Section 8

Working with the perpetrator

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Section overview

Awareness of the need to take a more active role in identifying perpetrators and holding them accountable has increased in recent years. Professionals in many fields work with perpetrators and this section outlines how to work safely with them:

1. Understand who perpetrates violence
2. Be aware of how perpetrators may use the victim's substance use or mental ill-health
3. Hold perpetrators accountable - substance use and mental ill-health are no excuse for abuse
4. Screen for perpetrators
5. Respond appropriately
6. Assess risk
7. Refer on safety
8. Prioritise victim safety

1. Who perpetrates violence and abuse?

This section relates primarily to adults who are violent and abusive towards other adults within a context of an intimate partner or family-type relationship.

In addition, section 1.3 incorporates information about child-to-parent violence, of which some perpetrators will be children or young people.

We do not address how to respond to people who abuse children outside of a domestic violence context.

1.1 Men who perpetrate abuse

Domestic and sexual violence is not about a desire to be violent or abusive as such. For the vast majority of perpetrators, they use violence and abuse as a means to exert **power and control** over their partner, family, a friend or acquaintance (the latter specifically in cases of sexual violence[1]).

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Within society, the idea of power is very gendered and linked to culturally constructed ideas of how heterosexual men and women should behave and their role in society. Typical gender stereotypes portray men as strong, powerful decision-makers, and women as weaker, emotional homemakers.

Research[2] has found that these beliefs are also strongly held by perpetrators of domestic and sexual violence, who are primarily heterosexual men who perpetrate abuse towards women. Meanings attributed to and expectations associated with gender can also impact on the ways in which professionals approach and respond to perpetrators and survivors.[3]

Although the widely cited figure of 1 in 4 women and 1 in 6 men may suggest both genders experience similar levels of violence, 47% of male victims and 28% of female victims report a single incident. On average, men experience 7 incidents and women 20 incidents of domestic violence per year. 89% of people who suffer four or more domestic violence assaults are women.[4]

Research[5] has shown that men and women use violence in different ways. For example:

- men are more likely to use physical violence, threats and harassment than women, with the violence being more severe
- men are more likely to damage women's property, whilst women damage their own
- men's violence tends to create a context of fear and control compared with women's use of violence

There are many proposed explanations for why men perpetrate domestic violence. Factors associated with domestic violence include abuse in childhood, witnessing domestic violence, experiencing other trauma, anger, depression, substance use and low self-esteem.[5] However, common factors are not causal explanations; their absence does not guarantee domestic violence will not occur. Furthermore, none of these factors are present in the majority of abusers, and the majority of people who experience childhood abuse,

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problems with drugs and alcohol or have depression do not abuse their partners.

Never forget – safety first
Two women a week in England and Wales continue to be murdered by a partner or ex-partner. Many more will be physically hurt (some seriously) as well as suffering emotional and psychological harm.

With every intervention involving perpetrators, always:

1. ask yourself 'Is this going to make the survivor and/or her child(ren) safer?'

2. continually assess and reassess risk – for example, consider how a perpetrator's abusive behaviour may increase on entering drug or alcohol treatment.

3. ensure you share concerns about increased risk to the survivor and/or her child(ren) with the relevant parties, e.g. your line manager, safeguarding lead, MARAC co-ordinator. Do not work alone.

1.2 Women who use violence

Whilst the majority of perpetrators are men, you may also come into contact with women who use violence. For various reasons, this is particularly true where one or both partners have problems with drugs, alcohol and mental health. Particularly in relationships where both people drink heavily, violence by both partners is more commonplace. Information about 'bi-directional' violence can be found on p.185.

Whilst a small proportion of women perpetrate violence against a partner in the same way as male perpetrators, research [7] using a range of different methodologies has found that women are less likely to use an on-going pattern of abuse using coercive and controlling behaviours that enable a perpetrator to exert power and induce fear in the survivor.

Instead, many women who disclose hitting a partner are often lashing out or responding in frustration to long-periods of emotional or physical control – commonly referred to as violent resistance to abuse.

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Research[8] has found that survivors may also engage in:

- violent self-defence - violence is used for protection in order to prevent or end a violent attack.

- violent retaliation or reaction to abuse – aggression is the product of stress, frustration and disempowerment. There is an accumulation of anger caused by suppression of negative emotions and feelings of powerlessness, whereby violence is used.

- violent self-destructive behaviour - filled with self-blame, guilt and self-hatred, violence is aimed inwards as the individual enacts a cycle of self-destructive behaviour. Problematic alcohol and drug use, suicide attempts and self-harming have been documented amongst this group.

