UnitingCare

Evaluation of UnitingCare Men's Behaviour Change Programs

| STAGE TWO REPORT |

October 2020

Professor Annabel Taylor
Dr Sue Carswell
Dr Nicola Cheyne
Dr Bronwyn Honorato
Vicki Lowik (PhD candidate)

QCDFVR
Queensland Centre for Domestic and Family Violence Research

CQUniversity AUSTRALIA

Foreword

UnitingCare is committed to the creation of safer communities where individuals and families can thrive. As part of our commitment, UnitingCare delivers behaviour change programs for men who use domestic and family violence. The purpose of these programs is to increase men's accountability for their behaviour, address underlying beliefs and attitudes, and improve the safety of women and children.

Men's behaviour change (MBC) programs are regarded as an important violence prevention activity; however, an internal literature review conducted in 2016 found that evidence of program effectiveness is mixed. As one of the largest providers of MBC programs in Queensland (in five regions currently), UnitingCare acknowledged its responsibility to contribute to evidence-building, beginning with an evaluation of our *Men Choosing Change* program. Our aim was threefold: assess program effectiveness, support practice improvement, and contribute knowledge about MBC programs to the existing evidence base.

In 2018 we initiated a research consultancy with the Queensland Centre for Domestic and Family Violence Research (QCDFVR) at CQUniversity. Early discussions with QCDFVR centred on the challenges of evidence-building in the MBC space, highlighting the need for a reciprocal way of working. This dialogue set the tone for a partnership characterised by co-design, knowledge exchange and shared capacity development. A combined process and longitudinal (12 months) outcomes evaluation commenced in early 2019.

This report of initial findings provides scope for cautious optimism. It appears that *Men Choosing Change* does contribute to the reduction of violence, but not for all men, and we do not yet know if changes are sustained over time. Importantly, we have identified several challenges that impact program outcomes, including program funding and resourcing, workforce capacity and capability, barriers to program completion, meeting the diverse needs of participants, and limited options for post-program support. These findings will now drive our efforts to improve our work.

I would like to extend special thanks to the MBC practitioners and program managers who invested significant time and effort in sharing knowledge and expertise, co-designing the evaluation, and supporting months of data collection. This project was only possible because of the passion and commitment that you bring to your work, including this evaluation.

I would also like to thank our external stakeholders, who represent a wide range of provider and government agencies. Community responses to domestic and family violence are stronger when we work together, and your contribution to co-design workshops and participation in interviews has greatly enhanced the evaluation.

Above all, I would like to thank the men and women who contributed their experience of our program through surveys and interviews and will continue to do so through the longitudinal evaluation phase. Your voices are vital to strengthening our work into the future.

Brent McCracken

Group Executive, Family and Disability Services

Executive Summary

This report provides findings from Stage Two of the evaluation of UnitingCare Men's Behaviour Change Programs (MBCPs) delivered within five regions across Queensland. This stage of the evaluation was informed by Stage One, a co-design process including Theory of Change workshops with practitioners, managers and key stakeholders at each evaluation site and a review of recent literature.

Stage Two of the evaluation examines early outcomes from men's self-reported attitudes pre-and post-program at exit, and partners' and ex-partners' observations of any changes to men's attitudes and behaviours over the course of the program. Partners and ex-partners were also interviewed to understand to what extent they had been supported by the Domestic and Family Violence Women's Advocates (DFV Advocates). Stage Two also examined how the MBCPs were being implemented (process evaluation) and involved interviews with program managers, MBCP facilitators, external stakeholders and DFV Advocates.

Factors to examine in the outcome evaluation

The co-design process identified the following factors as central to understanding program outcomes for men:

- Level of engagement with the program and motivation of the men to change attitudes and behaviours
- Increase in knowledge about DFV and its impact on partners and ex-partners and their children
- Potential increase in sense of empathy
- Changes in level of self-awareness and motivations for the men's behaviour towards others
- Development of new skills, tools, strategies and behaviours by the men to reduce violence against their partners and ex-partners
- The role of facilitator engagement, knowledge and skills in creating group dynamics where men are supported to make positive changes.

Factors identified to investigate the impact of the MBCP on partners and ex-partners and their children included:

- Changes the partners and ex-partners observed on the men's attitudes and behaviours while the men attended the program and immediately after
- Changes in the men's attitudes and behaviours towards their children
- Increased safety and reduction in risk for partners and ex-partners and their children
- How the DFV Advocate role assisted and supported the partners and ex-partners and their children.

Early outcomes in relation to men

Our findings indicated that the MBCP program appeared to increase men's understanding of the impact of DFV, increase their self-awareness and skills to regulate their emotions, and improve their interpersonal communication skills. The combination of this learning appeared to contribute to a decrease in more violent behaviour and to improve men's respectfulness. Changes appeared to be more noticeable in the weeks and months immediately following the program. However, some partners and ex-partners reported that these changes were short lived and that there needed to be a follow up maintenance or support program to consolidate what the men had learned.

Early outcomes in relation to partners and ex-partners

Partners and ex-partners reported a decrease in physical violence while the men attended the program, and half the women reported that their sense of safety had increased which they attributed to the MBCP. Some women reported that the men's aggression had increased after

the program and that legal measures such as the use of Domestic Violence Orders helped to keep them in check with the threat of prison. The majority of partners and ex-partners valued the support of the DFV Advocate in terms of undertaking risk assessment and increasing their safety with information, advice and referral. Ongoing contact was valued and helped the partners and ex-partners to cope with traumatic stress and to continue to take action to protect themselves and their children.

Voices from the field: key findings from the process evaluation

Six areas were identified as part of the co-design phase for this study in order to explore the experience of managers, MBCP facilitators, DFV Advocates and community stakeholders. Semi-structured interviews were developed based on the key areas identified for investigation.

These areas included:

- Facilitator experiences in delivering the MBCPs
- The role of DFV Advocates and their contribution to the safety of women and children
- The degree to which the MBCPs worked with the wider DFV service system
- The perspectives of key stakeholders regarding the implementation of the MBCPs and their involvement
- The degree to which the MBCPs took account of client diversity.

Management and administration of MBCPs

In this highly skilled and challenging area of social service practice, recruitment and retention were described as difficult due to the lack of qualified facilitators and training available in this specialist area of group work. Access to professional supervisors who were familiar with DFV and behaviour change group programs was also described as limited.

Managers found that lack of funding placed limitations on program scope and depth, with demand reported as exceeding supply. Additional costs of travel were incurred in delivering and managing the MBC program across multiple regional sites. This also impacted on opportunities for professional development and for staff to participate in planning and development. Where managers had the time and resources to work with their teams to develop shared understanding of the program material, the underpinning theories and ongoing focus on accountability were reported to work well.

MBCP facilitator reflections on program delivery

Facilitators reported the satisfaction they experienced when group facilitation was effective in the men gaining insight into their use of violence and the impact it had on victims. They felt that the men responded well to the structure of the program session material and particularly to the shared 'catch up' at the beginning of each session. Co-gendered facilitation was reported as requiring particular skills and an acute knowledge and sensitivity to role modelling mutually respectful relationships based on an awareness of gendered power dynamics.

Facilitators spoke highly of their collaboration with the DFV Advocates and how the input of information concerning the situation of the men's partners or ex-partners and children helped to maintain authenticity and support men's accountability. Most facilitators found that the DFV Advocate position was under-resourced, and identified the need to involve the Advocates in intake and assessment, in ongoing case management, and above all, to ensure that there were sufficient resources to be able to contact all partners and ex-partners.

Domestic and Family Violence Advocates' reflections on program delivery

The DFV Advocates connection to partners and ex-partners of program participants provided insights into the extent of men's behaviour change. The DFV Advocates noted an overall reduction in physical violence, or the physical violence ceasing altogether. However, name-calling, put-downs and verbal abuse appeared to continue. There were improvements in the men's communication skills and women described how, as a couple, they had developed new strategies in settling arguments. In some instances, the partners and ex-partners reported that the men had changed a lot and in a positive way.

The DFV Advocates referred partners and ex-partners to support services, particularly DVConnect and specialist domestic violence services, and were able to undertake risk assessment and safety planning with them. Where appropriate, Advocates referred women to high risk teams. An overall observation was that the men's attendance in the program gave women their first opportunity to feel sufficiently safe to be able to take steps to separate from the men. An ongoing challenge for the DFV Advocates was the development and maintenance of trust in working with the

facilitators and maintaining a shared understanding of the level of information disclosure and how this would be incorporated in working with the men.

Reflections of stakeholders on the UnitingCare MBCP

Stakeholders valued a high level of communication with MBCP personnel in order to manage risk, safety and accountability. Close working relationships and high levels of cooperation were particularly noticeable at those sites where Queensland Government-funded Integrated Response trials had been introduced.

The limitations to MBCP resourcing and high demand for these services led to some stakeholders being frustrated by the lengthy waiting lists affecting men's access to the MBCP. Stakeholders recommended that more programs become available, and that there needed to be more flexibility to run the programs outside of work hours to enable greater access for men. Some stakeholders also expressed concern about the suitability of MBCPs for some men, particularly high-risk clients, those with substance dependency and those who abused family members rather than their partners.

Stakeholders stated that they would have liked more available information about the programs and a higher level of information-sharing related to the progress of individual men while on the program.

Without exception, stakeholders regarded the DFV Advocate position as essential in supporting women and children's safety and the accountability of the men attending the MBCP. They also acknowledged that these 2 goals were sometimes difficult to achieve due to the high workloads of the DFV Advocates and insufficient funding for the positions.

Key overall findings

Key themes emerged from this study, and these included funding and resourcing of the programs, workforce capacity and capability, barriers and facilitators to men's completion and responding to diversity.

Funding and resourcing

The process evaluation identified concerns regarding the level of funding across the MBCP service system and the implications for outcomes that could be achieved by MBCPs in this context. Lack of sufficient funding for the number of MBCPs hampered men's timely access to programs. For professional staff, insufficient funding led to limited opportunities for education and professional development, and in some instances, limited regular professional supervision.

Funding constraints led DFV Advocates to focus mainly on high-risk situations and a heavy reliance on telephone contact only. Insufficient specialist support services are available for referral for victims/survivors, including longer term post-crisis recovery, which addresses practical and therapeutic needs of women and supports/referrals for their children.

An ongoing theme in relation to the program expressed across the MBCP service system was the need for an ongoing maintenance program of some form, with further involvement by the men who completed the program to support their progress. Many of the men, partners and ex-partners expressed this need with the desire to consolidate learning and achieve deeper insight and sustain changes.

Workforce capability – education, training and skills development

The MBCPs rely on a highly skilled workforce, and there were some examples of intensive mentoring and coaching for new staff as they moved into these roles in the absence of readily accessible specialist education and training. This level of mentoring and training demands a high resource cost from the host organisation. UnitingCare appeared committed to providing this workforce preparation as much as possible within the funding and contracting limitations. A deficiency in education and training on the role of gender in DFV, and how to incorporate this seamlessly in the program manual and in practice skills may alleviate some of the tensions that can develop between individuals across the program. Advanced group work skills training in the context of achieving individual accountability along with behaviour change were identified as critical to program effectiveness.

Barriers and facilitators to men's completion

Findings from this study indicate that completion rates of the MBCP were primarily impacted by the personal situation of the men, which ranged from relocating due to employment, losing access to transport, timing and availability of the programs, substance dependency issues and other personal factors such as homelessness. It was rare to find that a man was reported as unsuitable for the program once they had been through the intake and assessment process. A consideration for future development may be the recommendation from facilitators that provision of more individual sessions alongside the

group program would address individual issues for the men and support the likelihood of program completion. This would facilitate more tailored approaches to engagement and the ability to respond to trauma or other socio-ecological needs alongside the group sessions.

Service system collaboration and information-sharing

The issue of information-sharing was threaded throughout the findings. It was clear from this study that the DFV service systems within which the UnitingCare MBCPs are situated had varying degrees of cooperation and information-sharing. Where the MBCP was situated in one of the Department of Child Safety, Youth and Women (DCSYW) funded Integrated Response sites, higher levels of cooperation and well-established protocols for information-sharing were more likely. The development and maintenance of trust required for effective information-sharing requires ongoing time and effort by services and individuals in developing agreed protocols. This is similar to other findings that have resource implications, but the potential costs of failing to share critical information at the right time may have a significant human cost. Access to education and training on information-sharing, as the Queensland Government intended in its recent legislation and guidelines (Department of Communities, Child Safety and Disability Services, 2017), would assist the DFV service system to develop community-based systems and protocols.

Responding to diversity

Threaded throughout the process evaluation there were considerations as to the cultural appropriateness of the program for diverse populations. This is in line with the recent ANROWS report: Developing Programs for perpetrators and victims/survivors of domestic and family violence (2020) related to the 'heterosexual face' of domestic violence. The prevailing design and implementation of perpetrator programs in Queensland are predicated on assumptions based on the dynamics of heterosexual DFV. Arguably, the same may be said for the program design and appropriateness for Aboriginal and Torres Strait Islander and culturally diverse populations. While the UnitingCare MBCP staff made efforts to liaise and work with local Aboriginal and Torres Strait Islander communities to link with the MBCPs, the program design and content would need to be developed with a different cultural lens. Significant investment is needed to build capacity for MBCPs to provide relevant learning contexts and learning styles to reach Indigenous and diverse communities. Until appropriate resources are available to make this possible through the involvement of cultural advisers, the program can only hope that it will be relevant for some groups of men and their partners and ex-partners.

This report constitutes Stage Two of the evaluation of the Uniting Care MBCPs which built on the co-design process of Stage One and a literature review. A suite of survey and interview tools were developed to understand the potential shift in the attitudes and behaviours of men who use violence and the safety and the wellbeing of their partners, ex partners and children. The limitations of the study relate to the reliance on survey and semi-structured interview methods which confined the results to specifically identified factors and measures in relation to men's behaviour change. It was not possible to capture the full potential range of influences on the lives of the participants. In Stage 3, the longitudinal phase of the evaluation which is currently underway, it is planned to widen the scope of the research interviews to incorporate more qualitative exploration of how the Uniting Care MBCPs have impacted over a longer period of time. This will facilitate greater involvement by the participants as to how the MBCPs have contributed to their safety and wellbeing.

Acknowledgements

The evaluation team would like to acknowledge UnitingCare Child & Family Services, in particular, Donna Shkalla, General Manager Practice Improvement and Development, and Dr Chez Leggatt-Cook, Principal Advisor Research and Evaluation, who supported this research and enabled its facilitation. Practice Development Consultant, Margaret Cameron, also provided ongoing support, and in addition, Anna Gillbard, who worked tirelessly to assist with recruitment of partners/ex-partners and has made the data collection possible for this second stage of the evaluation.

The team would also like to thank the Men's Behaviour Change Program facilitators, the Domestic and Family Violence Advocates, and the key stakeholders at each program delivery site for their participation and their practice wisdom. Their willingness to 'go the extra mile' in sharing their knowledge and experience has been invaluable. We also gratefully acknowledge the effort of facilitators to recruit program participants to take part in this evaluation.

The team sincerely thanks all the partners and ex-partners who participated in telephone interviews for sharing their experiences as their feedback is vital for understanding the extent to which the MBCP contributes towards men's behaviour change. We also sincerely thank the men who participated in the pre- and post-program surveys and provided feedback about the program.

The team would like to acknowledge the support of Dr Heather Lovatt, the Director of the Queensland Centre for Domestic and Family Violence Research, for her strategic support throughout the project. Above all, this is a challenging field of human services practice, and we acknowledge the dedication of all those who are striving to end violence against women and children.

Evaluation Team

Professor Annabel Taylor

Dr Sue Carswell

Dr Nicola Cheyne

Dr Bronwyn Honorato

Vicki Lowik (PhD candidate)

Acknowledgement of Country

We acknowledge the Traditional Owners of the lands on which we live and work, and recognise that these lands have always been places of learning. We pay respect to their Elders—past, present and emerging—and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play in responding to domestic and family violence.

About the **Queensland Centre for Domestic and Family Violence Research**

The Queensland Centre for Domestic and Family Violence Research (QCDFVR) contributes to the prevention of domestic and family violence by informing, promoting and supporting the actions of individuals, communities, services and governments through research, evaluation and knowledge creation, sector support and education and training.

Hosted by Central Queensland University, the Centre's research function is to initiate, undertake and collaborate on innovative and interdisciplinary research and publications to reduce deficits in domestic and family violence knowledge and literature. QCDFVR is also committed to undertaking applied research and evaluation that supports the development of policy and practice in the field of domestic and family violence prevention.

We are a Zero Tolerance organization and committed to preventing men's violence against women and children. Our vision is: *to influence policy and practice in domestic and family violence prevention through knowledge creation from research; knowledge translation into resources; and knowledge exchange through education and training, in the gendered violence field.*

QCDFVR has a strong commitment to Aboriginal and Torres Strait Islanders through building capacity of Indigenous researchers, Indigenous DFV sector workforce and working closely with Indigenous owners.

CONTENTS

Foreword	2
Executive Summary	3
Acknowledgements	7
Acknowledgement of Country	7
1 INTRODUCTION	10
1.1 Purpose	10
1.2 The UnitingCare MBCP models at the time of the evaluation	11
1.3 Co-design of Stage Two process and early outcome evaluation	12
1.4 Outline of report	13
2 METHODS FOR EARLY OUTCOME EVALUATION	14
2.1 Considerations for designing tools	14
2.2 MBCP participant surveys	15
2.3 Partner/ex-partner survey/interview	16
3 EARLY OUTCOME FINDINGS FROM MEN'S AND PARTNER/ EX-PARTNER SURVEYS	18
3.1 Men's survey key findings	18
3.2 Partners/ex-partners key findings	24
3.3 Discussion	33
4 VOICES FROM THE FIELD: IMPLEMENTATION OF THE UnitingCare MBCPS – PROCESS EVALUATION FINDINGS	35
4.1 Process Evaluation Design	35
4.2 Managers	37
4.3 MBCP facilitators	40
4.4 Key stakeholders	50
4.5 Domestic and Family Violence Advocates	53
4.6 Discussion	56
5 CONCLUSION	61
5.1 Bringing together key findings from early outcomes and process evaluation	61
References	65

1 INTRODUCTION

1.1 Purpose

This report comprises the second stage of our evaluation of UnitingCare Men's Behaviour Change Programs (MBCP) delivered in five Queensland regions: Fraser Coast, Moreton Bay, North Coast, Ipswich and Mackay.

The evaluation sites delivered 2 types of MBCPs called *Men Choosing Change* and *Men Stopping Violence* which had considerable overlap in their relative program content. From January 2020, all UnitingCare sites now deliver the *Men Choosing Change* program. We use the generic term MBCP to refer to both programs and to refer to research and evaluation of MBCPs in Australia more generally.

A process evaluation approach involving consultation with practitioners, managers and key stakeholders was used to examine the implementation of MBCPs across the five UnitingCare regions. We examined early outcomes from an examination of men's self-reported attitudes pre-and post-program at exit and partners/ex-partners' observations in changes to men's attitudes and behaviours over the course of the program.

The purpose of the process and early outcome evaluation components of Stage Two are as follows.

Process evaluation

1. To explore the experiences of UnitingCare MBCP participants to identify facilitators and barriers to their engagement and what they found as the most helpful aspects of the program.
2. To examine the organisational and contextual influences on program delivery such as workforce factors, site specific differences and local service context.
3. To examine how MBCPs manage and respond to risk, and to what extent they participate in collaborative approaches such as integrated responses or community coordinated responses to domestic and family violence (DFV).

Early outcome evaluation

4. To determine what effect the MBCP has on participants' empathy, attitudes and behaviours in the short term.
5. To investigate the difference that MBCPs make to partners/ex-partners and their children in relation to risk, safety and recovery in the short term.

1.2 The UnitingCare MBCP models at the time of the evaluation

At the time of undertaking data collection for this evaluation in 2019, UnitingCare had for some time implemented the Men Stopping Violence (in Ipswich) and Men Choosing Change Programs (at all other sites).

These programs were guided by a common service manual (Men's Domestic Violence Intervention Programs (DVIP) Service Manual June 2018) which provided the broad outline of the common purpose, and underpinning practice goals and principles of the 2 programs. Key principles outlined included a focus on the MBCPs as part of a wider service system, a focus on safety (and safety planning), and a list of preclusions such as not providing couples counselling or focussing solely on anger management and avoiding leisure or recreational activities (Men's DVIP Service Manual June 2018, p.12). Risk assessment was an expectation for all clients, as was case management in terms of providing advice and referral as appropriate. Linking closely with child protection services as appropriate was stated as a priority and overall conforming with the Queensland Practice Standards for Working With Women Affected by Domestic and Family Violence. [1]

Men are required to be assessed for suitability for the program in initial individual interviews where program staff focussed on the potential for behaviour change and group work suitability. The program was designed to comprise of 16 x 3-hour group sessions and to be 'rolling', in that men were able to enter at any point during the year. Sessions were usually held in the evenings; although, some sites also offered daytime options. Staff were recruited mainly from the psychology, counselling and social work professions.

The following list outlines the mix of professional frameworks expected to guide the weekly MBC program:

- Person-centred Care
- Strengths-based Practice
- Trauma-informed Practice
- Systemic Family Therapy
- Motivational Interviewing
- The Duluth Model
- The Safe and Together model
- Narrative Therapy
- Cognitive Behaviour Therapy.

In addition to these frameworks, the *Men Choosing Change* program was informed by theoretical insights from neuro-psychotherapy, notably "how the brain works during the process of change and the unhelpful patterns of behaviour that get in the way of change" (*Men Choosing Change* Facilitator Manual 2016, p.15). *Men Choosing Change* group sessions included discussion of neuroplasticity to encourage the development of new attitudes and behaviours. In addition, mindfulness breathing was practised at the close of each group session to "provide participants with skills to reduce stress, rise above self-limiting beliefs, improve focus, develop self-awareness, facilitate calmness and handle difficult emotions" (*Men Choosing Change* Facilitator Manual 2016, p.15).

For both *Men Choosing Change* and *Men Stopping Violence*, a broad guideline as to expectations of how each session would be conducted included 'check-ins' with the men, challenging negative attitudes and disrespect, and modelling strategies for individual change. The group process is expected to focus on denial, minimisation and blame in relation to abusive attitudes and behaviours, and how to develop the skills for maintaining respectful relationships. Facilitators had the scope to determine the specifics of engagement activity and how to deliver the broad program content in line with adult learning approaches, at the same time as adhering to the designated sequence of program content.

Running parallel to the programs provided for the men was the expectation of support for their partners, ex-partners and children. Domestic and Family Violence Women's Advocates (DFV Advocates) were required to be appointed to each site delivering a MBC program, to establish contact with the partners and families of the men and to work closely with the facilitators to ensure their safety and wellbeing. As part of the investment model, it was intended that the DFV Advocates would provide support for partners, ex-partners and their children for a period of six months post program.

Since early 2020, all UnitingCare regions now deliver the *Men Choosing Change* program.

[1] https://www.csyw.qld.gov.au/violence-prevention/service-providers/practice-principles-standards-guidance

1.3 Co-design of Stage Two process and early outcome evaluation

Prior to embarking on this evaluation with UnitingCare, the researchers based at QCDFVR at CQUniversity undertook a literature review which was an in-kind contribution to the research. This review helped to inform our evaluation methodology.

Stage One of this evaluation established a co-design process and developed a program logic and theory of change (ToC) to establish clarity about the components of the MBCP, expected outcomes, and the rationale as to why program activities would achieve these outcomes. The evaluation team established contact with each of the participating sites and conducted workshops with facilitators, managers and stakeholders about the key elements to measure and explore in Stage Two of the evaluation. At these meetings, consideration was given to the practicability of various methods of measurement and interviewing that would fit within the implementation demands of the programs as they were delivered. The meetings also provided an opportunity for those involved in the UnitingCare MBCPs to become familiar with the evaluators and to raise any questions or concerns. A summary report of findings from the co-design process was submitted to UnitingCare at the end of 2018, with the final report signed off in February 2019.

It became apparent during this co-design phase that there would be practical and logistical limitations on the methods to be employed in the evaluation. This was due to the programs being offered in various regional locations and the availability of resources. The complexity of delivering MBCPs in terms of engagement with the men and the timing of intake, assessment and enrolment protocols were some of the factors that determined how and when participants would be involved, and the relative roles of the researchers and the program staff. Recognition must be given at the outset of this report to the contributions of the UnitingCare MBCP facilitators, the DFV Advocates and their managers/senior managers and the UnitingCare Principal Advisor Research and Evaluation, Dr Chez Leggatt-Cook, to problem solving and supporting the research in order to optimise participation.

