

Start of change:

Mapping engagement with male perpetrators of violence

Practice Inquiry 2018



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A total of 21 practitioners from five service providers participated in this project. Thank you to each of you for your time and the invaluable contributions you have made not only to this project, but to the broader body of knowledge with respect to men’s behaviour change programs and perpetrator interventions.

About our organisations

Connections UnitingCare

Connections UnitingCare is a community organisation supporting over 2000 people every week. They work on family strengthening and early intervention services for people in need. Connections UnitingCare make a practical difference in people's everyday lives giving them a better chance in life now and in the future.

Connections has a long and proud history of supporting those in the community who are experiencing severe marginalisation and hopelessness. Their Vision, Purpose and Values both shape and guide their work. This work is underpinned by a deep belief in addressing the impact of disadvantage for those with whom they work. Over the years they have spent a considerable amount of time and energy harnessing the knowledge of their predecessors to become a leading organisation in the sector. This has been through the realisation of a number of key strategies that has positioned them as an organisation that consistently works towards providing leading practice.

Connections has at its core, a comprehensive and well-informed understanding of the needs of vulnerable children and their families and the nature of the services critical to meeting their needs. They continue to find new and innovative approaches to addressing the needs of those with whom they work.

Connections runs over 40 diverse programs across 14 sites in Melbourne's south east.

WAYSS

WAYSS Women's Services consists of seven program areas which are designed to offer an integrated response for women and women with children who may enter the service at any of the six intake points within the WAYSS catchment (Cities of Greater Dandenong, Casey and Frankston, and the Shire of Cardinia). These program areas include:

- L17 Triage Response
- Family Violence Crisis & Crisis Accommodation Response
- Risk Assessment Management Panel
- Intake & Assessment Response
- Family Violence Outreach Response
- Women's Outreach Response
- Children's Services Response (including Animal Assisted Empathy Training)

The Family Violence Crisis Service operates from a 24/7 high security facility which accommodates up to eight women and 20 children in independent on-site units.

WAYSS Family Violence Outreach Service provides holistic case managed support to clients requiring longer term information, options and support to address all aspects of family violence. This service includes case managed support for clients experiencing recurring homelessness due to complex issues.

Good Shepherd Australia New Zealand

This Practice Inquiry has been prepared by Good Shepherd Australia New Zealand, a community services organisation that aims to disrupt the intergenerational cycle of disadvantage with a focus on women and girls. We achieve this through services that address social and economic exclusion. A central part of our mission is to challenge the systems that entrench poverty, disadvantage and gender inequality. We do this through research, advocacy and policy development.

Our specific expertise is in:

- **Safety and resilience**
supporting women to be resilient provides a buffer between an individual and adversity, allowing them to achieve improved outcomes in spite of difficulties.
- **Financial security**
supporting women to ensure they have access to sufficient economic resources to meet their material needs so that they can live with dignity.
- **Educational pathways**
assisting women and girls to overcome the obstacles in their life that hinder them from achieving their educational/vocational capacity.
- **Outcomes and evaluations**
developing evidence-based program designs across all Good Shepherd Australia New Zealand programs and services.
- **Research, social policy and advocacy**
researching emerging issues, identifying effective change interventions for program design, policy analysis and advocacy.

Good Shepherd Australia New Zealand is part of a global network of services and advocates established by the Congregation of Our Lady of Charity of the Good Shepherd, with representation at the United Nations as a Non-Government Organisation.

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Acronyms

ABS	Australian Bureau of Statistics
AFM	Affected Family Member
CBT	Cognitive Behaviour Therapy
CP	Child Protection
CRAF	Common Risk Assessment and Risk Management Framework
DHHS	Department of Health and Human Services (Victoria)
MBCP	Men's Behaviour Change Program or Men's Behavioural Change Program
MRS	Men's Referral Service
NCRVWC	National Council to Reduce Violence against Women and their Children
NTV	No To Violence
RCFV	Royal Commission into Family Violence (Victoria)
RNR	Risk Needs Responsivity

Definitions of key terms

Affected Family Member (AFM)	An Affected Family Member is an individual who is considered affected by events or conduct occurring during or in relation to a family violence incident. Affected Family Member is defined within the <i>Family Violence Protection Act 2008</i> (Vic) s 4 to mean the family member whose person or property is the subject of an application for an order.
Assessment	Assessment for the purpose of this project refers to the operational practices commencing within each of the four MBCP providers once initial intake has occurred.
Behaviour Change Program	Behaviour or Behavioural Change Program refers to a program delivered in a group setting for perpetrators of family violence against a partner or former partner. These programs can also be known as perpetrator programs or programs for men who use violence. These are referred to throughout this report as Men's Behaviour Change Programs or MBCPs.
Child	A person who is under the age of 18 years (<i>Children, Youth and Families Act 2005</i> (Vic)).
Child FIRST	Child and Family Information Referral and Support Teams (Child FIRST) provides a central referral point to a range of community-based family services within sub-regional catchments. Child FIRST organisations have statutory obligations under the <i>Children, Youth and Families Act 2005</i> (Vic) (State of Victoria, 2017d).
Child Protection	<p>The Victorian Child Protection Service is specifically targeted to those children and young people at risk of harm or where families are unable or unwilling to protect them.</p> <p>The main functions of Child Protection are to:</p> <ul style="list-style-type: none">• investigate matters where it is alleged that a child is at risk of harm• refer children and families to services that assist in providing the ongoing safety and wellbeing of children• take matters before the Children's Court if the child's safety cannot be ensured within the family• supervise children on legal orders granted by the Children's Court• provide and fund accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need (DHHS, 2016).

Client	A client is a reference to a client of an MBCP – that is, a person who has engaged in family violence and has enrolled in, or is participating in a group behaviour change program.
Completion	<p>‘Completion’ for the purpose of this project refers to the circumstance where a man who has been accepted into a men’s behavioural change program has proceeded through to meet the minimum requirements of the program.</p> <p>We note that some MBCP providers prefer to use the term ‘attended’ rather than ‘completion’ as the latter may imply that men have changed their behaviour or successfully ‘passed’ the program. The NTV Minimum Standard 11 specifies that programs provide men with access to a minimum of 24 contact hours of men’s behaviour change group work, spread over a minimum of 12 sessions and spaced no more than fortnightly. Time spent at initial assessment and on follow up processes is not included in these calculations.</p>
Domestic Violence	See Family Violence below. The terms family violence and domestic violence are often used interchangeably. In this report the term family violence is used.
Family Services	Services funded by the Department of Health and Human Services (DHHS) (Victoria) to provide support and assistance to vulnerable children, young people and their families where there are concerns about the wellbeing of the child or young person (DHHS, 2013).
Family Violence	<p>The term family violence, rather than domestic violence, is used in this report, following legal convention in the state of Victoria. Family violence, in this report is understood to encompass the use of violent, threatening, coercive or controlling behaviour by an individual against a family member or members, or someone with whom they have or have had an intimate relationship.</p> <p>Family violence can include abusive behaviour that is physical, sexual, emotional, psychological, economical, technological and spiritual. It can include behaviour that is threatening or coercive, or that seeks to control or dominate a family member and causes that family member to fear for their safety or the safety of another (<i>Family Violence Protection Act, 2008 (Vic) s5</i>). It also includes behaviour by a person that causes a child to hear or witness these abusive types of behaviours (<i>Family Violence Protection Act, 2008 (Vic) s5</i>). Family violence can occur in or outside of the home. It is widely accepted that family violence is gendered violence and that perpetrators are far more likely to be men (OurWatch, 2016).</p>

Family violence specialist services

Services funded by the DHHS to specifically respond to family violence, although the organisations that deliver these services may do work in other areas as well. There are three main types of specialist family violence services for women and children: support services, accommodation services (refuges), and family violence counselling services. Services that provide support to men who are violent including MBCPs, are not categorised as 'family violence specialist services' for the purpose of this report. Further, this report deals only with support services (State of Victoria, 2016, Chapter 8, p.2)

Intake

A structured process to obtain information from a client who may receive services. For the purposes of this project, intake refers to the operational practices within each of the four MBCP providers commencing once a referral (either from an external organisation or self-referral) is received to access MBCP.

L17/police referral

The Victorian Police Risk Assessment and Risk Management Report - L17 - is the mechanism by which Police who attend family violence incidents can make referrals to community agencies and/or reports to Child Protection (State of Victoria, 2017c).

L17 Portal

The L17 Portal provides an electronic means for Victoria Police to make referrals to services and to make reports. The functions of the Portal include enabling services to:

- See all L17s referred to their service
- Triage L17s
- Assign an L17 to an individual practitioner
- Monitor and manage L17s
- See which other services have received the L17
- Edit client contact information for safety purposes
- Record actions taken and outcomes of the L17
- See an audit trail to show who has actioned the L17
- Copy information into their existing case management systems.

(State of Victoria, 2017c).

Men's Referral Service

A men's family violence telephone counselling, information and referral service operating in Victoria, New South Wales and Tasmania. Men's referral service is the central point of contact for men taking responsibility for their violent behaviour, and also provides support and referrals for women and men seeking information on behalf of their male partners, friends or family members. The service is operated by No To Violence.

Offender/ Perpetrator	Where reference is made to a perpetrator or offender, this includes a person who has engaged in family violence. The terms perpetrator and offender encompasses both individuals who have been convicted of family violence, and those who have not. It may include clients of MBCPs.
Respondent	An individual who has an application for a Family Violence Intervention Order made against them.
Risk assessment	Risk assessment is the process of identifying the presence of a risk factor and determining the likelihood of an adverse event, its consequence and its timing. In family violence, risk and safety for the victim is determined by considering the range of factors that affect the likelihood and severity of future violence (State of Victoria, 2016, Chapter 19, p.4).
Safety planning	In this context, safety planning involves looking at a woman and children's situation and their risk of family violence and putting in place measures to help women and children feel and be safer (Western Integrated Family Violence Partnership, no date).
Victim/survivor	In acknowledgment of the gendered nature of family violence, the term victim/survivor refers to women and children who have experienced, or are experiencing, family violence in any of its forms.

Executive summary

Awareness and understanding of family violence has increased substantially in recent years.


Research into areas of family violence that have historically been pushed to the margins, such as perpetrator interventions, has also expanded significantly. Much of the research into perpetrator programs has focused on theoretical frameworks, program design and evaluation of program effectiveness. What is missing, however, is a detailed exploration of the engagement techniques that practitioners employ, and intake and assessment practices more broadly. The research undertaken through this Practice Inquiry attends to this knowledge gap.

This research has been commissioned by the Bayside Peninsula Integrated Family Violence Partnership and the Southern Melbourne Integrated Family Violence Partnership. Using a ground-up approach that privileges the voices of frontline practitioners, it aims to improve understanding of practice within Men's Behaviour Change Programs (MBCPs) operating in these regions of Victoria.

While there is a need for comprehensive evaluations of MBCPs and perpetrator interventions more broadly, this Practice Inquiry does not evaluate effectiveness in relation to behaviour change. Instead, it investigates intake and assessment practices in relation to men completing MBCPs as perceived by professionals from five organisations within the two regions:

- Family Life
- Peninsula Health
- Star Health (formerly Inner South Community Health)
- Relationships Australia Victoria and
- Corrections Victoria.

The objectives of this Practice Inquiry are to:

- map current strategy and practice in engaging men who have been referred to MBCP providers in the Bayside Peninsula and Southern Melbourne region of greater Melbourne
 - gain a comprehensive understanding about intake and assessment, and engagement practices, and how these may influence further engagement, from a practitioner perspective and
 - share findings among service providers, policy makers and researchers of the various engagement processes used at intake and assessment to better understand their impact, including making recommendations for change in the context of the landmark Victorian Royal Commission in Family Violence (RCFV) reforms.
- 

The Practice Inquiry found that intake and assessment processes at each of the MBCPs offer a critical opportunity for tailored, client-focused interventions. Practitioners highlighted that the intake process - for men who both voluntarily make contact and those who are mandated to attend – can influence the manner in which men perceive the service, its workers and how they engage in the MBCP. It was found that a supportive and receptive intake can uncover what is important to the man, as well as identifying any contextual issues that may present barriers to effective engagement. Similarly, the intake process offers the opportunity for practitioners to identify and scaffold the man's intentions and motivations to inspire him to maintain engagement.

The process of mapping the various program models and their underlying theories can itself offer insight into the effectiveness of the tools, techniques and strategies employed by MBCP intake and assessment practitioners.

Factors that hinder a man's completion of a MBCP were revealed through interviews and focus groups with practitioners. A number of factors were identified:

- sense of shame
- substance abuse
- trauma and poor mental health and
- over-subscribed programs.

Practitioners expressed frustration relating to court mandated clients, namely that the determination of MBCP eligibility for these men is made by the courts rather than MBCP providers. As such, some court mandated men fail to present to the MBCP service provider as 'group ready' at the assessment interview. As a result, individual work and support with the man was required before he was able to join a group.

MBCPs are the central platform for intervening with men who use violence in their relationships. The assessment process is therefore critical, and perhaps the only opportunity to engage meaningfully one-on-one with a perpetrator. The process provides an opportunity to hear a man's story, develop individualised motivation strategies, and to frame and develop responses to his individual needs. Practitioners identified that the availability of an in-house counselling service could assist to keep a man engaged with a MBCP provider throughout his journey to completion of the program.

Practitioners from multiple organisations also identified the need for greater flexibility to be built into court mandated orders to allow for a broader suite of interventions. For some men who are court ordered to attend a MBCP, eligibility is currently determined by the court, thus posing challenges if and when they present to a MBCP. Research participants detailed how this situation affected their organisational processes, often requiring practitioners to seek variations to a court order, particularly for men who were not suited to group work. In response, practitioners identified that the role of the Respondent Workers at Magistrates' Courts could be elevated to provide recommendations to the Court as to a man's eligibility and readiness to participate in a MBCP. Respondent Workers could also identify additional supports that may be suitable for the man, depending on his specific needs.

With increased State Government investment in the development and implementation of MBCPs in Victoria, the findings from this Practice Inquiry provide an evidence base for a suite of improvements which would support practitioners and boost capacity for behavioural impact from the very start of the change process.

Recommendations

Intake and assessment practice

Recommendation 1

As part of implementing Royal Commission into Family Violence recommendations in relation to perpetrator interventions, increase the suite of interventions to which assessment workers can divert men who use violence, to include:

- complementary case management
- concurrent one-on-one counselling and
- longer term interventions, including increasing program duration.

Recommendation 2

As part of implementing Royal Commission into Family Violence recommendations in relation to perpetrator interventions, ensure that MBCPs are complemented by a continuum of services that address additional issues identified by practitioners, for example, Children's Contact Services and trauma based interventions.

Recommendation 3

To strengthen the work of MBCPs and ensure that practice is aligned with other parts of the service sector in line with *Building from Strength: 10-Year Industry Plan for Family Violence Prevention and Response*, ensure that partner contact service provision is consistent across all MBCP service providers, in recognition that many perpetrators are still in relationships with the Affected Family Member, with flexibility to offer outreach as well as engage with children.

Recommendation 4

In line with Victorian Government's Diversity and Intersectionality Framework and in response to intersectional risk, increase resourcing in the sector to enable more MBCPs to meet the needs of Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse (CALD) communities, LGBTI communities and people with a disability.

Professional and workforce development

Recommendation 5

Develop specific actions for the MBCP specialist workforce as part of the *Building from Strength: 10-Year Industry Plan for Family Violence Prevention and Response* Rolling Action Plans and No To Violence's development of a long term workforce strategy to address:

- health and wellbeing issues, including the high burnout rate
- lack of pathways into the profession
- relative high cost of qualifications and
- ongoing professional development needs including: modelling respectful relationships in groups; motivational interviewing; dealing with 'hardened' groups; and intake and assessment training and skill development.

Recommendation 6

As part of Family Safety Victoria's Centre for Workforce Excellence remit to boost capability and support learning, and the MBCP workforce development strategy, improve practice development, learning and peer support resources for the MBCP specialist workforce including:

- establishing a central repository of resources to support best practice
- support the reestablishment of the No To Violence-convened 'Only Woman in the Room' network group and
- consider other peer support opportunities for practitioners.

Standards and guidelines

Recommendation 7

To support the strengthening and continuous improvement of MBCPs, the Department of Health and Human Services should consider establishing a mechanism to ensure MBCP providers are adequately meeting minimum standards, with an emphasis placed on:

- ensuring evidence-based theories of change underpin each program
- initial assessment processes are robust and designed to maximise motivation and engagement and
- MBCPs working with CALD communities, Aboriginal and Torres Strait Islander communities, LGBTI communities, men with mental health conditions, men with substance abuse issues, men with disability and men experiencing homelessness are firmly grounded in an intersectional approach.

Justice/Court processes

Recommendation 8

In response to insurmountable barriers to group admission for some court mandated clients, court orders should provide for a broader suite of responses, including therapeutic interventions, to address the needs of men unsuited to MBCP group work.

Recommendation 9

To alleviate pressures for MBCP practitioners, elevate the role of the Respondent Worker at each of the Magistrates' Courts so that they can provide greater support to presiding Magistrates and the intake processes of MBCPs. This could be achieved by having the Respondent Worker provide recommendations to the Court as to the Respondent's readiness for MBCP, as well as identifying additional supports that the Respondent may need either in conjunction with attending a MBCP and/or prior to attending.

Context of the Practice Inquiry:

A time of substantial change in the family violence sector

On average, one woman a week in Australia is murdered by her current or former partner (Our Watch, Australia's National Research Organisation for Women's Safety (ANROWS) and VicHealth, 2015). One in six Australian women have experienced physical and/or sexual violence by a current or previous partner (Australian Institute of Health and Welfare, 2018) and one in four have experienced emotional abuse by a current or former partner. In 2014-15, almost eight women were hospitalised each day after being assaulted by their spouse or partner (Australian Institute of Health and Welfare, 2018). Women aged 18 to 24 are more likely to experience physical or sexual violence than women in any other age group (Australian Bureau of Statistics, 2013). The incidence of sexual assault for women in this age group is twice as high as for all women, while for women aged 15 to 19, it could be as much as four times higher (Tarczon & Quadara, 2012). A 2015 report by Youth Action states that young people experience violence in their own relationships, with approximately one third of adolescents experiencing some type of violence from an intimate partner, with an estimated 12 per cent experiencing physical violence (McKenzie, 2015).

Children and young people are significantly impacted by family violence, either directly or indirectly. According to the 2016 Personal Safety Survey, approximately 50 per cent of women who had children in their care when they experienced violence by a current partner reported that the children had seen or heard the violence (Australian Bureau of Statistics, 2017). In 2015-16, 92 per cent of clients of specialist homelessness services who were experiencing family and domestic violence were women and children (Australian Institute of Health and Welfare, 2016). National child protection data also reveals that of the 45,714 Australian children who were the subject of substantiated child protection notifications, 45 per cent had experienced emotional abuse, and 18 per cent had experienced physical abuse (Australian Institute of Health and Welfare, 2017). Children also comprise the second most affected group of victims of family and domestic homicide after intimate partner homicide (21 per cent and 56 per cent respectively) (Cussen & Bryant, 2015).

It is well known that the overwhelming majority of perpetrators of family violence are men. AIHW's 2018 report indicates that three in four victims of domestic family violence reported a male perpetrator (Australian Institute of Health and Welfare, 2018). Data provided by the Crime Statistics Agency to the Royal Commission into Family Violence (RCFV) also reported that:

- 78 per cent of respondents to family violence intervention orders in the Magistrates' Court of Victoria over the five years from 2009-10 to 2013-14 were men.
- Of the 23,388 male respondents in the Magistrates' Court in 2013-14, 73 per cent were between 20 and 44 years of age, with the largest age group being those between 30 and 34 years of age.
- In 2013-14, police recorded that 19 per cent of incidents involved perpetrators who were definitely affected by alcohol and 16 per cent of incidents involved perpetrators who were possibly affected by alcohol.
- In 2013-14, police recorded that nine per cent of incidents involved perpetrators who were definitely drug-affected and 21 per cent of incidents involved perpetrators who were possibly drug-affected.
- In 2013-14, the mental health of the perpetrators was recorded as a factor by police in 20 per cent of incidents.
- In 2013-14, 13 per cent of incidents involved perpetrators who were unemployed (State of Victoria, 2016).

