure 7) demonstrates the components of case formulation, planning and monitoring, and highlights that assessing risk does not occur just once. Rather, it is regularly reviewed and followed by actions to address risk.

Figure 7: Elements of case planning



'Your response can be of immense help. How you respond to me when I share with you, and in the time that follows, matters significantly to me. I might tell you parts of my experience to test out how safe I am with you and to explore how you react or retreat. I'll be looking to see:

> *what you think of what I have shared*
> *that you believe me*
> *what you think of me and if/how that changes now that you know more about me*
> *whether you give more weight to what the person abusing me says than what I say*
> *whether the person abusing me will be able to influence your thinking and make you think differently about me*
> *and what this means next.'*

– *Follow My Lead*, Insight Exchange, 2018.

2.2.7.2 Risk reviews

Risk management, like risk assessment, is not static and should be reviewed regularly. Risk review is intended as a mechanism for MBCP and multi-agency collaborations to stay abreast of risk issues, ensuring that responses to victim-survivors are timely, appropriate, fully informed, and coordinated, and that outcomes are monitored. Risk reviews are an important source of information for MBCP facilitators to develop risk-informed and responsive individual or group work interventions with men who use violence. Updated risk assessment, risk management and information sharing is done in a way that protects the safety and confidentiality of the victim-survivors, with MBCP facilitators tactfully weaving information obtained via Women's and Children's Advocates into interventions in a generic way. Risk reviews are documented by updating the contents of the **Risk assessment tool – user of violence** and/or the **Structured risk assessment tool**.

2.2.7.3 Safety and accountability planning

While safety and accountability plans prepare the man for the completion of the behaviour change intervention and aim to support a sustainable transition following the gains made during the program, ideally they should be developed early in the user of violence's engagement with the MBCP. The plan, developed with the user of violence, identifies potential risk situations and develops strategies to maintain safe and respectful relationships and parenting. The planning process should be oriented around the safety and wellbeing needs of those affected by the man's use of violence.

Safety and accountability plans further individualise program responses to the specific characteristics of each participant and form a component of the case formulation and planning process. The plans are developed by men to emphasise personal responsibility with support from a practitioner, in addition to identifying his own risk factors and developing strategies for self-regulation and management.

The process requires the client to consider and document the impacts of their behaviours on family members and others. The plan details these behaviours and the strategies to interrupt them, to increase accountability for family safety.

Sharing safety and accountability plans with relevant services collaborating in risk management is recommended as a way of maintaining strong networks of monitoring and support during and following completion of the program. Should people who use DFV have contact with the service system in the future, these plans can provide a point of reference for future risk management, case planning and further MBCP intervention if required. Safety and accountability plans may be provided to family members and others, where appropriate, who may also have a commitment to holding him accountable to the plan.

2.2.7.4 Women's and children's advocacy

Women's and children's advocacy (also known as partner contact) expresses the core purpose of MBC work; that is, to identify risks to the dignity and safety of victim-survivors and to work collaboratively with them to develop risk management and safety planning. It can be provided in-house by a team member, trained in supporting DFV victim-survivors, or by a victim-survivor specialist service through an agreement such as a MOU.

Resistance to violence is a natural and human response to the injustice and indignity of violence, abuse and coercion. Behaviour that would otherwise appear extraordinary; in the context of a history of abuse, controlling behaviours and violation; can be more clearly understood as resistance to violence, and an attempt to restore safety and dignity. Practitioners apply a strengths-based lens to acts of resistance from both adult and child victim-survivors of violence and abuse. **Acts of resistance are not to be portrayed out of context** as isolated actions, but as **responses in the context of ongoing patterns of violence, abuse, and control** (DVSM, 2018).

Services should seek to identify adult and child victim-survivor responses and resistance to the violence through a strengths-based lens, seeking to understand how their efforts can be interpreted as attempts to restore safety and dignity under fearful and dangerous circumstances. Services align their risk and safety responses with **victim-survivors' efforts to restore safety and dignity** through communicating understanding and validation of victim-survivors' situations and partnering with their safety efforts.

Victim-survivor advocacy is an assertive invitational outreach service where initial contact is sometimes made without prior client knowledge or consent, due to safety concerns. This requires sensitive contact and engagement to obtain informed consent and agreement regarding future contact and support.