On the whole, women are less likely to initiate violence.[9] Victims of abuse may, however, initiate violence when there is an imminent threat of violence from the abuser.

No violence or abuse can be condoned. If you are working with male or female perpetrators or with a case of bidirectional violence, ring the Respect Phoneline (0808 802 4040). The helpline can offer support and help to perpetrators and professionals to clarify patterns of abuse and provide information about relevant services.

1.3 Child to parent violence

Between a rock and a hard place
The information in this section is drawn largely from *Between a rock and a hard place,* a report of research conducted by AVA and Adfam into parents' experience of violence and abuse from children who use drugs or alcohol problematically. The full report can be downloaded from http://tinyurl.com/c78z6y3.

There is increasing awareness of the violence and abuse some parents experience from their child(ren), often but not exclusively when either the child or parent has problems with drugs, alcohol or their mental health. As with individuals who perpetrate abuse against a partner, however, the substance use and mental ill-health often masks a sense of entitlement and desire for the child to have power and control over their parent.

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Child to parent violence (CPV) is similar to other types of domestic violence in that:

1. The majority of perpetrators are male, and the majority of survivors are female.

2. Among adolescent perpetrators, research has shown similar negative views of women to adult male perpetrators.

3. The types of abuse includes emotional abuse, financial exploitation, death threats, serious physical assaults with weapons, destruction of property in the home and social isolation caused by emotional manipulation, but an absence of reported sexual violence.

4. In some cases the child has been exposed to domestic violence in the home.

5. Parents have similar feelings to other survivors: long-term worry, fear, profound emotional distress, financial worries, lack of sleep, guilt, feelings of failure and of being (at least partly) to blame.

6. There is a reluctance to name the experience as abuse as it involves acknowledging the painful reality that a loved one is abusive.

7. Knowing what to call CPV and how to conceptualise it can be very problematic for parents. Very few consider it to be domestic violence so most survivors are unlikely to access dedicated domestic violence services.

8. Where the child has drug, alcohol or mental health problems, this is often seen as the cause of the abusive behaviour by both parents and professionals. The parent commonly looks for help for their child rather than protection and support for themselves.

9. There is sense among parents of *"of being passed from agency to agency, of being disbelieved, of having to wait months and months for a service"*. Similarly to other survivors, parents often turn to a trusted friend or the internet for support, at least as a first step, rather than professionals.[10]

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"I can't see him hurt in any way, I've got a very soft spot for him"
Survivor's voice

In the same way that parents can struggle to identify their child's behaviour as abusive, it can also be difficult for professionals. To increase the identification of child to parent violence, practitioners should:

1. Be aware that not all child to parent violence is perpetrated by people under the age of 18. The majority, in fact, is perpetrated by adult children.

2. Be alert to the possibility that what appears to be normal problematic behaviour of moody teenagers could actually be abusive behaviour by an adolescent perpetrator. In the same way as professionals are encouraged to identify the 'primary aggressor' in cases of domestic violence, with regard to child to parent violence practitioners should consider the extent to which the young person's behaviour is giving him control over the parent and the parent's level of fear.

3. Not assume that parents hold a position of power within a child-parent relationship, and thus misidentify domestic violence and/or who the perpetrator is.

4. Recognise that child to parent violence does happen. Many parents report dismissive and judgemental responses from professionals, as well as from friends and members of the community.[11]

5. Support parents to understand that what is happening is abuse. Child to parent violence involves high levels of emotional abuse which can be difficult to recognise. For example, in cases where the child is drug or alcohol dependent, financial abuse often centres on demands being made for money to buy substances. Often these are reinforced with a threat that the personal safety of the child was at risk if the parents did not provide a certain amount of cash to pay off debts to dealers. It isn't always possible for parents to know whether this was just an excuse used for leverage or if the safety of their loved one really was in danger and this uncertainly is painful in itself.

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When working with parents who are experiencing violence or abuse from their child, it is important to remember that:

1. The perpetrator is responsible for their behaviour. Professionals can be more likely to view the child's behaviour (particularly when they are young) as a direct result of poor parenting and thus hold the parent/survivor responsible for the child/perpetrator's behaviour.

2. The abuse is a manifestation of domestic violence which the perpetrator should address through changed behaviour. Suggestions to improve boundaries and other parenting skills again places responsibility on the parent/survivor and may not be effective.