Holding perpetrators accountable is one of the six priorities of the Commonwealth Government's Third Action Plan 2016-2019 of the National Plan to Reduce Violence against Women and their Children 2010-2022 (Third Action Plan). The Third Action Plan articulates that in keeping women and children safe from violence, it is essential to maintain a focus on perpetrators to target them for behaviour change and hold them accountable for their actions. Concurrently, implementation of the Victorian Family Violence Rolling Action Plan 2017-2020 (Rolling Action Plan) involves a range of system reforms and service interventions influencing perpetrator accountability including: early intervention strategies; improved referral pathways pertaining to perpetrators; reforms to family violence intervention orders and police responses to family violence; and increased funding to expand specialist family violence courts.

The sharp focus on family violence in Victoria has been consistent in recent years. Sadly, this attention has been in the wake of a series of family violence-related deaths in Victoria, including that of 11-year-old Luke Batty, who was killed by his father in 2014 after years of abusive behaviours directed against Luke's mother, Rosie Batty. The world-first RCFV was established as a result of these deaths in acknowledgement:

[O]f the seriousness with which the Victorian community has come to regard family violence and its consequences for individuals and families – it reflects our growing awareness of its scale, a recognition that existing policy responses have been insufficient to reduce the prevalence and severity of the violence, the priority the community is prepared to accord it in order to address the problems (State of Victoria, 2016, p. 1).

Recommendations made by the Royal Commission were specific and far reaching. In total, 227 recommendations were made and ranged from risk assessment and management, information sharing, family violence and the child protection system, police operations and workforce, courts, perpetrators, the role of the health system, and industry planning. Recommendations specific to particular population groups were also made, such as Aboriginal and Torres Strait Islander communities, people with disabilities and lesbian, gay, bisexual, transgender and intersex (LGBTI) communities.

In response to the RCFV's report and recommendations, in 2017 the Victorian Government invested a record \$1.9 billion over four years to implement all 227 recommendations (State of Victoria, 2017), building on funding of \$572 million in the 2016-17 budget. A further investment of \$42.5 million was announced in May 2018 (State of Victoria, 2018). This is more than any other state or federal government in Australia.

As of the 1 May 2018, 90 of the recommendations have been implemented. Relevant to this Practice Inquiry, these include:

- Development and strengthening of guidelines for further engagement with perpetrators of family violence (Recommendation 25).
- Mapping roles and responsibilities of all organisations in contact with perpetrators (Recommendation 85).
- Convene a committee of experts on perpetrator interventions and behaviour change programs (Recommendation 86).

The remaining 137 recommendations are currently in progress. These include a number of recommendations which are specific to perpetrators of family violence, including:

- Recommendation 87 – Research trial and evaluate interventions for perpetrators.
- Recommendation 88 – Provide dedicated funding for future perpetrator programs.
- Recommendation 89 – A broader range of providers engaged in counselling services for perpetrators.
- Recommendation 90 – An improved process for monitoring attendance at behaviour change programs.
- Recommendation 91 – Review and update the minimum standards for men's behaviour change programs.
- Recommendation 92 – Sufficient funding for men's behaviour change programs to meet new demand.
- Recommendation 146 – Prioritise adequate funding for Aboriginal community controlled organisations.

For the recommendations currently in progress, this includes:

- \$7.36 million for a new case management model for perpetrators of family violence (State of Victoria, 2018).
- \$11.4 million to create an additional 4000 community-based men's behaviour change places (State of Victoria, 2018).
- \$2.3 million for men's intake and referral services (State of Victoria, 2018).
- \$4.83 million to support trials of family violence perpetrator interventions that target diverse groups (State of Victoria, 2018).
- \$1.75 million to be shared by five organisations to help reduce family violence by expanding the delivery of specialist perpetrator intervention programs under the Family Violence Perpetrator Intervention Grants Program (State of Victoria, 2018).

The investment that has been made to address and prevent family violence in Victoria in a coordinated, integrated and evidence-based manner is unprecedented. The growing public attention on the issue, and on gender inequality more broadly, signals a deep shift in community understanding and awareness. The investment in perpetrator accountability is underscored by an integrated, cross-sectoral approach to embedding best practice and a commitment to review, change and innovate organisational practices at the local level.

Men's behaviour change programs in Victoria

Currently a small suite of strategically directed interventions operate across Victoria to hold perpetrators of family violence to account. Principal amongst these interventions are Men's Behaviour Change Programs (MBCPs) (State of Victoria, 2016). MBCPs began to proliferate in Australia in the early 1990s, growing out of the feminist movement as a means of addressing violence perpetrated by men against their female partners or other family members. The programs situate responsibility for the violence with the perpetrator. MBCPs seek to challenge attitudes and reform individual behaviours in a group engagement environment. They also promote the safety of women and children.

No To Violence (NTV) incorporating the Men's Referral Service (NTV/MRS) is the Victorian peak body for organisations and individuals working with men to end their violence and abuse against family members. NTV/MRS oversees the standards of practice for MBCPs delivered by more than 100 members, delivers the Graduate Certificate in Male Family Violence which is the core qualification for facilitators of MBCPs, and undertakes practice and policy development work to ensure men who use violence are held accountable for their behaviour and actions. The MRS takes over 1,000 calls per month across Australia and has had over 150,000 conversations with men about their use of violence over the last 25 years. Working specifically in Victoria, New South Wales and Tasmania, NTV responds to police referrals for men, and currently proactively call approximately 70,000 men each year to provide the support they need.

The vast majority of MBCPs in Victoria receive funding from the Department of Health and Human Services (DHHS). Service programming and practice can vary, but all providers are required, as a funding condition, to satisfy minimum standards in delivery and to maintain membership with NTV/MRS. NTV membership itself is contingent upon compliance with the standards (Family Safety Victoria, 2017; No To Violence, 2018).

Referral pathways into men's behaviour change programs in Victoria

There are a number of pathways into a MBCP. Some men are mandated to attend a program via a third party such as a consequence of a court order (imposed by the Magistrates' or Special Family Violence Courts, Family Court, or Children's Court). Men may also be referred by a family violence service or they can self-refer instigating their own contact directly with a program by contacting the MRS. Predominantly men are referred from other services or practitioners such as police or other first responders, family law or criminal lawyers, family services, health professionals, community agencies or via the court system. Many such referrals are informal or 'voluntary'; in these instances there is no formal obligation on behalf of the perpetrator to pursue the referral. This means that many referred men may not proceed to make contact with a program provider or participate in a program. Some men do make initial contact, but withdraw before commencing a program, or part way through. For a number of men, however, attendance is mandatory and subject to a court order or condition imposed by the parole board.

According to the (Crime Statistics Agency, 2016) formal referrals for perpetrators made by Victoria Police after attending a family incident increased from 6,297 (July 2009-June 2010) to 43,578 (July 2013-June 2014), with informal referrals decreasing from 11,837 to 9,031 in the same time period.

'Voluntary' engagement and self-referral is often compelled by social or familial pressure, or can be on the basis of professional advice and referral. For example, a legal professional or social worker might suggest attendance or make a referral in an attempt to pre-empt a court order, or as a demonstration of commitment to change in the hope of bolstering court or parenting plan outcomes. A referral for voluntary participation may also have come as a consequence of contact with the MRS (State of Victoria, 2016). As a result, men presenting to MBCP providers may have widely varying levels of commitment, willingness and preparedness to change. Some men will attend voluntarily, and some more reluctantly. Some men may have experienced a relationship breakdown or crisis. Responding to these differences requires practitioners to be flexible, attentive and adaptive at the point of initial intake and assessment, and throughout the course of a program.

In its submission to the RCFV, NTV noted that this web of referral pathways and lack of unified oversight of these pathways means the service system can seem optional for perpetrators (No to Violence: Men's Referral Service, 2015). As illustrated by Figure 1, NTV note that men are able to 'opt out' at multiple points after an L17 police referral has been made. For example, men may opt out at or after contact with the MRS After-Hours service or after initial intake with a MBCP (No to Violence: Men's Referral Service, 2015).

In attempt to support existing MBCPs in dealing with increased demand, the then Department of Human Services (DHS) provided funding for the Enhanced Services Intake (ESI) initiative, building on existing intake services for MBCPs. The ESI initiative was designed to increase the number of men engaging with MBCPs by increasing service provision offered by the MRS to provide an ESI response to weekend L17 referrals from Victoria Police.

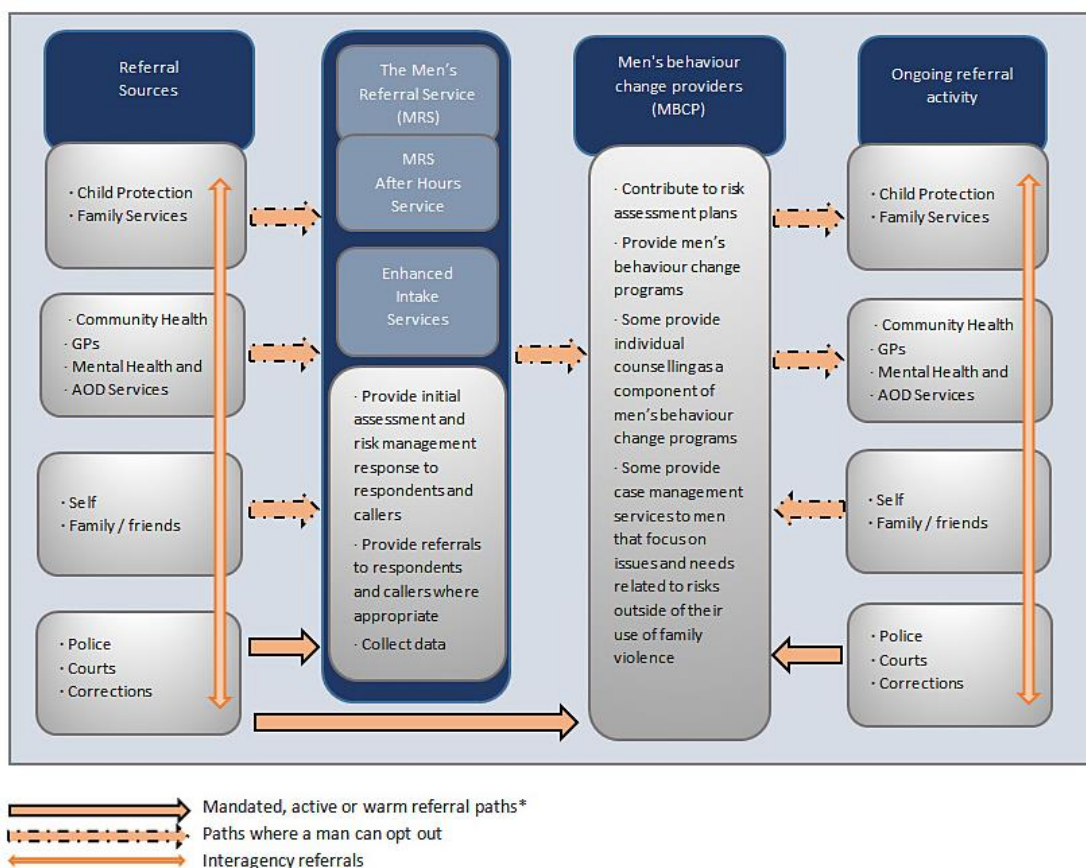


Figure 1: Referral pathways to MBCP and paths where a perpetrator can opt out (NTV/MRS submission to RCFV, p. 23)

The need for a Practice Inquiry

As family violence awareness has increased and the associated issues discussed more openly in the public domain, research into perpetrator interventions has expanded. The focus of much of this research has been upon theoretical frameworks, program design and evaluation of the effectiveness of programs in reducing recidivism. Intake and assessment are often given cursory treatment in these studies, and there is limited exploration of the engagement techniques practitioners find most effective in facilitating men's entry into and completion of programs. Little scrutiny has been directed at the practices, tools and methods used at service level to engage men, to respond to often different and complex needs, and to foster the motivation and desire in men to see a program through to its conclusion. There is limited analysis of how intake and assessment processes are used by service providers to identify those who are 'not ready' and to assess the most appropriate alternative intervention, and where possible, facilitate engagement with that alternative service. The existing literature is not sufficient to enable determination of assessment procedures and interventions most effective in responding to family violence in the community (McEwan, Wood, & Ogloff, 2015, p. 18).

The RCFV highlighted that perpetrator interventions in Victoria are currently limited in breadth and variety, with MBCPs being the most common programmatic intervention (State of Victoria, 2016). The RCFV highlighted the ways in which perpetrator programs remain dislocated from other related services such as those that address mental illness and drug and alcohol misuse. The RCFV also noted scope for improved understandings of the extent to which existing programs are successful in addressing these issues. Further, the RCFV observed that existing programs do not cater for different cohorts of perpetrators and are not designed to respond to the needs of perpetrators for whom group work is unsuitable (State of Victoria, 2016, p. 28).

This Practice Inquiry attends to these knowledge gaps with a focus on improving understanding of MBCP intake and assessment practices, including practitioner engagement techniques that have emerged within existing practice guidelines and funding parameters.

Scope of the Practice Inquiry

While there is a need for comprehensive evaluations of MBCPs and perpetrator interventions more broadly, this Practice Inquiry does not evaluate effectiveness in relation to behaviour change. Instead, it investigates intake and assessment practices in relation to men completing MBCPs as perceived by professionals from five organisations within the two regions:

- Family Life
- Peninsula Health
- Star Health (formerly Inner South Community Health)
- Relationships Australia Victoria and
- Corrections Victoria.

This Practice Inquiry explores aspects of internal engagement practices, approaches and processes perceived by professionals to be associated with men completing MBCPs, and factors outside of the MBCP provider's control that can contribute to or hinder completion. In the process, we ask practitioners whether any suggested improvements could be made to the frameworks which guide practice in MBCPs, including the DHHS Men's Behaviour Change Programs: Service Intake Model and Practice Guide, and the NTV Men's Behaviour Change Group Work Minimum Standards and Quality Practice Standards and Guidelines.

The objectives of this Practice Inquiry are to:

- map current strategy and practice in engaging men who have been referred to MBCP providers in the Bayside Peninsula and Southern Melbourne region of greater Melbourne
- gain a comprehensive understanding about intake and assessment, and engagement practices, and how these may influence further engagement, from a practitioner perspective and
- share findings among service providers, policy makers and researchers of the various engagement processes used at intake and assessment to better understand their impact, including making recommendations for change in the context of the landmark Victorian Royal Commission in Family Violence (RCFV) reforms.

Project outcomes will also be useful for knowledge transfer among service provider participants and the broader family violence service sector, and contributing to an evidence-informed model for MBCPs at the point of intake and assessment.

Method for the Practice Inquiry

Fieldwork for the Practice Inquiry was undertaken from April-December 2017, followed by further consultation on the development of recommendations in 2018. This process involved:

- A review of perpetrator intervention literature and policy
- Focus group discussions with practitioners at five MBCP providers in the Bayside Peninsula and Southern Melbourne regions
- Semi-structured interviews with key personnel within each of the MBCPs
- Mapping of the current internal processes and practices for referral and intake within each of the MBCPs and
- A stakeholder forum to share, reflect and provide feedback on 'good practice' in MBCPs as identified through consultations, and reflect upon and provide feedback on gaps and opportunities for improvement.

In order to establish a comprehensive understanding of the processes involved, key personnel were sought from the intake point through to facilitators of MBCPs, as well as Team Leaders or Program Managers.

The qualitative data collected across the project provided a clear understanding of the relationships and processes involved when men access MBCPs. The data analysis methods included:

- Mapping referral and intake processes for Bayside Peninsula and Southern Melbourne regions-specific MBCPs.
- Identifying components/elements of best practice in the referral and intake process as outlined by the peak body for men's services (NTV/MRS).
- Analysis of the publicly available quantitative data relating to referrals made to MBCPs, specifically in the Bayside Peninsula and Southern Melbourne regions.
- Reflection with practitioners around the qualitative data collected through interviews, and analysis of this data through facilitated workshops.
- Identifying referral and intake process gaps and opportunities for improvement through the mapping process.
- Analysing relationships between intake and assessment processes, engagement practices, and perpetrator MBCP attendance and completion through facilitated workshops with practitioners.

The primary quantitative data component of the project methodology was the total number of police-initiated referrals (publicly available data on L17s) made for perpetrators of family violence received by the Men's Active Referral Services (MARS) for the 2015-16 financial year. It is important to note that while L17s received by MARS reflect the high demand placed on MBCPs, this is not the only pathway into a MBCP, and does not provide a true reflection of the number of referrals received by MBCPs across the state.

Focus group consultations

A series of group discussions with practitioners at four of the five service providing organisations explored the following four key questions:

- What intake and assessment practices are perceived to be most effective in men engaging or completing MBCPs?
- What aspects of internal engagement practices are perceived to be associated with those men engaging or completing the MBCP (i.e. processes, approaches, engagement practices etc.)?
- What factors outside of the MBCPs' control can be identified that may contribute to or hinder engagement or completion of the MBCP?
- In what ways, if any, can suggested improvements (feedback; insights; observations; knowledge) be made to the DHS *Men's Behaviour Change Programs: Service Intake Model and Practice Guide* and/or the NTV *Men's Behaviour Change Group Work Minimum Standards and Quality Practice Standards and Guidelines*?

The Practice Inquiry also interviewed one staff member from Community Corrections Services to understand practices applying specifically to their clients.

Limitations of the Practice Inquiry

Given current practice model limitations of MBCPs, the service providers involved in this Practice Inquiry only provide the MBCP to male perpetrators of violence, and more specifically, male perpetrators who use violence against their female partners or former partners or other family members. As such, this Practice Inquiry is unable to consider similarities and/or differences in intake and assessment and engagement practices with respect to perpetrators who identify as gay, bisexual, transgender or gender diverse or intersex.

Given the dataset which this Practice Inquiry draws from, factors such as socio-economic status, cultural background, ethnicity, preferred language and age – and how, if at all, these factors influenced or informed intake, assessment and/or engagement practices – were outside of scope.

Although two participants who contributed to focus groups are employed specifically as Women's Workers within a MBCP service provider organisation, the focus of this Practice Inquiry is on intake and assessment and engagement with perpetrators of violence, rather than victim/survivors. As such, no analysis is provided on how intake, assessment and/or engagement practices with MBCP participants may have broader implications for victim/survivors.

Part One:

Literature and
policy overview

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Part One: Literature and policy overview

While there is an increased focus on bringing perpetrators of family violence into view, there is limited evidence concerning what best practice involves. The RCFV highlighted that perpetrator interventions available in Victoria are currently limited in breadth and variety, with MBCPs being the most common programmatic intervention. Specifically, the RCFV noted scope for:

- improvement of understanding of the extent to which existing programs are successful
- addressing issues of access to programs
- monitoring completion of a program and
- investigating methodologies implemented by different programs.

With respect to MBCP intake and assessment practices, there is limited specific examination in the literature, and comprehensive research remains to be undertaken to definitively answer the question of what works for whom in achieving perpetrator behaviour change (Greal, Wallace, Lai, Bodiam, & Dowler, 2012). The literature that does exist sheds little light on which of the many and varied assessment procedures and interventions most successfully responds to family violence in the community (McEwan, Wood, & Ogloff, 2015).

This section reviews the policy context for MBCPs and provides an overview of research into effective practice, with a particular focus on intake and assessment practices and their implications.

Perpetrator accountability and focus on behaviour change

The concept of perpetrator accountability is broad and includes: keeping women and children safe; ensuring legal and police responses are adequate and include penalties for breach of orders; and a focus on encouraging the perpetrator to understand and take responsibility for their actions. MBCPs are therefore an integral part of ensuring perpetrator accountability.

These principles are recognised nationally and embedded within the Commonwealth Government's twelve-year *National Plan to Reduce Violence against Women and their Children 2010-2022* (Commonwealth of Australia, 2010). The Third Action Plan, the most current of the twelve year plan, referencing women and children's safety as its central tenet, notes:

It is not possible to keep women and children safe from violence without a focus on perpetrators. While our highest priority is responding to crisis for women and children and then ensuring their long-term support and stability, there is also a need to target perpetrators to change their behaviour, as this increases the safety of women and their children. Perpetrators must be kept in focus and held accountable for their actions (Australian Government, 2016, p.33).

The Third Action Plan prioritises keeping perpetrators accountable and engaging them for behaviour change. Actions within the priority area include:

- supporting research into perpetrator interventions
- improving mechanisms to make early referrals for perpetrators to appropriate interventions based on individual risk factors
- trialling and evaluating the impact of early integrated case management and counselling prior to, and after, participation in men's behaviour change programs
- trialling and evaluating innovative models of perpetrator interventions (especially designed for specific demographics, such as Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD) people, adolescents, and/or Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) people) and
- improving the quality and consistency of behavior change programs nationally.

