



Evaluation readiness, program quality and outcomes in men's behaviour change programs

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AUSTRALIA'S NATIONAL RESEARCH
ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

RESEARCH REPORT
ISSUE 01 | APRIL 2019

ANROWS acknowledgement

This material was produced with funding from the Australian Government and the Australian state and territory governments. Australia's National Research Organisation for Women's Safety (ANROWS) gratefully acknowledges the financial and other support it has received from these governments, without which this work would not have been possible. The findings and views reported in this paper are those of the authors and cannot be attributed to the Australian Government, or any Australian state or territory government.

Acknowledgement of Country

ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander elders past, present and emerging, and we value Aboriginal and Torres Strait Islander histories, cultures and knowledge.

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Published by

Australia's National Research Organisation for Women's Safety Limited (ANROWS)
PO Box Q389, Queen Victoria Building, NSW, 1230 | www.anrows.org.au | Phone +61 2 8374 4000
ABN 67 162 349 171

Evaluation readiness, program quality and outcomes in men's behaviour change programs (Research report) / Andrew Day et al.

Sydney : ANROWS, c2019.

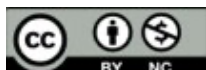
Pages ; 30 cm. (Research report, Issue 01/2019)

I. Family violence - Australia - Prevention. II. Abusive men - Behavior modification - Evaluation. III. Behavior therapy - Evaluation. IV. Abusive men - Services for - Australia.
I. Day, Andrew. II. Vlasis, Rodney. III. Chung, Donna. IV. Green, Damian John.

ISBN: 978-1-925925-01-2 (print) | 978-1-925925-02-9 (online)

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Evaluation readiness, program quality and outcomes in men's behaviour change programs

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This report addresses work covered in the ANROWS research project PI.17.03 *Evaluation readiness, program quality and outcomes in men's behaviour change programs*. Please consult the ANROWS website for more information on this project.

ANROWS research contributes to the six national outcomes of the *National Plan to Reduce Violence against Women and their Children 2010-2022*. This research addresses National Plan Outcome 6 – Perpetrators stop their violence and are held to account.

This work is part of the ANROWS Research Report series. ANROWS Research Reports are in-depth reports on empirical research produced under ANROWS's Research Program.

Material contained in this Report covering men's behaviour change program standards in Australia has previously been published in the following article: Day, A., Vlasis, R., Chung, D., & Green, D. (2018). Standards of practice in domestic and family violence behaviour change programs in Australia and New Zealand. *Australian and New Zealand Journal of Family Therapy*, 39(4), 501-513. doi:10.1002/anzf.1332

Suggested citation:

Day, A., Vlasis, 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.



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Author acknowledgement

We would like to sincerely thank our research partners: Rashmi Kumar and Michael Brandenburg, (formerly) No To Violence, Victoria; Dr Henry Pharo, Department for Correctional Services South Australia (SA); Dr Shaymaa Elkaadi, Corrections Victoria; Rod West, Centrecare; and project reference group (Dallas Colley, Australian Children's Safety Alliance; Fiona Mort, Office for Women, SA; Ginny Cisneros, Central Domestic Violence Service, SA) for supporting this research and providing feedback over the course of the project. We are indebted to our interviewees who freely gave their time to support this research. The views expressed in this report do not necessarily reflect those of the research partners, reference group members or the agencies that they represent.

Acknowledgement of lived experiences of violence

We acknowledge the lives and experiences of the women and children affected by domestic, family, sexual violence and neglect who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing.

Recommended support services include: 1800 RESPECT - 1800 737 732 and Lifeline - 13 11 14.

Contents

Executive summary	7
Introduction	10
State of knowledge review	11
Men’s behaviour change program (MBCP) outcomes and issues	11
Methodology	13
Review of the published literature	13
Jurisdictional scan	13
Part 1:	
Standards of practice	16
Program quality assurance	17
Systemic considerations	18
Content of standards	19
Compliance with standards	19
Approaches to program standards in other settings	20
Standards in Australia	24
Queensland	24
Victoria	27
Western Australia	30
New South Wales	33
Part 2:	
Evaluation design and the evidence-based assessment of change	37
Program logic as the driver of outcome measurement	37
Understanding evidence	38
Randomised controlled trials	42
Identifying key outcomes	43

Selecting assessment tools	43
Risk assessment tools	45
Assessments based on face validity	45
Interpretation of evaluation data	48
Safety and accountability planning	54
Part 3:	
Focus group and in-depth interview research	60
Focus group and interview methodology	60
Common themes	61
Female partner experiences of participation in MBCPs	68
Part 4:	
Key findings and opportunities for practice development	72
The need for consistent minimum standards	72
Standards and professional practice guidelines	72
Adapting standards for particular context	73
Complaints mechanisms	73
Monitoring compliance through service agreements and contracts	74
Characteristics of more considered compliance monitoring processes	74
The need to develop the evidence base to inform standards	76
Building evidence as a way to build confidence	77
Beyond “tick and flick” accreditation processes	78
Consulting practitioners	78
The need to develop theories of change and to articulate program logic	79
The need to develop standard evaluation frameworks and consistent outcome measurement	80
Minimum data sets	81
The need to strengthen safety and accountability planning	82
The need to engage with victims/survivors	83
The need for a peak body	84
Issues to address	85

Knowledge translation and exchange	89
Limitations of the research	91
Conclusion	92
Recommendations	93
References	96
Appendix A:	
Review of international practice standards	105
United States	105
Colorado	107
Illinois	111
Texas	113
Canada	117
Alberta	118
Aotearoa/New Zealand	120
England and Wales	125
Scotland	127

List of tables

Table 1: Example of principles of effective correctional practice (adapted from Matthews, Hubbard, & Latessa, 2001, pp. 455-456)	21
Table 2: Domains of the CPAI-2000 (adapted from Smith, Gendreau, & Swartz, 2009)	21
Table 3: Theories of behaviour change and program activities (adapted from Casey, Day, Ward, & Vess, 2012)	38
Table 4: Evaluation logic example	39
Table 5: The Maryland Scale (adapted from Sherman et al., 1998)	41
Table 6: Psychometric properties of assessment tools	46
Table 7: Mapping static and stable dynamic risk factors (adapted from Beech & Craig, 2012, p. 172)	47
Table 8: Categories of change (adapted from Bowen, 2012)	50
Table 9: Session monitoring sheet example (New South Wales. Department of Attorney General and Justice, 2012, p. 253)	53

List of figures

Figure 1: Flow of information from identification to inclusion of studies	14
Figure 2: Example program logic for Corrections Victoria's ChangeAbout MBCP	40

Key abbreviations

ANROWS	Australia's National Research Organisation for Women's Safety Limited
COAG	Council of Australian Governments
DFV	Domestic and family violence
MBCP	Men's behaviour change program
RNR	Risk-Need-Responsivity
WWP EN	European Network for the Work with Perpetrators of Domestic Violence

Key terms

Domestic and family violence (DFV)	Domestic and family violence is the term used in this report to encompass a range of violent and abusive behaviours – physical, psychological, sexual, social, financial, technology facilitated and neglectful – that are predominantly perpetrated by men against women and their children in current or past intimate or familial or kinship relationships. A more detailed description can be found in the <i>Third Action Plan 2016-2019 of the National Plan to Reduce Violence against Women and their Children 2010-2022</i> (Australia. Department of Social Services, 2016, pp. 43-44).
Evaluation-readiness	For the purposes of this research report, evaluation-readiness refers to an organisation or program's ability to successfully implement an evaluation project or framework.
Formative evaluation	Evaluation activity conducted in the developmental and early implementation phases of a new intervention or program, to assist the program model to mature in the light of early implementation experience.
Jurisdictions	For the purposes of this research report, the term jurisdictions is used in line with its legal meaning, rather than geographical area.
Men's behaviour change program (MBCP)	The term MBCP is used in this report to refer to any planned intervention that has the aim of reducing violence towards women and children by known perpetrators, and includes programs offered to high-risk offenders who are managed by correctional services.
Partner contact	Provision of safety planning and support to current and former partners of participants in a MBCP, parallel to the men's participation in the program.
Perpetrators	The offenders or respondents, responsible for the DFV.
Program logic models	A visual representation of the intended mechanisms through which a program or intervention is set to achieve medium-term impacts and long-term outcomes. A program logic model is a prerequisite for evaluation purposes, and for program integrity checking processes, to determine if the program is being implemented as planned.
Risk-Need-Responsivity	The Risk-Need-Responsivity framework provides guidance on how to tailor corrections-based interventions towards offender risk profiles, criminogenic needs, and issues affecting responsivity and motivation to participate in the intervention.
Standards	In the context of MBCP work, standards refer to minimum expectations for safe and appropriate practice and systems embeddedness, set by governments or other overseeing authorities. The intent of standards is to minimise the risk of harm caused by unsafe and inappropriate practice, and to improve the quality of program delivery and of MBCP contributions to integrated DFV systems, enhancing the capacity of those systems to assess and manage risk.
Victim/survivor	A woman, child or other person who has experienced or is experiencing domestic and family violence.
Victim-centred	Victim-centred refers to practices that put the needs of the victim/survivor first. In the context of collaborative work, it means that agencies coordinate their responses so as to avoid jeopardising the safety and wellbeing of victims/survivors, for instance, through re-traumatisation.

Executive summary

In 2015, ANROWS published *Perpetrator interventions in Australia: Part one – Literature review* (Mackay, Gibson, Lam, & Beecham, 2015), which provided an account of the current state of knowledge relevant to interventions for perpetrators of domestic and family violence (DFV) and sexual assault in Australia and internationally. The authors concluded that current evaluations of men's behaviour change programs (MBCPs) have produced mixed results and that, even when a program has been shown to reduce further violence against women, the effects are usually small. The authors concluded that there is no evidence to suggest that any one type of program is more effective than any other, noting that the current evidence base is simply not robust enough to support detailed prescriptions about best practice. Not only was there a lack of robust evaluation data, but concerns were expressed that MBCP providers generally did not have the funding, the resources or the methodological expertise to routinely and systematically collect the type of process, impact or outcome data that is needed to establish program outcomes.

This research report considers a range of issues that are relevant to developing a better understanding of the effectiveness of MBCPs, including how to identify those aspects of MBCPs that are likely to be most strongly associated with behavioural change, and how to measure changes that occur over time. It is anticipated that this research will help the sector to support existing programs in ways that allow them to become evaluation-ready, and facilitate discussion across the sector about how best to strengthen program integrity and conceptual clarity about the way in which behavioural change takes place. This impact at sector level will allow governments, agencies and peak bodies across Australia to develop better quality standards and accreditation processes for MBCPs that will, in turn, improve the consistency of practice. It is important to note, however, that there is currently insufficient empirical evidence to demonstrate the link between adherence to specific standards and improved MBCP outcomes. In addition, there is currently a lack of consensus across the sector on a range of key issues, including the accreditation of practitioners, the reporting of MBCP outcomes, and how quality assurance initiatives should be resourced.

This report provides a resource that can be used to support efforts to assess and strengthen the quality of MBCPs. Currently, program *completion* is often considered to be the main outcome of many programs, with *attendance* sometimes viewed as a “consequence” (a form of containment, supervision, or monitoring) rather than as the means by which behaviour change occurs. It is, however, well established that perpetrator behaviour change is a long-term process that goes beyond attendance at a MBCP and inevitably involves a longer-term process through which beliefs and values that have been developed over a lifetime are changed. This suggests the need to move away from *incident-based* understandings of DFV to focus more on the patterns of violence that develop over the course of a lifetime and over the course of a specific relationship. It follows that relatively brief interventions, of the type typically available in any MBCP, should not always be expected to lead to long-term behavioural change, and that the primary outcome of program attendance should be a coherent understanding of how violence can stop, documented in a way that can be shared between key stakeholders.

In this research a series of meetings with MBCP providers, supported by interviews with partners of MBCP participants, identified the need to:

- improve outcome measurement;
- improve safety planning; and
- strengthen current approaches to assessment, partner contact and intervention.

This led to a total of 17 recommendations that are organised into four main areas. Each of these recommendations, in our view, requires consideration to enhance the safety of women and children and the accountability of men using violence against family members. Addressing these areas of MBCP practice will help to redefine what a realistic outcome of attendance at a MBCP should be and inform the ongoing development of practice standards and accreditation systems that can be implemented across Australia. The recommendations are not presented in any order of importance. Rather, their purpose is to invite reflection, discussion and comment from the field.

TRANSLATING THE
EVIDENCE
TO IMPROVE
CURRENT MBCPs

RECOMMENDATION 1

Program providers should be supported to give more attention to their program's theory of change, including the development of program logic models.

RECOMMENDATION 2

Program logic models should consider systems-level, individual-level and (if appropriate) community-level impacts and outcomes.

RECOMMENDATION 3

Program providers should be supported to implement processes that monitor and improve program integrity and fidelity, but not in a way that leads to rigid, over-manualised approaches.

RECOMMENDATION 11

Program providers should be supported to extend their program logic models into evaluation and performance monitoring plans, even if not all aspects of the plan can be implemented immediately.

RECOMMENDATION 14

Evaluation plans should include measures of impacts on adult and child victims/survivors that do not rely on changes in the perpetrator's behaviour.

OVERARCHING
CONSIDERATIONS
FOR IMPROVING
AND ENHANCING
MBCPs IN
AUSTRALIA

RECOMMENDATION 8

Safety and accountability planning should be prioritised in sector and practice development efforts as a potentially high-impact way to improve the quality and effectiveness of MBCP provision.

RECOMMENDATION 9

If calls are to continue for community-based MBCP providers to adopt Risk-Need-Responsivity (RNR) and other principles to tailor their programs to individual perpetrator and family circumstances, providers need to be funded and equipped to do so.

RECOMMENDATION 17

Partner support and safety work needs to be properly funded and prioritised, rather than remaining secondary relative to resources allocated to engaging perpetrators.

RECOMMENDATION 13

A suite of outcome evaluation tools should include victim-centred measures that focus on exposure to coercive control.

RECOMMENDATION 15

Proximal measures of the impact of MBCPs offer considerable promise to guide clinical and program evaluation efforts, but work in this area needs to be embedded within a research and evaluation stream that is adequately resourced.

FUTURE
CONSIDERATIONS
FOR THE
DEVELOPMENT OF
STANDARDS AND
ACCREDITATION
SYSTEMS

RECOMMENDATION 4

The development of minimum standards, at the current time, should be based on sufficiently detailed, articulated and nuanced practice principles rather than practice prescriptions.

RECOMMENDATION 5

Minimum standards should focus as much on an organisation's capacity to safely and sustainably provide a range of specialist perpetrator interventions as on the specifics of any particular program offered.

RECOMMENDATION 6

Accreditation systems based on monitoring program provider compliance with minimum standards need to be multi-component rather than binary, singular "tick and flick" registration processes and include observations of live practice as one means of assessing for accreditation.

RECOMMENDATION 7

Accreditation systems should be developed and implemented in ways that support program providers to reflect upon and improve the quality of their practice in line with agency-level vision and ethos, not only as a means to monitor adherence to standards.

DEVELOPING
FUTURE EVIDENCE
ABOUT AUSTRALIAN
MBCP REACH AND
EFFECTIVENESS

RECOMMENDATION 10

A national MBCP outcomes framework should be developed to engender some consistency in evaluation frameworks and evaluation activity, and to help build the evidence base.

RECOMMENDATION 12

Australian jurisdictions should consider shared work to develop the equivalent of the European Project Impact outcome evaluation tools and researcher-practitioner partnerships.

RECOMMENDATION 16

Research to identify quality practice in partner support and safety work is urgently needed.



Introduction

The context for this research is the call from governments, domestic and family violence (DFV) service systems, and victim/survivor advocates for an increased focus on perpetrator accountability and participation in behaviour change interventions. These calls are consistent with a shift away from the (often-asked, victim-blaming) question of “why doesn’t she leave?” towards the more relevant question of “why doesn’t he stop his use of violence?”. MBCPs are one approach to addressing the source of the problem – how men coercively control, entrap, frighten and terrorise adult and child victims/survivors.

MBCPs have a 30-plus year history in Australia, and while they have undergone considerable evolution during this time, they remain contentious (Mackay, Gibson, Lam, & Beecham, 2015). Debates still occur regarding whether MBCPs actually contribute to the safety and freedom of victims/survivors, the scale and scope of unintended negative consequences arising from program attendance, and whether a focus on working with individual perpetrators obscures the need to address DFV as a social problem embedded in structural and systemic processes of society-wide patriarchy (Vlais, Ridley, Green, & Chung, 2017). And so, it is in this context that it becomes crucial that MBCPs are planned, developed and implemented with great care.

Maximising the safety and quality of these interventions requires attention to a number of key issues that, we argue, have been given insufficient attention to date. This is through no fault of program providers and practitioners: rather, it is a reflection of the still emerging state of knowledge of the field and the historical lack of resources and support provided for this highly difficult work.

This research report begins with a review of current approaches to setting standards of practice, including accreditation approaches, for MBCPs. In Part 1, we consider international standards and then provide an overview of work currently underway across Australia. Part 2 of the report discusses approaches to program evaluation and how change should be assessed at both the individual and the group level. A key issue here is the quality of available information for each participant following the completion of a MBCP about the risk of future violence. Parts 3 and 4 of the report

document key findings and opportunities for practice and evaluation improvement that form the empirical component of this research, which included focus groups with MBCP practitioners and interviews with women partners of MBCP participants.

State of knowledge review

MBCP outcomes and issues

A number of previous reviews have sought to identify the extent to which MBCPs promote the safety of women and children (Akoensi, Koehler, Lösel, & Humphreys, 2013; Arias, Arce, & Vilariño, 2013; Connors, Mills, & Gray, 2013; Coulter & VandeWeerd, 2009; Crockett, Keneski, Yeager, & Loving, 2015; Eckhardt et al., 2013; Eckhardt, Murphy, Black, & Suhr, 2006; Gondolf, 1997; Sartin, Hansen, & Huss, 2006). However, both the outcomes evaluated and the methods used are not always reported in detail (e.g. Eckhardt et al. 2006; Gondolf, 1997; 2004; 2010), with most existing evaluation studies utilising non-experimental or quasi-experimental designs (see Eckhardt et al. 2013). This limits the extent to which causal conclusions about program effectiveness can be drawn. A number of further methodological issues have been identified as limiting the strength of evidence currently available. These include:

- high attrition rates;
- follow-up periods of less than 6 months post-intervention;¹
- small sample sizes and/or specific research sites, which mean that evaluation findings cannot be generalised or applied to wider populations;
- not knowing which *component* of any intervention was more effective than any other (or if any part was effective); and
- within-group differences in effectiveness, including the effects of matching program intensity to the risk level of participants.

It comes as no surprise then that many reviewers simply conclude that more evaluation research is required to establish that participation in a MBCP consistently leads to reductions in further violence. At the same time, however, numerous descriptions of practice have been published (Cunha & Gonçalves, 2014; Dalton, 2007; Dunford, 2000; Easton, Mandel, Babuscio, Rounsaville, & Carroll 2007; Echaury, Fernández-Montalvo, Martínez, & Azkarate, 2013; Scott, Heslop, Randal, & Kelly, 2017), highlighting an ongoing concern with understanding more about the wide range of issues that potentially influence the quality of current

programs.² The focus of this literature is on two specific aspects of MBCPs that are relevant to evaluation efforts:

1. the identification of good practice and the development and implementation of program standards; and
2. how change might be best conceptualised and measured.

There is also a body of work that considers the administrative and organisational context in which MBCPs are offered (Clarke & Wydall, 2013). Although this research report focuses on the program level, it is important to note Gondolf's (2012) landmark study of perpetrator programs in the United States (US) that highlighted the importance of nesting perpetrator programs in a robust and coordinated service system. While differing in approach and evaluation methodology, the work of Westmarland and Kelly (2013) in the United Kingdom (UK) also points to the importance of systemic responses to DFV, particularly in relation to defining MBCP "success" in a complex service system where a number of parties are involved. These researchers rightly point to the danger of relying solely on administrative data outcomes, such as recidivism, to determine program success.³ Various terms have been used to describe these service arrangements, including coordinated responses, integrated responses and multi-agency working, although, the practice arrangements are mostly referred to as collaborative or partnership working. These approaches tend to include an agreed upon assessment and intervention, with case management underpinning the management of tasks/requirements (Wong, 2013).

The need for collaborative working is based on the assumption that important information can be missed (and the safety of women and children further jeopardised) without communication and triangulation between agencies (Gamache,

¹ This may reflect a "honeymoon period" at the immediate completion of the program, indicative of only short-term successes.

² Much of this work is documented in the ANROWS report *Perpetrator interventions in Australia: Part one - Literature review* (Mackay et al., 2015).

³ Arias et al. (2013) found that recidivism rates reported by victims/survivors and perpetrators were much higher than officially reported rates. Klein and Crowe's (2008) study showed higher rates of recidivism in a group that received specialist victim/survivor support than in a group that did not. This unexpected finding was thought to have been the result of victims/survivors having more confidence to call the police to report breaches, rather than the ineffectiveness of the support program. A study by Javdani, Allen, Todd, and Anderson (2011) suggested that the number of processes in place between the offence occurring and attendance at an MBCP allows for various exit points from the system, regardless of the effectiveness of any specific service.

2012). In relation to MBCPs, coordinated responses are critical to ensuring that information about perpetrators' risk and whereabouts is up to date and available, so varying levels and types of response can be provided. They can also provide other agencies with important knowledge when a perpetrator has not been engaged (e.g. in situations of child protection/safety where the intervention may have been solely with the mother) (Stanley, Graham-Kevan, & Borthwick, 2012).⁴ Similarly, victims'/survivors' reports are central to gaining an understanding of perpetrators' violence and coercive control while they are undertaking a MBCP. Thus a key element of any coordinated response is interagency information sharing, which has increasingly led to revised legislation and the development of enabling government protocols (McGuirk, O'Neill, & Mee, 2015; Peel & Rowley, 2010).

These studies highlight the need to better understand the logic, operations, and coordination and systemic responses before individual program outcomes can be assessed. It is also clear that information sharing in this context requires individual practitioners across agencies to be clear about the basis for any judgements of ongoing risk. In light of the findings of one review of Victorian MBCPs, which concluded that many information sharing and reporting practices were not well developed (Diemer, Humphreys, Laming, & Smith, 2015), one aim of this report is to consider how these areas of practice might be strengthened. It is also clear from the available evidence that MBCPs cannot be effectively assessed independently of the coordinated response in which they are offered (Vlais et al., 2017).

4 The agencies involved include specialist DFV services (such as refuges, women's support programs and MBCPs), mainstream services with key roles in DFV (e.g. police, courts, corrective services, child protection, family support services) and other services involved with DFV (e.g. health, drug and alcohol services and homelessness services).

Methodology

Review of the published literature

This report utilises literature identified from a systematic review of English language studies on MBCPs using the *Preferred Reporting Items for Systematic reviews and Meta-Analysis guidelines* (PRISMA). The search focused on peer-reviewed studies, and unpublished dissertations were excluded. No date or place of publication restriction was used. The databases searched included: PsycInfo (via Ovid); PubMed; Embase (via the Embase platform); FAMILY and CINCH (via Informit); and Social Work Abstracts, SocINDEX and CINAHL (via Ebsco). The resulting publications were then supplemented with grey literature identified using Google advanced.

The databases were last searched on 22 July 2016 using a three-step search strategy. Firstly, a limited search was undertaken in the databases in order to analyse text words contained in the titles and abstracts of articles, as well as specific index terms used to describe articles. Keywords used in the initial search included variations of domestic violence and abuse, intimate partner violence and abuse, spouse violence and abuse, and batterer. These were cross-referenced with terms such as program, evaluation, treatment, intervention and therapy. Secondly, all identified keywords, index terms and search words were used to search all databases. All searches were then screened in two stages, to identify any material that was not related to MBCPs and then to exclude any remaining literature that not concerned with issues relating to program quality or standards. Thirdly, the reference lists of all relevant articles were manually searched to identify additional studies.

A flow diagram of search results is displayed in Figure 1. The initial search yielded 11,304 hits. After duplicates were removed (n=1,120), titles and abstracts were screened (n=10,184); of these 269 studies were considered potentially relevant. Full-text articles were then accessed. This search resulted in a total of 92 applicable articles being included in the synthesis.

Jurisdictional scan

A review of the community-based MBCP sectors across four Australian jurisdictions was completed, including Queensland, Victoria, Western Australia and New South Wales.⁵ An overview of selected UK, Canada, US and New Zealand standards is provided in Appendix A. Each jurisdiction, in Australia and internationally, was then reviewed through a combination of:

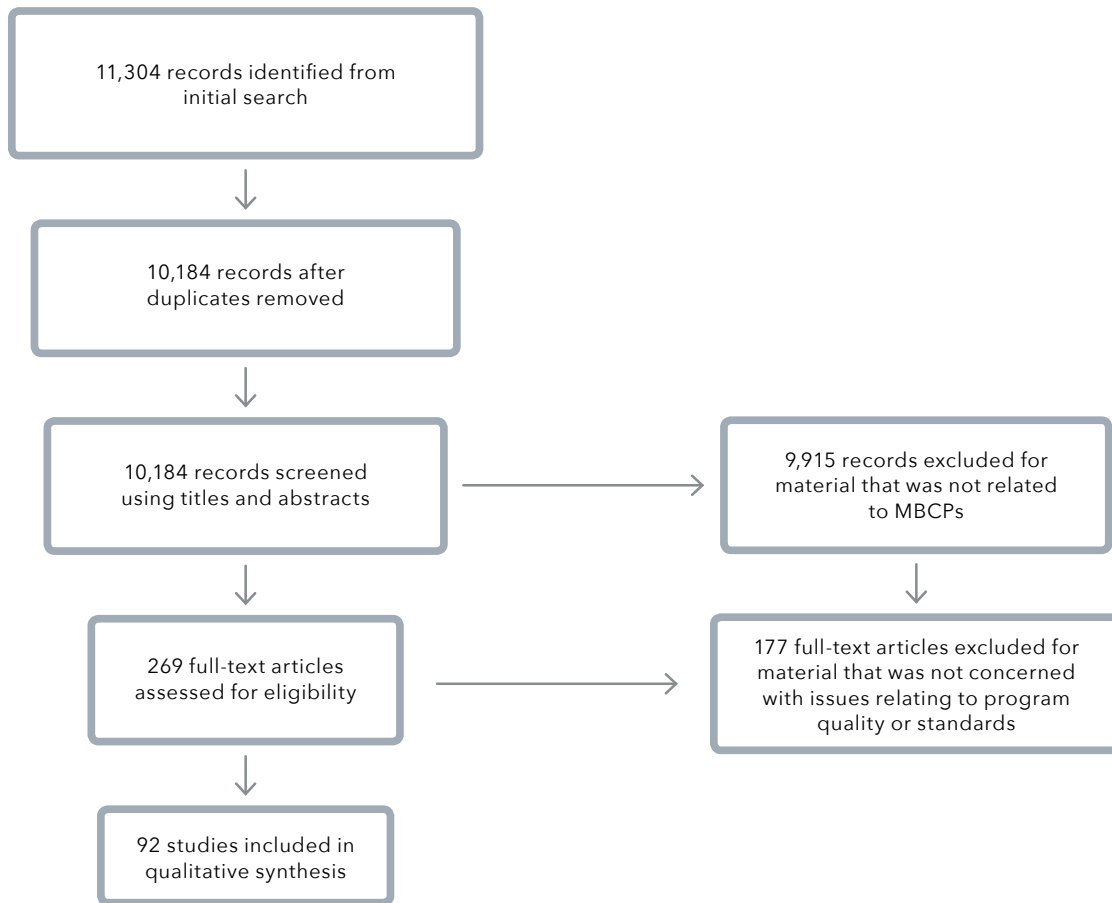
- desktop review of available grey literature;
- Skype or telephone-based interviews with jurisdictional representatives, identified as holding a key position of formal or informal leadership within that jurisdiction's MBCP sector, and located either within government or in a non-government organisation (NGO) or peak body representing MBCP providers; and
- additional email contact with these representatives where further clarity was required on particular issues.

It is important to note that the term community-based MBCPs refers to programs that are run by NGOs or private providers rather than by a state, provincial or national government, often through corrections departments. There is a broad range of referral pathways into these programs, including for those perpetrators who are on probation or community corrections orders. For some of the jurisdictions reviewed (for example, Aotearoa/New Zealand and those in the US), community-based providers do, however, receive most of their referrals from correctional services. These programs and sectors are given as much consideration as those that take referrals mostly through health, human and family service systems.

For the US, the focus is on a sample of jurisdictions that appear to offer particular learnings relevant to understanding the processes of support and accountability that are in place for community-based MBCP providers. Of four that are identified as leading practice – Colorado, Hawaii, Illinois and Texas – there was sufficient information regarding three. For Canada, it was not possible to obtain information regarding the one

⁵ Community-based MBCPs do not (and, in our view, should not) represent their own "sector" separate from other specialist DFV services, such as those for women and children. The term is used here for expediency purposes only.

FIGURE 1 Flow of information from identification to inclusion of studies



province or territory (Alberta) that has implemented both minimum standards for community-based MBCP providers and an active mechanism to monitor compliance (Heslop et al., 2017). Aotearoa/New Zealand, and England, Wales and Scotland, are each single jurisdictions, without significant internal regional differences in relevant policies, legislation or sector patterns.

It was apparent that few European countries have established minimum standards or compliance monitoring processes, and given language differences a decision was made not to attempt a review within any constituent jurisdictions. However, the European Network for the Work with Perpetrators of Domestic Violence (WWP EN) is globally one of the most active member-based organisations focused on enhancing the quality of DFV perpetrator program work, with significant work streams supporting research and program evaluation (see, for example, Project IMPACT and the working papers on program evaluation methodologies and measures), in addition to country-level support (“European Network for the Work with Perpetrators of Domestic Violence, 2018). The

WWP EN is currently working with its membership across the continent to develop a set of minimum standards applicable across diverse political and program provision contexts.

Personal communication with sector representatives was an essential part of this process, given the lack of publicly or readily discernible relevant information for most jurisdictions. Skype and telephone interviews averaged 90 minutes in length, and in addition to directly providing valuable information, helped to source additional grey literature not available through the desktop review. A semi-structured guide was used to help structure the interviews.

A template format was used to represent analysis for most of the jurisdictions reviewed, modified slightly for analyses for Canada, Europe and the US at the national/continent level. The template comprised:

- opening contextual notes about the development, history or general nature of the community-based MBCP field in that jurisdiction;

- characteristics of the field, such as the approximate number and type of providers;
- relevant DFV legislation, and action plans or other key government documentation setting out the jurisdiction's approach to addressing DFV;
- the availability and nature of any peak body or similar organisation dedicated to capacity-building in the field;
- minimum standards or professional practice guidelines for the jurisdiction;
- the nature of any compliance framework and monitoring processes in relation to these standards;
- the use by program providers of program logic or other program integrity building methods;
- any foundational training offered to practitioners in the jurisdiction specifically focusing on MBCP work;
- other professional development or community-of-practice opportunities related to MBCP practice; and
- references and reading sources for the jurisdiction.

Part 1:

Standards of practice

Guidelines to support MBCP design and delivery were first introduced in the mid-1980s, largely in response to a proliferation of new programs that followed the implementation of mandatory arrest laws for domestic violence in the US (Gondolf, 1997). The general aim of these guidelines was to encourage providers to follow broad practice principles identified by victim/survivor advocates in the battered women's movement, such as helping perpetrators to understand the cycle of violence and how issues of power and control come to characterise their use of violence in relationships (Stover & Lent, 2014). While some offered only general guidance, others clearly specified recommended practice methods, including intervention format and duration of MBCPs, which quickly became adopted as standards of practice (Saunders, 2001). By 2008, at least 45 US states were reported to have developed some form of standards to regulate program practices (Maiuro & Eberle, 2008).

This section of the report aims to document current thinking and evidence about both the development and implementation of these practice standards. It is to be read in conjunction with the overview of current national and international practice in this area, documented in Appendix A. The literature reviewed primarily reflects the context of MBCPs in the US, where service delivery systems may or may not compare directly with work carried out in Australia. For example, standards regarding issues relating to culturally safe practice when working with Indigenous perpetrators are not included in the reviewed US standards. Further, many of the published papers in this area, with some notable exceptions, were published around 15 years ago, at a time when standards had recently become established in the US, and critiques published around this time potentially reflect these original standards rather than those developed more recently.

Boal and Mankowski (2014b) have noted that while the adoption of standards is commonplace (across the US at least), some state standards (or specific components within them) are still written as guidelines rather than legal requirements. Arias, Dankwort, Douglas, Dutton, and Stein (2002) further note that standards also vary according to the means by which they are enforced or regulated. In the US, for example, this could be a local judicial board (e.g. in Colorado), another criminal justice body (e.g. in Iowa), a state code agency such

as public health (e.g. in Massachusetts), child protection (e.g. in Washington), or human services agency (e.g. in Illinois) (Bennett & Vincent, 2001, p. 3). As such, two basic categories of standards exist. These are:

- mandatory standards, with or without accompanying legislation, to which programs are required to adhere to as a condition of being funded and/or licensed to operate; and
- voluntary standards, where there is little or no inducement to comply (Arias et al., 2002).

There have been a number of published analyses of MBCP standards that have examined the content of those standards that are in place in the US and Canada (e.g. Geffner, 1995). In one of the largest of these, Austin and Dankwort (1999) classified the different elements into seven broad areas:

- philosophy;
- purpose and procedures;
- protocol for programs;
- staff ethics and qualifications;
- intake procedures;
- intervention (format, mode content and duration); and
- discharge criteria.

Bennett and Vincent (2001) subsequently presented a similar list, but argued that standards should also include explicit statements on:

- sanctions for any violation of standards;
- the duty that staff have to report violence and to warn victims/survivors;
- an outline of "accountability plans" for the perpetrator;
- fee policy; and
- the information that must be collected about each participant.

More recently, Stover and Lent (2014) have considered specific standards relevant to the training of staff. They concluded that while there are general themes throughout most training programs (such as an understanding of confidentiality, empathy for victims/survivors and their children, and a comprehension of the dynamics of domestic violence), the exact content of training is often difficult to discern and there

is a notable absence of standards to guide how competency to provide service should be assessed.

The rationale for having program standards is largely uncontroversial (Arias et al., 2002). For example, there is general agreement that standards are needed to ensure some consistency of practice in a context where many different approaches to intervention have been tried (Bowen, 2012). Murphy (2001) notes, for example, that the Maryland guidelines were developed in response to concerns that unqualified practitioners with little or no expertise in domestic violence were irresponsibly treating court-ordered referrals (see also Boal & Mankowski, 2014b). Bennett and Vincent (2001) also argued that critics have generally not opposed the development of standards, only the process used to develop them and, in some circumstances, their restrictive nature. For example, the setting of higher standards will inevitably result in fewer programs that meet the criteria required for them to be delivered, but, in theory, at least, this approach offers a higher degree of confidence that a program will be effective when implemented more widely. Setting a lower standard should come with a lower risk of failure. There have also been concerns expressed about the actual content of the standards and the way in which standards are implemented.

The introduction of program standards should, in principle, lead to greater transparency about service responses within and across law enforcement, specialist DFV services and other agencies. Perpetrators, victims/survivors and service providers should all have access to information about what they should expect from a MBCP (Saunders, 2001). As Arias et al. (2002) have argued, the setting of standards should facilitate a process by which those with varying interests and particular mandates can work together, as well as legitimise the need for specialised knowledge, training and intervention approaches. An important question nonetheless is whether the introduction of standards does indeed achieve the overarching goal of improved program performance and enhanced victim/survivor safety.

Formative evaluations of US state standards, including evaluation of need, implementation, context, characteristics and cost are rare (Bennett & Vincent, 2001). In one of the few published attempts to assess the effect that standards

have had on the actual policies and practices of MBCPs, Boal and Mankowski (2014b) compared the characteristics and practices of 74 different programs delivered across the state of Oregon at three time points between 2004 and 2008 – before and after the standards were adopted. Their analysis suggested that across all programs, the use of mixed gender group co-facilitation had increased over time (by 14%), and program length had increased by approximately 12 weeks. However, other practices such as coordination with community partners did not change. The relationship between the introduction and implementation of standards and improvements in the safety of adult and child victims/survivors remains unclear.

A key issue that arises throughout this report is the use of terminology. In some jurisdictions, for example, minimum standards are termed “professional practice guidelines” or just “guidelines”. It is often unclear, however, what differentiates the use of the term “guidelines” from “standards”, with some systems in place where there is a two-tiered standards system involving minimum standards and a second layer of “optimal” or “good practice” guidelines. Given the similar purposes that these documents serve, these terms are generally used interchangeably throughout this report, despite their different meanings.

Program quality assurance

The purpose of a program manual is to prescribe particular activities or program content that should be covered, with accreditation guidelines often requiring separate manuals to be written that address different areas of a program (e.g. theoretical basis, program activities, staff training, and quality assurance and evaluation). This level of detail appears to be largely absent from the MBCP sector in Australia. Attempts to analyse the conceptual clarity of program manuals, to provide detailed information about a theory of change, and the conceptual underpinnings of program activities, are also relatively rare.

A particularly important aspect of quality assurance is the need to assess the integrity of the actual delivery of program content and processes (Carbajosa, Boira, & Marcuello, 2013).

In this context, the term “program integrity” refers to the extent to which an intervention program is delivered in practice, as intended in theory and design (Hollin, 1995). Assessing integrity typically involves two components:

1. adherence to the theoretical and operational aspects of the program manual; and
2. facilitator competence in delivering the program.