3. What may appear to be 'lax' parenting and a parent who permits her child to behave outrageously and manipulate her may actually be a mother who is worn down and stressed by living with abuse. Like other survivors of domestic violence, mothers may manage the abuse by not challenging the perpetrator's actions.

4. Child to parent violence occurs disproportionately in single parent families. Providing support to the parent in terms of maximising income, finding stable accommodation and developing support networks may be helpful in strengthening the parent's resources to deal with the violence.

5. Parents, particularly mothers, may be less likely than other survivors to lose contact with the perpetrator. They may also wish to continue carrying out their parenting duties despite the abuse.

6. Even if they did wish to somehow cut off their children, parents do not have the same legal recourse as survivors of domestic violence from an intimate partner.

"The effect of fear on parenting creates the impression of a 'permissive parent' to the outsider"[12]

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1.4 Bi-directional violence

You may come across cases where both partners claim to be victims. In cases where both individuals have used violence against each other, the clarity of what is happening in that relationship can become clouded.

In these circumstances, it is important to remember that domestic violence is a pattern of behaviour comprising various forms of controlling behaviour and not just an individual event.

In most situations, violence and abuse are not perpetrated equally by both parties:

1. In some cases, you will be working with a perpetrator and a survivor that uses violence, and

2. In others, there will be a so-called primary and a secondary aggressor.

Good practice recommends that, wherever possible, practitioners determine who is the primary aggressor[13] in order to make appropriate referrals.

In assessing mutual allegations of domestic violence, practitioners trained in this field will take into consideration:[14]

- **Context, Intent and Effect.** For example, did the person use violence to induce fear or to protect themselves? And what effect did the violence have?

- **Agency.** i.e. ability to make decisions for oneself. In the context of an abusive relationship, the survivor is less likely to be able to make decisions for themselves and/or the perpetrator will always make the final decision in their own favour.

- **Empathy.** Survivors of domestic violence will empathise with their partner, whilst perpetrators are less likely to empathise and may minimise their partner's feelings.

- **Entitlement.** Linked to a lack of empathy, a sense of entitlement allows someone to assert their will over others (in particular, their partner). This may include particular attitudes towards roles within a relationship or family.

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- **Fear.** If someone is in fear of their partner this is a good indication of an abusive relationship. Fear may be expressed verbally or could be evident in terms of behaviour.

In many cases, however, practitioners will not have sufficient information about both parties, nor the dynamics within the relationship to be able to reliably determine the direction of abuse.

Where you are not sure who is the perpetrator and the survivor, or if they are both perpetrators, it is advisable to contact the Respect Phoneline (0808 802 4040) to clarify dynamics in the relationship.

Alternatively, you can give the number of the Respect Phoneline (see above for number) to both parties. Staff at Respect are trained to screen all calls (using the aforementioned tool) to identify perpetrators and survivors; this is in recognition of the fact that many women (and some men) who contact the service with concerns about their own behaviour are more often survivors who use violence as a form of resistance.

	In coercive control OVER partner/ex, because of own use of violence, abuse, controlling behaviour, threats etc ↓	Under coercive control FROM partner/ex, who has used violence, abuse, controlling behaviour, threats etc ↓
Uses or has used physical or non physical violence against partner/ex →	**Perpetrator of intimate partner violence**	**Victim who has used some form of violent resistance**
Experienced or experiencing physical or non physical violence from partner/ex →	**Perpetrator whose victim has used some form of violent resistance**	**Victim of intimate partner violence**

Figure 8 - Respect Matrix of use and experience of intimate partner violence (copyright Respect, www.respect.uk.net)

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2. Blaming the victim

When partners are abusive, they do not have to use violence to gain power and control over their partner or to instill fear. The Power and Control Wheel (see below) illustrates the many different types of abuse perpetrators use in addition to physical and sexual violence:

A copy of the Power and Control wheel and a fuller list of the perpetrator's actions, specifically where the victim has drug, alcohol and/or mental health problems, can be downloaded and printed from from appendix G

© Domestic Abuse Intervention Project (www.duluth-model.org)

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If the victim has difficulties with their mental health and/or use of substances, this can be used by the perpetrator in many different ways. For example a perpetrator may:

- Isolate the survivor by preventing access to medical services/ medication/drug and alcohol treatment, which exacerbates mental health/substance use problems.

- Damage the survivor's self-esteem by making her feel incompetent because of her mental health or substance use problems; using verbal insults, e.g. she's useless, an unfit mother, crazy, mad, junkie; humiliating her by telling others that she is crazy, mad, a user, an addict.