Victim-survivor advocacy offers information about:

- the program's priority of adult and child victim-survivor safety
- their rights, including rights to safety, legal protection, support and information
- responses to intersectional needs where appropriate
- the prevalence and dynamics of DFV
- validating their experiences of the violence and normalising their responses
- the user of violence's responsibility for addressing their violence and coercive controlling behaviour
- what is involved in the man's participation in a behaviour change intervention and content of the program
- the limitations of MBCPs, including the real possibility that the violence may not stop, may change in form or that men may learn new ways to exert control

- victim-survivor support groups, services and resources
- trauma-informed parenting support where appropriate
- children's support services
- how the program provider will respond if:
  - a participant makes any threats
  - a participant breaches a court order
  - a participant commits an act of violence against the victim-survivor and/or their children
  - the provider becomes aware of additional information concerning risk and safety.

Ensure that all contact with victim-survivors is documented and risk review information is shared, with victim-survivor consent, in line with a multi-agency response, as outlined in section 1.4.

2.2.7.5 Children's safety, wellbeing and developmental needs

There is increased emphasis on advocating for and responding to risk for children and considering their specific safety, wellbeing and developmental needs. Children and young people are impacted in the following ways:

- directly targeted by abuse, violence and controlling behaviours
- being present to or learning about the violence against their mother and/or siblings
- being used in a tactic to undermine and impair the non-offending partner's parenting efforts
- harm to family ecology and functioning.

The impacts are made visible by skilled assessment, which may or may not be most appropriately carried out by an MBCP practitioner. It should be communicated to the user of violence that DFV is a parenting choice that harms the child/ren, the non-offending parent and overall family functioning.

Assessment of children's safety and needs occurs either through working with protective, non-offending adults or directly with children to provide them with a voice, where age appropriate and safe to do so. Practitioners should consider:

- what aspects of the child victim-survivors' situation may be targeted by the man's tactics of control?
- in what ways does the man undermine the non-offending parent's authority and relationship with the child/ren?
- in what ways does the man specifically impact the child/ren's safety, stability and development?
- how are the man's tactics impacting the children's and family's connection with services?

Strong working relationships between the Department of Communities and Justice, family support services, women's and children's services, and MBCPs require:

- referrals and comprehensive information sharing
- ongoing input into case planning and risk review
- provision of detailed written reports to the Department of Communities and Justice throughout and upon the man's completion of the MBCP
- strong child and fathering focus in MBCP
- strong processes for assessing safe fathering in MBCP
- ongoing engagement with the father to reduce engagement barriers within MBCPs and increase his motivation to participate meaningfully and set/revise goals.

'Such levels of collaboration, and joint assessments of any changes towards child-centred, safe parenting capacity and of perpetrator actions to support rather than sabotage the mother's parenting, is rarely seen at this time. This collaboration, however, is essential if child protection, family services and family violence systems are to collaborate in ways that meet the safety, wellbeing and developmental needs of children.'

– Vlais et al., 2017.

2.2.7.6 Documentation

Documentation of risk, action taken in response to risk, and the outcomes of such action is vital for several reasons:

> demonstrates that an organisation has taken all necessary steps to fulfil their duty of care and complied with legislative and mandatory reporting requirements
> to respond to a subpoena, which may require all information recorded about a man's participation in service provision and the risk he poses to be provided
> to support information sharing, which maximises the visibility of the perpetrator and the risk he poses, maximising his accountability whilst actively promoting the safety of victim-survivors.

All documentation in the RSSF must be completed and stored according to agency policy and practice, reporting protocols and legal obligations, including the *National Privacy Principles* (Office of the Australian Information Commissioner, 2014). Information relating to risk is recorded and shared with other relevant stakeholders who are involved in a multi-agency response, in line with the *Domestic Violence Information Sharing Protocol* and Part 13A Crimes (Domestic and Personal Violence) Act 2007. All documentation including case notes, risk assessments and emails must be written without opinion or interpretation, based on observable evidence and if appropriate, may include a professional judgement based on the observable evidence.

Caution must be taken to ensure that sensitive information provided by, or about, adult and child victim-survivors that may compromise their safety is not recorded in the user of violence's case file. This is to ensure that it is not accessed by the perpetrator if the file were subpoenaed.

2.2.8 Considerations for diverse communities

Refer to section 2.1.8.

2.2.9 Related resources and tools

> **Risk assessment tool – user of violence** (RSSF part three)
> **Structured risk assessment tool** (RSSF part three)
> **Safety and accountability plan** (RSSF part three)
> **Case plan template** (RSSF part three)
> **Information exchange template** (RSSF part three)
> *Compliance Framework for Men's Behaviour Change Programs*

2.2.10 Response/action pathways

A priority for MBCPs is to support safety planning for victim-survivors, including referral to Safer Pathway where appropriate.

Upon completion of the **Risk assessment tool – user of violence** and the **Structured risk assessment tool**, practitioners should consult with the Women's and Children's Advocate to develop and implement a safety plan for the user of violence, using the **Risk action matrix** (RSSF part three). Practitioners should also share risk-related information with relevant parties and formulate a case plan based on the user of violence's individual **Risk, Needs and Responsivity** factors.