It is expected that programs with higher levels of integrity will achieve better outcomes. Assessing adherence usually involves the use of checklists that both facilitators and participants complete to see if the program is actually delivered as the manual specifies. This can also involve direct observation and detailed case audits to determine if practice is consistent with the program’s conceptual and theoretical foundation and associated theories of change. Although facilitators are likely to have some biases in their perceptions of sessions, and program participants may not have the level of knowledge required to assess integrity accurately, these sources of data are commonly utilised when checking for integrity (Moncher & Prinz, 1991). Moore (2016, p. 26) has further identified three different types of implementation fidelity:

- *program fidelity*, which is concerned with what is delivered, and with ensuring the faithful delivery of proven programs and strategies according to their original design;
- *process fidelity*, which is concerned with how services are delivered, and with ensuring that services are delivered in ways that are known to be effective in engaging participants and changing behaviours; and
- *values fidelity*, which is concerned with ensuring that the focus of service and method of service delivery are consistent with program values.

Systemic considerations

Minimum standards are often influenced by overarching policies that characterise government and other stakeholders’ understanding of the nature and causes of DFV. The most obvious example here arises from an evidence-based understanding of DFV as an expression of gender-based and intersecting forms of power, in which all responsibility for the use of violence is ascribed to perpetrators (as well as

the social, cultural and institutional factors that influence their choices). All state and territory DFV policy frameworks emphasise, to a greater or lesser extent, that:

- DFV is patterned rather than incident-based behaviour consisting of a range of coercive controlling tactics that perpetrators use for purposes of power and control in their intimate and familial relationships.
- The experience of DFV can be affected, and multiplied, through other forms of marginalisation (and discrimination) intersecting with gender-based oppression.
- Responding to DFV requires multi-agency collaboration prioritising victim/survivor safety and perpetrator accountability.
- Causation of DFV rests with how perpetrators operationalise gender-based privilege, entitlement and hierarchy, dominant norms around masculinity, and gender inequality. For some cohorts, these causal factors intersect with other forms of privilege or oppression in complex ways.

In this context, some types of intervention might be deemed unacceptable, regardless of any evidence that exists to support its application. In our view, these policy considerations are often more than ideological; they are based on positions about how to prevent DFV and violence against women more generally and are developed from prevention approaches that are far broader than those involved in MBCPs. These positions stem from a much broader evidence base than that which exists with respect to the application of any particular intervention, exemplified, for example, by the evidence base outlined in the VicHealth framework for preventing violence against women (VicHealth, 2015).

MBCPs are sometimes delivered as part of an intensive and tailored case management model, although community-based MBCPs do not always have the resources to do this. Case management, as an intervention in its own right, can be especially difficult to evaluate as it involves assessment, service planning and service coordination with a view to addressing multiple areas of need (Ashery, 1994). Attention should also be paid to the quality of the program implementation, and to identifying and understanding the particular service context in which case management is implemented. The

service context includes the utilisation of allied services; consideration should be given to whether perpetrators take up referrals to other agencies and if so, the attrition rate within these services.

Bennett and Vincent (2001) discuss the Illinois standards that list 11 mechanisms that programs can use to maintain accountable relationships with the community. They then asked 23 different programs which of these standards they adhered to. A large majority stated that they held meetings with women's advocates, used male-female co-facilitation teams, had telephone contact with victims/survivors and had written policies for communicating non-compliance with the court (Bennett & Vincent, 2001, p. 12). A minority of programs used women's advocates for supervision or case staffing, although all of these were in-house programs provided by victim/survivor services agencies. About half of the MBCPs involved advocates at the level of program development, but not in program staffing or monitoring. Adopting these types of system level approaches to identifying outcomes inevitably requires that perpetrators are tracked across all agencies that contribute to an integrated response.

Content of standards

Given the inconsistent and inconclusive evidence regarding the characteristics of behaviour change programs that are optimally effective, those responsible for developing standards have been left to rely largely on the clinical experience of providers, victim/survivor advocates and criminal justice perspectives, as well as the practices adopted in other jurisdictions. Arias et al. (2002), for example, have observed that, in the US, standards were developed by committees that comprised practitioners (women's advocates, MBCP facilitators, criminal justice personnel and mental health professionals). Unsurprisingly then, the main critiques of existing standards have come from those who have questioned the scientific basis for their inclusion (Austin & Dankwort, 1999; Gelles, 2001).⁶ Holtzworth-Munroe (2001) argued that research data simply did not validate many of

the assumptions underlying the standards in the US at that time. These included the assumptions that: conjoint treatment is never appropriate; that a single approach to intervention is desirable; that it is possible to describe the best length, content and process of treatment; and that doing something is better than doing nothing.

It is, however, the specification (or restriction) of intervention approaches that has elicited most criticism. This is largely because there is still no clear empirical evidence that one type of intervention works better than another. Related to this are arguments that the adoption of standards limits innovation (Austin & Dankwort, 1999), prohibits practices that might be beneficial for specific populations (Holtzworth-Munroe, 2001), and generally inhibits program development strategies that involve implementing the findings from evaluation research and other empirical practice analyses (Boal & Mankowski, 2014b).

Compliance with standards

Boal and Mankowski (2014b) have noted that while the adoption of standards is now common across the US, requirements surrounding compliance vary widely. Arias et al. (2002) have also suggested that in some cases voluntary standards may be more likely to be followed than mandatory standards, perhaps because particular voluntary standards are more readily accessible and/or less specific to particular agencies or settings. There is, nonetheless, often a high degree of overlap between different sets of standards, whether these are voluntary or compulsory.

The difficulties faced by MBCP providers in meeting standards have been noted. In one study by Boal and Mankowski (2014a), nine separate challenges to comply were identified, including:

- difficulties in finding qualified facilitators;
- inadequate funding;
- difficulty meeting training requirements;
- high workloads;
- trouble creating and maintaining collaborations;
- inability to accommodate diverse participant needs;

⁶ The approach has often been to draw on what might be termed "practice-based evidence", although the rapid consultation processes often used with MBCP practitioners to develop and update standards does not enable practice-based evidence to be collected with rigour.

- conflict between state standards and county requirements; and
- perceived gaps between standards and evidence-based practices.

This is clearly illustrated in the following quote by Velonis, Cheff, Finn, Davloor, and O’Campo (2016, p. 2), which describes a reasonably typical scenario:

Budgets get cut, referrals increase or decrease, participants resent attending mandated programs, staff feel overworked and underappreciated, and the list goes on. Even under the best of conditions, behaviour change is difficult, and programs often use multiple theoretical strategies to help clients move along the path to improvement. Intervention programs for batterers are particularly tricky...regardless of the specific therapeutic, philosophical or political framework used, these programs are impacted by a variety of internal and external factors, including the characteristics and experiences of participants and staff, the mission of the lead organisation, the levels of communication between the programs, the local courts or probationary departments, victim-centred domestic violence services, and the social and political climate of the larger community.

In Australia, the challenges faced by the non-government sector to comply with contractually set standards were illustrated in a study by Carson, Chung, and Day (2009). While it was expected that funding and reporting mechanisms (such as contract management) would enforce a standardised approach to service delivery, Carson et al. (2009) found that MBCP providers maintained considerable autonomy. This was despite the fact that the contract only stipulated inputs (e.g. time allocated to assess men’s suitability for a group program, time allocated for victim/survivor contact and support, time allocated for running a MBCP) rather than outputs (Carson et al., 2009). This demonstrates that the complexities of implementing MBCPs and the diversity of programs have significant impacts on service providers’ abilities to adhere to mandatory standards and therefore the likelihood of them doing so.

Approaches to program standards in other settings

Correctional services

Radatz and Wright (2016) have recently commented on standards that have become widely utilised to support program practice in correctional settings and, in particular, the growth of accreditation practices that ensure adherence to accepted principles of effective intervention. These have been widely endorsed by correctional services in the jurisdictions reviewed (Wormith et al., 2007). They broadly require practitioners who work in these settings to focus their efforts on those who are most likely to reoffend (“high-risk” offenders), to target those factors that are directly associated with offending, and to deliver interventions in ways that have been identified as most likely to bring about change. Although these three core principles are the most well-known, Bonta and Andrews (2007) have identified a number of different principles that are thought to be associated with improved service outcomes, although, the evidence underpinning each does vary. These are illustrated in Table 1.

The Correctional Program Assessment Inventory (CPAI-2000) (Gendreau & Andrews, 2001) is a 131 item assessment/audit protocol that assesses program quality against eight different domains drawn from these principles (see Table 2). Two studies have examined the extent to which CPAI-2000 scores correlate with reductions in recidivism (Nesovic, 2003; Lowenkamp, Latessa, & Smith, 2006, cited by Smith, Gendreau, & Swartz, 2009), both of which found that total CPAI-2000 scores correlated with program effectiveness, as assessed by resulting reductions in recidivism.

To illustrate the way in which integrity and fidelity can be assessed, Corrections Victoria has developed the *Program Integrity and Effectiveness Accountability Standards* for use with offending behaviour programs. These contain the following advice:

- Any significant deviations from the program manual should be discussed in supervision and forwarded to relevant managers for consideration and endorsement prior to implementation.

TABLE 1 Example of principles of effective correctional practice (adapted from Matthews, Hubbard, & Latessa, 2001, pp. 455-456)

-
1. Effective interventions are behavioural in nature.
 2. Levels of service should be matched to the risk level of the offender.
 3. Offenders should be matched to services designed to improve their specific criminogenic needs, such as antisocial attitudes, substance abuse, family communication and peer association.
 4. Treatment approaches and service providers are matched to the learning style or personality of the offender.
 5. Services for “high-risk” offenders should be intensive, occupying 40-70 percent of the offenders’ time over a 3-9 month period.
 6. The program is highly structured, and contingencies are enforced in a firm but fair way.
 7. Staff members relate to offenders in interpersonally sensitive and constructive ways and are trained and supervised appropriately.
 8. Staff members monitor offender change on intermediate targets of treatment.
 9. Relapse prevention and after-care services are employed in the community.
 10. Family members or significant others are trained on how to assist clients during problem situations.
 11. High levels of advocacy and brokerage occur if community services are appropriate.
-

TABLE 2 Domains of the CPAI-2000 (adapted from Smith, Gendreau, & Swartz, 2009)

Organisational culture

Program implementation/maintenance

Management/staff characteristics

Client risk/need practices

Program characteristics

Core correctional practices (including relationship and skill factors)

Interagency communication

Evaluation

- Facilitation methods will be appropriate to the program design, purpose and target group (facilitators need to ensure that they are responsive to the needs of the group by being flexible and creative in their delivery style).
- The program is delivered according to its intended dose and intensity.
- Participants should attend all sessions of the program and participants should notify the facilitators of any absences or barriers to attendance, with absences documented in the case file.
- Any warnings about absences or inappropriate behaviour given to participants should be documented in the case file and verbally communicated to case managers.
- Participants who miss more than three sessions for acceptable reasons should be removed (at facilitator discretion) and placed on the waiting list for the next available program.
- Participants who miss more than three sessions for unacceptable reasons are required to meet individually with the facilitators to discuss their motivation to attend. Based on this discussion, a decision will be made as to whether they will be placed on the waiting list for the next available program.
- In the case that a participant is removed/withdrawn from the program due to unacceptable absences or inappropriate behaviour, facilitators should document decisions on the file to:
 - inform the case manager of the decision;
 - jointly inform the participant of the decision; and
 - discuss options for further intervention.

A program completion report is to be completed by facilitators within one month of program cessation.

In addition, the Corrections Victoria standards require programs to be audited to assess adherence to the program model at least once in every four times it is delivered. Audit checklists are used to assess whether:

- the objectives of the program were clearly explained to participants;
- the objectives of the overall program were met;
- the objectives of the session were met;

- session content and activity-based exercises were appropriately used;
- connection with other sessions was made;
- session tasks were accomplished;
- the program content was linked to program goals;
- the program was delivered in accordance with the planned dose and intensity;
- any departure from the prescribed dose and intensity was approved by the program managers;
- all participant absences were documented in the case file, with the reason for absence given and a description of any follow-up; and
- end-of-program reports had been completed within one month of program cessation.

Vlais et al. (2017, p.75) have noted that “maximising program integrity has been an important consideration for correctional programs for some years, through the application of treatment and program integrity checking processes and templates”. As correctional services provide violent offending behaviour programs – including those in the sexual assault and DFV offence categories – based on the implementation of comprehensive and detailed program manuals, program integrity has often focused largely on the extent to which the manual was followed when implementing the program (Vlais et al., 2017, p. 75). Vlais and colleagues argue that:

this has led to some criticism about the dangers of ‘over-manualised’ approaches where practitioners commit to following the manual to such an extent that they lose sight of the change processes they are trying to imbue in the men”, and that “narrow pursuits of program integrity have the potential to undermine the conceptual clarity upon which a program is based (Vlais et al., 2017, p. 75)

Health

In healthcare settings, the notion of “empirically supported” and “evidence-based” treatment has been around for many years now, with research knowledge applied to service delivery through the application of clinical practice guidelines, rather than standards. These are “systematically developed statements formulated to assist health practitioners, consumers

and policy makers to make appropriate decisions about health care”, and are “based on a thorough evaluation of the evidence from published research studies on the outcomes of treatment or other health care procedures” (NHMRC, 1999, p. 21). In essence, these represent a set of practice-based action statements that need to be adhered to if a service is to make any claims of applying best practice. The distinction between practice guidelines and standards is an important one for the DFV sector to consider.

Practice guidelines – sets of statements formulated to guide or assist practitioners in their practice, or “how to” guidelines (Thomson, 2013) – for program delivery are relatively uncommon in relation to MBCP delivery. The New South Wales (NSW) practice guide, *Towards safe families* (2012), however, is an exception.

Standards in Australia

This section of the report aims to identify similar and unique features across four Australian jurisdictions and to explore how they have approached the task of developing processes for supporting program providers to become evaluation ready. It is clear that the sector is developing rapidly across the country; however, the community-based MBCP sectors in other states and territories were considered too small to enable a separate jurisdictional review for the following reasons:

- The Australian Capital Territory government funds one agency to provide a community-based MBCP, with this program still in the establishment phase at the time of writing.
- The Northern Territory has one MBCP that is run by a community-based provider.
- The South Australian Government is in a consolidation phase with respect to all services delivering interventions to perpetrators of domestic, family and sexual violence, as well as any organisations supporting women and children while the perpetrator is engaging with the accountability system.
- The Tasmanian Government funds one provider of community-based MBCP work across three sites.

Timing of this review

A review such as this can only capture MBCPs at a particular point in time. An effort was made during interviews with sector representatives to attempt to “future proof” the review by looking at intentions and plans for sector development priorities over the medium to long-term. However, this was limited both by what government-based representatives were able to share and also by the evolving nature of the field. In many English-speaking jurisdictions, including Australia, there is significant government attention on MBCPs, and increasingly policy and funding initiatives are being developed and implemented in this field. Initiatives in development at the time of this review include:

- the update of minimum standards/professional practice guidelines for community-based MBCP work and the development of compliance frameworks and provider monitoring mechanisms in Victoria and Queensland;
- the development of a compliance framework and monitoring mechanisms for Western Australian program

providers in relation to the recently revised professional practice guidelines for that state, and the evolution of a new peak body in Western Australia for MBCP work, “Stopping Family Violence Inc.”;

- the development of minimum standards for community-based MBCP work in South Australia;
- an update of UK Respect’s accreditation standard and reform of its accreditation system for community-based providers;
- publishing milestones for a major US study on standards and compliance processes for batterer intervention programs across all 50 states, including the development of a website to enable standards and compliance systems to be compared across these jurisdictions, led by Dr Mankowski from Portland State University; and
- significant further developments in minimum standards development in some European countries, such as Croatia and Ireland.⁷

Queensland

The MBCP sector in Queensland is undergoing significant reform, and contemporary developments should be considered when drawing on this review.

Characteristics of the community-based MBCP field

Queensland MBCPs were first developed in the late 1980s, with the field experiencing a rapid development of activity in the first half of the 1990s, a similar pattern to Victoria and Western Australia. By the mid-1990s, growth in the number of state-funded programs had slowed, such that 20 years later the number of funded programs was only marginally higher. The Department of Child Safety, Youth and Women currently funds 24 services to deliver perpetrator interventions in the community. The 2016-17 State Budget allocated \$10.3

⁷ Through personal communication and an interview with Dr Mankowski and a colleague from his team, our jurisdictional review benefitted from the yet unpublished results of their research; however, we were able to derive only general indications from their detailed current analytic work of the data, and an overview of some of the themes. We are very grateful to Dr Mankowski, Rachel Smith, and the project team for providing us with some preliminary findings prior to publication.

million over 4 years to implement perpetrator intervention services, the Walking with Dads pilot, and to engage an external organisation to review practice standards. New services funding has been directed to service gaps, taking into account existing and proposed perpetrator services including specialist magistrates courts and Child and Family Reform, and prioritising areas where high-risk teams are established. At least one Aboriginal and Torres Strait Island-specific MBCP is run in Queensland (in Rockhampton), with further programs and initiatives working with Aboriginal and/or Torres Strait Islander men who perpetrate family violence in the state's far north.

The Queensland *Professional Practice Standards - Working with men who perpetrate domestic and family violence* (Queensland. Department of Child Safety, Youth and Women, 2016a) stipulate a minimum program length of 32 hours, with most programs around 32-40 hours' duration spread over 13-16 weeks. While MBCP fields in the rest of Australia are starting to move in this direction, Queensland is unique in that additional individual sessions to complement group work activity has been a feature of programs in that state for quite some time. Most programs either conduct court respondent worker services in their local magistrates court or are fed referrals from other organisations who conduct court-based work. Major referral sources for programs include perpetrators on probation or parole, child protection services, magistrates courts (through court respondent workers or intervention orders), DV Connect Mensline, family law solicitors, internal referrals within larger relationship service-based agencies, and police active referrals (Monsour, 2014).

Significant growth in referrals to MBCPs is likely to come through child protection and state-funded family support services. Recent reforms have seen designated family violence practitioners being placed within family support services. However, to date, with a few exceptions, this placement has not focused on strengthening practitioners' capacity to engage with perpetrators or to provide referrals to MBCPs. Simultaneously, the Walking with Dads initiative has involved recruiting and equipping a small number of specialist perpetrator engagement practitioners within child protection across five trial sites and has been matched with funding for the development of new MBCPs in these locations. This

initiative provides the potential for systemic collaboration between child protection services and MBCP providers in assessing and working towards safe parenting capacity for DFV perpetrators.

A further relevant initiative in the Queensland context is the increasing number of referrals stemming from civil protection order proceedings in the magistrates courts. Respondents to a domestic violence (protection) order can provide consent for the order to be associated with a voluntary intervention order (to be retitled intervention order in pending legislation), which would then mandate the perpetrator to participate in MBCP or equivalent individual-focused counselling. This is different to the counselling order system operating in some gazetted areas of Victoria, in that in Queensland the respondent's consent is required in order for participation in a MBCP to be mandated in this way; however, once mandated, they cannot withdraw their consent.

Guiding legislation and action plans

The *Domestic and Family Violence Protection Act 2012* (Qld), which was under review at the time of writing, is the key legislation relevant to MBCP delivery in Queensland.

Not now, not ever: Putting an end to domestic and family violence in Queensland (Special Taskforce on Domestic and Family Violence in Queensland, 2015) is a crucial document for DFV sector reform in Queensland. Researched and written by a taskforce led by the former Australian Governor-general Quentin Bryce, the report makes 140 recommendations, including a small number of broad recommendations focusing on the development of the MBCP field in Queensland (Special Taskforce on Domestic and Family Violence in Queensland, 2015). The recommendations have helped to inform the Queensland *Domestic and family violence prevention strategy 2016-2026*, which is currently in the *Second action plan of the domestic and family violence prevention strategy 2016-17 to 2018-19* (Queensland. Department of Child Safety, Youth and Women, 2016b). This second action plan includes strategies to:

- expand the number of perpetrator intervention services to increase their capacity to respond to more perpetrators, and engage new services where there are gaps identified

(including where high-risk teams are being rolled out as part of an integrated service response to DFV);

- review and update the *Professional practice standards: Working with men who perpetrate domestic and family violence* (DCSYW, 2016a), broadening the scope to include individual counselling, culturally appropriate approaches to Aboriginal and Torres Strait Islander clients, young offenders and provision of information to respondents appearing at court;
- develop a quality assurance framework and audit process to ensure ongoing compliance with the *Professional practice standards: Working with men who perpetrate domestic and family violence* (DCSYW, 2016a);
- continue to identify opportunities to streamline systems for engagement of interpreters for civil DFV court proceedings;
- consider strategies to increase perpetrators' participation in intervention programs as part of the development of integrated service response pilots; and
- conduct research on options to monitor high-risk perpetrators of DFV (DCSYW, 2016b, pp. 19-20).

Peak body or dedicated capacity-building organisation

Services and Practitioners for the Elimination of Abuse Queensland (SPEAQ) is a network of service providers and individual practitioners focusing on perpetrator interventions, including MBCP providers. A forerunner of SPEAQ, the Queensland Network of Men's Family Violence Service Providers, established in South East Queensland in the early 1990s, was Australia's first such network. However, unlike Victoria's No to Violence, SPEAQ has not been provided with government funding. The network has operated on the basis of membership fees only, evolving from an initial focus on the south-east corner of the state into a statewide network with a secretariat in the second half of the 2000s (Monsour, 2014). At the time of writing, SPEAQ had recently been provided with a grant by the Queensland Government to develop a website as a resource for the MBCP field and referrers, to support its sector networking and professional development focus.

Standards or professional practice guidelines

Professional practice standards for work with DFV perpetrators were first developed in Queensland in 1997, and updated in 2007. The standards drew upon Victoria's No to Violence minimum standards, and the 2004 Comparative Assessment of Good Practice for perpetrator interventions stemming from the Commonwealth's Partnerships Against Domestic Violence workstream (Chung, O'Leary, & Zannettino, 2004). They were developed through a program provider driven, "bottom-up" process, and are consistent with other minimum standards sets in Australia. They do not reference relevant literatures or indicate whether or how the evidence base was used to inform the standards. The professional practice standards contain a medium level of detail, more so than some of the leaner standards such as those in New South Wales and Western Australia, but less than the Victorian set.

The Queensland Government has commissioned a review of the minimum standards as part of its *Second action plan 2016-2019* (DCSYW, 2016b). The scope of this review includes developing practice guidelines for some perpetrator interventions beyond MBCP provision, such as for court respondent workers, and for working with adolescents who use violence within relationships. The scope of the review also includes recommendations for accreditation or other systems to monitor program provider compliance with the standards.

Compliance monitoring

There is currently no compliance monitoring mechanism in relation to MBCP standards, although this will be developed as part of the state government's *Second action plan 2016-2019* (DCSYW, 2016b) and program review.

Foundational training for practitioners

Historically, no foundational training options have been available for Queensland practitioners. In 2017, however, Queensland Council of Unions, through the Queensland Centre for Domestic and Family Violence Research, commenced delivery of a Graduate Certificate in Facilitating

Men's Behaviour Change. This is being delivered through distance education (online means), to enable accessibility for rural and regional practitioners. Course entry is not limited to practitioners in Queensland.

Professional development and community-of-practice activities

In the context of very limited resources, SPEAQ:

- conducts regular teleconferences with network members to discuss trends, issues, patterns, challenges and opportunities in perpetrator intervention work, and to facilitate the exchange of industry-relevant information;
- holds an annual 2-day forum for practitioners;
- runs an annual program manager forum; and
- participates in other sector development activities where capacity allows.

SPEAQ also provides input and submissions into state and Commonwealth government inquiries and reforms related to DFV.

Victoria

Victoria saw the fastest growth in the MBCP field in the mid to late 1980s and early 1990s. Until 2013, Victoria had Australia's only funded peak body or network dedicated to capacity-building in this field, and still to this day has the largest number of funded program providers and program sites in Australia. At the time of writing, approximately 4000 places were funded for Victorian MBCP work. Approximately two-thirds of this funding comes through the Department of Health and Human Services, with the remainder through the justice system. Justice-funded referrals come through the civil justice system (in a small number of gazetted areas in Victoria, magistrates have the authority to mandate perpetrators who are respondents to a family violence intervention order (protection order) to participate) and through Corrections Victoria, which funds community-based MBCP providers to work with offenders on community corrections orders who are deemed to be "low risk".

Characteristics of the community-based MBCP field

At the time of writing, approximately 25 providers of MBCPs run programs across approximately 40 sites in total. While many providers run programs at a single site, approximately 40 percent conduct work at between 2-6 sites. In general, only one program or intake is run at each site, though in the case of the largest program providers, several sequenced intakes or parallel programs might be run. This might consist, for example, of a provider running an open entry group for new program participants soon after they have completed assessment in parallel with a second-stage closed group for participants who have progressed in terms of their readiness to change.⁸ In a small but growing number of cases, providers have the capacity to run multiple parallel intakes at the same site.

Two MBCPs are run in languages other than English (Vietnamese and Arabic), with a third focusing specifically on men from South Asian countries (run in English). A small number of other programs specific to culture are in conceptual or development phases. One program is run specifically for gay and bisexual men who perpetrate family violence and takes referrals for perpetrators from other parts of the LGBTIQ community. Approximately three Aboriginal-specific MBCPs exist, run either by Aboriginal community controlled organisations or community health services. However, the status of these programs in relation to the Victorian MBCP minimum standards (and more fundamentally, the applicability of these standards to Aboriginal and Torres Strait Islander programs) has not been explored beyond the adaptation of standards at an individual program level.

Victorian community-based MBCPs generally provide approximately 12-20 group work sessions after one or two sessions of individual comprehensive assessment. The Department of Justice and Corrections, Victoria, funded

⁸ The proportion of providers who run multi-stage programs where participants progress through two or three stages of group work across a period of 5 months or more has declined over the past 5 years. While approximately 25 percent of providers sequenced program participation in this fashion in the 2000s, this is now less common as these providers have needed to shorten and rationalise their programs to make available resources stretch to significantly increasing demand in the 2010s.

programs have some limited additional capacity to supplement group work with one-on-one sessions where indicated. Referral sources into MBCPs have diversified since the Victorian Government introduced statewide reforms in the middle of the previous decade to strengthen service system integration. At that time the majority of referrals could be classified as self-referrals, often in the context of a “social mandate” involving significant pressure to self-refer from the perpetrator’s family or networks of influence. Since that time the proportion of referrals stemming from “soft” (e.g. from child protection) or “hard” mandates have increased substantially, and now make up over half of all participants in these programs. The statewide telephone referral service for men who perpetrate family violence, the Men’s Referral Service, has also been a significant source of referrals for more than 20 years.

The Victorian community-based MBCP field is undergoing a period of significant evolution and growth. Several recommendations of the Victorian Royal Commission into Family Violence relate to strengthening MBCP practice, in part through diversifying the nature and contexts in which these programs run, and through adopting evidence-based practices from the correctional rehabilitation literature (see Day, Chung, O’Leary, & Carson, 2009a). A significant new injection of funding into the field is arising through the implementation of relevant Victorian Royal Commission into Family Violence recommendations. This includes a substantial increase in the unit cost funding for MBCP work in recognition of the increased complexity and demands on this work since funding formulas were first established by the Victorian Government. It also reflects specifically targeted innovation funding to seed new approaches to delivering men’s behaviour change work for specific cohorts of perpetrators.

Guiding legislation and action plans

The *Family Violence Protection Act 2008* (Vic) is the key Victorian legislation for all DFV matters. In addition, the Victorian Government has released new legislation that will enable stronger and more consistent information sharing to respond to the risk posed by perpetrators. The final report of the Victorian Royal Commission into Family Violence is pivotal to future developments in the MBCP field in Victoria,

and to perpetrator interventions more generally. The Victorian Government has invested historically unprecedented levels of funding and created a dedicated agency, Family Safety Victoria (FSV), to oversee the implementation of the Commission’s 227 recommendations.

Peak body or dedicated capacity-building organisation

No To Violence (NTV), incorporating the Men’s Referral Service, has existed as a peak body for Victorian MBCP providers for approximately 20 years. One of the few such peak bodies worldwide, NTV has gradually extended its capacity over this time to perform a significant role in policy development, training and professional development, and to some extent research on a state and national scale. The Victorian Government has drawn heavily upon NTV to participate in committees and working groups focusing on family violence reforms. NTV has also worked closely with peak and statewide women’s and children’s family violence representative organisations in responding to and advocating for new and potential government initiatives.

Standards or professional practice guidelines

NTV developed the first minimum standards for MBCP work in Australia, published in 1996. These were subsequently revised 10 years later and recently underwent their second review. The Victorian standards have been quite influential on a national scale.

The initial iteration of the standards was developed largely through concern by Victorian MBCP practitioners about the need to develop consistency across the field, and that some programs arising through a men’s health lens would not adopt sufficient rigour in terms of safety and accountability. Indeed, NTV first arose through this networking of practitioners to develop minimum standards. The 1996 standards were therefore largely practitioner-led, and are based on the accumulated expertise concerning minimum requirements for safe practice. The 2006 update incorporated a somewhat closer look at the available MBCP evidence-based literature; however, due to the general absence of empirical consensus,

a methodology of extensive consultations with program providers and practitioners in the field was used as the main basis for the review. Other relevant literature (e.g. correctional, addictions) was not researched as part of standards development.

The recent review of the minimum standards by FSV has resulted in a considerable change to their structure. The new minimum standards are aligned with the Principles for Perpetrator Interventions developed by FSV and are a mixture of quite high-level statements and more detailed prescriptions.

Compliance monitoring

A “self-regulatory” monitoring framework was introduced with the 2006 update of the minimum standards. Membership of NTV was considered a prerequisite for NGOs to be eligible for Victorian Government funding for MBCP work, and to be a member of NTV, an NGO needed to declare that it met the minimum standards. NTV established a complaints mechanism whereby any member of the public could register a complaint against a program provider in relation to alleged non-compliance with the minimum standards; however, the number of complaints lodged through this process has been low. While Victorian Government funding bodies theoretically have a role to monitor compliance through provider liaison in the course of funded service agreement contract management, in reality, this has rarely occurred. The Victorian Government, based on a recommendation of the Royal Commission, has commissioned work to develop an accreditation and monitoring framework for Victorian MBCP providers that will, one assumes, go beyond the current self-regulatory framework.

Use of program logic and other program integrity building methods

Victorian MBCPs originated in a localised, diverse fashion. Many programs developed through integrating understandings and practices from Duluth, cognitive-behavioural and narrative practices. The development of a program curriculum, and core practices around assessment and partner contact,

have come to define these programs over time, with each program adopting a different curriculum depending on the idiosyncratic nature of that program’s development, and the particular change models influencing key practitioners.

A number of programs have subsequently been reviewed in response to changing staffing and management arrangements. While program logics or documented theories of change have often not been incorporated into these reviews, some providers have sought to strengthen the conceptual clarity of their programs, for example by arranging high-quality external supervision.

The section of the (now defunct) NTV standards manual on quality resources – a set of tools and templates to assist program providers with various facets of their program – includes a tool whereby observers can sit in on one or more MBCP sessions to provide feedback to facilitators on various aspects of the session and the facilitation process. Observers regularly attend MBCP sessions, as students conducting an observational practicum as part of their foundational training in MBCP work (see the next section), as stakeholders, or as practitioners from partner agencies collaborating with the MBCP provider as part of a systemic response; there is the potential for this tool to provide useful feedback for facilitators.

Foundational training for practitioners

In 2000, NTV partnered with Swinburne University of Technology to develop possibly the world’s first substantive, competency-based entry training, specifically designed for MBCP practitioners. Pitched at the Graduate Certificate level, this remained Australia’s only such foundational training until very recently. In 2018, the NSW Education Centre Against Violence initiated a Graduate Certificate in Men’s Behaviour Change Individual and Groupwork Interventions, with six of its nine units developed specifically for the course. Also, in 2018, an online MBCP practitioner course at the Graduate Certificate level was developed by Central Queensland University.

Despite the advent of the NTV/Swinburne University course, workforce development remains a major constraining issue

to the quality and growth of MBCP work in Victoria. The Victorian Government and NTV are conducting a workforce analysis to determine the reasons for the shortage of qualified practitioners in relation to the demand. Hypotheses for the shortage include the possibility of high staff turnover due to the complex nature, low pay, night-time working hours and casual/part-time nature of much of the workforce; and the lack of a sufficiently large pool of professionals initially interested in considering the work. The growing professionalisation of MBCP and DFV work in general over the past 15 years may also be a factor, reducing opportunities for people without qualifications in psychology or social work from entering the field.

In both Victoria and NSW at least, the recruitment by MBCP providers of a number of new practitioners into the field, to enable capacity for program provision growth, has resulted in an increased need for training. This presents a challenge for the field, in terms of how to minimise unsafe practice by new practitioners who have not yet had an opportunity to participate in Graduate Certificate level training.

Professional development and community-of-practice activities

NTV conducts a number of professional development events for MBCP practitioners, ranging from the very occasional conference, through to 4-day training events, to shorter professional development activities. NTV also conducts training for practitioners from partner agencies (e.g. child protection and family services practitioners, magistrates and allied sector health workers) in recognising and responding to male family violence.

NTV has recently developed and run a large number of 4-day training courses for new MBCP practitioners entering the field, as a prerequisite for participation in more substantial competency-based training.

Western Australia

At the time of writing, the MBCP sector in Western Australia (WA) was undergoing a significant transition.

Characteristics of the community-based MBCP field

The MBCP sector in WA has existed for at least 25 years. Throughout much of this time, a small number of providers (2-4) have provided programs across multiple sites. Currently, four providers are contracted by state government agencies to provide programs over approximately 12 locations, with most of these situated in Perth. There are few programs located in the state's vast rural and remote regions.⁹

Funding for program providers has arisen mainly through the recently renamed Department of Communities and the Department of Corrective Services. Western Australia recently had six specialist family violence courts feeding referrals into MBCPs, which have been dismantled into a new model currently being trialled, to respond to family violence offenders in mainstream courts. The Western Australian Government also recently announced legislation to develop a mandatory referral pathway for perpetrators into MBCPs arising through civil justice system protection order processes. However, at the time of writing, work to enact this pathway had not commenced.

Western Australia is one of the few jurisdictions where most MBCPs are of approximately 6 months duration, characteristically over about 26 sessions of group work activity. Innovations in MBCP program provision in the state include a residential MBCP, operating since 2003, and a conjoint MBCP and substance abuse intervention program (see Communicare, 2018).

⁹ There is some current activity to develop Aboriginal-focused programs in the Kimberley and Pilbara regions, and programs exist or have existed at times in Albany, Bunbury, Kalgoorlie and Geraldton.

Guiding legislation and action plans

The *Restraining Orders Act 1997* (WA) has recently been updated through the *Restraining Orders and Related Legislation Amendment (Family Violence) Bill 2016* (WA). This new legislation enables several significant changes to the state's civil and criminal justice system approach to DFV perpetration, providing a pattern-based definition of DFV as coercive control rather than the previous focus on abusive incidents. The legislation potentially enables courts to mandate perpetrators through the civil justice system to attend a MBCP or appropriate intervention through the introduction of Family Violence Restraining Orders.

Western Australia's family and domestic violence prevention strategy to 2022 includes the following reference to perpetrator interventions:

Identify gaps in current services for perpetrators, or those at risk of perpetrating, family and domestic violence and improve the quality and availability of services and programs working with perpetrators, or those at risk of perpetrating, family and domestic violence. (Western Australia. Department for Child Protection, 2015, p. 10)

Peak body or dedicated capacity-building organisation

Stopping Family Violence Inc. (SFV) is a newly formed NGO in Western Australia with a focus on research, policy and advocacy in perpetrator interventions and perpetrator intervention systems, including but not limited to MBCPs. SFV assisted with the development of the state's *National Outcome Standards for Perpetrator Interventions* (NOSPI) response plan, has developed and auspiced a Western Australian Men's Behaviour Change Network (WAMBCN) for program providers, and plans to develop an accreditation framework for provider compliance in relation to the state's professional practice standards for MBCP work.

The WAMBCN meets approximately bi-monthly and is a member-led network that nominates a representative to sit on the board of SFV. The SFV provides the secretariat and support functions for the network and is undertaking

some initial leadership functions. However, the network is a separate entity to SFV, focusing specifically on the common needs of MBCP providers concerning training, professional development, advocacy and improving the quality of practice; whereas SFV's focus is on the policy and practice cycle of perpetrator interventions more generally. As WAMBCN commenced in early 2017, it is premature to predict in detail the nature of its activities or the capacity it will be able to build.

Standards or professional practice guidelines

Initially developed in 2000, the *Practice standards for perpetrator intervention* as they are now termed were updated in 2015 (Western Australia. Department for Child Protection and Family Support, 2015, p. 8). This is a very succinctly written document focusing on five headline standards worded exactly the same as the NSW minimum standards:

- Safety of women and children must be given the highest priority.
- Victim/survivor safety and perpetrator accountability are best achieved through an integrated systems response that ensures that all relevant agencies work together.
- Challenging family and domestic violence requires a sustained commitment to professional and evidence-based practice.
- Perpetrators of family and domestic violence must be held accountable for their behaviour.
- Programs should respond to the diverse needs of the participants and partners.

Four key ethics principles are also outlined:

1. An important source of information about risk, safety and behaviour change is the man's current and/or former intimate partner/s.
2. The operation of men's behaviour change programs must occur in partnership with agencies and organisations in the community and be open and transparent with those agency partners.
3. Information sharing is critical for assessing, managing and monitoring risk and must be an ongoing feature of men's behaviour change practice.
4. A commitment to evidence-based practice including

continual monitoring, review and evaluation is imperative for furthering the safety of women and children (Western Australia. Department for Child Protection and Family Support, 2015, p. 8).

The five headline standards are associated with 31 individual standards, drawing heavily from, but not entirely reproducing, the NSW standards.¹⁰ These are written succinctly and in a form that enables considerable flexibility for providers to be able to meet the particular standard. A brief amount of explanatory text is provided for each individual standard. To provide an indication of the intentional brevity, the overall standards document is approximately 20 pages of highly spaced text in large font. Clearly, the standards were written to be as minimally prescriptive as possible.