- Threaten to call social services, the police, have the survivor sectioned.

- Encourage dependence on the perpetrator - telling victim she could not cope on their own, cannot manage money, controlling access to drugs/alcohol, etc.; lying about times/information then saying she appears to get things wrong (proving to self and others that she can't manage); moving or taking property to cause confusion.

- Deny the abuse by suggesting the survivor has imagined it - "you're hearing/seeing things/ crazy/high/drunk" – caused the injuries themselves when unwell, intoxicated or by self-harming.

- Blame the survivor, e.g. "You drove me to it", "If you weren't such a nightmare to live with, I wouldn't have to behave in this way", "It's for your own good/ safety – you can't cope on your own, manage money/medication, etc."

In terms of blaming the victim, it is important to be aware that:

- Perpetrators may minimise the types of abuse they use ("Well, I didn't hit her") and the impact ("She gives as good as she gets"). Survivors may also minimise the abuse as a coping mechanism or to avoid 'making a fuss'.

- Perpetrators may deny the abuse, its frequency or impact. Survivors may also deny what has happened, again as a

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coping strategy or for fear of the consequences, e.g. agency involvement, fear of perpetrator response, fear of social care.

- Perpetrators may blame the survivor, and the survivor may also blame themselves and believe the perpetrator's excuses.

Perpetrators may also claim to be the victim. This is particularly true if the police have been involved, they are involved in court proceedings, or where their partner has used violence in self-defence or resistance.

Professionals should be cautious of male service users who report that their partner has used violence against them – be mindful of the context in which the violence was used and the impact on the service user (see p.180 for more information). In many cases, however, you will not have sufficient information to be able assess for yourself if the person is a victim or perpetrator.

All men who report violence and abuse from their partner should be signposted to the Men's Advice Line (see appendix H for details). The helpline is run by Respect, and staff are trained to screen all callers to identify victims and perpetrators and respond accordingly.

PROFESSIONAL BLAME

Without sufficient knowledge about domestic violence, professionals may reinforce victim-blaming by:

- Asking the survivor what they did or said to provoke the abuser
- Misdiagnosing genuine fear as irrational anxiety related to mental ill-health or substance use
- Prescribing medication or recommending treatment for substance use to the survivor as a way of changing the perpetrator's behaviour
- Labelling a survivor as challenging/difficult to work with and potentially implying that they must be challenging/difficult to live with.

Regardless of how challenging someone's behaviour might be, this is NEVER an excuse to use violence and abuse against them.

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3. Holding perpetrators accountable

A fundamental role for all professionals working with perpetrators is to hold them accountable for their behaviour.

In the overwhelming majority of cases of domestic and sexual violence, the perpetrator has control over his actions and chooses to behave in an abusive or violent manner. There are, however, associations with both substance use and mental ill-health that need to be understood in order to avoid colluding with perpetrators.

3.1 Substance use as an excuse

There is a strong association between domestic violence and substance use, as well substances figuring in incidents of sexual violence.[15] Findings from a review of British Crime Surveys found 44% of domestic violence perpetrators were under the influence of alcohol and 12% affected by drugs when they committed acts of physical violence.[15] Similarly, an inquiry into homicide convictions found that around half of all people convicted for murder in England and Wales have a history of problematic alcohol and/or drug use.[16]

Both alcohol and drug use can increase the likelihood and severity of domestic violence, but alcohol appears to be particularly important in escalating existing conflict.[17] Not all people attending alcohol treatment, however, are abusive, nor do the majority of domestic violence incidents take place when the perpetrator was drinking or using drugs.

This therefore means there is no simple causal relationship between substance use and domestic violence.

Rather than the physiological effects of alcohol (or other substances) causing someone to be violent solely when intoxicated, survivors consistently report experiencing violence and abuse from their partner when he has not been drinking.[18] Women also report that even when their partners have seemed “uncontrollably drunk” during a physical assault they routinely exhibit the ability to stop the abuse when there is an outside intervention, e.g. children, police.

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Substance use is therefore better understood as a 'disinhibitor' which gives a perpetrator the belief that they will not be held accountable or responsible for their behaviour. Galvani[19] terms this 'responsible disinhibition', i.e. that whilst perpetrator may experience some level of disinhibition as an effect of consuming alcohol, they are still responsible for their actions and should be held accountable. See figure 9 on p.187 for more information.

In addressing perpetrators who use or drink problematically, it is therefore not sufficient to only address their substance use.