Prior to completion of the agreed outcomes framework and evaluation methodology, these were sent for review by Paul Monsour, convenor of the peak body in Queensland for MBCPs (Services and Practitioners for the Elimination of Abuse—SPEAQ), Leanne Downes (Project Officer with the Walking With Dads program in the Department of Child Safety, Youth and Women—DCSYW), Simon O'Neill (Perpetrator Interventions Manager, Office for Women and Violence Prevention, DCSYW) and Dr Deborah Walsh (Lecturer, School of Nursing, Midwifery and Social Work, University of Queensland). Review suggestions were incorporated as agreed with UnitingCare into the final research design.

Ethics approval was achieved for Stage Two of the evaluation on 21 August 2018 from CQUniversity Human Research Ethics Committee (No. 000021436) and the UnitingCare Human Research Ethics Committee (Approval Taylor 1912018). Two further variations to the application were approved on 10 May 2019 and 3 November 2019. The variations will be explained in greater detail in the section concerning data collection challenges later in this report.

The key recommendations that represented the culmination of the Stage One consultation process focused on the need to:

- measure changes in victim/survivor safety and understanding their situations;
- measure the changes in key attitudes and behaviours that perpetrators make as a result of attending the UnitingCare MBCP;
- understand the challenges that UnitingCare MBCP facilitators experience in delivering programs;
- understand the contribution that DFV Advocates make to the programs and to the safety of women and children;
- understand the degree to which the MBCPs work with the wider DFV service system;
- understand the perspectives of key stakeholders in regard to the effectiveness of MBCPs;

- understand the contribution that the organisational context makes to the programs; and
- understand how the programs take account of client diversity.

Based on these recommendations, the research team in consultation with Dr Chez Leggatt-Cook, developed survey and interview tools for the distinct participant groups. In order to respond to the above list of objectives, consideration was given as much as possible throughout the design of the methods to 'real world' factors (Bamberger, 2015) that could impact on data collection. These factors will be discussed as part of the reporting of the findings.

Throughout the conduct of the research, the QCDFVR team members formed a partnership with UnitingCare in order to collaborate in the co-creation of knowledge in recognition of the practice wisdom and experience of the frontline practitioners (Finsterwalder, Foote, Nicholas, Taylor, Hepi, Baker & Dayal, 2017; Greenhalgh, Jackson, Shaw & Janamian, 2016). In line with this approach to research collaboration, a key consideration was how the UnitingCare MBCP formed part of a meso service system response involving key stakeholders, and in turn, how wider socio-ecological factors impacted on the program participants and their partners/ex-partners and children. Weekly meetings were held throughout the implementation of the evaluation with Dr Chez Leggatt-Cook, who in turn liaised with managers of the organisation.

1.4 Outline of report

Section 2 provides an overview of the design of evaluation tools and recruitment processes for the early outcome evaluation with MBCP participants, partners and ex-partners.

Section 3 reports on the findings of the quantitative and qualitative evaluation findings of MBCP participants, partners and ex-partners. This section ends with a discussion, bringing together findings to examine the short-term effectiveness of the MBCP, the implications to sustain and build on positive changes for men, and the recovery journey for women and children.

Section 4 begins with an overview of the design and methodology for the process evaluation. Qualitative findings are reported from interviews with the different groups of professionals: program facilitators, UnitingCare managers, DFV Advocates, and stakeholders from other services who work closely with the MBCP. The findings highlight effective practices for implementing the MBCP and areas for further development.

Section 5 brings together the findings from the early outcome evaluation and process evaluation to examine the overall implications for UnitingCare MBCP operations and practice development.

2 METHODS FOR EARLY OUTCOME EVALUATION

2.1 Considerations for designing tools

The national and Queensland state policy frameworks, particularly the National Outcome Standards for Perpetrator Interventions (NOSPI), emphasise the safety of women and children and the embedding of perpetrator programs within a wider accountability system.[2]

A recent review of perpetrator programs in Australia in relation to evaluation research (Day, 2019), identified limited evidence of the effectiveness of MBCPs internationally and within Australia. In line with the NOSPI standards referred to earlier, the review also emphasises the need for safety and accountability, for programs to have explicit logic models to guide evaluations, and for engagement with victims/survivors (Day, 2019). One recommendation of particular relevance for this evaluation is that MBCPs develop a theory of change, which may in turn help inform evaluation design (Day, 2019).

Priorities have been expressed in the literature for measurement to be aligned with the wider research on these types of evaluations where it is recognised that the evaluation of a program needs to reflect its particular characteristics (Velonis, Cheff, Finn, Davloor & Campo, 2016). Kelly and Westmarland (2015) in their seminal evaluation based on the Mirabal project, recommend six criteria that need to be taken into account when designing MBCP evaluation outcomes. These criteria include evidence of:

- improved relationships based on respect between perpetrators and their partners/ex partners;
- the empowerment of partners/ex-partners by increasing their opportunities to make choices that improve their wellbeing;
- freedom from violence and increased safety for women and children;
- improvement in safe positive and shared parenting;
- increasing awareness of self and others, where the men in programs understand the impact of their violence on women and children; and
- increased safety of children and healthier childhoods where they feel heard and cared about (Kelly & Westmarland, 2015, p.7).

[2] https://www.coag.gov.au/sites/default/files/communique/National_Outcome_Standards_Perpetrator_Interventions.pdf

With this background in mind, the evaluation team scoped measurement tools that aligned with the outcomes of the Stage One Theory of Change workshops and were informed by existing models. Specific survey tools were selected for the men and partners/ex-partners based on feedback from program stakeholders and from a scope of the literature on the evaluation of perpetrator programs.

The specific context of administering the surveys during cycles of the UnitingCare MBCPs also influenced the choice of survey tools. The evaluation team was mindful of the limited time that the facilitators had to support the men participating in the pre- and post-surveys. The survey was designed for men to fill in the survey themselves and be supported by the facilitators if they required clarification. To this end, the research team deliberately selected brief scales that could be completed within 30-40 minutes at most. For men with literacy issues, they were offered the option of an external interviewer from QCDFVR administering the survey.

The draft surveys were reviewed by the UnitingCare cultural advisors, including the Men's Wellbeing Group and the Multicultural Partnerships and Engagement Advisor. This resulted in some minor revisions to survey language.

The following sections describe the specific tools that were agreed upon and applied for men participating in the MBCP and their partners/ex-partners.

2.2 MBCP participant surveys

A survey format with primarily quantitative scales was selected for ease of self-administration with the men enrolled in a MBCP.

The focus of the surveys was to assess the degree of change that may have occurred over the length of the program. Pre-surveys were administered during the intake and assessment, which was concurrent with the first session of the program. If there was not time, then men were given the survey to take home to complete and bring back at the next group session. Post surveys were administered on completion of the 16-week program during the exit interview. Some men were given the post survey to take home to complete.

The sample of men for Stage Two were recruited between February and May 2019. In addition to a range of demographic variables and qualitative questions on the experience of participating in a UnitingCare MBCP, a range of established measures of attitudinal and behavioural change in the context of MBCPs was scoped. The role of empathy and whether MBCPs could have the effect of increasing perpetrator empathy (Romero-Martinez, Lila, Martinez, Perdon-Rico, & Moya-Albiol, 2016) was identified for inclusion. The rationale for applying the Toronto Empathy Questionnaire (TEQ) (Spreng, McKinnon, Mar & Levine, 2009), a well-established tool for measuring empathy, was based on the assumption that a key purpose of the MBCP is to increase respectful attitudes and behaviours towards victims/survivors, and to achieve this, men needed to be able to empathise with their partner/ex-partner and their children. To this end, the TEQ was adopted as one of the key measures of emotional and attitudinal change. A limitation of using the TEQ for this study is that it measures empathy towards all people rather than to partners or ex-partners specifically.

Related to the need to measure empathy was the need to assess attitudinal change, since the design of the UnitingCare MBCP was also focussed on reducing victim-blaming as a form of justification for abusing a partner/ex-partner. Martin-Fernandez, Garcia & Lila (2018) developed and tested a victim-blaming scale and found it to be reliable in measuring attitudes of DFV offenders. The authors offered a shorter version that was suitable for inclusion in larger surveys that measured other outcomes (Martin-Fernandez, Gracia & Lila, 2018). The Victim Blaming-Intimate Partner Violence Against Women (VB-IPVAW) brief version comprises a five-item scale.

The final selection of scaled questions was drawn from Project Mirabal, which has a strong focus on the safety and wellbeing of partners/ex-partners and their children, and also on changes in attitudes and behaviour in relation to parenting (Kelly & Westmarland, 2015). The selection of scales based on Project Mirabal

tools employed in the partner/ex-partner survey included:

- Respectful communication
- Shared parenting
- Safety of partner/ex-partner and children (Kelly & Westmarland, 2015).

The men's survey ends with a small number of qualitative questions about their experience of engaging with the MBCP and any suggestions they had for improving the program.

Facilitators and their relationship with men who use violence

A recommendation from the co-design process (Stage One) with the UnitingCare MBCP stakeholders was to provide the program facilitators with a deeper understanding about the working relationship they formed with the men attending the groups. In order to explore this relationship, the evaluation team initially planned to employ the Working Alliance Inventory-Observor Short Version (Santirso, Martin-Fernandez, Lila, Gracia & Terreros, 2018). This brief survey, which has been tested with DFV perpetrators, asks questions related to the level of facilitator engagement and perpetrator responsiveness during group sessions. The survey was planned to be undertaken at the end of the 16-week program by both the facilitators and the men. However, we discovered that none of the facilitators had time to sit down with the men and complete the form, or they had forgotten to distribute the form due to their busyness. This is the reality of conducting evaluations in 'real-world' settings with busy frontline contexts and we adapted our design accordingly.

2.3 Partner/ex-partner survey/interview

The partners/ex-partners of the men participating in the evaluation were to undertake the surveys by telephone interview shortly after men had commenced the MBCP and then on exit from the program.

Our desire to involve the partners/ex-partners was in line with policy and practice that recommends their involvement in order for program and evaluations to be more authentic and accountable (McGinn, McColgan, Daly & Taylor, 2019; Morrison et al., 2017; Pallatino et al., 2019). However, following our first contact with 2 partners/ex-partners, it soon became apparent that when men were initially engaging in the MBCP, women were highly stressed and emotional, and found it difficult to engage with the researchers and the survey questions. It became clear that the circumstances prompting the men's enrolment in the MBCP involved recent violence towards their partners and acts of coercion and control, particularly where children were involved. The women's distress was evident and for this reason we agreed that we needed to interview the partners only after the men had completed the program, in the hope that by the end of the 16 weeks the women would have had a chance to access support, and the immediate crisis issues would have been resolved.

The partners/ex-partners survey tools were redesigned to incorporate a reflection on men's behaviour pre- and post-program. The recruitment of partners/ex-partners after men completed the program worked well with the assistance of UnitingCare making the initial invitation and seeking permission for the evaluation team to make contact.

The focus of the partner/ex-partner survey was on their and their children's safety, their experience of violence and observations of any changes in men's attitudes and behaviours post completion of the program compared to before the programs. The survey was administered over the telephone by members of the evaluation team. Along with selected survey tools, the interview included a number of qualitative questions to provide women with an opportunity to express their views about the influence of the program and to what extent it had contributed to the changes they observed.

Many of the selected survey tools were based on those from Project Mirabal including:

- Respectful communication by the perpetrator
- Shared parenting
- Space for action
- Physical and sexual violence
- Harassment and other abusive acts (Kelly & Westmarland, 2015).

Stage 3 of the evaluation examines longer term outcomes for partners/ex-partners and men who participated in the UnitingCare MBCPs during 2019. We interview evaluation participants (partners/ex-partners and men) up to 12 months post participation. To boost the small sample of Stage Two evaluation participants (called Group 1), with the assistance of UnitingCare, we have recruited 2 further groups:

Group 1: men who consented to take part in the evaluation prior to starting the MBCP and completed the pre- and post-program survey. Partners/ex-partners of these men were invited to take part in a telephone interview after the men exited the program.

Group 2: men who completed the program during October to December 2019 were asked if they would like to take part in the evaluation when they exited the program. They completed a post-program survey. Partners/ex-partners of these men were invited to take part in a telephone interview after the men exited the program.

Group 3: all men who completed a MBCP in 2019 who have not previously opted into the evaluation. This group were contacted by email/letter/phoned by the facilitator to take part in a phone interview at 6-12 months post program. Partners/ex-partners of these men were invited to take part in a telephone interview after the men exit the program.

3 EARLY OUTCOME FINDINGS FROM MEN'S AND PARTNER/ EX-PARTNER SURVEYS

This section reports key selected findings, firstly from the surveys with the men, and secondly with their partners/ ex-partners. The section concludes with a discussion about the implications of the findings for assessing the short-term effectiveness of MBCPs for participants and partners/ex-partners and their children. We consider the findings from this relatively small sample within the context of other evaluations of MBCPs.

3.1 Men's survey key findings

The rationale for the selection of key quantitative findings was derived from how these related to the questions raised in the co-design process. Above all, UnitingCare stakeholders wanted to know whether the MBCPs changed the attitudes and behaviour of the men who completed the programs.

The surveys were self-administered and therefore relied on the men's literacy levels and understanding of the questions. It was clear that some scales were more understandable than others, and so the selection of findings was also based on the results that had the highest and most consistent responses. Not all the sets of questions were completed by some respondents, and only those that were completed were included in the findings.

There were 39 men between February to May 2019 who agreed to participate in the research. Out of this cohort, 15 men left and did not complete the program. From the remaining 24 men who completed the program, 15 men completed both pre- and post-surveys, and this constituted our final sample of men (2 other men completed the post survey only and were thus excluded from the following comparative analyses). Given complete data existed for 15 of the 24 men, this enhances the reliability of the findings in being more likely to be representative of the sample.

Given the small overall size of the sample, it was only possible to conduct descriptive analyses of the data, as there were not sufficient numbers to conduct inferential statistical tests. Not all men completed each scale, and only some men completed all the questions within each scale. As a total score could only be calculated for a scale where all questions had been completed (to avoid falsely categorising participants as low on, for example, empathy or respectful communication due to not having answered all questions), the results reported below differ in the number of men deemed to have complete responses (Table 1).

Table 1: Summary of information about the sample of men

Variables	Information about the sample of 15 men
Ethnicity	14 were born in Australia and 1 overseas No one identified as an Aboriginal and/or Torres Strait Islander person
Age range	25 – 51 years: • 3 men in their 20s • 5 men in their 30s • 6 men in their 40s • 1 man in his 50s
Relationship status	• 2 men were married • 2 men were separated • 1 man was divorced • 6 men were in a de-facto relationship • 3 men were single • 1 man identified as being in some other type of relationship
Living situation	• 6 men were living with their partner and children • 4 men were living alone • 3 men were living with other family members • 2 men were living with others unrelated to them
Children under 18 years	10 men had children under the age of 18 years
Children's care arrangements	4 men have their children aged under 18 years living with them full-time and 3 men had their children part-time. Another 2 men saw their children sometimes, while another 2 men had no contact with their children

Hopes for the Program

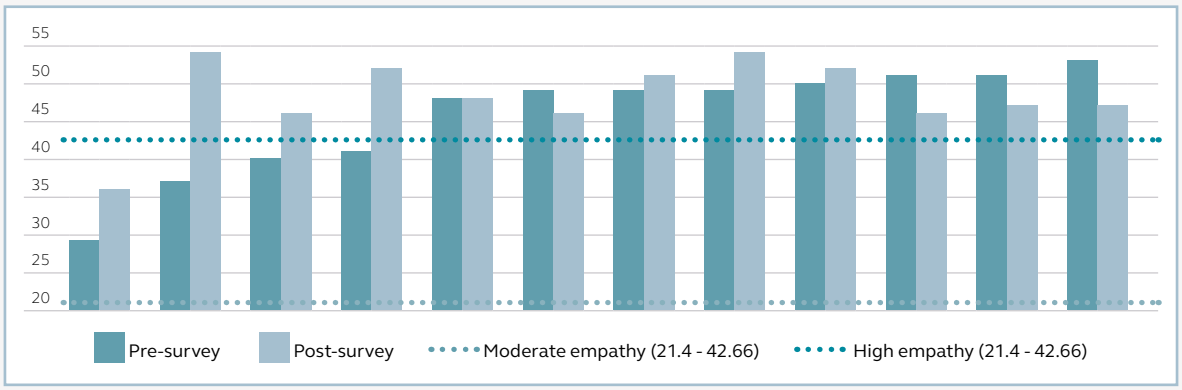
On the pre-survey, men were asked to relate their personal hopes for the program. Their answers included being a better person, including as a father and partner; an understanding of themselves and their actions; learning to control themselves and their emotions; learning different ways of behaving and thinking and leading more positive lives. The men were also asked to describe their family's hopes for the outcomes of the program. The men focused on being a better person, mostly as a father and partner, and changing their behaviour to create a safe and peaceful home environment.

Toronto Empathy Questionnaire

One of the key scales on the survey was the Toronto Empathy Questionnaire (TEQ) which is a 15-item scale, where participants rate how often each of the 15 statements is true of them, on a 5-point Likert scale (1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always). The scale is a mix of positively and negatively worded statements, so the negatively worded statements were reverse coded to enable summation of the responses across all statements to create an overall score for each participant on the TEQ. The scores were split into low (0 – 21.33), moderate (21.4 – 42.66) and high (42.7 – 64) empathy scores. Consequently, **higher scores on the TEQ represent higher levels of empathy**. Twelve men completed all questions on the TEQ at pre- and post-survey, and their scores are presented in Figure 1.

Eight of the men rated their empathy as high on the pre-survey, with all but one man indicating they were high on empathy at the post survey. For 7 of the men, their score increased from pre-survey to post-survey, but 4 men had a decreased score, with one man having the same empathy score. This may not necessarily indicate that their empathy decreased following the program, but that they conducted a more realistic evaluation of their empathy at post survey with the information they learned in the program.

Figure 1: Toronto Empathy Questionnaire scores pre- and post-program for 12 men



Intimate Partner Violence Against Women – Victim Blaming Scale

The men also completed the 12-item IPVAW-VB scale (Figure 2). This scale measured general attitudes towards violence against women. Each question was responded to on a 4-point Likert scale (1 – strongly disagree, 2 – disagree, 3 – agree, and 4 – strongly agree). To calculate the total score on the scale, each response was weighted to reflect the relative contribution of each question to the overall victim blaming score, as determined by the authors of the scale. **Lower scores on this scale represent less victim blaming.**

Most men indicated they were low on victim blaming at the pre-survey, with almost all men in the post-survey indicating they were low on victim blaming. No men noted that they were high on victim-blaming at the pre- or post-survey.

Respectful Communication Scale

Moving to specific measures of behaviours towards their partners, the men also completed the 4-item Respectful Communication scale from the Mirabal survey, which was specifically in relation to how they communicated with their partner (Figure 3). They noted how often they respectfully communicated with their partner (respected how their partner wanted to be in contact, supported their partner's decisions, acted in a considerate manner towards their partner, and negotiated with their partner when they had disagreements). The rating was on a 5-point Likert scale (1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always). The responses to each question were summed to create an overall score on the scale. The lowest possible score was 4, and the highest possible score was 20. **Higher scores on the respectful communication scale indicated more frequent respectful communication.**

Most scores indicated a higher level of respectful communication following the program compared with scores on the pre-survey prior to the program.

Figure 2: IPVAW-VB scale pre- and post-program for 10 men

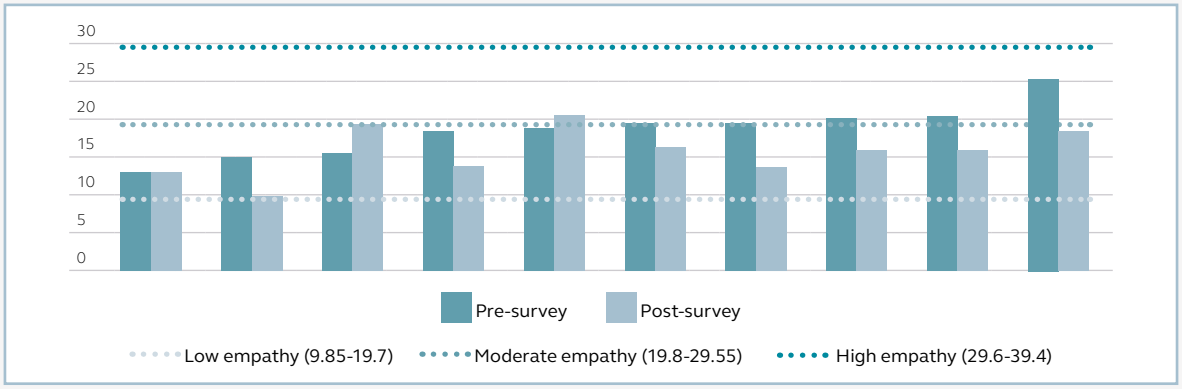
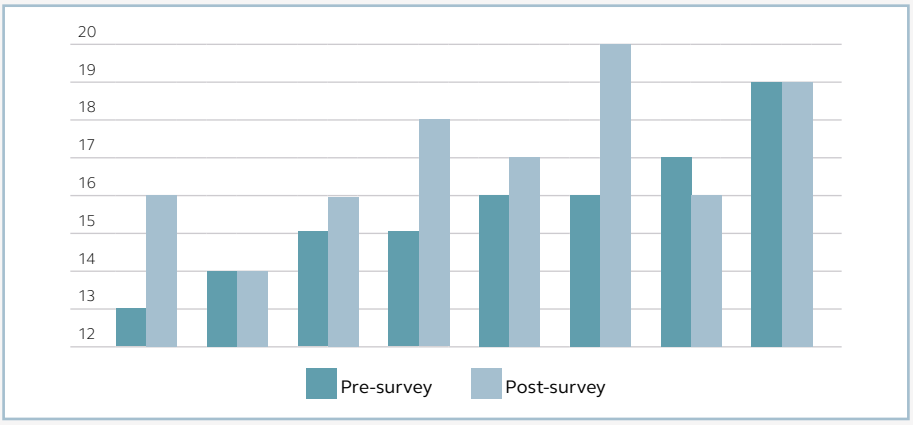


Figure 3: Respectful Communication scores pre- and post-program for 8 men



Shared Parenting Scale

Another scale on the Mirabal survey was the Shared Parenting scale (Figure 4). Respondents answered the questions on a 5-point Likert scale (1 – never, 2 – rarely, 3 – sometimes, 4 – often, 5 – always). **Lower scores on this scale represented better parenting**, that is the children were not being involved in monitoring the mother or witnessing poor behaviour towards the mother. The lowest score is 5, and the highest score is 25. Half of the men noted that their behaviour was beyond reproach in the pre-survey (with a score of 5 indicating they never engaged in any of the negative parenting behaviours). There were 4 slightly lower scores on the post-survey, indicating that some men believed they were even better fathers following the program, with an additional 2 fathers believing their conduct was now beyond reproach.

Figure 4: Shared Parenting scores pre- and post-program for 8 men

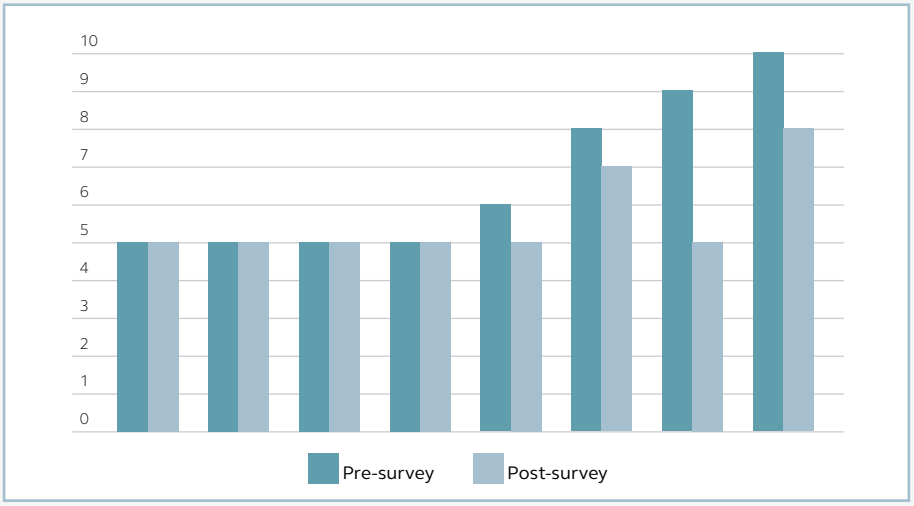
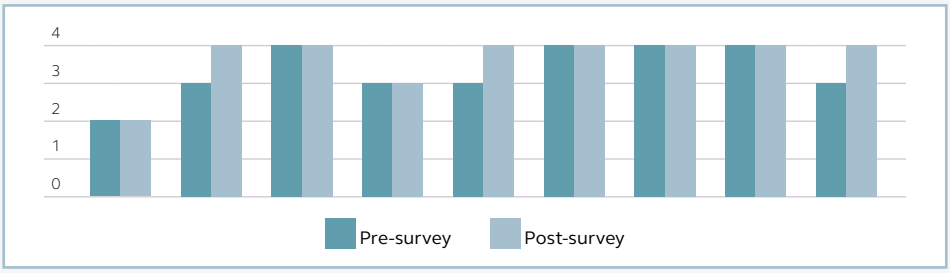


Figure 5: Perceptions of children's safety pre- and post-program for 9 men



Perceptions of Safety Scales

The men were asked to rate how safe their children and partner/ex-partner felt based on the man's behaviour (Figures 5 and 6). These ratings occurred on a 4-point Likert scale (1 – very unsafe, 2 – somewhat unsafe, 3 – somewhat safe, and 4 – very safe). According to the perceptions of the men, it appeared that children were often thought to be somewhat safe or very safe on the pre-survey, with only a few higher ratings on the post-survey. Regarding their partners, half of the men stated that their partners felt somewhat unsafe on the pre-survey, with almost all of those ratings increasing on the post-survey, indicating that the men believed their partner felt more safe based upon their behaviour.