Compliance monitoring

No current system of monitoring the compliance of MBCP providers to the professional practice standards exists. The previous iteration of the professional practice standards in 2000 had a fairly “low profile” role in the sector, and the degree to which they were influential in contract development and management is uncertain. The Western Australian Government, however, has clearly signalled the need for the development of a compliance monitoring system for MBCPs in relation to the updated 2015 professional practice standards and has funded SFV to consult with the sector and recommend the development of a system going forward.

Use of program logic and other program integrity building methods

As with most other jurisdictions, program providers in Western Australia have not historically used program logic models or invested significant time specifically in assessing and building program integrity for their interventions. However, some providers have conducted program reviews

in recent years, and as part of this process have focused on the conceptual clarity and consistency within their program, and how program theory is translated into practice. These reviews have arisen in part out of a recognition of program drift and of interventions being run according to the theoretical and therapeutic preferences of individual program practitioners, rather than stemming from a consistent and articulated conceptual and theoretical base at the program level. Minimum standard 4.2 of the updated professional practice guidelines states:

Programs must be grounded in an evidence-based theory of change.

The theoretical approach of programs will vary; however, it is important that programs are based on evidence of what works. Programs must clearly articulate how the program is intended to change the behaviour of the participants. The programs’ content and delivery should be consistent with this theoretical base. (Western Australia. Department for Child Protection and Family Support, 2015, p.18)

Foundational training for practitioners

There is no competency-based foundational MBCP-focused training for practitioners in Western Australia. However, STV has developed and is implementing a training and professional development plan that will culminate in the individual registration of MBCP practitioners in the state. This will include a 5-day training program for MBCP practitioners and assessments of videotaped recordings of practice. The individual registration of practitioners will be a preliminary step towards a multi-pronged, program provider focused, accreditation framework and system.

Professional development and community-of-practice activities

As relatively large agencies with their own training service delivery arms, the four MBCP providers have the capacity to periodically organise 1-day training focusing on men’s behaviour change work. However, historically this training has been largely opportunistic and not systematically planned across the sector. STV, through the development of the WAMBCN, is developing a more strategic approach to

¹⁰ The two standards sets are almost identical, with the Western Australian document containing three additional standards and rewording a few others. For example, standard 3.7 in the NSW document - “Program providers will evaluate the impact of programs on the behaviour and attitudes of group participants” - was reworded to “Program providers will evaluate the impact of programs on the safety of the participants’ (ex) partner and children”.

professional development for the sector. It is also the intention of the network to develop more regular and fluid community-of-practice processes, likely to evolve more fully into 2019.

New South Wales

While a handful of NSW programs commenced in the 1990s, state government funding for MBCP providers was not available until 2015, through the introduction of significant funding for four pilot sites. Funding for providers delivering programs in other sites was in the process of being released at the time of writing.

Characteristics of the community-based MBCP field

At the time of writing, nine providers were registered in NSW, providing programs across 18 sites. Given that NSW is Australia's most populous state, with a number of regional and rural population centres, this coverage is particularly low. Most programs are located in the Sydney region and along the eastern seaboard, though coverage in a few other areas of the state is gradually expanding through the release of funding tranches. The expansion will almost double the number of programs and services, which will be located more broadly across NSW.

Funding for the four pilot sites is administered through Women NSW (Department of Family and Community Services). The responsibility for minimum standards and compliance monitoring processes is held by the NSW Department of Justice. The funding for the four pilot sites is at an unprecedented level for the Australian context, enabling providers to enhance standard MBCP delivery with individualised case planning, stronger partner contact and more attention to program evaluation.

Guiding legislation and action plans

The *Crimes (Domestic and Personal Violence) Act 2007* (NSW) is the key enabling legislation in the state. The NSW *domestic and family violence blueprint for reform 2016-2021*:

Safer lives for women, children and men is the key policy document driving the perpetrator intervention sector, with commitments to:

- increase and improve behaviour change interventions for high-risk domestic and family violence offenders;
- trial initiatives to reduce Apprehended Domestic Violence Order breaches through behavioural insights strategies;
- expand NGO community-based men's behaviour change interventions;
- develop the capacity of the community-based MBC sector;
- implement a statewide referral pathway between police and the Men's Referral Service to help offenders change behaviour;
- roll out the first two Police High Risk Offender Teams to target recidivist offenders and investigate domestic and family violence incidents; and
- assess the feasibility and effectiveness of providing accommodation for perpetrators to reduce immediate reoffending (NSW Ministry of Health, 2016, p. 3).

Peak body or dedicated capacity-building organisation

From 2013-16, the NSW Government provided a small amount of funding to enable a NSW Men's Behaviour Change Network (MBCN) to conduct activities across registered MBCP providers. This included convening an annual (small-scale) conference, 1-day professional development forums (approximately 2-3 per year) and member forums (Men's Behaviour Change Network NSW, 2018). The network also evolved to provide a common point of provider feedback to government in relation to DFV reforms, including those affecting the perpetrator intervention field. The network proved very effective in supporting program providers to identify common needs and goals despite the presence of a competitive tendering environment. Women NSW (Department of Family and Community Services) has funded Victoria's No to Violence (NTV) for a sector support coordinator to continue to progress the NSW MBCP network and network activities.

Standards or professional practice guidelines

Minimum standards for MBCP delivery in NSW were first launched in 2012. This proved quite contentious for the sector, as program providers, who at that stage received no state government funding for MBCP delivery, were required to meet the minimum standards in order to obtain referrals from state government authorities and services (child protection, community corrections and police) and to be considered “in the tent” of the state’s network of providers. The minimum standards document is very succinct, substantively running to 10 pages with 28 standards across five principles. The principles are as follows:

- The safety of women and children must be given the highest priority.
- Victim/survivor safety and offender accountability are best achieved through an integrated, systemic response that ensures that all relevant agencies work together.
- Challenging domestic and family violence requires a sustained commitment to professional and evidence-based practice.
- Perpetrators of domestic and family violence must be held accountable for their behaviour.
- Programs should respond to the diverse needs of the participants and partners (New South Wales. Department of Attorney General and Justice, 2012, p. 3).

The standards document states that the standards were developed in part based on “an extensive review of the literature regarding program standards for domestic violence behaviour change programs” (New South Wales. Department of Attorney General and Justice, 2012, p. 3). However, this literature review is not publicly available, nor is the evidence base for any of the standards in the document outlined.

A practice guide was commissioned by the (then) NSW Department of Attorney General and Justice to accompany the standards, to provide detailed practice guidelines on how providers could meet each of the standards at acceptable and optimal (i.e. above the bar set by the standards) levels. *Towards safe families: A men’s domestic violence behaviour change practice guide* has become Australia’s only relatively up-to-date and detailed practice guide for MBCP work,

which has influenced practice outside of NSW (New South Wales. Department of Attorney General and Justice, 2012). Compared to the brevity of the minimum standards document, the practice guide is approximately 280 pages, with half devoted to a series of program tools and templates that program providers can download and adjust for their local circumstances.

The NSW minimum standards have been updated recently, with a compliance framework due to be released in early 2019. The new standards:

- remove some of the previous prescriptive detail to give program providers more flexibility to develop new and innovative practice;
- focus on targeted, evidence-based approaches to make sure MBCPs are fit-for-purpose according to the risk level, needs and ability of participants;
- have clearer processes for victim/survivor safety and the utilisation of Safer Pathway,¹¹ including the NSW Government’s coordinated approach to supporting victims/survivors of domestic violence and their children;
- include strengthened requirements for MBCPs to understand and respond to the diverse needs of participants; and
- contain revised language and structure to better support MBCPs to understand the standards and how they can demonstrate compliance.

Compliance monitoring

Only registered NSW MBCPs are eligible to receive funding and referrals from government authorities and services. The NSW Department of Justice operates a registration process, whereby program providers must complete a detailed process addressing each of the minimum standards individually. The applicant is required to provide a narrative expressing how they are meeting the particular standard and is also required to attach documentary evidence. Examples of the latter include:

¹¹ Safer Pathway is a set of protocols developed by the NSW Government to encourage appropriate information sharing, risk assessment and risk management activity by partner agencies within DFV service systems. See <http://www.domesticviolence.nsw.gov.au/for-service-providers/safer-pathway>.

- various policies and procedures relating to risk assessment and risk management;
- position descriptions of the program's partner support worker (or a memorandum of understanding with a victim/survivor service if partner contact is provided externally);
- procedures document for partner support activities;
- program manual;
- policy regarding knowledge and training requirements of program staff;
- Terms of Reference for the program reference group;
- policy for clinical supervision;
- policy for professional development of program practitioners;
- assessment protocols and templates; and
- evaluation plan.¹²

The registration process consists entirely of a desktop review of the provider's application, with no liaison or follow-up with providers outside of administrative purposes. No monitoring or auditing activities occur until re-registration is required. This is, in part, a pragmatic consequence of the lack of MBCP expertise within the NSW Government to conduct auditing processes beyond initial registration.

Use of program logic and other program integrity building methods

NSW is one of the few jurisdictions that has invested time and resources in developing a program logic for MBCP work. As part of the rollout of funding for four MBCP pilot programs, Women NSW commissioned a consulting firm to work with the Department of Justice to develop a program logic and performance and monitoring framework for the NSW men's behaviour change program pilots. Three processes were combined to develop the framework:

- A knowledge review to identify process and outcome indicators utilised in national and international evaluations of men's behaviour change programs as well as examples of tools used to monitor and measure change and progress in these programs.

- Visits to each pilot to gain a comprehensive understanding of their approach, model and operating context.
- A series of meetings and workshops with the Reference Group established to oversee the pilots comprising government representatives (from Women NSW, the Department of Family and Community Services, the Department of Justice, Aboriginal Affairs NSW, the four program providers, and the NSW Men's Behaviour Change Network).

The key focus of the framework is to:

- measure three core outcomes (improved safety of women and children; behavioural and attitudinal change among men; improved capacity of services to identify, support and refer women and men for support);
- assess the value and benefit of individual model components;
- capture developing learnings regarding best practice, program design and development;
- document the capacity-building elements of the MBCP, the service sector and the broader community;
- identify implementation barriers and facilitators; and
- identify core data that could be included in the evaluation.

The framework outlines key evaluation questions, key indicators and data sources for each of the ten process outcomes, six intermediate outcomes and six systemic outcomes that comprise the program logic model. While it is a government document focused on supporting data collection and evaluation across the four pilot sites, it is the only such document identified in the searches that both outlines the program logic underpinning MBCP activity and that extends the program logic "rightwards" across the page to guide evaluation activity.

Foundational training for practitioners

As is the case for all states and territories in Australia excepting Victoria, NSW has historically had no foundational training for MBCP practitioners occurring within the state. However, the NSW Education Centre Against Violence (ECAV) has been funded by the NSW Government (Women NSW, Department of Family and Community Services) to develop

¹² This is not an exhaustive list. Approximately 20 different documents are required overall as part of the application.

a range of training programs for engaging perpetrators of DFV. These include:

- the introduction of a Graduate Certificate in Men's Behaviour Change Individual and Groupwork Interventions;
- a series of 4-day Essential Skills Training in Men's Domestic and Family Violence Interventions for a range of non-specialist workforces, run in urban and rural locations across the state;
- a 5-day training program for new MBCP practitioners as a prerequisite for their participation in the new Graduate Certificate course, again run in multiple locations; and
- other professional development workshops focusing on particular areas of practice (NSW Health. Education Centre Against Violence, 2018, 2018).

Professional development and community-of-practice activities

ECAV is developing a professional development program, in partnership with NTV's NSW sector development work, based on identified areas of need stemming from the updated NSW minimum standards. One of the areas of focus will be the application of Risk-Need-Responsivity (RNR) principles to community-based MBCP contexts.

Part 2:

Evaluation design and the evidence-based assessment of change

The starting point for any attempt to evaluate the extent to which change occurs as a result of participation in a MBCP is to gain clarity about the way in which DFV is conceptualised. There are, of course, many theories that seek to explain the causes and correlates of DFV, or violent or antisocial behaviour more broadly. Several attempts have been made to thematically organise these according to whether they take a broad, large-scale and society-wide “macro” view, or adopt a “micro” approach that considers violence from the perspective of the individual. While structural explanations for DFV are clearly important when seeking to implement broad social change and influence the setting and conditions that allow DFV to occur, at the level of the MBCP the focus is always on the individual participant, even when this is based on an understanding of how individual behaviour is driven through harmful social norms.

A second set of theories, theories of behaviour change, are also directly relevant to program design and evaluation activity. These provide a different level of understanding that is relevant to the identification of the causal mechanisms through which interventions bring about change in the individual perpetrator. Casey, Day, Ward, and Vess (2012) have proposed that these can be used to develop program activities in ways that maximise opportunities for behaviour change, as described in Table 3.

In addition, models of behaviour enactment aim to describe how participation in program activities leads to change. Broadly speaking, the transtheoretical model (TTM) of change (Prochaska & DiClemente, 1984; 1986) is perhaps the most influential of all behaviour enactment models. It focuses on mechanisms that enable goal setting and goal striving (de Ridder & de Wit, 2006). The model is underpinned by two important assumptions:

1. that behaviour change processes pass through distinct stages, with various factors influencing stage transition; and
2. that behaviour in each state is qualitatively different, which requires that interventions targeting change are varied from stage to stage (Weinstein, Rothman, & Sutton, 1998).

These theories, when applied to MBCPs, can help to articulate the types of within-program change that are being sought, as

well as help to identify relevant methods of assessing change for evaluation purposes. They are implicit in the program logic that underpins the delivery of any MBCP.

Program logic as the driver of outcome measurement

The use of program logic as a tool for program providers to achieve clarity regarding their programs’ theoretical underpinnings, key assumptions and pathways towards desired long-term outcomes is relatively uncommon in the community-based DFV program field, despite a strong program logic both reflecting and driving vital considerations in program evaluation. By way of illustration, there are substantial implications for outcome measurement depending on how a program conceptualises the nature of DFV: a focus on DFV as part of a pattern of coercive control (and as distinct from an incident-based understanding), for example, would result in quite different understandings of what program success might look like and the choice of appropriate evaluation measures.

At the centre of a program logic are, from left to right, sets of process markers (short-term), program impacts (medium-term) and outcomes (long-term). Program logic statements – across process, impact and outcome – can be made at the program level (reflecting core program activities with the perpetrator and with victims/survivors) and systems level (objectives relating to the contribution of the program to enhance integrated systemic responses of which it is a part).

Key assumptions underpin the ways in which the process markers are meant to result in program impacts, and a second set of assumptions underlay how program impacts contribute to long-term outcomes. Where possible, these assumptions are ideally based on evidence, or at the very least, are clearly articulated in ways that can be interrogated through research activities over time. A criticism of many program logics in this respect is that in the attempt to fit everything on a single A3 or A4 page, these assumptions can tend to be reduced to just a few keywords that inadequately express the mechanisms of the model.

TABLE 3 Theories of behaviour change and program activities (adapted from Casey, Day, Ward, & Vess, 2012)

Change is facilitated when...	Example MBCP activity
Information is provided about the link between risk behaviour and DFV.	Provide general information about how risk increases under certain circumstances (e.g. alcohol use).
Information is provided about the consequences of DFV.	Provide information on the costs and benefits of acting violently or non-violently.
Information about the approval of others is given.	Consider others' reactions to DFV, including their views on stopping DFV.
When the intention to change is prompted by program attendance.	Encourage the perpetrator to make a commitment to change (behavioural resolution).
When barriers to change are identified.	Identify barriers to stopping violence and how to overcome them.
When general encouragement is offered.	Praise or reward effort or performance, without it being contingent on meeting goals.
When graded tasks are set.	Set easy tasks and increase difficulty until risk behaviour is eliminated.
When instruction is provided.	Tell the perpetrator how to behave in certain circumstances.
When appropriate behaviour is modelled or demonstrated.	Show the person how to behave non-violently (e.g. resolve conflict).

The program logic model can then be extended rightwards across the page so that each program logic statement, particularly with respect to process and impact, becomes associated with one or more performance indicator. Three further columns to the right specify the key evaluation questions associated with the logic statement, the sources of data that would be used to measure each performance indicator, and any considerations in the collection of that data. A hypothetical row of such an evaluation framework is represented in Table 4.

Program logic models are often depicted in terms of a diagram, such as the one developed for the ChangeAbout program delivered by Corrections Victoria (Figure 2). Note, however, that this logic model does not include partner report as a key component of the change process.

Given that long-term outcomes are often difficult to measure within program evaluation budgets, and given that a wide range of factors outside of the program's control can contribute towards these outcomes, evaluation frameworks of this kind, that stem from a program logic, often focus only on logic

statements at the level of program and systems in the process markers and impacts columns. MBCP logic models are thus typically restrained in the amount of detail they contain and are designed to provide a succinct visual representation of the elements and assumptions stemming from an underlying theory of change.

Understanding evidence

Carson, Chung, and Day (2012) have suggested that evidence-based policy and practice have been the touchstones of recent debates about social welfare provision, notwithstanding heated debates about what constitutes evidence, how one prioritises different types of data and what methodological paradigms are privileged in these rankings. They suggest that the assessment of the social impact of domestic violence programs is theoretically and administratively possible (at a higher level by documenting correlations between a program introduction and changes in crime rates, drug use, recidivism, and at a more specific level, by reporting the consequences of participation for particular categories of participants),

TABLE 4 Evaluation logic example

Logic statement	Key evaluation questions	Key indicators	Data sources	Data measurement
Partner agencies work with the program to manage risk (process marker column; systemic level).	<p>What are the mechanisms through which the program collaborates with partner agencies to respond to and manage risks posed by the perpetrator?</p> <p>How are risk management plans developed and reviewed?</p>	<p>Case snapshots where multi-agency risk management processes were required.</p> <p>Outcomes of risk management plans.</p> <p>Risk management procedures and protocols.</p>	<p>Program manual.</p> <p>Use of risk management plan tools and templates.</p> <p>Risk management plan and review entries.</p> <p>Notes from risk review meetings.</p> <p>Documentation of self-audit and reflective practice activities concerning risk assessment and risk management practice.</p> <p>Audit of a representative sample of case files.</p>	Audit best done by an independent evaluator.
Women and children feel safer to remain in the family home (impact column; program level).	Do program activities directed towards the perpetrator contribute to staying in the family home being a safer option for women and children?	<p>Proportion of women assessed at high risk, with their ex/partner participating in the program, who stay at home.*</p> <p>Individualised intervention plans with perpetrators that include an intervention goal to contain risk sufficiently so that family members can stay at home.</p>	<p>Partner case files.</p> <p>Audit of Individual Intervention Plans.</p>	Collection of this data occurs routinely through the program's assessment and intervention activities.

* Interpreting this statistic can be difficult without a matched comparison sample of women at the same levels of risk provided with the same services by Domestic Violence Crisis Service, with the one difference being that their ex/partners do not participate in *Room4Change*.

FIGURE 2 Example program logic for Corrections Victoria's ChangeAbout MBCP

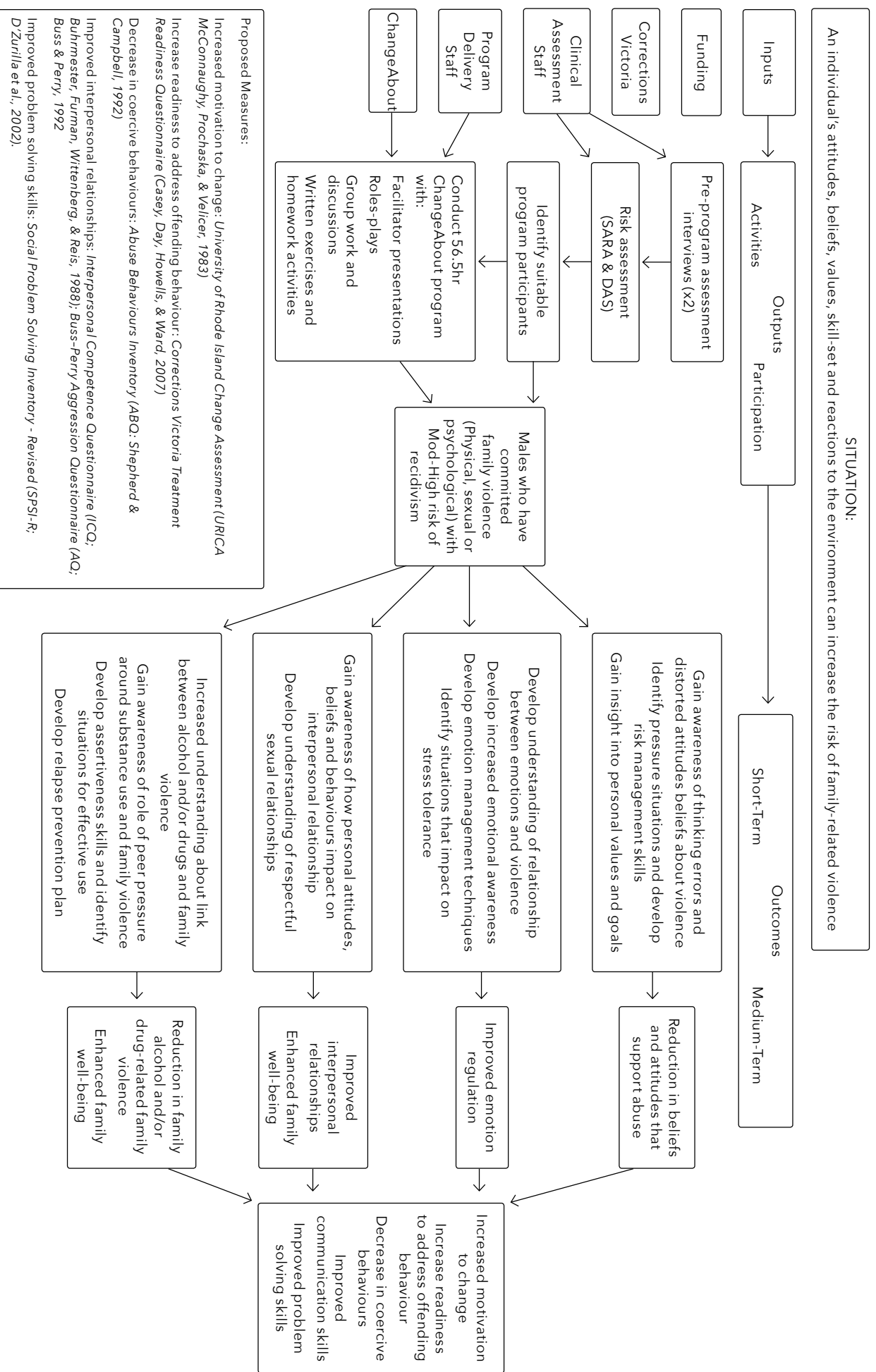


TABLE 5 The Maryland Scale (adapted from Sherman et al., 1998)

Level	Key criteria
1.	Correlation between a crime prevention program and a measure of crime or crime risk factors at a single point in time.
2.	Temporal sequence between the program and the crime or risk outcome clearly observed, or the presence of a comparison group without demonstrated comparability to the treatment group.
3.	A comparison between two or more comparable units of analysis, one with and one without the program.
4.	Comparison between multiple units with and without the program, controlling for other factors, or using comparison units that evidence only minor differences.
5.	Random assignment and analysis of comparable units to program and comparable groups.

although reporting drivers may also constrain the range of service options made available and unnecessarily constrain the professionalism of workers in community service agencies.¹³

More widely, the move towards evidence-based programming has led to the introduction of the requirement that only cost-effective, proven programs and practices should be eligible for funding. Mihalic and Elliott (2015) note, however, that the term “evidence-based” requires definition given that a number of different agencies and groups have developed standards for assessing research relevant to the effectiveness of programs, with some applying a more rigorous standard than others. For example, Axford, Elliott, and Little (2012) argue that a program can only be considered to be “evidence-based” when it has been evaluated through randomised controlled trials or quasi-experimental designs and found unequivocally to have a positive effect on one or more relevant outcomes. This is similar to the approach often adopted in the crime prevention arena, where the quality of an evaluation study design is assessed according to the Maryland Scale for Scientific Rigor (Sherman et al., 1998). The Maryland Scale is a measure of the overall internal validity of scientific methods and is rated from 1-5, with a score of 1 representing the weakest design (see Table 5). Typically, only studies that achieve a level 4 or 5 rating are considered robust enough to provide relevant information about effectiveness (e.g. Day et al., 2010).

A specific problem with this approach, and one that is relevant to the development of standards about the type of MBCP that can be offered, is that it can lead to summaries of evidence (or lists of evidence-based programs) that become

prescribed practice. Fonagy et al. (2014), in writing about family interventions, are particularly critical of this practice:

Historically, there has been a tendency to assume that a treatment can be “branded” once and for all as an evidence-based practice, so that no further reflection on how or for whom it is to be implemented is necessary. This “idealisation” evidence must be avoided at all costs, as the existence of evidence increases the chances of a treatment being effective but is by no means sufficient to ensure success. I/we now know that evidence-based practice cannot be assured by “choosing” a treatment from a list of approved options. This is but a parody of evidence-based practice and tantamount to mistaking the cover of a book for its contents.

An alternative is to apply the principles for the identification of empirically supported interventions (Wampold, Lichtenberg, & Waehler, 2002), which were originally developed to assess behaviour change programs in the mental health arena. Each of the seven principles of empirically supported interventions can be used to assess the strength of current evidence about MBCP outcomes (for women and children, perpetrators and other stakeholders). Principle one, for example, suggests that interventions can be supported at four levels of specificity, extending from the broadest and most general for large populations, through to very specific interventions applied to specific populations with certain characteristics. As a further example, principle two suggests that problems should not be defined entirely in terms of diagnostic or behavioural categories but should consider other client characteristics, such as ethnicity and gender.

¹³ Measures of unmet demand for services may also be relevant here. The Australian Institute of Health and Welfare, for example, publishes data on unmet demand for domestic violence shelters.

These are flexible principles from which to organise an evidence base in a way that focuses attention on important issues and topics in need of attention. However, the review of the outcome literature revealed very few aspects of MBCP delivery that adhered to these principles. Thus, for example, it was expected that MBCPs with the best evidence of effectiveness would utilise two or more intervention components and target multiple elements of violence. They would include psycho-education about behaviours that are considered violent and how to understand the victim's/survivor's experience and involve cognitive interventions to change beliefs and values about violence and masculinity combined with skills training to reduce impulsive and antagonistic behaviour in the face of perceived provocation. They might also have been expected to include methods that support men to resist those patriarchal social norms and cultural influences that encourage the subordination and objectification of women. The point here is that, while these may well be features of effective practice, there is currently insufficient evidence to demonstrate that they lead to behavioural change. As such, mandating the delivery of content in these areas in program standards would appear to be premature.

Randomised controlled trials

It remains the case that in order to truly infer causality it is necessary to undertake a study that adopts a randomised controlled trial (RCT) design (i.e. where participants are randomly assigned to either receive the intervention or assigned to a "no-treatment" comparison ("control") group). The inclusion of the comparison or control group is particularly important because of problems associated with self-selection into programs, as well as establishing that any changes result from the intervention rather than being a function of time or some other influence. There are, however, considerable challenges to conducting RCTs in applied settings (e.g. heterogeneity of the population, program length, potential confounding effects of other services offered, voluntary participation versus mandatory participation).

A potentially greater limitation in conducting a RCT is the difficulty associated with creating two groups that are truly "equivalent" to each other: even with random assignment, one

cannot expect that the groups will be exactly the same. Instead, there is a reliance on probability and the assumption that any two groups are "probabilistically equivalent" or equivalent within known probabilistic ranges.¹⁴ There is also an ethical issue associated with not providing treatment to individuals who pose a risk to society. Finally, while RCTs may be the "gold standard" for establishing causality (Kaptchuck, 2001), this particular methodology is often beyond the resources and scope available to many MBCP providers.

One alternative is to adopt a quasi-experimental design, such as a waiting-list control – a comparison group (generally randomised) that will receive the identical intervention to the treatment group, but at a later date. In the absence of random assignment, it is important that the historical cases identified for the comparison group are as close a match as possible to those offenders currently referred to a MBCP in terms of, for example, age, risk level, offence type, first adult offence, sex distribution of sample, ethnicity, and so on. Statistical analyses can then be undertaken to assess the similarity between the "treatment" group and the comparison group to establish the degree of similarity between the groups (e.g. conducting *t*-tests to ensure no significance between-group differences in terms of offender age or time spent in the justice system; Chi-square analysis to check that the groups are comparable on, for example, ethnicity, offence type, risk level). However, given the low numbers in many programs, it may still take considerable time to achieve a meaningful outcome, and what both of these evaluation designs fail to assess is the quality of a program or how well it has been delivered. This applies in relation to how offenders engage with program content and the strength of the alliance formed with program facilitators; it also applies to the extent to which the program content is delivered in accordance with the intent of program developers (i.e. program integrity).

¹⁴ Probabilistic equivalence refers to knowing the odds that groups will not be equal. For example, through random assignment and the law of large numbers, when setting a significance level to .05 (i.e. *alpha* = .05), five times out of every 100 when randomly assigning two groups, there will be a significant difference at the .05 level of significance. The only reason these groups can differ is because of chance assignment because their assignment is entirely based on the randomness of assignment (Trochim, 2006).

Identifying key outcomes

A key issue in any evaluation is determining how the desired outcome is measured. Typically, this will rely on recorded reconvictions, police reports of further violence or partner self-report. It is often beyond the capacity of MBCP providers to conduct research that documents these outcomes in a meaningful way and so there is a need to focus on assessing intermediate outcomes. The task here is to collect the type of evidence that can be used to establish that change has occurred over the course of participation in a MBCP. This will typically rely on a perpetrator self-report and the use of structured assessment tools to measure the different elements of risk that are targeted in the program, as well as the observation of program facilitators and feedback from partners. For example, *Towards safe families* (New South Wales. Department of Attorney General and Justice, 2012) describes a perpetrator self-report tool that focuses mostly on perceptions of what the participant has learnt through the program, and suggestions for improvement. Ratings of attitudinal and behavioural changes were deliberately not included by the developers of these guidelines, given the potential unreliability of perpetrator self-reports as a measure of actual change. The program evaluation form for women, among other things, asks for women's (victims'/survivors') retrospective views of the extent to which the use of seven main tactics of violence (e.g. physical violence, verbal and emotional abuse, controlling behaviour) has changed across the course of the perpetrator's participation in the program, and the extent to which she feels that she and her children are safer as a result. Five-point Likert-type scales are used, ranging from "noticeable change for the worse" to "noticeable change for the better".

It is important to note, however, that MBCP providers are often restricted to collecting data relevant to satisfying service agreements and/or contracts with funding bodies. For example, many providers collect and analyse service participation statistics to include in their agency's annual report, or as part of periodical service reviews (this type of reporting is likely to increase as providers feel pressure to provide at least some information pertaining to program usage and effectiveness to stakeholders, even if they are not requested to do so). This often takes the form of "consumer satisfaction" questionnaires where program participants

are provided with opportunities at one or two points in the program to provide feedback about how the program is run. In some instances, this is accompanied by items assessing the men's self-reports about their use of violence.

Obtaining data from partners is more difficult, as providers vary significantly in the proportion of perpetrators' ex/ partners that they are able to establish contact with: this can significantly limit the application of victim-based evaluation activities and measures. In addition, the ways in which partner reports about the perpetrator's behaviour are recorded, are generally not in a quantifiable form. Nonetheless, it is reasonable for providers to document what they do know (as well as what they don't) about ongoing risk at the end of a service contact.

Selecting assessment tools

There has been no Australian review of impact, process and outcome measures used in MBCPs either at a national level or within any of the eight states and territories. In the US, most evaluation studies have relied on criminal justice system data concerning reported rates of re-offending, and there have been no studies that survey how program providers routinely collect such data. Indeed, given most US batterer intervention programs receive no government funding, and the high proportion of private for-profit providers, it is likely that most providers do not feel obliged to collect this type of data. Very few international standards mandate the use of a particular outcome tool. The UK Respect accreditation standard, for example, includes the following standards relating to evaluation activity (Respect UK, 2017):

- Staff maintain clear records that meet the requirements of the service.
- The organisation collects and analyses output data.
- The organisation collects outcome data (as per an outcomes framework associated with the accreditation standard).
- The organisation obtains and uses the views of service users on the service offered to them.
- The governing body, the lead member of staff and others as appropriate use output and outcome data as key performance indicators. They routinely identify

emerging risk and issues and set targets for improvement when necessary.

The only review of evaluation measures at a program level identified in our searches was conducted across Europe by Geldschläger, Ginés, Nax, and Ponce (2013) in which 134 European providers across 22 countries responded to a survey, with over half of the responses from program providers in Spain, Germany and the UK. Key points from the European review include:

- Approximately two-thirds of respondents reported that they collected annual statistics or activity reports, while just over two-fifths did not collect data on program drop-out or completion rates. Approximately 80 percent of respondents reported measuring outcomes, the most common form of which (in 83% of cases) consisted of case note reviews and observations of perpetrators across the program, with slightly under two-thirds using questionnaires.
- Risk assessment tools were used by 56 percent of those providers who reported measuring outcomes through the use of questionnaires; two-thirds of these used some form of structured or unstructured instrument or means of measuring behavioural change; and 55 percent used some form of instrument to measure relevant beliefs and attitudes.
- Slightly less than half of the providers reported measuring outcomes derived through partner reports, with the main reasons for not doing so being:
 - the lack of any provision of partner contact, legal or institutional barriers against collecting this information;¹⁵
 - that the collection of data from partners was not part of the goals or tasks of the program; and
 - a lack of resources and/or time.

A consistent theme was the diverse range of measures that are used in terms of risk assessment instruments, questionnaires that measure violence, questionnaires that measure attitudes and beliefs, and other categories of measures.

- It was rare for a single instrument to be used by more than 15 of the providers who attempted to measure a particular type of outcome: for example, the most common measure of attitudes and beliefs was the Ambivalent Sexism Inventory, accounting for 13 percent of providers who attempted some form of attitudinal measurement; the equivalent most common measure of violence as an outcome was the Conflict Tactics Scale at a similar 13 percent. As different measures have been developed on the basis of quite different assumptions about the nature of DFV, this lack of consistency has marked implications for the use of data derived at a program level outside the context of formal research studies. For example, data derived from the Conflict Tactics Scale would be meaningless in comparison to data obtained from Project Mirabal's¹⁶ quantitative measures, as the two instruments make polar opposite assumptions about the nature of DFV and what needs to be measured to capture it.

The Geldschläger et al., (2013) survey also asked program providers what they perceived to be the main obstacles to measuring outcomes at the program level. Three-fifths cited a lack of resources and just over half a lack of time. This included not only the lack of resources to administer measures and record and analyse data but also to purchase standardised instruments that are protected by copyright. Some providers emphasised the tension between needing to put scarce resources into the quality of the program itself or in measuring outcomes, and that they felt it was impossible to do both. It is also notable that slightly less than 40 percent of providers in this study reported that they had participated in a formal evaluation study at some point in their history, conducted either by external or internal researchers, which led to the analyses being published in a report. When asked what would make the most difference in expanding their capacity to measure outcomes, the two most common suggestions were increased resources and time. However, just under two-thirds suggested that the development of an evaluation toolkit with methodologies would be of assistance.

¹⁵ For example, due to the extensive history of privacy violation as part of the Franco regime, significant legal barriers exist in Spain for DFV program providers to proactively contact partners to offer them support.

¹⁶ Project Mirabal measures were developed subsequent to this European review. Project Mirabal is discussed in more detail below, under 'Assessments based on face validity' on page 45.

In the absence of any equivalent local data, it is difficult to assess the generalisability of these findings to Australian jurisdictions. Two contextual differences that might impact on this include the significant psychological focus in some Scandinavian DFV perpetrator programs (though Scandinavian programs represented less than 10 percent of respondents in the Geldschläger et al. 2013 study), and the pioneering and difficult country-level contexts in which programs in some parts of the European Union (e.g. the Balkans) are delivered. Certainly, Australian program providers are becoming more conscious of the importance of evaluation efforts, given a lack of quality Australian program outcome studies, and the limited (and ambivalent) evaluation evidence base that is currently available. However, as program evaluation is generally not incorporated within funding models for MBCP provision, there is no reason to expect that Australian practice will differ markedly from that reported across Europe. Australian program provider efforts at collecting outcome measures are likely to be similarly idiosyncratic, inconsistent (both within and across jurisdictions), and collect data in a form that cannot easily be utilised or captured by formal evaluation studies (see Carson et al., 2012; Day, Chung, O’Leary, Carson, 2009a). There is simply no existing “data gold” that is waiting to be mined.

When considering which tools to use to assess change, attention needs to be paid to their psychometric properties,¹⁷ the most important of which are: norms, internal consistency, inter-rater reliability, test-retest reliability, content validity, construct validity, validity generalisation and clinical utility (see Table 6 for a brief description of each category). While it might be preferable to consider only those measures that meet the criteria for each of these categories, in practice, this is rarely possible, principally because measure development is an ongoing process. Nonetheless, those measures with the strongest psychometric properties are those that should be identified for use in program evaluation activities. One of the major limitations of self-report tests is the use of non-standard or outdated psychological tests that have not been specifically designed for use with offenders or validated with perpetrator populations (Wakeling & Barnett, 2014).

¹⁷ For more information about the development of evidence-based assessment protocols and specific criteria to evaluate some of the tools used more frequently in both research and practice, see the special issue of *Psychological Assessment*, 2005, 17(2).