Even if alcohol or drug treatment is able to reduce the severity of the violence, it will not address the many social and cultural factors such as perpetrator's sense of entitlement and attitudes towards women nor the complex dynamics of power and control that underpin domestic violence. Therefore, work that specifically addresses these issues – ideally conducted by appropriately trained staff within the setting of a perpetrator programme – should always accompany a treatment plan.

3.2 Mental health as an excuse

Similarly to substance use, the perpetrator's mental health is often cited as a cause of their violent or abusive behaviour.

This belief plays into a common misperception that people who experience mental ill-health are more likely than people without these experiences to be violent. In reality, whilst there is some research suggesting a modest link between mental health problems, such as psychosis and violent conduct, the majority of such crimes are actually associated with drug and alcohol use.[20]

Overall, people who experience problems with their mental health use violence in the same ways as other people who are not mentally unwell.[21]

In terms of domestic violence, research has found that the majority of perpetrators also do not have mental health problems.[20] There are, however, some associations between the two issues:

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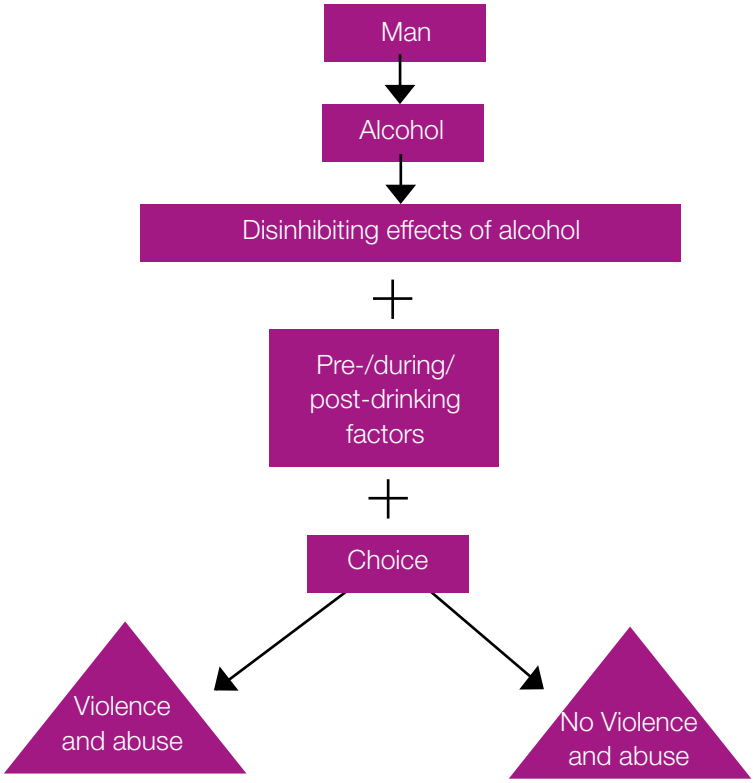
- Research[23] has found that just under a quarter of convicted male perpetrators reported being depressed. Practice-based evidence also suggests that perpetrators often approach their GP with symptoms of depression as a first step in seeking help.
- This does not, however, point to a causal link between depression and the perpetration of domestic violence. Conversely, it is more likely that perpetrators feel, at some level, bad about their behaviour or low as a result of the consequences of being abusive.

Figure 9 - Galvani's model of responsible disinhibition



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This could include recognising the impact their behaviour has on a partner or children, or if they are arrested for or convicted of domestic violence-related offences.

- Perpetrators use threats or attempts to commit suicide as a means to control their partner. This is not necessarily a sign of mental ill-health. **Depression, self-harming and threats/attempts are, however, established factors in domestic violence murders and should be taken seriously.**

- Research has found that perpetrators frequently display traits of different personality types, with most perpetrators being categorised into anti-social and narcissistic 'typologies'.[24]

- There is a consistent thread, however, between the 'typologies' of **perpetrators holding hostile attitudes to women and having an inflated sense of self rather than low self-esteem.**[25]

- Symptoms associated with some mental health diagnoses mirror behaviours common to many male perpetrators; this can make it particular difficult for practitioners to understand the motivations for violence and how to respond.

When working with a perpetrator who also has an established mental health problem, practitioners should bear in mind that:

1. The mental health problem should not be used as an excuse for being abusive. Perpetrators need to be held accountable for their behaviour.