Perceptions of the Program

When the men were asked whether the program had helped to change their violent behaviour, all of the men agreed that it had.

In what ways had men changed

When the men were asked how the program helped, the men largely discussed the skills and strategies they had learned and the awareness of their triggers.

> *New communication skills, awareness of triggers.*
>
> *All the different ways and strategies. Also I learnt things that I didn't know before.*
>
> *I believe I have learnt skills that will help me to not lash out in future in the manner which I have previously.*
>
> *Learning to breath[sic], talk more with my partner.*

A few men also discussed their new understanding of domestic violence arising from the program and the insight that gave them into their behaviours.

> *Understanding more on what DV is, and then applying strategies to prevent any relapses/events.*
>
> *It enabled me to reflect on one's own actions.*
>
> *By identifying my…behaviours.*

One man spoke of the benefits received by being part of the group:

> *Hearing everyone else's story, didn't feel alone.*

Another man went so far as to say that the program should be introduced on a wider scale:

> *This program should be introduced into the QLD/State or federal curriculum in high school.*

What men found helpful to facilitate change

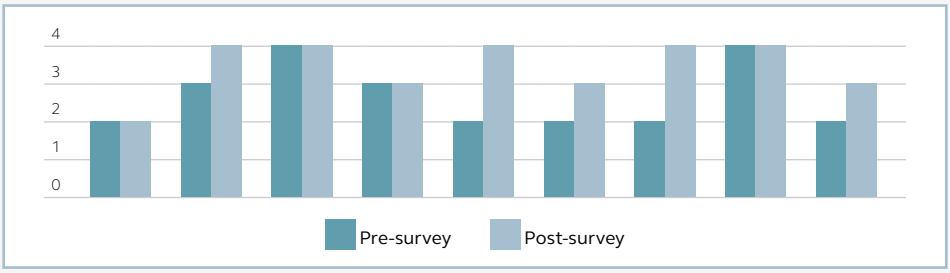
When the men were asked what they found helpful about the program in changing their behaviour, a few men noted that they found all of the content helpful.

> *All of the content.*
>
> *The whole course. Everything I learn't[sic] helped me everyday life.*
>
> *All the tactics to help calm down, and overall the whole program is something I haven't learned about before.*

Other men discussed the specific understandings, skills and strategies that they had learned:

> *Subject matter, check ins, learning my triggers and ways to deal with them, learning to communicate with my current partner.*
>
> *Looking at things with different perspective; learning to control outbursts; learning and using different tools.*
>
> *Identifying[sic] what is Domestic Violence, understanding where it comes from.*
>
> *Identifying triggers and my behaviour. The biggest thing out of the course was that it shows how resilient I am.*

Figure 6: Perceptions of partner's/ex-partner's safety pre- and post-program for 9 men



…tools, parallel processing, awareness.

Understand communication, self-awareness, language of love, started new relationship… never built a foundation in the past, a lot of male privilege.

Another frequent comment was about the group environment:

Meeting people with the same problems.

The mentors were always super friendly, I never felt judged or prosecuted. The other men always had stellar advice or stories that made me sit back and reflect and go well hang on I was a dick there or hey I could use that strategy. The lessons always had tonnes to digest and take on. All in all I feel like a better person.

Having someone to listen and question my actions and my part in the break up.

What men did not find helpful

The men also answered 'what aspects of the program they did not find helpful'. Many of the men answered that nothing was unhelpful about the program. A couple of men made specific comments about aspects of the group being problematic:

Changing the group so often. Rotation makes it tough.

Men who didn't want to change in the group.

Although, another man noted the dramatic changes which could be accomplished through the group:

A really really good group, one fellow - completely 'this is bullshit' he was a completely different fella at the end of it.

Another man indicated that he thought there were times when the content was not relatable to his partner and himself, and did not help him self-reflect, as he thought he had his situation sorted out. However, he still found the sessions informative and good.

Finally, another participant in the program highlighted that the program could be more digitised through having course material online, an online forum, or homework online.

3.2 Partners/ex-partners key findings

Eleven women were interviewed as partners or ex-partners of men who had completed the UnitingCare MBCP program. The women were asked to reflect on any changes they had observed in the man's behaviour before and after the program. To contextualise women's situations at the time of the interview, we provide some background information in Table 2.

All the women identified as Australian or of European descent. There were no Aboriginal and Torres Strait Islander or culturally and linguistically diverse (CALD) women in this sample. The ages of women were evenly spread across their 20s, 30s and 40s. Most women (n=8) were no longer with the man who participated in the MBC program, and most (n=9) were the primary carer for children under 18 years.

Table 2: Summary of information about the sample of women interviewed

Variables	Information about the sample of 11 women
Ethnicity	10 were born in Australia and 1 overseas The women described their ethnicity as: Australian n=6; Caucasian n=2; White n=1; European n=1 No one identified as an Aboriginal and Torres Strait Islander person
Age range	22 – 48 years: • 3 women in their 20s • 4 women in their 30s • 4 women in their 40s
Relationship status	• 3 women are married (to men who participated in MBCP) • 5 women are separated • 1 woman is divorced • 2 women are in a de-facto relationship
Living situation	• 3 women are living with their partner and children • 5 women are living with their children only • 2 women are staying with friends or family members • 1 woman is living alone
Children under 18 years	9 women have children under the age of 18 years
Children's care arrangements	8 women have their children aged under 18 years living with them full-time. One woman has had her children removed by Child Safety. Some of the women have arrangements with ex-partners for visits with children.
Sample cohort	10 women are partners/ex-partners of men from Group 1 who agreed to take part in the evaluation at the beginning of the MBCP. 1 woman is a partner/ex-partner of a man from Group 2 who agreed to take part in the evaluation upon exiting the MBCP, and was included in this sample analysis as they were able to provide the same reflections on any behaviour change pre- and post-program.

Feelings of safety

Women were asked *'Have your feelings of safety changed at all since your partner/ex-partner went to this program?'* The findings show a variety of experiences with 2 women saying they had never felt unsafe, while another 2 women said they did not feel any safer since their partner/ex-partner was on the program.

> *He is not going to make it easy.*
>
> *No safety has not changed. He still gets anxious and stressed…*

Six women described how their sense of safety had increased and how the program had contributed towards this.

> *Yes, feel safer and less wary.*
>
> *I feel a bit safer.*

One woman said that she never liked being around him when he was drinking, and the program had given him *'a different mindset about drinking'* which had increased her sense of safety.

Another woman said her sense of security had increased, and while she had started to feel safer before he went to the program, she thought the program helped to make sure he did not act violently again.

Two women described initially feeling safer while he was on the program and shortly after, but subsequently incidents started occurring. One woman described how this brought the fear back, and another said that since he had become aggressive again towards her, she was covered by a Domestic Violence Order (DVO). She also noted that her ex-partner had not hit the children since doing the program.

Another woman also found having a DVO in place helped her feel safer. Both women who had DVOs stated that although the men had breached many times, they were now facing prison if they breached again and that kept them in check.

> *Safety felt improved with the court order. He does whatever he wanted to be nice to get his own way. He breached his Order many times (now has prison facing him if he breaches again).*

Feedback about the DFV Advocate

Nine of the eleven women said they had been contacted by a DFV Advocate and 2 had not. While we tried to establish if the DVA who contacted them was due to their partner/ex-partner starting the MBCP, in some cases they did not know. One woman had been contacted and given the opportunity to access DFV services several times but never felt she needed to. She said she had support from family and friends when she required it.

The 8 women who used the DFV Advocate were asked how helpful they had been. Most indicated they had been very or extremely helpful (n=5), or helpful (n=1). However, 2 did not find them helpful at all (Figure 7).

The type of assistance women received from the DFV Advocate included:

> *Offering information about places, found it quite comforting, not just focusing on him, considering both parties. Rang after first couple of weeks [of MBCP] to check up.*
>
> *Providing someone for me to say anything to. Being an ear.*
>
> *Provided advice and let me know I can ring anytime.*
>
> *Non-judgemental, kept in contact for 6 months and then closed case as I was staying with him.*

One woman said she felt hesitant to say too much to the DFV Advocate as the advocate was associated with the MBC program her ex-partner was attending. She was scared of the possibility

Figure 7: Helpfulness of the DFV Advocate for 8 partners/ex-partners

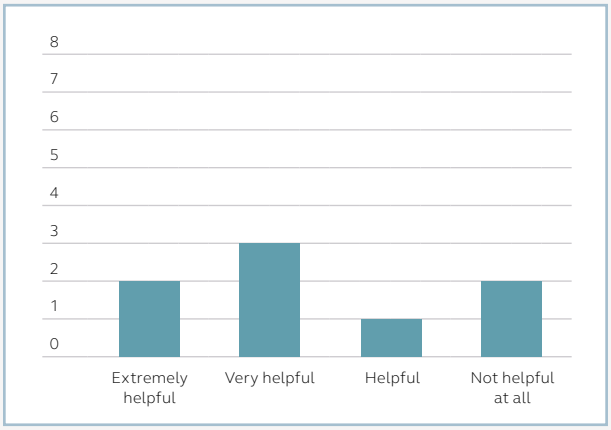
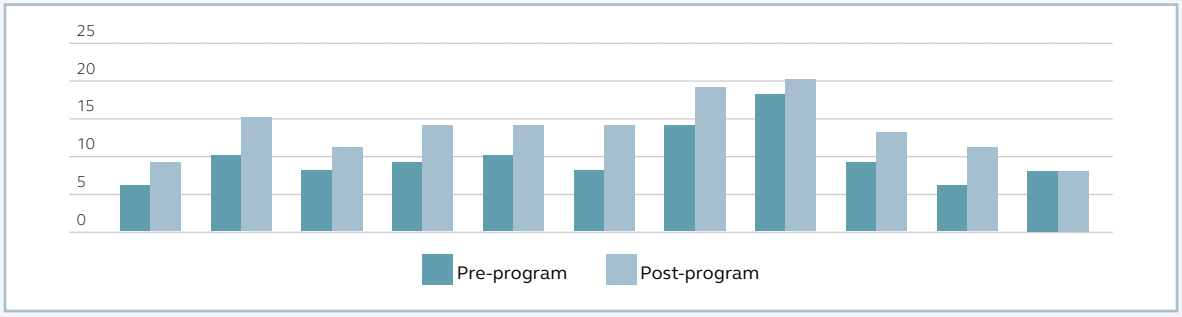


Figure 8: Respectful Communication scores pre- and post-program for 11 partners/ex-partners



that the DFV Advocate may have contact with her ex-partner. This DFV Advocate put her in touch with a counsellor at UnitingCare which she found supportive.

For the 2 women who did not find the DFV Advocate helpful, this was related to the approach. In one case, the woman felt like she was 'being grilled', and said the manner of the DFV Advocate did not feel supportive at all. The other woman said the information provided was not useful, and she found the best information was from DVConnect and a free legal service.

Respectful communication

The behaviours highlighted in the Respectful Communication tool are important measures as "an improved relationship between men on programs and their (ex)partners is underpinned by respect and effective communication" (Kelly and Westmarland, 2015, p.11). Kelly and Westmarland (2015, p.12) state:

Abusive men attempt to enforce acceptance of their views, opinions, standards, emotions and needs, creating what women and children experience as disrespectful one-way communication. This can take a number of forms: presumption of automatic respect; speaking to women as if they were children; issuing orders and demands; refusal to countenance criticism; presumption of entitlement to make all the decisions in the relationship/family; needing to win an argument; interrupting, listening and/or a disinterest in the views of others. The principle of this style of communication is that women and children should recognise and adhere to the man's perspectives.

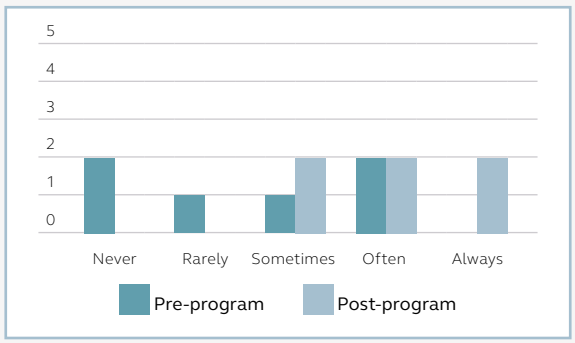
Each item in the Mirabel Respectful Communication tool is a positive statement of ways to communicate, and partners/ex-partners were asked how often the man demonstrated these behaviours before and after attending the MBC program. Overall, the findings on different dimensions of respectful communication show positive changes in men's behaviour compared to before they started the program.

The scores for partners/ex-partners showed a positive shift across the 4 items for nearly all the women interviewed (Figure 8).

The following examines each item on the scale to investigate areas of change.

The first statement was asked to women who were separated or divorced: *'Your ex-partner respects how you want to be in contact with him.'* We obtained answers from 6 ex-partners, and while this is a small sample, it shows an improvement post-program with no women saying 'never' or 'rarely' and increases in 'sometimes' and 'always' (Figure 9).

Figure 9: Respectful communication responses to 'Your ex-partner respects how you want to be in contact with him' for 6 ex-partners



The second statement asked all partners/ex-partners: 'He supports the decisions and choices that you make'. Eleven women answered this question and nearly all participants indicated that there had been an improvement, with 8 women saying he often (n=4) or always (n=4) supported their decisions and choices post-program compared to 3 women pre-program who stated often (n=2) and always (n=1) (Figure 10).

The third statement asked all partners/ex-partners: 'He acts in a considerate manner towards you'. Eleven women answered this question, and with the exception of one woman, there was an improvement post-program with 8 women saying he often (n=4) or always (n=4) acted considerately compared to 4 women pre-program, who stated often (n=3) and always (n=1) (Figure 11).

The fourth statement asked all partners/ex-partners: 'He negotiates with you when you have disagreements.' Eleven women answered this question, and nearly all participants indicated that there had been an improvement, with six women saying he often (n=3) or always (n=3) supported their decisions and choices post-program compared to one woman pre-program who stated 'often' (Figure 12).

Figure 10: Respectful communication responses to 'He supports the decisions and choices you make' for 11 partners/ex-partners

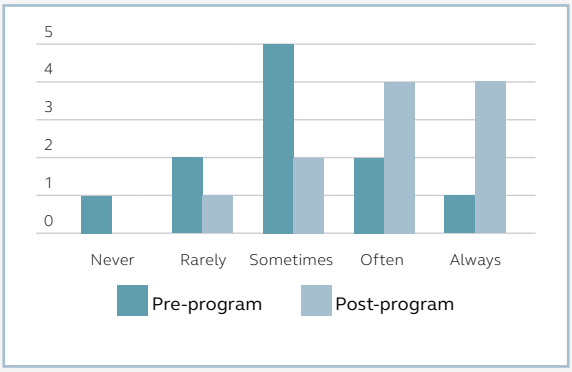


Figure 11: Respectful communication responses to 'He acts in a considerate manner towards you' for 11 partners/ex-partners

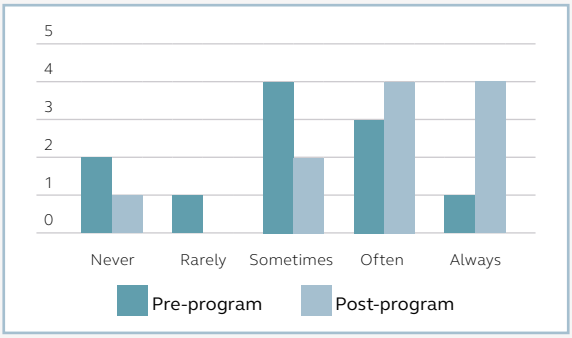
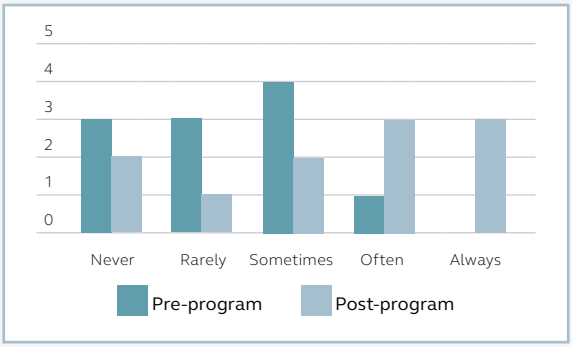


Figure 12: Respectful communication responses to 'He negotiates with you when you have disagreements' for 11 partners/ex-partners



Shared parenting

The survey measures for safe, positive and shared parenting based on the Mirabal Shared Parenting tool and asks women 4 questions framed as negative behaviours. Therefore, the Likert scale we used is reversed (compared to the previous section) where 'never' is the most positive answer. Eight women, who had children under 18 years with their partner/ex-partner, answered these questions. Some partners/ex-partners stated that the man did not behave this way pre-program. Where women reported these behaviours pre-program there were some positive shifts across the 4 questions, albeit only slightly in some cases. Some women said changes were the result of changes in living situations, including men's limited access to children.

The first question asked, 'Does your partner/ex-partner ask the children to report on what you are doing and where you have been?' There was minimal change overall with only a slight positive shift for 2 women who answered this question (Figure 13).

The second question asked, 'Does he criticise you as a mother either to the children or in front of them?' Again, there was minimal change overall with only a slight positive shift for 2 women (Figure 14).

The third question asked, 'Does he blame you for the children's behaviour?' There were positive changes for 3 women (Figure 15).

The fourth question related to the safety of the children, 'Do you worry about leaving the children alone with your partner/ ex-partner?' There were positive changes for 4 women who answered this question. For another woman there was an increase in worry due to changes in her living situation (Figure 16).

Space for action

The measures for 'Space for action' "draw explicitly on the understanding that safety is insufficient to undo the harms of abuse, women need to have the freedom restored

Figure 13: Shared parenting responses to 'Does your partner/ex-partner ask the children to report on what you are doing and where you have been?' for 6 partners/ex-partners

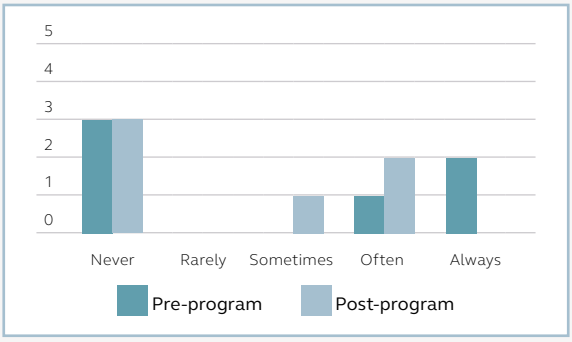
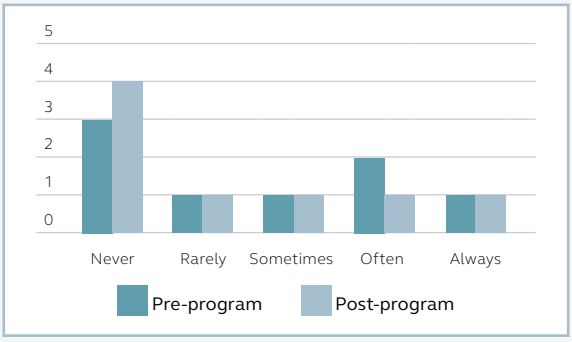


Figure 14: Shared parenting responses to 'Does he criticise you as a mother either to the children or in front of them?' for 8 partners/ex-partners



that abuse restricts" (Kelly and Westmarland, 2015, p. 4). The measures selected reflect the monitoring, restrictions and 'micro-regulations' of performing 'proper' femininity as expected by the man (Stark 2007 cited in Kelly and Westmarland, 2015, p.15).

Our sample for this tool is based on interviews with 9 partners/ ex-partners (2 interviewees did not answer these questions). The indicators are framed as statements about how a man restricts and controls a woman's behaviour, relationships, finances and movement with a yes/ no response. As we were only interviewing partners/ex-partners after the man had exited the program, we first asked the woman to respond to how he currently behaves (post-program) and then asked how he behaved before he went to the program (pre-program). Figure 17 shows the number of partners/ex-partners who said 'yes' they experienced these behaviours pre- and post-program. This also applies to the tools used for comparing physical and sexual violence (Figure 18) and harassment and other abuse (Figure 19) below.

Overall, there is a reduction in most of these types of behaviours after the man has completed the program. The measures which appear to decrease the most are in relation to having to be careful around the man if he is in a bad mood, and restrictions on who visits the house and controlling who the women see. Some of these decreases are due to separations. There are no increases in negative behaviours, and several measures stayed the same.

The qualitative analysis shows that women had different experiences, with some types of behaviours more pervasive than others, and that for women who were now separated or divorced, some of the measures no longer applied. Women reported varying degrees of change, with some lessening of restrictions, but not all the behaviours had disappeared, and there was still some anxiety about certain areas which is similar to the findings from Project Mirabel (Kelly & Westmarland, 2015, p.14-17).

Figure 15: Shared parenting responses to 'Does he blame you for the children's behaviour?' for 8 partners/ex-partners

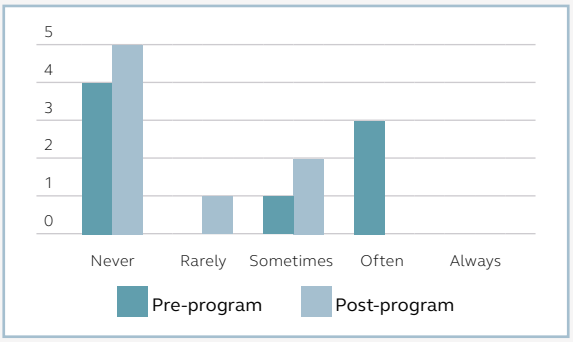
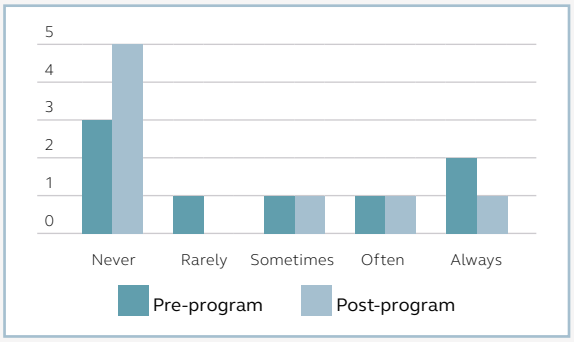


Figure 16: Shared parenting responses to 'Do you worry about leaving the children alone with your partner/ex-partner?' for 8 partners/ex-partners



Physical and sexual violence

The measures for physical and sexual violence are framed as statements of different violent behaviours towards victims with a yes/no response and are based on the Mirabal Project scale (Kelly and Westmarland, 2015).

Our sample for this tool is interviews with 8 partners/ex-partners. The findings indicate a reduction in physical and violent behaviours across all 7 items. Women had experienced different types of behaviours, with most women experiencing being slapped and pushed, and the perpetrator damaging walls, furniture and slamming doors etc. Similar to the findings from Project Mirabal, damage to property was the most common behaviour post-program (Kelly and Westmarland, 2015, p.18). Some women thought the changes were due to the program, while a few women said that men were aware of the consequences to breaches of DVOs, including prison, which acted as a deterrent.

Harassment and other abusive acts

The measures for harassment and other abusive acts are framed as statements of different abusive behaviours towards victims with a yes/no response and are based on the Mirabal Project scale (Kelly and Westmarland, 2015).

Our sample for this tool is interviews with 8 partners/ex-partners. The findings indicate a reduction in harassment and other abusive behaviours across all 7 items. Of particular note is the reduction in harassment using technology. This could be partially due to the consequences in breaches of DVOs, as abusive messages provide evidence of a breach.