Risk assessment tools

Specialised risk assessment tools for predicting DFV are increasingly common, although evidence of their ability to predict future violence is not particularly strong. Olver and Jung (2017) have recently examined the incremental predictive validity of three widely used measures of risk for intimate partner violence (IPV): the Spousal Assault Risk Assessment (SARA); the Ontario Domestic Assault Risk Assessment (ODARA), and the Family Violence Investigative Report (FVIR) outcomes. Their Canadian sample was made up of 289 men and women who were reported to police for IPV and convicted, and then followed up for approximately 3 years post-release. Scores on the SARA showed incremental validity for IPV recidivism; ODARA scores incrementally predicted general violence; and both tools incrementally predicted general recidivism.

The FVIR did not incrementally predict any outcomes. Further analysis demonstrated that the psychosocial adjustment domain of the SARA contributed uniquely to the prediction of IPV. They suggest that the SARA and ODARA should both be used to appraise the risk of IPV or general criminal recidivism. However, there have been no previous investigations of the extent to which risk (as assessed by these tools) changes over time or after participation in a MBCP.

Assessment tools that purport to measure a change in dynamic risk over the course of program attendance have, however, been developed for use in sexual offender treatment programs. Some of the most commonly used tools are reported in Table 7, with what are labelled “dynamic risk factors” being those areas in which change would be desired in two key areas of functioning: sexual interests; and attitudes supportive of sexual assault.

Assessments based on face validity

The UK Project Mirabal evaluation study has provided another recent set of assessment measures with potential applicability to other jurisdictions and circumstances. Based on an initial qualitative phase of research investigating the outcomes that partners of MBCP participants most wanted to arise from the

TABLE 6 Psychometric properties of assessment tools

Category	Criteria for use
Norms	For standardised instruments, norms and criterion-based cut-off scores are necessary to enable the accurate interpretation of individual test scores. Samples should be truly representative of the sample population from which the individual is drawn in terms of demographics (e.g. age, sex) and other important characteristics (e.g. clinical vs non-clinical or offender vs non-offender samples). Used to determine pre- and post-treatment functioning and evaluate whether any change is clinically meaningful. Ratings of “adequate” require data from a single, large clinical sample; “good” requires normative data from multiple samples (including population-specific samples); while “excellent” requires data from large, representative samples.
Internal consistency	All items that purport to measure a single construct (e.g. treatment readiness) should contribute in a consistent way to the data obtained for that measure (i.e. items that reflect the same construct should yield similar results). While internal consistency can be reported as the average inter-item correlation, average item-total correlation, and split-half reliability, the most commonly used measure is Cronbach’s alpha (α).
Inter-rater reliability	Similar results should be obtained when a measure is used or scored by a clinician or researcher. Inter-rater (or inter-observer) reliability should be established outside of the study for which the results are reported (e.g. in a pilot study).
Test-retest reliability	The same results should be obtained if the test is administered to the same sample on two different occasions (i.e. assumes no substantial change in the construct under investigation between the two occasions). Two important caveats that are used when considering test-retest reliability are that: (1) the time between measurement needs to be sufficient to ensure the outcome is not influenced by temporal factors (e.g. too short a period may result in practice effects); and (2) some constructs are not expected to show temporal stability (e.g. measures of state-like variables).
Content validity	Items should reflect the content domain of the construct purportedly measured by an instrument (i.e. items should represent the various aspects or facets of the construct an instrument was designed to measure). The degree to which a test is a representative sample of the content of whatever objectives or specifications the test was originally designed to measure. To investigate the degree of match, test developers often enlist well-trained colleagues to make judgements about the degree to which the test items matched the test objectives or specifications.
Construct validity	A relationship should exist between a theoretical construct and any instrument that purports to measure that construct. A measure has strong construct validity if it has both convergent and discriminant validity. Convergent validity is shown when there is an acceptable level of agreement between different instruments that purport to measure the same construct (e.g. scores on two instruments that purport to measure depression are shown to be highly correlated). Discriminant (or divergent validity) tests whether constructs that should not be related are, in fact, unrelated.
Validity generalisation	Evidence for validity generalisation is dependent upon a body of accumulated research supporting the use of a particular instrument across both situations and populations (i.e. the predictor or criterion generalises across studies and will continue to show similar parameters when the situation changes).
Clinical utility	Refers to the ease and efficiency of using an assessment tool and the (clinical) relevance and meaningfulness of the information it provides. Utility generally comprises: <ul style="list-style-type: none"> • availability and ease of use; • administration time; • “learnability” and clinician’s qualifications; • format; • scoring and information derived; and • meaningful and relevant information obtained.

TABLE 7 Mapping static and stable dynamic risk factors (adapted from Beech & Craig, 2012, p. 172)

	Static risk factor assessments				Dynamic risk factor assessments		
Stable dynamic factors	Static-99/2002	SORAG	SVR-20	Risk Matrix 2000/S	Beech Deviancy Classification	STABLE 2007	SRA
Sexual interests	Non-contact sexual offence	Deviant sexual preference	Deviant sexual preference	Sexual appearances	Sexually obsessed	Sexual pre-occupation/sex drive	Sexual pre-occupation (obsession)
	Unrelated victim	Prior sexual convictions	High frequency sex offences	Sexual offences against a male	Sex deviance patterns (child molestation) marked	Sex as a coping strategy	Sexual preference for children
	Stranger victim		Multiple sexual offences	Non-contact sexual offence		Deviant sexual interests	Sexualised violence
	Prior sex offence		Escalation of sexual offences	Stranger victim			Offence-related sexual interests (fetish)
	Sentencing occasions						
	Male victim						
Attitudes supportive of sexual assault			Pro-offending attitudes		Distorted attitudes about children, children's sexuality, own victims	Sexual entitlement	Adversarial sexual attitudes
					Justifications for sexual deviance	Pro-rape attitudes	Sexual entitlement
						Child molester attitudes	Child abuse supportive attitudes

perpetrator's participation in the program, six quantitative measures were derived, with each measure based on a set of specific items or indicators, they are as follows:

- respectful communication (5 indicators);
- space for action (12 indicators);
- safety and freedom from violence and abuse for women and children (18 indicators, covering: physical and sexual violence; harassment and other abusive acts; and felt safety);
- shared parenting (5 indicators);
- awareness of self and others (6 indicators); and

- safer and healthier childhoods (8 indicators) (Kelly & Westmarland, 2015).

Each scale acts as a checklist, with the ex/partner endorsing it as present or absent over a particular time period. The set of six measures is not designed for perpetrator self-report. These measures are unique for not only being developed based on women's own accounts of what counted as successful outcomes for their ex/partner's participation in a DFV perpetrator program, but also in their coverage of perpetrator coercive

controlling tactics. For example, the space for action items are as follows:

- “I feel afraid of how the domestic violence perpetrator (DVP) would react if I got a new partner.”
- “I feel like I have to be very careful around the DVP if he is in a bad mood.”
- “Makes the final decision about whether people can visit/ stay in the house.”
- “Tries to restrict where I go.”
- “Tells me to change the way I dress or my appearance.”
- “Prescribes or criticises the way housework is done.”
- “Tries to look at my messages and contacts.”
- “Tries to use money/finances to control me.”
- “Tries to prevent me participating in activities/groups outside the home.”
- “Is suspicious if I have been with another man/someone else.”
- “Insists on knowing where I am or what I am doing.”
- “Tries to prevent me seeing or contacting my friends/ family” (Kelly & Westmarland, 2015, p. 15).

The use of the Project Mirabal measures is, therefore, particularly relevant for programs based on an understanding of DFV as a form of coercive control, and which focus on outcomes beyond the cessation of violence, such as the perpetrator’s healthy involvement in family life and in contributing towards safe and healthy childhoods for children.

An important area of future research will be the further development of psychometrically robust measures to assess this type of short-term change. The Batterer Intervention Proximal Program Outcomes Survey (BIPPOS, 2016) scale appears to hold considerable promise in this regard, utilising a series of questions that ask directly about change in five key areas targeted in MBCPs (Mankowski, personal communication). These are:

- *personal responsibility* (e.g. Item 2: I am responsible for my abusive behaviour. Item 7: My partner’s behaviour forces me to act abusively (reverse score). Item 30: I have a choice about whether I am abusive or not);
- *power and control beliefs* (e.g. Item 4: In a conflict with

my partner, I usually get what I want (reverse score). Item 32: I use violence to help me get what I want from my partner (reverse score). Item 34: I feel better about my relationship with my partner when I’m the one in control (reverse score));

- *understanding the effects of abuse* (e.g. Item 5: My abusive behaviour has caused my family members to trust me less. Item 14: I have lost relationships due to my abusive behaviour. Item 17: My abusive behaviour has had long-lasting effects on my family members);
- *anger control and management* (e.g. Item 20: I can express my anger without becoming abusive. Item 21: Thinking positively about myself helps me avoid becoming abusive. Item 24: When I am becoming angry, I can feel it in my body); and
- *dependency on partner* (e.g. Item 12: I worry that my partner is going to leave me (reverse score). Item 18: I don’t know what I would do without my partner (reverse score). Item 29: I feel jealous when my partner spends too much time with other people (reverse score) (MacLeod, Pi, Smith, & Rose-Goodwin, 2008).

There is also work underway to find ways to assess women’s experiences of coercive control that has the potential to be applied to any assessment of change following participation in a MBCP. Sharp-Jeffs, Kelly, and Klein (2017), for example, have recently reported the development of two new scales (“coercive control” and “space for action”, the latter from the Project Mirabal study) that assess women’s experiences of perpetrator’s coercive controlling tactics and the freedom women have in their lives.

Interpretation of evaluation data

Assessing group level change

An important requirement of evidence-based practice is that MBCPs are expected to be able to demonstrate that they bring about positive change in those areas of functioning that they target. It follows that the average scores on measures of need in these areas should be lower after groups of participants have completed a program than before they began. This

type of psychometric testing also allows the assessor to place the individual or group being assessed in relation to the “normal” community population, while also providing a scientifically defensible basis for determining ongoing need or the significance of change. However, short-term outcome measurement of this nature is insufficient for evaluation purposes or establishing the extent to which a program is evidence-based.¹⁸ Thus, while an evaluation of the magnitude and statistical significance of short-term group level change provides an indication of whether change has occurred (Nunes, Babchisin, & Cortoni, 2011), this method cannot provide any valid indication of causality.

At present, some MBCPs utilise a pre- and post-assessment form, often developed locally, that is completed for all perpetrators who access their services. This would often record general monitoring information: case management attendance; accommodation and referral, attendance, and progress data; risk assessment details; offence information; and client goals. Program outcomes can be measured at three levels: short-term, medium-term and long-term. Short-term outcomes are the immediate or early results of the program (i.e. outcomes that occur during the course of the program or by its conclusion). Medium-term outcomes reflect further progress in reaching a program goal. Long-term outcomes reflect the ultimate goal of the program to reduce DFV, which is the primary measure of the effectiveness of any MBCP.

Individual level change

While group level change can be used to determine whether there is an overall change in the group being assessed, statistical significance tests (even in RCTs) are limited in the information that they provide about how an individual has changed. This even applies to being able to report the proportion of individuals who have improved as a result of the intervention.

¹⁸ Dvoskin, Skeem, Novaco, and Douglas (2012, p. 295) put it this way: “For every program, the same questions should be asked: ‘How do you know it works?’ ‘How strong is the evidence?’ Those who choose interventions and implement them must be critical consumers, mindful of fads and questionably grounded procedures that are actively sold to various criminal justice agencies. For some interventions, the phrase ‘evidence-based’ is not much more than a marketing slogan. Rigorous and meaningful controlled evaluations of programs (not pre/post-tests) are essential for establishing an evidence base.”

Change in treatment targets at the level of the individual participant can provide an indication of program effectiveness. An individual whose scores on a questionnaire have dropped may still be considered to be a risk if the post-program scores are still within a dysfunctional range. In other words, there is a threshold against which the level of change should be considered significant; even when change is significant in a statistical sense, this may be insufficient to expect the desired level of behavioural change to occur. The term “individually significant change” (or clinically significant change) is used to refer to whether (or not) an individual reaches some specified level of functioning during the course of an intervention (Jacobson & Revenstorf, 1988; Jacobson, Roberts, Berns, & McGlinchey, 1999). Clinical significance, for example, has been defined by Jacobson, Follette, and Revenstorf (1984, p. 340) as “a change...when the client moves from the dysfunctional to the functional range during the course of therapy”. Cut-off scores (e.g. based on the normative information) are used to determine shifts in whether the individual has moved from a dysfunctional range to a functional range following participation in an intervention.

An assessment of reliable change (based on Jacobson & Truax’s 1991 Reliable Change Index (RCI)) can then be undertaken to determine the extent to which change from pre- to post-treatment is reliable and not simply due to chance or measurement error.¹⁹

One useful way of distinguishing whether treatment-based improvement has occurred using the RCI is outlined by Bowen (2012) and summarised in Table 8.

Of course, any application of this method relies on the collection of data that provides norms for both violent and non-violent DFV perpetrators.

¹⁹ To determine reliable change, the standard deviation of the normative population and internal consistency reliability of the scale are used to identify whether the degree of change is significant. The post-treatment observed score is subtracted from the pre-treatment observed score, and this is divided by the standard error of the differences. If the product is larger than the Z-score desired level of significance, in this case 1.96 ($p < .05$), the change in pre- to post-treatment scores is said to occur beyond that of chance variation. The formula uses the standard error of measurement, and this is calculated using standard deviations and reliability coefficients of normative samples.

TABLE 8 Categories of change (adapted from Bowen, 2012)

	Category	Definition
1.	Normal/Always okay	Individual scores start and remain in functional population.
2.	Recovered	Individually significant reliable change, scores changing from dysfunctional to functional.
3.	Improved	Reliable expected change that is not clinically significant, scores starting and ending in the dysfunctional group albeit closer to the functional distribution.
4.	Deteriorated	Statistically reliable change in the opposite direction to that intended with initial scores in the normal population.
5.	Regressed	Statistically reliable change in the opposite direction to that intended from scores originating in the normal population but changing to within the dysfunctional population.
6.	Unreliable/Unchanged	Statistically unreliable change regardless of starting point and relation to clinical cut-off.

Understanding core competencies

Since the evolution of MBCPs in the US in the late 1970s, and in Australia in the mid-1980s, program developers have constructed group work curricula based on their perspectives and assumptions of what changes need to be achieved through the program. In the main, program designers are used to thinking of areas of change as “topics” that need to be covered in the curriculum or program manual; in other words, they are thought of as outputs. A different approach, however, is to consider these changes as competencies or elements that, through the course of participation in the program (and in life outside group work sessions), the perpetrator would need to demonstrate in order to show that he is on a path towards sustained behaviour change. This is best exemplified by the Colorado approach (see Appendix A), with individualised treatment plans for each perpetrator focusing on their achievement of a set of core competencies outlined in our jurisdictional review. A key consideration both for individual clinical decision-making and for program evaluation is how to measure the demonstration of each of these competencies.

Mankowski, Silvergleid, Patrick, and Wilson (personal communication, 1 November 2017) have argued that the underlying logic of MBCPs is that greater achievement of the program’s proximal goals will lead to subsequent reductions in the distal outcome of reduced DFV. Their review of the (albeit limited) literature on the processes of change in MBCPs (Silvergleid & Mankowski, 2006) informed the development of a new measure that purports to indicate

the degree to which program participants have achieved the proximal program outcomes of the intervention. This tool, the Batterer Intervention Proximal Program Outcomes Survey (BIPPOS), measures four constructs commonly targeted by MBCPs and referred to in the literature as contributors to (or causes of) DFV. These are:

1. accepting personal responsibility for IPV and overcoming denial;
2. reducing power and control beliefs and motives in intimate partner relationships;
3. understanding the effects of abuse on victims/survivors (and on the self); and
4. managing or controlling anger.

A fifth construct, reducing feelings of dependency on the partner, was subsequently added because of the frequent references in the literature to men’s exaggerated feelings of dependency on their partners and the effects these feelings have on efforts to control or harm partners, particularly at the most dangerous time when their partners are leaving the relationship (e.g. Buttell & Jones, 2001). Although there is more research required to establish the psychometric properties of the BIPPOS, there is preliminary empirical evidence that improvements in scores on these proximal program goals do predict reduced physical and psychological abuse, with this also predicting lower levels of self-reported domestic violence.

The Colorado approach leads to a more individually focused model of assessing change, related to the development of individual treatment plans and monitoring progress through the program. As the assessment of whether a perpetrator has demonstrated particular core competencies is made subjectively by the multidisciplinary treatment team (consisting of program practitioners, the victim/survivor advocate and probation officer), research is currently underway to determine the feasibility of developing more standard assessment processes or tools to do so.

Empirical research assessing the extent to which MBCP participants demonstrate competencies is limited, but Semiatin, Murphy, and Elliott (2013) have reported the findings of one study that appears relevant. In this study, “spontaneous verbalisations” of a sample of 82 partner-violent men receiving community-based treatment, were assessed.²⁰ The coding focused on the assumption of personal responsibility for abusive acts, confirmation and support of others’ change talk and statements regarding the value of treatment. The findings suggested that men who initiated more pro-therapeutic behaviour during the latter sessions of group treatment engaged in less psychological and physical violence during the 6 months following intervention than men who displayed fewer pro-therapeutic behaviours. Pro-therapeutic group behaviours also positively correlated with client self-reported motivation to change prior to and during treatment, compliance with cognitive-behavioural homework assignments, and therapist-rated working alliance. These approaches in our view, hold considerable promise both in terms of the conceptual development of proximal outcomes potentially correlated to reductions in the use of violence and in how to assess change.

Program engagement as a measure of change

Individual participants change over the course of a program as they apply the skills that they have learned and develop greater self-awareness. The extent to which offenders engage collaboratively in the intervention process, develop the ability to identify pertinent treatment goals, successfully negotiate group activities and develop an emotional bond, is

widely thought to be an important predictor of outcome. The measurement of these factors (often referred to in terms of the working alliance) can occur from three different perspectives:

1. participants tracking their experiences over the course of a program;
2. facilitators reflecting on the quality of their engagement with individual participants; and
3. supervisor views based on observations of program interactions.

The assessment of each of these perspectives throughout the course of a program both facilitates participant feedback and, according to some theoretical orientations, provides facilitators with opportunities to reflect on the efficacy of program delivery.

Asking participants about their program experiences may also assist in creating a group climate that both welcomes feedback non-defensively and allows facilitators to respond to ruptures in their working relationship with the men. These latter are an inevitable part of any intervention, and an absence of ruptures can signal that participants are coasting through programs or responding idealistically to content. The importance of attending to ruptures is highlighted in research that demonstrates a positive correlation between both the working alliance and positive behaviour change across a range of different offending behaviour programs (Beech & Hamilton-Giachritsis, 2005; Joe, Simpson, Dansereau, & Rowan-Szal, 2001; Semiatin et al., 2013). Regular feedback is also useful in assessing the consistency between clients’ self-report (i.e. what they say about their program experience) and behaviour (i.e. their behaviour towards others, both staff and other offenders).

A measure such as the Group Session Rating Scale (GSRS) (Duncan et al., 2003) is a succinct and easy to administer method of assessing participants’ experience of group programs. It comprises four visual analogue scales on which participants indicate their experience of four different program areas:

1. their relationship with facilitators and the group;
2. the goals and topics covered in the group;

²⁰ Spontaneous verbalisations are unscripted and unrehearsed comments made by MBCP participants.

3. the approach or method used in the group; and
4. their overall group experience.

The GSRS is scored by measuring, to the nearest centimetre, the length of each 10 cm scale indicated by participants and then summing these scores from a possible 40. Facilitators are able to use this feedback to guide the discussion in the group about both concerns and positive aspects of treatment. The clinical cut-off for scores on the GSRS is 36, and particular attention should be given to any participant who scores below this.

In addition, the Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks, & Claud, 2003) also comprises four visual analogue scales. These require participants to indicate, on a 10 cm line, their progress in the previous week in four domains: “individual”, “interpersonal”, “social” and “overall”. A general sense of the participant’s wellbeing is derived by measuring, to the nearest centimetre, the length of each scale indicated by participants and then summing up the scores. The clinical cut-off for scores on the ORS is 25, and scores below this are suggestive of participant distress, although it is not uncommon for mandated clients’ initial scores to be higher (under these circumstances, it may be more useful to ask participants to complete the ORS from the perspective of their case manager or other referrer to the program). Repeat administration of the ORS also allows facilitators to track self-reported wellbeing over the course of a program, with changes in scores of 5 or more during treatment, in either direction, considered reliable.

Some community-based MBCPs have created their own session rating scales. For example, the NSW practice guide for MBCPs, *Towards safe families*, provides a form that assists facilitators to record and track their observations of each participant’s behaviours, values and attitudes in the group, according to six dimensions that can be modified to reflect the elements of practice appropriate to a particular program (New South Wales. Department of Attorney General and Justice, 2012). The practice guide notes, however, that facilitator ratings may not match actual behaviour as experienced by the (ex) partner and/or children. These are described in Table 9.

A simpler approach, described by Day, O’Leary, Chung, and Justo (2009b), was developed for use in a Queensland community program. It asks facilitators to first make ratings of the participants’ use of minimisation, denial, blame and manipulation using a 10-point scale and then their understanding of main concepts, articulation/use of examples to demonstrate understanding, self-disclosure and position-taking on non-violence. Obtaining feedback from participants using measures such as these should enhance program outcomes by providing facilitators with pertinent information about progress. The completed scales can then be considered in each facilitator debriefing session. This provides facilitators with an opportunity to identify any participant concerns while also noting discrepancies between participant reports and behaviour that should be addressed in the following session.

The mid-treatment point of a MBCP provides an opportunity for participants and facilitators to review progress. Discussion of the quality of engagement with program content is an important part of this process, including a review of the relevance of existing goals and additional in-session or out-of-session goals pertinent to each individual participant. This can be supported by the use of psychometric measures such as the Treatment Engagement Scale (TES) (Casey, Day, Howells, & Ward, 2007).

The TES has 17-items and comprises three sub-scales: the strength of the alliance; experiences in relation to group process; and self-confidence in changing offending behaviour. Responses are made on a 5-point Likert-type scale from “strongly agree”, “agree”, “unsure”, “disagree” and “strongly disagree”. Item scores are summed to reach a final score from 17-85. The scale is then re-administered at the completion of the program to determine changes in levels of engagement (i.e. if improvement over time has occurred). The final feedback session should occur shortly after program completion/non-completion.

TABLE 9 Session monitoring sheet example (New South Wales. Department of Attorney General and Justice, 2012, p. 253)

Responsibility-taking	Other-centredness
Admits the nature and level of his violent behaviour.	Does not display or collude with sexist understandings or comments.
Accepts and understands the types and breadth of his use of violence and controlling behaviour.	Speaks respectfully about his partner and children.
Does not minimise, deny, justify or blame partner or external factors for his use of violence.	Speaks respectfully about women and children in general.
Does not play "the victim".	Understands the perspectives and emotions of those affected by his violence.
Does not use violence-supporting narratives and beliefs to make a case for his use of violence.	Understands the effects of his violence on others.
Does not collude with other participants' attempts to minimise responsibility.	Understands how those in his family might be responding to him due to his past (and present) use of violence.
Challenges other members' use of violence and the excuses they make.	Shows genuine empathy rather than only intellectualising these understandings.
	Feels other-centred rather than self-centred remorse.
Interactions with others in the group and facilitators	Conceptualisation
Attended session on time.	Understands discussion, concepts and strategies towards change.
Lets others speak without interrupting.	Engages openly with new ideas and perspectives.
Listens intently to what others say.	Participates actively in group activities focusing on particular topics or themes.
Acknowledges and responds positively to others.	Reflects on his own behaviour.
Does not interrogate or overly try to fix the problems of others.	Identifies his entitlement-based and self-righteous attitudes and behaviours.
Was not disruptive or dominant.	
Depth of participation	Application
Shows interest and engagement.	Talks about attempts to use strategies to avoid violence.
Displays attentive body language and nonverbal behaviours.	Acts to keep partner and children safe.
Speaks with feeling.	Does homework tasks and/or attempts to apply what was covered in recent sessions.
Reveals struggles, feelings, fears and self-doubts.	Discusses options with others in the group and/or the facilitators.
Does not withhold or evade issues.	Is open on how to improve the application of strategies, and to new strategies.
Is not defensive.	
Does not use humour inappropriately.	
Engages in homework tasks.	

Ways forward

Some of the most notable developments in program evaluation methodology in recent years have emerged from Europe. A survey of more than 130 European programs found that outside of increased resourcing, developing a consistent and standardised approach to outcome measurement was the most important enabler for evaluation activity (Geldschläger et al., 2013). This led to the development of Project IMPACT, a key initiative by the European Network for the Work with Perpetrators of Domestic Violence (WWP EN) that aims to support evaluators and program providers to adopt a consistent approach towards program evaluation across Europe.

Through a partnership with the University of Bristol, new outcome measurement tools for use with perpetrators and victims/survivors have been developed, each to be administered at four points across a perpetrator's participation in a program and beyond. The tools were developed specifically with practitioner application in mind – without relying on independent evaluators – and hence are relatively brief. A practice guide and additional support are available to assist program providers to use the tools, with the initial focus being on the UK and Italy. Importantly, the project, through the University of Bristol, provides a service to individual program providers, as well as collecting data across agencies that can be aggregated for higher-level analyses. Program providers who agree to participate in the project send the data they collect through the use of these tools to the university either in spreadsheet form or entered directly into a database. The university then conducts and provides them with a program-specific analysis of their data. This systematic approach to collecting the necessary data to develop evidence-based practice is largely absent in Australia.

In summary, much more work is required to determine which assessment tools should be used to evaluate short-term change in MBCPs. This review suggests that a set of core assessment tools should be identified that meet the standards of evidence-based assessment and that can be routinely administered pre- and post-program delivery to assess short-term change in program participants. However, the contexts in which MBCPs are delivered are often unique, and areas of need specific to the local population are often

identified in the program logic models. Accordingly, a set of supplementary assessment tools should also be identified that can be used for the purposes of outcome measurement in each individual program. The identification of core assessment tools, nonetheless, represents an attempt to rationalise the number of different tools that are used across MBCPs, as well as to reduce the administrative burden on both program staff and program participants. The aim is to ensure the routine collection of data that will allow simple conclusions to be drawn about change at both the group and the individual level.

Safety and accountability planning

A safety and accountability plan outlines specific strategies that the perpetrator should put into place to maintain any attitudinal and behavioural change. There is very little literature of any kind, peer-reviewed or grey, which focuses on the use of exit or accountability planning in the context of MBCP work. As such, practitioners are left to rely on references to exit and accountability planning in existing minimum standards documentation, in addition to the small number of detailed practice guides that have been developed to guide this area of work. In this report, the term *safety and accountability plans* is used, although the predominant term used in the field is *exit plans*, or much less frequently *accountability plans*. It is suggested that, regardless of the measures used to assess short-term change in MBCPs at the individual level, the end product has to be a professional opinion about the ongoing level of risk and how this can be most appropriately managed. This opinion should be based on the assessment of change as well as knowledge about the circumstances of the perpetrator.

It is important to start by commenting on what safety and accountability plans are (and what they are not). They are not, for example, initial case plans or case formulations developed to individualise and guide intervention plans after an initial assessment, nor formal reviews of these case plans/formulations at later points in the program. Nor are they discharge or program completion summaries that are prepared when the program provider reports back to the referrer (e.g. to courts, corrections or child protection)

about participation and progress (see Shephard-Bayly, 2010). These other documents, however, are clearly relevant to the development of a safety and accountability plan: indeed, they can be a prerequisite for the development of these plans and for evaluating outcomes by providing specific benchmarks against which to measure individual-level change.²¹ A safety and accountability plan outlines specific strategies that the perpetrator should put into place to maintain any attitudinal and behavioural change identified as important in the case plan, and also identifies areas where change is still considered necessary.

Commenting on the New Zealand context, McMaster (2013) outlines the following questions as essential to the development of individualised case formulation in the context of group-based non-violence programs. Many of these questions are also highly relevant to the development of safety and accountability plans:

- Who is this man and family/whanau (cultural and social considerations)?
- What place does abusive practice play in their lives?
- What are the barriers to change?
- What pathways can enhance change?
- What are the key factors that underpin and sustain pathways of abusive practice?
- What strategies can be suggested to minimise the barriers and establish new pathways to safety?
- Who do I/we need to involve when implementing these strategies?
- How do I/we help the man and their family/whanau to implement the strategies?

Individual treatment plans

While the Colorado standards for DFV perpetrator programs do not make specific references to safety and accountability

planning, the centrality of the case formulation (derived through individual treatment plans) would form the basis of such plans. Each perpetrator's progress is documented in relation to 18 core competencies of attitudinal and behavioural change, in addition to any change in dynamic risk factors. This is then used to make decisions regarding when a perpetrator is considered sufficiently safe to leave the program. Although progress of this type is measured subjectively (in lieu of any actuarial scales or other measures of competencies), the intention here is to base decisions regarding treatment continuation, intensity and cessation on specific attitudinal and behavioural factors, rather than global judgements about safety.

For most perpetrators, it is unlikely that any single program will change all patterns of coercive control. Safety and accountability plans should, therefore, focus both on what is required for the perpetrator to sustain changes in the use of coercive control and on what still needs to change (e.g. those "tactics" that are still used, have intensified, or have been substituted for others). This requires that the program provider has a comprehensive understanding of each perpetrator's specific patterns of violence, as documented in the case formulation developed near the start of the program (and strengthened as more is learnt through the course of program participation and partner contact).

Some of the other considerations in case planning also influence the development of safety and accountability plans. Vlasis (2014; 2017) and Vlasis et al. (2017), for example, outline the following as desirable considerations in individualised case planning in the context of group-based programs:

- criminogenic needs (risk factors that can change over time and through intervention) exacerbating the intensity and frequency of violence. Included here is ongoing consideration of acute dynamic or "spikes" in risk;
- factors relevant to the ongoing development of motivation to change;
- ongoing risk assessment in relation to not only the risk that the perpetrator poses to his family members, but also to patterns of coercive control;
- ongoing tracking of the quality of the perpetrator's participation in the program;

²¹ In the child protection context, for example, detailed elements have been defined to guide the development of case plans for addressing DFV perpetrator behaviour that puts children at risk (Western Australia. Department for Child Protection, 2013). These specificities in a case plan regarding what the perpetrator needs to stop doing and to start doing (or do more of) so that he contributes positively to, rather than sabotages, family functioning forms the basis of his potential exit and accountability plan for when the intervention ends.

- understanding the perpetrator’s preferred learning and engagement styles; and
- understanding how different aspects of the perpetrator’s social milieu, including his peer networks and micro-communities of belonging and identity, might influence progress.

Purpose of plans

Safety and accountability planning serves at least three main purposes in the context of MBCP work:

- To support the transition of a participant at the end of the program towards putting into practice new attitudes and behaviours after program completion. Indeed, in many situations, the exit plan is the transition strategy, the sole method used by the program to promote the sustainability of gains made during the program to the post-program context. For example, Australia’s only contemporary practice guide for MBCP work states that exit planning “should address matters such as predicting and managing high-risk situations, implementing learning and deepening understanding, and practical strategies to minimise lapses into unhelpful ways of thinking and relating” (New South Wales. Department of Attorney General and Justice, 2012, p. 136).
- To allow group-based programs to be tailored to each individual perpetrator. This follows calls, both in Australia and overseas, for MBCPs to move away from what has been critiqued as a “one size fits all approach” without diluting the importance of group-based components to the work (Day et al., 2009a; Mackay et al., 2015; Polaschek, 2016; Radatz & Wright, 2016; Victoria. Royal Commission into Family Violence, 2016; Vlasis et al., 2017). Related to this is the potential of exit and accountability planning to strengthen any application of the RNR framework in program design and delivery.
- To support systemic change, beyond the perpetrator’s own use of his plan. Here, Vlasis et al. (2017) argue that a strong case can also be made for a perpetrator’s exit and accountability plan to be provided to the referring agency, and to other partner agencies taking an active role in ongoing risk assessment and risk management in relation to the threats he poses to family members.

They argue that:

...if accessible by perpetrator intervention system agencies, the plan could be a living document that is reviewed and updated if the perpetrator comes into contact with the system again at a later point”. (Vlasis et al., 2017, pp. 84-85)

Continuing with this theme, Vlasis et al. (2017) have argued that safety and accountability plans should draw upon information already held by the integrated service system about the perpetrator’s patterns of coercive control, including new information obtained by partner agencies during the course of his participation in the program. They suggest that, in some instances, plans be co-designed by the MBCP provider and the referring agency where the latter has an ongoing role and stake in managing the perpetrator’s risk potentially beyond his participation in the program. In short, the plans should not be “privately” held only by the perpetrator, but be made available to key government and non-government agencies that are involved in managing the risk posed by the perpetrator into the future.

This also means that the plans are:

...written in a way that’s not only readable and clear for the perpetrator, but also for family members and (depending on the context) potentially a small number of others in his community who might have the commitment and understanding required to help to hold him accountable to the plan. (Vlasis et al., 2017, p. 85)

This suggestion reflects the New Zealand practice in some sexual offender programs where accountability planning, when it is safe to do so, is made part of a continuum of processes that supports direct accountability to family and (carefully chosen) community members. These accountability processes are currently being trialled in New Zealand in the family and domestic violence perpetrator program context (Cagney & McMaster, 2013).

Content of plans

In Australia, exit planning is often conducted towards the very end of a perpetrator’s participation in a MBCP. While

some program providers have the capacity to conduct exit planning in a one-to-one session, often it is folded into the final group sessions and generated through group activities. Australia's only practice guide for MBCP work contains an "Exit form and interview prompts" resource to guide NSW program providers in exit planning (New South Wales. Department of Attorney General and Justice, 2012, pp. 261-263). This consists of a two-page template using the headings:

- "the value of being non-abusive and non-controlling" (covering motivational factors);
- "my family's journey" (experiences and needs of family members);
- "things that support me being non-abusive and non-controlling";
- "things that don't help me to be non-abusive and non-controlling";
- "different situations where I might step closer to using violence";
- "strategies for managing these difficult situations";
- "people who can support me to be and remain non-violent";
- "continuing my journey" (focusing on secondary desistance issues); and
- a separate page that outlines a series of questions and interview prompts that the MBCP practitioner can use with the perpetrator to help him provide the detail for each of the sections.

The extent to which this exit planning template is used by NSW or other program providers, however, is unknown.

New Zealand non-violence programs are guided in the use of exit planning by what is termed the Behaving Safely Plan, part of the suite of resources contained in their Code of Practice for family violence services. This template includes fields for the following:

- "The physical signs in my body that I am getting unsafe are...When I notice these signs or have them pointed out I will...";
- "The emotional signs (things I am feeling) that let me know I am becoming unsafe are...When I notice these signs or have them pointed out I will...";
- "The behavioural (things I am doing) signs that I am

getting unsafe are...When I notice these signs or have them pointed out I will...";

- "When I am into the cycle of abuse these are the things I do most often...If I start to do these things or other abusive things or have it pointed out that I am doing them I will...";
- "These beliefs and thoughts could make it hard for me to be safe and respectful in the future...When I recognise these I will...";
- "My time-out strategy that I have agreed with my partner, or worked out for me...I will remember the 4 D's – don't drink, drive, drug or do anything dangerous. Where will you go? How will you get there? Who will you talk to / check in with for safety?";
- "My high-risk situations are...When I realise I am in, or am heading for a high-risk situation I will..."; and
- "My support network includes the following people...".

This is identified as an area of work that has the potential to be developed in Australian MBCPs to strengthen outcomes. There are nonetheless several complexities and factors complicating the routine use of safety and accountability planning in MBCP work. Some of these are outlined below.

Lack of research into the how

Our searches of the published literature found no studies that considered the use and utility of safety and accountability planning in DFV perpetrator programs work. Many minimum standards and good practice guidelines are expressions of what the field considers to be necessary to maximise the likelihood that interventions will not cause harm and might increase safety. Safety and accountability planning falls squarely into this category. Furthermore, the "clinical wisdom" used to substantiate the importance of safety and accountability planning is much broader than the DFV field, as ongoing case and exit planning is increasingly a feature of what is considered to be "good practice" across intervention and rehabilitation programs in the mental health, human services and behavioural sciences fields (see the relapse prevention literature, for example). There are many questions here that the MBCP literature provides no guidance on, including:

- How detailed plans should be: for example, should they be based mainly on short-hand prompts and reminders of goals, motivational factors, high-risk situations and strategies, or should they go into some of the detail behind these?
- How do plans best capture the breadth of perpetrator coercive controlling tactics? How detailed should they be in specifying goals towards sustainably ceasing individual tactics across several types of violence? How important is this detail? Should there be two “layers” of each plan, one that can be more easily digested, serving as prompts and reminders, and one underneath with the detail?
- How are family members’ needs and goals best represented in these plans and, if relevant, those of a close-knit community that the family might be a part of?
- How might plans best weave a strengths-based focus on enabling strategies, existing strengths, positive goals and so on with more accountability-based language based on what the perpetrator needs to (continue to) stop doing?
- What are the best mechanisms and media for representing the plans to maximise their use by perpetrators, including how best to match with different perpetrators’ preferred learning styles and ways of processing information, and written literacy levels?
- In what ways should the perpetrator be involved with input or co-designing the plan over time – what types of input are more likely to result in a sense of his ownership over the plan?
- How should the plan best capture issues relating to the perpetrator’s social milieu that might influence his choices to use violence, relevant attitudes and his attachment to particular masculine identities – issues that the perpetrator might have only indirect control over at best?
- To what extent should these plans be developed, reviewed and reshaped over time during the course of the program, rather than being developed mainly at the end?
- What is the importance of perpetrators being able to practice the implementation of these plans before their contact with the program ceases, to enable refinement and review based on implementation experience?
- Who else should have a copy of the plan outside of the perpetrator, program provider and partner agencies involved in managing the perpetrator’s risk? Should

his ex/partner, and others affected by his violence, have a copy of his plan? Is it important for one or two mentors who the perpetrator trusts to also have a copy of the plan...analogous to a sponsor in an Alcoholics Anonymous arrangement?