MBCPs may take the lead in coordinating a multi-agency response to risk and actively collaborating with services to facilitate a referral and/or share information.

2.2.11 Practice tips

Remember that it is not possible to state with certainty that risk has been reduced or eliminated. A practitioner's professional judgement when assessing and responding to risk may be based on observed behaviour changes over time, a perpetrator's level of participation and engagement in the program, the victim-survivor's experiences and levels of fear, and their prior experience as a practitioner.

Practitioners aim to:

> maintain a women's-and-children's-advocacy lens in all risk analyses and responses
> establish rapport with users of violence (without collusion) as an important first step in being able to obtain their honest input into risk assessment and management, including goal setting and safety planning
> obtain detailed information from a wide variety of sources when undertaking structured risk assessment
> continuously review and document risk, including any changes or spikes in risk
> monitor and respond to changes in risk, tactics, patterns and attitudes
> develop a clear safety and accountability plan with the user of violence where possible, and encourage their ownership of the plan.

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Appendices

Appendices

A. Implementation of the Risk, Safety and Support Framework

The links below are resources that support implementation of the RSSF.

> *Domestic Violence Information Sharing Protocol*
http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/It%20stop/DV-info-Sharing-Protocol.pdf

> Safer Pathway, *Domestic Violence and Child Protection Guidelines*
http://www.crimeprevention.nsw.gov.au/domesticviolence/Documents/It%20stop/dv_cp%20guidelines.pdf

> Domestic Violence Safety Assessment Tool (DVSAT)
http://www.domesticviolence.nsw.gov.au/__data/assets/file/0020/301178/DVSAT.pdf

> Crimes (Domestic and Personal Violence) Act 2007
https://www.legislation.nsw.gov.au/view/whole/html/inforce/current/act-2007-080

> *National Risk Assessment Principles for domestic and family violence, Companion resource, Quick reference guide for practitioners* (Toivonen & Backhouse, 2018)
https://www.anrows.org.au/research-program/national-risk-assessment-principles/

> NSW Health Education Centre Against Violence (ECAV) Position Paper: *Interrupting Male Violence with Men who use Domestic and Family Violence* (Twisleton L, Coleman D & Coorey L, 2017)
http://www.ecav.health.nsw.gov.au/knowledge-hub/positionpaper/

> Toward an Aboriginal and Torres Strait Islander Violence Prevention Framework for Men and Boys (The Healing Foundation & White Ribbon, 2017)
https://www.whiteribbon.org.au/awcontent/whiteribbon/documents/White-Ribbon-Australia-Towards-an-Aboriginal-and-Torres-Strait-Islander-violence-prevention-framework.pdf

> *Good Practice Guidelines for the Domestic and Family Violence Sector in NSW* (DVNSW, 2018)
http://dvnsw.org.au/work/resources/good-practice-guidelines-for-the-nsw-dfv-sector/

> Domestic Violence Service Management (DVSM), *About Language and Violence resource kit*
https://www.insightexchange.net/wp-content/uploads/2018/12/Language-and-Violence-Resource-Kit.pdf

> Safe and Together Institute, *Domestic Violence-Informed Continuum of Practice*
https://safeandtogetherinstitute.com/wp-content/uploads/2015/08/DOMESTIC-VIOLENCE-INFORMED-CONTINUUM-ONEPAGER-BW-copy.pdf

> *Predominant Aggressor Identification and Victim Misidentification* (No to Violence, 2019)
https://ntv.org.au/wp-content/uploads/2020/06/20191121-NTV-Discussion-Paper-Predominant-Aggressor-FINAL.pdf

B. Resources for working with women and children experiencing domestic and family violence

The links below are resources for practitioners who are working with women and children to prioritise safety and centre their voices in response to experiencing violence.

> 1800RESPECT, Safety planning guide
https://www.1800respect.org.au/help-and-support/safety-planning

> Domestic Violence Service Management (DVSM), Practitioner toolkit
https://dvnswsm.org.au/resources/resources-practitioners/

> Insight Exchange (DVSM)
https://www.insightexchange.net/

Specific resources available in the toolkit include:

- *Follow My Lead* – a resource for social and service responders to understand concepts of safety.
https://www.insightexchange.net/follow-my-lead/
- *My Safety Kit* – a resource for people experiencing DFV to support reflection. Also includes guidance for service responders in service responder edition.
https://www.insightexchange.net/follow-my-lead/my-safety-kit/
- *My Dignity – My body is mine* – an information and reflection resource for anyone who may be experiencing or has experienced sexualised violence, and for anyone who may be responding.
https://www.insightexchange.net/my-dignity-2/
- other resources – example topics include:
  - dignity, resistance and responses to violence
  - the significance of context and of social responses
  - the significance of language.