Figure 17: Space for action: number of partners/ex-partners who said 'yes' to experiencing each of these behaviours pre-program and post-program from sample of 9 women

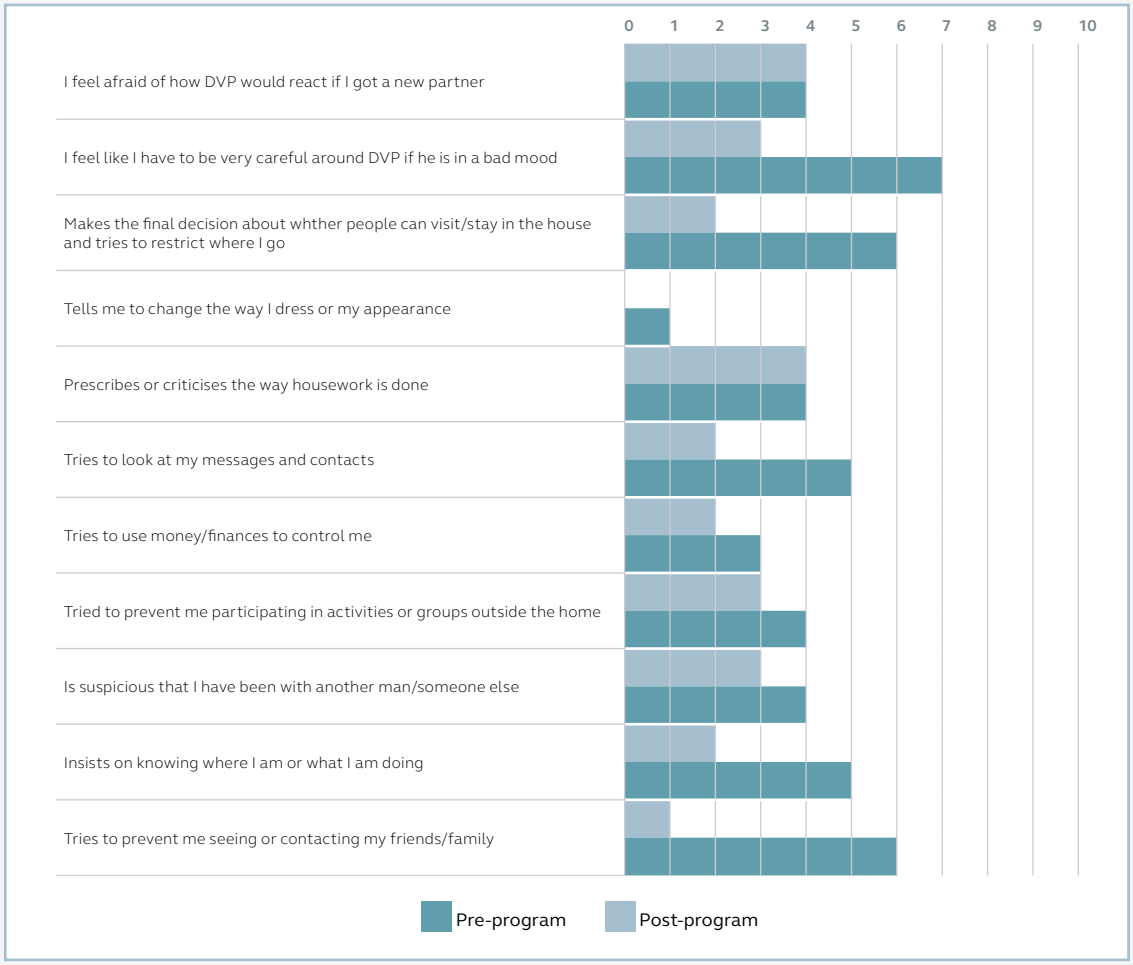


Figure 18: Physical and sexual violence: number of partners/ex-partners who said 'yes' to experiencing each of these behaviours pre-program and post-program from sample of 8 women

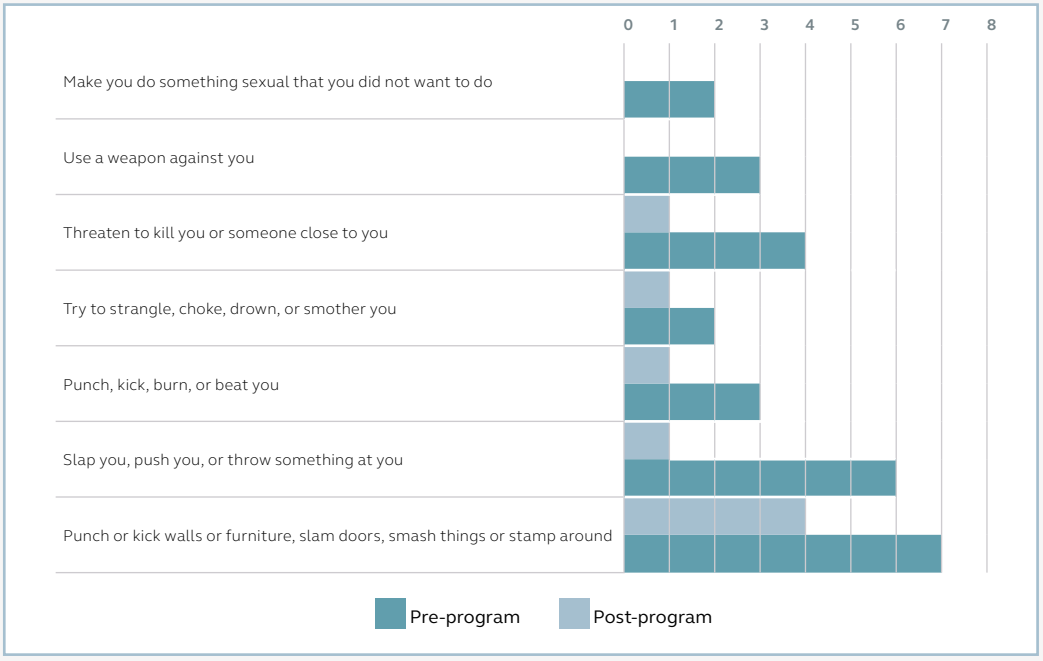
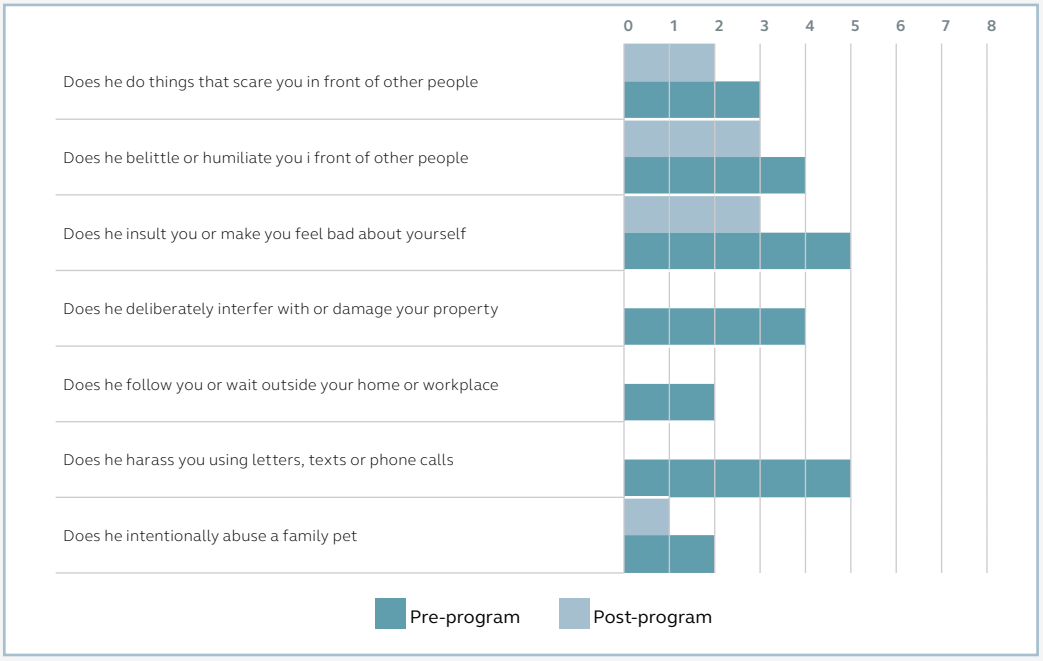


Figure 19: Harassment and other abusive acts: number of partners/ex-partners who said 'yes' to experiencing each of these behaviours pre-program and post-program from sample of 8 women



Overall feedback about the program

Women were asked 'Have you noticed any changes to your partner/ex-partner since he went on the MBCP?' All the women said they had noted some positive changes, with some noting a lot more positive changes than others. Most of the women suggested there needed to be further follow-up in the form of a course and/or counselling. One woman suggested an outreach service, as her partner was too shy to seek help. Another woman said a follow-up course should be mandatory.

Some of the women said that the MBCP made men more aware of the impact of what they were doing to women and children and gave them more self-awareness, along with practical tools and strategies to manage their feelings. The findings also suggest that, for some men, having a DVO in place provided important consequences that ensured they did not continue abusive, violent behaviours.

For several women there were very mixed results, and unfortunately, in 3 cases they said the man used what they learnt in the program against them:

> *Slightly, he does try harder, but the undermining patterns are still there. Change hasn't been great, but his attitude has improved, and he is more positive. Still gets angry, criticism etc. He finished in ... 6 months [ago]. Using some of the tools he gained against me...*
>
> *Yes, he has taken more responsibility for his actions with children. Leaving him shook him up big time. Taken onboard that his anger is an issue. But uses course against me, manipulative as uses something from the course, his word last word.*

Other women described changes to the way men managed their emotions and anger, and how the MBC program taught the men ways to communicate, including listening more and accepting other perspectives.

> *The MBCP made him focus on himself and understanding his own emotions. He's never apologised. ... He was a bit less aggressive during group.*
>
> *Yes, he is a lot calmer and not as argumentative. The program helped as he learnt to be very mindful and also to be much more open.*
>
> *Love the course he did, he thinks of things. Best thing he did do, now open to other points of view, opinions, take others advice and listens with what learnt in course. He was frustrated and now uses techniques he learnt which has changed how he communicates.*
>
> *Yes way he communicates – his frustration changed too, ... the strategies to keep calm.*
>
> *Yes, helped with putting stuff in place to manage anger. Calmer slower to anger. A lot more reasonable. Very pleased.*
>
> *Yes, I have noticed changes. He used to lose his temper 3x a week and now it is 1x a month.*
>
> *He is more articulate about how he is feeling and better at backing off. He is better able to cope with surprises. The program helped him realise what he was doing was DV.*
>
> *He is willing and wanting to change. He doesn't shout, takes a breath and handles situations much better. Learnt strategies at the program. Would come home and tell me about them – say learnt this today which was interesting...*

Another woman said she definitely noticed changes, and that the program had been a positive influence and helped her partner/ex-partner to look at himself more, communicate better, and be less agitated. She noted that he would come home and talk about what he'd learnt in the program and was really positive about it.

3.3 Discussion

The early outcome findings are encouraging as the partner/ex-partners and MBCP participants surveys/interviews show an overall positive shift in men's attitudes and behaviours from pre-program to post-program. Women and men who participated in Stage Two provided examples about how the UnitingCare MBCP had contributed towards these changes.

Feedback from the partners/ex-partners strongly suggests that while the program helped many of the men to make changes, they needed to continue this journey with further work such as additional programs and counselling. UnitingCare recognises the importance of sustaining and building on changes men have made during the core MBCP, and has designed a 'maintenance' program, named Men Sustaining Change, which they are seeking to pilot.

This immediate positive shift in attitudes post-program is reflected in a recent and large study by Brown, Flynn, Fernandez-Arias & Clavijo (2016). This study included over 300 men and partners from programs across 3 states in Australia, 8 agencies and 12 sites, and followed up with men over a 2-year period. The study showed positive findings with an initial sharp fall in violence immediately post-program. These reductions were maintained and reduced further one year and 2 years later. Qualitative interviews with men highlighted "how difficult this was and how precarious they felt their successes were" (Brown, Flynn, Fernandez Arias, Clavijo, 2016, p.ii). Interestingly, many of the men sought therapy and counselling post-program and continued this for the entire 2-year follow-up period. This study, along with the early outcome findings of the UnitingCare MBCP evaluation, supports the importance of men continuing their journeys of change and the need to provide access to support services to do so.

How does the program contribute towards men's change?

The first stage of our study involved the development of a Theory of Change that modelled how the MBCP activities are intended to contribute towards positive outcomes for men and partners/ex-partners and children. The theory of change workshops with UnitingCare MBCP facilitators, managers, DFV Advocates and key stakeholders across the MBCP sites identified program related factors that they perceived facilitated changes for MBCP participants including:

- Engaging and motivating men to change attitudes and behaviours
- Increase men's knowledge about what DFV is and its impact on partners/ex-partners and children
- Increase their sense of empathy
- Increase their understanding about themselves, why they act in certain ways and to develop more self-awareness
- Provide men with skills, tools and strategies to enable behaviour changes
- Recognition of importance of MBCP facilitators' knowledge and skills in engaging men in change and facilitating group dynamics so that men are supporting each other to make positive changes.

Our findings on early outcomes suggest these factors are important for enabling men to change. The qualitative feedback from partners/ex-partners and men indicated some men had gained an increased understanding of the impact of DFV, self-awareness and skills to regulate their emotions from the program. This appears to have contributed to a decrease in more violent behaviour and improved some men's ability to communicate more respectfully and openly. This aligns with feedback from the MBCP facilitators and DFV Advocates that are discussed in the following sections.

The findings in relation to the Project Mirabal measures and qualitative feedback are similar to Kelly and Westmarland's (2015) study. While women experienced an overall positive shift, it is variable and reflects the complexity of how change occurs. Kelly and Westmarland explored the process of change with men, including examining the idea of the 'lightbulb moment' where men suddenly 'get it', that some accounts of domestic violence behaviour change programs refer to. They found instead that men's change "requires layers of new understandings, reflection and translation into behaviour. Change is better understood as a series of sparks, different for each man, and not all of which are activated" (Kelly and Westmarland, 2015, p.34).

Vlais and Campbell's (2019, p.9) study includes an examination of pathways to desist from family violence which emphasises the importance of the readiness to change and engage in MBCPs, and situational factors such as stable life situations, in order

for men to benefit from the intervention.

Similarly, Brown, Flynn, Fernandez Arias, Clavijo (2016, p.iii) found that while the MBCP's enable "the men to make changes, the programs were not a silver bullet that stopped all men from being violent or stopped all the violence of the men who made changes. Rather, programs are one of the tools available to directly address male violence to their intimate partner and, for some men, to other family members, including their children."

How does the program contribute towards changes for women and children?

The interviews with partners/ex-partners highlighted that women are in different situations regarding their experiences of violence, and different types of violence and abuse. Quite a few of the women interviewed had separated or divorced, so these changes in living situation pre- and post-program also impacted on their experiences of violence and 'space for action'. About half the women (n=6) interviewed, said their sense of safety had increased and they thought the program had contributed towards this. Several women also described initially feeling safer, especially while the man was in the program, but post-program these men had become more aggressive and the DVO had helped to keep these men in check with the threat of prison. This highlights the importance of having a combination of strategies to address perpetrator behaviour, including formal consequences to keep men accountable. This supports the link to integrated collaborative responses which is discussed in the following sections.

The findings regarding shared parenting were variable. Some partners/ex-partners stated that the man did not treat children badly or use them to criticise and monitor their movements before the program. Where this did occur, there were some positive shifts, albeit only slightly in some cases. Some women said that the changes noted were the result of new living situations, including men's limited access to children.

Men tended to regard their shared parenting behaviours more positively than women. Half of the 8 men who answered the shared parenting questions responded with the most positive answers pre-survey and this increased to 6 men post-survey, with a further 2 showing positive shifts.

Program related factors to benefit partners/ex-partners identified in Stage One included offering them support via the DFV Advocate and providing an effective collaborative response to identified risks and safety needs. Our findings are very similar to those of a recent major study on the prioritisation of women's safety and the role of the DFV Advocate in MBCPs. The authors state:

> *Partner contact support is also important because former partners and children of MBCP participants frequently have little or no contact with formal support services. Therefore, partner contact creates a pathway for support for women who have not previously sought it. (ANROWS 2020, p.3)*

It was sometimes difficult to establish during interviews with women if the DFV Advocate who contacted them was as a result of the man going to a MBCP. Most women we interviewed had contact with a DFV Advocate at some stage, and most found them very or extremely helpful in providing information, advice and someone to talk to. Two women did not find them helpful at all and another woman was concerned about the association with the MBCP and whether the DFV Advocate would be in contact with her ex-partner. Not all women were contacted and one woman stated she did not need their services.

The literature has highlighted that key barriers for DFV Advocates are having the resourcing to contact all women and the difficulties of making contact, and it has been strongly recommended that more resourcing is provided to the role (ANROWS, 2020). The role of the DFV Advocate will be further discussed in the next section.

Partners/ex-partners also talked about the importance of the support they got from family and friends. This raises a consideration for community focused prevention resources to inform family members and friends about both DFV resources and helplines but also ways they can safely support women and children.

This section provided preliminary short-term outcomes for a small sample of men who attended the MBCP during 2019 and their partners/ex-partners. The next stage of evaluation will examine the longer-term outcomes with an increased sample of evaluation participants as described in Section 2 (Groups 2 and 3). The focus on longer-term outcomes of a larger sample will provide a more in-depth examination of the influence the MBCP has on outcomes for women, children and men.

4 VOICES FROM THE FIELD: IMPLEMENTATION OF THE UnitingCare MBCPS – PROCESS EVALUATION FINDINGS

This section discusses the findings from UnitingCare managers, facilitators and DFV Advocates who work with men who use violence and their partners, and also with the community of stakeholders who help to support the UnitingCare MBCPs. Their reflections and insights provide a valuable perspective on the experience of delivering MBCPs. Summaries of the data and themes derived from the interviews with the practitioners and managers are presented initially, followed by analysis and discussion.

4.1 Process Evaluation Design

At the outset, it is worthwhile revisiting the six areas identified during the co-design phase for exploration that involved the implementation of the MBCPs:

- Understand the challenges that UnitingCare MBCP facilitators experience in delivering programs
- Understand the contribution that DFV Advocates make to the programs and to the safety of women and children
- Understand the degree to which the MBCPs work with the wider DFV service system
- Understand the perspectives of key stakeholders in regard to the effectiveness of MBCPs
- Understand the contribution that the organisational context makes to the programs
- Understand how the programs take account of client diversity.

The program was delivered across five regions. Involvement in the evaluation was subject to staff capacity within each region, which did vary during the time the evaluation was undertaken. Table 3 identifies the region, location of program delivery and site participation.

In total, 23 participants were interviewed for the process evaluation across 4 organisational subgroups, with specific roles in relation to delivery of the UnitingCare MBCPs and associated key stakeholders (Table 4). Participants were sent invitations to participate in research interviews.

Semi-structured telephone interviews were held over a 4-month period, from May to September 2019. It must be noted that the interviews represent a snapshot in time during which the UnitingCare MBCP evolved, and some changes were inevitably implemented throughout the data collection period. Interviews were usually of one-hour duration.

The interview questions were drawn from the co-design process and reflected the key areas of interest and concern for the UnitingCare MBCP service system. Each group of stakeholders who were present during the theory of change workshops added their own views about priority areas they wanted to know about in relation to the MBC program and about their respective roles and contributions. Collective feedback was collated and triangulated with the literature review findings to check as to whether key issues identified in this field of practice elsewhere were reflected in the interview tools. The questionnaires included workforce capacity factors such as demographics, position-related questions in relation to management, supervision, education and training, and understanding of the program. Program-related questions included barriers and facilitators to program involvement, the role of the DFV Advocate and cultural suitability of the program. The questionnaires ended with an invitation for overall qualitative feedback.

Table 3: UnitingCare MBCP region and site participation

Region funded	Locations for program delivery	Participation in evaluation
North Coast	Maroochydore Gympie	Two part-time staff who worked at the Gympie office did not participate in the evaluation due to capacity issues; however, Maroochydore staff did contribute, so as a whole, North Coast did contribute.
Moreton Bay	Caboolture Redcliffe Lawnton	Full participation
Fraser Coast	Hervey Bay Maryborough	Did not contribute to outcomes evaluation due to capacity issues. Staff did participate in process evaluation interviews.
Mackay	Mackay	Full participation
Ipswich	Ipswich	Full participation

Table 4: Interview sample by organisational subgroup

Organisational subgroups	
UnitingCare Managers	2
MBCP Facilitators	9
DV Advocates	4
Stakeholders	8

4.2 Managers

Program revision

A process of program design revision was noted at the time of the interviews and was completed in early 2020. This revision involved updating program content and tools based on recent evidence, with the aim of increasing men's engagement. Interactive activities were being introduced to make it easier for the facilitators to engage with the men, although some sites expressed concerns regarding the need for new resources, especially audio-visual aids.

Recruitment and retention of group facilitators

Recruitment was described as a challenge across the positions required for the MBCPs.

The recruitment of facilitators was described as difficult, with an 18-month period of vacancies in one case.

> *Finding good men is difficult; recruiting male facilitators is very difficult. Recruiting facilitators with the appropriate skills is already difficult, yeah, in that area, yeah.*

Some vacancies were filled by contractors, creating challenges with program practice consistency and cost. The staff recruited to UnitingCare programs came from different theoretical and practice perspectives, with a split between those who came from a psychotherapeutic/mental health tradition and those that understood and were committed to the Duluth gendered social learning perspective. Many of the positions were part-time and sometimes this contributed to difficulties in recruitment and retention, though managers stated that one of the benefits of programs being hosted by a large organisation like UnitingCare was its ability to provide access to other employment within the organisation internally.

Retention was also a challenge, although this appeared to fluctuate:

> *Well, I certainly did at the beginning because I lost just about all of my facilitators at the beginning when I first took over, they all moved on... Yeah, so I've been really, really lucky, I've had a team – a stable team now for over 12 months, which is wonderful.*

Of the facilitators who had left, it was reported that one moved to another similar service, one took up a management role elsewhere and another chose to return to one-on-one counselling because he preferred this mode of practice. One other staff member left "because she was not happy" and another found the work too stressful as "it is a high-pressure area to work, there's a lot of administrative tasks and follow-up that needs to be done".

The diverse qualifications of the facilitators reflected a range of practices that were evidenced in the different approaches to working with men's behaviour change. In relation to the wider service system, there was concern expressed about the lack of availability of individual counsellors with expertise in DFV for referral where appropriate. Individual counselling is not funded under the current Investment Specifications for the MBC program, and facilitators relied on referral to appropriate social services in their particular area for issues related to substance abuse or mental health issues.

It was noted that academic degree programs had failed to provide many facilitators with the skills and training to work with groups and/or sufficient knowledge and understanding about the complexity of DFV with a few exceptions.

Theoretical and practice perspectives

> *There are 2 very different ways that people facilitate or talk about behaviour change models - either from this historical social model or they come from the mental health model.*

These differences impacted on staff dynamics, the challenge of staff being on board at all with understanding the dynamics of DFV, and the need to manage some conflict. Managers emphasised that the program is funded 'under the Duluth' model, which was more about holding the men accountable for their behaviour and liaising with the DFV Advocates in order to ensure victim/survivor voice and support were incorporated in the practice. There was also the recognition that the 'mental health model' meant less acceptance of the need to work collaboratively with other stakeholders, such as Probation and Parole, in order to maintain accountability.

At the time of the interviews, it was indicated that a review of the curriculum for the program was planned in the next few months. It was not clear as to what extent the intended review would consider theoretical perspectives; however, the Queensland DFV Practice Standards at the time required a strong emphasis on accountability as opposed to a therapeutic approach. Nevertheless, managers also spoke about the necessity for a program design that enabled engagement with the men, and needing skilled facilitators to achieve engagement, in order to convey the accountability message.

Management and supervision of staff

In relation to both management and professional supervision, managers who had previously provided clinical supervision found they needed to distinguish their line supervision role versus their clinical inclinations. When staff were away and contract staff were employed, managers found supervision more challenging. Managers spoke of the need for safety meetings that had a specific focus on collaborating with the DFV Advocates and ensuring appropriate information was shared with stakeholders and the high risk teams based on the requirements of the Queensland DFV legislation. There were cost implications for adequate supervision and managers spoke of advocating for increased funding in order to resource the multiple purposes of supervision, management and safety meetings. Where staff accessed external professional supervision, they were encouraged to receive this from a registered provider, although this was not a requirement.

Expressed as a major concern was the lack of the availability of the DFV Advocates and "… a really big lack of managers … that understand the work". It was reflected that MBCP work is complex and requires knowledge and multiple skills of managers; particularly knowledge of the impact of coercion and control and the ability to recognise associated behaviours. This was seen as ultimately costly, in that extra time was needed in order to explain levels of risk and the strategies required to protect partners/victims and their children to managers. An example was described of how a mother precipitated violence from her partner by drinking alcohol in the afternoons on weekdays so that her children would not observe the violence after returning home from school. An uninformed observer may judge this mother for her alcohol use, whereas her behaviour can also be seen as protective of her children. In this circumstance, "… you really need to understand the work from the historical social model, because it's not about the men's trauma. For sure there is stuff and that impacts that, but that's not what they're here for with the programs – you need to be mindful of that". From an understanding of DFV, this partner's actions may be perceived as protective of her children.