Lack of program logic and proximal outcome measures

The infrequent use of program logic models (see Part 3), and of proximal outcome measures that stem from monitoring and evaluation frameworks derived from these models, limits the application of exit and accountability planning. If a program does not have a clearly articulated model of how it works towards change at the individual level, nor of the change processes that perpetrators need to engage in to work towards non-violence, exit and accountability plans are unlikely to have a solid basis rooted in the very mechanisms of the program. Indeed, the extent to which safety and accountability plans reflect the underlying program logic is one indicator of program integrity. This is often reflected in proximal outcome measures of the perpetrator’s participation in the program.

Lack of integration with secondary and tertiary desistance goals

Reporting on the work of Scottish criminologist Fergus McNeill, Vlasis et al. (2017) point to the relevance of concepts of secondary and tertiary desistance to sustaining long-term change. McNeill (2006) defines three levels of desistance:

- *Primary desistance*, or the short-/medium-term cessation of violent behaviour.
- *Secondary desistance*, where a person makes fundamental changes over time to his self-identity, general ways of being in the world, his social environments and sometimes other factors in his life (e.g. his fields of employment, or male peer cultures to which he belongs) to strive to become a “new person” who is fundamentally incompatible with violent offending.
- *Tertiary desistance*, where a person’s new personal identity of non-violence is valued and reflected in (new and/or existing) social groups and networks to which he

belongs, where his newly evolving identity has a sense of “social home”.

Addressing secondary, let alone tertiary, desistance goals in the context of exit and accountability planning can be challenging. Secondary desistance implies that behaviour change is a life project involving the perpetrator becoming a “new man”, whereas tertiary desistance necessitates this “new man” being valued in his peer networks and his micro-communities of belonging. While an exit and accountability plan can document some of the practices and life choices that a man can make towards these goals, change at this level may be too deep and relational to be documented in a simple “here’s your plan, now off you go” approach.

Opportunities to engage the perpetrator in the secondary and tertiary desistance aspects of his plan in the months after program cessation appear important in this respect. It is also important to note here that working towards secondary goals presents a significant quandary for community-based DFV perpetrator program providers. Both UK and US research demonstrates that the pathways towards secondary desistance are long, and are difficult to stimulate within the limitations of 20-session programs (or less) (Acker, 2013; Morran, 2011; 2013). For some medium-to-high risk perpetrators, however, long-term, sustainable change is unlikely without making some progress towards secondary desistance goals. For particularly high-risk, generally violent men with significant social dislocation and weak pro-social bonds, tertiary desistance goals can also be particularly important to sustain fledgling new identities (Vlais, 2017).

Lack of capacity to implement individualised planning

Thorough safety and accountability planning, in the ways defined in this section, requires sufficient program resources to implement. Such planning involves the commitment of practitioner time through:

- collecting and reviewing individual-level assessment (including from family members) and program participation data on an ongoing basis;
- detailed ongoing goal-setting work influenced not only by

- the perpetrator but also by his partner’s and family’s goals;
- monitoring of the perpetrator’s participation in the program;
- case reviews, sometimes in collaboration with the referring agency;
- individual sessions, or individual dedicated time with the perpetrator, to make the above happen; and
- some group-based time devoted to activities that assist the perpetrator to input into his plan over the course of the program, including homework activities.

Generally, in Australia, community-based MBCP providers have simply not been adequately resourced for sufficient analytical, planning and engagement time on an individual, perpetrator-by-perpetrator basis to make this possible. More fundamentally, program providers have generally not had the capacity to engage in individualised case planning and formulation that serves as the prerequisite of safety and accountability planning.

This limited capacity has generally meant that exit and accountability planning is something done only at the end of the program. With the plan developed in the final week (or, at most, the final 2-3 weeks) of the program, there is no opportunity to scaffold and support the perpetrator to put the plan into practice and to reshape and refine the plan based on this implementation experience. While an exit and accountability plan should incorporate strategies that the perpetrator has already practised at earlier points in the program, developing the plan right at the end of the program, without any subsequent review based on implementation experience, can implicitly communicate to the perpetrator that the plan is not considered important.

In summary, the process of exit and accountability involves careful consideration of the changes that have taken place over the course of participation in a MBCP, and guidance for the range of stakeholders that may have an interest in preventing future violence to women and children, based on the knowledge about future risk developed over the course of the program.

Part 3:

Focus group and in-depth interview research

Focus group and interview methodology

A series of focus groups with MBCP staff and managers from both the correctional and community sectors were conducted between July and September 2017. Participants were invited to join a general discussion about program quality, with a focus on the (actual and ideal) use of safety and accountability plans. They were asked to articulate the aims of their program (linking these, where possible, to specific program content and activities), as well as to describe how effectiveness is currently assessed and the possibilities for improving practice in this area. This included consideration of how linkages between networks or systems might work to better understand how MBCPs operate within a broader system. The process was planned to follow a predetermined structure, although the group discussions were not fixed to specific content. The ethical aspects of this research were approved by a university ethics committee. These included:

- consent form administration and participant signatures;
- introductions and role in programs;
- overview of the purpose, methodology and findings of the project;
- outline of the safety and accountability plan concept; and
- discussions about the extent to which the quality of a plan can be used as a marker of program quality more generally.

Questions for participants included:

Question 1: *What current practices do your programs use that approximate the intent of safety and accountability planning?*

Question 2: (a) *How much do your practices/plans reflect what happens across a program?* (b) *Is your program guided by a program logic? If so, in what ways do your current safety and accountability planning practices reflect the program logic?* Probe reasons for discrepancies. If few or no participants use program logic models, re-ask the question in relation to documented theories of change/theory section of their program manual.

Question 3: *What are the key features or areas/issues covered, from your perspective, of an end-of-program safety and accountability plan?*

Question 4: *What would be quality processes and practices in the development of safety and accountability plans?* Depending on what issues are covered in responses to this question, probe for when/how these plans should be developed, what the perpetrator's participation should be, how the plan could/should be written up or visually represented, use of new technologies, etc.

Question 5: *How should the plan be used systemically?* Depending on responses, might need to follow up with prompts asking how the plans could be used by partner agencies, at later time points, the role of the plan if the perpetrator is re-referred to that or a different MBCP or other type of perpetrator intervention.

Question 6: *What would help your program the most to further develop its practice in safety and accountability planning?*

Question 7: *How does your program assess client-level outcomes for participants and their families?* After general discussion, prompt for specific tools used. If general responses are given such as "partner feedback", probe for how this information is collected and used. Follow up with questions exploring the use of the data collected in case reviews, and report writing.

Question 8: *Is this data collated and analysed for program evaluation purposes? If so, how?*

Question 9: (only if time) *What would help you the most to extend your program's ability to assess client-level outcomes for participants and their families, and to use these for program evaluation purposes?*

The focus group facilitators took detailed notes during and after each session, which were then collated by the research team. The interview data were analysed using conventional content analysis. This involved reading the notes several times, as a whole, prior to coding and then organising content in open coding (that is, written notes and comments in the text while reading). Following this step, a process of condensing was undertaken where the notes were shortened into categories that still conveyed the essential meaning of the text, leading to the identification of meaning codes or themes where there was significant latent meaning (for examples of this approach, please see Hsieh & Shannon, 2005).

Individual interviews with women partners also explored perceptions about the quality of services offered to perpetrators, as well as their views on any information they had received from the MBCP relevant to their ongoing safety and accountability. These interviews were used to inform the interpretation of the analysis and to maintain a clear focus on safety and accountability. The summary themes that arose from the focus groups and interviews were then provided to the research project reference group for further feedback.

Participants

Three groups of participants were recruited to participate in this research, including:

1. correctional staff (in South Australia, n=7; and Victoria, n=6) who had experience of MBCP delivery with mandated clients in a justice service context;
2. community sector program providers (in Western Australia, n=9; and Victoria, n=4 across three organisations) who deliver programs to both voluntary and mandated clients referred by correctional services; and
3. female partners of MBCP participants from one program (n=6).

Participants in the practitioner focus groups were all responsible for the delivery and management of MBCPs in both prison and community corrections settings, although their experience in MBCP program delivery varied (with some having only recently delivered the program and others having experience across a range of other violence programs within correctional services).

Ethical considerations

The study was carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. Key ethical considerations in this study, as in all research with humans, are managing potential risks, maintaining privacy and confidentiality, ensuring participation is voluntary and offering the right to withdraw.

All participants were informed in writing of the following:

- *Potential risk*: There is the potential for participants to experience some level of discomfort or distress during the interview. If they experience any distress or discomfort, they will be asked to notify the research team who can then take steps to deal with the distress or discomfort.
- *Privacy, confidentiality and disclosure of information*: All information obtained in the research will be retained by the researchers. Data will be combined in a written report or publication so that no individual responses can be identified. A report summarising the findings, but not containing any identifying information, will be provided to the partner organisations.
- *Voluntary participation*: Participation in any research project is voluntary, and individuals are not obliged to take part. Whether or not they decide to participate in the study will not affect the services they receive in the prison.
- *Right to withdraw*: Participants have the right to withdraw from the study at any stage with no negative implications (current or future).

Common themes

The researchers made particular note of the enthusiasm with which participants engaged with this study. It appeared that many were grateful for the opportunity to discuss and share various aspects of MBCP delivery, as well as share frustration at the limited possibilities that exist in their local setting for safety and accountability planning and the delivery of programs that are of optimal quality.

The following themes were identified in all groups (which are not disaggregated to protect anonymity) and emerged following a meeting of the researchers to compare initial notes. These are presented as common themes although a number of differences were noted, particularly between programs who worked in either custodial or community environments. For example, in community programs, it was noted that:

- there is often a high attrition rate;
- participants sometimes know each other outside of the group; and

- attendance may be impacted by a range of external issues such as housing or the completion of any order or mandate to attend.

In their responses to the focus group questions, participants in the community-based provider groups focused both on programs they were contracted to run for corrections, and their other programs that accepted referrals from a wide range of other sources.

The importance of managing low levels of readiness to change

Some participants in community programs commented that perpetrators often seemed unaware of what kind of service they had been referred to, or lacked any clear understanding of the intended purpose of their participation. They described them as poorly prepared for the program and, in many cases, this was compounded by the time lag between the precipitating incident and the referral, which could occur many months later, or, in several cases, years. Perpetrators were generally described as arriving with little motivation to undertake the program, often approaching it simply as something that needed to be complied with.

Participants from the correctional focus groups made similar observations about readiness. They noted, for example, that many perpetrators are resistant to the program at the start (e.g. victim-blaming, police blaming), but also that those who do complete it can be very positive about their experience.

The importance of good assessment

Generally, for the correctional program providers, there was a clear process by which potential participants were identified (flagged) and then triaged; typically, this followed the administration of risk assessment tools. These tools were, however, described as mainly designed for use with a general offender population (or with those who were violent outside of families) and their validity in predicting the future risk of DFV was questioned. In short, the view was expressed that the assessment tools did not always identify those who were in most need of the MBCP and that program content was not

directly associated with the specific risk factors identified in these assessments.

In the correctional setting, all potential program participants were then interviewed by a MBCP facilitator. These interviews focused on areas such as:

- victim/survivor blaming, responsibility and empathy;
- problem recognition;
- awareness of victim/survivor impact; and
- commitment to change.

The function of the interview was, however, described as being as much about engaging and motivating attendance as it was about identifying criminogenic need.

In one jurisdiction, a battery of self-report assessments was also administered at this time to establish a baseline against which change could potentially be assessed. These tools were scored independently, and a report was provided to the program facilitator to flag areas of need (although the participants were largely unaware of how these thresholds are determined). The psychometric assessments did not, however, in the opinion of some participants, always mirror the program logic and were mainly focused on measuring knowledge or beliefs about DFV. They may have been supplemented with a weekly assessment that records any reports or observations of coercive controlling behaviour.

Participants in one of the community provider focus groups highlighted the assessment process as a key component in rapport building and cultivating a context for change. Additionally, the assessment phase was viewed as an opportunity to address other issues, including mental health, drug and alcohol, and trauma for which referral on to other services may be required. Participants further reported that they felt that facilitators running the group should also be doing the initial assessments. However, in some services, men could be assessed for a MBCP by a number of practitioners who may not be running the group. This was identified as a lost opportunity for building rapport and motivation for change at the outset.

The importance of good program content

An important determinant of program quality identified in one focus group was the program content itself, some of which was considered unsuitable for use with corrections clients. It was noted that one MBCP corrections program had not been subject to any process of evaluation since it was developed and that significant problems existed in relation to the way in which material from the workbook was integrated with that in the program manual (“some bits make no sense”, “it is a nightmare to run and quite stressful”, “there’s no way I’m going to do this [some activities] as it makes us look like fools”, and “you have to modify it a lot”). In short, there was a view that poor program integrity could result from the quality of the program materials.

Another group commented that the program they provided focused on IPV and that there was limited (or no) capacity for individual work, work with same-sex violence, transgender violence or lateral violence. There was a specialist Aboriginal and Torres Strait Islander family violence service that sat outside of this service, but there was no consideration of any culture-specific criminogenic needs in any of the assessments. As a result, the program was not considered to be appropriate for many Aboriginal and/or Torres Strait Islander men.

The importance of setting realistic thresholds for change

When asked to consider what type of outcome would constitute success, one program provider in a correctional focus group commented that “if one out of five returned (to corrections) that would be successful”. Expectations for change were also generally modest (“if they can take one thing from the whole program, then they have done well”). Another, however, stated that case managers had provided positive feedback about the type of change that had occurred following participation, although another commented that the stress of participating in the program is, for some, very high and can increase risk, especially when participation impacts on their employment.

Positive change was regarded as relating to change in attitude, increased confidence in the ability to not use violence in the future, and greater insight into or understanding of

violent behaviour. It was also noted that program success may be broader than that which is only defined in relation to individual change (e.g. decreasing the risk for partners who choose to separate), although no formal documentation process was in place that allowed any assessment of these additional outcomes.

For those who worked in the community, disclosure about changes in behaviour at home was regarded as a positive sign, particularly when MBCP participants could provide concrete examples of behavioural change (such as being more patient or more able to have difficult conversations). It was also noted that many MBCP participants are keen to let facilitators know about these changes. A further source of information that informed judgements about change came from the group itself. This not only included interactions within the group (e.g. how they linked group discussion to intervention targets), but also body language (e.g. demeanour and eye contact) and general openness to the facilitator, as well as the way in which the MBCP participant responded to female facilitators.

Finally, it was noted that feedback could potentially be elicited from observations of family interactions, corroborating information from others involved in service delivery (e.g. the family liaison staff member), and information on police call-outs. There was also general recognition of the role that external motivators for program attendance could play (“they would do anything to get their kids back”) and the importance of accurately judging impression management.

While confidence about change was seen as a positive attribute, overconfidence (when participants rate themselves too positively) was identified as a possible risk factor. It was also noted that the extent to which the end-of-program report documenting change carries meaning for the participant determines its value (“one person couldn’t recall anything about the plan”). There was also a general view that different facilitators could rate change (and future risk) differently, and that judgements of ongoing risk may also vary between locations.

In summary, there was limited clarity in the focus groups regarding the strength of any conclusions that might be made about whether a particular participant has changed. It appeared that there was a lack of consistency about the type of short-term change required to indicate genuine attitudinal and behavioural change.

The importance of outcome measurement

For some participants in the community focus group, while outcome measurement was recognised as highly important, they could only “dream” of having the capacity for this type of activity. Two of the three agencies in one of the community focus groups reported, for example, that they currently use no quantitative means to evaluate program outcomes for individual participants, and therefore are unable to aggregate data for program-level evaluation.

For the other community providers, current measurements of change were described as a mixture of facilitator assessments of participants, consisting largely of professional judgement, participant review tools, and partners’ contact ratings. For example, in one program, change was measured through weekly assessments by program facilitators that were then charted along a graph over the duration of the program. These assessments were based on a participant review tool used at the end of each session to track self-evaluated progress and then compared to the rating of behaviour change made by current/former partners (the women rated the behaviour change of the participants from 0-10 in terms of safety and respect, and this was then compared to the men’s own evaluations). One participant in this group also highlighted the importance of monthly meetings between individual practitioners, relationship counsellors and MBCP program staff as an opportunity to discuss and reflect upon change in their mutual clients.

One of the community agency representatives described the process of change monitoring in their agency the following way:

Goal setting is done at the beginning of the program through a one-on-one session. The men usually have very basic goals at this stage (not much more really than wanting to get the program done and over with to comply with

the conditions of the order). We then, half-way through the 14-week program, provide them with a template for them to review how they think they have progressed in relation to the goals they identified at the start, but also, as an opportunity to identify new goals – this is critical, as the men, as they progress through the program, can start to think more deeply about goals for participation in the program. The men fill this out themselves, it’s not through a one-on-one session. Then, at the last session in the 14-session group, I/we ask each man to come in about half-an-hour early so that we can spend a bit of time with them again reviewing their goals, one-on-one, as a form of exit planning. We also, on the last night, arrange a call-in by another practitioner. (Community MBCP focus group member)

However, the situation was very different for another community agency (which delivers corrections-funded programs):

We don’t do any individualised planning. We don’t do exit interviews. One of the reasons for this is that we run our corrections programs in locations that require us to make an agreement with other agencies that have premises we can use...we don’t have offices in these locations. This means that we can’t use the premises before 5pm. As we commence the groups at 5:30pm, it means that we can’t bring the men in early for individual case planning catch-ups. We do however on the last group session, run an activity that encourages men to think about what they’ve learnt through the program. (Community MBCP focus group member)

There was also discussion about the need to continue outcome measurement after the program has finished. Until recently, one provider was running a “reconnect” program where any graduate of the MBCP group could come back to a men’s group four times a year. It was described as an opportunity to “support and sustain the ongoing safety of victims/survivors and development of the guys”, and program staff were disappointed that this program was no longer running, given the opportunities it afforded to track behaviour change. This post-program follow-up service was seen as a crucial component of effective change assessment.

For other MBCP providers, there was no formal process for following up with participants after they completed the program (“once the program finishes, that’s it”) and, as a result, there was no feedback for facilitators about program effectiveness. One suggested that it would be helpful to have another follow-up session, after the current session that occurred 3 weeks after completion.

It was often only when a MBCP participant re-offended and came back to the same service that there was an opportunity to learn from what happened. If a person committed a further violent offence after completion then they were automatically re-assessed. Reviews could be called for those who were in custody for many years after completing a program in the early stages of their sentence.

The correctional service focus group participants were very interested and engaged in the discussion about how to best assess program performance and collect the types of data that can evidence some of the claims that are made in their end of program assessments. There was a lot of discussion about the different methods that were used to inform the post-program assessment reports, although these methods did not always appear to be well integrated. There was, for example, a standardised treatment completion report that required the facilitator to make comments about a number of areas, including, behaviour in the program, insight, victim/survivor stance and so on. These areas were not rated, with the only formal re-assessment occurring if there was a re-scoring of the original risk assessments, which might only occur following a new offence. The perpetrator could also access these through a Freedom of Information request.

In one MBCP, for example, there was a focus on developing self-management plans for coping with high-risk situations, including the use of scenario planning, while in another the participants completed their own safety plans (structured in line with program content). The pre-program structured assessments of risk used by correctional agencies (e.g. the Violence Risk Scale and the SARA) were not viewed as particularly helpful in assessing change (and were described by one participant as “not fit for purpose”). Some participants noted that although psychometrics were re-administered at the end of the program, they were not formally reported in the

end-of-program report. The weekly assessment of program performance was not collated in these either. Rather, a free-text proforma was completed (with the following headings: program participation; responsibility taking; commitment to non-violence; alternatives to using violence; impact of violence and abuse; dangerous thinking; and summary and recommendations).

The importance of safety planning

In one correctional agency, the perpetrator was required to complete a safety plan containing:

- my commitments;
- my responsibilities;
- a figure about choice (indulge thinking/challenge thinking; my rights/my responsibilities; blame/not blame; control/care); and
- a worked example of thinking (and challenges to this thinking) in response to a scenario.

This safety plan represents “a mirror of the program modules” and was available internally, but the processes for wider dissemination were not systematic. A concern was expressed that documenting risk might also disadvantage the perpetrator as other service providers may have interpreted a risk rating as higher than was appropriate. Nonetheless, information sharing in higher risk cases did occur.

In the other correctional jurisdiction, safety planning was an extensive process when the program was delivered in a prison, and often the plan would be a 30-page document. This document was then placed on a shared database and was available to others who worked with the offender (e.g. the parole officer). The plan was summarised in the end-of-treatment report and recommendations were made, which may have included re-assessment in the community, maintenance sessions as part of a community order, or referral to other programs (e.g. parenting or substance use). One participant stated that time was taken to make referrals to other agencies (e.g. housing), given the understanding that other factors could significantly elevate perpetrator risk. However, this was not part of the participant’s role.

In the focus groups with community-based program providers, safety and accountability planning processes appeared to be better developed for human services-funded programs than for those that were funded by corrections (although practice in other jurisdictions may be stronger). One participant from a correctional service-funded MBCP commented:

At the end of the man's participation in the program, we write a completion report. A lot of it is filling in administrative fields. Tick box type form. There's also space for writing in other notes about risk, the man's participation in the program, etc. (Correctional service MBCP focus group member)

The community providers were more engaged with activities consistent with a safety planning approach:

We [community-funded program provider] have a constellation of activities that collectively point towards safety and accountability planning, but in a general sort of way. We run a particular activity two or three times over the course of the program focusing on helping the men to develop "action plans", or concrete strategies towards behaviour change. We don't introduce this too early as the men will filter it out – [we] introduce this after some of the preliminary early sessions on "becoming the man you want to be", male role socialisation and learning male privilege, etc. Repeating the activity is important as the men get more out of it as they progress through the program. Group work activity, not done through individual sessions. (Community MBCP focus group member)

Another related component in this program was that the men progressively developed a resource folder (across their participation in the program) that contained a range of things relevant to their behaviour change, including other services to access. Participants often showed their folder to their partner, to some other relatives/men influential in their lives. This folder was not a plan as such, but a collection of things that they could draw from when they left the program.

A second community program provider noted:

In our 20-week program, we work with the perpetrator to identify goals for the program during the initial intake/assessment process. At the 10-week mark, participants

engage in their own written review of how they are progressing with respect to their goals, and an opportunity to identify new goals. Then at the end of the program we have a face-to-face exit interview. This focuses in part on strategies to keep their behaviour safe, sources of support that they can draw upon, etc., but a big part is to provide a sense of "closure" for the men. The exit interview focuses on services that can support their journey of change, the goals that they have achieved through participating in the program, their journey through the program, situations that they are at higher risk of using violence and strategies to stay violence-free in these situations, and people who can support them to maintain their changes. (Community MBCP focus group member)

This agency also completed a general assessment of each perpetrator after every 10 weeks. Unlike the written goal review, this was done without the perpetrator's involvement. It was guided by a template, where the perpetrator was scored on a number of indicators of participation in the program. This was scored separately by each facilitator, enabling scores to be compared. The partner contact information was also viewed as important. From this process, recommendations were set for the next 10 weeks in the program.

All of the community agencies represented in this focus group said that many perpetrators wanted to do more MBCP work or obtain additional support after completing a program. They were described as feeling vulnerable after leaving the program. In the other community provider focus groups, participants reported that the men are asked during the assessment what they would like to have achieved and gained from the program. In one program, at the end of the 24 weeks, they were also given a semi-structured exit interview where they pledged the changes they would make, and a copy was given to them. Questions in this interview covered areas such as:

- "What will keep you non-abusive?"
- "What are the risks of you being abusive again?"
- "What are your triggers, where are your support systems and how will you navigate them?"
- "How does your abuse impact on your partner and children?"

The men may also be referred on to other programs including parenting programs, family dispute resolution, addiction counselling or individual counselling.

The importance of including partners

The feedback received from the women at the end, and throughout, the program was perceived as a pivotal measure of the effective work of MBCPs. It was emphasised that this should be considered the most important indicator when ranking the extent to which a program had been successful in contributing towards behavioural change. Questions asking the women about their feelings of safety and marked improvement in behaviour change were offered as examples of possible measures of change. At the same time, there appeared to be marked variations in how partner contact was managed.

In one corrections service, partners received weekly updates on progress (through an external NGO contracted to provide this service). However, the facilitators noted that partners rarely took up this offer. Furthermore, while partner contact was deemed to be good practice, there was often no routine “feedback loop” from MBCPs back to partners unless there was “a physical safety issue”. Nonetheless, the practice of communicating to the MBCP group clearly and up-front that their partners would be contacted was identified as an area that contributed to effective practice, even in correctional programs where this happened less frequently.

For men who no longer had contact with their partner, it was suggested that the former partner could also be contacted to contribute to the safety and accountability planning process. While this process was deemed good practice, it was not documented policy for MBCPs.

The importance of service level contracts

Service provision for community providers who provided services on behalf of correctional agencies was reported to be constrained by the contracts that are in place. These contracts were described as tightly specified, with program providers free to use their own program, but only within

fairly tight parameters of what was funded. Frustrations were expressed with different contract managers in the same region providing conflicting information about the attendance requirements, and this was something that was often picked up on by perpetrators:

The perpetrators also know exactly what the minimum participation is that they need to do to comply. They know how many sessions they can miss, and generally don't want to do any more than the minimum...it's hit and miss whether men attend the individual exit interview we arrange for them at the end of the program. (Correctional service MBCP focus group member)

Participants, particularly those in the community-based corrections-funded programs, felt that major systemic barriers limited their ability to apply safety and accountability planning. They felt that it was their responsibility to simply administer the program, but that the community corrections staff inputs to safety and accountability planning were largely administrative and bureaucratic in nature. This was a source of some frustration. For example, it was reported that the case note written after each session (for each perpetrator) was not necessarily read by the community corrections officer, but rather was put on file to access if needed at a later point (e.g. if a critical incident had occurred). Hence communication between the MBCP and the correctional case manager was described as poor, outside of fulfilling purely administrative functions:

It's not an equal partnership between corrections and us. It does vary between regions, some regions are more proactive, and in one region, there's been a few times where a corrections case manager has met with a MBCP provider to discuss individual offenders (though this is rare – very few case reviews involving both the case manager and the MBCP provider appear to occur). (Correctional service MBCP focus group member)

Feedback loops were also described as insufficient by the same community provider:

The processes for MBCPs, police and other relevant services to inform each other about developments with respect to a perpetrator aren't in place. Agencies notify each other of urgent or duty of care risk issues, but important

developments that aren't of the serious and imminent risk kind don't get fed back to other agencies. This means we don't all have the same pertinent information to assist with planning. (Correctional service MBCP focus group member)

Finally, workforce capacity barriers were identified as a significant limitation on safety and accountability planning, as well as determining the provision of MBCPs. Some agencies were struggling to find facilitators to run programs, let alone to strengthen safety and accountability planning in them. The use of inexperienced facilitators co-facilitating MBCPs was also identified as a problem.

We are fortunate in that I/we have a generalist casework counsellor at our agency who has MBCP experience. This means we have someone who can assist our program to do one-on-one sessions. But if we didn't have him! We have had the experience of using a different generalist casework counsellor to do some one-on-one work with MBCP participants – big mistake. The men came back with their violence-supporting narratives strengthened from this work! It was obviously collusive practice. (Community MBCP focus group member)

It was also suggested that there was a need for facilitators to receive more support than they currently do, particularly in managing abuse from perpetrators, and that this can directly impact on program quality.

Notions of harnessing the power of religious institutions, religious elders and multicultural centres to instil behaviour change were also highlighted as a systemic factor that potentially enhanced outcomes. The level of power that religious institutions can have, for example, in influencing women to stay in relationships with men who perpetrate violence, or to drop protection orders, and the social alienation women can feel from their communities as victims/survivors of DFV was noted. Some program staff also noted the huge negative impacts some faith leaders can have on women's safety. Drawing on practices in the drug and alcohol sector, an ambassador program that offered ongoing support and someone to clearly hold men accountable was also suggested.

Female partner experiences of participation in MBCPs

A total of ten women expressed interest in participating in an interview to discuss their partner's (or ex-partner's) attendance at a MBCP. The final number who were interviewed was, however, six, as four women who volunteered were subsequently unable to participate. Attempts to recruit further participants were unsuccessful, but although the sample was small there was a range of diverse experiences among the interviewees, and their lives and circumstances varied considerably.

Women ranged in age from 30-42 years. The length of their relationships varied from around 5-13 years. Five of the six women had children, and four had children with the perpetrator. Three of the women's families included stepchildren. In one case the partner had children prior to the relationship; in another, the perpetrator was the stepfather, and in one case both parties had children prior to the relationship. Two participants had current protection orders against violent ex-partners who were participating in MBCPs.

Three of the men who had attended a MBCP had a court order to attend, and in one case this was a parole condition after release from prison. The remaining men were attending a non-mandated program. Women had separated from the three court-ordered men and one of the non-mandated participants. Two of the research participants whose partners were in the non-mandated group were currently living with the men. The safety of participants was of paramount concern to the research team at all times. This meant that the processes of both recruitment and participation were designed to ensure that taking part in an interview did not place the women at any additional risk and that their safety was monitored at all times. Particular care was taken to de-identify quotations.

The value of MBCPs

Five of the six women who were interviewed expressed relief that their partner was in a program. Of these, three commented that this was partly because it meant that an

“outsider” and “professional” had an “eye on him” and knew what he had done. It seemed to act both as a form of external accountability and as a form of safety that other people knew that he had the capacity for violence and that her safety was an ongoing concern.

All of the women hoped that the program would help their partner to change. One participant was less confident because this was the third program her partner had attended. The first one was for substance misuse and the second one for DFV. Underlying her limited confidence in the capacity for change was the belief that her partner could not make changes while still “using drugs and drinking”.

The type and value of partner contact services

All of the women had experience of partner contact, although the contact type and content differed. One woman described the partner contact as valuable as it linked her into her own support services, while the partner attended the program, and her son was also given the option to attend a group for children. She was generally pleased with the services she had received. Her only concern was that the referral for her 11-year-old son did not eventuate and she felt that support for him was much needed (so he had the “chance to tell someone what had happened without worrying what would happen”). After her son experienced a mental health crisis, she described “really letting rip about things” in the partner group. In her words:

Because, I was just like, look, you know, you have these services available, and I’m asking you for them, but yet I don’t get them. You know, you don’t follow up, you don’t call me back, you don’t...you know, you said that, you’d try and do this, and I don’t hear from you. I get that it’s [he’s?] the one with the problem, you know I understand that he’s the one that needs fixing, but he’s left a trail of destruction in his wake, and the kids need help, you know, let alone me. My kids need help, I can deal with myself, but when you have got a child who is trying to stab himself, and he’s cutting himself with glass, what more is it going to take, for you to listen and help?

This quote highlights how important the provision of a joined-up, coordinated, and timely response for all family

members can be (see Stanley et al., 2012). In this instance, the woman felt that the adults’ needs were being prioritised over those of the children, although she was satisfied with the MBCP and the support available for partners.

Two of the women whose partners were in the same non-court-ordered program reported that the telephone contact with partners seemed abrupt and to be predominantly focused on safety. One described the partner contact as follows:

They said “I/we will also check up on you”, or, “he can withdraw any time”, or, “if you have any sort of information that you think is important let us know”. Oh, they gave me a phone number to call when I need help, instead of just asking me questions at the time.

This woman experienced the partner contact approach as rather invasive. She explained that as someone from a minority culture she might have different expectations about what is acceptable in terms of discussing her private life with someone on the phone whom she has not met.

In discussing her hopes that the program would bring about change, another participant described a disappointing partner contact response:

And that’s where I hope he’ll [the partner] change. You know because it would be very good to see them [all program participants] get the other side of it. I mean I was really disappointed, I honestly thought they were going to have me in there.

When asked if this is what she was expecting, this participant replied: “Yeah. He told me they were actually going to have me in there: ‘Oh, you are going to be contacted by someone’”. She then agreed with the interviewer’s statement that they did not follow up fully: “Exactly. They just called. I didn’t say much. I thought that I did that when I went there”.

One participant said that she would have liked the contact to have occurred more quickly than it did. This is in contrast with the experience of partner contact workers who report that it is often very difficult to get in touch with partners/ex-partners. This participant did not feel at risk from her partner, describing the abuse as “only psychological” and

“not physical”, and felt that the contact worker did not assess what she was seeking, or want to engage in a conversation about the program itself, which is what she was interested in:

...because everything I know about the program is from him. Like, what’s going on, what’s the steps, one-to-one, or he told me about something they’re moving on to, like, a group or maybe you need one-to-one, or you need bookings, and if he doesn’t tell me I would not know.

This point has been raised in previous partner contact research (e.g. McGinn, Taylor, McColgan, & Lagdon, 2016), particularly in relation to providing support for women who are at the time of the MBCP still living with their partner. There have also been accounts of risky situations arising from when women did not have partner contact so had to rely on the perpetrator’s account of what went on in the group. In some cases, perpetrators have been reported to use this to tell the woman that the violence is “her fault” (e.g. Day et al., 2009b). This does highlight the importance of sharing some basic information about the MBCP approach, such as being clear with partners that perpetrators are solely responsible for their use of violence against a partner.

Some MBCPs in Australia have offered “partner nights” where women meet with workers to find out about the program. However, workers have fed back that they have had only limited success in attracting partners for reasons often related to access. For example, as some of the “partner nights” were held in the evening, they may not have been accessible to those with childcare responsibilities or without transport. Other women may not wish to participate in a group setting. One participant suggested that MBCPs develop a PDF document or similar with contacts for further information that is emailed or sent via SMS as part of the standard partner contact. This participant pointed out that as workers are busy, this could be an efficient use of their time and would not need to be repeated with each partner contact.

Do MBCPs make a difference?

Interviewee responses to this question were varied. One woman thought that her partner had made some changes in his behaviour and reported that her fear of him had reduced.

She described feeling more comfortable with him having child contact (although still did not like the way he spoke to his daughter, who was the interviewee’s stepdaughter). She explained that he did not speak to her children in that way and that because contact with his daughter was not in jeopardy, he could speak to her as he wished. Here, the interviewee aptly describes what other women have also reported about changes in men’s behaviour – that is, they worry that it is temporary and that he can “change back” at any time (Westmarland & Kelly, 2013), as illustrated in the following quote:

...umm, I don’t trust him, I don’t...it’s...it’s not that I don’t...I do love him, I love him very, very much, but I don’t think that if I did...if we did get back together, and it...you know, we went to counselling, and everything, and everything is going fine, and then I think, umm... because he has proven in the past, umm, because I/we did go to marriage counselling and whatnot, you know, a year into our marriage, for the same thing, umm, and then, the minute my guard was down, after we had finished counselling, umm, you know, things did go... they went straight back...

Another participant similarly commented that while she hoped her partner would change, she does not like to trust that he will. In this case, the woman’s vigilance to avoid confrontation prior to the MBCP turned into waiting for the violence to return and a lack of confidence that change would be sustained. At the same time, and as noted above, the women do also attribute change to the men taking part in group work and, in particular, to the fact that others know about his situation. Part of their concern here is about when the group finishes. This is also what McGinn et al. (2016) have observed:

Studies of perpetrator perspectives (Sheehan, Thakor, & Stewart, 2012, p.247) have highlighted how IPV perpetrators believe that they themselves experienced “turning points” and went on to drive the change to violence-free relationships. It is interesting that survivors have not echoed this sentiment; in contrast, they suggested that their empowerment and refusal to accept abuse was a key factor in the improvement of their situation. While perpetrators speak of taking responsibility, survivors speak about holding them to account.

Other participants described their partners as now asking more about their concerns and perspectives and listening to them – behaviours that they had not previously experienced. They valued these changes as they felt “heard” and a little “less fearful”. There was also hope that these changes would not be short-lived.

Where to from here with partner contact

There was a sense among five of the six women that the perpetrator had been able to show the facilitators that he had made progress. However, despite hoping that this reflected some permanent change, the women did not necessarily trust this and noted the possibility of impression management (e.g. “performing” for the hours required).

Women in this group did feel that partner contact was important and should encourage women to offer their perspectives in detail. They also thought that partner contact could be more assertive. The main area that women identified as requiring further development was providing descriptions and details about what happens in a MBCP. This was often like a “black box” to them and, it was suggested, could be simply addressed by sending out some FAQs that women could read when the time suited them. They also very much saw the value of victim/survivor knowledge about the perpetrator being available to facilitators as well as the need for better support options for their children.

Part 4:

Key findings and opportunities for practice development

The findings of the three methodological elements of our research (literature review, jurisdictional scan and qualitative research with MBCP providers and victims/survivors) were used to inform the identification of a series of key areas for further development if progress is to be made with improving the outcomes and quality of current Australian MBCPs. These relate to all aspects of program delivery, from program design and conceptualisation through to outcome measurement, and safety and accountability planning processes.

The overarching objective, however, should be to develop high-quality, evidence-based standards that can guide practice. It is clear that further development in this area is needed, including identifying approaches that are specific to the provision of MBCPs in different service settings and/or with distinctive perpetrator groups. However, some broad findings have emerged:

The need for consistent minimum standards

It is clear that minimum standards vary significantly across jurisdictions. They differ in terms of the:

- degree to which they focus on program-level factors and the organisational capacity of providers to run programs sustainably into the future;
- extent to which they prescribe particular program content;
- detail in which the standards are pitched;
- room for providers to meet any given standard in self-determined or localised ways;
- manner in which they are written according to any compliance or accreditation framework accompanying the standards; and
- differentiation between minimum standards and any accompanying practice guidelines.

At the time of writing there was significant activity in the development or update of minimum standards and practice guidelines across Australia. It will be important to ensure that these efforts are carefully coordinated in terms of the nature and scope of standards, the extent to which they are

voluntary or mandated, how they are monitored, and how compliance is assessed. It is reasonable for the community to expect the same standard of MBCP service, regardless of where in Australia a program is delivered.