2. Symptoms of mental health problems can exacerbate domestic violence behaviours. Perpetrators who do have a mental health problem are, however, likely to be abusive even when well. Their behaviour should not only be addressed as illness-related violence.

3. A dual diagnosis of mental ill-health and substance use is more likely to increase the risk of violence and abuse

4. Current psychological interventions alone are unlikely to address the complex dynamics centred on power and control

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issues that underlie domestic violence committed by the majority of offenders. In some cases they can reinforce the 'poor me' symptom common to most perpetrators.

5. Alongside specialist support to address abusive and controlling behaviour, some men they may need therapeutic help to deal with emotional and psychological scars associated with childhood or other traumatic experiences (e.g. military).

6. It remains unclear whether adapting treatment to match different 'typologies' of domestic violence offenders has any effect on treatment outcomes.

A perpetrator's mental health problems can play a role in why survivors remain in an abusive relationship. Practitioners may need to address survivors' concerns about who will care for the perpetrator or how he will manage if the relationship were to end.

4. Screening for perpetrators

In some settings, such as drug and alcohol and mental health services, clients may already be screened for any violent behaviour. For other professionals, this may be a new area of enquiry.

4.1 Reasons to screen for perpetrators

Even if you do not routinely screen for client's violent or abusive behaviour, there may be occasions where it is important to talk to a client about perpetrating domestic or sexual violence:

- Both the client and their partner use your service, and you have a duty of care to the person who may be the victim of abuse.

- Under Section 17 of the Crime and Disorder Act there is a responsibility to take 'reasonable' action to prevent a crime. This includes domestic and sexual violence. Asking your client about their behaviour and exploring motivation to address this may be appropriate.

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- Under Article 2 Human Rights Act 1998 public authorities have a duty to protect life and therefore must take positive action to reduce /remove any risks when they are identified.

- At some level most perpetrators are unhappy with their behaviour and this may be an underlying cause or a factor contributing towards states of depression or other mental health problems.

- Your client may express hope that reducing or stopping drinking/ using drugs will result in changes to abusive behaviour.

4.2 Ways to approach perpetrators

Perpetrators are unlikely to approach services with a full and honest disclosure about the extent of their abusive behaviours. Instead, a perpetrator is more likely to report other concerns about his relationship or behaviour:

My wife and I are fighting a lot/need counselling

I'm depressed/anxious/stressed/not sleeping/not coping/ not myself
I'm worried about my rage at work, in the car/street, at the football

I need anger management

I'm worried about the amount I have started drinking

Some perpetrators may seek help for their behaviour if their partner threatens to leave them or if the police have involved which could have consequences, e.g. in terms of their employment.

If the person presents with one of these 'mitigating factors', you could approach the conversation in different ways.

If the person indicates that domestic violence is an issue, these are useful questions to ask:

What worries you most about your behaviour?

It sounds like your behaviour can be frightening; does your partner say she is frightened of you?

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How have the children been affected?

Have you ever felt your behaviour got out of hand? If yes, what happened?

Have the police ever been called because of your behaviour?

If the person discloses using violence or abuse, or even indicates that they might, it is important to give an appropriate response (see below) and collect as much information as possible to assess the level of risk to the survivor and/or her children.

5. Appropriate responses

Where someone discloses or alludes to being abusive, you may find the following approaches useful: [26]

1. Give positive feedback where violent or abusive behaviour has been disclosed; be positive about and promote the possibility of change:

It sounds like you want to make some changes for your benefit and for your partner/children. What choices do you have? What can you do about it? What help would assist you to make these changes?

Acknowledging to yourself and others that you have been abusive in the past is a really important step in making changes. It's not easy as it opens up many emotions that you don't want to feel, so the fact that you are talking to me about this is a really important first step.

Change is possible. You are in control over whether you change your behaviour and no-one else. The problem is not you, it's your behaviour.

2. Name domestic violence and explain it is a range of behaviours, not just physical.

3. Emphasise there is no excuse for the behaviour; encourage perpetrators to think about when they use violence – is it only under the influence of substances or when unwell?

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How do you think your bi-polar/ depression/anxiety affects your behaviour? Can you remember being abusive/violent when you were not feeling depressed/anxious?

Have you ever hit, kicked or pushed your partner or child when intoxicated? Have you ever harmed or frightened your family when you were sober?

How has your partner/child(ren) been affected by your behaviour?

What's it like for your partner/ child(ren) being around you when you are at your best, at your worst?

Has your partner/child(ren) asked you to change? If yes, in what ways?