When DFV Advocates were employed by another agency, but were under contract to UnitingCare, the situation was considered to be sometimes difficult to manage. Attrition of the DFV Advocates was noted as high, partly due to the very high levels of work and risk management involved in the position. It was noted that regular team meetings and supervision including the DFV Advocates produced multiple positive outcomes. These included reduction in working in isolation and the risks attendant on this, a more developed response to protecting client safety, and the generation of a culture of mutual trust and support. Where DFV Advocates were located in different offices and under different service contracts it was noted that there were:

> *Very high levels of work, very high risk in a very short time with one worker. And it's very difficult, I think, at times, for workers who sit in the advocate role unless you're really being told, to turn off at five, this is all you can do in that space for one person.*

Team meetings were described as essential for increasing support for the DFV Advocate role, especially where the DFV Advocate was located geographically in the same office as the facilitators and where a constant flow of communication could be achieved. While a close working arrangement with the DFV Advocates was described as essential to the effectiveness of the MBCP, it was also noted that a high degree of trust needed to exist between the workers. Such a level of trust required a strong emphasis on team work, problem solving and willingness to share critical information. This was connected back to the importance of management supervisors and professional supervisors having in-depth knowledge of the complexity of DFV and the management of safety and risk.

The role of stakeholders

Relationships with key referrers were seen as important, but the quality of referrals and information provided appeared to vary. Relationships with some key stakeholders were described as reliable and effective, particularly with Queensland Corrective Services (formerly known as 'Probation and Parole'), whereas referrals from Queensland Police Service were experienced as 'unreliable' in quality with less collaborative attitudes expressed. Referrals from the Family Court were viewed as particularly problematic and frequently inappropriate. Experience with other courts was also described as unsatisfactory:

> *But I do find that even with magistrate's court or state court, magistrates court that still there's not a lot of accountability, it's still based on the woman to go, or the police to act and the woman to support that.*

A high level of interaction was reported with the nearest specialist women's services. This was reinforced by the role of the DFV Advocates which was particularly evident where high risk teams or their equivalent were in operation. In these contexts, information sharing appeared to be less problematic with greater

understanding of the limits of confidentiality, and when it was appropriate and necessary to share information.

Overall, the relationships with stakeholders were seen as time consuming to maintain due to the high turnover of staff and the continual need to form new working relationships. When 2 not-for-profits competed for the same service contracts, it negatively impacted on trust and relationship building. Information sharing was challenging if agencies that "don't even want to work together" disagree about what information can be shared and rely on their own privacy policy to withhold information. The issue of information sharing and effective collaboration was observed as easier when working with some coordinating teams than with others. This feedback has implications for commissioning of services and appreciating that competitive tendering may have a negative consequence on stakeholder and community cooperation; thereby, adversely impacting on professional relationships. The irony is that MBC programs is a field of practice that requires high levels of trust and cooperation; both of which take time and resources to build (Lamothe & Lamothe, 2010).

Responding to diversity

Managers thought that data on diversity was not currently captured, and it would be difficult to capture this data when the initial intake and assessment process screened prospective clients on the appropriateness of the service to meet their needs. In other words, at intake it was reported that Aboriginal and Torres Strait Islander and other prospective clients would be screened out on the basis that the program would be unsuitable for their particular needs. There was also concern expressed about the possible harmful effects of the program on Aboriginal and Torres Strait Islander peoples or CALD clients when the appropriateness of the prevailing language and learning styles were not considered. There appeared to be a higher number of Aboriginal and Torres Strait Islander women and CALD women accessing the DFV Advocate service.

Ongoing efforts were described as being made to link with the local Murri Court (where this was available) and MBCP staff had been invited to attend and observe court sittings. Concern was raised about the potential impact of the MBCP in terms of challenging attitudes and behaviours in the context of men who may be in high levels of distress and resistant to the model of delivery. Where assessments had been undertaken with Aboriginal and Torres Strait Islander men it was reported that they appeared to experience high levels of substance dependency, homelessness, struggles with literacy and related social distress. Not all facilitators felt competent to work with Aboriginal and Torres Strait Islander or CALD clients where it was felt that specialist cultural knowledge was required. It was acknowledged that "there's definitely room to grow" in this area of practice. In some instances, after forming positive relationships with the Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP) workers or cultural advisers, these relationships would sometimes break down when specific staff left, as alternate contact people were unknown. It was acknowledged that it was important to build trust with the local Aboriginal and Torres Strait Islander communities, and that this takes "a long time to build".

What would you change?

Greater resourcing was reported as being necessary, as referrals were noted to outstrip the ability to respond, in some areas, to the extent of 20 referrals a day. Recommended changes included:

- The cost of travel to regional sites needing to be recognised in contracting frameworks of the Department of Child Safety, Youth and Women. These costs appeared to be absorbed by UnitingCare but meant a reduction in some areas of service delivery.
- A longer program that also focussed on the impact of sexual violence against women, and an increased focus on the impact of the men's violence on children were seen as areas to be improved.
- A lengthier induction in order to assist men to be better prepared for the program, along with the need for a maintenance program in order to consolidate the men's behaviour change.

Along with the common theme of insufficient funding for the DFV Advocate role, a question was raised as to the contribution that the Department of Child Safety, Youth and Women were making in provision for partners, ex-partners and their children in terms of access to DFV specialist services.

Key themes that the managers raised are reflected in wider research, particularly challenges in recruitment and retention, the limitations placed on program scope and depth by lack of funding, and the recognition of areas needing further development, such as reaching out to diverse populations (Morrison et al., 2019). Australian-based research has pointed to the lack of attention paid to DFV workers and the pressing need to strengthen the workforce in recognition of the high level of challenge and complexity of the work (Wendt, Natalier, Seymour, King & Macaitis, 2020).

4.3 MBCP facilitators

Nine facilitators with an average age of 53.7 were interviewed. There were 3 male and 4 female facilitators who reported diverse types of academic degrees and training. The most useful qualifications for their work as MBCP facilitators were described as:

- Counselling with specialist DFV training
- The CQUniversity Postgraduate Certificate in Domestic and Family Violence (with MBCP specialism)[3]
- Specialist group work training as part of another degree, e.g. Social Work.

A number of participants referred to the value they thought that gender studies offered in a variety of social science courses in helping them to understand the socio-historical aspects of violence against women.

It can be seen from Table 5 below that there were 3 facilitators with more than 5 years' experience facilitating MBCP's while the remainder had less than 5 years' experience. Two had been employed as MBCP facilitators for 13 months.

Supervision

The sites varied in relation to frequency of supervision. Line supervision was reported as more regular, while professional supervision appeared to be less frequent or not provided, and in some cases was self-funded. Multiple forms of supervision were reported including:

- Line supervision sometimes with professional supervision
- External professional supervision with an experienced expert
- Team supervision along with line supervision
- Dyadic supervision, i.e. with co-facilitator
- Monthly line supervision with no professional supervision.

Table 5: Length of time facilitating MBCPs

FAC1	15 years
FAC2	4 years
FAC3	1.5 years
FAC4	13 months
FAC5	8 years
FAC6	2 years
FAC7	12 years
FAC8	13 months
FAC9	2 years

Understanding of theories and perspectives underpinning the program

There was broad agreement that the UnitingCare MBCP followed the Duluth social-historical model of addressing men's behaviour change (Miller, 2010) with a focus on understanding gendered power relations and the need for individual accountability.

> *A gendered approach – so it's a feminist position but there are also a number of theories that happen through education such as CBT [cognitive behaviour therapy], psychoeducation, narrative approaches, neuro-psychiatry … so it's always bringing them back to 'if your partner was here' or 'how does that link into your partner's safety or your children's safety?' Accountability is fundamental, otherwise it's a loose therapeutic group and that's not why they're there.*

One facilitator highlighted the importance of basing MBCPs on the involvement of a women's advocate (the DVF Advocate) to represent the partners/ex-partners' interests:

> *We've always fought for the Women's Advocate role. It's sort of been a bit ad hoc. We really value it - Ken McMaster (the developer of a model of MBCP based in New Zealand) talks about victim-informed assessment—how can you understand what's really going on unless you actually hear from the women.*

The list of theories and approaches included, along with reference to the above, were Ken McMaster's work[4], social learning theory, Alan Jenkins's

[3] The research team is employed by CQUniversity with 2 members in academic positions in the DFV Postgraduate Diploma program

[4] www.hma.co.nz/resources/family-violence

Invitations to Responsibility (1990), motivational techniques and systemic family therapy.

Despite the number of theoretical and practice approaches available to the facilitators to incorporate in their session design, a facilitator highlighted gaps in the available frameworks:

> *But they don't actually encapsulate the skills that are needed to work with the coercive behaviour and the skill set that men use to explain away and rationalise their abusive behaviour. So my practice has been informed by all of those, primarily Duluth obviously. But even that doesn't satisfactorily, for me, explain the depth of coercion and manipulative behaviour that is in this cohort.*

In response to a question as to whether the MBCP theoretical approach could be compared with forensic counselling, the point was reiterated that none of the prevailing human services theoretical and practice frameworks adequately explained the knowledge and skills required in this specific field of group work.

> *There are aspects of that obviously, but I consider that to be sort of a forensic and sort of a scientific model. It doesn't explain the human behaviour element as much, I don't think, although it gives some perspective to it, it's a technical, or a scientific evidence based and there are some things that can't be evidence based but you just know that these men are … some of these men are quite skilled at manipulative and coercive behaviour. So they can mask, if you're not careful, mask their true intention, which can be missed on some occasions, I think.*

Other participants reinforced how they operationalised an overlying gendered perspective to the practice perspectives such as narrative approaches, CBT and motivational techniques in order to adapt these to be applicable to domestic and family violence.

> *Well, I guess the first thing I would say is we've got a gendered nature while there's a feminist theory there, there's some … but some of the work is taken from Duluth model, that's probably one big aspect. It's also, yeah, scientific, yeah, psychological based as well. We work within that framework in the program. We also touch on social learning theory, attachment theory, cognitive behavioural therapy in some of the work as well. We look at theories of anger as well, I guess, anger management theory, expression of anger… I mean there are others that we probably touch on, but that's probably the key ones that we work with.*

The adaptation of theories and practice approaches was widely reported with some variation as to which specific ones were preferred. The extant literature on explanatory theories of domestic violence has grown in recent years but reflects diverse theoretical perspectives that have emanated from different academic and practice disciplines (Dixon & Graham-Kevan, 2011). The importance of explanatory theories is their implication for practice approaches, and it is the varying evidence from the practice approaches that then goes on to inform new ways of working (Dixon & Graham-Kevan, 2011). This field of theory development continues to generate strongly held differences as to how to explain domestic and family violence and therefore how to respond. The range of theoretical perspectives described by the facilitators in this study illustrate the challenges in developing practice frameworks for group work with men who perpetrate domestic and family violence in the context of marked differences between the human services disciplines.

Reviews of perpetrator programs internationally have reinforced that a feminist approach predominates in the human services organisations delivering MBC programs (Pence & Peymar, 1993; Bates, Graham-Kevan, Bolam & Thornton, 2017). There appears to be wide agreement, however, that interventions need to be evidence-based and that group work with perpetrators requires multiple practice skills. At this point in time in the evolution of group work with male perpetrators of domestic and family violence, it is not surprising that the facilitators in this study described varied disciplines and theories that informed their work. This multiplicity is also reflected in their feedback in regard to the use of the UnitingCare MBCP Manual.

Use of the UnitingCare MBCP Manual

The manual developed by UnitingCare some years ago was undergoing revision at the time of this evaluation (the version in use was the Men's Domestic Violence Intervention Programs (DVIP) Service Manual June 2018). It provides a guide for facilitators on the theoretical background of the material to be delivered during progressive sessions with the men, and practical guidance on resources and forms of engagement activities, all of which are informed by experience. There was general consensus that the manual was structured well and worked well. Where the facilitators found the language too sophisticated for their groups, they adapted the content to be more appropriate to their learning abilities. The facilitators appeared to work hard to adapt material, to

source new ways of presenting the core messages and to introduce new ways of engaging with the men. The majority (7) reported adapting content and materials 'quite a lot', while 2 reported a 'small amount'.

Comments on the manual stressed the importance of the relationship the facilitators felt they needed to form with the men in the group, as they saw this as key to supporting the men's motivation to change.

> *The relationship is the biggest part of the change. If you see it as 'the program' that we just deliver as you would say a parenting education program or something like that, I don't think that works. These men are extremely difficult. It requires intensive work and you're going to get a lot further if they trust you enough for you to work with them, and if you change facilitators too much that doesn't happen, yeah.*

> *We had the framework purpose and goals, but we drew in exercises and activities that we felt fitted with it and we held joint discussion. It wasn't going to the manual and doing it. There was (sic) 5 of us who planned the sessions each week.*

These comments illustrate how difficult practice in this field of group work can be and the ongoing time and effort needed to continuously make the material relevant and effective with each group, by way of serving the group's purpose but at the same time engaging with the men as individual learners.

Other feedback suggested that adapting all aspects of the content and skills development required applying a feminist lens and interpretation of the implications of this:

> *And the healthy relationships refer to Gottman material, which would usually be used with couple counselling. Now, because we don't do couple counselling where domestic violence exists, what I've done there is I've put the feminist lens on where I can't see it in the manual.*

> *So I explain to the men that when we're looking at styles of communication, I put that feminine lens on top of it. And it's then why, because if they start saying, "Well, my partner's passive, she doesn't have to be assertive." And I'm saying, "Why would that be, what would that be about?" So I'm pushing the feminine lens on top of that, so I might not see that in detail in the manual but I know other facilitators do the same thing.*

Gottman's (2008) material on healthy couple relationships was reported as a guide for facilitators in the Manual; however, this facilitator is recognising (along with other commentators) that the role of gender remains central to explaining men's violence against women in intimate partner relationships (Wendt & Zannettino, 2014). This does raise the question as to whether further guidance may be optimum in supporting facilitators, particularly those new to the field, in how to adapt learning materials in this context. In terms of the Manual content, some areas were seen as more effective in engaging the men than others, particularly those which focussed on parenting, fathering and the impact of DFV on children and young people. Male socialisation, family history and learned beliefs and behaviours were also reported to resonate with the men. Learning practical skills in relation to respectful communication and recognising the role of their emotions and how to manage these were also described as effective, which aligns with the early outcome findings from the men's and partners/ex-partners' surveys/interviews.

However, it was reported that during the processes of engagement in the early stages of the program and throughout the following sessions, it was important to maintain a dual focus on accountability and engagement:

> *It's absolutely accountability, so always in my mind is the balance between engagement and accountability. So being accountable for behaviour, men can't come into the program unless they're willing to take accountability. And we talk about that right upfront from the front, so when men are in the program we talk about, "You will be confronted in this group." Because that's how we can move forward, it's about ownership. And I think some people get confused with the neuropsychotherapy and think that that boils down to well, I'm doing this because I'm angry and I've moved to fight flight. No, that enables men to have a bit of a tool to understand this is what happens to my body and my brain when I'm angry. And so therefore I can use this information to help me make better choices around safety.*

The facilitators are making it clear in this example how they expect the information presented from the Manual to be interpreted by the men in the group, particularly that information pertaining to child development and neuropsychotherapy. The challenge in ensuring that the group members adhere to this expectation relies to a degree on the communication with the DFV Advocates who can add another layer of accountability for the facilitators. Where men use the neuropsychiatry information to excuse their violence to their partners, ideally this needs to be fed back to the facilitators.

Other practices in implementing the Manual related to how to translate the content into teaching materials that matched the men's learning styles:

> *Yeah, like I said, what the manual had to offer in relation to activities and bits and pieces, when I took snippets of that, we found other stuff that we felt was more easy to adapt and the guys kind of got more of, so yeah.*

> *Look, I think for me I'm a bit quirky in how I do presentations and bits and pieces so I tend to like to throw in some clips and all that adult learning material. And we've raided TED Talk as TED Talks, we've raided quite a few of those and just a whole range of other different bits of research and material that we've found. And we've added those into the certain topics at group and it fits for the way the guys learn. So, we do a lot of writing on the whiteboard, we do handouts, we do little action things that we need to do, yeah, so there's a whole range. And each session has a different way, if you know what I mean.*

Knowledge of group work skills and how to design activities that would engage and communicate key messages were described as critical to MBCP facilitation. Above all, as mentioned earlier, facilitators are required to maintain a careful balance between a therapeutic approach and accountability.

Different types of supervision and its availability were important to the facilitators in supporting them to manage risk and stress. Few of the facilitators described the psychological stress of their work; although, some referred to the impact of some of the information disclosed to them by the DFV Advocates and how to incorporate this in the group sessions.

There were some reports of high turnover of staff and the additional work this required in supporting their induction into the MBCP. The changes to staff also had implications for managing the interactions within the groups with different personalities and motivations affecting the men's participation.

It has been acknowledged elsewhere that this type of work can lead to burn out and in terms of recruitment and retention, investment in high quality supervision is seen as underpinning the quality of the program (Moran, 2008). In the DFV sector, there appears to have been little investigation into the impact of this type of human service practice on practitioners and the implications for organisations. A study in 2012 with MBCP facilitators found a high level of intrinsic motivation and commitment to changing men's behaviour by the practitioners, but that they also experienced challenges in relation to the role of the criminal justice system and lack of community support for the programs (Barclay, 2016). These factors, along with the multiple skills required and the intense nature of this type of group facilitation work, have implications also for ongoing professional development and healthy workplace practices.

A recent Australian report has highlighted the risks attached to this type of group work in relation to the use of self-disclosure and the potential for collusion with the men, the emotional toll in managing the group work and maintaining professional boundaries, and the support that organisations need to provide to facilitators (Reimer, 2020).

Interviews with this group of facilitators revealed dedicated professionals, committed to ongoing practice improvement necessary to maintain their effectiveness. The researchers were impressed with the ways in which individual staff were self-motivated to continue to seek new ways of working, to increase their knowledge of different modes of intervention and to share their skills, particularly with newer and less experienced staff.

Co-facilitation/co-gendered facilitation

The majority of facilitators reported working well with their co-facilitator; however, 3 indicated that there were some difficulties. One female facilitator reported an unhappy experience with another male facilitator but was happy with her current co-worker. Her unhappiness related to the use of power during a session where she felt a lack of respect for her involvement. The experience did not appear to have been raised with senior staff and it appeared to have a lasting impact on the woman involved.

Another described how important it was to rely on each other during sessions and to follow up whenever problematic attitudes were expressed:

> *So my 'moderately facilitator' was not well, which is why he's left, and he wasn't always catching where there might be those little niggly things about women or some sort of something happening in the background. And so I have been put in a position at times where I've had to step in and say, "Look, I'm going to pull it up here." And I'm thinking, where are you? Whereas last night my facilitator who stepped in, that was excellent because we were both together on the same things, picking up on similar things and backing each other up.*

In this example, the female facilitator described how she

would frequently be "the one that's constantly challenging" and the importance of feeling that she could rely on her co-facilitator to have a "good understanding of domestic violence".

There was overall mixed feedback in regard to co-facilitation with the quality of the experience dependent on the combination of the individuals concerned.

> *I would say ... so if I'm thinking about the facilitator, that was, that I worked with the best, I would say extremely well. The person that I worked with probably for the most of the time over the last 2 years I would say, yeah, like pretty well, pretty well but not perfect.*

There is limited research concerning the practice of co-facilitation in MBCPs, but this is a growing area of interest. Morrison et al., (2017) have described how co-facilitation was preferred by facilitators they interviewed based on the need to have 2 sets of eyes and ears on observing the interactions and responses of the group. Co-gendered facilitation was particularly supported in order to avoid the "pitfall of subtly reinforcing the very behaviours they were attempting to change" (Morrison et al., 2017, p.484).

Other research has reinforced the opportunity for gender role socialisation that co-gendered facilitation offers in breaking down rigid sex role stereotyping (Roy, Lindsay & Dallaire, 2013). The proviso is that the co-facilitation does not "further reproduce" such stereotypes (Roy, Lindsay & Dallaire, 203, p.7).

Feedback from the male participants in MBCPs indicates that they value facilitators who assist them with adjusting to the group process, in being non-judgemental, being honest with them and challenging their behaviour (Morrison et al., 2019). They also valued co-gendered facilitation and saw this as aiding their engagement with the program and learning more effectively (Morrison et al., 2019). However, a recent Australian study has found that the experience of female co-facilitators at the sites involved in the research were concerningly negative and that particular support is needed for their roles (Reimer, 2020). Supporting the female facilitators requires addressing not just collusive behaviour by the MBCP participants but also male privilege in relation to facilitator conduct (Reimer, 2020).

Barriers and facilitators to men attending the program

Facilitators spoke about the inclination of the men to view attending any type of group as contrary to their masculinity and the ways in which their views of masculinity shaped their responses to attending the program.

> *....and we talked about that, you know, their concept of going to a group with a mob of men who they may believe are sharing their feelings. You know, so if they don't actually get to group it's often because they think it's not a man's thing to do. So there's that socialised learning stuff, once they get in they usually change their mind, but that was a discussion we had last night actually, we call it the man box stuff.*

> *At (a) toxic level, yeah, one of the guys said, "Yes, that's what we think." He said, ..."Yeah, I did think it was bloody pansy shit." The word was pansy, he said, "By a group of pansies." But he's been the most engaged guy and he's this tough guy, as you would know, having been involved with this in the past,*

Table 6: How well did you work with your co-facilitator in delivering the program?

Facilitator	Extremely well	Very well	Neutral	Moderately well	Not well
FAC1		✓			
FAC2				✓	
FAC3		✓			
FAC4	✓				
FAC5			✓		
FAC6		✓			
FAC7		✓			
FAC8		✓			
FAC9				✓	

but once they actually get in and they start seeing the changes and the benefits.

Other responses indicated that some men were concerned about stigma in that they didn't "want to be seen as one of those blokes that abuse women" and didn't "want to sit next to one of those blokes".

Studies which have shown how negative attitudes towards women are held by men who access MBCPs, and how men account for their own violence and the ways in which such attitudes need to be challenged during the program (Anderson & Umberson, 2001). Other studies have discussed how difficult the balance between 'care' and 'control' is in this type of group work for facilitators in terms of their therapeutic purpose in creating a context that encourages men to change their attitudes towards violence, versus the control they need to exercise in the group setting in addressing minimisation, blame and denial (Day, Chung, O'Leary & Carson, 2009).

There was some concern expressed about the intake and assessment (I&A) process, as to whether all the men who expressed an interest in the program were accepted. There was a shared view that it would be beneficial for the facilitators to conduct I&A so that they could start to form a relationship with a man immediately, and that this would be useful to build on once the men joined the group.

The men's hours of work, substance use/misuse issues, lack of transport and personal situations, such as homelessness, interfered with their ability to complete the program. Lack of motivation by the men was seen as a barrier to completion, along with their belief that they did not need to do the program. The facilitators observed that their ongoing efforts to check in on the men when they missed a session was valuable, as they were able to further understand the life situations the men sometimes had to deal with.

It was also thought that the rolling group model employed by UnitingCare could interfere with positive peer group influence developing, in that when new men joined the group, a new set of relationships had to be formed. Conversely, it was noted that the rolling group allowed men to enter the program at any time, making engagement in the program more accessible.

In terms of supportive influences, a non-judgemental attitude balanced with the need to challenge was described as necessary in order to fulfil the purpose of the program, and once again the quality of the relationship formed with both individuals and the whole group was seen as instrumental in men staying in the program. Strong motivation to remain in the group was also reported to be related to improving their relationship with their children, and the converse occurred when they appeared to lose motivation if they lost access to their children.

It was recognised as foundational to delivery of the program that there be no collusion with the men. On occasion, this was described as challenging when men were highly manipulative, were able to negatively influence the group, and attempted to undermine the guidance of the facilitators.

Checking in with the men at the beginning of each session enabled the facilitators to adjust the program material to be relevant to the men's particular situations, as well as maintaining confidentiality. In line with previous feedback, positive modelling between the male and female facilitators was seen as vital to demonstrating to the men how to communicate respectfully. Establishing group values at the beginning of a program and upholding these during the sessions seemed to provide some men with new skills they could translate into their own lives.

The role of the DFV Advocate

With the exception of one practitioner, the facilitators reported meeting with the DFV Advocates regularly. Examples were provided of how closely the facilitators worked with the DFV Advocates in order to increase safety for the partners/ex-partners and their children; to case manage various issues and needs as they arose; and how at some sites, it was possible with the resources available to support the partner/ex-partner and her children despite the perpetrator not attending the program.