Standards and professional practice guidelines

In some jurisdictions, minimum standards are termed “professional practice guidelines” or just “guidelines”. It is often unclear, however, what differentiates the use of the term “guidelines” from “standards”, as in some cases (e.g. Texas, US) providers are audited against the guidelines. Certainly, some program manuals that encase minimum standards provide practical guidance as to how each standard might be met. However, the presence and degree of such detail vary significantly across different jurisdictions, as does the level of referencing or connection of practice guidance to MBCP, DFV and other relevant literatures.

A small number of jurisdictions have developed a two-tiered standards system involving minimum standards and a second layer of “optimal” or “good practice” guidelines. The 2006 Victorian minimum standards, for example, contained an approximately equal number of “good practice guidelines” and “minimum standards”, with the former covering issues where there was not sufficient consensus among practitioners in the field to introduce requirements. NSW commissioned the development of a detailed practice guide, *Towards safe families* (2012), that provides contextual and explanatory text and concrete examples of what it would look like for providers to meet each standard competently, sufficiently and optimally. This guide, therefore, outlines a layer of optimal practice beyond the minimum requirement for providers to meet the standards.

This raises the question of what constitutes a minimum standard rather than a practice guideline. Some minimum standards are written with intentional brevity and, such as those in Western Australia and New South Wales, to give program providers the flexibility and room to meet each standard in locally and program-determined ways. This minimal level of prescriptiveness further enables the

creation of a second document focusing on wider-ranging and more in-depth voluntary practice guidelines that support program providers to implement the standards. Other minimum standards documents, however, contain significantly more detail, both in explaining the rationale behind the standards and in suggesting ways in which program providers might meet the standards.

Adapting standards for particular contexts

The jurisdictional review raised issues concerning the ability of program providers to meet standards in particular contexts. A significant debate, for example, has arisen regarding the application of some minimum standards for program provision in Aboriginal and Torres Strait Islander communities. This debate includes:

- the absence of some specific considerations regarded as crucial to working with Aboriginal and Torres Strait Islander perpetrators of family violence, including healing work;
- philosophical contention (both across Aboriginal and Torres Strait Islander stakeholders and the wider DFV sector) concerning the intersectionality of gender and culture;
- cultural constraints in the applicability of some standards (e.g. some Aboriginal communities advise against mixed gender co-facilitation on cultural and spiritual grounds);
- the community accountability context underpinning program implementation, such as the potential role of Elders and involvement of the wider community; and
- lack of flexibility within the standards.

Minimum standards also generally focus only on the predominant dynamic of adult men's use of DFV against family members in the context of heterosexual relationships. Adolescent violence in the home, teenage dating violence, use of violence by women and other unique cohorts or types of DFV are not covered. Examples of the adaptation of minimum standards for specific cohorts are rare, although standards are under development in the UK for programs working with young perpetrators as well as in Illinois, US, regarding work with female perpetrators.

Minimum standards have also not kept up with the expanding understanding and diversification of specialist perpetrator interventions beyond standard MBCP work. A significant proportion of perpetrator interventions are conducted in the confines of one-on-one individual counselling relationships, whether by specialist perpetrator intervention practitioners, or by generalist counselling or private practitioners without any specific training in working with perpetrators. With no standards or practice guidelines to underpin this work, much of this practice is likely to be unsafe. There are also no minimum standards guiding the development of programs for fathers who are DFV perpetrators.

Complaints mechanisms

Some jurisdictions included mechanisms for members of the community, including program clients, service system stakeholders, and practitioners from other programs, to make a complaint about a program in relation to not achieving minimum standards. A state government board (in the case of some US jurisdictions), or a specially convened panel (in the case of No to Violence in Victoria, Australia), would then be responsible for collecting information and liaising with the program. A complaints mechanism can be a useful adjunct to other monitoring processes, but is insufficient on its own. Not only does this rely on problematic practices being detected, but also the small and insular nature of the field can result in potential complainants being hesitant to come forward through fear of identification.

Complaints processes have also been used unsuccessfully in attempts to assist program providers in finding solutions when they are unable to meet a particular standard. In Victoria, at least theoretically, program providers could report themselves to the peak body when they are struggling to meet a particular standard (e.g. in cases of rural program providers unable to recruit a female practitioner to enable mixed gender co-facilitation). In theory, the program provider could:

- explain the situation;
- propose a temporary solution involving measures to implement the spirit of the relevant standard (i.e. find alternative ways to address what the standard is attempting to achieve); and

- outline a timeline and steps towards meeting the standard in full.

In practice, however, this process appears to be rarely followed and is perhaps the wrong mechanism to provide proactive support to program providers who require temporary exemptions in relation to particular standards.

Compliance monitoring processes such as those that exist in Alberta, Canada; Texas, US; and New Zealand, which involve regular (often yearly) auditing or other exploratory processes with each program provider, offer a potentially better means to identifying standards that a program provider might be struggling to meet. Capacity to assist the program provider to develop alternative, temporary solutions and to work towards meeting the standards in full are an important flow-on to these regular liaison processes. Available capacity by an NGO peak body (such as the Texas Council Against Family Violence, UK Respect, and No To Violence), or by a government authority (as is the case with Alberta Health, and the New Zealand Ministry of Justice), to provide such flow-on support to program providers is crucial.

Monitoring compliance through service agreements and contracts

Theoretically, program adherence to standards can be monitored as part of funded service agreements, with the funded body taking responsibility for monitoring compliance as part of contract administration, oversight and renewal. However, there was little evidence that funding bodies have (or seek to create) the capacity to do so. Local or regional managers generally oversee a large number of contracts and may have little time, knowledge or skill to review specific programs in depth. The focus groups with community-based providers of MBCPs found that relationships between program providers and funding contract managers were not strong, often involving minimal contact.

Corrections contract managers can potentially draw upon internal program-integrity checking resources to assist in monitoring the compliance of funded MBCP agencies with

agency standards of practice. An example is provided by the New Zealand Department of Corrections, which intends to introduce a process of integrity monitoring with its funded MBCP community-based providers using its existing treatment and program integrity checks (currently applied only to internally run offending behaviour programs), and observation of MBCP practice in some situations. The difference, when compared to the Australian context, is that the New Zealand Department of Corrections requires funded NGOs to run the exact same program developed by the Department of Corrections itself. The program's introduction in 2015 caused considerable consternation in the community-based sector due to a perceived loss of ability to develop and continuously evolve their programs in the context of localised coordinated community responses. Furthermore, while specifications for program implementation as part of NGO contractual arrangements can be detailed in some situations, covering a number of the issues included in minimum standards sets, their inclusion in contractual arrangements keeps these specifications out of the public domain. This raises important issues regarding transparency and the ability of other stakeholders and the public to know what is entailed in these specifications.

Characteristics of more considered compliance monitoring processes

We found relatively few examples of what could be termed proper accreditation processes for community-based MBCP work, such as in the UK (administered by Respect) and in Texas, US (Texas Council on Family Violence (TCFV)). These processes stood out in several ways:

- Accreditation processes were generally administered either by an NGO (as in the case of Respect and TCFV) or by a government board with significant representation by members with DFV and MBCP practice experience. This appears to be a crucial characteristic to ensure that the accreditation process can penetrate into program delivery quality and move beyond a superficial “tick and flick”. Respect, for example, has substantial expertise in DFV program policy, research and knowledge transfer and exchange activities; while TCFV is staffed in part by experienced victim/survivor advocates, some of whom are involved in the auditing process.

- Accreditors performing the actual auditing work were carefully chosen and specifically trained for this purpose.
- The accrediting body had an ongoing relationship with program providers, rather than being at arm's length. In particular, the accrediting body played an active role in assisting program providers to become accreditation-ready, a process that might take several months. The accrediting body was not positioned as a distant, bureaucratic accountability measure, but rather as an ally and support for program providers to maximise the quality and effectiveness of their work. This was reinforced through accreditation bodies consisting of members who have conducted DFV and/or MBCP work.
- The accrediting body had an ongoing and active relationship with approximately 20-40 providers (some of whom would be providing programs at multiple sites and running multiple groups per week). Working with a volume of providers beyond this range was understood to apply pressure on accrediting bodies to compromise the depth of auditing processes required to discern the quality of practice.
- The accrediting bodies performed capacity, capability and skill-building functions other than administering accreditation processes, such as organising and conducting training and professional development for program providers and involving themselves in research activities. Accreditation was positioned as part of a broader and integrated suite of strategies to support program providers to provide quality practice under difficult circumstances (limited funding, contention about the effectiveness of MBCP work).
- Significant observation of MBCP practice formed a central part of accreditation processes. Respect requires program providers applying for full accreditation to provide 6 months of video- or audio-recorded group practice, enabling a random sample of practice to be reviewed, while TCFV observes a significant volume of group work practice for each provider, each year. The emphasis on observing a sufficient volume of group work practice is to ensure that most or all facilitators are covered through the accreditation process and to assist the auditors in discerning practice trends. It further enables opportunities for auditors to determine how the agency responds when significant practitioner or facilitator challenges or mistakes in practice arise, particularly in regard to the quality of the agency's practice management and supervision processes, to address issues in quality of practice.
- Analyses of staff files were undertaken to determine, for example, if minimum requirements regarding foundational training and participation in ongoing professional development had been met.
- Analyses of client files were undertaken to check on the language used by program practitioners in note taking, risk assessments, case reviews and report writing to referrers; and to check what was included or might be missing in initial and ongoing assessments, intervention plans, risk management plans, client reviews, reports to referrers, and exit and accountability plans. Several jurisdictions placed a high value on a detailed analysis of client-related documentation as a means of determining the extent to which practice is meeting minimum standards.
- Tools and templates were used to both support program providers in compiling information required for the audit, and in guiding auditors in their observations of group work and analysis of staff and client files. This not only supported a sense of transparency regarding what information was collected and why, but also provided parameters regarding the potentially vast amounts of information that could be generated through an accreditation process beyond what could feasibly be analysed.
- Care was taken in the feedback processes to program providers. This is consistent with accreditation being positioned as a process to assist providers to meet their existing goals and to maximise the quality and potential effectiveness of their practice.
- The Respect accreditation standard was found to be structured in a unique fashion that outlines (non-prescriptive) examples of how providers might be able to demonstrate each particular standard. While a feature of the UK accreditation process, in particular, standards that are written in a way that is consistent with the nature of the accreditation process are relatively rare.

The need to develop the evidence base to inform standards

In the jurisdictions reviewed, both in Australia and overseas, the two most important sources of input and influence guiding the development of minimum standards have been:

- commonly held principles and assumptions about DFV, and about MBCP work; and
- practitioner-based wisdom concerning safe and potentially effective MBCP work derived through consultations with practitioners and assumed knowledge within the field.

In the US, for example, many sets of minimum standards resemble each other or share significant content, based on the above two factors. In Australia (i.e. Victoria, New South Wales, Queensland and Western Australia), processes to develop and update minimum standards and professional practice guidelines have relied predominantly on consultations with program practitioners and providers within their respective jurisdictions, in part to ensure that providers have felt part of a process for which they would (ultimately) be held accountable. The Victorian minimum standards were used as a significant benchmark for the subsequent development of standards and professional practice guidelines in other states. A similar situation occurred in the US, where the development of initial sets of “reputable” standards were subsequently drawn upon by other jurisdictions.

Evidence-based practice has played a relatively small, though not absent, role in the development of these standards. This has been due to the following:

- The impetus for the initial development of minimum standards was to affirm a gender-based understanding of domestic violence based on patriarchal socio-structural drivers of perpetrator behaviour, in the context of a competing and contentious view that positioned perpetrator program work as therapy focusing on interpersonal dynamics.
- Many standards were initially developed in the 1990s when there was very little published research specific to MBCPs. While the knowledge base has progressed somewhat over the past 10 years, there is still very little evidence-based consensus or guidance on a number of

key issues typically covered by minimum standards sets.

- Where evidence does exist, the methodologies and outcomes captured by the research are often too narrow to inform the construction of related standards. Program length is only one of many examples here, but is particularly notable in this respect. The limited number of studies that have attempted to discern the impact of program length have reported inconclusive findings and have not investigated a range of issues that experienced practitioners and industry experts argue are important (e.g. the need for longer programs to keep perpetrators, particularly those at moderate or high risk, within view of the service system; to address patterns of coercive control beyond the use of injurious physical violence; and to promote outcomes for children by working on fathering). There is no evidence base from which to evaluate this practitioner-based expertise, as studies focusing on program length have not measured these variables.
- Drawing upon the evidence base from related fields has required a “leap of faith” that can be difficult to navigate, particularly when there is no consensus about the underlying program theory. For example, there has been a hesitancy to draw upon evidence stemming from the general psychotherapy literature due to concerns that this would position MBCP work as “therapy”.
- Significant cultural and world-view differences between corrections and community-based gendered approaches have meant that evidence-based practice from the former has generally not been incorporated into the latter. The importation of the corrections approach into community-based contexts is not at all straightforward, given that different assumptions may be made about the nature of DFV.
- Those responsible for developing and updating standards, both within governments and NGOs, do not necessarily have a sufficiently wide-ranging and nuanced understanding of the research literature to assess claims that are made about particular practices being “evidence-based”.

It was very difficult, from the jurisdictional review, to determine the extent to which the minimum standards of any jurisdiction actually drew from the evaluation evidence. While the claim was often made that there was “evidence” behind the standards, this was often not transparent, and

very few minimum standards or professional practice guidelines contain supporting references. None contained a literature review section or a review of relevant evidence (if such reviews were conducted, they were not in the public domain). Without such transparency, it is difficult to know how particular standards were developed.

Some types of standards may, of course, rely more on evidence than others. A good example is standards that relate more to “safe clinical practice”, derived from evolving and strengthening practitioner-based knowledge both specific to the DFV field and more broadly related to practitioner and organisational responses to risk. Some standards are administrative in nature, while others relate to the accessibility of programs for particular (marginalised) cohorts or are pitched more at the organisational level in terms of the ability of the agency to sustainably implement programs over time. Some standards also focus more on systemic roles and responsibilities of the program provider in relation to working with partner agencies. Other standards focus on data collection and evaluation.

Identifying the evidence base that supports the inclusion of these different “types” of standards requires a wide lens and perspective. For example, the literature pertaining to organisational psychology and third sector development in the light of contractualism and social services sector reforms could assist with setting standards in terms of sustainable organisational capacity to run programs. Literatures this far afield from the MBCP evidence base are rarely considered in this context.

The jurisdictional review did, however, suggest that there is a willingness in the sector for minimum standards to become more influenced by the existing evidence base. This includes recognition of the need to explore related research evidence when little exists that is MBCP-specific. The issue of program length here is a case in point. In the absence of any evidence to evaluate practitioner-based expertise concerning minimum lengths for MBCP participation (or at least minimum lengths for different perpetrator cohorts defined by risk and complexity of criminogenic needs), minimum standards related to program length can be informed by the evidence base in related intervention and therapeutic fields.

These include general (not DFV-specific) violent offending programs offered in correctional contexts, and alcohol and other drug or mental health interventions that attempt to address entrenched behaviour.

Building evidence as a way to build confidence

The UK’s Realising Ambition consortium, while focused on social service interventions for children and young people, has developed a set of program insights concerning the generation of evidence that may be applicable to the MBCP field (Realising Ambition, 2015). The consortium recommends that program developers and evaluators work towards improving stakeholder confidence that the program provides beneficial outcomes and can be replicable or scaled-up to other contexts; in other words, providing “evidence as confidence” rather than evidence as “proof”. In the consortium’s own words:

Irrespective of the specific question being asked, too often we rely on evidence to support unequivocal claims of truth. We say things like “this works” and this is “cost-beneficial”, yet the truth is often more nuanced than this. In relation to evidence of impact, for example, even with the most robust evaluations, we cannot unequivocally conclude “this works and this does not”. Rather, at best, we might be able to say that the evidence suggests that a particular intervention (or practice, or approach) is effective (or ineffective) in improving one or more specified outcomes (assuming certain contextual factors hold). (Realising Ambition, 2015, p. 7)

The consortium proposes a multi-phase, multi-component framework towards improving “confidence in the evidence” that a particular program should be replicated and/or increased in scale. This model includes, among other things:

- Evidence of a tightly defined service derived through a strong program logic, a clearly articulated and defined set of core activities, the availability of research evidence demonstrating that the core activities will lead to the desired outcomes, and through manuals, implementation handbooks and training.
- Evidence that the core service is being developed with fidelity in a way that is faithful to the planned delivery

model. This includes ensuring that program participants are provided with interventions with the right duration and/or intensity, and that the program implementation is monitored to ensure its adherence to the core components – the key elements of the program that according to the program logic are hypothesised (ideally supported by research) to result in the desired program outcomes.

- Evidence from prior evaluation studies of varying degrees of methodological rigour.
- Evidence that the program is cost-beneficial and that there is a strong business case, or potential social or budgetary return on investment, for replicating or scaling it up.
- Evidence that there is sufficient organisational or systemic infrastructure and capacity to replicate or scale-up the program, including organisational financial stability and a sufficiently skilled and trained workforce (Realising Ambition, 2015).

While the framework is significantly more sophisticated than represented here, it is consistent with the sequence that underlies our broad recommendations for improving the quality of MBCPs (see Realising Ambition, 2015, p. 8). It is likely to be the case that moving straight to the selection of particular evaluation measures without undergoing these preceding steps will not provide funders and stakeholders with “confidence in the evidence” that MBCP work achieves the desired outcomes.

Beyond “tick and flick” accreditation processes

Few examples of compliance or accreditation frameworks for monitoring minimum standards were identified. Most US jurisdictions have registration systems, where prospective program providers are required to provide some written information that is deemed necessary to become a program provider. Often this information is minimal, though might include the provision of evidence that particular state standards have been met (e.g. that program practitioners have participated in prerequisite training).

In some cases, the registration process is accompanied by a site visit and/or the requirement for more extensive program documentation related to the wider set of standards. The NSW Department of Justice conducts a registration process of this kind, requiring a reasonably extensive set of documentation for prospective providers and for re-registration of existing providers in relation to the state’s minimum standards (though with no accompanying site visit).

These registration processes are generally implemented by state government employees with little or no direct experience of MBCPs or other forms of service provision. In their least robust form, these processes are bureaucratic, “tick and flick” approaches that provide minimal checks in relation to a program’s capacity to meet minimum standards. Registration processes that focus on more extensive policy documentation do facilitate some level of insight into whether the provider understands the full set of minimum standards, and provide evidence that the provider has met more than just a handful of key requirements. Even these more considered registration processes have significant limitations, however. They are not able to:

- gauge or monitor program quality;
- determine whether there is a difference between what providers say they do, via registration documentation, and what they actually put into practice;
- discern to what extent documentation derived during the registration process was written especially for that purpose and is then “put on the shelf” after registration has been achieved; or
- determine the program’s systemic context and relationships with partner agencies.

Consulting practitioners

While minimum standards are often developed partly or largely on the basis of consultations with MBCP providers, practitioners and other industry experts, these processes are generally insufficiently rigorous to systematically apply practitioner knowledge. Practice-based evidence can be an important complement to evidence-based practice, and the only source of evidence where research relevant to a particular issue does not exist. Generating practitioner-based evidence,

however, involves more than simply running workshops or forums to obtain practitioner input and views. Vlasis et al., (2017) describe the RE-PROVIDE project in the UK, led by the University of Bristol, as an example of how this might proceed. This project will:

- synthesise the available evidence on programs for men who are using abusive behaviour in order to identify the domestic violence perpetrator programs with the greatest likelihood of effectiveness;
- invite experts in the field to be members of a consensus panel that considers the findings of the evidence synthesis alongside practical issues of implementation;
- identify the key ingredients from the evidence synthesis of programs, which will then be used to develop a “best bet” perpetrator program model, and how to establish if the model is effective or not (i.e. the most appropriate outcome measures to use); and
- pilot the model in a community or primary care setting with a small group of men using abusive behaviour, with partners or ex-partners invited to participate in the study.

The modified Delphi method used in this process involves multiple iterations of industry experts and practitioners reflecting on the existing evidence base and their own knowledge and experience, rather than just one-off forums for them to voice their views.

The need to develop theories of change and to articulate program logic

The jurisdictional review revealed little formalised use of a theory of change or program logic models to articulate, in documented form, program philosophies, assumptions and objectives. The systematic or near-systematic use of such models appeared not to be present in any of the jurisdictions reviewed.

In the jurisdictional scan, we came across only one approach where the development of a program logic was used as the starting point for an evaluation framework. In order to assist evaluation work by an independent evaluator with four

recently funded MBCPs within their jurisdiction, Women NSW (Department of Family and Community Services) spent considerable consultative time with providers and other industry experts to develop an evaluation and performance monitoring framework in this form. Across 12 medium-term impacts (termed “intermediate outcomes”, with six referring to impacts at the program level and six to impacts of the program in strengthening local integrated DFV systems), and 10 “immediate, process outcomes” (not differentiated between program and systems levels), the framework defines key evaluation questions, and recommends indicators and data sources across all 22 logic statements. A similar process of program logic development and a subsequent evaluation framework has been applied for a new MBCP recently initiated in the ACT. The model of practice developed in Scotland (see Appendix A) is particularly interesting in relation to the model of change that services are based upon. In this jurisdiction, the focus is on working with high-risk perpetrators towards achieving secondary desistance goals that involve changes in the perpetrator’s identity, lifestyle, social milieu and general approach to taking responsibility in life.

The focus group discussions about current approaches to outcome measurement revealed a lack of connection between any existing program logic and the way in which short- and medium-term indicators of change are identified and with data collected to inform decision-making.

This is not to say that programs are not based on deliberate and well-considered philosophies, assumptions and objectives. Rather, that these are often not documented in detail (or at all), and stay as verbal (or implicit) knowledge held by program practitioners, coordinators or managers. Many or most programs are guided by a program operational manual; however, components on theory in these manuals often have little detail. The front-end focus in these manuals is often on principles of the work (e.g. that violence is a choice, or MBCP work is different from anger management), and as important as these and other principles are, they are generally not accompanied by a detailed description of the theoretical assumptions that underpin practice.

Documentation appears to be generally lacking not only with respect to the theoretical approach of the programs

but also the assumptions and objectives of a program in its systemic context. The intended ways in which the program might contribute to coordinated community responses towards identifying and reducing perpetrator risk are often not spelt out.

Again, this does not mean that MBCP staff have not thought about how the program fits within DFV response systems, rather that this has not been fully articulated in documented form. This makes it (significantly) harder for a program to ensure that it operates in a way that is consistent with the program theory. Documented articulation increases the likelihood that existing and new staff understand how the program is meant to work, and make clinical and risk management decisions based on this understanding. Integrity checking also becomes easier (and less biased) when there are verbal or written representations of program theory, as does the choice of valid assessment tools.

The need to develop standard evaluation frameworks and consistent outcome measurement

We found little evidence of consistency within (let alone across) jurisdictions about program evaluation approaches. For example, few community-based MBCP providers in the jurisdictions we researched had sufficient resources to collect process, impact or outcome data beyond what they were required to report to satisfy service agreements and contracts with funding bodies. In some jurisdictions, where no government funding is provided, no data reporting requirements exist (this is often the case in US jurisdictions).

As noted above, a fundamental driver of the lack of evaluation frameworks is the lack of use of program logic models. A program logic drives the development of an evaluation and performance monitoring framework, as it establishes the short-term (process), medium-term (impact) and long-term (outcome) objectives that the program strives to work towards, both at the individual/client level (partner, children and perpetrator) and systems level (objectives relating to the contribution of the program to enhance integrated systemic

responses of which it is a part). The program logic can be extended such that one or more of the performance indicators is associated with each of the model's logic statements/objectives, and the sources of data to measure each of these are specified. The ability to put this into practice appears, however, to be significantly limited by program resources and independent evaluation expertise, and resources may well be required to deliver better quality evaluation work.

In addition to a lack of evaluation frameworks and the need for their development, inconsistency in outcome measurement approaches, when these are applied, was highly evident through our jurisdictional review and focus groups. We found only one example of a comprehensive effort to assist program providers within or across jurisdictions to use a consistent outcome measure, and that is Project IMPACT. This is a key initiative of the WWP EN, which aims to support evaluators and program providers to adopt a consistent approach towards program evaluation across Europe (WWP EN, 2018).

Project IMPACT is based on a survey of more than 130 European programs that demonstrated an exceptionally strong desire by providers to improve outcome measurement; developing a consistent and standardised outcome measurement tool was prioritised as the most important enabler for this to occur (Geldschläger et al., 2013). Through a partnership with the University of Bristol, Project IMPACT has developed new outcome measurement tools for use with perpetrators and victims/survivors, each to be administered at four points across the perpetrator's participation in a program and beyond. The tools were developed specifically with practitioner application in mind – without relying on independent evaluators – and hence are relatively brief. A practice guide and additional support are available to assist program providers in using the tools, with the initial focus being on the UK and Italy. Importantly, the project, through the University of Bristol, not only provides a service to individual program providers but also collects data across agencies that can be aggregated for higher-level analyses. Program providers who agree to participate in the project send the data they collect through the use of these tools to the University of Bristol, either in spreadsheet form or inputted directly into a database. The university then conducts (and provides them with) a program-specific analysis of their data.

Project IMPACT is one part of a multi-pronged sequence of work across Europe, conducted in partnership between the WWP EN and primary research institutions, to develop research methodologies for DFV perpetrator program evaluation. This includes the publication of a paper that focuses on recommendations for multi-site, multi-context research design methodologies to attempt to evaluate the impact of these programs in the context of integrated systems responses (Scambor, Wojnicka, & Scambor, 2014).

Minimum data sets

Jurisdictions that provide funding for DFV perpetrator programs often require providers to collect and report service participation data as part of service-level agreements and contracts. The data collected and reported through minimum data sets are generally minimal, in part because such data are often entered into health and human services databases designed to record service activity across a wide range of funded programs. These databases were often not initially designed with DFV data collection in mind, and attempting to modify these databases, once established, can be difficult and costly. For example, providers might differ in how they attempt to enter service activity data pertaining to partner contact, risk review meetings or multi-agency risk management work. This creates challenges in obtaining an accurate picture of actual practice in these areas. In addition, data captured by minimum data sets often include:

- demographic variables;
- referral sources;
- number of assessment sessions attended;
- number of group sessions attended;
- numbers of other service activities (one-to-one sessions, partner contacts);
- presence of court orders (civil, criminal, children's); and
- referrals that the program has made to other services.

There is limited information collected about indicators of program impact, such as subjective ratings made by program practitioners concerning change in behaviour or level of risk. Thus, while minimum data sets enable funding bodies to monitor provider activity in relation to funded service

targets, they fall short in either obtaining a snapshot of the program in relation to the system or in indicating program effectiveness. The focus groups involving correctional service MBCP providers revealed that substantial effort is put into this area in their programs, although there are still variations in the type and quality of data that are collected between jurisdictions, and evaluation activities are still under development.

Sample profiling is one area that requires attention. A recent review of European program evaluations by Lilley-Walker, Hester, and Turner (2016) concluded that this provides critical knowledge in any attempt to understand the effectiveness of MBCPs. They argue that:

...in addition to information regarding the nature of the intervention approach, we need to understand who is participating and why; who is dropping out, when and why; who is completing; and who is changing, when, why, and how? Our review of all European evaluations highlighted that evaluation research did indeed address these questions/aspects but not all of these within any one evaluation. (Lilley-Walker et al., 2016, p. 11)

The authors go on to propose a simple structure for data collection across five time points that can be used to strengthen practice in this area.

In summary, while minimum data sets enable funding bodies to monitor provider activity in relation to funded service targets, they fall far short in either obtaining a snapshot of the program in relation to the system or in indicating program effectiveness. In Victoria, for example, due to the inadequacies of the minimum data set in capturing systemic data, and of the health and human services database used by funded agencies to input this data, the peak body, No To Violence, has had to conduct periodical sector snapshot studies in order to determine basic trends concerning waitlist times and service demand (No To Violence, 2006; 2014).

Correctional services do collect more comprehensive data relevant to understanding ongoing dynamic risk, although further work is required to ensure consistency in this work and to understand how it informs outcome evaluation. The

NSW Department of Justice is, for example, seeking to extend its minimum data set to include program provider ratings beyond service participation. These might include ratings on the participants’:

- level of understanding of program content;
- level of program engagement;
- reasons if exited from the program;
- reductions in physical/sexual violence;
- reductions in emotional violence; and
- attitudinal change.

The proposed extended data set would also provide indicators for the presence of non-DFV offending issues related to risk, services referred to address these issues and potentially one or two other indicators relevant to the application of the RNR framework.

The need to strengthen safety and accountability planning

It was clear through the focus group research that MBCP providers are attempting to put some elements of safety and accountability planning into practice, and doing so to the best of their abilities given resource constraints and the limited opportunities for one-on-one sessions with perpetrators afforded through existing funding and service agreements. While we found no MBCP-specific research literature to guide practice in this area, it is clear that program providers, under different circumstances, could be engaging in far more robust and involved safety and accountability planning processes. The constraints they face in doing so reflect the barriers against program providers being able to tailor MBCP work to each perpetrator (Vlais et al., 2017). Funding and service agreements rarely incorporate or recognise case formulations, case planning and case management as important components of MBCP work, without which safety and accountability planning becomes difficult to execute with any rigour.

Our research highlighted the need for risk assessment tools to be used in ways that better drive case plans. Generally, these assessments need to be able to reliably assess:

- dynamic/evidence-based risk factors;
- coercive control tactics;
- factors relating to the safety, stability and development of children (and how the perpetrator affects the family’s social ecology and the other parent’s parenting and relationship with children); and
- genuine strengths-based factors.

There is much work to be done to develop this type of assessment and how it informs active, strong collaborative arrangements with partner agencies.

Service coordination is required to ensure that all services working with the perpetrator are accountable to appropriate and specific roles and responsibilities. Such accountability requires active liaison with case-managed services in the context of strong, coordinated community responses. This might involve:

- referring and partner agencies that share a sense of collective responsibility for scaffolding long-term, multi-agency processes to promote perpetrator accountability and who see themselves as having defined roles and responsibilities for perpetrator engagement;
- information sharing between agencies that ‘follows the perpetrator’, such as information related to patterns of coercive control towards family members and the associated risks; and
- some degree of co-case planning and involvement in case reviews.

Relevant to safety and accountability planning is the need to articulate clear goals for each perpetrator at the start of his participation in the MBCP, to be revised and reviewed throughout his participation in the program. These goals need to be stated quite specifically (i.e. the demonstrable things that need to change) and focus on ongoing risk of DFV. In other words, the focus for questions about each perpetrator should be less of the form “has he changed?” or “what progress has he made?”, but rather, “what risk or threat does he currently pose to family members?”, and “how does this differ to the risk/threat posed at the start of the program?” (Shephard-Bayly, 2010).

The approach to competency development developed in Colorado, US, offers some useful suggestions for practice in this area. We also note, however, that patterns of coercive controlling behaviour will not always have been eliminated, so the important questions relate to their current nature during and after completion of a MBCP, and what this means for the ongoing safety of women and children. It is also important to note here that behavioural change is not typically a linear process, with steps backwards and forwards, sometimes triggered by external factors and circumstances. Case planning activities should track this as much as possible.

The need to engage with victims/survivors

In-depth interviews with six victims/survivors conducted as part of our research reiterated previous Australian studies that demonstrate the vital importance of partner safety support associated with MBCP provision (Howard & Wright, 2008; Opitz, 2014; Smith, Humphreys, & Laming, 2013). These victim/survivor experiences of partner support were mixed; furthermore, their expectations of and desired intensity of support varied.

For some, partner support served as a lifeline, in the context of significant vulnerability for themselves and their children. Developing trust in the partner support service was a huge step. Relying totally on phone-based contact as the medium for partner support appeared to place constraints on the power of these services to offer support.

Consistent across the victim/survivor stories, partner support was (potentially) an important means for women to receive accurate information about the program and the man's participation in it, rather than relying only on the information he provides. Previous research has identified how some perpetrators distort what they tell their partners about the program, and can use such distortions as tactics of control (Opitz, 2014).

The findings from these in-depth interviews have important implications for the success criteria used to evaluate programs. Vlasis et al. (2017, p. 37) note:

Providers generally have good intent regarding the importance of partner support work. However, in terms of the allocation of resources for this work relative to working with men, and the use of language to describe the work with women, partner support often manifests as a second priority tied mainly to the man's participation in the program (Dowse, 2016; Vlasis, 2014b). This is seen clearly in how many providers cease partner support work at the point of, or soon after, a man's discontinuation or completion of the program. This is despite the fact that a man either dropping out of a program or "successfully" completing it, can each represent a time of increased risk for family members, necessitating increased support and renewed safety planning for those affected by his use of violence. (Smith et al., 2013; Vlasis, 2014b)

For Vlasis and colleagues (2017), a discussion is needed regarding whether the provision of partner contact should remain, as is generally the case in MBCP provision in Australia, through a sole worker employed by the MBCP provider. They argue that for direct work with ex/partners (and direct or indirect work with their children) to be a central feature in the service mix, with a degree of independence from the man's participation in the program, the funded provision of this work by specialist women's DFV agencies should be considered an equally appropriate arrangement.

This relates to the central question of the influential UK Project Mirabal evaluation – does DFV perpetrator program work contribute, or add to, the system's ability to work towards the safety and wellbeing of women and children (Kelly & Westmarland, 2015). Echoing a similar sentiment about the centrality of partner support work to understanding success in the context of MBCP work, Denne, Coombes, and Morgan (2013, pp. 31-32) found through qualitative research with New Zealand women:

The women's accounts of victim advocacy in the current study suggest that there is a need to broaden our understandings of "effectiveness" when evaluating living without violence program provision... Regardless of whether their (ex) partners experienced reductions in their level of abuse and violence, the women's feelings of safety and wellbeing increased as a result of partner and family support services. The women were not dependent

on the men's processes of change, but instead were enabled to nurture their own wellbeing independently...What would it mean to expand our constructions of "safety" in evaluation research to include elements independent of the man's behaviour? What would it look like if we were able to assess programs on their ability to provide multi-faceted responses that approach the reduction of violence from a victim-centred [both adult and child victim], strengths-based platform?

The need for a peak body

In this report, themes relevant to the identification of promising approaches from different jurisdictions, the literature on program quality assurance and evaluation measures, and the views of MBCP program providers are drawn together. Our overwhelming sense from this is that for most jurisdictions, MBCP providers receive insufficient support to strengthen practice, enhance program integrity and facilitate robust evaluation. The availability of support, whether this be from a peak body or similar organisation, appears to be an essential requirement if many of the issues identified in this report are to be addressed. Organisational support should include:

- assisting program providers to become accreditation-ready or to meet minimum standards of practice;
- identifying and providing training and professional development;
- facilitating community-of-practice activities;
- conducting knowledge transfer and exchange activities;
- providing a conduit of information between program providers, and between program providers and key stakeholders (including government);
- strengthening understanding by other stakeholders in MBCP work;
- participating in or supporting relevant research;
- attempting to influence relevant government policies;
- participating in, or helping to drive, relevant workforce development strategies and activities; and
- in the case of peak bodies, representing members and conducting advocacy work in other ways.

It was clear that providers worked in a highly isolated fashion in those jurisdictions that lack the support of a dedicated organisation. In these jurisdictions, MBCP work was much less transparent to referrers and key stakeholders, making it difficult to know who is doing what, and what influences their practice. We identified just five peak bodies or similar dedicated organisations (two in Australia) with sufficient capacity to conduct more than two or three of the activity areas listed above: WWP EN, Respect, Texas Council on Family Violence, No To Violence and Stopping Family Violence.

The WWP EN is unique among these capacity-building organisations in that it works across (a substantial number of) jurisdictions. The network was established in this way based on the concept of the single European Entity, but also in recognition that outside of the UK none of the approximately 50 nations within Europe had its own organisation dedicated to strengthening DFV perpetrator program work. This continent-wide span makes the work of the network very challenging, due to substantial differences between European nations in relevant legislation, community sector capacity, economic and sovereign stability and approaches to gender equality.

The Respect accreditation process in the UK is probably the most comprehensive and adaptive response to the current evidence base (or lack thereof) in MBCP work, in that it:

- pitches standards in terms of practice principles rather than practice prescriptions, enabling program providers to implement the principles in ways that make sense to local and specific intervention contextual factors;
- is relevant to a range of specialist perpetrator interventions, including one-on-one case management interventions, specialist DFV fathering programs and young people's violence programs, and not just MBCPs in their traditional form;
- provides guidance for innovation in applying the practice principles in new ways, for testing innovations and for contributing towards the evidence base via the concept of "evidence as confidence" (rather than "evidence as certainty");
- focuses on organisational capacity to safely and sustainably develop, implement and evaluate different MBCPs and perpetrator interventions over time, rather than accrediting each and every program as a single, separate entity;

- adopts a comprehensive, multi-component approach to accreditation, as distinct from more commonplace “tick and flick” systems used in many other jurisdictions;
- adopts a two-stage process so that program providers can apply to be accredited as providing safe, minimum practice while they work towards becoming ready for full accreditation and
- does not expect program providers applying for accreditation to be automatically accreditation-ready.

Respect did not launch its accreditation system until it had the capacity both to sustainably enact its comprehensive approach and to support program providers over a period of often many months to become accreditation-ready.

Until 2013, Australia has had only one government-funded peak body or equivalent focusing on MBCP work: No to Violence, located in Victoria. Since then this number has grown to four. SPEAQ, which for 20 years subsisted purely on membership fees, received a one-off government grant for the first time (to develop a website for the Queensland MBCP sector). Over a 2-year period, the NSW Men’s Behaviour Change Network received small amounts of funding to facilitate network activities in that state; however, its activities were absorbed by No to Violence and expanded with increased NSW Government funding for this work. A new NGO in Western Australia, Stopping Family Violence Inc., has recently commenced a formal Western Australian MBCP network, and is engaging in policy, research and sector development activities.