To this end, priority six of the Third Action Plan has seen the development of Outcome Standards for Perpetrator Interventions. Although non-binding, the Standards signal a significant effort to drive the implementation of more effective and consistent interventions across all Australian jurisdictions (Australian Government, 2016).

Within Victoria, the focus upon perpetrator accountability has been sharpened in response to State Coroner Ian Gray's observations in the Luke Batty inquest, and the RCFV. Judge Gray observed:

It is critical that perpetrators become engaged, or are forced to engage, with the family violence system and the criminal justice system at every possible opportunity to ensure they are not only held to account for their behaviour but also to ensure they receive appropriate treatment, counselling and management to assist them to change that behaviour (Coroners Court of Victoria, 2015).

To date, MBCPs remain the most common intervention to address men's violent behaviours in the context of family violence. However it is commonly accepted that behaviour change generally can be difficult even in ideal situations. For example, a meta-analysis of 47 studies on self-improvement interventions (including for example, using sun protection, increasing exercise or quitting smoking) found that even when the individual has a medium-to-large *intention* to change, *actual* behaviour change is only small-to-medium (Webb & Sheeran, 2006). Because MBCPs are often court-ordered, it cannot be assumed that all men who participate in them have a high degree of intention to change. With respect to family violence, a meta-analysis of 22 studies found that treatment programs did not reduce recidivism above the effect of imprisonment (Babcock, Green, & Robie, 2004). It is therefore important to approach MBCPs with realistic expectations.

Overview of underpinning program theory

There are several theoretical models which underpin programmatic responses to men's perpetration of violence against women. The following section provides a brief overview of the main models and their application within the five services reviewed by this Practice Inquiry.

Feminist theories of masculinity

Critical feminist analysis has informed a developing area of scholarship into men and masculinities over the last three decades. Within this field of research, the exertion of power and control in the context of family violence – and violence against women more broadly – is viewed as a defining feature of gender inequality. Challenging hegemonic constructions of masculinity and undoing its harmful manifestations plays a role in many programs designed for men who perpetrate family violence (Jewkes, et al., 2015).

A recent NTV conference (National Working with Men to Tackle Family Violence Conference, 2017) identified 'toxic masculinity' – that is, masculinity as defined by violence, sexual dominance, status and aggression – as the heart of a culture that normalises sexism and allows family violence to occur. Challenging toxic masculinity or harmful notions of masculinity, referred to in the literature as 'hegemonic masculinity', therefore plays an important role in working with perpetrators within MBCP settings (Jewkes, et al., 2015).

It is important to consider the ways in which hegemonic masculinity, broadly defined as a set of traits which define 'real men' as those in a position of domination over women and other men, intersects with the experience of individual men. For practitioners working with male perpetrators of violence, this means:

... not only focusing on their lived masculinity expressed through power and force, but also paying attention to their own vulnerabilities and sense of marginalizations as men ... it is important to recognise the interlinkages between dominant masculine norms, experienced vulnerability, and violent behaviour. Working with perpetrators requires carefully understanding their living environment, their experiences, and their reality (Loncarevic & Reisewitz, 2016).

Furthermore, Jewkes et al (Jewkes, et al., 2015) also caution against presenting masculinity as inherently problematic, but rather ensuring that programs focus on the social concept of male privilege and the possibility for change in individual practices and overarching ideals.

Significantly, four of the five services engaged for the Practice Inquiry explicitly draw on a feminist theoretical foundation as the basis for their programs. The fifth service provider bases its framework on three evidence-based theories. The degree to which the practitioners referred to a feminist perspective, or specifically labelled it as such, varied. In this way, critical feminist analysis was understood to be implicit across all of the programs.

In general, a variety of different frameworks are drawn upon to inform various perpetrator interventions, and these subsequently influence intake and assessment practices. Perpetrator interventions principally adopt either a psycho-educational or psycho-therapeutic approach, or alternatively, a combination of both. This section provides a brief overview of the primary models in use.

The Duluth model

The Duluth model is perhaps the most widely employed approach to MBCP programming. It emerged in the 1980s in the city of Duluth in Minnesota, United States, and has had significant influence upon the development of MBCPs in Victoria (State of Victoria, 2016). This model can be characterised as psycho-educational and gender-driven, although it often incorporates some elements of cognitive behavioural theory (Day, Chung, O'Leary, & Carson, 2009).

In its elemental form, the Duluth model is a coordinated multi-agency approach that promotes collaboration across the justice and community service systems. It engages a feminist lens to educate male participants about entrenched understandings of masculine and feminine norms, gender power relations and the harmful impacts of gender inequality and patriarchal ideologies (Grealy, Wallace, Lai, Bodiam, & Dowler, 2012; State of Victoria, 2016). It is underpinned by the notion that men use violence to exercise power and control in their relationships. Accordingly, emphasis is placed on encouraging perpetrators to assume responsibility for their behaviours. Participants are typically met and interviewed individually prior to joining the program which is then delivered in a group setting. Sessions on related topics are rolled out over a (typically) 12-18 week program, with participants encouraged to engage with the course content via dialogue and role-play.

A review of research conducted on the efficacy of the Duluth model reported that its ability to change behaviour was not greater than control groups (Dutton & Corvo, 2006). This model has also been challenged for its use of confrontation as an approach. Some reject the feminist basis of the model, arguing that violence should be seen as non-gendered; for example, Dutton and Corvo suggest that the feminist framing can lessen other contributing factors and these remain unaddressed (ibid). Other criticisms are that the model fails to adequately respond to individual differences and complexities (State of Victoria, 2016); for example, the model does not attend to the legacy of colonisation and dispossession with respect to Aboriginal and Torres Strait Islander men.

A further criticism of the Duluth model is that treatment offered to individuals is shallow and rarely individualised due to 'program drift' that comes about as a result of unclear program logics and limited guidance for maintaining program integrity (Day, Chung, O'Leary, & Carson, 2009).

With a foundational understanding of gender inequality as a driver of men's violence against women, the model has also been criticised for ignoring or minimising the role of compromised mental health or substance abuse among perpetrators (Corvo, Dutton, & Chen, 2009).

Cognitive Behavioural Therapy

Another approach that is often incorporated into Duluth-based MBCP programming is Cognitive Behavioural Therapy (CBT), an approach underpinned by the view that family violence is a product of psychological dysfunction. CBT is a popular approach to address a wide range of problems resulting from psychological dysfunction, and has been shown to be effective in treating issues such as anxiety, sleep disorders, stress and anger management (Hoffman, Asnaani, Vonk, Sawyer, & Fang, 2012). In promoting a psychotherapeutic approach to intervention (Grealy, Wallace, Lai, Bodiam, & Dowler, 2012), and categorising personal dysfunction as a core element in contribution to violent behaviour (Mackay, Gibson, Lam, & Beecham, 2015, p. 11), psychotherapeutic programs like CBT tend to be individualised and are conducted by trained psychologists.

In relation to perpetrator interventions, CBT is founded on the understanding that family violence is a learned behaviour, and that this learning can be reversed via education (Mackay, Gibson, Lam, & Beecham, 2015). In adopting CBT, the therapist and perpetrator work to pinpoint, test, challenge and then change the thought processes that contribute to the person's violent behaviour (Mackay, Gibson, Lam, & Beecham, 2015). CBT involves teaching the perpetrator new skill sets to help control the use of violence, such as skills relating to anger management or interpersonal communication (Mackay, Gibson, Lam, & Beecham, 2015). While CBT does appear to assist with anger management, the findings for perpetrators of family violence are that both CBT and the Duluth model have only a minimal impact on improving behaviour (Babcock, Green, & Robie, 2004).

The Risk Needs Responsivity approach

Common in criminal justice settings, the Risk Needs Responsivity (RNR) approach is emerging as an alternative to Duluth. Developed by Andrews and Bonta (Andrews & Bonta, 2010), the RNR framework is a broad set of principles rather than a specific model of intervention. The model posits that to be most effective, the following three principles should be applied:

- Differentiate interventions according to the risk posed by the offender, and do not mix high and low-risk offenders in the same intervention group.
- Identify and address criminogenic needs, or dynamic risk factors, related to the person's offending behaviour.
- Seek ways to make the program responsive to the individual's motivational possibilities and patterns, life situation, cultural context and other individual factors.

This model promotes the notion that family violence is tied to personal dysfunction and endeavours to understand and address the criminogenic risk factors specific to the individual. These include social, psychological and emotional factors such as substance abuse and unemployment that are linked to the perpetrator's conduct (State of Victoria, 2016). Whilst RNR's application to family violence theoretically addresses men's sense of entitlement to power and rigidity to gender roles, there is a risk that its implementation may fail to overtly acknowledge the importance of gender-related factors (Polaschek, 2016). Further it has been noted that "attributing violent behaviour to a perpetrator's use of alcohol or mental illness, may act to excuse, justify and normalise family violence" (State of Victoria, 2016, p. 255).

It is worth noting that the RCFV also stated that "[d]espite the perception that these different viewpoints are in opposition, there has been recognition of the value of combining approaches that address gender attitudes with those that address personal factors that contribute to, or exacerbate, family violence offending" (State of Victoria, 2016, p. 258).

Transtheoretical Model of Behaviour Change

A model increasingly seen as offering a relevant framework for intake and assessment purposes is the Transtheoretical Model of Change (also called the Stages of Change Model), originally developed by Prochaska and DiClemente (Prochaska & Di Clemente, 1984). The model describes the process of change in a problem-solving setting, as the individual moves through a series of stages towards complete change:

- Pre-contemplative
- Contemplative
- Preparation
- Action
- Relapse and Maintenance.

In the family violence context, a man engaged in behavioural change may initially be pre-contemplative – not recognising the problem or a need to change. At this stage he may minimise, excuse or deny his abusive behaviours and be unprepared to accept that he has a problem for which he ought to take responsibility (Day, Chung, O'Leary, & Carson, 2009). In response, treatment goals at the pre-contemplative stage are focussed upon increasing the individual's awareness and acknowledgement of the problem and in helping him to 'own' his behaviour and appreciate his capacity for self-regulation (Day, Chung, O'Leary, & Carson, 2009).

From the pre-contemplative stage the man may form the intention to change, thus moving to a contemplative stage, before then planning to take immediate action (preparation), followed by taking that action. At contemplative stage making a commitment to change is critical. In this stage educational interventions such as those which instil an appreciation for the impacts of violence and controlling behaviours on victims are considered most effective, along with group discussions that provide opportunity for group feedback, social comparison and self-re-evaluation (Day, Chung, O'Leary, & Carson, 2009).

In the action stage this model suggests therapeutic emphasis is shifted to the development of positive behavioural skills including stress and anger control. Once a perpetrator has moved through the action stage and has learned how to control and modify his behaviours, he may move into a maintenance phase and ultimately end the change process where no further steps are needed to prevent a relapse (Day, Chung, O'Leary, & Carson, 2009).

Maintenance then becomes about how to sustain behaviour change and prevent recurrence (Day, Chung, O'Leary, & Carson, 2009). While this process is less studied than the Duluth or CBT, there is some evidence that it holds promise. For example, Alexander et al. (Alexander, Morris, Tracy, & Frye, 2010) report that, compared to a CBT re-education approach, female partners reported a reduction in physical aggression. This research also shows that it appeared to be more effective for men who indicated they were ready to make a change.

Individuals making contact with an MBCP would typically be in the pre-contemplative or contemplative stage. To effectively engage the man – to maximise the opportunity of his presentation – intake and assessment workers are tasked with aiding the man to maintain momentum towards further action along the change continuum. Motivational discussions, then, become a critically important component of any communications between client and worker at this early stage when working within this model.

Motivational intake technique

There is some literature on the effectiveness of the motivational intake process, which is designed to assist perpetrators to both see the need for the intervention and want to engage with it. Kistenmacher and Weiss (Kistenmacher & Weiss, 2008) report that using a motivational intake process led to an increase in perpetrators verbalising the need to change and also taking responsibility for their violent behaviour. Musser et al. (Musser, Semiatin, & Murphy, 2008) also found that a motivational intake resulted in higher levels of compliance with homework and more external help-seeking. Murphy et al. (Murphy, Linchan, Reyner, Musser, & Taft, 2012) found that a motivational intake was more effective than a structured intake for some men, including for those who showed reluctance. However, the authors also caution that a motivational intake may not always yield positive results; for men who are in denial about wrongdoing it can make them less likely to engage in a service.

Practice in Australia

MBCP programs can vary significantly in terms of program duration, frequency of sessions, pre-requisites to program admission, cost and session structure. Different organisations adopt different strategies in making contact with the victim/survivor and making referrals to other services. Many of these variations impact upon and influence practice pertaining to intake and assessment. Victoria and New South Wales have developed and implemented minimum standards for all state-funded government perpetrator programs, and professional practice standards have also been developed in Queensland and Western Australia.

Despite these variations, a typical process once a man makes contact with a service provider will see the individual being asked to attend the service to participate in a one-to-one intake and assessment interview or interviews. Unless overt barriers to entry exist, or a significant delay to program commencement exist, the assessor will seek to determine if he is: suitably motivated; possesses sufficient insight and self-reflective capacity; and is able to make the necessary time commitment. If accepted into a program he will then be invited to attend a group session on a weekly basis for a time-limited period (12 to 24 weeks depending upon the model and provider). The period between initial contact and the interview can vary, as can the time between intake and commencement in a group.

With the Practice Inquiry focussing on services in the Bayside Peninsula and Southern Melbourne regions of greater Melbourne, it is important to highlight the Victorian context in particular. While service delivery practices of Victorian programs are guided by standards set through the National Plan and through funding arrangements which require adherence to the NTV Minimum Standards, how men are engaged in a practical sense by an MBCP provider can be subject to a range of influences. Individual skills and experiences, organisational practice, culture and theoretical groundings all have an effect on the perpetrator's experience of the service, commencing at initial intake and assessment.

In practice, MBCPs are often guided by a composite of theoretical perspectives (Grealy, Wallace, Lai, Bodiam, & Dowler, 2012). Victorian and Australian MBCPs tend to use a blend of educative and therapeutic approaches, with pro-feminist underpinnings (Smith, 2009). There is also marked diversity in the way in which programs purport to adhere to individual models are delivered (Day, Chung, O'Leary, & Carson, 2009). This is a fact rued by evaluators seeking to attribute outcomes to particular theories and conceptualisations, but may not be as problematic for those who facilitate or participate in the programs themselves. In practice, it may reflect and respond to a need amongst practitioners to have a suite of approaches available to enable them to flexibly adapt to different clients. It may also represent a recognition and response to perceived gaps in the principle model and determination that another approach might usefully be applied (Vlais, 2014). NTV has acknowledged the potential for a “pick and choose” approach to dilute program logics and values whilst also making the case for the deliberate melding of “different threads” and the combination of models (see Vlais, 2014). As such, Velonis et al. reinforce the importance of linking outcomes to the underlying theory by identifying the mechanisms for change and relating these back to a strong program logic (Velonis, Cheff, Finn, Davloor, & O'Campo, 2016). Further to this, while the fluidity of theoretical approaches can increase flexibility and help to customise program responses, Day et al. suggests that this approach may also be limiting the ease of evaluating program effectiveness in Australia (Day, Chung, O'Leary, & Carson, 2009).

What the Victorian men's behaviour change minimum standards specify

In line with recommendation 91 of the Royal Commission, the NTV Men's Behaviour Change Minimum Standards (2005) were reviewed in 2017 by Monash University (Monash University, 2018). The review recommended that the revised standards be:

organised according to 10 principles drawn from Victoria's Expert Advisory Committee on Perpetrator Interventions' principles for perpetrator interventions (principles 1 – 8) and the National Outcomes Standards for Perpetrator Interventions (principles 9 – 10) (No To Violence, 2018, p. 8).

The 10 principles underpinning the minimum standards are:

- Victims', including children's, safety and freedom unpins all interventions with perpetrators of family violence.
- Interventions with perpetrators are informed by victims and the needs of family members.
- Perpetrators take responsibility for their actions and are offered support to choose to end their violent behaviour and coercive control.
- Inter-agency risk assessment and risk management processes are consistent, robust and strong, and any risk associated with intervention is minimised.
- Perpetrators are kept in view through integrated interventions that build upon each other over time, are mutually reinforcing, and identify and respond to dynamic risk.
- Responses are tailored to meet the individual risk levels and patterns of coercive control by perpetrators, and address their diverse circumstances and backgrounds which may require a unique response.
- Perpetrators face a range of timely system responses for using family violence.

- A systems-wide approach collectively creates opportunities for perpetrator accountability, both as a partner and a parent. Actions across the system work together, share information where relevant, and demonstrate understanding of the dynamics of family violence.
- People working in perpetrator intervention systems are skilled in responding to the dynamics and impacts of domestic, family and sexual violence.
- Perpetrator interventions are driven by credible evidence to continuously improve.

Developed by the Expert Advisory Panel on Perpetrator Interventions, the 2017 minimum standards are no longer the responsibility of NTV, but rather Family Safety Victoria within DHHS. To support MBCP providers in implementing the revised minimum standards, NTV recently released the *Implementation guide: Men's Behaviour Change Minimum Standards* (No To Violence, 2018). All state government funded MBCP providers are bound by the minimum standards.

Indicating an emphasis on the specialisation of MBCP group facilitators, the minimum standards demand that groups be facilitated by at least one Principal Facilitator, a role now requiring additional pre-requisites (Family Safety Victoria, 2017). Similarly, facilitators who are not Principal Facilitators must also hold a relevant tertiary undergraduate degree, have had completed Victorian Risk Assessment and Risk Management training, and observed a minimum of 10 group sessions (ibid.). These requirements however do not apply to existing MBCP facilitators as “the application of these standards is subject to broader transition planning as part of the 10-Year Family Violence Industry Plan” (No To Violence, 2018, p. 74). As such, existing facilitators will remain under the 2005 minimum standards which specify that any staff who undertake assessments of men must hold a Graduate Certificate in Social Science (Male Family Violence – Group Facilitation), or the qualification of Level 3 (A) Facilitator, and have at least 200 hours of experience facilitating behaviour change groups (No to Violence, 2005).

Skill development amongst practitioners is an area that has been identified as of significant importance to engagement of men in MBCPs. Minimum standard 9.1 explicitly states that staff are required to have access to monthly supervision and undertake a minimum of four relevant professional development activities per year (Family Safety Victoria, 2017). Workforce training and continuing professional development is important to the quality of programs and can be a large factor in men's experiences of the program. The 10 year Industry Plan for Family Violence Prevention and Response is inclusive of practitioners who work in the MBCP setting.

As articulated by NTV, “assessment for eligibility is crucial to ensure perpetrators enter the MBCP with adequate cognitive capacity to grasp concepts and to make change” (No To Violence, 2018, p. 53).

As minimum standard 5.1 states:

The eligibility of all perpetrators seeking to access programs is assessed in line with the *Family Violence Protection Act 2008 s. 129(3)* (Vic):

- the respondent's character, personal history or language skills
- any disabilities of the respondent
- any severe psychiatric or psychological conditions of the respondent
- any alcohol or other drug problems of the respondent
- any other matters the specified person considers relevant.

The eligibility criteria is aimed at ensuring program participants are suited to group work environments and demonstrate an appropriate level of willingness and commitment to participation and personal change.

For perpetrators who are deemed ineligible to participate in a MBCP, minimum standard 5.3 sets out that referrals should be made to external services. This includes men who are court-mandated to attend a MBCP. As detailed by NTV, referrals to external services should be done with the aim of supporting men to make change, including addressing any barriers to participating in a MBCP, and providing alternatives for them to address their use of violence (e.g. one-on-one counselling and/or case management) (No To Violence, 2018, p. 53).

With the safety of a man's family members central to assessment, NTV's *Implementation guide* details, with reference to standard 1.2, that each perpetrator must:

- identify those who have been affected by his behaviour (including all children involved in relationships where the perpetrator has used violence as defined in the *Family Violence Protection Act 2008 (s.5, 1B)* (Vic)
- provide contact details if known and
- agree in writing that he understands that the program provider will contact those identified to hear their experience and assist with safety and providing service referrals as required (No To Violence, 2018, pp. 16-17).

A perpetrator's refusal to identify affected family members may result in his eligibility being reviewed.

Significantly, the revised standards expand the duration of MBCP groups from 24 contact hours spread over a minimum of 12 sessions to a minimum of 40 hours over a minimum of 20 weeks, held at regular intervals (Family Safety Victoria, 2017, p. 11). Acknowledging that MBCPs vary between MBCP providers, this new requirement will provide greater consistency across all MBCPs with respect to program duration. In addition to this, revised standard 7.2 articulates that contact with perpetrators take place at least every fortnight prior to the commencement of group work.