So we have a weekly case review which would be myself, co-facilitator, women's advocate and … from … So in there we will discuss any of her concerns, so where she's made contact. And then we run through the group members, or all participants, those which are suitable, those which are not and where they're going and her appropriateness of then contacting the partner. Because sometimes they may have to be referred then to Drug & Alcohol, or if there are mental health issues, so we then look at the women's advocate, if I've got consent, so she can still go ahead and contact that woman and child, because we don't want them to fall through the gaps even if that man's not coming into the group. I'll also get phone calls or touch base with the women's advocate throughout the day

if I have, you know, someone's … I've spoken, so when I go through the list today and those that didn't attend, if I come across anything then I would link in with the women's advocate. You know, it's definitely once a week, but it often happens more than that.

The facilitators reported at least weekly, and frequently, daily contact. There were limitations for the DFV Advocates as to how many meetings they could attend based on the hours for their position, and under these circumstances particular sites ensured that they shared information among the facilitators' team at that particular site. There were examples of effective co-working with the DFV Advocates, particularly where they shared offices and were able to hold impromptu meetings in response to issues as they arose.

There was consensus across the facilitators that there needed to be more resources apportioned for this role, as it was acknowledged that the high client load meant the Advocates could only effectively focus on those partners/ex-partners who were deemed to be high risk. All facilitators described the importance of the information provided by the DFV Advocate for the authenticity of the program. They also recognised how effective this knowledge could be in informing session material:

So, if we have a case review where I'm hearing that, so for example, the other day I heard from the women's advocate that a mother was concerned about her son that was in her care, who was 15, who was apparently being home schooled, but she said she felt he was falling behind. So, we moved into impacts on children, so we move and change the structure depending on how the ground is moving, so how things unfold.

Concern was expressed about the complexity of the role where the safety of women and children had to be balanced with accountability of the men. There were a number of accounts of how careful the facilitators had to be with regards to incorporating the knowledge they gained from the DFV Advocate. There were concerns about how to manage confidentiality:

We were concerned that the information that we share was getting to the partners and the risk issues around that.

While in other instances, where there was trust between the practitioners, if the man's behaviours raised concerns the facilitators could ask the DFV Advocate to follow up and vice versa.

Without exception, the DFV Advocate role was considered critical to the overall effectiveness of the program, because by conveying the women's voices and the children's perspectives to the facilitators, this feedback could be incorporated into session planning. The role was also considered critical to the safety and wellbeing of women and children, and to the meaningfulness of the program by enabling the facilitators to have insight into the impact of the man's behaviour on his family. One example involved letting a facilitator know that a partner was pregnant, and this meant that the facilitator was able to incorporate material on the impact of DFV on unborn children.

There was overall concern expressed about the lack of funding for these positions and the limitations this placed on the scope of their role.

Yeah, and it's not funded enough. And the other thing I've found is, I don't know, this is just anecdotal, but the group of women that the women's advocate often contacts, like the partners and whatever, there's a lot of them that have never had contact with another DV service. There is a group of women that it's the only contact they're going to have, so I think it's vital.

Of particular concern to the facilitators and the DFV Advocates was the fact that for many of the partners/ex-partners and their children, contact with the Advocate was the first and only support they had been offered, and for some this would be their only support. In this field of social service practice, it is widely acknowledged that many victims/survivors do not seek help (Huecker & Smock, 2018) and this makes the DFV Advocate's role critically important.

Responding to cultural diversity

Aboriginal and Torres Strait Islander clients

There was a diversity of views and understandings of the appropriateness of the UnitingCare MBCP for people of Aboriginal and Torres Strait Islander origin. The majority of facilitators adopted a neutral position in response to this question.

In relation to the degree to which the program *catered* for Aboriginal and Torres Strait Islander clients, most responses ranged from 'neutral' to 'not well'. Questions were raised as to responsivity where it was thought that the program material would be relevant, but the delivery method would need to be culturally appropriate.

Table 7: How appropriate do you believe the MBC program is for Aboriginal and Torres Strait Islander clients?

Facilitator	Extremely appropriate	Very appropriate	Neutral	Moderately Appropriate	Not Appropriate
FAC1					✓
FAC2			✓		
FAC3				✓	
FAC4					✓
FAC5			✓		
FAC6				✓	
FAC7			✓		
FAC8				✓	
FAC9			✓		

It was thought that program staff would need to be more engaged with Aboriginal and Torres Strait Islander community events, particularly during DFV Prevention month and in developing relationships with local elders. There was a difference noted where some Indigenous men would come from urbanised locations where they had been brought up in European environments versus those who have been raised in discrete communities where their cultural needs may be more likely to be specific to particular traditional groups. It was also acknowledged that the standard conditions of attending the groups may not apply, as some men may need to miss sessions related to sorry business or other important cultural events.

Overall, the issue of inadequate resourcing was raised in order to develop and implement culturally specific groups. There were practical suggestions such as the potential to employ cultural advisers to a program who could support the needs of Aboriginal and Torres Strait Islander men. Despite the concerns about responsivity and the appropriateness of the current programs, a number of sites reported that they had Aboriginal and Torres Strait Islander men attending from time to time, but they were not sure how the material fitted with their understanding of family and their networks of relationships. It was recognised that the impact of colonisation, racism, child removals and intergenerational trauma would need to form part of a tailored response.

Culturally and Linguistically Diverse Clients

There was greater support for the suitability of the MBCP for CALD men, with one facilitator finding it 'extremely appropriate'. This appeared to depend on the ability of particular CALD groups to remain in the program, such as New Zealand Māori men who are seen in large numbers in some areas. In this case, the facilitator reflected as to whether they may struggle with some of the material.

Others raised concerns relating to how the program would not be suitable for CALD groups, due to the various cultural differences and beliefs held by these groups and due to the program material and engagement relying entirely on the English language. At most sites, men without some degree of English language proficiency were screened out, and the cost of providing interpreters was seen as outside the funding capacity of the program. It was also stated that the courts frequently struggled with accessing interpreters and that this meant it was unlikely they would be available.

The degree of success with working with CALD men appeared to rely on the degree to which they were enculturated into the dominant Australian culture based mainly on English language proficiency.

It has been acknowledged that more comprehensive data and

Table 8: How appropriate do you believe the MBC program is for Culturally and Linguistically Diverse (CALD) clients?

Facilitator	Extremely appropriate	Very appropriate	Neutral	Moderately Appropriate	Not Appropriate
FAC1				✓	
FAC2		✓			
FAC3				✓	
FAC4			✓		
FAC5			✓		
FAC6				✓	
FAC7		✓	*See a lot of Māori men but they'd probably struggle with some things.*		
FAC8	✓				
FAC9			✓		

research is needed in regard to responding to the needs of CALD populations in Australia and their experience of DFV (AIHW, 2018). A recent report has highlighted domestic violence supportive attitudes among the men consulted as part of this study (Koleth, Serova, & Trojanowska, 2020). The authors focussed on the need for much stronger social services engagement with specific CALD communities in particular localities, and to co-design and partner in the implementation of responses to DFV (Koleth, Serova & Trojanowska, 2020). This would require a whole of agency response and significant resources to be able to respond effectively.

LGBTIQ clients

There was greater consensus that the MBCP would not be suitable for LGBTIQ clients.

To begin with, it was noted that at intake and assessment the questions of a man's gender identity were not included. It was thought that asking this question may make the men feel uncomfortable. The program material is predicated on heterosexual relationships and therefore the question was raised as to how relevant it would be for LGBTIQ men. The overriding concern regarding suitability of the program was the response of other men in the group, and whether LGBTIQ men would be made to feel uncomfortable. One comment referred to people being far more accepting of differences in gender and sexuality, but nevertheless, there may still be a risk of discrimination expressed in the group. Along with Aboriginal and Torres Strait Islander and CALD men, the costs were seen as potentially high in developing specialist programs, and the numbers may not justify this level of investment.

The feedback from the facilitators in the account is relevant to the findings of the recent ANROWS report: *Developing Programs for perpetrators and victims/ survivors of domestic and family violence* (2020) related to the 'heterosexual face' of domestic violence. The prevailing design and implementation of perpetrator programs in Queensland are predicated on assumptions based on the dynamics of heterosexual DFV. As the ANROWS report highlights, specific programs would need to be tailored in order to meet the particular needs of LGBTIQ populations (ANROWS, 2020, p.1). However, this report also recommends that mainstream service providers need to improve their recognition and understanding of DFV in LGBTIQ populations in order to recognise and respond appropriately.

Facilitator views of what the best MBCP would look like

Organisational

In line with a strong theme in these findings, increased funding was identified as necessary for the improvements that were suggested under this question. Additional funding was also seen as essential for providing support groups for the partners/ ex-partners of the men so that they had much greater access to services. Resourcing of the DFV Advocates was seen as essential so they could be part of the team

Table 9: How appropriate do you believe the MBC program is for LGBTIQ clients?

Facilitator	Extremely appropriate	Very appropriate	Neutral	Moderately Appropriate	Not Appropriate
FAC1					✓ *Very inappropriate*
FAC2			✓		
FAC3					✓
FAC4					✓
FAC5			✓		
FAC6					✓
FAC6					✓
FAC8			✓		
FAC9			✓		

and attend regular, sometimes daily case management meetings, as their perspective was front and foremost in ensuring safety and wellbeing of partners/ex-partners and their children.

Workforce

Increased workforce capacity with more professional supervision, dyad supervision (referring to co-facilitator) and professional development were noted. It was considered necessary for quality assurance to have a structure for supporting the programs, involving agreed policies and procedures with training, support and accountability. Reinforcing previous comments, specific skills of facilitators were viewed as important, such as the ability of female facilitators to "cut through the misogyny". Knowledge and experience of DFV and practice frameworks were seen as essential prerequisites for working in this field of group work.

The program

The ability to increase the number of groups to be run at different times of the day and evening was seen as beneficial in enabling more men to attend.

Ongoing time set aside to continuously work on the manual was recommended in order to update it and to incorporate new knowledge and engagement strategies as they came to hand.

A strong theme throughout this group of interviews has been to strengthen the role of the DFV Advocates and their ability to reach all the partners/ex-partners of the men on the programs.

A unifying theme from the facilitators was the need for a follow-up maintenance program of support for the men and increased individual support over the course of the program. Access to individual services was viewed as valuable to reducing attrition from the program, and to providing men with the opportunity to gain greater value from attending the sessions.

4.4 Key stakeholders

There were 8 stakeholders interviewed from a mix of government organisations such as Queensland Police Service (QPS), Queensland Corrective Services (QCS), the Department of Child Safety, Youth and Women (DCSYW) and non-government organisations (NGOs), such as family support services and specialist domestic violence services.

Over the previous months at the time of interview, 3 stakeholders referred from 10 to 78 men to the MBCP with the highest number of 78 referred by QCS, 25 from the family support service and 25 from DCSYW. Due to the nature of their contribution to the DFV service system, 2 stakeholders did not make referrals of men but rather may have supported victims or been in policy-related positions. All 6 services that made referrals stated that it was very likely they would continue to do so.

Information and referral

In relation to how much information the stakeholders had received about the program, the majority reported they had 'a lot' or 'sufficient' with 2 services stating, 'not enough'. The issue of information related to the program was particularly relevant to the referring agencies; although, other services within an integrated response to DFV wanted more information in order to understand the nature of the program.

Four stakeholders reported that they attended presentations about the UnitingCare MBCP and 2 of these were informed of weekly session topics. Other sources included brochures, word of mouth, and an occasional overview of the program when the UnitingCare facilitators were invited to the office.

There were few referrals made to other MBC programs, as there were very few other providers. The reason that one participant stated they would refer to another MBCP preferably, was due to concerns about lack of information sharing on the part of the UnitingCare provider. This opinion needs to be balanced against the limits of confidentiality and differing interpretations among some stakeholders as to what information can be legitimately shared.

Reservations about the program

The main reservations about the program related to a lack of information with regards to feedback and sharing of information about the suitability of clients, their progress and participation in the program, their completion of the program, as well as the safety of partners. There were lengthy waiting lists reported by a number of referrers and this also hampered referrals. The referrers were also concerned about the lack of after-hours programs being available (at the time of the evaluation) and the limited suitability of the program for some men.

> *I guess… it's probably more about the individual man and the fit with the program and the facilitators, rather than do we want him to do that program. Like we always want them to do the program, but whether it's the right fit for them is sometimes a concern.*

Table 10: How much information were you provided with about the UnitingCare MBC program?

Stakeholder	A lot of information	Sufficient information	Neutral	Not enough information	No information
S1	✓				
S2		✓			
S3		✓			
S4				✓	
S5		✓			
S6	✓				
S7				✓	
S8		✓			

Information sharing

Challenges were reported in relation to information sharing with 7 out of 8 stakeholders stating they had difficulties with this aspect of the MBCP. Specific issues were described in some of the comments.

> *I share more to them than they share to me.*

> *Yeah, they want stuff from me and see, they'd get stuff more from me if they ask, but they don't ask. So yeah … I often feel like they don't have the whole puzzle.*

Mention was made of the fact that even though organisations had signed memoranda of understandings in relation to what information could be shared, they may not relate to the common purpose of addressing DFV, for example:

> *… like they don't voluntarily email me and say, 'Such and such turned up and we have concerns about him or such and such turned up and he's doing really well.*

One stakeholder advised that it was only after 3 years in her position that she discovered that there was a Women's Advocate (DFV Advocate) as part of the program, and that if the Advocate was told by the facilitators that a man was "really, really angry today", they'd be concerned for the partner's safety, but that this information was not being shared with them (although they acknowledged it might be shared with some other authority).

Another stakeholder advised that his staff reported that "they often tell me they're not able to get as much feedback by UnitingCare and progress or completion of programs". This was compared with other programs that provide "reports, completion certificates, urine testing results in like a 2-page document, which is great for us". However, the same stakeholder recognised that:

> *…it's absolutely no criticism, I also know the parameters of which they can share information, and consent issues.*

Barriers and facilitators for men completing the program

A stakeholder who worked with a large number of referrals to the UnitingCare program described barriers to completion as usually relating to personal circumstances:

> *They have either moved out of that area, a lot of them … I guess, generalising, it would be that they are, you know, they might have gained employment which means they can't continue at that particular program time. They are experiencing some sort of crisis or change in circumstances, so like one I can think of recently is that one of the men's mother became ill and was hospitalised. And so he said he was supporting her through that and so could not continue with the program. So it's sort of those changes in personal circumstances that would most likely rather than just any other reason, yeah.*

Partner/ex partners and the DFV Advocate

Without exception, the stakeholders agreed that it was 'extremely' important for the MBCP to be in contact with the partners/ex-partners. It was acknowledged that at times there would be difficulties with making contact with the partner/ex-partner, as some wanted to disengage from the man, others had a lack of trust of the program, for some contact details were not available, while the high workloads of the DFV Advocates also hampered contact. The DFV Advocate position was considered essential in supporting the safety and wellbeing of the partners/ex-partners and their children. In line with previously reported findings in this report, there were concerns about insufficient funding for the DFV Advocates, the fact that they were frequently part-time positions, that they were only able to contact the partner/ex-partners at high risk, and that the contact was more likely to be by telephone only. The positions were seen as critical to link partners/ex-partners with support services.

Suitability of men for the UnitingCare MBCP

Six out of 8 stakeholders stated that some client populations would not be suitable for the UnitingCare MBCP. These included high risk clients, those with substance use problems, those who abuse family members not partners, Aboriginal and Torres Strait Islander men, LGBTIQ men and those who are employed. Another participant believed that some men would be unsuitable based on whether they might be the 'right fit' and how they might respond to the program:

> *I guess kind of, but it's probably more about the individual man and the fit with the program and the facilitators rather than like do we want him to do that program. Like we always want them to do the program, but whether it's the right fit for them is sometimes a concern. And sometimes I guess, more broadly, I worry that they just kind of go through the motions and whether they learn new bad behaviour.*

Another stakeholder focussed on feedback they had about the cultural suitability of the MBCP:

The feedback I'm getting from the Aboriginal and Torre Strait Islander partners, they're saying it's not because I think there's a group that's started here in our region that is meant to support men from Aboriginal and Torres Strait Islander or CALD men. So the program itself I know they tried to maybe … I don't know if they tried to adjust it or adapt it. But I think it just needs to do a completely different program, yeah. From my perspective, as I said you'll have to check with other groups like specific Aboriginal and Torres Strait Islander groups themselves. But from our reports that I get is it's not useful for them. The group might not be suitable for some because of language issues, and maybe there's some cultural issues that comes in. Whether, you know, the model of male/female…

One example was provided where a stakeholder had discussed the issue of suitability with the UnitingCare MBC program staff and had concluded very much in line with the above feedback that:

Well, I think we've identified with UCC at the moment the groups are very catered to white Anglo-Saxon, and that's not their fault, it's just that that's … but I don't know that we would send Indigenous men there at this stage unless we had other support in place for them while they went. And the other area that UCC and us have identified is the LGBT group. You know, most of the men are in heterosexual relationships that go to these programs and, you know, we don't know how safe or comfortable someone in a same sex relationship would feel going to the program. So we have been in discussion because we feel that those are 2 cohorts that at this stage miss out.

Along with the cultural suitability of the program, the practical difficulty for men in employment and the timing of the program were also raised. It was thought that to be more culturally appropriate the program would need to have a stronger healing focus and preferably employ Aboriginal and Torres Strait Islander facilitators.

In concluding this section concerning the role of stakeholders, it can be seen that a socio-ecological view underpins their feedback as they all played a part in supporting the men with accountability while the men attended the program in various roles (Pallatino et al., 2019). The stakeholders also provided critical support for the partners/ex-partners and their children where this was available. They spoke of their desire for a high level of communication between the key organisations involved with perpetrators and their families in order to manage risk, safety and accountability. This is recognised as essential for a program to maintain its impact not just on the individuals on the program but on their wider familial networks (Pallatino et al., 2019). A shared understanding of the nature of DFV, and standardised responses to risk assessment and information sharing are necessary for an effective, coordinated response (Backhouse & Toivonen, 2018; Pallatino et al., 2019). As evidenced in this study, differences in mandates and philosophical approaches to information sharing, for example, continue to affect the quality of collaborative relationships and the building of trust (O'Leary, Young, Wilde & Tsantefski, 2018).

4.5 Domestic and Family Violence Advocates

Of the 4 DFV Advocates interviewed for this evaluation, 2 were employed by UnitingCare, while 2 were employed by other local DFV specialist services. All Advocates were employed on a part-time basis in their role, commonly 2-3 days per week.

A counselling degree of some kind was the predominant qualification for the DFV Advocates. One Advocate had completed a specialist DFV postgraduate certificate. Supervision, as with the facilitators, appeared to vary from monthly line supervision to every 6 weeks or 2 months. Professional supervision was reported by one Advocate, as occurring 3 times a year. One Advocate reported that she had group supervision.

Working with the MBCP facilitators

Regular contact with the facilitators for daily or weekly case reviews was reported. Those Advocates who were employed by UnitingCare reported they were involved in the intake and assessment of the men for the program while one reported that

she thought this process was a bit 'coveted' by the facilitators and she had not been provided with any details of the weekly program. Despite this she reported a strong working relationship in regular meetings with the facilitators, as did all the DFV Advocates. The high case load meant that many felt they were only able to work with high risk situations, and case discussions were nearly always focussed on high risk. The facilitators reported feedback on any issues of concern to the DFV Advocates when they arose.

The issue of risk and safety was raised by the DFV Advocates where they described needing ongoing vigilance. At times they disagreed with the suitability assessment of some men in relation to what they knew in terms of their histories of serious and prolonged abuse and the potential impact on the partner and children.

> *Well, I feel that perhaps he ought to not be suitable, because of a history, we know that he's a serial perpetrator, that he's done some extreme, horrific behaviour with multiple partners. And him doing the group has meant that the children are back in the house again, because, you know, with child safety that's ticked that box. But it is very, very difficult to keep eyes on them and yeah, I wonder what the benefit of him engaging in that could possibly be, the potential for him to kind of poison the well with the other guys based on his attitude is what I am concerned about.*

This comment relates to the degree to which the DFV Advocates may be involved in I&A and suggests that should funding allow, this may help to reinforce the collaboration between the 2 roles and the frontline decision-making.

The issue of the importance of trust between the DFV Advocates and the facilitators was raised where it was felt that on some occasions the facilitators risked colluding with the men by not respecting the professional judgement of the Advocate.

> *You know, maybe there's not like a broader understanding of like the tactics that the men will do to try and buy in the facilitators, to buy in to their story. And so I think the limitation is that potential to collude with these men and put that professional judgment with the men as opposed to trusting my professional judgment. I'm trying to be really respectful about it.*

Other feedback indicated that the type of contact between the DFV Advocates and the facilitators was mainly related to case management:

> *It's nearly always case discussion, or if there's been any kind of serious disclosures. So, if there's anything high risk that's flagged, because like the caseload is so massive, we kind of have to always just prioritise the highest risk ones that have been identified. I'm sure that there's plenty of other high risk ones that we don't have time to identify, but, yeah, that we kind of hold those ones up so if there's any, you know, updates, you know, like we'll discuss those. And yeah, if a guy's made any kind of disclosure in group that we might feel is risky, then yeah, they'll definitely email me and let me know.*

Due to the time constraints of the hours they worked and their caseload, there appeared to be strong emphasis on the management of risk, and this was focussed on those cases which were known to be high risk. There was concern raised by a number of Advocates about those high risk cases that were not known to authorities and where they felt further investigation and contact was warranted.

Working with partners/ ex-partners

The DFV Advocates, without exception, agreed that checking in with the partners/ex-partners of the men on the program was extremely important and that they generally responded very well to being contacted. It was found that some of the men in the program were reluctant to provide the contact details of their partners. Some of the partners/ ex-partners were concerned that contact from the DFV Advocate constituted a breach of a DVO and did not want to be contacted. The majority of the DFV Advocates were able to provide partners/ ex-partners with contact numbers of services, undertake risk assessment and safety plans with them, and check-in with them, particularly if they were deemed to be high risk. The average client load reported was 70 plus, and although some partners/ ex-partners were reported as requiring minimal support, the Advocates were concerned that they had insufficient time to reach all of those referred or to contact these clients when needed. There was a wide variation in the level of risk and need assessed:

> *Some of them I believe really do gain confidence … some don't even know they're in a DV relationship … like I can't believe that they can be bashed around like that and keep going back.*

> *If they're working with a DV counsellor I will try and work it out where I can have 5 minutes with them and the DV counsellor will give me feedback on how the relationship is going.*

So creating an awareness of like what danger they are actually in has been big for some of them. They haven't recognised the impact of what's going on for them.

Some Advocates spoke of being "completely swamped with caseload."

One of the main barriers reported in being able to engage with the partners/ex-partners was the reliance on telephone contact and the risks associated with contacting by phone.

It's usually the only barrier ... not the only one. The barrier would probably most likely be that I can't get the people to pick up the phone. And if we don't already have their name in my system, then I don't know if it's safe to leave them a text message or not. So there is a certain percentage of women who are non-contactable, which is always, yeah, a bit disappointing. But the other thing is when we have particularly really high risk case/cases, a barrier might be that it's actually, you know, we have one at the moment that he monitors every phone call that comes in. So, the barrier is adding another worker to that list of phone calls she's allowed to receive in a week, puts her at risk, so I can't do that. But we have a workaround through another counsellor who's doing that work with her instead.

The issue of telephone resources was raised by another DFV Advocate who raised concerns about sharing an office phone with others:

Okay, some of the barriers I've had is some just don't answer their phones, and we do have a phone here that I'm using, I'm kind of feeling like I should have a phone for the program, because then no calls or anything get missed coming back into that phone, you know what I mean? Because their phone's used very well in the office, you know there's 12 people that's using that one phone, I kind of think this program deserves a phone. You know, but some of the people, and I will quote them, "What the fuck are you ringing me for?" You know, those sorts of things, but they're rare, they are rare.

Observations of the impact of the UnitingCare MBCP on partners/ ex-partners

The DFV Advocates reported that there appeared to be an overall reduction in physical violence, or the physical violence stopped altogether while the men were engaged in the program. They were concerned program attendance had not appeared to make "an awful lot of difference to the name calling, put downs and verbal stuff". Some improvements in the men's communication skills were described, and couples had developed new strategies when arguments developed. Of particular note, was the ongoing tension the DFV Advocates experienced in managing the disclosure of information by the partners/ex-partners and the implications of sharing this information for the safety of partners/ex-partners.

There's such tensions there that after I think... I've been doing this for years, it's like I don't like that tension anymore, like I haven't found a satisfying way around that tension ... yeah.