This development reflects an increased recognition by some Australian governments of the need for a dedicated organisation within their jurisdiction to work towards strengthening the field. The significant differences in size and capacity of these organisations across Australia, and the fact that providers in four states and territories have no such representation, makes further evolution complex.

It is important, however, to reiterate that no peak body or dedicated organisation provides the full suite of possible functions to support the field in their jurisdiction. For example, few, if any, provided significant support to program

providers to develop program logic models or to enhance clarity in their philosophical underpinnings or theory of change. Only one peak body or capacity-building organisation in the MBCP field in Australia (Stopping Family Violence) is directly involved in primary research activities and the translation of consequent research findings into its policy and practice development work.

Issues to address

Basing standards and accreditation processes on practice principles, not prescriptions

There is little direct evidence to support many minimum standards commonly found in minimum standards sets. This does not mean that these standards are not appropriate or helpful: rather, that there is insufficient confidence in the evidence underpinning them (see the sub-section in Part 4 titled Building evidence as a way to build confidence).

For example, there is no evidence that we are aware of to provide confidence, that mixed gender co-facilitation is more effective than co-facilitation by two practitioners of the same gender. This does not mean that there are not strong reasons for mixed gender co-facilitation, such as to:

- model respectful engagement with women;
- bring a woman’s voice directly into the room;
- bring women’s experiences into the room;
- ensure that the group work session is not a “men only” space;
- introduce an aspect of the male practitioner’s accountability in terms of his own explorations of male entitlement and privilege in his work, through feedback from his female colleague; and
- (potentially) provide opportunities for program participants to work through their own sexist assumptions and attitudes towards the female facilitator.

These and other concerns and opportunities provide a strong rationale for mixed gender co-facilitation, even in the absence of an evidence base. However, while one approach is for minimum standards to be prescriptive (i.e. requiring a male and female practitioner to co-facilitate group work

in all circumstances), another approach is to see this as one example of how to put into place the underlying practice principles, such as those outlined in the dot points above, that make this a desirable practice.

This second approach opens up other or additional possibilities for a program to demonstrate underlying practice principles, for example through:

- two female facilitators and one male facilitator (which has the additional benefit of maximising solidarity and support between female practitioners, rather than her always being “the only woman in a male room”);
- two male facilitators with women practitioners, stakeholders or students observing;
- two male facilitators in sessions that focus specifically on women’s experiences, with the session content involving multi-media resources that bring women’s experiences directly into the room throughout the session; and
- women practitioners observing videotaped sessions of co-facilitation by two male practitioners.

Each of these and other alternative possibilities have potential drawbacks and implementation constraints and are not necessarily more desirable than the standard practice of one male and one female co-facilitating each group work session. However, pitching standards at the level of “practice principle” rather than “prescriptive practice” has the potential advantage of scaffolding program providers to deeply consider the reasons for adopting particular practices, rather than adopting a practice to “follow the letter of the law”.

Pitching standards at the level of practice principle also enables providers to demonstrate practice principles in ways that make sense to their local context and perpetrator cohorts. A prescription of one male and one female co-facilitator is contentious among some Aboriginal communities, and it discriminates against practitioners, in any program context, without cis-gendered privilege. It also provides no guidance for program providers in rural or remote contexts who might struggle to recruit facilitators of both genders on how to imbue the underlying reasons for this standard into their program if co-gendered facilitation is not an option for a period of time.

Pitching standards at the level of practice principle involves “elevating up” how standards are written and described. This represents a difficult balance, however, between making standards sufficiently high level to capture the principle and to enable implementation flexibility, but not so high as to be too broad to offer guidance at the program provider level. The Australian National Outcome Standards for Perpetrator Interventions, for example, are designed to guide and measure government and community agency actions, rather than set professional standards and are, therefore, pitched at a level that is too broad in this sense. The UK Respect accreditation standards are the best example that we are aware of in their attempts to get this balance right.

A further complexity of this approach is to encase it within an accreditation process that does not allow a “free for all” in terms of how program and intervention providers interpret and demonstrate the practice principles. Local implementation flexibility should not mean that “anything goes”. The accompanying accreditation process needs sufficient rigour to require program providers to clearly articulate their logic and reasoning as to how they have applied each practice principle. Furthermore, their particular application of each practice principle needs to be audited to determine whether this logic is being put into practice in the ways the provider intended.

Accreditation at the level of program or organisation

A further consideration reflects decisions about whether to pitch minimum standards at the level of program, provider or both. Setting some standards at the organisational level focuses attention on whether the agency can sustainably provide safe and potentially effective programs over time, and can innovate safely in developing new types of interventions. This has been a crucial consideration in the standards and accreditation processes in the UK and New Zealand, and in Australia, the Victorian Department of Health and Human Services requires all funded agencies to participate in 3-yearly audits against broad Human Services Standards. Although not specific to DFV or indeed any other human services sector, the standards relate to the ability of the organisation to provide any of its services in financially sound, accessible,

ethical and stable ways. How these broader processes interact with more-specific accreditation systems for DFV perpetrator programs is an important issue.

Increasingly, community-based providers of MBCPs will diversify the types of interventions they provide with DFV perpetrators, trialling new initiatives (such as conjoint work with alcohol and other drug service providers, individual interventions with perpetrators who do not have mental health or life organisation capacity for group work or fathering interventions). While many of these interventions might not be MBCPs per se, many of the standards and principles of MBCP work can be adapted to these contexts.

Furthermore, an agency's ability to provide safe, ethical, accessible and sustainable MBCP work over time, rests on a range of organisational variables sometimes not captured by minimum standards sets, such as their:

- agency-wide depth of understanding of DFV through a gendered, coercive controlling lens;
- financial resources to provide the program without needing to “cut corners”;
- agency-wide practice in disaggregating service usage data to determine trends; and
- gaps in terms of ethnicity, age, sexual orientation, gender identity and disability.

These and other organisational-level variables form an important focus of the Respect accreditation standard and accreditation processes, but are relatively absent from many others.

Accrediting practitioners

The Illinois approach to accrediting both program providers and individual practitioners is the only one of its kind that we are aware of. The Advisory Panel on Reducing Violence against Women and their Children convened by COAG in 2015-16, made a similar recommendation for the development of a professional accreditation system for perpetrator intervention practitioners (COAG, 2016).

This approach recognises that a significant volume of perpetrator interventions is conducted outside of the context of MBCP delivery, by individual practitioners who might move between intervention contexts over the course of time. With innovation and diversity in perpetrator interventions likely to expand through time, an increasing proportion of such interventions might not fall under the MBCP banner and therefore not be subject to minimum standards. The skill and approach of the individual practitioner involved in developing and implementing these interventions are therefore crucial. Furthermore, the ability of a program provider to meet minimum standards at the program level does not guarantee that constituent practitioners are all skilled and safe in their work. The high volume of one-on-one counselling interventions with DFV perpetrators is another reason to consider practitioner-level accreditation.

The Colorado compliance monitoring process also focuses on accrediting individual practitioners; however, it is more of a hybrid approach focused on providing programs with the ability to meet the minimum standards for program provision, rather than more generally accrediting practitioner competency to provide any form of specialist perpetrator interventions. The application and vetting process for practitioners seeking to become an approved provider is more involved, sophisticated and nuanced than the Illinois approach, and it enables practitioners to progress through four levels of increasing scope in terms of the roles and contexts in which they can provide services.

Positioning compliance within a broader system of support for program providers

It is important that any accreditation process is part of a more general strategy to support program providers to maximise the quality of their practice, such that it is viewed as a positive opportunity to reflect on the core vision and values of the program, and agency. Related to this is the need for standards monitoring committees to engage program providers in explorations of the rationale for particular minimum standards and to support the adaptation of the standards to their local contexts (Boal & Mankowski, 2014b). Although this lack of “arm’s length” distance between providers and the accrediting body could be seen as compromising

independence in the accreditation process, our jurisdictional review found that strong relationships between the accrediting body and providers were a prerequisite for accreditation systems that were more than a superficial “tick and flick” exercise. It supports the adoption of an active approach to supporting program providers to comply with minimum standards (e.g. by providing opportunities for regular, brief professional development events focusing on a particular standard or a particular cluster of standards at a time). The use of webinars is not uncommon here, enabling providers across the jurisdiction to participate in a discussion concerning the rationale and importance of the particular standard(s), and ways to put the standard into practice.

In this sense, the effectiveness of any set of minimum standards is tied to the effectiveness of the compliance monitoring framework and supports that program providers have available to them in implementing the standards. US research has demonstrated how the introduction of minimum standards without a compliance monitoring process can result in little impact on program provider practice in the areas covered by the standards (Boal & Mankowski, 2014b).

Assisting rural and remote program providers can be particularly important here. A number of minimum standards can be harder for program providers to meet in these contexts, including those relating to practitioner qualifications and experience, and program integrity and length. This creates a dilemma of whether to lower the bar of particular standards for all providers, to reflect the difficulties faced by rural providers, or to take an alternative approach of establishing a strong support mechanism that can provide temporary exemptions for rural providers in relation to particular standards.

In addition, there is a danger of introducing multiple levels of accreditation. In some jurisdictions, for example, funded agencies are required to go through accreditation processes against broad human services standards that apply to the complete range of their funded program (not specific to DFV or any other sector). The way in which these broad standards intersect with DFV-specific standards can create difficulties for providers. In Victoria, for example, the Human Services Standards auditing process takes quite a lot of effort on behalf of program providers, and Corrections Victoria has its own

program accreditation process. It would be administratively challenging for small community-based providers to be expected to go through multiple processes.

Reviewing and updating

Our jurisdictional review revealed that in most cases, the gap between reviews or updates of minimum standards is substantial. In Australia, the gap between previous and current iterations of minimum standards has averaged approximately 12 years.²² Many US jurisdictions are using minimum standards last updated at some point in the 2000s, although updates are occurring more frequently in the UK.²³ This is largely because standards update/review processes are seen as major projects involving a substantial overhaul of the previous iteration. In Australia, current activity concerning minimum standards and the development of accreditation processes has been driven by a recent unprecedented spotlight on DFV perpetrator programs at both the Commonwealth and state levels. In Victoria, for example, the 12-year gap between the 2006 and projected 2018 minimum standards created a major dilemma for program providers in relation to reporting back to referrers at the end of a perpetrator’s participation in a program (beyond “duty of care” reporting). Providers experienced internal and external pressure not to comply with the constraints around this standard, as by the early 2010s it became clear that this standard related to a “previous era” of understanding service system collaboration around risk management.

The Alberta approach is unique in this respect through its focus on conducting regular but smaller and more incremental updates of the standards over time. In this jurisdiction, updates have occurred every 2-3 years, through a process of continuously adjusting the standards according to feedback from program providers and new considerations from relevant evidence-based literature. In such an arrangement, the degree of change from one iteration to the next is contained so as not to confuse and overwhelm program providers. Adopting structures and processes that continuously review minimum

22 Western Australia 2000 & 2015; South Australia 1999 & 2018 (projected); Queensland 1997, 2007 & 2018 (projected); New South Wales 2012 & 2018 (projected); Victoria 1996, 2006 & 2018 (projected).

23 The Respect Accreditation Standard, developed in 2010, was updated in 2012 and again in 2017.

standards would also enable standards to be more current. The approach of developing and resourcing an ongoing committee or another process to consider relevant sources of information and adjust standards on a periodical basis is quite different from commissioning infrequent and major reviews as discrete projects.

Resourcing

A further consideration in the development of minimum standards is resourcing. Applying existing minimum standards to the circumstances in which each MBCP operates (e.g. in relation to more intensive assessment processes, individual intervention plans, strengthened case management, ongoing individual monitoring of risk, case reviews with referring agencies and more detailed individual exit planning) has significant implications for the resourcing of programs if they are to meet these expectations. It also has implications for practitioner skills and professional development. New requirements should be accompanied by support for program providers to develop the required capacity and resources to adapt.

It is also clear that enacting proper accreditation processes is resource intensive. Respect required 3-4 years of internal capacity-building before it felt confident that it had sufficient set-up to support program providers to become accreditation-ready, train auditors and develop the necessary tools and templates. Accreditation at this level can also represent a significant impost on providers. This is especially the case when providers, at an organisational level, are required to comply with broader accreditation processes concerning their agency as a whole and across the breadth of the services they provide (that is, not specific to DFV work). For example, Victorian MBCP providers, most or all of whom provide services across a range of health and human services sectors, participate in an intensive 3-yearly auditing process against the state's Human Services Standards. While this auditing process, by its broad nature, cannot delve deeply with any particular funded DFV service, it is still time-consuming.

The intensity of the accreditation process for program providers led Respect to develop a two-tiered process. After introducing its accreditation process in 2010, Respect received

feedback from some providers that while they would like to work towards accreditation over the course of some years, the process was too onerous for them to commit to.²⁴ A less intense second accreditation level was then developed to audit providers for more minimal expectations of providing safe and appropriate practice, as a stepping stone to the second stage of full accreditation.

The most obvious danger here is that minimum standards will be set too low because of the resourcing implications of setting the bar at an appropriate level, not because of a lack of evidence or industry consensus. Indeed, Boal and Mankowski's (2014a) study of the barriers to program provider implementation of the Oregon minimum standards found that resources and capacity constraints were a key concern.

Knowledge translation and exchange

As noted above, this research identified only five established and resourced peak bodies or other organisations internationally that are providing support for community-based program providers:

- WWP EN;
- No To Violence/Men's Referral Service (Victoria and NSW);
- Stopping Family Violence (WA);
- Respect UK; and
- Texas Council on Family Violence.

Other peak bodies or NGOs that are either establishing or have relatively less capacity to provide such support include:

- National Network of Stopping Violence Services (Aotearoa/New Zealand);²⁵ and
- SPEAQ (Queensland).

²⁴ Accreditation is a voluntary process in the UK – there is no government requirement for programs to be accredited; however, accreditation carries significant advantages for program providers in terms of credibility and competitive tendering.

²⁵ This NGO performed an active role in supporting men's behaviour change stopping violence services in Aotearoa/New Zealand until 2013, when resource constraints forced a significant downsize of the agency.

Few foundational training programs for MBCP work exist anywhere in the world. In most jurisdictions, practitioners in community-based MBCPs rely on piecing together professional development opportunities over time in addition to “on the job” learning. While this is not ideal, being able to do so in any systematic way requires the presence of a peak body or similarly dedicated capacity-building organisation to provide such professional development opportunities.

Organisations such as Respect, the Texas Council on Family Violence and No to Violence have demonstrated the capacity to at least informally assess the professional development needs of practitioners within their jurisdiction, and while not able to meet all or even most needs, they take their professional and practice development responsibilities seriously. This is a critical component of enhancing program quality. Directly relevant professional development and training activities in MBCP work do not spontaneously arise: a sufficiently resourced peak body or similar capacity-building organisation is required to develop them. Furthermore, while there are often relevant professional development and training events in other fields that can support MBCP practice in some areas, the ability to identify these opportunities and disseminate to the field is also important.

In the absence of competency- or subject-based foundational training at vocational education and training or higher education levels, Respect regularly conducts 3-6 day training programs on the fundamentals of MBCP practice. While not ideal, the combination of such training programs, briefer professional development opportunities such as webinars, on-the-job training and high-quality supervision can assist in the development of practitioner skill.

A further consideration here concerns observations and reflections of live practice. In Australia, it is rare for program providers to scaffold opportunities for practitioners to observe each other’s practice in the group room or to record sessions for this purpose.

While many program providers are open to observers from partner agencies sitting in to observe group work practice, with an accompanying template for observers to use to record

their reflections and provide feedback to the facilitators and program provider,²⁶ this is not the same as one’s practice being observed by a MBCP practitioner colleague. As highlighted previously, live observation or the recording of significant volumes of live practice is a necessary component of comprehensive auditing of MBCPs beyond superficial registration processes. The incorporation of live observations of practice in this way has the potential to introduce more generally a support culture of peer observation and reflection of practice.

Our jurisdictional review revealed that where a peak body or similar dedicated capacity-building organisation exists, some attempts are made to transfer research into practice. This is typically done through an annual conference, sometimes involving lectures or workshops by researchers focusing on the implications of their research for practice.

More regular and systematic knowledge transfer and exchange activities, however, were generally absent. We found few instances, for example, of:

- webinars with local or international researchers presenting on the findings of research relevant to MBCP practice;
- newsletters or other publications dedicated to identifying and summarising recently published or grey literature research in terms of the implications for practice; and
- the establishment of communities-of-practice networks (real or online) that enable practitioners and program providers to share practice innovations, trends, dilemmas and complexities, in terms of peer-to-peer knowledge translation and exchange.

The main inhibiting factor limiting the extent of such activities is capacity: it is “easier” for a resource-strapped network or NGO to climb the mountain of work required to organise a conference than to conduct more regular knowledge translation and exchange activities such as those listed above. Indeed, for Australian networks that have historically received little or no funding, such as SPEAQ in Queensland, and international equivalents such as the Batterer Intervention

²⁶ See the Resources section of *Towards safe families: A men’s domestic violence behaviour change program practice guide* for one example of such a template.

Services Coalition Michigan (US), conference organising is all that can be managed given these resource constraints.

Barriers still exist among relatively better funded peak bodies or equivalent capacity-building organisations, however. In particular, NGOs struggle to have access to electronic databases and electronic journals due to copyright restrictions, making it very difficult for them to keep up with research. Some NGOs in this situation develop close working relationships with one or two tertiary institutions, but this does not stretch towards keeping a regular handle on research conducted overseas.

Torres Strait Islander participants are offered or how current approaches to quality assurance interface with the cultural and community aspects of program delivery.

Limitations of the research

This report describes the process of collating information that is relevant to any consideration of the quality and effectiveness of MBCPs going forward. It relies on a desktop review of publicly available information and a series of personal communications with identified professionals who work in the sector around the Western world. As noted earlier in the report, however, this is an area which is changing rapidly and the information reported reflects that which was available at the time of data collection. There are likely to have been developments in the setting of practice standards both in Australia and New Zealand and internationally since this material was collated.

The focus groups and interviews with stakeholders, MBCP providers and victims/survivors should be considered to be preliminary given both the small size and diversity that exists in the sector (participants from two correctional agencies and community sites in two different States). This meant that only broad themes were able to be identified and that a more detailed analysis of the specific context in which each MBCP is offered is needed to fully understand issues impacting on the quality of program delivery. Nonetheless, these interviews do convey the need for MBCP providers to consider a wide range of program integrity issues before they commit to local evaluation. They also highlight the challenges that are inevitably associated with any efforts to set practice standards that apply across the whole sector. Finally, and importantly, the research did not consider the specific service delivery context in which MBCPs for Aboriginal and/or

Conclusion

Almost 20 years ago, Saunders (2001) argued that firm conclusions about best-practice guidelines for MBCPs seemed premature because of the limited knowledge that existed about program effectiveness. He argued that unless standards can be closely linked to research knowledge, they risk creating rigid paradigms that result in less effective and less efficient interventions. Furthermore, Saunders (2001) identified the danger of instilling a false sense of confidence in the effectiveness of those programs that are assessed as meeting standards.

It is clear from this review of the MBCP scientific literature that the strength of evidence required to translate current knowledge into standards is still not available. At the same time, elements of effective practice have been identified, drawing upon practitioner expertise and evidence from other justice, human services and health behaviour change fields. It is reasonable on this basis to make efforts to raise the general standard and consistency of practice.

In addition, there is a general lack of the use of the theory of change and project logic methodologies by the community-based perpetrator intervention field at the point of designing or redesigning programs. This front-end work is a crucial precursor to addressing the questions “what does success mean in MBCP work?” or more specifically “what does success mean in the context of this particular program or intervention?”. A carefully developed program logic constructed through iterative, participatory processes involving the program practitioner team, program management, core partner agencies and other key stakeholders is the foundation for determining the success criteria of a program. This, in turn, drives the selection of outcome and evaluation measures.

A further central finding is the importance and promise of safety and accountability planning to improve program quality, and how this potential is clearly not being met. Community-based providers of MBCPs are being increasingly criticised for taking a “one size fits all approach” towards program provision and for failing to adopt RNR principles to tailor their approach to individual perpetrators. The field is criticised for not adopting case formulations, case planning, case management, case review and proper exit planning processes, and for paying insufficient attention to dynamic risk factors

that do not drive but are correlated with risk (McMaster, 2013; Vlasis et al., 2017). It was clear from our research that program providers, both in the community-based sector and, to a lesser but still notable degree, in correctional contexts, struggle to tailor MBCP work in this way. Community-based program providers are simply not equipped via their funding and service agreements, contractual arrangements and resourcing to tailor interventions in a concerted way.

The key findings and identification of opportunities for practice development outlined above suggest there is scope for the further development of minimum standards and of the accreditation systems that maximise compliance. This report concludes with 17 more-concrete recommendations stemming from this research. These are not written in any order of importance. We invite reflection, discussion and comment from the field based on any or all of these, as they are offered as “works in progress” that the whole field can strengthen and evolve.

Recommendations

RECOMMENDATION 1

Program providers should be supported to give more attention to their program's theory of change, including the development of program logic models.

RECOMMENDATION 2

Program logic models should consider systems-level, individual-level and (if appropriate) community-level impacts and outcomes.

RECOMMENDATION 3

Program providers should be supported to implement processes that monitor and improve program integrity and fidelity, but not in a way that leads to rigid, over-manualised approaches.

RECOMMENDATION 4

The development of minimum standards, at the current time, should be based on sufficiently detailed, articulated and nuanced practice principles, rather than practice prescriptions.

RECOMMENDATION 5

Minimum standards should focus as much on an organisation's capacity to safely and sustainably provide a range of specialist perpetrator interventions as on the specifics of any particular program offered.

RECOMMENDATION 6

Accreditation systems based on monitoring program provider compliance with minimum standards need to be multi-component rather than binary, singular "tick and flick" registration processes and include observations of live practice as one means of assessing for accreditation.

RECOMMENDATION 7

Accreditation systems should be developed and implemented in ways that support program providers to reflect upon and improve the quality of their practice in line with agency-level vision and ethos, not only as a means to monitor adherence to standards.

RECOMMENDATION 8

Safety and accountability planning should be prioritised in sector and practice development efforts as a potentially high-impact way to improve the quality and effectiveness of MBCP provision.

RECOMMENDATION 9

If calls are to continue for community-based MBCP providers to adopt RNR and other principles to tailor their programs to individual perpetrator and family circumstances, they need to be funded and equipped to do so.

RECOMMENDATION 10

A national MBCP outcomes framework should be developed to engender some consistency in evaluation frameworks and evaluation activity, and to help build the evidence base.

RECOMMENDATION 11

Program providers should be supported to extend their program logic models into evaluation and performance monitoring plans, even if not all aspects of the plan can be immediately implemented.

RECOMMENDATION 12

Australian jurisdictions should consider shared work to develop the equivalent of the European Project IMPACT outcome evaluation tools and researcher-practitioner partnerships.

RECOMMENDATION 13

A suite of outcome evaluation tools should include victim-centred measures that focus on exposure to coercive control.

RECOMMENDATION 14

Evaluation plans should include measures of impacts on adult and child victims/survivors that do not rely on changes in the perpetrator's behaviour.

RECOMMENDATION 15

Proximal measures of the impact of MBCPs offer considerable promise to guide clinical and program evaluation efforts, but work in this area needs to be embedded within a research and evaluation stream that is adequately resourced.

RECOMMENDATION 16

Research to identify quality practice in partner support and safety work is urgently needed.

RECOMMENDATION 17

Partner support and safety work needs to be properly funded and prioritised, rather than remaining secondary relative to resources allocated to engaging perpetrators.

These 17 recommendations can be grouped into four main areas which, in our view, require consideration to enhance the safety of women and children and the accountability of men using violence against family members. Addressing each of these areas will help to redefine what a realistic outcome of attendance at a MBCP should be, and inform the ongoing development of practice standards and accreditation systems.

TRANSLATING THE EVIDENCE TO IMPROVE CURRENT MBCPs

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Evaluation plans should include measures of impacts on adult and child victims/survivors that do not rely on changes in the perpetrator’s behaviour.

OVERARCHING CONSIDERATIONS FOR IMPROVING AND ENHANCING MBCPs IN AUSTRALIA

RECOMMENDATION 8

Safety and accountability planning should be prioritised in sector and practice development efforts as a potentially high-impact way to improve the quality and effectiveness of MBCP provision.

RECOMMENDATION 9

If calls are to continue for community-based MBCP providers to adopt Risk-Need-Responsivity (RNR) and other principles to tailor their programs to individual perpetrator and family circumstances, providers need to be funded and equipped to do so.

RECOMMENDATION 17

Partner support and safety work needs to be properly funded and prioritised, rather than remaining secondary relative to resources allocated to engaging perpetrators.

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Proximal measures of the impact of MBCPs offer considerable promise to guide clinical and program evaluation efforts, but work in this area needs to be embedded within a research and evaluation stream that is adequately resourced.

**FUTURE
CONSIDERATIONS
FOR THE
DEVELOPMENT OF
STANDARDS AND
ACCREDITATION
SYSTEMS**

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**DEVELOPING
FUTURE EVIDENCE
ABOUT AUSTRALIAN
MBCP REACH AND
EFFECTIVENESS**

RECOMMENDATION 10

A national MBCP outcomes framework should be developed to engender some consistency in evaluation frameworks and evaluation activity, and to help build the evidence base

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Australian jurisdictions should consider shared work to develop the equivalent of the European Project Impact outcome evaluation tools and researcher-practitioner partnerships.

RECOMMENDATION 16

Research to identify quality practice in partner support and safety work is urgently needed.

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Appendix A:

Review of international practice standards

United States

Dr Eric Mankowski from Portland State University is leading a team that is currently conducting an analysis of minimum standards and compliance monitoring processes for Batterer Intervention Programs (BIPs), or MBCPs in Australia, across each of the 50 state-based jurisdictions in the US.²⁷ Their research specifically aims to investigate, among other things, the:

- processes used to develop minimum standards, including who and which organisations are involved in the development process;
- current processes to revise minimum standards, who is involved or helps to drive these processes, whether and if so, how program evaluations and program needs assessments contribute to the review process, and how published and unpublished research is utilised to help inform reviews and updates;
- make-up of current standards committees and monitoring bodies, for example, which organisations and agencies are represented;
- processes for monitoring programs, including frequency of monitoring activities, use of site visits, monitoring protocols and templates;
- consequences for programs that are non-compliant;
- use of formal certification, registration or accreditation of program providers;
- collection of any data in terms of which minimum standards are least or most complied with, and the barriers towards compliance with standards;
- application of any strategies, liaison or support processes to assist providers to meet the minimum standards as a whole, or to address particular standards that providers across the jurisdiction are having difficulties complying with; and
- application of the minimum standards to working with perpetrators of diverse genders.

In addition to peer-reviewed articles or other formal publications, the research team intends in the short-term to launch a website providing an in-depth comparison of the overall features of compliance/accreditation mechanisms across these jurisdictions. The intention of this website will be to support jurisdictions to learn from each other and to work towards best practice in monitoring and supporting BIP providers to meet relevant minimum standards.

The following notes on minimum standards, compliance monitoring and program support processes will draw in part from preliminary findings of this research.

Characteristics of the community-based MBCP field

The vast majority of BIPs in the US receive 90-95 percent of referrals through the criminal justice system, mostly for men who are on probation orders. This, in part, reflects the strong pro-arrest policies that are in place concerning DFV in many US jurisdictions, where police have powers to arrest and detain beyond those currently available in Australia.

It is very difficult to accurately assess the number of BIPs that run at any point in time in the US. In any week outside of key holiday weeks, the number of BIP groups in operation is likely to be in the thousands (Garvin & Cape, 2014). A high proportion of programs are run out of private practice or by small to medium-sized for-profit organisations; though not-for-profit organisations are involved in some programs. Some providers run large numbers of parallel intakes. The quality across program providers also varies considerably, as do the theoretical approaches and change models. The field is somewhat “split” in the US between those advocating for a gender-based cognitive-behavioural approach grounded in at least something of a socio-structural analysis of patriarchy, and a more medical, mental health model focusing on psychological variables and criminogenic needs but not necessarily related to attitudes towards women or male power and privilege. The large volume of available programs also raises issues of quality, with some providers delivering 20 or more programs over the course of a year, with little capacity for individualising or tailoring group-based interventions.

²⁷ Minimum standards and accompanying legislation apply on a state-based level in the US. However, in some circumstances DFV-based service systems and the application of legislation can differ significantly at a county level within a particular state. In California, BIP standards are set at the county level.

As most providers receive little or no government funding, in some circumstances relying on participant fees, a high volume of service delivery is required for the work to remain financially viable.

Peak body or dedicated capacity-building organisation

There is no national peak body or dedicated capacity-building organisation focusing on BIP work in the US. There are, however, a very small number of examples of national-focused organisations containing some articles or features of BIP work (see *Futures Without Violence*, 2018); however, those that do exist are fairly static collections and not designed to support a program or practitioner interface. Even at the state level, there are few NGOs or networks that have the capacity to support BIPs at a jurisdictional level. Those that do exist range from relatively more resourced organisations such as the Texas Council on Family Violence (see Texas jurisdictional review) to networks that rely entirely on volunteer input such as Battering Intervention Services Coalition of Michigan (BISC-MI) (2016). Some standards monitoring committees have some capacity to liaise with BIP program providers on more than an administrative level, with this being a big part of the committee's purpose in a handful or two of states.

Standards or professional practice guidelines

The research conducted by Mankowski and his team identified that approximately 90 percent of US state-based jurisdictions have minimum standards (44 out of 49 jurisdictions that participated in the study). In recent times, the most up-to-date listing and links to minimum standards documents across the US have been held on the BISC-MI website (BISC-MI, 2016). At the time of writing, this had last been updated in December 2014. Many US minimum standards are written succinctly, with a preamble and relatively brief conceptual and introductory notes. A minority of US minimum standards sets are written in the form of a manual, with more detailed text in supplementary documents – these include the standards for Colorado, Massachusetts, Santa Clara, Rhode Island, Vermont and Wyoming.

Most of the current US standards were initially developed through the practice-based experience of leaders and pioneers of BIP work, and from the battered women's movement. Through this, a consistent pool of practitioner-based knowledge and underlying principles emerged that have come to shape many minimum standards sets. Evidence-based practice, particularly from other intervention fields or sectors (given the relative lack of evidence-based guidance arising from the DFV perpetrator program field itself), has often not been explicitly drawn from. Very few standards documents or manuals reference the evidence base for their standards.

Some standards monitoring committees have taken a strongly manual-driven approach in an effort to promote greater consistency among program providers in their jurisdiction. Here the committee “hands down” a particular curriculum and funds providers to implement it. It appears that the choices for what to include in these centralised curricula and for how to run the program are generally not supported by research evidence. This results in programs that are compliant in relation to implementing the manual, but not compliant with standards in the deeper sense of how the program should be delivered.

Some other states, while not requiring providers to use a particular manual, prescribe a particular theory or model of change in their minimum standards. This practice of structuring standards around a singular theory is quite contentious. Standards compliance committees, such as those in Illinois and Oregon, have developed a unique approach to encourage the development of a knowledge base around innovation; program providers are permitted to trial an innovation that might not fit neatly within the state's minimum standards, provided it is based on a well-considered rationale, and provided the provider commits to a 2-year trial and evaluation. This process enables room for flexibility and space within the standards and is intended to help build an evidence base to support future standards review and update processes. Oregon also has one of the few standards compliance panels that includes one or more representatives with significant research expertise among its membership. This is considered to be an effective way of promoting the use of evidence-based practice when standards are reviewed.

Compliance monitoring

The research by Mankowski and his team revealed that approximately 90 percent of US jurisdictions with minimum standards for BIPs operate some form of formal or informal compliance monitoring process. Compliance monitoring bodies across these jurisdictions are located, without exception, either within an organisation focused specifically on DFV response or prevention or within the state's legal and justice systems. At the same time, a significant proportion of US standards committees engage in minimal monitoring of program compliance and have distant relationships with program providers. Typically, these committees might provide a phone number to hear complaints against providers, but little else. In these situations, the standards and corresponding monitoring processes are mostly about bureaucratic licensing. The approach taken to writing the standards and monitoring compliance draws upon processes used by the particular state government across numerous program areas and sectors, rather than taking into account the specificities of BIP or DFV more generally.

Other jurisdictions operate a more systematic approach towards standards monitoring. This might involve site visits on a regular basis, interviews with practitioners and observations of group sessions. In these jurisdictions, the monitoring is conducted by a well-established oversight committee comprising people who understand the specifics of DFV work, with a much stronger relationship to program providers. There is also a greater understanding of the important role of BIPs in the context of coordinated community responses. These jurisdictions value a collaborative process between the standards monitoring committees and program providers. They might organise webinars in which they explain the standards to program providers, the rationale as to why a particular standard exists as it is, and provide guidance regarding implementation. The historical pathways with which standards committees have come to put into place monitoring processes varies. Some jurisdictions commenced monitoring processes as soon as their standards were initially developed, while for other states these monitoring processes developed at a later point. Monitoring processes can also vary by county within states, as is the case in California. Significant urban and rural differences can occur, with monitoring in rural counties across the US falling behind.

Use of program logic and other program integrity building methods

Very few, if any, of the minimum standards in the US, focus comprehensively on issues of program integrity. While most provide coverage on some issues essential to program integrity – such as practitioner qualifications and supervision – there is generally little or no content within the standards about the development of program logic models, the underlying theory of change, the content of a theory manual, or other front-end strategies to strengthen program integrity and conceptual clarity.

Colorado

Colorado runs a differentiated response approach to its minimum standards, the only one of its kind that the authors are aware of. While relatively limited monitoring of the Colorado minimum standards currently occurs, the combination of the use of the evidence base to develop the standards and its unique differentiated approach warrants its inclusion in the jurisdictional review (Colorado Domestic Violence Offender Management Board, 2016; Gover, Richards, & Tomisch, 2015; Hansen, 2016). It is also one of the few minimum standards sets in the community-based sector that is strongly influenced by RNR framework.

Characteristics of the community-based MBCP field

Common to jurisdictions throughout the US, Colorado's BIPs receive the clear majority of their referrals through the criminal justice system. Unique to Colorado, however, perpetrators are streamed into low-, medium- and high-intensity interventions based on the Domestic Violence Risk and Needs Assessment (DVRNA) instrument, designed in Colorado specifically for this purpose.

The DVRNA, unlike most other DFV risk assessment tools, assesses both the level of risk and the complexity of criminogenic needs/dynamic risk factors that require addressing to reduce risk. In this respect, the DVRNA is a treatment intensity tool designed to indicate the minimum

level of intensity that the intervention should entail for any given perpetrator. Although the instrument is currently undergoing validation research²⁸, it is important to note that the DVRNA is not a static risk assessment tool and it is expected that perpetrators will be re-assigned to a different intensity level depending on the results of ongoing risk assessments and case reviews²⁹. New information that emerges during the course of the perpetrator's participation in the program related to risk or the complexity of his criminogenic needs can also result in him moving into a higher intensity category. The decisions about category assignment, either at the point of initial assessment or at subsequent times during the program, are generally not made by the program provider alone, but rather are based on collective decisions that include the victim/survivor advocate who might be working with the perpetrator's partner or former partner, and the probation officer.

The Colorado minimum standards require accredited BIP providers to provide differential responses to each intensity category. As a result, when re-assignment is required, the perpetrator does not need to start again with a new provider, but rather can somewhat seamlessly be stepped up into the higher category by the same provider.

Multi-treatment teams (MTTs) consisting of the BIP provider, victim/survivor advocate and probation officer make decisions about each perpetrator's individualised intervention plan, whether to change intensity categories, and whether the perpetrator has met all aspects of his treatment plan and is ready to leave the program. The MTT conducts intervention plan reviews on a regular basis with each perpetrator.

Process evaluations have been conducted to gauge whether the model is being implemented with integrity by Colorado BIP providers. Available on the Colorado Domestic Violence Offender Management Board website (Colorado Domestic Violence Offender Management Board, 2016), these evaluations demonstrate that treatment intensity and perpetrator pathways are congruous with risk assignment according to the DVRNA.

²⁸ Hansen, J. (in preparation).

²⁹ Moderate- and high-intensity perpetrators cannot be downgraded to low-intensity; however, high-intensity perpetrators can move into the moderate-intensity stream if the risk that they pose to family members decreases sufficiently.

For example, higher intensity categories are associated with both longer interventions and increased drop-out rates than lower intensity categories (Colorado Domestic Violence Offender Management Board, 2016).

Peak body or dedicated capacity-building organisation

The Domestic Violence Offender Management Board (DVOMB), part of the Division of Criminal Justice, oversees Colorado minimum standards and compliance processes. The board consists of representatives from a wide range of government, NGO and community services, and employs four staff equalling 2.6 full-time equivalent positions. Major activities of the DVOMB, in addition to setting and updating the minimum standards, include:

- receiving applications for approved provider status;
- commissioning research and evaluation activity focusing on their differentiated response model, to test various aspects of the model during implementation by program providers, and to recommend improvements, modifications and supports for program providers to address barriers towards implementation (substantial focus on this activity);
- seeking public comment on particular aspects of the minimum standards;
- providing training for BIP providers on the rationale for and implementation of the minimum standards;
- providing a small number of trainings in other areas, such as program evaluation;
- providing technical assistance to Colorado BIP providers to help them implement the differentiated response;
- organising BIP-provider network meetings for providers to meet with the board and discuss current trends and initiatives; and
- distributing a brief monthly newsletter.

Standards or professional practice guidelines

The Colorado minimum standards are compiled into a detailed document that is prefaced by 17 guiding principles. These principles are introduced by the following statement:

Domestic violence offender treatment is a developing field. The Board will remain current on the emerging research and literature and will modify these Standards based on an improved understanding of the issues. The Board must also make decisions and recommendations in the absence of clear research findings. Therefore, such decisions will be directed by the Guiding Principles, with the governing mandate being the priority of public safety and attention to commonly accepted standards of care. Additionally, the Board will endeavor to create state standards that reflect that Colorado communities have unique geographic features, challenges and resources (Colorado Domestic Violence Offender Management Board, 2016, pp. 2-3).