Characteristics of perpetrators

Men who engage with MBCPs come from a variety of backgrounds and circumstances. There is limited data captured in both official criminal justice system data and broader victim and safety survey process regarding the demographics and characteristics of family violence perpetrators (Grealy, Wallace, Lai, Bodiam, & Dowler, 2012).

Investigating evaluations of sexual and family violence and literature pertaining to the socio-demographic characteristics of perpetrators, Grealy et al. (Grealy, Wallace, Lai, Bodiam, & Dowler, 2012) observe that evidence suggests a need to match MBCPs to participant characteristics. In addition, they note that initial screening and assessment tools need to be reliable and valid (ibid.).

Incidence

L17 referral data

In the 2011-12 period in the Southern Metropolitan Region (encompassing Bayside, Cardinia, Casey, Frankston, Glen Eira, Greater Dandenong, Kingston, Mornington Peninsula, Port Phillip and Stonnington) there were 2,683 informal and 3,624 formal referrals made for the other party (Respondent) where the Affected Family Member (AFM) was female. In the same period 3,635 MBCP cases were recorded in the same region. This data reveals that while a little more than half of respondents are referred to a MBCP, approximately 42 per cent of respondents are not.

A 2017 analysis of Victoria Police family violence data in the Southern Metropolitan Region has also revealed a low rate of referrals to the Men's Active Referral Service (MARS): of the 21,000 direct referrals in 2015-16, 38 per cent were for men's behaviour change services, and almost twice as many referrals made for victim/survivors to women's support services (62 per cent). For the same period, of the L17s received by MARS, 36 per cent were unable to be actioned when first received because police had not spoken to the respondent or there was no phone number provided for the respondent (Hutcheson, 2017).

Integrated Reports and Information System

The table below illustrates the number of referrals to MBCPs and Women and Children's Family Violence services in Victoria from a range of referral sources between 2011/12 and 2015/16. As the data shows, there has been an increase in referrals to MBCPs over this period, with the exception of referrals from men's behaviour change central intake.

Table 1 Cases by source of referral to program or service,

July 2011 to June 2016

Program or Service type	Source of referral	2011-12	2012-13	2013-14	2014-15	2015-16
Men's Behaviour Change Program	Community welfare and local government welfare	151	239	154	165	235
	Corrections	124	237	312	316	243
	Courts	274	355	383	465	613
	DHHS	182	140	152	243	232
	Medical and hospital agencies	14	15	17	15	16
	Men's Behavioural Change central intake - L17 form	11,132	11,021	10,653	11,580	9,396
	Men's Referral Service	67	209	481	786	983
	Police	1,266	957	1,128	2,868	4,212
	Self, family friend	830	782	844	1,016	1,178
	Other referral source	201	135	138	1,537	1,098
	Not stated	31	24	86	51	157
Total (includes cases where the referral source was unknown)	14,272	14,115	14,348	19,042	18,363	
Women and Children's Family Violence Services	Community welfare and local government welfare	1,690	1,653	1,760	1,842	2,236
	Courts	55	85	58	85	86
	DHHS	556	646	801	696	960
	Medical and hospital agencies	103	96	82	86	78
	Men's Behavioural Change central intake - L17 form	280	167	116	131	116
	Men's Referral Service	14	7	≤ 3	6	14
	Police	414	477	362	165	221
	School (primary and secondary)	88	118	122	64	126
	Self, family friend	1,457	1,427	1,399	1,307	1,647
	Other referral source	334	336	291	370	538
	Not stated	32	32	42	36	110
Total	5,023	5,044	5,035	4,788	6,132	
Total (includes cases where the referral type was unknown)	19,401	19,215	19,532	23,965	24,585	

(Crime Statistics Agency, 2017)

MBCP initial contact

The contexts and factors involved in cases of family violence are complex and impact significantly on the ability of MBCPs to make a positive difference. For this reason, the intake and assessment process is critical to ensure treatment aligns with need (Stith, McCollum, Amanor-Baodu, & Smith, 2012). At the point of first contact the perpetrator may be experiencing a crisis or be otherwise in a state of anguish, shame or vulnerability. The initial contact is critical to building trust and rapport (State Government of Victoria, 2017). An individual – victim/survivor or perpetrator - who has a negative experience when first reaching out for support or assistance may withdraw or elect not to make further steps to safety or change as a result of this experience. Initial contact is therefore a critical step in securing motivation to engage with the program.

Alongside initial contact, intake provides an opportunity to emphasise that family violence, gender inequality and other forms of discrimination are not acceptable. It can also serve to prompt improved self-awareness and insight into the man's conduct and its impact on those in his familial sphere – partners, former partners and children. This is the point at which change can commence.

MBCP intake and assessment aims

A core and essential component of the men's behaviour change process, intake and assessment enables:

- the safety of women and children to be checked
- assessment of suitability to group work and
- engagement of the prospective participant (No To Violence, 2018).

An overview of assessment and evaluation practices is provided by Peterman and Dixon (Peterman & Dixon, 2001). They highlight the importance of a comprehensive intake and assessment process, including:

- Assess mental health: current state; psychosocial deficits; completing an assessment inventory (such as The Abusive Relationships Inventory); identify substance abuse.
- Review records: legal; police; and victim reports.
- Safety of women and children: determine homicide risk or possibility of other violent or stalking behaviour.

NTV's literature recognises that a potential participant's initial contact with a provider can make a difference to whether he proceeds to engage with a service or not. The 2018 *Implementation guide: Men's behaviour change minimum standards* specifically states that when a perpetrator makes initial contact with a MBCP provider:

is a critical time to intervene, where practitioners can build on this motivation through offering some form of service if the perpetrator must wait to get into a program (No To Violence, 2018, p. 64).

An overarching goal of MBCPs is to effect long-term behaviour change, but a parallel and broader aim is served by men's engagement in a program – commencing at the point of intake, his engagement brings those vulnerable to his violence into view and enables planning and risk management interventions to be put into place.

The assessment process typically incorporates an element of program induction, through which information is imparted to the prospective participant about:

- the importance of committing to the program for its duration
- expectations of participants/group members
- participants rights and responsibilities
- the provider's policies on limited confidentiality and disclosure of criminal acts and
- an overview of the program.

The intake and assessment phase also sees the commencement of contact with women as affected family members – “family safety contact work is undertaken as a means of providing risk assessment, safety planning and referrals” for family members impacted by family violence (No To Violence, 2018, p. 17). Affected family members are made aware of their own rights and responsibilities, as well as those pertaining to the man, during his period of engagement with the program (No To Violence, 2018).

According to NTV, the assessment process serves a purpose even where a man elects to opt-out of the intervention: all prospective participants are provided with information about male family violence. This ensures that, should the man not engage further, he has at a minimum received some basic information about male family violence and men’s behaviour change (No To Violence, 2018).

A critical component of the assessment process involves triangulation; in addition to information provided by the man and/or provided by a third-party, the workers also gather information about the experience of violence from affective family members, where those members agree to such contact. This ensures the veracity of the man’s own account (with some men prone to downplaying the frequency and severity of their violence). The MBCP minimum standards (Family Safety Victoria, 2017) and NTV implementation guide (No To Violence, 2018) suggest this is undertaken following the perpetrator’s initial assessment session to confirm the safety of affected women and children.

Providers use the assessment process to determine whether to accept a perpetrator into their program or not. They determine who is suitable and “group ready”. They gain a picture of the man in terms of his relationships and behavioural patterns. They identify any barriers to his participation (such as cultural and linguistic diversity, housing insecurity, substance or alcohol misuse, or mental health issues). Importantly, they also develop an awareness of safety issues present in relation to people affected by the man’s family violence. With a focus on program readiness, providers are able to incorporate motivational interviewing techniques into the assessment process, using the interview as a therapeutic opportunity to encourage the client to begin to move through the stages of behaviour change.

Engagement and disengagement with MBCPs

Programs are intended to be useful to men who want to cease or curb their violent and controlling behaviours, but the factors and circumstances that drive their engagement with an MBCP provider can vary. Research in the United States indicates that between 30 (Stover, Meadows, & Kaufman, 2009) and 35 per cent of men enrolled in MBCPs don't complete (Olver, Stockdale, & Wormith, 2011); this does not include men who choose not to enrol after the initial assessment. Therefore the intake and assessment process becomes particularly important to ensure engagement in programs going forward, and a greater possibility of men completing programs.

A meta-analysis of offender treatment literature was conducted in which 144 studies were reviewed. The literature identifies certain predictors that make men more likely to disengage from either enrolling in or completing a program (Olver, Stockdale, & Wormith, 2011). These include:

- having an anti-social personality
- a history of criminality
- non-mandated attendance
- younger age and
- little motivation for treatment.

The strongest predictor of non-completion was having prior family violence offences. It is also useful reviewing what characteristics are *not* correlated with non-completion: type of violence (e.g., physical, psychological or economic), demonstrating controlling behaviours, experiencing depression or anxiety, anger problems, alcohol use (but not abuse), and experiences of maltreatment as a child.

Ongoing engagement with the program may or may not be affected by a man's motivation for participation (No to Violence, 2005). As argued by Vlasis et al.:

a perpetrator's readiness to contact or participate in an appropriate service . . . is not the same as increasing his readiness to change . . . the perpetrator might feel a 'mandate' to participate in a service due to the perceived/likely negative consequences of not doing so, but this doesn't mean that he necessarily has developed some readiness to change (Vlasis, Ridley, Green, & Chung, 2017, p. 92).

In their research with domestic and family violence perpetrators, Walker et al. (2015) describe the process which can lead a perpetrator to start to desist from violence (Walker, Bowen, Brown, & Sleath, 2015). Walker et al. explain how the negative consequences of the perpetrator's use of violence can interact with his feelings of guilt, shame and fear to result in a decision to change. Importantly, Walker et al. identify that the accumulation of negative consequences in and of itself was not sufficient for perpetrators to make the decision to change. Rather, it is the interaction between these consequences *and* the perpetrator's own feelings of guilt and shame that provides the optimum chance for change (ibid.). Given this, as Vlasis et al. argue, MBCPs are in a unique position to assist perpetrators to:

find meaning in negative consequences as personal concerns related to changes they might like to make in how they wish to be in the world. This can be done, in part, through careful explorations of guilt, shame, fear for the future, and hope (Vlasis, Ridley, Green, & Chung, 2017, p. 94).

Self-referral; quasi-voluntary; voluntary and mandated

Some men self-refer to a program on the basis of self-reflection, even in circumstances where they fear their potential for violence but have not demonstrated such behaviour (No to Violence, 2005). Some are encouraged to reach out by an affected family member, a relative or housemate. Some are heeding the advice of a professional, such as a lawyer, in the hope this will obviate criminal sanction or other consequences (No to Violence, 2005).

Some men who engage as a result of involvement and (possibly) encouragement by those with whom they continue to cohabit with (partners, family etc.), could be described as driven by 'social mandate'. In other circumstances, a court or other statutory body will have mandated the men's participation in the MBCP; in such cases non-attendance of the program may invoke punitive sanction or penalty. Men's access to children for example, or release on bail or parole, may also be conditional upon participation in the program.

For many men, they can experience fear, embarrassment, guilt or shame when they initially engage with a service provider and are contemplating participation in an MBCP program. They can also feel alone - "to ask for help is a big step in honesty for most of us, as we have been taught from an early age to solve our own problems" (Frances, 1998). Men who are mandated to attend a MBCP are required to participate in the same intake and assessment process as those who engage voluntarily. The same conditions, rights and responsibilities apply, and contact with their family members, as well as the standards decreed, should occur in the same way as for other men (Family Safety Victoria, 2017; No To Violence, 2018).

Those who advocate for voluntary programs posit that compulsory attendance creates an environment of antipathy in which individuals and the group as a whole are less likely to accept responsibility for their choices (Smith, 2009). This perspective suggests that voluntary engagement is the first important step in taking responsibility and is therefore more likely to result in program completion and positive change. Some research however, suggests that voluntary participants are more prone to non-completion, with the threat of criminal sanction a significant motivator to continuing participation and the avoidance of further assaults (Gondolf, 1991). Conversely, Smith (Smith, 2009) finds that the research on retention and completion of mandated and voluntary participants is inconclusive, with high attrition rates evident in both classes of participant. Research does, however, support the view that disengagement rates (amongst both mandated and non-mandated clients) are reduced where programs are integrated with the wider service system (ibid).

Motivation and motivational interviewing

Most, if not all, practitioners working in this area can readily identify motivational problems on the part of program participants as a major factor determining progress in program sessions, and yet motivational issues have been curiously neglected in the domestic violence literature (Day, Chung, O'Leary, & Carson, 2009, p. 208).

The level of motivation demonstrated by a perpetrator towards program participation has been identified as a significant factor contributing to progress and change (Gray, et al., 2014). Factors influencing motivation can include potential criminal sanction, avoiding imprisonment and obtaining access to children (ibid). External pressures including work, finances and mental health conditions can affect participation and detract from an individual's commitment and motivation (ibid).

Many providers use motivational interviewing techniques as a framework for engaging with a perpetrator to decrease resistance, foster impetus and stimulate engagement. Researchers suggest that individually conducted motivational interviewing has the capacity to increase a perpetrator's engagement in the change process (Murphy & Meis, 2008). Individual treatment, they identify, can be beneficial as it provides scope for greater flexibility in responding to the client's stage of change, and can enable engagement with presenting concerns (such as substance abuse and mental health issues) that might affect client outcomes (ibid).

For perpetrators who are also parents, the parental relationship can become a useful 'hook' to engagement and motivation. Specific individual goals can be set around this point of 'buy in' and function as a reference point for men to gain insight into the impact of their violence. A Canadian study into the efficacy of the "Caring Dads" program found that a parent specific approach can produce positive results through a program of "motivation-enhancing, psycho-education, cognitive-behavioural and collaborative case management intervention" (Scott & Lishak, 2012, p. 680). The "Caring Dads" program is a community-based, individual and group intervention program for fathers who had abused or exposed their children to family violence. Currently being piloted in Victoria, the Caring Dads program identifies the development of sufficient trust and motivation to engage as one of four core goals critical to the successful engagement of perpetrators who are fathers (Crooks, Scott, Francis, Kelly, & Reid, 2006). Motivational interviewing in the context of perpetrators with children requires a cautious balance between awareness of the risk the perpetrator poses to the partner/ex-partner and children (ibid.), and the interviewer demonstrating a degree of understanding with the interviewee.

Findings from a 2008 study found pre-group motivational interviewing for family violence perpetrators can increase receptivity to partner violence interventions and may be associated with reduced partner reports of abuse in the months after program completion (Musser, Semiatin, & Murphy, 2008). Facilitators were guided to implement the five basic principles of motivational interviewing, which are: to express empathy, develop discrepancy, avoid argumentation, roll with resistance, and support self-efficacy. In another study of court-mandated family violence perpetrators, motivational interviewing was linked to greater improvement on the stages of change subscale and a significant decrease in perpetrators attributing their violence to external factors (ibid).

Service gaps

It is apparent that the MBCP service sector is one under increasing pressure. Demand has escalated dramatically as policing in the family violence space has become more proactive, and as awareness of the issue has grown in the community. Services are consequently managing longer waiting lists and perpetrators encounter delays to access programs (State of Victoria, 2016). The danger with such delay is that perpetrators may disengage, or 'fall through the cracks', during the wait period. Subsequently, this also means the risk to victims is not being attended to adequately. There are suggestions that where there are obstacles such as delay in a service being able to offer a potential participant a place within a program, the outcomes for that participant can be diminished, with waning motivation a factor (Gondolf, 2002).

Where a man cannot access a program immediately, under the minimum standards service providers are required to maintain connection to and engagement with the prospective participant (No To Violence, 2018; Family Safety Victoria, 2017). This might involve provision of associated literature such as pre-reading, supporting the man through individual sessions, or conducting multiple assessment sessions over a period of time.

A 2016 longitudinal study by Monash University identified that while men found the waiting time for entry to a program and program location an issue, a critical factor was in the quality of the programs. For these men, this determination was predicated on the quality of the facilitators. Group dynamics were also deemed an important factor (Brown, Flynn, Arias, & Clavijo, 2016).

The RCFV also highlighted the existence of perpetrator intervention service gaps for particular community cohorts including Aboriginal and Torres Strait Islander men, those from CALD communities, men with disabilities, and men with mental illness or substance abuse issues. Further, the RCFV noted that “perpetrator interventions must address the needs of these diverse groups and be developed in consultation with them” (State of Victoria, 2016, p. 278). It also drew attention to an apparent disconnect between perpetrator programs and related complementary or additional support services required by these particular cohorts of men (State of Victoria, 2016).

Adolescents who use violence in the home

This cohort of young perpetrators involves distinct complexities which may require distinct perpetrator interventions (Centre for Innovative Justice, November 2016; Holt, 2015). Research suggests that the most significant determinant for adolescent violence in the home is a child's and mother's experience of family violence (Howard, 2011). This may in part be the result of the effects of a parent's family violence on the adolescent's development, as well as their exposure to negative attitudes towards women (ibid). While adolescent violence against family members is less gendered than adult family violence, the majority of victims of adolescent family violence are women, and the majority of those using violence are young men: 64 per cent of those aged 17 years or younger who are violent towards their parents are male (State of Victoria, 2016). International research also presents similar results (Bobic, 2004; Daly & Nancarrow, 2009; Gallagher, 2004; Hunter, Nixon, & Parr, 2010).

Importantly, a significant proportion of adolescents who use violence in the home are either currently or recently victims of their father's perpetration of family violence, and as such:

[interventions] should be informed by the correlates of such violence rather than the notion that the parent-child dynamic mirrors that of the adult intimate relationship. Effective treatments must address the multiple determinants of the child-to-parent violence and offer broad level, complex interventions that consider childhood traumatic experiences and the role they play in child-to-parent violence (Nowakowski-Sims & Rowe, 2015, p. 1).

Programs for Aboriginal and Torres Strait Islander men

The Indigenous Family Violence 10 year plan *Strong Culture, Strong People, Strong Families* identifies healing for both Aboriginal and Torres Strait Islander victims and perpetrators as one of its eight objectives. Working from the premise that Indigenous male perpetrators of family violence have themselves experienced violence, discrimination, disadvantage and transgenerational trauma, the 10 year plan, in addition to submissions received by the RCFV, highlight the importance of a whole-of-family approach (State of Victoria, 2016, p. 21).

Submissions to the RCFV identified the lack of culturally safe, holistic and therapeutic interventions for Aboriginal and Torres Strait Islander men, and noted the “strong preference for Aboriginal community controlled organisation [MBCP] providers” (State of Victoria, 2016, p. 278). In response to this intervention gap, the Victorian Government has since provided dedicated funding to services to deliver more MBCPs to Aboriginal and Torres Strait Islander men.

Aboriginal-specific family violence programs are also delivered within the corrections context, with the Dardi Munwurro Strong Spirit program. This program is available to Aboriginal and Torres Strait Islander men who are on community correction orders and those who are serving custodial sentences. The Dardi Munwurro Strong Spirit program is the only culturally specific MBCP offered by Corrections Victoria, and is a six day program that runs over three weeks (State of Victoria, 2016).

Programs for immigrant and refugee men

Language barriers are an obvious challenge for MBCPs to engage with men from non-English speaking backgrounds. This, in addition to the gap in the provision of culturally appropriate and safe MBCPs further limits engagement of men from non-English speaking backgrounds. Such limitations impede on MBCPs' efficacy with this cohort of men. As noted by the RCFV, “the majority of programs do not take into account the cultural norms, beliefs and identity of men from CALD backgrounds and are therefore less effective in bringing about behaviour change” (State of Victoria, 2016, p. 279).

Of the 35 MBCPs that were operating at the time of release of the RCFV's report, only two were offered in languages other than English (State of Victoria, 2016, p. 279). According to the NTV website, three programs are listed specifically for non-English speaking perpetrators (No To Violence, 2018). To address this gap, recently the State Government announced that inTouch Multicultural Centre Against Family Violence will deliver in-language perpetrator interventions for men from culturally diverse backgrounds in the Greater Dandenong region of Melbourne (State of Victoria, 2018).

Programs for LGBTI people

Given the rates of violence against women, particularly in the context of family violence, it is unsurprising that discussions of family violence and available services are primarily focused on cisgender heterosexual men's violence against cisgender heterosexual women. However, as highlighted by evidence given during the RCFV, this framing of family violence renders LGBTI people's experiences of family violence largely invisible within mainstream services.