Similar to feedback from a few of the partners/ex-partners, DFV Advocates described some instances of the men turning the learning onto their partner to try and teach her, rather than "doing a lot of self-reflection for themselves". However, this was reported as less common than positive or neutral feedback. Where men had not changed after receiving their certificates, their partners/ex-partners reported that "He's using all this new language" and they were angry that his attendance appeared to be "image control" rather than genuine change.

The difference the UnitingCare MBCP made to the situation of children

Following participation in the program, the DFV Advocates thought that the partners/ex-partners no longer believed that the "kids don't hear" when there was violence in the house. Better communication was observed to develop between some ex-partners and the men on the program which had a positive effect with one being "more respectful to her daughter". Overall, there appeared to be increased awareness of the impact of DFV on the children with:

...some men being more compliant once they've gone through to Family Court, like being more agreeable to mutual consent orders or something like that when they've had already months or a big period of time of trying to fight things...

The key benefits of the UnitingCare MBCP

From the perspective of DFV Advocates, the overall benefits of the program related to changes in behaviours by way of the men being able to learn and put into practice new communication and relationship skills as a consequence of the program. The partners/ex-partners reported that in some instances the men had changed a lot and in a positive way. Importantly, the DFV Advocates reported that they were able to link partners/ ex-partners with support services, to undertake risk assessment with

them, and in some instances, to refer them to the High Risk Teams as a consequence of the program.

For quite a number of women the men's attendance in the program gave them the first opportunity of feeling sufficiently safe to be able to separate from the men. It was felt that just the fact that the women were now linked to a service or known to a service, their potential safety was increased.

Similar to the other groups involved in this evaluation, the DFV Advocates felt there needed to be follow-up with the men after completion of the program via a maintenance program, creating further opportunities for partners/ex-partners to be kept in sight. It was thought that the program was not long enough, and there was concern whether the men would be able to sustain the changes they had made.

The effectiveness of the DFV Advocate role

There was overwhelming concern about access to services for the partners/ex-partners due to waiting lists for DFV specialist services and there being no support services available in some areas. This field of social services practice was seen as intensive, highly stressful and under resourced. Some contracts were reported as requiring the DFV Advocates to maintain contact with the partners/ex-partners for 6 months after the man had completed the program. The workload was seen as:

> *… impossible and unsafe, and that's something that concerns me the most you know, like if I had more time, I could probably maybe close another 10 of those or something but I don't even have time to do that with the client work.*

> *I'd love to double the amount of funding of my utopia, it would be double the amount of because there is certainly enough work to do 4 days a week and have 2 people in the role so that you don't feel that sole responsibility of every one of those clients on your shoulders.*

It has been acknowledged that partner contact is a vital part of the design and implementation of MBCPs in Australia (ANROWS, 2020), but that these positions are "labour-intensive, under-resourced, and often a secondary priority" (ANROWS, 2020). Strong recommendations have been made that partner contact should be made available to all women (Chung, Anderson, Green, & Vlais, 2020) but as this UnitingCare study has shown in the current context of investment specifications and prioritisation, this is unachievable at present. It has been recommended that national standards need to be developed which would assist with greater clarity and understanding of the investment required to support the partners and ex-partners of DFV perpetrators more effectively and also to support their Advocates (Chung, Anderson, Green & Vlais, 2020). In the absence of such standards the accounts of the DFV Advocates raise a concern about the ongoing impact of traumatic stress in their work and the long-term toll this may take on their wellbeing.

Goodman and Epstein (2008) have described the range of diverse organisational settings where DFV Advocates may be situated and how these vary in the degree of support available to them. In other studies concern has been raised about the impact of traumatic stress and how access to regular and quality professional supervision assists with ameliorating its impact (Slattery & Goodman, 2009). Both regular clinical and administrative supervision have been recommended for frontline professionals in this type of high-risk work environment (Slattery & Goodman, 2009). Various levels of access to regular supervision have been described by the DFV Advocates in this study with some rarely having clinical or professional supervision. Increased funding would be necessary for this aspect of workplace support in this high-risk context to be strengthened in order to maintain standards of practice and worker safety.

4.6 Discussion

The value of learning from frontline practitioners in the field of gender-based violence has been well documented by Wies and Haldane (2011) in their accounts of workers who confront the intersection between government policy, community and organisational expectations on a daily basis. Managing these intersections has been explored in a range of domestic and family violence contexts that show how the attitudes and beliefs of workers affect their professional practice (Lapierre & Cote, 2011).

In the domestic violence field in Australia, research has raised the issue of the overall neglect of listening to the experience of frontline professionals in this field and also understanding the theories and perspectives that influence their decisions (Breckenridge & Hamer, 2014; Wendt, Natalier, Seymour, King & Macaitis, 2020).

In the field of men's behaviour change programs, it has recently been recognised that the experience of frontline professionals has much to offer in building on practice (Dixon & O'Connor, 2010; Morrison et al., 2017; O'Connor, 2018). This evaluation sought the views of those professionals who contribute to the delivery of the UnitingCare MBCPs in various roles in order to understand how they view their practice and the day to day challenges they faced.

Challenges in delivering the UnitingCare MBC program: funding and resources

Interviews with frontline professionals across the delivery of the UnitingCare MBCP revealed themes of shared challenges while there were specific aspects of program delivery experienced by each discrete group. A common theme of insufficient funding for the delivery of the programs to meet community demand was described across the range of occupations involved in this study. Key to the issue of funding inadequacy was the widely recognised complexity of delivering a behaviour change program in what is acknowledged as a high-risk area of practice (Juodis, Starzomski, Porter & Woodworth, 2014).

The model adopted by the UnitingCare MBCP to include brief intervention service support for partners/ex-partners through the appointment of DFV Advocates follows the Duluth model which recognises the importance of including the voices of victims/survivors in MBC programming (Gondolf, 2010). This key element in the program design was in line with the Queensland Government Domestic and Family Violence Practice Standards (Professional Practice Standards, Working with men who perpetrate domestic and family violence) which states "support and advocacy for those who experience abuse… an essential component of any work with men who perpetrate violence".

Whilst measures of MBC program effectiveness are commonly associated with reduction in violence-supportive attitudes and behaviours in a proportion of the men, the provision of some support services to partners/ex-partners demonstrated in this evaluation an important contribution to their immediate, and in some cases, to their longer-term safety. This finding is in line with Kelly and Westmarland's (2015) work and reinforces the need for MBCP measures to include outcomes for partners/ex-partners. This would suggest that investment in the DFV Advocate role and the further consolidating and expanding of this role may further contribute to the safety and wellbeing of victims/survivors and their children.

A common theme in the process evaluation findings was that an increase in funding would enable the MBCPs to be offered outside of working hours, enabling larger numbers of men to attend programs. Another persistent theme across all categories was the need for extension of the existing 16-week program (along with 3-4 individual sessions) so that the changes men achieved could be further consolidated with ongoing support and maintenance. Should funding for an extension become available it would be important to identify a program logic, theory of change, and evaluate its impact in order to contribute to development of policy and practice in the MBCP field in Australia (Day, Vlais, Chung & Green, 2019).

Fundamentally, across all the domains of the UnitingCare MBCP the evaluation participants highlighted ways in which increased investment would enhance their work, ranging from the length of the program to the provision of workforce support, and ultimately, to improving the program with increased safety and wellbeing of partners/ex-partners and their children.

Program underpinnings

There were diverse understandings expressed concerning the theoretical underpinnings of the MBCP, with one manager concerned that

there appeared to be 2 'camps' among the facilitators which broadly fell into a mental health (or individual characteristics of the men) versus a socio-historical and gender-based understanding of domestic violence perpetrated by men. It has been suggested that the tendency to view perpetration of domestic violence as having psychosocial versus criminal origins may be explained by way of the governmental source of funding for MBCPs which usually sits with Social Services rather than Courts or Corrections (Roy, Brodeur, Labarre, Bousquet & Sanhueza, 2019). However, interviews in this study found a more complex interplay between perspectives and approaches held by the facilitators that likely related to the qualifications and experience of the facilitators concerned. The majority of facilitators in this study expressed a strong commitment to continue to seek perspectives and approaches that would engage the men as well as keep them accountable, and this is acknowledged as difficult to achieve in practice.

Attitudes towards and understandings of domestic violence have been recognised as fundamentally affecting the way that practitioners respond across the DFV service system (Morrison et al., 2017; Pallatino et al., 2019; Roy, Brodeur, Labarre, Bousquet & Sanhuezam 2019). There have been increasing calls for practitioners and managers who are part of a MBCP service ecosystem to have in-depth knowledge and understanding of DFV (Morrison et al., 2017).

Workforce to support the UnitingCare MBCP

Recruitment and retention

A theme of a shortage of qualified and skilled staff in the field of MBCP facilitation was reported at all the sites involved in the evaluation, with one site unable to recruit a facilitator over the length of the data collection period. One of the flow-on impacts of this shortage was the ability of facilitators to move into preferred positions with other providers where employment benefits were perhaps seen as more generous. The lack of experience and qualifications, specifically in this field of group work, also had implications for UnitingCare to provide education, training and mentorship as the programs were being rolled out. As stated earlier, this field of human services practice is widely acknowledged as challenging in terms of achieving the balance between non-judgementalism and relationship-building, versus collusion and justification. The ongoing safety and risk factors, and the vulnerability of partners/ex-partners and their children require constant vigilance and management (Lewis, 2014; Medina-Maldonado, Median-Maldonado &Parada-Cores, 2014; Wendt, Natalier, Seymour, King & Macitis, 2020).

The role of the DFV Advocate was recognised as pivotal to the UnitingCare MBCP model in terms of ongoing accountability and the need to protect the safety and wellbeing of partners/ex-partners and their children. The Advocates described how the position required managing a delicate balance in relation to the support needs of their clients along with the accountability of the men. Complex issues of disclosure arose where the facilitators relied on triangulation between what the men were saying in the group versus what the partners/ex-partners were describing in the home. The limited resources of the DFV Advocates meant that they frequently were unable to reach out to all the partners/ex-partners and link them with support, a fundamental purpose of the MBCP design.

Where staff positions had to be filled by contract workers this raised challenges in consistency of approach, team management and increased costs. An ongoing theme emerged of the lack of education and training available in this field of practice, apart from some exceptions (a number of Graduate Certificate programs in Men's Behaviour Change are now available in Australia).

Management and supervision of staff

Various models of supervision were reported, ranging from professional supervision, to dyadic, group, team and individual line supervision. Ongoing client management meetings concerning safety and other issues appeared to occur on a daily basis in some instances. There appeared to be a high variability in relation to access to professional supervision versus line or management supervision, and to whether professional supervision was privately paid for or supported by UnitingCare. The distinction between clinical or professional supervision and line supervision is the opportunity for staff to access specialist and experienced practitioners with whom they can reflect on their practice and their decision-making in order to maintain their quality of practice and their own strength and wellbeing (Dixon & O'Connor, 2010). The majority of facilitators interviewed were counselling or social work trained, both professions having a longstanding history of professional supervision (Borders et al., 2014). There is ongoing research into professional supervision standards, and in this field of practice, as with management supervision, it would be important that all forms

of supervision are DFV-informed (Conley, 2012; Schmidt, 2012).

Skills and knowledge of the MBCP team

Particular skills and abilities in group work are required for working in MBCPs. It is widely recognised that a suite of intervention approaches is necessary in order to engage the men, thereby demanding a breadth of experience and knowledge in employing various knowledges and materials. Facilitation skills also require the ability to engage reluctant and frequently hostile clients, respond to denial, minimisation and blame of the victims, establish a therapeutic relationship in supporting change, and address toxic masculinity and gender-based attitudes. The facilitators in this study described a range of approaches they employed based on a mix of educational and therapeutic traditions, and the considerable satisfaction and achievement they experienced when they found material that connected well with the men in the programs. It has been proposed that the intervention mix needs to include:

> *… a variety of approaches and practical alternatives to the Duluth model (Pence & Paymar, 1993), such as: Solution-Focused Treatment; the Motivational Interview; Narrative Therapy; Strengths Focused Cognitive Behavioral Therapy (CBT); the Therapy Broaden-and Build Theory of Positive Emotions and the Good Lives Model (Carbajosa, Boira, Tomas-Aragones, 2012; Willis & Ward, 2013).*

Some facilitators recommended increasing the number of individual sessions that the men could access throughout the course of the program. This does have implications for increased funding, but recent research supports this approach based on improvements in men's attendance and reduction in violence supportive attitudes and behaviour (Lia, Gracia & Catala-Minana, 2018).

Fundamental to the MBCPs is the need to address men's gender-based attitudes which the facilitators described as directly associated with the men's ability to work with the group. Studies have found association between denial and minimisation of violence and higher rates of drop out from MBCPs (Catlett, Toews & Walilko, 2010). The UnitingCare facilitators also reported the difficulty of engaging some men and some men's ability to disrupt the group with such behaviours requiring skilled intervention to ensure that other group members are not impacted. This type of disruption has been found to interfere with the effectiveness of the program (Morrison et al., 2019a), and particular training is required to support some facilitators in confronting this type of lack of engagement.

Findings from studies of MBCPs that have been based on practitioner feedback have found that practitioners have focussed on 3 main aspects that underpin MBCP group work and these are:

- the optimal structure and size of the group and the length of the program;
- the characteristics of facilitators with a strong recommendation for co-facilitation; and
- the program approaches and their need to challenge the men at the same time as maintaining safety and engagement and being flexible to adapt to particular needs of clients (Morrison, et al., 2017).

Particular skill sets were identified as necessary for the DFV Advocates, and where the Advocates had been recruited from specialist DFV services they already had well established experience of risk assessment and safety planning. This position requires an advanced understanding of DFV and coercion and control and how these play out in the context of MBCPs. The desire for the MBCPs to have some effect and the need for facilitators to form therapeutic relationships with the men in order to effect change must always be balanced against what is happening for the partners/ex-partners and their children (Clarke & Wydall, 2013). This potential conflict of interest appeared to be managed in the MBCP contracting model by having separate providers arrange for the DFV Advocates. This was not always achieved in relation to the UnitingCare MBCPs, in which case UnitingCare managers spoke of arranging separate lines of internal management. The lack of partnership between DFV programs for women and those for men has been lamented in the literature (Pallatino et al., 2019). At the coalface this can lead to a lack of trust, and as evidenced in this study, to challenges with information sharing.

Co-facilitation and co-gendered facilitation

Co-gendered facilitation is recommended in various Australian state practice standards (see for example Queensland Practice Standards above) and this mode of group facilitation has been recommended as best practice elsewhere (Boston, 2010; Denne, Coombes & Morgan, 2013; Dixon & O'Connor, 2010). The facilitators generally spoke highly of their colleagues and co-facilitators; however, there were some who described negative experiences, particularly in co-gendered situations. There has been relatively little investigation of

co-facilitation in this context. An Australian study, of particular relevance, recommended an accreditation process for this particular role and the need to consider the impact of the behaviour of the men in the group where the female facilitator is targeted, as well as the impact of the relationship between the female facilitator and their male co-facilitator (Apps & Gregory, 2011).

In this study of the UnitingCare MBCPs, generally feedback was positive, but clearly negative experiences had long lasting impacts on both male and female facilitators. The Apps and Gregory study (2011) proposed the concept of a gender accountability process with specific training offered by training and service providers for managing power and gender issues. One male facilitator spoke of wanting his female co-worker to have the skills to "cut through the misogyny". This implies a degree of awareness of how misogyny plays out in the MBCP group process and illustrates the value of advanced training and skills development in this aspect of the program delivery. The same study recommended that state practice standards and guidelines needed to incorporate how to practice co-gendered facilitation. Other studies have provided evidence of the value of co-gendered facilitation in role modelling gender equity and addressing attitudes towards women (Mitchell & Chapman, 2014; Morisson et al., 2019; Price & Rosenbaum, 2009; Roy, Lindsay & Dallaire, 2013). Above all, the safety issue for women working in this space requires ongoing vigilance and monitoring (Cayouette, 2012).

There is little training and education available in group work skills, except for some provided as part of a small number of degree programs, and even these are unlikely to include the particular high-level skills required in MBCPs. In the absence of availability of this type of training, particularly the need to address accountability and gender-based attitudes of the men, it rests on organisations to provide this training. This in turn has implications for funding and capacity.

Information sharing

The issue of information sharing was threaded throughout the findings. The stakeholders related to the UnitingCare MBCP expressed a desire for greater information sharing, particularly Probation and Parole. The Queensland Government has introduced legislation and guidelines on the parameters of information sharing in the context of DFV and the DCSYW has rolled out training at those sites that have been selected as Integrated Response exemplars across the state (www.csyw.qld.gov.au/resources/campaign/end-violence/info-sharing-guidelines.pdf).

It was clear from this study that the DFV service systems, within which the UnitingCare MBCPs are situated, had varying degrees of cooperation and information sharing. Where the MBCP was situated in one of the DCSYW funded Integrated Response sites it appeared to be more likely that there were higher levels of cooperation and well-established protocols for information sharing. O'Leary, Young, Wilde & Tsantefski (2018) in a study of the Integrated Response model in Queensland found that even in these circumstances, tensions remain related to the different mandates of services and different understandings of DFV. International research has shown that information sharing remains a key operational challenge for MBCPs (Morrison et al., 2019b). Questions were raised in this study as to whether concerns about partner safety that arose out of the MBCP were being acted on and whether this information was being relayed to the DFV Advocates. Concerns were raised around the flow of information about partners/ex-partners from the DFV Advocates to the facilitators; this is information that enables facilitators to incorporate specific psycho-educative material in the program. Information sharing requires a high level of trust between organisations and individuals, and it would appear training, education and the development of agreed protocols is urgently needed in some locations.

Barriers and facilitators related to men's completion of the program

The majority of feedback in this study revealed a common view that completion rates of the MBCP were primarily impacted by the personal situations of the men, and these ranged from having to relocate for employment purposes, losing access to transport, changing employment conditions, substance dependency issues and other personal factors such as homelessness. Stage Two of this evaluation has not explored the reasons as to why men may leave the program; although, there has been some feedback from the practitioners as to why this was the case. Other research has identified particular characteristics of men who use violence in relation to program completion; these include the level of social support, alcohol use, seriousness of the violence and anger control (Murillo, Germes, Cataia & Conchell, 2014).

It is interesting to note that the facilitators recommended increasing the men's access to individual counselling and other services during the time of attending the MBCP in order

to support the men with any personal issues that arose. There is recent evidence suggesting that men attending MBCPs who access fewer other human services were more likely to complete the program, which may suggest that those who access additional services may have issues that would inevitably interfere with their completion of the program (Morrison et al., 2019c). However, facilitators are in a key position to assess the needs of their clients, and as such, targeted referral and additional counselling may be worth investigating should funds allow.

Diversity and cultural appropriateness

There were divergent views expressed about the appropriateness of the UnitingCare MBCP in its current form for Aboriginal and Torres Strait Islander people. A prevailing view was that in order to develop a suitable program, consultation and involvement by community elders in the specific locations of the programs would need to be undertaken. It was thought that much of the material may be relevant in relation to accountability of men and support for victims, but that the way the program is delivered would need to incorporate specific Indigenous cultural expertise and knowledge.

Olsen and Lovett's (2016) report goes further than this in that their recommendation is that Aboriginal and Torres Strait Islander people should have the ability and resources to conceptualise, design and implement a men's behaviour change program using their own traditional knowledge and healing approaches. Other recent work with Aboriginal men who facilitate MBCPs has revealed some programs have been developed by and for Indigenous men in Australia and utilise the impact of intergenerational trauma for both the perpetrator and victim, while at the same time upholding the right of women to live free from violence (Andrews, et al., 2018). Despite the lack of a specific Aboriginal and Torres Strait Islander program at any of the UnitingCare sites, Aboriginal and Torres Strait Islander men are referred regularly to some of the existing programs. It was not within the scope of this evaluation to explore the response of Aboriginal and Torres Strait Islander men specifically to the UnitingCare MBCP, but the facilitators themselves referred to the fact that they were not sure how the program was received.

Similar views were expressed concerning the cultural appropriateness of the UnitingCare MBCP for CALD populations. An additional issue that influenced the feedback in regard to CALD communities was the reliance of the program on familiarity with English language and the difficulty of sourcing interpreters who are already stretched. Differences were noted with some CALD populations that were proficient in English, such as Aotearoa/New Zealand Māori men who appeared to respond well to the program in some locations. Examples of tailored MBCPs for culturally diverse populations have been reported in the literature with some evidence of behaviour change where the programs were culturally specific, were delivered in a bi-lingual format, and incorporated positive aspects of the particular culture concerned (Emezue, Williams & Bloom, 2019). Other work has highlighted the need for culturally competent services for migrant survivors and specific understanding of their lives and help-seeking barriers (Rana, 2012).

In regard to LGBTIQ populations it was felt that the UnitingCare MBCP format was inappropriate, and concerns were held for the safety of men in the context of heterosexual groups. It was also seen as difficult and inappropriate to require a man to identify his sexual identity given continuing adverse community attitudes towards LBTIQ populations. This is a neglected area of service provision and further investigation is warranted as to the need for a specific program and how this might be implemented. The reoccurring theme of lack of funding was raised in relation to the ability to develop specialist responses to DFV perpetration.

5 CONCLUSION

5.1 Bringing together key findings from early outcomes and process evaluation

Men's Behaviour Change Program

In addition to the overarching goal of accountability for this form of gender-based violence (Pallatino et al., 2019) and in order to maintain currency and to build on best practice research, it is important that the UnitingCare MBCP teams continue to undertake ongoing review of purpose and program design. This includes reviewing the curriculum and manual, and constantly building on what has shown to work well in engaging the men and their partners/ex-partners. The service/program manual was being reviewed at the time of data collection, and UnitingCare has continued further review in early 2020. Research in this field is growing at a pace and new approaches to practice are constantly emerging. Among approaches that may be worthy of further developing are:

- relevant aspects of neuroscience, particularly in relation to the impact of trauma (Karakurt, Koc, Cetinsaya Ayluctarhan & Bolen, 2019; Schauss, Zettler & Russell, 2019; Wagner, Jones, Tsaroucha & Cumbers, 2019);
- a range of therapeutic approaches, for example, Acceptance and Commitment therapy (Zarling, Bannon & Berta, 2019), the use of Cognitive Behavioural Therapy (CBT) and Solution-focussed Therapy (SFT) (Bowen, Walker & Holdsworth, 2019) and narrative methods (Wendt, Buchanan, Dolman, & Moss, 2020);
- parenting/fathering skills (Humphrey, Diemer, Bornenisza, Soiteri-Satines, Kaspiew & Horsfall, 2019).

The relationship between the programs and their surrounding community was a common theme, particularly regarding diversity and interacting with and enabling greater interaction between program staff and their local communities. Program design optimally needs to include time and resources to build and maintain the community embeddedness of the MBCPs, and particularly how they relate to the DFV specialist services and family support services in each locale.

Impact of the program

There is sufficient combined evidence from this study to demonstrate the value and importance of the UnitingCare MBCP. Throughout the data collection, practitioners were at pains to point out how much more effective they felt they could be should they have access to greater resourcing, especially in the case of partners/ex-partners and their children. This response was supported by the partner/ex-partner data where it was clear that not all of them were

contacted by a DFV Advocate. Their feedback also highlighted the complexity related to partner/ex-partner support as to whether this is provided by an independent specialist DFV organisation or by UnitingCare. Issues related to the trust of partners/ex-partners as to whose interests are being served require careful consideration and efforts to build partner/ex-partner confidence in practice decisions. Just the fact that the program kept the men 'in sight' led to many of the partners/ex-partners reporting greater feelings of safety. Where partners/ex-partners had access to support from the DFV Advocate or another victim/survivor support service during the length of the program they reported having the courage to finally separate from the abusive relationship, and in some cases after experiencing the abuse for many years.

Others spoke of the new skills their partners learned, particularly communication skills; although, this was tempered by these same skills being used by some of the men to hone coercion and control tactics.

There was great willingness and desire for continuous improvement of the program, and efforts to support frontline practice and program delivery were ongoing throughout this evaluation. UnitingCare is to be commended overall for its commitment to MBCP enhancement and to creating an organisational culture of learning, adaptability and growth.

Resources for the program

There was a unified call for the existing core 16-week program to be lengthened, for greater resources to be available for individual counselling to run alongside the men's participation, and for more time for planning and development. Much greater resources for support services for partners/ex-partners and their children were called for. It must be noted here that the Maroochydore site has developed an innovative and joined-up approach to support services for partners/ex-partners and their children to run alongside the UnitingCare MBCP at the Maroochydore site. This model is worthy of further investigation to establish the difference that this may make to women and children's safety and to men's behaviour change. This wraparound concept of service provision stands to address some of the barriers to program completion reported in this study, particularly wider socio-ecological factors that impinge on men's program attendance.