4. Do NOT back him into a corner as this may stop him from talking to you again about his behaviour.

5. Ask him what effects his violence has upon himself and explore if this is how he would like to continue. Be aware that deep down he is somehow unhappy about the abuse.

6. Ask what effect the behaviour has on his children and partner. As well as revealing whether the perpetrator is able empathise with the survivor, this might promote motivation to change:

7. Explore whether the individual shows a desire to change. If not, broach the subject again in future sessions.

8. Where appropriate and safe, you may wish to help your service user to explore the links between the substance use and the abuse – when did the abuse and violence first start, what were the circumstances. Allow him to talk to support analysis of his attitudes, values, insights, defensiveness, powers of self-analysis and commitment to change.

9. Inform the perpetrator of the limits on confidentiality. Your agency could consider including a few sentences in your confidentiality agreement which give permission

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to contact a partner and pass on information to professionals with regards to acts of violence towards a partner or children.

6. Assess risk

Similar to working with survivors, following disclosures of abuse by a perpetrator, practitioners are encouraged to ask more direct questions relating to heightened risk factors, for example:

Have you ever assaulted or threatened your partner with a knife or other weapon?

Have you ever grabbed your partner by the throat?

Did/has your behaviour change(d) towards your partner during pregnancy?

Have you assaulted your partner in front of the children?

Do you feel jealous when your partner spends time with other people (e.g. family and friends)? How do you show this?

Do you feel unhappy about your partner seeing friends or family - do you ever try to stop her?

What has been the worst occasion of violence?

Do you feel that your behaviour has got worse?

Whilst it is not suitable to complete the DASH risk identification checklist with a perpetrator, bear in mind what you know about risk factors relating to domestic violence (p.108 and p.238 for more information). Consider these when deciding whether to inform your line manager or involve other agencies.

Finally, remember to continually reassess risk. Risk is not static, and risk levels can change quickly. Remain alert to risk and share information with managers and other agencies as needed. **Do not work in isolation with perpetrators.**

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7. Refer safely

Similarly to survivors, perpetrators may experience barriers to acknowledging the abuse and seeking help because, for example, of their own sense of shame or fear of the children being removed. They may also deny responsibility for their actions, blame the victim or find ways to justify their behaviour which means they are not open to offers of help to change their behaviour.

Some perpetrators may, however, ask to be referred to specialist support for their behaviour. This could reflect a genuine desire to change or, as is more often the case, the partner has told the perpetrator they must get help 'or I will leave'. As with substance treatment, the most effective intervention takes place if an abuser acknowledges the problem and wishes to change.

If the individual shows any desire to change, they should be referred to a specialist perpetrator service. Professionals and perpetrators can call the Respect Phoneline (see appendix H for details) for information about local services. The Respect Phoneline also provides a clear, non-collusive response to men concerned about their abusive behaviour and advice on short-term strategies to prevent further abuse.

You may also want to consider the following referrals:

1. If you have established any child or adult protection concerns, you may need to refer the case to your **safeguarding lead.**

2. Under Section 17 of the Crime and Disorder Act 1998, there is responsibility to take 'reasonable' action to prevent a crime. If you have concrete information that a crime may be committed, you may need to report this to the **police.**

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WHAT HAPPENS ON A PERPETRATOR PROGRAMME? IS IT EFFECTIVE?

Perpetrator programmes in England and Wales are predominantly based on the Duluth model of understanding perpetrator's behaviour as being rooted in the perpetrator's desire to have power and control over their partner. As such, the programme:

- Addresses the strong traditional gender stereotypes and negative attitudes towards women that the majority of heterosexual perpetrators hold.[28]
- Uses Cognitive Behavioural Therapy techniques to raise perpetrators' awareness about the level of choice and control they have over their own behaviour.
- Provides guidance on how to deal with conflict and difficult emotions without violence or abuse.
- May offer additional individual support for perpetrators to address issues such as experiences of child abuse and other trauma.
- Should employ a women's safety worker to support victims
- Usually compromise weekly groupwork sessions over a period of approximately six months.

There has not been a systematic review of perpetrator programme in UK as yet. Evaluations from the US suggest that the Duluth model does have a positive impact on perpetration of violence, although other types of abuse may not stop completely.[29]

It is important to remember that perpetrator programmes routinely aim to change long-term held beliefs and well-established patterns of behaviour. In the same way that there is an understanding that drug and alcohol treatment is not always effective first time round, neither are perpetrators programmes. Making long-lasting change takes time (see p.69 for more information on behaviour change).