While there is limited data on the prevalence of family violence among LGBTI communities, data that is available indicates that LGBTI people experience family violence at rates equal to or greater than other cohorts (Our Watch, 2018). LGBTI people may also experience unique forms of family violence, for example threats of 'outing' by a partner, while fear of discrimination within the family violence service system can dissuade people from accessing support (LGBTIQ Domestic and Family Violence Interagency and the Centre for Social Research in Health, University of NSW, 2014).

The RCFV made a number of specific recommendations to respond to the needs of LGBTI people who experience family violence (including the needs of LGBTI people who perpetrate family violence). Since the release of the RCFV report and recommendations, the State Government has funded perpetrator case management specifically for LGBTI people, and the trialling of an LGBTI applicant practitioner and LGBTI respondent practitioner in the Magistrates' Court at two locations. In addition, funding has been provided to trial perpetrator interventions for cisgender women (heterosexual, bisexual and lesbian women) and trans and gender diverse perpetrators (State Government of Victoria, 2018).

Criticisms of Men's Behaviour Change Programs

It is useful to consider common and current criticisms of MBCPs to reflect upon how individual and organisational practices may be responding to or addressing these concerns.

A common criticism is that MBCPs represent only one specialist family violence intervention available to and targeting men outside of a corrections response. Limited options may not appropriately cater to family violence cases that vary widely in complexity and where offenders have nuanced and differing needs. Additionally, it remains unclear how effective these programs are in actually curbing violent behaviour. Feder & Wilson (Feder & Wilson, 2005) found that victims report no improvement whatsoever from court-mandated programs, and there may even be a small harmful effect compared to a no-treatment comparison. Further, Arias et al. (Arias, Arce, & Vilarino, 2013) found that reports from the couple indicated much higher rates of recidivism than official reports. Therefore these criticisms need to be considered in light of potential repercussions for victim/survivors around issues of danger and safety.

The RCFV report mirrored these concerns and deemed the current response to perpetrators to be under-developed. The report recommends that a broader suite of interventions be implemented in line with current evidence of what is effective in changing perpetrator behaviour and maintaining the safety of victims (State of Victoria, 2016).

The Centre for Forensic and Behavioural Science criticises what it sees as the one-size-fits-all approach provided by MBCPs focussed predominantly on gender-related attitudes and accountability (McEwan, Wood, & Ogloff, 2015, p. ii). The authors suggest that current modes of program design create missed opportunities for intervening and assessing perpetrators in a more comprehensive fashion. In addition, they point to a body of evidence suggesting that programs adhering to the Risk Needs Responsivity principle are more effective than more commonly practised models of MBCP.

The RNR principle is underpinned by the notion that treatment levels must be: tailored and proportionate to the level of risk manifested by the individual; that treatment must be focussed on criminogenic needs;¹ and that the offender's ability to learn from a rehabilitative intervention is maximised by providing CBT and tailoring the intervention to the specific learning style, motivation, abilities and strengths of the perpetrator (Bonta & Andrews, 2006).

Alternatives to Men's Behaviour Change Programs

Short term interventions are unlikely to influence the future conduct of high risk offenders. MBCPs in their current form, it is argued, are unlikely to affect longer term behavioural change. Instead a range of treatment options should be offered with differing levels of intensity, particularly where the perpetrator's family violence sits amongst a range of other problematic behaviours (McEwan, Wood, & Ogloff, 2015). It would follow that, at the point of assessment, a man would be comprehensively assessed and then channelled into the most appropriate treatment response (or provided with a tailored treatment program) relevant to his needs. Ideally, this could allow for multiple, parallel and integrated interventions to be provided. It is important that these criticisms of MBCPs are considered in future funding, resource and implementation priorities.

Interventions for perpetrators are typically group-based, and many argue this to be the most appropriate format for influencing attitudinal and behaviour change:

A group setting reduces the social isolation experienced by many perpetrators and provides greater opportunities for role-play, feedback and confrontation of existing beliefs (Labriola, Rempel, & Davis, 2008).

Whilst the group format can facilitate role-play and help challenge problematic behaviours, others contend it problematically offers limited opportunity to respond to individual needs. Further, the group dynamics may also reduce or curtail engagement by perpetrators who are less motivated to change (Murphy & Eckhardt, 2005; Murphy & Meis, 2008).

Studies continue to emerge suggesting that individual or individualised interventions increase the likelihood of program completion and reduce recidivism. Amongst others, Murphy and Meis (Murphy & Meis, 2008) suggest that individualised programs can be more effective than group-based programs in reducing recidivism because they are able to be tailored to each individual's motivation levels or stage, and readiness to change. One-to-one interventions may also provide greater capacity for individual change targets to be set and monitored.

¹ Dynamic risk factors directly linked to criminal behaviour, for example, anti-social personality pattern, pro-criminal attitudes, social supports for crime, substance abuse, poor family/marital relationships, poor work/school performance, lack of involvement in prosocial activities. See Bonta, J. and Andrews, D.A., (2006) *Risk-Needs-Responsivity Model for Offender Assessment and Rehabilitation*, Public Safety Canada.

Murphy and Meis (ibid.) suggest that individual, one-to-one treatment formats for family violence perpetrators may offer potential benefits that are less accessible in group treatment contexts. They note that existing research into psychosocial perpetrator interventions has largely ignored individual treatment models and almost exclusively focussed on group models, whereas research relating to other types of behavioural problems have predominantly used the individual treatment format.

Murphy and Meis's position is supported by Dutton and Corvo (Dutton & Corvo, 2006), who argue that identifying and treating the psychology of abusive behaviour is the most effective intervention; and by Day et al, who, considering theories and models of change in MBCPs, conclude it to be likely that interventions matched to individual offender needs will be more effective than those which are not (Day, Chung, O'Leary, & Carson, 2009). They argue that issues of treatment integrity and theories of change are not adequately addressed in the original Duluth model and that stage matched interventions, including motivational interviewing, and matching treatments to individual need are not well established in the family violence sector:

... analyses all point to the importance of individualised assessment of each client's treatment needs, such that interventions can be matched to the particular needs of the individual offender (Day, Chung, O'Leary, & Carson, 2009).

The notion that MBCPs ought not to be the chief intervention available to address men's offending has also been supported by NTV (State of Victoria, 2016). Further, it is important to uncover what interventions work, and for which cohorts. As noted above, perpetrators are not a homogenous group, and tailored programs are required to ensure that men's behaviour change interventions address the specific needs of perpetrators, whether in a group or one-on-one setting.

Ultimately, the issues around a composite of program theories, and the benefits or otherwise of group-based versus individual case work, is perhaps best addressed by recognising that while some men are suited to group engagement, other men are not. In this instance it is often necessary to supplement or replace group interventions with individual counselling, or to offer both concurrently. If it is accepted that men have different needs and that group work will not be effective for all, then intake and assessment offers the primary opportunity to identify the most appropriate intervention for each individual man. Whilst recognising the need for additional funding, resource and implementation capabilities associated with diversifying perpetrator intervention options, intake and assessment is vital. This Practice Inquiry provides insights into these processes, with the aim to improve understandings of these critical engagement points with perpetrators of family violence.

Part Two:

What the Practice
Inquiry found

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Part Two: What the Practice Inquiry found

The point of initial contact, intake and assessment offers a critical opportunity for tailored, client-focused interventions with perpetrators of family violence. Within a framework that gives primacy to the safety of women and children, the point of initial contact with perpetrators – whether voluntary or mandated – was consistently identified by practitioners to be one of the most effective points in engaging potential clients.

Building on the insights gained from the policy and literature review, this section provides practitioner reflections and insights on:

- effective intake practices
- effective assessment practices
- the client narrative
- counselling and group facilitation
- motivations for change
- team support and role modelling
- how assessment processes inform group work and
- barriers to access and factors that hinder completion.

Intake process maps for four of the participating organisations are provided towards the end of this section.

Practitioner reflections - Effective intake practices

Intake and assessment processes at all MBCP provider organisations operate within the overarching framework applying to family violence services for men. This framework as it applies to intake has, as its first principle, the requirement that programs will give primacy to the safety of women and children, with the primary objective to increase safety by assisting men to stop their violent and abusive behaviours (No To Violence, 2018; Family Safety Victoria, 2017).

Additional principles stipulate that programs:

- operate within a gender-based analysis of family violence
- hold men who use violent and controlling behaviour toward family members to account
- be accessible to men from diverse backgrounds, cultures and life experiences and
- be implemented by well-supported, skilled and trained practitioners with the ability to recognise, respond to and challenge men's violent and controlling behaviour (ibid).

When practitioners were asked to reflect on the most effective methods for engaging clients, they consistently indicated intake as a challenging but critical point for engagement. It was also noted that initial contact plays a significant role in a practitioner's engagement with men who voluntarily make contact but who have not definitively decided to proceed to group participation.

On the other hand, men who are compelled to attend a service, can, at the time of initiating contact, be in a heightened state of anxiety or experiencing a range of emotions from anger through to shame, vulnerability or embarrassment. This means the reception he receives at first contact can influence how he processes these emotions and the manner in which he perceives the service, its workers and how he engages going forward.

At intake, practitioners asserted, the approach should be focussed upon offering support, building a respectful relationship and tapping in to the values of the client. It is essential that a warm reception is offered, which is responsive to the ambivalence or heightened emotional state of the potential client.

A supportive and receptive intake can begin to uncover what is important to the man, stemming from the question of why he has reached out to the organisation. Whether mandated or not, a man may disclose contextual issues that will present barriers to effective engagement, or conversely that might be used to inspire him to maintain engagement. Further, the worker must be alert to any needs that are immediately apparent. This includes using the discussion as an early opportunity to recommend or make complementary referrals, and to note indications of potential motivational factors or barriers to eligibility or to access and engagement.

Intake should also be centred on the overt assessment of risk. To do this, it was identified that intake workers need strong listening skills and sufficient time. In addition, they need to develop rapport, validate feelings and express an appreciation for where a man is on the continuum towards change. Workers need to recognise that the man may have been referred from service to service, may be dealing with significant shame and struggling with being labelled a perpetrator.

Practitioner reflections - Effective assessment practices

Practitioners uniformly regard the initial assessment as fundamental, and recognise the need to get it right from the start. One worker labelled the assessment interview as a 'make or break' situation.

Practitioners are acutely aware that the client's ongoing engagement with the service hinges critically upon: the way the assessment progresses; the capacity of the assessor to address the man's concerns and issues; and the degree to which the client feels supported.

The time invested in this process is critical. Where assessments were short or rushed, workers felt that men were more likely to 'fall off the wagon' and not be as engaged. Where a longer and more comprehensive assessment interview is undertaken, the interview can be more therapeutic. That is, men are able to move towards group readiness and are therefore better prepared, leading to a more functional and safe group program. As one practitioner noted:

The assessment is key to setting up for a group. What we do here will help him in the group – get him group ready.

Additionally, those men who disengage or lapse are far more likely to return to the program when an appropriate amount of time is allowed for a complete assessment process and they are more able to take up referrals and links that they have been provided with. One practitioner reflected:

Longer assessments are more holistic and add to our retention and engagement, and the men are more prepared [for group].

It was noted that men typically come to the assessment in one of two states of mind –either highly embarrassed or highly emotional. Practitioners describe them as needing space, time and dignity, and as needing recognition for the courage it took them to call the service. This sentiment is reflected in the following practitioner observation:

We need to slow it down – the men have been hyper vigilant up to this point – we say to them ‘this is important for you and your family’. The assessor needs time to pick up that hook, otherwise the message sent is that the man is just a number.

The assessment can also give insight into how the client may present in a group and how the client may fit into group dynamics.

Below is the collation of practitioner reflections on assessment practices considered most effective in engaging men and seeing them complete the MBCP. Practitioners state that effective practice is:

**grounded *respectful *non-pathologising *upfront *comfortable and able to ask “hairy” questions *able to understand non-verbal cues *possesses techniques to bring the man around *coming from a position of care *applying a therapeutic lens *counselling skills *able to use body language effectively in an interview situation *has the skills to know when not to unpack a comment from a client *trauma informed *curious *understanding of group dynamics *has an understanding of risk *assessment is critical to effective group engagement **

Practitioners reflected that effective workers possess:

**containment skills *knowledge of and relationships across the sector *compassion *time *professionalism *years of experience *inclusive approach *ability to motivate *therapeutic skills *ability to build trust *knowledge of what the MBCP provider organisation needs *an understanding of what the group needs *motivational interviewing *narrative conversation and invitational interviewing skills **

Practitioners undertake comprehensive assessment in line with minimum standards, and as guided by NTV. They aim to assess the suitability of potential clients for MBCP group programs, assess the client's needs for preliminary or concurrent service support, and give primary attention to identifying risks to the safety of any women, children or other affected persons in the man's life. The intake and assessment processes serve to identify risk levels, relevant criminal histories and triggers that may pertain to the prospective MBCP participant.

In reality, however, assessment staff work to a far more complex set of objectives during the two to three hours they spend with a man for an assessment interview or interviews. To meet the multifaceted demands of their role, practitioners draw on a broad skill set and personal attributes, which extend beyond those which would typically be gleaned from minimum qualification requirements stipulated by the minimum standards (Family Safety Victoria, 2017).

Assessment processes, as described by practitioners from Star Health, Relationships Australia Victoria, Peninsula Health and Family Life involve a range of distinct components. These elements of the assessment process range from assessing safety risks to the man's partner, former partner and/or other

affected family members, through to thinking forward to group programming, and assessing how the man might fit into, cope with or potentially derail others in the group.

The client narrative

Assessors from one of the organisations highlighted the importance of the assessment interview as a forum in which it is safe and permitted for the man to really talk and 'tell his story'. The interview is an opportunity that does not arise in the subsequent group program where facilitation of discussions remains very focussed on behaviour rather than narratives that can explain or minimise this behaviour. If men are not afforded the opportunity to share their story during the assessment phase, group facilitators have found that they are 'bursting' to tell their story in the group sessions. Allowing this to occur could undermine group processes given that many men may be experiencing high levels of anger, feel hard done by and that the system is unfair.

While practitioners reported that men feel heard when allowed to share their stories in the one-on-one assessment, they were also acutely sensitive of the need to not collude with the man in any sense of injustice he expresses. Instead, the assessor can point the man towards how the group sessions will run and what to expect to prepare him for the program by giving him an idea of the style of questioning that will occur. A conversation is introduced about the need to recognise the range of behaviours that fall within the definition of family violence and abuse, and to prompt him to reflect upon his own degree of accountability (and hopefully to awaken a sense of responsibility). They might, for example, ask him to reflect realistically on his degree of culpability in comparison to how responsible his partner was for his behaviours.

In this respect, practitioners spoke about the importance of language – of situating responsibility for change with the man through the way in which questions are posed:

I hear that this is what is happening for you. What is outside of your control? What can you control?

What kind of father do you want to be?

We encourage them to name their reluctance or frustrations and then we work through how we can make the process of benefit to them.

The assessors touch upon the issues of men's health, suicide, depression and violence, and the need for a new and healthier understanding of masculinity. The concept of 'toxic masculinity' and stereotypes that inform binary ideas of gender (such as to be male is to be 'aggressive', 'strong', 'a protector' etc.) are explored to consider their damaging impact on men as well as women and create space for a new understanding of masculinity.

The practitioners seek to remove the shame of the client without colluding – seeking to ensure the client feels heard, but also demanding a level of accountability. The assessment interview highlights for many clients that it is their choice to use violence.

Counselling and group facilitation

Practitioners highlighted that assessors need to have both comprehensive counselling and group facilitation skills. They articulated the benefit of program facilitators themselves conducting assessment interviews; facilitators of group sessions prefer to have done the assessment themselves.

It was noted that it would be beneficial to have the assessor assigned as a co-facilitator of the group into which the client entered. Where the same worker is able to undertake the assessment and be the group facilitator, the participant can settle more easily into the group dynamics – a fact attributed to their being relaxed because they are familiar with the worker.

There are however a number of constraints to this as many group facilitators are sessional workers and employed in full time work elsewhere or have other engagements. When co-facilitation with an assessor cannot be achieved, the assessor will set the scene for the first group session so the client will know to expect different staff to be facilitating. The assessor also makes clear that the assessment details will be shared openly and fully with the facilitator.

As well as better ensuring a client's familiarity with group workers as a means of better engagement, it is considered very advantageous to have insight into the man's views and goals in a meaningful way in the group setting. This can be difficult to glean from a written record of an assessment undertaken by another worker. This can impact their ongoing engagement towards program completion, or gauging in the first instance if the MBCP is appropriate for the client.

One practitioner provided an example which highlights the importance of thorough assessment processes. In this case, only a very basic assessment was undertaken and little information obtained. The assessor was not one of the group facilitators, which made it more difficult to gain a full picture of the client's situation. When assessors sought to meet with the client prior to the group commencing he refused and then started the program late. These factors contributed to him soon being exited from the group as he was too disruptive. The client was then worked with in a one-on-one process. The group facilitators maintained that had the assessment been undertaken more adequately, he could have been diverted to one-on-one support from the outset and avoided disruption to the other group participants.

A second example provided by a practitioner relating to their experience at another workplace:

A sessional staff member had conducted the assessment. The facilitators taking the group consequently entered the program 'blind'. Their safety was diminished by not knowing the men who would be part of the group. The man in question was a high risk offender and had not been appropriately screened out of the program. Of eleven initial participants in that group only four completed the program. The police had to be called on two separate occasions.

This example points to a range of issues: lack of resourcing for permanent staff; lack of program or service processes to ensure continuity of care across practitioners (for both worker and client); lack of adequate and timely assessment of potential clients to identify and screen out those not appropriate for group work before commencement of program; and the bind of mandated cases that do not allow for the flexibility to modify orders easily.

Practitioner engagement and skills

Practitioners highlighted the importance of being actively engaged when working with the men, and that they are not simply working off a script or running through intake and assessment forms with clients. They spoke at length about the need for workers to have a blend of skills, including basic counselling and clinical skills, mental health awareness and understandings of substance abuse issues. One practitioner shared:

Men will tell you everything about their offending. It's how you ask.

Practitioners all highlighted that in the vast majority of instances their clients are individuals who have complex needs, so a comprehensive understanding of the broader family violence system is essential to address and support these needs. Practitioners must have an acute understanding of risks, and the ability to identify them.

Reflecting upon valuable skills in an assessment or intake worker (and program facilitator), staff described highly effective workers as those who are able to meet the challenge of working with men who are accustomed to exercising power and control. To this end, practitioners expressed that containment skills are important, as well as an understanding of what their respective organisations require of potential program participants.

Sector knowledge and connections to other services – that is, established professional relationships in the sector – are highly valued and a practical asset for practitioners. It was also noted that knowing the touchpoints to other parts of the service was critically useful during assessment stages, aiding workers to coordinate immediate interventions for the client. One practitioner reflected that:

It is highly complex and challenging to work with a man who has been manipulative for so long.

As practitioners noted, effective interviewing skills in assessment comprise more than asking set questions:

There is a danger in intake and assessment in just doing the checklist.

This means workers need to be attuned to why each question is being asked – they need to remain cognisant of the larger picture, not just the answer to an individual question. Workers need to be able to balance counselling skills with an ability to ask difficult and provocative questions. They need also to be observational and have the ability to read non-verbal cues. One practitioner said on this point:

I might ask 'what made you smile when you talked about that choking incident?'. Some workers are uncomfortable to ask the hard questions, or questions they don't want to know the answers to, but at certain points the focus has to be on him, on what was going on for him at that time.

Above all, and at a more fundamental level, workers need to be engaging. They need to be able to offer a nurturing and caring side and be cognisant of the importance of checking in on the client in meaningful ways. For example, if a client is distressed, the interview might not go into detail on that point of distress. Practitioners frequently referenced the skill of balancing the need to be understanding with avoiding collusion. Similarly, they also spoke about the importance of maintaining both lenses; that is, of being

able to work with and understand the man but also hold in mind the safety of the woman and child or other family member(s).

Motivation for change

When asked about the degree to which men's levels of engagement were wavering when coming to assessment, practitioners asserted that most initially present as sceptical and uncertain. One practitioner reported:

99 per cent are wavering!

Ongoing engagement also hinges on the extent to which the client is amenable to change. For many men, this requires a significant shift during the assessment interview itself – a shift that the assessor frequently needs to be highly instrumental in driving. Prompting this shift means being attuned to how the client presents, his characteristics, tendencies, circumstances, and the variety of factors that might stimulate him to want to change or stand in the way of such change. One practitioner reflection included:

The deeper story comes out in the assessment.

Practitioners describe their overall interviewing technique as invitational and motivational. They describe using motivational interviewing as solution-based and collaborative, focussed on the behaviour and what will happen within the group.