A common theme was the need for follow-up support through a variety of means, such as a maintenance program or ongoing telephone contact with facilitators, perhaps with online support combined with continuing group check-ins. Here again, UnitingCare has developed the basis for an ongoing maintenance program (Men Sustaining Change), and in terms of continuous improvement, this initiative urgently justifies trialling at one or 2 sites to establish potential impact. A major theme from the partners/ex-partners was that where positive change had occurred with the men after program completion, they needed to continue this journey with further work such as additional programs and counselling. Some of the women spoke passionately of the need for further programming in terms of their ongoing safety and support and holding the men accountable.

The importance of services for partners/ex-partners and their families has been demonstrated by this study, and these need urgent investment to ensure that all families of clients may be contacted and offered support. The DFV Advocates situated in larger communities uniformly reported lack of time and resources to contact and offer support to all partners/ex-partners. Whilst efforts were made to contact those families deemed to be at high risk, this is a complex phenomenon where homicides have occurred in seemingly low risk situations. The results of this evaluation are similar to Project Mirabal in the UK (Kelly & Westmarland, 2015), which illustrated the value of having the perpetrator 'in view' enabling the partner/ex-partner and her children to access vital safety and support.

The longer-term recovery of partners/ex-partners and their children also requires consideration. There were examples of the DFV Advocates referring women to counsellors at UnitingCare and referring to support services which was appreciated. In 2018, the DCSYW started funding a new service to support women's long-term recovery from gender-based violence—the Women's Health and Wellbeing Support Services (WHWSS). The WHWSS focuses post-crisis and aims to address practical and therapeutic needs of women and supports/referrals for their children. This new service investment was in recognition that most DFV services only have the resources to focus on crisis work. The WHWSS are guided by trauma-informed practice and an understanding of how DFV violence impacts women and children. The UnitingCare DFV Advocates may already be referring women to these services at locations where they are available. We suggest UnitingCare, in consultation with DFV Advocates and local WHWSS, consider building referral

pathways to connect partners/ex-partners with this kind of specialist service.

Workforce capacity

Similar to other studies cited elsewhere, this research has highlighted the need for a skilled and well qualified workforce in what is acknowledged as a challenging and complex field of practice. Basic knowledge of DFV was seen as essential for all the parts of the DFV service system in each locality, including for administrators and managers in support organisations. At the one site involved with the evaluation which was a trial site for developing integrated responses to DFV by the DCSYW, a common understanding and knowledge of DFV, relevant information sharing legislation and risk management appeared to strengthen cooperation and collaboration between response services. The need to continue investment in education and training at this site was described as necessary to ensure that all new staff in the service system became similarly informed. Extending this investment across Queensland would enhance DFV service responses and help to reduce inconsistencies in knowledge and practice.

In relation to men's behaviour change skills and practice there are few training courses available across Australia. Queensland has one course available through CQUniversity at Graduate Certificate level while another has been provided for some time in Victoria. Much greater investment and resourcing is required for facilitator training, and in this field specifically, the skills of co-gendered facilitation. This type of facilitation supports vital modelling of gender equity and mutual power sharing in relationships.

Responding to gender and intersectionality

Gender

Fundamental to the UnitingCare MBCP model is adherence to the Duluth model combined with other attitudinal and behaviour change approaches as outlined in this report. The strength of the Duluth model is its integration within the wider DFV service system, recognising the need to change community attitudes towards violence against women and interconnection with the wider community (Gondolf, 2010; Pender, 2012). The feedback from stakeholders and practitioners, particularly those involved in Queensland Government supported integrated responses, illustrated the value in investing in educating and training for a community response system. In addition to a common knowledge and understanding of the mechanics of DFV risk decision-making, the integrated response site appeared to also create a high level of agree of accord as to the origins of gender-based violence and how to respond.

Indigeneity and diversity

Community responsiveness to Aboriginal and Torres Strait Islander populations is intrinsically related to integrated responses to DFV, education and training, funding and capacity, and the need for programs to be designed and implemented to be culturally relevant. It was widely acknowledged that MBCPs developed in Queensland and designed on a model emanating from the US were not necessarily tailored to Aboriginal and Torres Strait Islander people's cultural needs. Even though some UnitingCare MBCP sites reported that Indigenous men attended the programs there was doubt as to program appropriateness and effectiveness for these men, and assessing this was beyond the scope of this evaluation.

Where Aboriginal and Torres Strait Islander men have been raised in European environments this raises questions concerning their access to their culture, their clan origins and the role of colonisation. The need to contextualise understandings of Indigenous family violence (Cripps & Adams, 2014) for the development of innovative response models (Blagg et al., 2018) and incorporation of traditional spirituality in approaches (Puchala, Paul, Kennedy & Mehl-Cardrona, 2010) have been called for. However, it has been widely acknowledged that there is a dearth of research and development of Indigenous responses to DFV in Australia. Significant funding and investment are priorities for the development of programs to be responsive to Indigeneity, and until such time as this, programs such as the UnitingCare MBCP do the best they can to cater to the needs of Aboriginal and Torres Strait Islander clients.

The question of cultural appropriateness of current MBCP designs for CALD populations was also raised in this study. The UnitingCare programs accepted CALD men and their partners/ex-partners at some sites, but this appeared dependent on English language proficiency. This raises the question of tailoring the content of programs so that they are culturally relevant, along with providing access to interpreters. This has implications for the ability to train and employ specifically qualified staff and the funding required in order to provide for the diverse ethnicities in migrant populations in Australia.

Similar fundamental constraints were identified in provision for LGBTIQ populations with the

difference that since much of the UnitingCare MBC program material is predicated on heterosexual populations the issue of responsivity is a critical one. There was overwhelming recognition that men from same sex relationships were likely to feel unsafe, particularly in relation to the attitudes of other men in the group. While it was thought the material concerning coercion and control was applicable across LGBTIQ relationships, specific cultural differences would need to be catered for and separate programs made available. This finding from this research accords with the recent release of the ANROWS report "Developing LGBTIQ programs for perpetrators and victims/survivors of domestic and family violence" (May, 2020). Only 3 perpetrators were interviewed for this project, and its findings therefore need to be appreciated in this light. In line with the conclusions above, much greater investment and evaluation has been called for in order to develop appropriate programs for this population.

In conclusion, this study has added to the evidence base for MBCP development in Queensland and elsewhere and has demonstrated the value of partnership between universities and the NFP sector in contributing to knowledge to assist with further policy and program development. Building on the findings from this study, UnitingCare has committed to further longitudinal evaluation of its MBCPs, and to this end Stage Three of this evaluation is currently underway and due to complete in early 2021.

References

Australia's National Research Organisation for Women's Safety. (2020). *Prioritising women's safety in Australian perpetrator interventions: Mapping the purpose and practices of partner contact* (Research to policy and practice, 08/2020). Sydney: ANROWS.

Australia's National Research Organisation for Women's Safety. (2020). *Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence* (Research to policy and practice, 10/2020). Sydney: ANROWS.

Australian Institute of Health and Welfare 2018. *Family, domestic and sexual violence in Australia 2018*. Cat. no. FDV 2. Canberra: AIHW.

Anderson, K. L., & Umberson, D. (2001). Gendering violence: Masculinity and power in men's accounts of domestic violence. Gender & society, 15(3), 358-380.Andrews, S., Gallant, D., Humphreys, C., Ellis, D., Bamblett, A., Briggs, R., & Harrison, W. (2018). Holistic program developments and responses to Aboriginal men who use violence against women. *International Social Work*, 0020872818807272.

Apps, J., & Gregory, R. (2011). You're only there cos you're a woman': A study of the experiences of women who co-facilitate men's behaviour change group programs. *Women Against Violence: An Australian Feminist Journal*, (23), 29.

Backhouse, C. O. R. I. N. A., & Toivonen, C. H. E. R. I. E. (2018). National Risk Assessment Principles for domestic and family violence: Companion resource. *A summary of the evidence-base supporting the development and implementation of the National Risk Assessment Principles for domestic and family violence (ANROWS Insights 09/2018). Sydney, NSW: ANROWS*

Bamberger, M. (2015). Innovations in the use of mixed methods in real-world evaluation. *Journal of Development Effectiveness*, 7(3), 317-326.

Barclay, E.M. (2016). *Domestic Violence Intervention Program Facilitators' Motivation for Working With Repeat Offenders*. Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy Human Services, Walden University.

Bates, E. A., Graham-Kevan, N., Bolam, L. T., & Thornton, A. J. (2017). *A review of domestic violence perpetrator programs in the United Kingdom*. Partner Abuse, 8(1), 3-46.

Beddoe, L. (2012). External supervision in social work: Power, space, risk, and the search for safety. *Australian Social Work*, 65(2), 197-213.

Boston, Dorothy Lynne, *Gendered Perceptions of Batterer Intervention Co-Facilitation* (2010). Theses, Dissertations and Capstones. Paper 506.

Bowen, E., Walker, K., & Holdsworth, E. (2019). Applying a strengths-based psychoeducational model of rehabilitation to the treatment of intimate partner violence: program theory and logic model. *International journal of offender therapy and comparative criminology*, 63(3), 500-517.

Borders, L. D., Glosoff, H. L., Welfare, L. E., Hays, D. G., DeKruyf, L., Fernando, D. M., & Page, B. (2014). Best practices in clinical supervision: Evolution of a counselling specialty. *The Clinical Supervisor*, 33(1), 26-44.

Breckenridge, J., & Hamer, J. (2014). *Traversing the Maze of 'evidence' and 'best Practice' in Domestic and Family Violence Service Provision in Australia*. Australian Domestic & Family Violence Clearinghouse.

Brown, T., Flynn, C., Arias, P. F., & Clavijo, C. (2016). *A study of the impact on men & their partners in the short term & in the long term of attending men's behaviour change programs*. Violence Free Families.

Carbajosa, P., Boira, S., & Tomás-Aragonés, L. (2013). Difficulties, skills and therapy strategies in interventions with court-ordered batterers in Spain. *Aggression and Violent Behavior*, 18(1), 118-124.

Catlett, B. S., Toews, M. L., & Walilko, V. (2010). Men's gendered constructions of intimate partner violence as predictors of court-mandated batterer treatment drop out. *American Journal of Community Psychology*, 45(1-2), 107-123.

Cayouette, S. (2012). Safety issues for women co-facilitating groups for violent men. *In Working with men for change* (pp. 165-178). Routledge.

Chung, D., Anderson, S., Green, D., & Vlais, R. (2020). *Prioritising women's safety in Australian perpetrator interventions: The purpose and practices of partner contact* (Research report, 08/2020). Sydney: ANROWS.

Clarke, A., & Wydall, S. (2013). 'Making Safe': a coordinated community response to empowering victims and tackling perpetrators of domestic violence. *Social Policy and Society*, 12(3), 393-406.

Conley, Heather D. (2012). *Supervision and Training Needs of Practitioners Working in Batterer Intervention Programs*. Retrieved from Sophia, the St. Catherine University repository website: sophia.stkate.edu/msw_papers/15

Cripps, K., & Adams, M. (2014). *Indigenous family violence: Pathways forward*. Chapter 23, Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice Publisher: Department of Prime Minister and Cabinet: Canberra

Day, A. (2019) *Men's behaviour change programs: Measuring outcomes and improving program quality: Key findings and future directions* (Research to policy and practice, 01/2019). Australia's National Research Organisation for Women's Safety. Sydney, NSW: ANROWS.

Day, A., Chung, D., O'Leary, P., & Carson, E. (2009). Programs for men who perpetrate domestic violence: An examination of the issues underlying the effectiveness of intervention programs. *Journal of Family Violence*, 24(3), 203-212.

Day, A., Vlais, R., Chung, D., & Green, D. J. (2019). *Evaluation readiness, program quality and outcomes in men's behaviour change programs* (Research report, 01/2019). Sydney, NSW: ANROWS.

Denne, S., Coombes, L., & Morgan, M. (2013). *Evaluating the effectiveness of programs and services provided by Te Manawa Services: a community intervention into family violence.*

Dixon, G., & O'Connor, K. (2010). *Facilitating domestic violence programs: Listening to voices from the field.* Wellington, New Zealand: *Relationship Services Whakawhanaungatanga.*

Dixon, L., & Graham-Kevan, N. (2011). Understanding the nature and etiology of intimate partner violence and implications for practice and policy. *Clinical psychology review*, 31(7), 1145-1155.

Emezue, C. N., Williams, O. J., & Bloom, T. L. (2019). Culturally-Differentiated Batterer Intervention Programs for Immigrant Male Batterers (IMB): An Integrative Review. *Journal of Aggression, Maltreatment & Trauma*, 1-24.

Finsterwalder, J.,Foote, J., Nicholas, G., Taylor, A., Hepi, M., Baker, V., & Dayal, N. (2017). Conceptual underpinnings for transformative research in a service ecosystems context to resolve social issues – framework foundations and extensions. *The Service Industries Journal*, 37(11-12), 766-782. doi:10.1080/02642069.2017.1351550

Gondolf, E. W. (2010). The contributions of Ellen Pence to batterer programming. *Violence against women*, 16(9), 992-1006.

Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health and justice*. Washington, DC: American Psychological Association.

Goodman, L. A., Cattaneo, L. B., Thomas, K., Woulfe, J., Chong, S. K., & Smyth, K. F. (2015). Advancing domestic violence program evaluation: Development and validation of the Measure of Victim Empowerment Related to Safety (MOVERS). *Psychology of Violence*, 5(4), 355.

Gottman, J. M. (2008). Gottman method couple therapy. *Clinical handbook of couple therapy*, 4(8), 138-164.

Gray, W. (2001). Clinical governance: combining clinical and management supervision. *Nursing Management (through 2013)*, 8(6), 14.

Gray, R., Walker, T., Hamer, J., Broady, T., Kean, J., Ling, J., & Bear, B. (2020). *Developing LGBTIQW programs for perpetrators and victims/survivors of domestic and family violence, Research Report 10*, Australia's National Research Organisation for Women's Safety (ANROWS). Sydney, Australia.

Humphreys, C., Diemer, K., Bornemisza, A., Spiteri-Staines, A., Kaspiew, R., & Horsfall, B. (2019). *More present than absent: Men who use domestic violence and their fathering. Child & Family Social Work*, 24(2), 321-329.

Jenkins, A. (1990). *Invitations to responsibility.* Adelaide, South Australia: Dulwich Centre Publications.

Gondolf, E. W. (2010). The contributions of Ellen Pence to batterer programming. *Violence against women*, 16(9), 992-1006.

Greenhalgh, T., Jackson, C., Shaw, S., & Janamian, T. (2016). Achieving research impact through co-creation in community-based health services: literature review and case study. *The Milbank Quarterly*, 94(2), 392-429.

Huecker MR, Smock W. *Domestic Violence. In: StatPearls*. StatPearls Publishing, Treasure Island (FL); 2019.

Juodis, M., Starzomski, A., Porter, S., Woodworth, M. (2014). What can be done about high-risk perpetrators of domestic violence? *Journal of Family Violence*, 29, 381-390.

Karakurt, G., Koç, E., Çetinsaya, E. E., Ayluçtarhan, Z., & Bolen, S. (2019). Meta-analysis and systematic review for the treatment of perpetrators of intimate partner violence. *Neuroscience & Biobehavioral Reviews*.

Kelly, L., & Westmarland, N. (2015). Domestic violence perpetrator programs: Steps towards change. *Project Mirabal final report*.

Koleth, M., Serova, N., & Trojanowska, B. K. (2020). *Prevention and safer pathways to services for migrant and refugee communities: Ten research insights from the Culturally and Linguistically Diverse Projects with Action Research* (CALD PAR) initiative (ANROWS Insights, 01/2020). Sydney, NSW: ANROWS.

Labarre, M., Brodeur, N., Roy, V., & Bousquet, M. A. (2019). Practitioners' views on IPV and its solutions: An integrative literature review. *Trauma, Violence, & Abuse*, 20(5), 679-692.

Lamothe, M., & Lamothe, S. (2010). Competing for what? Linking competition to performance in social service contracting. *The American Review of Public Administration*, 40(3), 326-350.

Lapierre, S., & Côté, I. (2011). "I made her realise that I could be there for her, that I could support her": Child Protection Practices with Women in Domestic Violence Cases. *Child Care in Practice*, 17(4), 311-325.

Lewis, S. (2014). Responding to domestic abuse: multi-agented systems, probation programs and emergent outcomes. *Applying complexity theory: Whole systems approaches to criminal justice and social work*, 47181, 220-245.

Lila, M., Gracia, E., & Catalá-Miñana, A. (2018). Individualized motivational plans in batterer intervention programs: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 86(4), 309.

Mackay, E., Gibson, A., Lam, H., & Beecham, D. (2015) *Perpetrator Interventions in Australia: Part One-Literature Review State of Knowledge Paper*, Australia's National Research Organisation for Women's Safety: Sydney, Australia.

Martín-Fernández, M., Gracia, E., & Lila, M. (2018). Assessing victim-blaming attitudes in cases of intimate partner violence against women: Development and validation of the VB-IPVAW scale. *Psychosocial Intervention*.

McGinn, T., McColgan, M., Daly, M., & Taylor, B. (2019). Participants' views about the survivor contact element of IPV perpetrator programs: a preliminary study. *Violence and victims*, 34(6), 889-909.

Martin-Fernandez, M., Gracia, E., Lila, M. (2018). Assessing victim-blaming attitudes in cases of intimate partner violence against women: Development and validation of the VB-IPVAW Sale. *Psychosocial Intervention*, 27(3), 133-143.

Medina-Maldonado, V. E., Medina-Maldonado, R., & Parada-Cores, G. (2014). A complexity-based approach to batterer intervention programs. *Revista de salud publica*, 16(3), 470-479.

Mitchell & Chapman (2014). *Men at Work*, Men's views of a stopping violence service, Nelson, New Zealand.

Morran, D. (2008). *Firing up and burning out: The personal and professional impact of working in domestic violence offender programs.* Probation Journal, 55(2), 139-152.

Morrison, P. K., Cluss, P. A., Miller, E. P., Fleming, R., Hawker, L., Bicehouse, T., George, D., Wright, K., & Chang, J. C. (2017). Elements needed for quality batterer intervention programs: Perspectives of professionals who deal with intimate partner violence. *Journal of family violence*, 32(5), 481-491.

Morrison, P. K., Cluss, P. A., Miller, E. P., Fleming, R., Hawker, L., Bicehouse, T., George, D., Wright, K., & Chang, J. C. (2019a). Male IPV Perpetrators' Perspectives on Facilitation of Batterer Intervention Program: Results From a 2-Year Study. *Partner Abuse*, 10(4), 483-506.

Morrison, P. K., Hawker, L., Miller, E. P., Cluss, P. A., George, D., Fleming, R., ... & Chang, J. C. (2019b). The operational challenges for batterer intervention programs: Results from a 2-year study. *Journal of interpersonal violence*, 34(13), 2674-2696.

Morrison, P. K., Jones, K., Miller, E., Cluss, P. A., George, D., Fleming, R., Hawker, L., Bicehouse, T. & Chang, J. C. (2019c). Human services utilization among male IPV perpetrators: relationship to timing and completion of batterer intervention programs. *Violence and victims*, 34(4), 635-660.

Murillo, M. L., Germes, A. O., CatalÃ, A., & Conchell, R. (2014). Recidivism risk reduction assessment in batterer intervention programs: A key indicator for program efficacy evaluation. *Psychosocial intervention*, 23(3), 217-223.

O'Leary, P., Young, A., Wilde, T., & Tsantefski, M. (2018). Interagency working in child protection and domestic violence. *Australian social work*, 71(2), 175-188.

Olsen, A., & Lovett, R. (2016). Existing knowledge, practices and responses to violence against women in Australian Indigenous communities: Key findings and future directions. *Compass* Issue No. 1. Sydney: ANROWS. Retrieved 14/4/17 from media.aomx.com/anrows.org.au/C1_3.2%20AIATSIS%20Compass.pdf

Pallatino, C., Morrison, P., Miller, E., Burke, J., Cluss, P., Fleming, R., Hawker, L., George, D., Bicehouse, T., & Chang, J. (2019). The role of accountability in batterers intervention programs and community response to intimate partner violence. *Journal of Family Violence*, 34(7), 631-643.

Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York, NY: Springer Publishing Company.

Pender, R. L. (2012). ASGW best practice guidelines: An evaluation of the Duluth model. *The Journal for Specialists in Group Work*, 37(3), 218-231.

Price, B.J., & Rosenbaum, A. (2009). Batterer intervention programs: A report from the field. *Violence and Victims*, 24(6), 757-770.

Queensland Government, *Professional Practice Standards, Working with men who perpetrate domestic and family violence*, www.publications.qld.gov.au/dataset/153992d0-4624-429a-9cda-978a40a233d1/resource/8e4ac12b-e578-4abc-9e42-2cbdf7fda989/fs_download/professional-practice-standards.pdf

Puchala, C., Paul, S., Kennedy, C., & Mehl-Madrona, L. (2010). Using traditional spirituality to reduce domestic violence within aboriginal communities. *The Journal of Alternative and Complementary Medicine*, 16(1), 89-96.

Rana, S. (2012). Addressing domestic violence in immigrant communities: Critical issues for culturally competent services. *National Resource Center on Domestic Violence*.

Reimer, E. C. (2020). *Growing to be a better person: Exploring the client-worker relationship in men's behaviour change program* (Research report, 15/2020). Sydney: ANROWS.

Romero-Martínez, Á., Lila, M., Martínez, M., Pedrón-Rico, V., & Moya-Albiol, L. (2016). Improvements in empathy and cognitive flexibility after court-mandated intervention program in intimate partner violence perpetrators: The role of alcohol abuse. *International journal of environmental research and public health*, 13(4), 394.

Roy, V., Brodeur, N., Labarre, M., Bousquet, M., & Sanhueza, T. (2019). How do practitioners and program managers working with male perpetrators, view IPV? A Quebec Study. *Journal of Family Violence* (online 29 November 2019).

Roy, V., Lindsay, J., & Dallaire, L. F. (2013). Mixed-gender co-facilitation in therapeutic groups for men who have perpetrated intimate partner violence: group members' perspectives. *The Journal for Specialists in Group Work*, 38(1), 3-29.

Santirso, F. A., Martín-Fernández, M., Lila, M., Gracia, E., & Terreros, E. (2018). Validation of the Working Alliance Inventory–Observer Short Version with male intimate partner violence offenders. *International journal of clinical and health psychology*, 18(2), 152-161.

Schauss, E., Zettler, H. R., & Russell, A. (2019). Examining ACTV: an argument for implementing neuroscience-based and trauma-informed treatment models in offender treatment programs. *Aggression and violent behavior*, 46, 1-7.

Schmidt, D. (2012). Essential elements and standards for batterer intervention programs. *Topeka: Kansas Attorney General*.

Spreng, R. N., McKinnon, M. C., Mar, A., M. & Levine, B. (2009). Scale development and initial validation of a factor-analytic solution to multiple empath measures. *J Personality Assessment*, 91(1): 62-71.

Velonis, A. J., Cheff, R., Finn, D., Davloor, W., & O'Campo, P. (2016). Searching for the mechanisms of change: a protocol for a realist review of batterer treatment programs. *BMJ open*, 6(4), e010173.

Vlais, R. and Campbell, E., (2019) *Bringing pathways towards accountability together – Perpetrator journeys and system roles and responsibilities*, RMIT University, Melbourne.

Wagner, J., Jones, S., Tsaroucha, A., & Cumbers, H. (2019). Intergenerational transmission of domestic violence: practitioners' perceptions and experiences of working with adult victims and perpetrators in the UK. *Child abuse review*, 28(1), 39-51.

Wendt, S., & Zannettino, L. (2014). *Domestic violence in diverse contexts: A re-examination of gender*. Routledge.

Wendt, S., Natalier, K., Seymour, K., King, D., & Macaitis, K. (2020). Strengthening the domestic and family violence workforce: Key questions. *Australian Social Work*, 73(2), 236-244.

Wies, J. R., & Haldane, H. J. (2011). Ethnographic notes from the front lines of gender-based violence. *Anthropology at the Front Lines of Gender-based Violence*. Vanderbilt University Press, Nashville, USA, 1-17.

Willis, G., & Ward, T. (2013). The good lives model: Evidence that works. In L. Craig, L. Dixon, & T.A. Gannon, *What works in offender rehabilitation: An evidence based approach to assessment and treatment* (pp. 305-318). West Sussex, UK: John Wiley & Sons.

Telephone

07 3253 4000

Address

Level 5
192 Ann Street
Brisbane QLD
Australia 4000

Mailing address

GPO Box 45, Brisbane QLD 4001

Email

contact@ucareqld.com.au

unitingcareqld.com.au

UnitingCare

Proudly representing
Blue Care | Lifeline | ARRCS | The Wesley Hospital | Buderim Private Hospital
St Stephen's Hospital | St Andrew's War Memorial Hospital