> Women's Legal Services NSW, Domestic violence resources
https://www.wlsnsw.org.au/legal-services/domestic-violence-legal-service/

> Women's Domestic Violence Court Advocacy Service (WDVCAS)
https://www.legalaid.nsw.gov.au/what-we-do/community-partnerships/womens-domestic-violence-court-advocacy-program

Appendices

C. Understanding current policy context in NSW

The following information and links provide further detail regarding the current policy context.

> NSW domestic and family violence reforms and standards

The development of Safer Pathway has led to state-wide risk assessment and referral processes that aim to provide a consistent pathway and set of responses for victims of DFV. The key components of Safer Pathway build on existing service response. These are:

- a Domestic Violence Safety Assessment Tool (DVSAT: see link in Appendix B) to better and consistently identify the level of domestic violence threat to victims
- a Central Referral Point to electronically manage and monitor referrals
- a state-wide network of Local Coordination Points that facilitate local responses and provide victims with case coordination and support. Serious threat and high-risk cases are referred to Safety Action Meetings to coordinate an integrated response to the immediate safety needs of victim-survivors (Women NSW, 2014).

For more information on Safer Pathway go to https://www.dcj.nsw.gov.au/families-and-communities/safer-pathway

> NSW *Domestic and Family Violence Blueprint for Reform 2016–2021*

The *Blueprint* contains six actions to prevent DFV, which include: intervene early, support victims, hold perpetrators accountable, deliver quality services, and improve the service system. While all the actions are relevant to the development of the RSSF, actions three and four are most relevant:

- **action 3: supporting victims** seeks to provide victims with crisis and ongoing support services that are person-centred to address immediate and long-term safety and recovery needs
- **action 4: holding perpetrators accountable**, ensures accountability is embedded in system responses and perpetrators receive timely and effective behaviour change interventions.

  For more information go to http://domesticviolence.nsw.gov.au/__data/assets/pdf_file/0004/379849/dfv-blueprint-for-reform.pdf

> NSW *Practice Standards for Men's Domestic Violence Behaviour Change Programs*

In 2017, the then NSW Department of Justice released its *Practice Standards for Men's Domestic Violence Behaviour Change Programs*. The *Practice Standards* set out the guidance and expectations for Men's Behaviour Change Programs (MBCPs) to ensure consistent, safe, and effective practice.

The RSSF is complementary to the *Practice Standards* in that it describes a common and consistent approach to perpetrator risk. The RSSF provides structure and tools to safely, accountably and effectively conduct risk assessment, risk management, and safety planning. The RSSF is an instrument to support MBCP providers to demonstrate their compliance with the *Practice Standards*.

For detailed information on the *Practice Standards* and who they apply to, go to http://www.crimeprevention.nsw.gov.au/domesticviolence/Pages/MiniStandardsforMen'sBehaviour/Minimum_Standards_for_Men's_Behahviour.aspx

> *Compliance Framework for Men's Behaviour Change Programs*

The Department of Communities and Justice *Compliance Framework for Men's Behaviour Change Programs* provides detailed information for program providers on how to register their compliance and understand how their programs will be assessed.

D. Links to further useful resources and information

> NSW Health Education Centre Against Violence (ECAV) specialist training courses

https://swecav.hss.health.nsw.gov.au/ECAVWebsite/Home/ByDepartment?department=Domestic%20Violence

> PATRICIA Project – *A Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: Bridging the Research and Practice Divide*

https://www.anrows.org.au/project/pathways-and-research-in-collaborative-inter-agency-working/

> Community Housing Industry Association NSW, *Working with Perpetrators of Domestic and Family Violence toolkit*

http://communityhousing.org.au/wp-content/uploads/2018/11/Working-with-DFV-perpetrators-toolkit.pdf

> Domestic Violence Service Management – Insight Exchange, DFV and Acquired Brain Injury project

https://dvnswsm.org.au/resources/projects-and-initiatives/dfvabi/

> NSW Health Brain Injury Rehabilitation Program

https://www.aci.health.nsw.gov.au/networks/brain-injury-rehabilitation/about/brain-injury-rehabilitation-program

> Brain Injury Australia

https://www.braininjuryaustralia.org.au/

> Synapse NSW

https://synapse.org.au/

Notes

Notes

No to Violence head office

03 9487 4500
info@ntv.org.au
PO Box 277, Flinders Lane VIC 8009

Men's Referral Service

1300 766 491

- Counsellors available everyday
- Interpreters available upon request

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