Workers seek to tap into the personal circumstances and motivations of each client that might aid them to maintain engagement.

Of course court orders themselves are an effective aid to engagement. But additionally, many men seek to engage in a program for their children or for the purposes of seeking to save their marriage or reunite with a partner. Workers endeavour to prompt for a deeper, more personal level of engagement, as one practitioner put it, by asking him to:

Do it not just for your kids or partner. Do it for yourself. For your own benefit.

Some practitioners use the 'tip of the iceberg' exercise in narrative conversation (that is, issues identified are potentially underpinned by much larger problems), inviting the men to engage in discussions that are geared toward assessing how they will fare in a group context. A psycho-educational approach is adopted in these processes to help men to become group ready.

One practitioner identified willingness to change as a key factor behind men fully engaging. Feelings of shame may inhibit the process of engagement depending on how it is managed and how it affects the man. Similarly, fear of negative court outcomes or criminal charges can seem to motivate men, but there was some hesitation as to whether this was significant enough to drive change for some men.

Practitioners observe that some of those who are mandated to attend "just sit" through the program. This is usually openly discussed, but it can be difficult to reach a participant who takes this approach.

Team support and role modelling

Practitioners spoke highly of the importance of a good team, which is understood as workers who are genuine, authentic and who have a 'fair dinkum, I'm here for you' approach. Practitioner reflections also highlighted organisational support and culture as critical to effective practice. Staff reported their organisations to be very responsive to staff feedback, to have a clear focus on safety and to foster a learning environment that assists staff development.

Furthermore, practitioners articulated the importance of presenting a uniformed and united front that carries through to the group sessions. Workers who conducted assessment interviews in pairs spoke of the critical importance of the relationship between the male and female assessors in the interview (and in the group sessions themselves).

There is significant benefit for the female worker, her co-facilitator and for the group itself where time is invested in developing a good working relationship between co-facilitators. Workers need to be aware of the structures that underpin family violence, of gender and male privilege and how they themselves model ideal behaviours. Female workers need to feel safe in the assessment and the group. The dynamic modelled between the assessors sets up expectations for the group. One practitioner noted:

Co-gendered facilitation [of interviews and groups] in this domain is top of the list. We have to model best practice in working together.

One team spoke explicitly about the female facilitator as being the only woman in the group, and the potential for this to be damaging for her if interactions with her co-worker were not consistently reflective of equality. They spoke of the additional load carried by the female worker in interviews and group programming. As the only woman in a room full of twelve male perpetrators and a male facilitator, a strong professional and supportive relationship between the co-facilitators is critical. It is essential that the male worker models positive engagement with the female worker 100 per cent of the time. Star Health facilitators spoke of the need for both to work collaboratively to keep her safe in that environment, to model a "united front" and for the female facilitator to trust that her co-facilitator "has her back". One practitioner said:

The male worker needs to look at the female. They both need to be very aware of their [interpersonal] dynamic and of keeping her safe. We've done a lot of work on building that – a very united front. We are mindful of the dynamic. Witnessing [us doing this well] can be a learning experience for group members.

Not all services are adequately resourced to have interviews conducted by two assessors, although some workers from those sites did suggest this would be beneficial. Regardless, the assessment interview is the first juncture at which the organisation can begin to educate the man towards an understanding of the gendered nature of violence and how the exercise of power and control is situated within gendered norms and male privilege. They can do this through challenging statements made by the man, or make clear expectations for conduct towards facilitators and other group participants.

How a client engaged at assessment gives the workers crucial insight into where the client is at in relation to accepting responsibility for their violent behaviour. Additionally, in the interview setting, workers can give the client a 'taste' of what is to come in the program. Workers gave the following examples:

If negative attitudes towards women show up in the assessment, I dig into this and call it out.

You want a little level of discomfort aroused at assessment. This is about preparing them for [the] group, setting the foundation.

How assessment processes inform group work

Practitioners use information gleaned from assessment interviews to inform group activities. Facilitators can frame group questions to challenge positions and views that emerged in assessments, and they can reorient the group and group members back to shared or client goals where refocussing is needed.

Focusing on safety

In line with requirements set out in the minimum standards, workers focus on the safety of women and children throughout their engagement with men. They articulated one means of addressing safety as giving the men the skills to be able to engage in respectful, violence-free relationships:

Practitioners are focussed on the safety of women and kids. We are very clear on this purpose as our end game.

We work to keep the men safe too – for example if they're homeless or have financial problems.

Constant effort is made to bring men to a point where they will take some ownership and accept that they are accountable for their actions. This is based upon the idea that if a man is able to do this he will engage in the process. A focus on safety during the assessment process plays a significant role in determining whether or not a man is suitable for group work, and ultimately this serves to ensure the safety of women and children whilst men are engaged with a MBCP.

Different group models

Practitioners discussed the benefits of varying models – rolling open groups compared to closed groups. They reflected that generally the building of trust and disclosure functioned better within closed groups where there was consistency in terms of participants and facilitator. Closed groups provide for greater continuity and therapeutic outcomes.

Barriers to access and factors that hinder completion

Below is the collation of practitioner reflections on barriers to access and factors that hinder completion of MBCP:

** mental health issues * entrenched views * not accepting responsibility * housing security issues * suicidal ideation * acquired brain injuries * ongoing criminal behaviour * waiting periods * the requirement to give contact details for partner contact * travel and transport (and associated financial) issues * work commitments * gaining employee approval to be absent from work * substance abuse * incarceration * feelings of shame and feeling too confronted * youth or immaturity * personal trauma
or own family violence victimisation history (including men who are victims and have been subject to a cross-order) * potential to or likely to derail the group * anxiety * language barriers * current experience of crisis * pending criminal charges * failure to agree to abide by group rules*

Oversubscribed programs

Workers identified not guaranteeing potential clients a place in a program as a potential barrier to ongoing client engagement. This echoes the NTV/MRS submission to the RCFV:

Significant wait times result in men losing motivation and opting out of the service system . . . Men's internal motivations to participate in a service are very fickle, and can easily evaporate with an extended wait (No to Violence: Men's Referral Service, 2015, p. 32).

Some MBCP services also spoke of the inherent tension in “holding risk” for men and their families where a perpetrator cannot be accommodated within a program in the short term. In the instance of a potential participant engaging on a voluntary basis, he may be advised that there are no program spaces currently available. He will then be advised to contact other services in surrounding areas or to call back at a later date. Presumably this has possible negative repercussions for men who are already reluctant to engage in a MBCP or are experiencing feelings of shame and alike, who may then discontinue following through finding an available place in a MBCP. Any delay in placement in a program impacting the man's motivation raises the issue of women's and children's safety during this time.

For court mandated clients, assessment and contact is maintained by community corrections until a program position becomes available. It was reported that this could take as long as four months.

Shame

For some men the capacity to attend sessions is inhibited by factors associated with shame and their desire to not be exposed in their workplace or local community as a MBCP attendee or perpetrator of family violence. For this reason, many men choose or prefer to attend a program outside of their local area – they seek out programs that can offer them anonymity and enable them to avoid coming into contact with other local residents in the context of family violence services. This can mean travelling greater distances to assessment interviews and group sessions with the potential to affect work hours. The need

to obtain employer approval to leave work early each week to attend a session may be a trigger for some to either not engage or to disengage from a program prior to completion.

Practitioners reflected that men who have self-referred and who present with intense shame tend to drop out during intake and assessment phases, or early in a group program, as they come to realise the level of disclosure required and the expectations around accepting personal responsibility.

Substance abuse

Substance abuse can also be an issue hampering engagement with a MBCP provider. Clients who are misusing alcohol or drugs may be deemed ineligible for program entry if they are not linked in to adequate support, or may self-exclude on this basis.

Being self-referred and belonging to group

Some men find the environment and process too confronting and personal. Some feel they do not fit in or belong where other group attendees are predominantly court mandated or otherwise “more hardened”. Practitioners are acutely aware of the need for intake and assessment processes to have a highly supportive feel – of the need to make men feel comfortable, and to encourage men and acknowledge the effort they have made to engage. This support and sense of belonging, however, needs to extend to identifying the motivational factors that resonate uniquely with the man and his circumstances.

Other responsibilities

Another hampering influence on men’s engagement can be family responsibilities and particularly “child access”. One of the group of facilitators reported that the timing of child access or handover of children between parents who have separated has, for a number of men, clashed with program timing, presenting an inflexible barrier to ongoing program attendance.

Trauma and mental health

Practitioners reflected that men with personal trauma or who have their own experience of family violence (including men who are victims and have been subject to a cross-order) can interfere with their likelihood of completing a program. At assessment, and subsequently during program sessions, men who have been both victim and perpetrator can, in some instances, have more difficulty taking responsibility and tend to focus on their own victimisation. This demands more intense focus during assessment on bringing the man to a point of accepting responsibility.

Men who are experiencing mental health issues or who are suicidal may be deemed non-group ready due to the need to focus on their own wellbeing and also the potential risk they pose to group cohesiveness and safety. Several of the organisations modify their interventions with this cohort to offer one-on-one counselling services that might mirror the program. Alternatively, a pause may be placed upon program participation whilst one-on-one counselling takes place, with the potential to join a group once reassessed. Program participants with mental illness or acquired brain injuries were also identified as a cohort likely to not contribute in group settings and more likely to drop out.

Criminal justice

A number of men disengage due to further contact with the criminal justice system that may see them incarcerated or needing to relocate to satisfy the requirements of an intervention order.

The needs of men who are at high risk of reoffending are unlikely to be met by a MBCP – individual interventions can be more appropriate, but practitioners raised concern that there are limited options for where to refer these men.

Court referrals and group readiness

Workers reported some frustration with external processes relating to a small number of court mandated clients; workers identified the often problematic situation where a court determines a man's eligibility for MBCP. In some of these cases, men fail to present to the MBCP service provider as group ready at the assessment interview or when placed directly into a group program. It was acknowledged that this difference in presentation could in some instances be attributed to the heightened anxiety aroused by the court environment or to men presenting differently in court where they are very much focused on achieving a judgement in their favour.

Several practitioners related stories of having to refer clients back to court to seek order variations. In some instances these are not granted, leaving the provider having to persist in trying to accommodate disruptive or otherwise non-group ready men into their group sessions. It was suggested that court orders should be broader, encompassing the possibility of offering individual work. An example was given of a court mandated client whose participation in a particular group was very stifling and interfered with the successful completion by other men. In that situation the organisation could not, without court approval, remove him from the group and direct him into case management or counselling. Multiple practitioners discussed the need for greater flexibility to be built into court orders to enable practitioner options where non-group readiness is identified during assessment.

To access the program men must demonstrate they are accountable, and that they accept a certain level of responsibility. One worker suggested it would be insulting to other group members if someone was admitted to the program without taking the requisite degree of responsibility.

Men assessed as not group ready may have made a disclosure of trauma during the interview, or may be quite young and lack a degree of maturity. Others who are not group ready may have demonstrated difficulty in moving from entrenched positions of denial, guilt or shame during the assessment.

Assessors recognise these factors as presenting issues that may interfere with the effectiveness of group programming both for the group, but also for the client. These men need individual work and support before joining the group. For these men, individual counselling services are offered as a preliminary option, following which they have the opportunity to be reassessed for eligibility for a MBCP. The availability of an in-house counselling service is a major benefit in keeping the men engaged – making them more likely to continue on after counselling into a program and through to completion.

Risk and family safety contact worker

Women's and Children's Counsellors consulted during the focus group sessions highlighted that their role is positioned as a core aim of MBCP intake and assessments and the minimum standards (Family Safety Victoria, 2017). The importance of family safety contact workers is referred to throughout the minimum standards and implementation guide (Family Safety Victoria, 2017; No To Violence, 2018).

The focus of the family safety contact worker role is to undertake risk assessments, develop safety plans, and make appropriate safety and support referrals for impacted family members. The role also "provides a counterpoint to the perpetrator's under-reporting of his use of violence" (No To Violence, 2018, p. 5). With respect to children, NTV suggests that risk assessments "must be incorporated at all points where a perpetrator is being assessed for admission to an MBCP" (No To Violence, 2018, p. 19). It is from this perspective that Women's and Children's Counsellors expressed concern about intake workers or facilitators who do not have prior experience of working with women and/or children as victims of family violence, as attention to risk can receive less attention than it should. As a result if risk is not assessed properly it exposes women and/or children to further violence.

Part Three:

Process maps for
four participating
organisations

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Part Three: Process maps for four participating organisations

Family Life

Family Life is a provider of counselling, mediation, mental health services, community development, personal support and community educational services, outreach to homes, case coordination, innovative community businesses and advocacy. It is an independent organisation focussed on delivering services to children, women, men, families, schools and communities, with a priority to assist those who are at risk or vulnerable. The catchment area for the program is the Bayside Peninsula region, however generally, referrals are generated from the Bayside to Frankston LGAs. Its services are located in the suburbs of Sandringham, Frankston, Cheltenham, Tootgarook, Dandenong and Cranbourne. The MBCP team is based primarily at that Sandringham office. In practice no official geographic limitations are imposed to restrict client access.

Family Life provides MBCP programs within the context of its broader offering of specialist family violence services. Other services for men include youth support, dad's playgroups and family and relationship support. Currently, Family Life runs three MBCPs per annum. Group programs run over 16 weeks, and each group aims for 15 men in each cycle. Practitioners are supportive of the organisation's commitment to move to smaller groups running over more sessions, but recognise this presents problems in terms of funding and staffing. Program cost is \$10 per session, with concession and waiver available to clients for whom cost is prohibitive.

Family Life's MBCP offering can be supplemented by individual counselling prior to and after the group program. Its website makes clear that partner contact is maintained during the program "to monitor wellbeing and facilitate the transfer of learning into the home and family relationships where possible".

As depicted in Figure 2 Family Life MBCP intake process map, potential clients of the MBCP are referred by the MRS, Magistrates' Courts, Police and L17 processes or via self-referral. Some clients are also referred internally from the organisation's couples counselling program – via screening for family violence in that program.

Intake

Intake processes follow initial contact with the organisation by a potential client. Typically, men call the central Family Life phone number. Their details are logged in the organisation's database by general service support staff. From this point the intake worker will act upon the referral, contacting the client by phone.

The intake form utilised by the service captures:

- preliminary contact information
- requires an explanation of and client consent to limited confidentiality
- how client came to call the service
- basic demographic data
- a basic history including:
 - presenting issue (service required)
 - any concerns for children
 - details of any recent family violence incidents and a description of these
 - type of family violence conduct
 - whether any charges or court orders are in effect and conditions specified in the orders and
 - whether the caller has been referred by the court or not.

On the basis of the above, the worker will assess and rate the risk level associated with the client, including the risk of committing further family violence – high, medium or low. A safety plan may also be discussed and crisis numbers shared with the client if applicable. The date and times of upcoming MBCP programs are discussed and the client is informed that he will be placed on a waiting list for assessment with no guarantees.

Assessment

One practitioner stated:

The initial assessment is 'make or break'... It is integral to engagement.

Clients may be on a waiting list for as long as 12 weeks, however, usually the waiting time is closer to six to eight weeks. Feedback from practitioners included:

There is a period of high risk during any waiting period. The men may consider that they have done what they needed to do and then for 6-8 weeks they may be without support, as this only really kicks in once they are assessed (unless the case is identified as 'high risk' at intake). There are no eyes on them.

About six weeks prior to a program commencing, a MBCP facilitator will contact the client to arrange an assessment interview. Following the assessment interview, contact is maintained in the lead up to the program itself.

Assessment interviews typically take between 90 and 120 minutes. The assessor discusses Family Life services and the MBCP program, works through the client information brochure and explains client rights and the complaints processes. Client confidentiality is discussed with the explanation that information is kept confidential unless for example a safety issue arises for the client or others, in which case information may need to be released. It is explained that Family Life does not write court reports, but may provide a letter confirming attendance at their service.

The practitioner then guides the potential client through the assessment phase of the interview.

The assessment record captures:

- name
- date of birth
- address and other contact details
- cultural background
- interpreter needs
- family relationship status
- current employment status/income source
- legal status (whether subject to intervention order, whether mandated to attend MBCP, history of intervention orders and breaches)
- parenting status and details
- genogram of current household members including gender and age
- alcohol and drug issues
- past and present mental or physical health issues
- existing service supports
- details of incident leading to contact with provider, including client's own ranking of seriousness of the incident and
- discussion of various types of violence and abuse:
 - physical
 - verbal
 - sexual
 - emotional/psychological
 - financial
 - social
 - spiritual
 - object related, including destruction of property or theft.

Clients are then asked to rank how responsible they believe they are for their conduct, how controlling they think they are, and how safe they or affected family members are from further harm of any nature. Assessors and clients then explore contexts that are key triggers for abuse and violence by the client before the interview moves to a discussion of the effects of family violence on children and adolescents who the client may be in contact with. From this point the interview is very much focussed on motivational factors. The client is supported to develop three or more personal goals to work towards during the program.

Then an exploration of resources the client can draw on to support these aims (such as family, friends and services) follows.

Before the interview concludes, safety planning is undertaken taking into account client responses to a safety matrix which gives insight into whether the client or partner has access to weapons, combat training, suicidal tendencies, health issues, is pregnant, is isolated, has health issues, has been threatened, has financial difficulties, has recently separated or has other major issues or problems.

At the end of the assessment the client is informed if they are deemed suitable for the MBCP program and any appropriate referrals are made or recommended to the client. Some clients will be referred to one-on-one counselling at Family Life if deemed appropriate. Those with drug and alcohol, housing, financial or mental health issues are typically connected to external support services. The client is obliged to consent to partner/AFM contact as a condition of program entry.

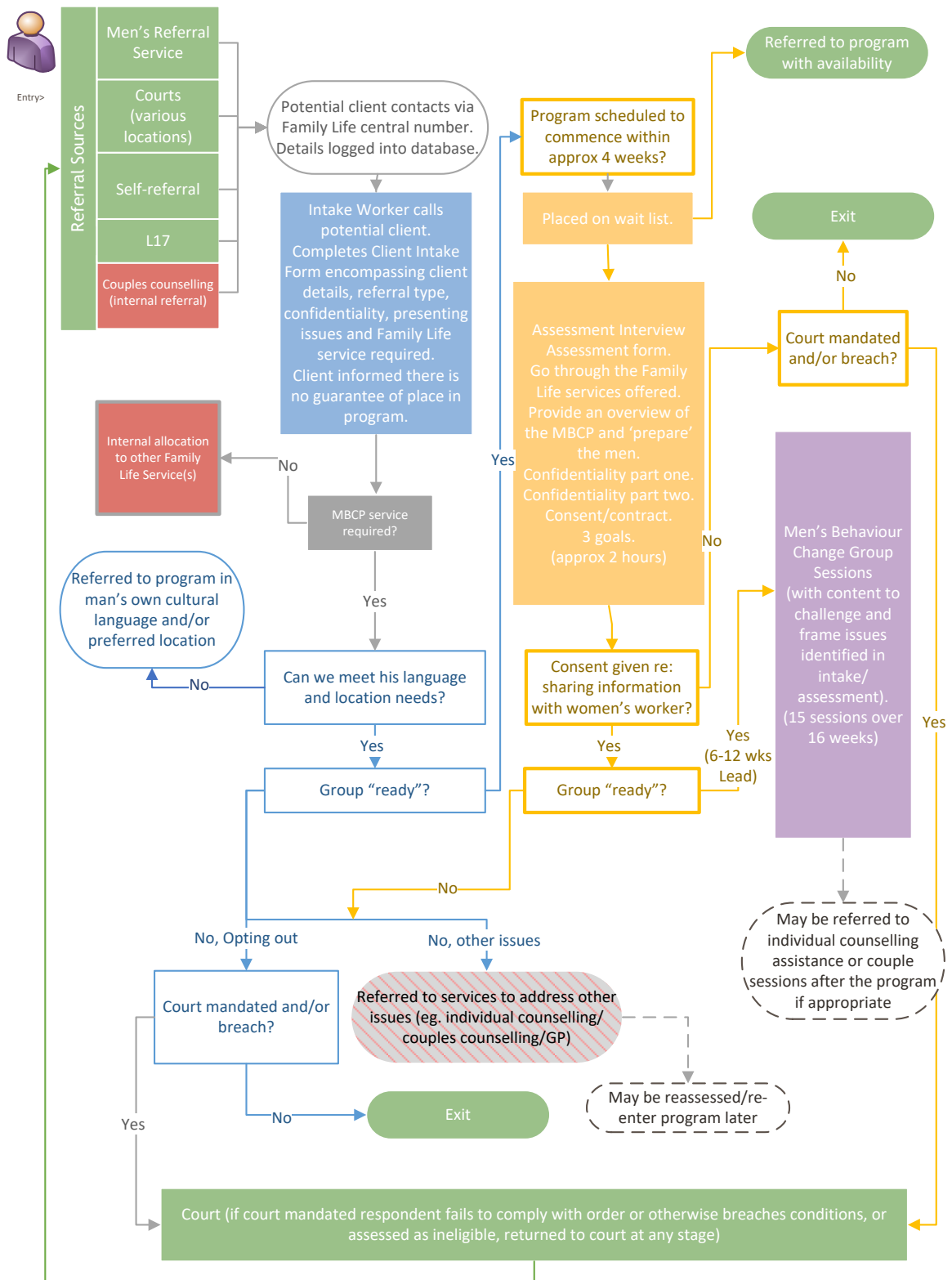


Figure 2: Family Life MBCP intake process map

Relationships Australia Victoria

Relationships Australia Victoria (RAV) is part of a national service network that delivers a wide range of specialist family and relationship services and courses. Their offering of men's programs includes MBCPs and parenting courses for fathers who have used violence in their relationships. The MBCP is a prerequisite for the father's parenting course.