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3. **Perpetrator programmes** are run both by probation (for people convicted of domestic-violence related offences) and in the community. If you have a community programme in your area, you may want to talk to your client about this option. Only refer to perpetrator programmes that are accredited by Respect and provide a women's safety officer. Perpetrators who use drugs and alcohol or who have mental health problems will be assessed as to their suitability for, and ability to participate in the programme. In some cases substance use and mental ill-health may exclude perpetrators from being able to engage in on-going group work but is not always the case.

4. Referrals to **other services,** including for drug, alcohol or mental health problems, may also be appropriate as perpetrators may have concurrent issues that need to be addressed. However, addressing these additional issues rarely affects the perpetrator's use of violence and thus is no substitute for specialist perpetrator services.

WARNING!!! DO NOT REFER TO:

- **Anger management** as this approach fails to account for premeditated controlling behaviours associated with domestic violence and does not specifically address perpetrators' attitudes towards women.

- **Couples or family counselling** because it can add to the belief that victims are somehow to blame for the abuse and may provide a space for perpetrators to reinforce this. It is unlikely to be successful when one partner is fearful of what they can disclose. More information about the risks associated with couples and family counselling can be found on p.169.

8. Victim safety

Due to the limited availability of perpetrator programmes, the reality is that in most areas you will not be able to refer perpetrators for specialist support but will have to manage their behaviour and the potential risk of harm to survivors and/or their children with your agency and any relevant multi-agency systems, e.g. MARAC and MAPPA (see glossary for more details).

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Remember, survivor safety is the main priority.

As a professional, there are several things you can do when working with perpetrators that can help towards this:

Avoid collusion

Perpetrators can be very manipulative. You may inadvertently collude with a perpetrator by:

- Inappropriately nodding/smiling as part of active listening.
- Minimising the abuse with words such as 'just' and 'only'. For example, when reflecting back saying "So you just lost it?" or "It was just this once" – particularly if you do not further investigate what happened.
- Copying his words that support his excuses, e.g. "When she kept going on at you, what did you do?".
- Accepting his account without further investigation/exploration.
- Maintaining confidentiality for him.
- Seeing the perpetrator as a victim of something else, e.g. stress, abuse in childhood, substance use, mental ill-health, that causes him to use violence and abuse. Whilst it is important to acknowledge that the perpetrator may being experiencing difficulties with such issues and may need support for them, it is never an excuse to be violent or abusive.
- Providing him with information that may put the survivor at risk.

Do not work with the perpetrator and the survivor together

There will be situations where the perpetrator and survivor use the same agencies, for example drug and alcohol, mental health or family support services. In this case, the couple should be seen as individuals by two different workers. This will help avoid collusion.

Where you have contact with both parties, do not share information given to you by the survivor with the perpetrator – do NOT divulge what the survivor has told you about the perpetrator's behaviour as this could increase the risk of abuse.

DO NOT act as a go-between between the survivor and perpetrator.

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Be mindful of the safety of different interventions

Anger management, couples and family counselling are known to be ineffective and even dangerous in cases of domestic violence (see p.170 for further information). Be alert to the risks of child contact: some perpetrators may use contact with the children as a route to further abuse them and their mother.

Do not work alone

You should always seek support and advice from your manager if you suspect or identify a perpetrator. Working with support and in partnership is the best way to improve the safety of women and children.

Further to this, domestic violence is a complex crime that requires a multi-agency response. Be aware that the perpetrator may have been discussed at the MARAC or may be subject to MAPPA. Where you are concerned about a change in the level of risk a perpetrator poses to their partner (or even someone other than their partner), advice must be sought from the community safety team, police public protection team or MAPPA so that an appropriate safety or protection plan can be activated.

Agencies should have in place clear agreed policies on information-sharing, which advise on the 'need to know'. The rationale for any disclosure without consent, e.g. to prevent harm, should be clearly documented.

Consider your own safety

It is important to find a balance between challenging the abusive behaviour whilst maintaining the development of the therapeutic relationship and keeping yourself safe. Be especially careful if he is under the influence of alcohol or other substances and do not engage with him about his violence at such times.

Record what you are doing

It is important to keep detailed records if someone discloses abusive behaviour. Be sure to write down what the perpetrator has said rather than your interpretation of what has happened. This information will enable a continuity of care and may also be helpful in any future legal proceedings. While records are generally confidential, if an individual, especially a child, is at risk of significant harm, this will override any requirement to keep information confidential. You should explain this to the perpetrator.

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