MBCPs are offered in the Knox, Kew, Ringwood, Dandenong, Narre Warren, Cranbourne, Berwick and Sunshine areas. RAV offers six groups every 26 weeks in the Cranbourne region where the consultations for this project were conducted. Most programs are offered in English language, however RAV does deliver a Vietnamese program in Sunshine (outside the area for this Practice Inquiry). It works with approximately 260 men per year from its Cranbourne site, and in the region more broadly assesses 500 potential clients per year, and fields a significantly larger number of calls and enquiries.

Programs are operated as closed groups that run for 14 weeks. Previously, men were able to engage in an open/rolling group for 4 weeks before progressing to a second tier which was a closed group that ran for a further 10 weeks. This model has been discontinued as it was found to contribute to issues with continuity of the group. With the first tier requiring lower levels of accountability it was found not to be sufficiently challenging for participants. In the current model this issue has been removed – very high levels of accountability are demanded and this helps to foster trust in the group. Workers did comment however that they feel programs needed to be longer than 14 weeks:

We are trying to address 30 years of behaviour in 28 hours of program!

As illustrated in Figure 3 - Relationships Australia Victoria MBCP intake process map, clients are referred to RAV from Corrections Victoria, various Magistrates' Courts or family violence services. Some clients self-refer

to the service. No referrals are accepted from affected family members to ensure accountability of the perpetrator; that is, the man must make contact himself. Many men who access the service are from the local area or generally from the south east of Melbourne. Some travel from further locations including Melbourne, the Mornington Peninsula or suburbs closer to the north of Melbourne.

MBCP programs typically run in the evenings between 6:30pm and 8:30pm, or on Saturday mornings. Intake occurs within business hours, but assessment interviews can be conducted during the day or evening. Practitioners noted:

Clients are often looking for group times that fit with their work commitments.

The demography of the client group for RAV's MBCPs varies widely. One practitioner commented:

Some clients could be defined as working poor, others appear to be more wealthy – some turn up in their BMWs.

The intake process is consistent regardless of referral point.

RAV draws upon a casual pool of practitioners to resource its MBCP program.

Intake

When contacting the service in the first instance, a potential client will speak to a Client Service Officer (CSO) who takes the client through the intake process (see Figure 3). Intake operates as a screening and triage process.

Where RAV does not anticipate a MBCP program to commence within two months, the potential client is advised of the waiting time. Intake may be deferred in these circumstances and the client offered access to an alternative internal program or MBCP at another service or location. Responsibility to engage with another program or alternative service in these circumstances is left with the men. This practice was mirrored at other MBCP service providers, out of concern to not hold a client for an extended period of time on the waiting list and be unable to adequately support him and affected family members in the interim. Other services discussed this as a concern about “holding risk” for too long. RAV practitioners reported that in most instances the potential client does call back closer to the start time as advised. One practitioner gave the following example:

Some men call when it is crisis time – they got the order 10 months ago and now its last minute – they need to get in to a program. We say sorry, there are a lot of men in your situation, but the pressure can't be ours, we need them to take responsibility.

At the time of our consultation with RAV, the waiting time was approximately two weeks as they had recently been able to open up extra groups.

Where proceeding with intake, the CSO will spend a significant amount of time on the telephone with the client (often up to 45 minutes) discussing the program participation criteria, cost, rights and responsibilities, and explaining the legal or other documentation the client needs to provide.

Specific questions are worked through at this point such as ‘Is there current family violence?’ and ‘Is drug or alcohol involved?’. The CSO at this stage is seeking to ascertain any potential risks facing the client, his partner, children or other affected family members. The CSO will give the opportunity for the client to ask any questions they may have. They will also ask the client to forward copies of any relevant court or corrections orders. RAV practitioners greatly value the role of the CSO in these early communications with the client. Practitioners noted:

The CSOs are very good at being non-confrontational.

Practitioners spoke about a small number of clients putting up some resistance at this point, but most are able to be ‘talked through’ and are willing or prepared to provide information and generally cooperate with the process.

Any presenting issues from the potential client will be responded to by the CSO, and an appropriate referral made if applicable. Indigenous clients may be referred to the Dandenong Cooperative, but it was reported that this offer is not usually taken up. With respect to CALD clients, RAV practitioners recognised they are not always able to meet demand and the needs of this client group. It was reported that CALD clients cannot always be readily accepted in to a group. Whilst CALD clients referred from Corrections Victoria can be offered an interpreter for one-on-one sessions, MBCPs are not always resourced to provide these services. In some instances MBCPs are able to refer some CALD clients to an appropriate program in their community (e.g. at InTouch or Kildonan).

At the conclusion of the intake an assessment time is then scheduled. Typically, the assessment interview will take place within two or three weeks of initial intake.

Assessment

The assessment process can vary depending upon how the client presents, and upon the worker conducting the assessment – it is very much tailored to the circumstances and presentation of the client. A typical assessment interview will take between 90 minutes and two hours.

Core components of the interview include:

- reviewing any court orders
- discussing program details, fee, participation criteria, support services, what constitutes family violence, effects of family violence on children, and preliminary strategies for getting started with behaviour change
- provision of information pack including:
 - RAV Charter of Rights and Responsibilities
 - Complaints policy
 - Privacy and Confidentiality summaries
 - Information brochure of agency programs
- completion of Violent Behaviours Checklist – self-assessment
- a Men's Behaviour Change Program Participation Agreement is worked through in detail
- assessment by practitioner addressing contact and demographic information, employment and income status, genogram of those affected by violence, client health (general and mental), use of alcohol and other drugs, gambling, chronology of events, legal status, weapons, and clients account of the conduct
- completion of Partner/Family Safety Contact Information
- assessment of suitability and risk factors, including whether the client presents with high risk or safety concerns and
- referrals to services and support for any factors that will assist the client to resolve personal issues or become more group ready (for example homelessness services, financial or other counselling).

This process operates in a person centred manner. The primary focus at the start of the assessment is to gauge how the client is feeling, to help him feel settled and to present RAV as the provider of a service to him.

Clients are required to bring all of their documentation (orders etc.) to the assessment interview. The assessor will read through these early on in the interview.

If the client presents as resistant to the notion of participating in the program or moving to a place of accepting responsibility, the assessor will concentrate on the documentation and the requirements that exist both for the client and the service. It is made clear, particularly for clients who are mandated to participate, that whilst they are required to attend, the service is not obligated to accept him into their program. This point is made in the context of motivating the client to engage – to realise that the service and client must work together.

If, during the assessment interview, the client is not engaging in the process, assessors will work through the organisation's behaviour checklist. This checklist asks the man to explore the scope and frequency of the various violent and controlling behaviours used, ranging through the use of:

- coercion and threats
- intimidation
- economic and financial abuse
- emotional abuse
- isolation
- using children
- physical abuse
- sexual abuse
- gender or social privilege
- minimising, denying, blaming
- alcohol and other drugs and
- road rage.

A series of statements sit under each of the above categories, detailing specific examples of manifestations of the type of conduct constituting family violence. The man is asked to rate how frequently he has used those tactics or forms of conduct towards a family member or child. This checklist serves as a tool to help the man recognise his behaviours as falling within the various forms of family violence. Through this recognition the man moves towards greater realisation and acceptance of responsibility for his actions. The discussions that accompany working through the checklist are solution focused. Usually assessors find the assessment process runs relatively smoothly. For example, one practitioner said:

They know we are there to help and support them, including with kids or partner issues.

Workers make it clear that the framework for the service is to help them, not appease the courts.

Many clients present with complex needs. Some of these needs, as above, may have been identified during intake, but many issues also become more apparent during the assessment process. Needs can relate to homelessness, financial problems, debts, and Centrelink dependency. 'Warm referrals' are made on the spot to appropriate agencies, with care being taken not to overload the man.

The Participation Agreement is, as above, worked through with the client in great detail. The third expectation set out in the Agreement – that pertaining to the requirement to provide contact details for affected family members impacted by the violence – was noted as causing potential clients the most discomfort. Some workers described a perceptible shift in the interview at this point. Workers at this stage reiterate their role as supporting both the client and the affected family members.

It was reported that men who present with high risk are typically referred in to case management support rather than the group program.

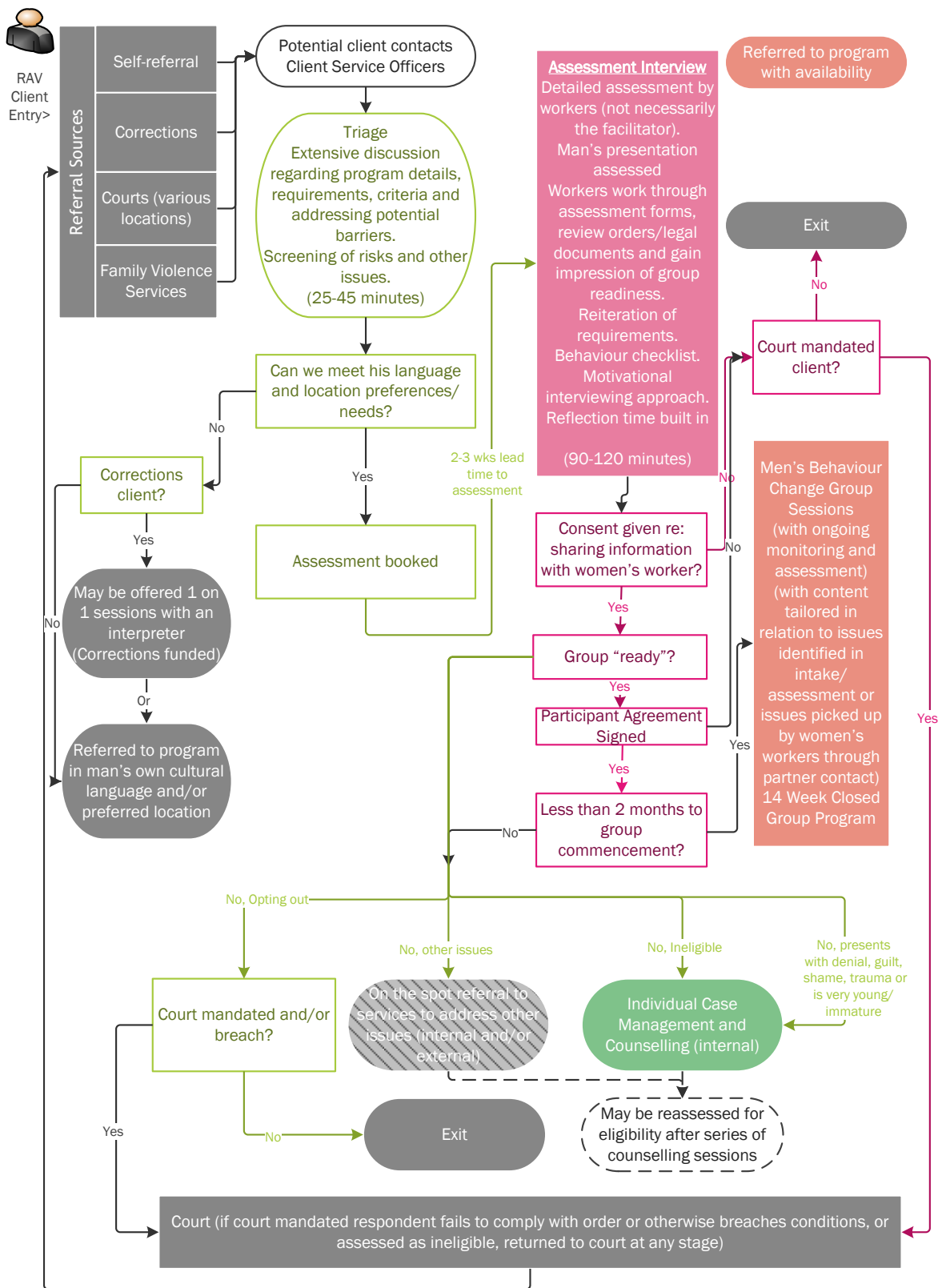


Figure 3: Relationships Australia Victoria MBCP intake process map

Star Health

Star Health (formerly Inner South Community Health Service) is a provider of primary health care services in the inner south area. Its services are located in Prahran, St Kilda, Cheltenham and South Melbourne. Star Health offers MBCP group programs as well as individual counselling and case management for men who use violence against their families. Star Health's website provides a contact telephone number for referrals and intake on its home page. Men's family violence services are targeted to men (and their families) living or working in the areas of Port Phillip, Stonnington, Bayside, Kingston and Glen Eira, however, in practice no catchment boundaries are applied to the provision of these services. Practitioners said:

If they can get here, that's okay – there's not really a catchment restriction.

Star Health workers who participated in this Practice Inquiry all shared the belief that there is a difference between various organisations and how MBCPs are delivered. Star Health practitioners acknowledged that greater resourcing to the sector has helped them to improve their offerings and responsiveness to need and demand.

Furthermore, Star Health's MBCP services have been subject to a recent practice review that has altered the way that intake and particularly assessment is undertaken by the organisation. One of the chief practice modifications introduced through the review was to add a second stage to the assessment so that the process now involves two on-site interviews (refer to Figure 4 – Star Health MCBP intake process map). The first of these focusses on general assessment and administrative elements of intake. The second stage enables the assessor to explore goal setting and motivational factors in more detail with the potential client. Emphasis is on thoroughness and ensuring that all relevant information is captured on the assessment forms for future reference.

Intake

As illustrated in Figure 4, intake processes are initiated when a referral is received or the man contacts Star Health's general reception. Clients also come to the MBCP via MRS, the courts, police and L17 referrals. Basic details are recorded and an email is sent to the MBCP team.

An MBCP team member will return the potential client's call as soon as possible – but always within a week - for a brief intake phone call. The call encompasses introductions, discussion of the program (overview, duration and criteria), exploration of specific client needs and preferences (location, supports) and the making of any preliminary referrals. Expectations and criteria are also detailed, including the requirement for limited confidentiality and consent to partner contact. Practitioners noted that most of the men are accepting of the partner contact requirement, appreciating the transparency surrounding this process. Partner contact is initiated within two days of receipt of consent.

Workers acknowledge the initial phone call as difficult for many men to make. The intake phone call is used as an opportunity to put the man at ease, acknowledging that making contact is a difficult step for many men. The initial call also assesses risk and addresses safety – requesting full contact details, and stipulating men bring in court documents/IVO paperwork.

An invitation is then extended to the man to attend an assessment interview. If a program is not due to commence for some time (more than six weeks), the assessment may be postponed and alternative (timely) options discussed. As noted by other organisations in the study, there is a concern about managing and holding the risk for a man and his family where direct engagement with the service is delayed due to program start dates. To manage these circumstances the client may be referred to another MBCP provider with program availability, or to case management or counselling with weekly to fortnightly follow up. No client is turned away in blanket fashion.

If the program is at capacity due to high demand a client will be provided details of other services or asked to recontact closer to the next group.

Assessment

As one practitioner commented:

What we do here will help in the group – get them group ready – set up the foundation for the group.

All assessment interviews are conducted on site at Star Health, typically within three to seven days of the initial telephone call. As above, assessments at Star Health are undertaken over the course of two interviews, typically one week apart. The first assessment interview generally takes about ninety minutes. Formerly the first session was of shorter duration but practitioners have found it beneficial to have extended time to explore issues in detail and to mitigate against 'minimisation' by some men. The session is usually conducted by two workers with every effort made to ensure that those two workers will be the ones facilitating the group in due course. Star Health's recent practice review expanded the time allocated to this component of the assessment process to allow more time to have a comprehensive conversation. One practitioner stated the following:

In-depth discussion at assessment can make the difference between a good or a bad group. It gives us the ability to help put in safety measures.

Practitioners ask the client why he is attending. They explore recent behaviours, triggers and the background to the family violence conduct. It involves re-communication of program expectations.

During the first interview the practitioners use what is termed the "four P's approach" examining client issues. This strength based approach seeks to understand the client's:

- predisposing factors (historical factors contributing to the current problem)
- precipitating factors (the current triggers that sets off the problem or conduct)
- perpetuating factors (internal and external thoughts and behaviours that foster the problem) and
- protective factors (strengths, social supports and positive patterns of behaviour) that might underpin the possibility of progress. Workers talk with the man about the times when he is not violent. This process can sometimes lead to disclosure of previous trauma.

In the past, practices at Star Health had seen perpetrators waiting for up to six months before commencing a program. Their recent practice review included an audit of the service in terms of its child focus. As a result, the two stage assessment process was introduced enabling the second session to focus, where relevant, upon fathering (as a motivational factor). Where applicable, as part of goal setting this might involve honing in upon the man's role as a father or upon other related aims that he has.

As such the second assessment is often a child focused assessment which recognises the importance of keeping children safe and exploring men's relationship with children, their understanding of the impact of their use of violence on the children and their role as a parent. The second assessment also serves to facilitate the continual rapport building between the man and the service, as well as address barriers that may impact on his group readiness. Where the perpetrator is not a parent, the second session will delve further into the man's motivations or goals and explore issues discussed at the first session and will involve an assessment of where the man is at in terms of change.

Working across two sessions assessors are able to work at a slower pace in the first interview, to build trust and a professional relationship with the man. It provides an opportunity for being responsive to any anxiety

or difficulties, and to be able to say "that is okay – you don't need to answer that question just now, take your time". The two step process enables workers to take their time where there is some hesitancy in the potential participant, or to circle back to difficult questions later or in the subsequent session.

Immediately after the first assessment the partner referral is given to the women's workers who will then make contact with the partner within two days.

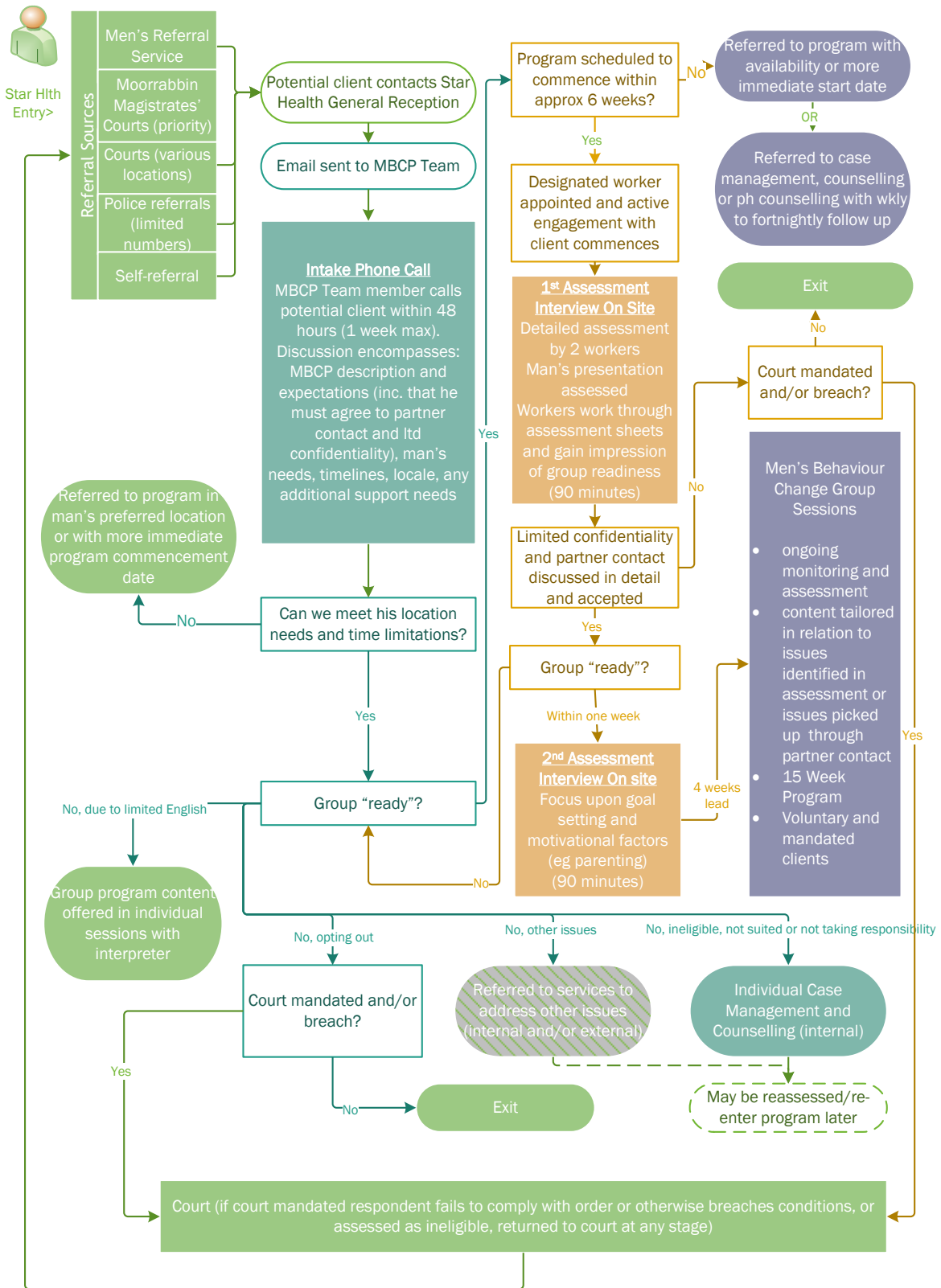


Figure 4: Star Health MBCP intake process map

Peninsula Health

Peninsula Health is the major health care service for metropolitan and regional areas on the Mornington Peninsula. Its services include aged care, rehabilitation, and community health and hospital services. Its services are located in Frankston, Hastings, Mornington and Rosebud. Peninsula Health also auspices the Men's Active Referral Service for the Bayside Peninsula and Southern Melbourne Regions, providing a response to male perpetrators 18 years and over for the four local government areas on the Peninsula. This equates to approximately 10,000 referrals per year, meaning Peninsula Health oversees directing all cases in the region to an appropriate MBCP. The 10,000 referrals represent the total received and therefore includes L17s, referrals from third parties as well as self-referrals.

Peninsula Health's MBCP is known as the Men Exploring Non-violent Solutions (MENS) program. This service is offered in Frankston and Mornington, with priority given to men from the Frankston, Mornington and surrounding local government areas. There are however, no geographical limitations imposed by the service.

Referrals to the service come via the Magistrates' Court, MRS, Corrections Victoria and Victoria Police (L17s). Many men are court directed but not strictly mandated. Men may also self-refer to the service. Peninsula Health is currently taking part in a court mandated counselling pilot project providing men with a direct pathway from Court to the service - the Respondent Worker at Frankston Magistrates' Court conducts an eligibility test with men and is then able to fast track them into designated appointments for assessment.

There is no fee for participation in the MBCP program. Programs are run on Monday, Tuesday and Wednesday evenings between 6:30 and 8:30pm. A fourth group is offered for young men. This young men's group is a closed group with a capped age applying to participants. It runs with adapted content. The other three principle groups are open and rolling. New group members are admitted into the group every four weeks, after first undertaking a thirty minute introductory session in which they are provided with information about the philosophy of the program and about group expectations. Men are required to participate in 16 weeks of programming, however those who are on a counselling order (see below) are required to attend only 12 weeks (although they are given the option to complete the full 16 weeks).

Intake

Intake to the Peninsula Health MBCP is via the organisation's central phone number. As illustrated by Figure 5 – Peninsula Health MBCP intake process map, the Access Worker conducts a preliminary intake. In the main this is uniform for all Peninsula Health clients – that is, using a standard screening tool that applies to all service clients. The intake is brief, with the entering of key information into the organisation's client database. Information is provided to the client about the health service and its guidelines, information is also given about other offerings as well client rights. Questions are asked about why the man is referring to the service, current safety risks, his family structure and current living arrangements, and whether any intervention orders are in operation. These details are recorded in the organisation's central database.

The Access Worker provides some preliminary information about the MBCP and informs the potential client that there is a waiting list, updated monthly, for entry to the group program. If safety risks were disclosed during the intake, the file will be flagged as a priority and follow up contact expedited. Otherwise, the client is then advised there is a waiting list for assessment and program entry. The Access Worker plays a triage role and will facilitate referral to other internal and/or external services where applicable, for example alcohol or mental health issues, or homelessness.

As mentioned above, a second intake stream is also in operation, with Peninsula Health being part of a pilot initiative via which the Respondent Worker at the Magistrates' Court is able to conduct eligibility tests with men. Where men meet the program eligibility criteria, the Respondent Worker is able to directly book them in to a pre-allocated assessment appointment time at Peninsula Health.

Workers noted that as many as three quarters of those who 'self-refer' are prompted to do so by external factors, such as legal advice. This is a phenomenon the service is seeing more and more, particularly in the context of parenting orders and other family court proceedings.

Assessment

All men who go through initial intake and who wish to continue to engage with a MBCP at Peninsula Health are invited to an assessment interview by an assessment worker (who is also an MBCP facilitator). Unless a case has been flagged as a priority, assessments are undertaken in waiting list order. Recognising that attrition can occur between intake and assessment processes, assessment workers reach out to men via telephone call and additionally send text message and written correspondence to prompt attendance at the assessment interview. The waiting time from intake phone call to assessment interview is usually two to four weeks but it has in the past, extended to as long as eight months. The waiting time from assessment to group admission is approximately four weeks.

When inviting men for an assessment interview interest in the program is reconfirmed, and if he wishes to proceed, an interview appointment time will be set. Men are at this stage provided with more detailed information about the program, eligibility and other requirements. Men are required to bring any court orders with them to the assessment.

Assessment interviews take two to three hours and are conducted by a single worker. The interview follows

a standard structure. In the first hour a standard assessment form is completed. A genogram is mapped out and a record made of circumstances in which the man identifies himself as likely to engage in inappropriate behaviours. They then drill into the specific incident or incidents that prompted his enquiry about the MBCP program. In his responses to this questioning, practitioners seek to gauge the level of responsibility he is assuming for the conduct and more information about his relationships with partners, children or other family members. They prompt for information about how he relates to these people and if he modifies his behaviour around children (if he is a father) or whether they seem afraid of him. One practitioner voiced:

Over time we've honed our questioning style to encourage the men to open up.

Enquiries are made about whether the man has any drug or health issues, previous convictions and charges, whether he was regularly in fights at school, whether he is on medication, receiving counselling or psychological support, and whether he has previously undertaken any type of group work program. Men are asked to complete a questionnaire detailing how they relax and to rate themselves on a quality of life scale (in terms of support networks etc.). Practitioners find that at this juncture the man begins to relax.

Information is provided about the service, client rights, confidentiality, MBCP program background and session times. He is provided with information about group rules. The standard behaviour checklist is completed; which workers report helps him to become more reflective:

We leave the room when he does the checklist. Whether they choose to be honest with it or not, they are sitting with it, processing, getting benefit from it.

The man is then required to give consent to limited confidentiality and to partner and ex-partner contact. Practitioners note that it is often at this point that a man may 'bail out', for example:

You are going to speak to my ex?!

If the man refuses to give consent the interview is stopped, but he is given information about what will happen in respect of any court or counselling order that may be in place. As one practitioner advised:

We are contracted to run the group and if he feels it's not for him there is not much we can do – it's up to him. We are not here to force them, although many men feel and act as though that is the case.

We take the approach of encouraging them – trying to help them see that it is an opportunity.

We say it's about responsibility. We do offer him time to go away and think about it. . .

In addition, practitioners observe that even in this instance of the interview stopping, it may still be considered the start of change.

Workers noted that their own assessment process can sometimes uncover eligibility issues that the Court or Respondent Worker was not aware of. This may occur because questions are asked in a different way, or because, at Court, the man was in a heightened emotional state and therefore answered questions differently – that is, wanting better outcomes in the judgement. Workers suggest that in many instances a man will push back against the process as a continuing manifestation of his desire to exercise power and control.

Workers suggested that a possible means of eliminating the issue of men going back and forth between courts due to eligibility issues, would be for counselling orders to not be set until the assessment takes place.

Peninsula Health practitioners use the interview to work through risk issues and to help the man to understand what will be asked of him in the group setting. Workers are conscious to stress to the client the importance of what they are doing, and they frequently 'check in' with him during the interview to give him an opportunity to ask questions to ensure he understands what is being discussed.

Practitioners describe the assessment process as a warm-up for group. They note for example that they can be the first people listening to the man. They ask questions and lead discussion with a view to being engaging, but also work to promote his group readiness, challenging him in some parts of the interview, but also facilitating reflection.

As above, once a man has been assessed as eligible he will next be invited to an introductory session as a prerequisite to group entry. The introductory session is conducted in a small group environment and provides further specific information about the philosophy of the group program. Group expectations are reiterated.

Practitioners reflected that it is their preference for the assessment worker to also be one of the facilitators for the group the man is assigned to, although this is not always possible, and the facilitators must then rely on the extensive case notes made during the assessment interview for insight into the individual. For the Young Men's Group, more effort is made to ensure that the assessment worker is also the group facilitator.

Practitioners noted that the requirement for clients to complete an enrolment agreement is an important aid to group functioning. It can be used to bring the man back on track if he is not conforming to group rules and it can legitimate exiting a man from a group who has breached the agreement.

Practitioners reported that systemic gaps exist in the sector in relation to a strong theoretical base for programs. NTV training does not provide this and it can be left to individual organisations to formulate their own underpinning theories of change. In addition, they noted that most Victorian MBCPs are based upon the Duluth model, but that training in this model was not offered when programs were set up and remains largely absent from the professional development offerings in the state. Practitioners suggested that there is scope for further ethical and professional standards for the sector.

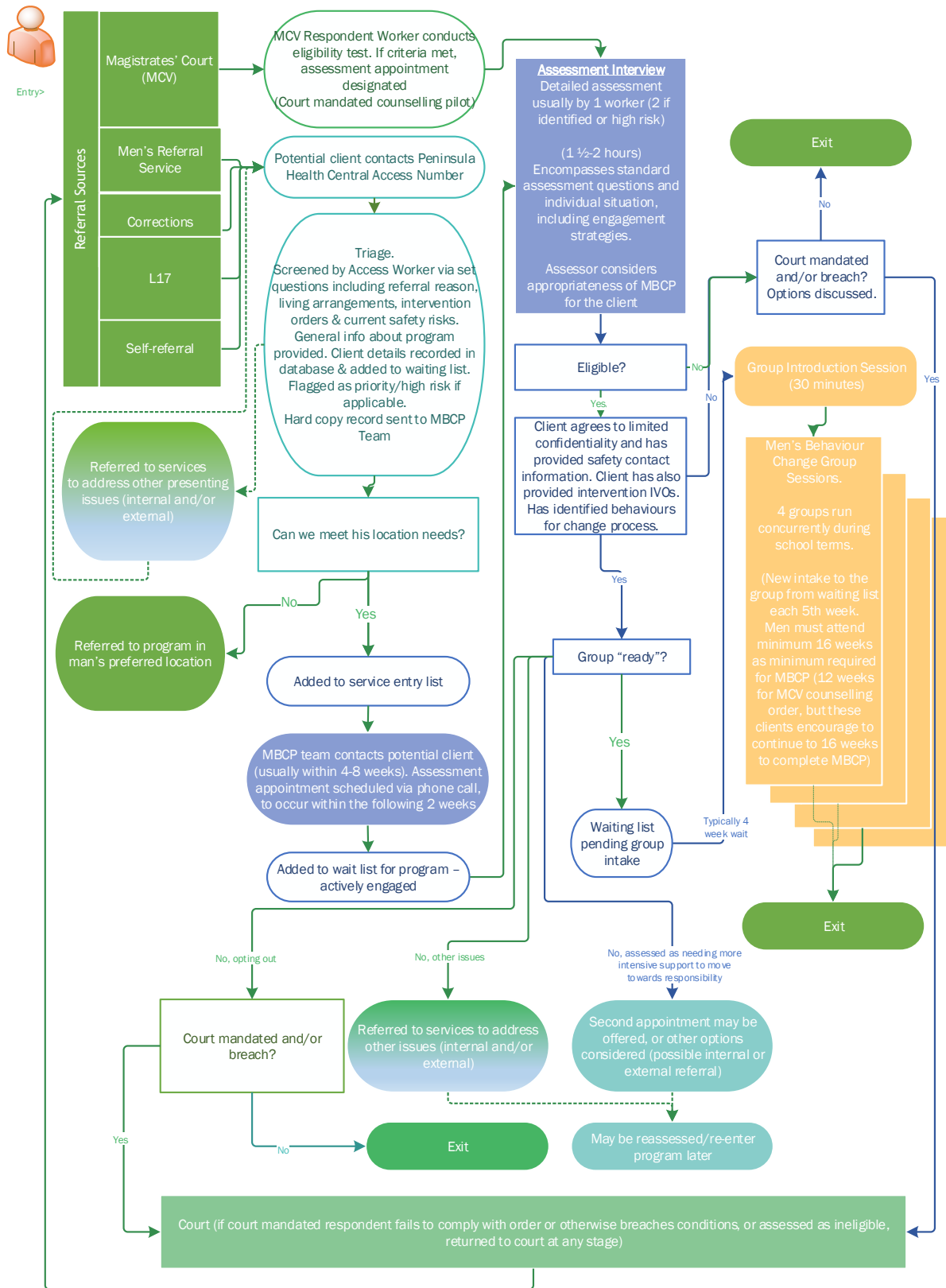


Figure 5: Peninsula Health MBCP intake process map

Summary of process maps

As reflected in the process maps presented, there are several aspects and processes involved during MBCP intake and assessment phases. With respect to assessment processes, practitioners at Star Health, Relationships Victoria, Peninsula Health and Family Life described common elements of assessment. These common elements involve a focus on the following:

- *Individual needs, rights and responsibilities*
 - informing the client of their rights and responsibilities related to the agency and MBCP
 - contemplating additional supports that might better enable long-term behaviour change for the client
 - assessing whether personal trauma is at play, and making assessments as to the most effective interventions and referrals to address this trauma
 - explaining what family violence is to the client
 - seeking to understand and respond to the client's complex needs and emotions
 - seeking to understand the client's learning style and
 - providing space for the client to share his own story thereby reducing his anxiety.
- *Risk assessment and safety planning*
 - assessing safety risks to partners, former partners and/or other affected family members and
 - contemplating the safety of the client himself.
- *Assessing suitability and group readiness*
 - thinking about issues emerging in the interview that should be woven into group programming should the client proceed to a MBCP group
 - clinically assessing where the client is situated on the behaviour change continuum
 - determining any factors which may operate to motivate him to change and to complete the program
 - identifying and then setting in motion resolutions to any possible barriers to participation
 - taking preliminary steps to move the client along the change continuum to a point of beginning to take responsibility and ceasing to minimise or deny his conduct as violent
 - preparing the client for the group program by challenging him on certain issues
 - thinking forward to group programming and assessing how the client might fit into, cope with, or potentially also derail others in the group and
 - challenging his behaviours and prompting self-reflection.
- *Professional requirements*
 - role modelling gender equality
 - maintaining alertness and acute self-awareness to avoid collusion with the client
 - offering support and encouragement, and building rapport and trust with the client
 - reading body language and other cues that give insight into his attitudes, traits and triggers
 - contracting with the client regarding group agreements
 - obtaining formal agreement for partner contact
 - generating a written record of the assessment discussions and
 - working through a range of checklists and other necessary prompts for assessment purposes.

While acknowledging that this is not an exhaustive list, it does demonstrate the vast amount of work undertaken prior to clients commencing in a program. The mapping also highlights the importance of intake and assessment processes, particularly when assessment interviews are used as a vehicle for identifying need and developing matched interventions. With respect to MBCPs more broadly, further examination of intake and assessment processes would assist in future planning and development of MBCPs across Victoria.

Conclusion

The significant investment in reforms underway in Victoria is necessary to prevent and respond to family violence. The RCFV called for the government to treat family violence as a core area of responsibility and highlighted the need for a “whole-of-government approach to stop family violence, support victims and hold perpetrators accountable” (State of Victoria, 2016, p. 12).

Drawing on a review of literature and policy and a series of consultations with practitioners, this Practice Inquiry has explored the complexity of intake and assessment practices of MBCPs. We find that MPCPs are a central platform for perpetrator accountability and are often the only opportunity for the service system to engage one-on-one with a perpetrator in a meaningful way. Having the time, tools and techniques to hear a man’s story, gauge his level of responsibility for his conduct, and explore his motivations and state of readiness paves the way to the start of behavioural change.

While assessment practitioners undertake a comprehensive assessment in line with minimum standards, in a practical sense practitioners work to a far more complex set of objectives. These objectives include how to most appropriately meet the multifaceted demands of their role, necessitating a broad set of skills and personal attributes which extend far beyond those typically gleaned from minimum qualification standards. In some respects the emphasis that practitioners place upon assessment, and the degree of skilled work required to complete the process, points toward the need for more individualised interventions for men who use violence. In turn this raises the issue of sufficient resourcing, funding and training to support such initiatives, as well as specific funding to measure and evaluate the efficacy of reform activities.

The situated wisdom of practitioners has provided a unique understanding of the day-to-day challenges of behaviour change work. This report’s findings underscore the importance of engaging with frontline workers, particularly during a time of substantial change in the family violence sector. We hope that our findings and recommendations will assist with the implementation of the family violence reforms in Victoria, support practitioners to continue and improve their practice, and ultimately to achieve positive behavioural change outcomes and increase safety for women and children.

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Appendix 1 – Engagement:

Initial Contact & Intake

- What types of referrals does the organisation receive?
- From whom/where/catchment?
- Who makes the initial contact and who responds to the initial contact?
What variations exist within this model of operation?
- What happens at initial contact? What information is taken/given/shared/recorded?
Talk us through one or two typical intake processes, and any common variations.
- Is the initial engagement strategy different at the point of first contact depending on whether or not the perpetrator's compliance is voluntary or not? If so, in what way?

Assessment

- Describe the assessment process? How are clients assessed, and at what point?
E.g. From initial contact, or after?
- What occurs at the assessment interview to influence the individual's decision to engage in the program?
- What other issues do individuals present with that hamper their engagement with the program?
What other needs?
- What steps are followed in linking an individual in to a MBCP?
- What happens if there is a waiting period before a program commences, or if a man can't be accommodated by your service?

Organisational Tools and other offerings

- What documented practice guides are followed? Are there any deviations from these guides?
In what circumstances?
- (Are copies available for our report?)
- What else is offered? Are complementary services and programs available at your organisation?
Are referrals made to other services?

Practice reflection

- What intake and assessment practices/elements/components are most effective in seeing men complete an MBCP (in terms of engagement)?
- What do you believe to be most effective in enabling or supporting a man to complete a Men's Behaviour Change Program from the point of intake and assessment?
- What do you perceive works well – in terms of your organisation's internal engagement practices – to encourage/facilitate men staying in an MBCP through to completion?
- What does “good” look like in relation to practitioner skills at the point of the first contact & intake?
- What does “good” look like in relation to practitioner skills at the point of the first assessment interview, and then subsequently?
- What factors outside of the organisation or MBCPs' control can be identified that may contribute to or hinder completion of the MBCP? E.g.
 - Client needs
 - Geography
 - External supports or imperatives
 - Session availability, wait times, cost
- What reasons do men have for being legitimately unable to complete the program (new sentence? Check form) what factors can contribute to their withdrawal and non-completion?
- What elements do you believe would be critical if a base-line or standard model was implemented across a number MBCP providers in this and other regions?
- Do fees factor in the success of the MBCP?
- In what ways, if any, could improvements be made to any of the guides or standards that apply to Men's Behaviour Change Programs – in relation to intake, assessment and engagement?
- Are there any particular activities that seem to have more success in engaging men from particular cohorts? How do you maximise inclusiveness?
- Is your service meeting current demand?

Broader questions the inquiry seeks to answer

- How do initial contact strategies vary across the providers in the Bayside Peninsula and Southern Melbourne regions?
- What opportunities are there for information sharing between the services?
- What do alternative practice models offer?
- Anything else we've not covered?