The remainder of the document covers approximately 80 standards categorised into offender evaluation, offender treatment, offender confidentiality, victim/survivor advocacy coordination, coordination with the criminal justice system, provider qualification, specific offender populations and administrative standards. The length of the document reflects not only the number of minimum standards but also the efforts taken to explain the rationale for many of the standards. In some cases, the evidence base used to derive a particular standard is referenced or outlined – however, this is not consistently the case throughout the standards. Furthermore, the attempt to explain the rationale behind particular standards is, in our view, let down somewhat by its design and layout.

Up until 2000, like most US jurisdictions Colorado specified a minimum length of intervention for approved BIP providers (36 weeks). The standards were substantially reviewed in 2010 (and updated in 2016) to reflect a very different approach. A minimum length of intervention is no longer specified, with the rationale that intervention length needs to be based on a comprehensive case-by-case assessment and intervention plan. The MTTs described previously determine when a perpetrator is ready to complete the program depending on his achievement of “core competencies” in attitudinal and behavioural change, and on victim/survivor reports and other evidence regarding any changes in risk. The standards suggest that intervention ends when the perpetrator has met the conditions of his intervention plan, rather than when he

has completed a fixed number of intervention sessions. The concept of core competencies to guide intervention planning and length is also unique to the Colorado standards.³⁰ The core competencies are that the offender:

- commits to the elimination of abusive behaviour by beginning to develop a comprehensive Personal Change Plan that is approved by the MTT;
- demonstrates change by working on the comprehensive Personal Change Plan;
- completes a comprehensive Personal Change Plan;
- demonstrates empathy;
- accepts full responsibility for the offence and abusive history;
- identifies and progressively reduces patterns of power and control behaviours, beliefs and attitudes of entitlement;
- demonstrates accountability;
- accepts that one’s behaviour has, and should have, consequences;
- participates and cooperates in treatment;
- demonstrates the ability to define types of domestic violence;
- demonstrates the ability to understand, identify and manage one’s personal pattern of violence;
- demonstrates understanding, identification, and management of one’s personal pattern of violence ;
- demonstrates understanding and use of appropriate communication skills;
- demonstrates understanding and use of “time-outs”;
- recognises financial abuse and management of financial responsibility;
- eliminates all forms of violence and abuse;
- is prohibited from purchasing, possessing, or using firearms or ammunition; and
- identifies and challenges cognitive distortions that play a role in the offender’s violence.

³⁰ The Colorado concept of core competencies was modified and adopted in the NSW *Towards safe families* practice guide (2012), but was not constituted as part of the NSW minimum standards as it was positioned as an optimal practice suggestion only.

Additional competencies are also outlined for use in particular circumstances – for example, when the perpetrator has contact with children, is abusing substances, is experiencing psychiatric or mental health conditions, or requires the mobilisation of pro-social community supports and mentors to sustain any gains being made in the program.

Guidance is provided in the standards to assist providers to determine whether each of the competencies are being met by the perpetrator. However, operationalising and measuring these competencies is done in a variety of ways by providers across the state, including the administration of written tests to group participants, the use of Likert scales to measure progress or regress across the program for each of the competencies, and role plays or experiential methods to measure behavioural components. A University of Colorado researcher is currently working with a number of providers to investigate how they are measuring the core competencies – particularly crucial research given the importance that ratings on the achievement of the competencies play in determining treatment progress and completion, and the lack of any standardised and consistent measures or tool to guide MTT decisions with respect to this.

As highlighted above, another key feature of the model is the flexible categorisation of perpetrators into different intervention intensity categories depending on the initial and ongoing DVRNA assessment. Thus, while intervention length is not prescribed, each intensity category is associated with specifications for minimum intervention intensity:

- Low-intensity category: for perpetrators whose use of DFV does not appear as part of an ongoing pattern, who have a pro-social support system, no or minimal criminal history, and no evidence of significant mental health or substance abuse issues; perpetrators are to attend one group session per week until they have reached program completion.
- Moderate-intensity category: for perpetrators who have an identified pattern of ongoing violent behaviour, may or may not have a pro-social support system, may have some criminal history, and may be experiencing moderate degrees of substance abuse or mental health issues; perpetrators are to receive at least one clinical intervention per month to address denial and resistance, and any substance abuse or mental health issue, in addition to weekly group sessions.
- High-intensity category: for perpetrators who exhibit multiple risk factors, do not have a pro-social support system, are likely to have criminal histories and/or significant substance abuse or mental health issues, and often have employment and/or financial instability; perpetrators are required to have a minimum of two contacts per week.

Compliance monitoring

Colorado's compliance monitoring system is based on an approval process directed at the ability of individual practitioners to run a DFV perpetrator program that meets the minimum standards. Programs are not audited per se, but rather the focus is on the capacity and competency of lead practitioners to run compliant programs. Practitioners can apply to become an approved provider of a Colorado DFV perpetrator program at one of four levels – Entry Level, Provisional Level, Full Operating Level and DV Clinical Supervisor Level, with the minimum standards providing definitions and differentiation between the four levels.³¹

Applicants for the Full Operating Level, for example, in addition to criminal background checks and professional association licensing details, are required to submit the following information:

- reference letters from a probation officer, DV clinical supervisor and victim/survivor advocate;
- a signed statement of compliance with the minimum standards;
- verification of educational qualifications and the foundational training requirements outlined in the standards;
- verification of program provision experience hours and hours spent in supervision;
- verification of ongoing supervision arrangements; and

³¹ The term "provider" is used in this jurisdictional review to refer to practitioners who provide DFV programs in Colorado – not in the sense of an organisational provider used throughout the rest of this document.

- detailed analyses of actual offender treatment assessments, treatment contracts and treatment plans by a DV clinical supervisor, using a template that focuses on the applicant's demonstrated ability to meet relevant minimum standards.

Ongoing monitoring of approved provider adherence to the minimum standards has two components:

1. The DVOMB receives and processes complaints against approved providers that are alleged to have violated the standards. These complaints are reviewed by the Application Review Committee (ARC), a committee of the DVOMB and comprising board members. If the ARC believes standards are indeed being violated, the complaint will be investigated by a contracted independent agency. Depending on the outcome of the investigation, the provider's history, and their level and experience, the ARC can then either: 1) downgrade the provider to a lower level (e.g. clinical supervisor to entry level); 2) delist the provider, meaning they can no longer work with convicted DV offenders in Colorado; or 3) administer a Compliance Action Plan (CAP). The downside to this process is that the investigation can take a significant amount of time.
2. Paper audits of providers termed Quality Assurance Reviews (QARs), of which only four are conducted each year (two for providers subject to anonymous complaints or alleged issues of non-compliance with standards, and two chosen randomly).³² QARs enable a window into the provider's work through requiring the provider to submit actual documentation of their practice (assessments, treatment contracts and treatment plans). If the provider is found to be non-compliant, the ARC typically will administer a CAP for a period of time, whereby the provider must demonstrate that they have addressed the deficiencies found in the QAR. If a provider fails to successfully come into compliance, the ARC can then elect to delist the provider due to noncompliance.

Use of program logic and other program integrity building methods

Colorado is one of the few jurisdictions that has conducted research into program provider compliance with the minimum

³² The limitation of four QARs is due to capacity constraints – at the rate of four QARs per year, it would take a few decades for all providers in the state to be audited.

standards in terms of the integrity with which the standards are being implemented and the identification of issues and barriers (Gover et al., 2015; Hansen, 2016). This research has been of significant scale, involving not only program providers but also probation officers and victim/survivor advocates (given their crucial role in the context of MTTs). Research outcomes directly influence DVOMB's activities to promote a positive culture of program compliance.

Professional development and community-of-practice activities

The DVOMB provides regular trainings on the standards and related policy changes so that providers can understand the requirements and have an opportunity to ask questions and learn. This includes a focus on regional training to provide access to rural providers. The DVOMB has an expressed objective of attempting to foster a culture over the long-term where providers feel inspired to follow the minimum standards.

Illinois

This jurisdictional review is based on a desktop analysis of relevant documents only – the authors were unable to contact a representative from Illinois to interview. However, this jurisdiction takes one of the more active approaches towards compliance monitoring.

Characteristics of the community-based MBCP field

MBCPs in Illinois are termed Partner Abuse Intervention Programs (PAIPs). Programs are available over 110 specific sites (including more than 20 in Chicago) and are accredited as meeting the Illinois Protocol for Partner Abuse Intervention Programs, with some providers presumably offering multiple simultaneous intakes at the one site at different times of the week. To put this into perspective, this is a notably greater volume of program sites than in Australia as a whole, despite Illinois having a population of approximately 10 million less.

Approximately 25 percent of programs are provided with funding by the Illinois Government through the Department of Human Services. Social services, victim/survivor services and private practice are the three most common types of providers, with others including mental health agencies, substance abuse providers and organisations dedicated solely to the provision of PAIPs.

Illinois is distinct from many US states in that program funding and monitoring arises through its human services department rather than the justice system – this could reflect a greater proportion of referrals into Illinois programs coming from sources other than probation. As of 2010, the state’s PAIPs were conducted in 11 languages: English, Spanish, Polish, Russian, Hindi, Urdu, Punjabi, Arabic, Persian, Gujrati and Filipino.

Guiding legislation and action plans

The *Illinois Domestic Violence Act*, originally proclaimed in 1986, is the guiding legislation. Including the provision of protection orders, Illinois legislation allows for the specific DFV crimes of domestic battery and aggravated domestic battery.

Peak body or dedicated capacity-building organisation

The Illinois Coalition Against Domestic Violence is the state’s peak body for domestic violence agencies and services. It does not appear to play a strong or central role in supporting the PAIP field. The Illinois Department of Human Services (IDHS) provides technical advice and support for PAIPs. It is within IDHS’s remit to provide training to support program providers to comply with the protocol; however, we are unaware of the nature or frequency of this training. IDHS provides on-site technical assistance as part of its assessment process in relation to compliance with the protocol.

Standards or professional practice guidelines

The Illinois Department of Human Services issued the *Illinois Protocol for Partner Abuse Intervention Programs* (Illinois,

Department of Human Service, 2002) initially in 1994, with at least three subsequent revisions. The protocol, written in succinct form, focuses on the purpose and principles of PAIPs, relatively detailed specifications on the required educative component of programs, program design and minimum length, facilitator teams and group composition, service coordination and multi-agency collaboration, public awareness work, intake and assessment, exclusion criteria, managing risks to children, participant contracts, completion standards for participants to be deemed ready to exit the program, evaluation, victim/survivor safety, ethical considerations, reporting, victim/survivor contact, referrals, fee payments, staff competency, staff supervision, innovation and data maintenance. Some of the unique features of the standards include that providers are required to:

- conduct community education activities regarding DFV;
- consider follow-up contact with participants after they have completed the program (which has resulted in many programs enabling former participants to return to the program, often without cost); and
- have separate protocols for male perpetrators and for female perpetrators of heterosexual intimate partner violence.

No explanation is provided in the protocol concerning the rationale or evidence base for particular standards.

Compliance monitoring

IDHS conducts some form of assessment of each program provider each year. IDHS provides details of these assessments to the Partner Abuse Services Committee, which is made up of representatives from victim/survivor services, social service organisations, the department itself, and university social work departments. The committee recommends whether the provider is compliant, requires corrective action to become compliant, or is non-compliant. The assessment process involves:

- a program interview focusing on service delivery trends and patterns, perceived areas of growth or success, or areas of concern;
- data reporting focusing on a minimum data set;
- a file review to determine through case notes whether particular aspects of the protocol are being met through

service delivery (e.g. participant contracts, participant completion criteria and follow-up services);

- observations of group work practice, with the assessors using a coding tool consisting of a five-point Likert scale (from excellent to poor) across 13 items focusing mostly on group work process and attention to core educational and conceptual issues outlined in the protocol, and a further item also addressing the proportion of the group session time spent on power and control, legal problems, personal problems, relationship issues and anger management; and
- information from partner agencies and collateral contacts about the program (e.g. from courts, victim/survivor services and local DFV coordinating councils).

In addition to program monitoring, Illinois has introduced a certification process for PAIP practitioners, who if certified become an Illinois Certified Partner Abuse Intervention Professional. This is the only jurisdiction, that we are aware of, either within or outside the US that combines an accreditation process at the program level with a certification process at the individual practitioner level. IDHS has contracted out the implementation of the individual certification scheme to a private organisation specialising in examination-based licencing systems. To become certified, a practitioner must first:

- have completed a minimum 40-hour general DFV training from an approved provider;
- have completed a minimum 20-hour training specific to partner abuse intervention;
- be supervised for at least 150 hours in an approved PAIP;
- meet conditions about being violence-free over a minimum period;
- agree to abide by the Code of Ethics for Certified Partner Abuse Intervention Professionals; and
- agree to a minimum of 30 hours continued education every 2 years to maintain certification (Certified Domestic Violence Professionals, 2016; Continental Testing Services, 2011).

The second stage of the certification process involves the practitioner sitting an exam. The examination focuses on a number of questions assessing the knowledge and attitudes of the examinee, and a set of references are provided beforehand

to indicate the types of issues that might be explored through the exam. Certification lasts for 2 years, upon which a new certification application is required.

Texas

The Texas Council on Family Violence (TCFV) is a membership-based NGO that exists to support DFV service providers, provide training, and influence policy and legislation. Its members include service providers, victims/survivors, business and faith organisations. Texas was chosen as one of the US states to review as few such NGOs exist in that country that have the capacity to actively support and audit BIP providers.

Characteristics of the community-based MBCP field

Texas has approximately 155 BIP providers across a state of approximately 27 million people. Many of these providers run multiple simultaneous programs to meet demand – it is not uncommon for some of the larger providers of BIPs in the US to run 10 or more simultaneous groups or programs out of a major population centre, for example. To put this in perspective, depending on how MBCPs are defined, Australia, with a population 85 percent that of Texas, has approximately 60 providers of programs across approximately 100 sites. In a few cases, Australian providers do run more than one program simultaneously at the same site.

Texas is characteristic of the US in that the range of providers of these programs is much wider than currently exists in Australia. While in Australia few providers can afford to run programs without at least some government funding, most US BIPs are unfunded, deriving income from participant fees only, or in some circumstances through a mental health diagnosis associated with the perpetrator enabling health insurance payments (this is controversial within the field due to concerns about positioning DFV perpetration as a mental health issue). Many programs are run out of for-profit psychology or mental health focused private practices or small companies, running significant numbers of parallel groups to generate a sufficient volume of incoming fees to support the work; some providers, however, are NGOs.

As a result, and due to a different philosophy concerning partner contact compared to Australian, UK and New Zealand jurisdictions, many providers do not have a partner contact component or regularly share information with victim/survivor advocacy services on a case-by-case basis. Indeed, this is often discouraged out of a concern that such information sharing could unduly influence the independent work of victim/survivor advocacy services and create a burden for them (by focusing on the perpetrator). However, the Texas standards (like most in the US) do include a component on victim/survivor contact, focusing on minimum victim/survivor contact requirements for BIPs (e.g. written notification to victims/survivors within 5 days of the perpetrator's initial assessment and of his exit from the program), and the need for providers to have documented policies and procedures when they choose to initiate victim/survivor contact or when contacted by the victim/survivor.

As with many US states, becoming registered as a BIP provider is not an onerous process. Registration is overseen by the Texas Department of Criminal Justice. A potential provider pays an administrative fee (approximately US\$300), must satisfy a criminal background check for (only) one practitioner, and must show evidence that each practitioner has participated in the prerequisite 40 hours of relevant training (25 hours of which need to focus directly on BIP work, and the remaining 15 on DFV more broadly). This low bar results in quite a wide variety of providers seeking to do this work; however, there is an element of "self-selection", as those providers whose work is not trusted by the local probation officers and the court may not receive a sufficient volume of referrals for a BIP program to remain financially viable. Some probation officers provide perpetrators with a list of BIP providers, and hence supply and demand issues play a role in terms of financial viability for potential new providers. For example, although approximately 155 providers are registered in Texas, some of these receive few referrals and are thought to be unlikely to renew their registration.

As throughout most of the US, the majority of referrals come from the criminal justice system for men on probation or parole orders. Most US programs receive upwards of 90 percent of their referrals this way, with a few high-profile exceptions of providers who work hard to facilitate non-mandated referrals

(e.g. Emerge in Boston and Men Stopping Violence in Atlanta). The proportion of child protection-directed referrals in Texas is increasing, however, and overall, according to 2009 and 2010 data, approximately one in three referrals to Texan BIPs arose through sources other than probation and parole (Texas Council on Family Violence, 2012).

Approximately 25-30 (roughly 15-20%) of Texan BIP providers receive funding from the Texas Government to conduct their programs. The level of funding, however, is quite low by Australian standards – in 2009 this amounted to US\$165 per perpetrator participating in a Texas program (TCFV, 2012), though it is important to note that US programs elicit a much higher level of subsidisation from participant fees, both in terms of fee levels and the greater volumes of perpetrators. These are the programs that TCFV can have a direct influence on in terms of auditing.

Guiding legislation and action plans

Texas has legislation enabling family violence protection orders in addition to protection orders for three crimes specific to DFV – Domestic Assault, Aggravated Domestic Assault, and Continuous Crimes Against the Family (defined by two or more assaults within a 12-month period, irrespective of whether either resulted in an arrest or conviction, and against the same or different victims/survivors). The state plan to address DFV – *Access to safety, justice, and opportunity: A blueprint for domestic violence interventions in Texas* (TCFV, 2013) – was compiled and published by TCFV itself, in close collaboration with state government funders of DFV services. The fact that TCFV had the authority, as an NGO, to develop the state plan indicates the significant role that the coalition has in overall DFV policy for the state.

Peak body or dedicated capacity-building organisation

The TCFV is a significant-sized organisation. Its activities include:

- running seven advocacy-based caucuses to enable victims/survivors and marginalised communities to influence service delivery and policy;

- providing a range of resources and support functions for victim/survivor advocacy and other DFV service providers;
- responding to requests from DFV service providers for technical assistance on a range of topics, including several hundred per year from BIP providers;
- conducting a range of training programs for service providers and community-based networks and organisations;
- providing training and accreditation for BIP providers;
- focusing on primary prevention and community-level activities; and
- influencing DFV public policy and liaison with Texas legislators.

Standards or professional practice guidelines

The Texas Department of Criminal Justice produces the state's BIPP Accreditation Guidelines, first published in 1995 and last updated in 2014 (Texas Department of Criminal Justice, 2014). The standards contain 29 guidelines focusing on the issues of background police checks for staff, initial training requirements, staff development, staff supervision, case records, confidentiality, fee payment scales and procedures, program duration, program format, curriculum (in broad terms of core foci that should form the basis of any curriculum used by a program provider, focusing on an understanding of DFV as an intentional expression of power and control), assessment procedures, program exiting, individualised case planning, written participation agreements, victim/survivor contact, reporting requirements, and community education/community-based referral processes.

The guidelines are succinct, focusing on minimum requirements and enabling considerable space for providers to implement them in different ways. For example, while the guidelines require that criminal background checks be conducted with all staff, they do not specify how providers should respond when a prospective staff member has a criminal record (that is, the standards do not automatically disqualify them), as this is left to the discretion of the provider. Many of the 29 guidelines are written within the range of 75-250 words each, with no contextual text, referencing or links to the evidence base.

The standards provide some best-practice suggestions that go beyond the minimum guidelines. For example, while the standard for program duration is a minimum of 18 2-hour sessions conducted no more frequently than weekly, the guidelines recommend 52-week programs as consistent with national best practice. Other best-practice recommendations focus on collaboration and coordination with partner agencies (justice system, victim/survivor services), collaboration with substance abuse treatment providers, community education and participation in research activities. The standards include a small number of templates and forms for providers to use, mostly to assist providers to document and demonstrate staff training and professional development requirements.

Compliance monitoring

TCFV engages in a thorough compliance monitoring process for the 25-30 providers that obtain state funding. This does result in something of a two-tier system, with the relatively small proportion of state-funded programs monitored and supported in a way that the larger number of unfunded programs are not. TCFV auditing for funded programs consists of three parts:

- Auditing staff files for evidence that all staff have had criminal background checks, the prerequisite 40 hours of foundational training, sufficient ongoing professional development and monthly supervision. Increasingly, program providers are uploading evidence of meeting these requirements online so that for this component TCFV staff do not need to visit the agency to view actual staff files.
- Auditing client files to review the content and language of monthly reports and exit reports to referrers, and letters to victims/survivors.
- Group work observations through TCFV auditors sitting in on one session of at least 50 percent of the parallel groups/programs that a provider runs each year. Hence, if a hypothetical provider runs eight parallel group work streams, TCFV auditors would seek to sit in on at least four group sessions per year. The auditors are guided by a tool that assists them to focus their observations on the core curricula themes outlined in the minimum standards, such as whether group work sessions are based on a power and control analysis, and on men's responsibility and violence as a choice.

The annual nature of observations of live practice results in TCFV auditors gaining a strong relationship with many of these funded providers and, over time, getting to know the particularities of individual facilitator practice. TCFV emphasises that this enables the auditing process to have a strong element of professional and practice development for practitioners in the funded agencies, given the provision of yearly feedback based on observing multiple group sessions.

TCFV stresses that auditors must be carefully chosen. They are often experienced DFV victim/survivor advocates in the NGO sector, and in this way, the auditing system promotes BIP program accountability to practitioners who have focused much of their working lives on advocating for victims/survivors. As most auditors have not had prior experience running perpetrator interventions themselves, it is important for them to have the capacity to keep a “poker face” when observing live practice and to keep an equilibrium when witnessing directly, the misogynist attitudes of many perpetrators. Auditors are thoroughly trained by TCFV to ensure that they are not too lenient nor too harsh, based on the agency’s experience of providing auditing over the past 20 or more years.

If an audit results in concerns about practice, a program provider has a year to improve based on the feedback they receive. If this improvement isn’t achieved, TCFV recommends to the Texas Government that their funding be withdrawn. However, paradoxically, this does not result in immediate withdrawal of their registration as a BIP provider by the Texas Department of Criminal Justice – program providers will often remain registered for the remainder of their 3-year registration period. This fact underscores the highly bureaucratic and static nature of many state government registration/accreditation boards across the US. TCFV uses two main audit tools to assist with these processes. The Battering Intervention and Prevention Program Onsite Auditing Report (Texas Department of Criminal Justice, 2014) contains the following sections:

- fields for recording compliance with respect to criminal background checks, staff training, staff development and supervision for each staff member;
- a focus on a random sample of 10 percent of case files created since September 2015, with fields to record

compliance with the separation of victim/survivor and perpetrator information, notification to victims/survivors of participant entry into and exit from the program, the presence and timing of progress reports to referral sources and notification to the perpetrator, and the development of an individualised plan for each case;

- fields to review the group curriculum in relation to the standards;
- a section based on auditing group sessions in relation to the standards, based on overall features of the program such as duration, and on group session observations (a second tool is available to guide auditors to record these observations and to feed into the auditing report); and
- templates to summarise the audit results and for any corrective action plan that’s required.

Foundational training for practitioners

As is the case throughout most or all of the US, no specific intensive foundational training program exists for BIP practitioners.

Professional development and community-of-practice activities

TCFV provides an annual conference and a range of in-person trainings, online trainings and webinars for BIP practitioners. TCFV is one of the relatively few NGOs in the US that offer BIP specific training beyond conference organising. A current focus of professional development support is to strengthen the ability of program providers to implement the Duluth approach with integrity, through a combination of face-to-face training and follow-up webinars by the Domestic Abuse Intervention Programs. TCFV hopes to use these trainings as the start of a community-of-practice in Texas focusing on the Duluth approach. TCFV also has a strong focus in its professional development activities on helping providers to strengthen the coordinated community response/integrated service systems focus of their work. TCFV also responds to a high volume of requests from BIP providers for technical assistance on a range of program provision issues.

The agency's professional development and support for program providers extends beyond funded BIP providers and is available to all registered providers in the state.

Canada

Information about Canadian community-based MBCPs has been surprisingly difficult to find. We are grateful to Professor Katreena Scott, Canada Research Chair in Family Violence Prevention and Intervention at the University of Toronto, and her colleagues for providing much of the information represented here. In some respects, the Canadian MBCP field shares many similarities with the Australian context. Programs vary significantly from each other in terms of orientation, design, structure, length and degree of embeddedness within integrated responses. The most common approaches are Duluth (or at least versions of), cognitive-behavioural and narrative, with many providers describing that they adopt a mixture of approaches.³³ Programs focus mostly on group work and, like their Australian counterparts, are yet to fully (or even partially) embrace learnings from the corrections and associated literatures in terms of how to tailor group-work-based programs for each perpetrator (Heslop, Kelly, Randal, & Scott, 2017; Scott, Thompson-Walsh & Nsiri, 2018).

Compared to Australian jurisdictions, however, provincial and territory justice departments provide the bulk of funding for DFV perpetrator program work.³⁴ For ten of Canada's 13 provinces and territories, specialist DFV courts exist to refer perpetrators to programs. Many of these specialist courts provide a differential pathway for mandating referrals based on a categorisation of risk, with offenders assessed as being moderate to high risk proceeding through the usual prosecution, conviction and sentencing pathway with mandated attendance at a program a condition of their probation. "Low risk" perpetrators in many of these jurisdictions have the option, if pleading guilty, to have their sentencing postponed while they participate in a DFV perpetrator program; or alternatively they may receive a

peace bond where participation in a program is a condition of the bond. It is important to note, however, that these specialist courts do not necessarily have provincial- or territory-wide coverage (Scott et al., 2018). These differentiated mandated pathways are associated in some instances with differentiated intervention responses. In some provinces, moderate to high-risk perpetrators are streamed in programs that are of a different form and slightly longer³⁵ than those accepting referrals of low-risk offenders, and in others, the same program works with both categories of perpetrator. However, irrespective of whether the same or a different type of program is used, those working with higher risk men tend to be embedded to a greater degree within the justice system, involving closer collaboration and more regular information exchange (Heslop et al., 2017; Scott et al., 2018).

The streaming of offenders through the justice system into different categories of risk, and potentially different intensities of intervention, is not common in Australian jurisdictions (see Guiding legislation and action plans). While many corrections departments classify violent offenders as low, medium or high risk, generally they might refer only low-risk men to community-based providers and provide internal programs for those at higher risk. It is important to note, however, that the Canadian system of streaming appears to fall quite short of the best-practice elements of the Colorado differentiated model described elsewhere in this report.

Canadian MBCPs are run by a range of organisations, varying from small NGOs with substantial histories in providing MBCPs, to more sizeable family and relationships services providers, to large health services conglomerates with a province-wide contract to run programs in particular contexts (e.g. programs for lower risk men across a province).

Guiding legislation and action plans

Criminal law is federal through the Canadian Criminal Code; unlike Australia, constituent provinces and territories do not

³³ The influence of narrative practice, while significant in Australia, appears even stronger in many parts of Canada.

³⁴ While justice or corrections funding for MBCP work is significant in some Australian jurisdictions, the majority of funding for this work arises through departments focusing on human services, community sectors and health.

³⁵ Program length and intensity among programs earmarked for higher risk perpetrators is still considerably less than what the corrections literature would state is necessary for this cohort. Most Canadian programs for higher risk perpetrators are approximately 15-20 group work sessions in length, with programs for lower risk perpetrators generally 10-15.

have their own criminal law. As with most jurisdictions in Australia, there are no specific DFV offences through the Canadian Criminal Code, with general offence categories (e.g. relating to assault) used to charge and prosecute offenders. Action plans related to DFV, however, are created at the provincial level. The mechanisms through which these plans specify pathways for referring perpetrators to community-based intervention programs differ significantly between provinces and territories.

Peak body or dedicated capacity-building organisation

There are no peak bodies in Canada or similar dedicated organisations or entities focusing on capacity building and improving practice for the community-based MBCPs, either at a federal level or within any of its provinces or territories. A network of program providers existed in British Columbia some years ago; however, that has since disbanded.

Standards or professional practice guidelines

We are aware of standards of practice that exist in the public domain in only two of Canada's 13 provinces and territories: Alberta and Ontario. New Brunswick recently had standards, but these appear to have been abandoned. The Alberta standards are referred to separately in this document through its own jurisdictional review. The Ontario standards are difficult to find in the public domain; they were written for the purpose of guiding contracts and funded service agreements between the Ontario Government and program providers. They were initially drafted in 1992 as "interim guidelines" and were updated in 2003.

However, it is important to note that funding service agreements and contracts between Canadian providers of MBCPs and provincial Justice departments often do include specifications on a number of issues commonly addressed in minimum standards, such as length of intervention (or at least, the number of group work sessions that will be funded), partner contact, referral pathways and information sharing. In British Columbia, this goes further, where program providers are contracted to implement a particular program developed by the Ministry of Justice.

Compliance monitoring

Of the two Canadian provinces that currently have minimum standards, only Alberta implements an active compliance monitoring process that is independent of funding contractual arrangements (see the Alberta review for details). For other provinces, compliance is monitored as a part of contractual arrangements, focusing on the numbers of men who completed the program, evidence that in broad terms the NGO provided the program it was contracted to provide.

Foundational training for practitioners

There are no Canadian foundational training programs in DFV perpetrator program work (as far as can be ascertained at the time of writing).

Professional development and community-of-practice activities

The one systematic initiative that the authors are aware of is an annual Canadian Domestic Violence Conference, which is held as a nationwide, grassroots initiative with support from the Bridges Institute, a leading centre for Canadian practice in working with perpetrators from a narrative perspective.

Alberta

Alberta is considered one of Canada's leading provinces in government responses to family violence and in perpetrator program work. It is also the centre of some of Canada's most prolific research and evaluation work in the field, through the University of Calgary. The regional and rural nature of much of Alberta has influenced the development of programs. Given the significantly different contexts between running programs in Alberta's main cities, regional centres and rural locations, significant flexibility and localised program development are encouraged, provided that the minimum standards are met.

Characteristics of the community-based MBCP field

DFV perpetrator programs are provided through the justice system and community counselling centres. Domestic violence courts located in eight centres in the province provide a significant proportion of justice system referrals. The Provincial Family Violence Treatment Program (PFVTP) involves funding agencies in approximately 23 localities in Alberta to provide programs according to minimum standards. Approximately 85 percent of referrals to these funded programs are made through court for offenders on probation, with the remainder self-referrals, referrals by a defence council or referrals through child protection. The proportion of referrals into these programs through non-court pathways is steadily increasing.

The PFVTP is unique in how it has developed through a strong partnership between Alberta health services, including addiction and mental health, and the justice system. Its approach and the standards that underlie them emphasise the importance of an integrated treatment approach involving addictions and mental health interventions in addition to perpetrator program group work. This partnership also supports a centralised law justice database approach to data collection.

Guiding legislation and action plans

The guiding legislation is the *Protection Against Family Violence Act 2000*, which is Alberta-specific legislation focusing mainly on civil law responses to family violence, with the latest amendments in 2011.

The provincial action plan *Family violence hurts everyone: A framework to end family violence in Alberta* (Wells, Ferguson & Interdepartmental Committee on Family Violence and Bullying, 2013) contains a relatively small sub-section on treatment programs for perpetrators.

Peak body or dedicated capacity-building organisation

As the funding body, Alberta Health Service provides a greater degree of active liaison and direct support for program providers compared to funders in many other jurisdictions we reviewed. This includes some (but not all) activities that might normally be associated with a peak body, such as research, policy and support for program providers in implementing the minimum standards.

Standards or professional practice guidelines

The standards of practice underlying the PFVTP were initially developed in 2009, and have been reviewed three times, with a further review being undertaken at the time of writing this report. Regular reviews are considered important to enable the standards to respond to local contextual considerations, evaluation feedback and relevant evidence-based literatures.

A major evaluation conducted in the early to mid-2000s, based on Alberta's existing DFV perpetrator programs at the time, was used to inform the development of these standards. This evaluation resulted in conclusions being drawn regarding optimal program length (with 15 sessions or 30 hours of group work considered to be optimal, or at the lower end of an optimal range), and the importance of addictions and mental health interventions for many DFV perpetrators.

Compared to many minimum standards sets, the Alberta standards attempt to not be too ambitious or prescriptive – a “just enough, but not too much, approach”. This was deliberate in order to focus on the minimum foundations required for consistent, safe practice across the province, including across the three different types of locations (large city, regional centre and rural). The RNR framework is influential in the standards, but no actual model of practice is prescribed.

The standards include “base” and “enhanced” versions in some instances to provide guidance among better funded agencies (e.g. in Alberta's main cities) seeking to go beyond the minimums. Eight core concepts form the spine of the standards: exploring and defining abuse, responsibility and

accountability, emotional regulation, skill development, boundaries, safety, healthy parenting and substance abuse. Addictions and mental health counselling are considered central to these interventions, particularly for higher risk men. The standards emphasise the coordinated community response contexts of perpetrator interventions. In addition to victim/survivor services, local collaboration between health and justice services is stressed to enable a case management and intervention approach focusing on the perpetrator's criminogenic needs.

At the time of writing, the standards were undergoing another iteration as part of the system of regular reviews. They are likely to propose a maximum treatment length (possibly approximately 28 weeks) as well as a minimum, and to include a transition approach for supporting perpetrators to maintain changes once they have completed a program. As with previous updates, explorations of relevant evidence-based literatures help to inform any changes that are made, as will consultations with program providers.

Compliance monitoring

The Alberta Health Service intends to develop and introduce a system of service audits for its funded DFV perpetrator programs. The nature of these audits is yet to be determined. The standards have considerable space for program providers to "breathe" in terms of how they meet them according to local conditions, circumstances and resources; however, it is recognised that a system of service audits will help to identify those providers that stray outside the allowable range of particular standards due to local pressures – for example, fiscal pressures among less resourced rural regions to reduce the length of programs below the acceptable minimum due to economic downturn. The Alberta Health Service provides direct support for program providers who might need some assistance in complying with the minimum standards.

Foundational training for practitioners

No entry-level training for DFV perpetrator programs exists in Canada.

Professional development and community-of-practice activities

No systematic options for professional development exist. However, the Calgary Counselling Centre intends to develop certificate-level training options for DFV practitioners over the coming years, which might include options for work with perpetrators.

Aotearoa/New Zealand

Compared to Australia, New Zealand has a longer history of addressing DFV as a major policy issue at a national level. For example, its first public education campaigns date back to 1993, and were quite innovative for their time (Donovan & Vlasis, 2005).

Characteristics of the community-based MBCP field

Aotearoa/New Zealand has approximately 100 community-based providers of men's stopping violence programs, the term used for DFV perpetrator programs in that country. While this is an impressive number for a country of 4.5 million, some of these providers are quite small and work with only a small number of men per year.

Considerable demand is created for stopping violence services, as all respondents to a family violence protection order, except where contraindicated, are referred to a program. As a result, the Ministry of Justice is the largest funder of this work in New Zealand. Major changes were introduced in 2014 in terms of how the ministry provides funding, with a new funding model introduced that attempts to shape provider practice by introducing individual treatment plans with each perpetrator. This model contrasts with the previous approach of funding programs to provide a particular number of program places per year. Some 92 program providers were contracted by the ministry to provide stopping violence programs, at the time of writing this report. The Department of Corrections funds a number of providers to run its internally developed program for convicted DFV offenders on probation. This was a major

change from the previous arrangement where providers were funded to deliver their own programs to this cohort.

The 2014 changes were somewhat contentious (at least at the time), in terms of the attempt by the New Zealand Government to change the way providers were approaching their work. These changes were pre-empted by McMaster (2013), and are based on the incorporation of RNR and other principles characteristic of the correctional approaches to changing offending behaviour. The changes (in the approaches of both the Department of Corrections and Ministry of Justice to MBCPs) reflected a strong emphasis on:

- developing individualised treatment plans based on a more thorough assessment;
- tailoring interventions to each individual perpetrator;
- focusing on dynamic risk factors and criminogenic needs, including a more flexible approach to risk, as distinct from just putting perpetrators through programs; and
- motivational interviewing so that perpetrators develop more of a stake in their own change process for the benefit of their own lives, families and communities.³⁶

From the government's perspective, these changes were felt necessary to promote consistency in program delivery and to strengthen evidence-based therapeutic components. The changes also corresponded with a major loss of capacity in New Zealand's peak body for stopping violence services and significant changes in how programs were accredited and monitored. It is also noted that the Ministry of Social Development provides a relatively small amount of funding for providers to work with men referred through other pathways, such as self-referrals or child protection. Unlike justice or corrections referrals, however, there are no standards or guidelines that underpin provider responses to these referrals, beyond broader human services standards (not specific to DFV) that all DFV service providers funded by the New Zealand Government are required to meet.

Most providers of MBCPs in New Zealand are well established, with very few new providers emerging in recent years. It was reported that some program providers felt that the changes

diminished their ability to control program design and provision as part of meeting the conditions and requirements of local communities, and possibly watered down a "gender-based" approach. For example, one leader in the New Zealand perpetrator intervention field who was interviewed for this jurisdictional review commented that the totality and complexity of minimum standards can make it difficult for potential new providers to build their capacity over time to become approved program providers. This is particularly the case for rural providers; it was expressed that jurisdictions often create minimum standards that are suited to relatively larger urban providers, but which rural organisations might struggle to implement.

Guiding legislation and action plans

The *Domestic Violence Amendment Act 2013* (NZ) has a central legislative role in DFV service provision in New Zealand, with a new Part 2A covering stopping violence programs. Section 51D of this legislation states:

- (1) On making a protection order, the court must direct the respondent to –
 - (a) undertake an assessment; and
 - (b) attend a non-violence program.
- (2) The court need not make a direction under subsection (1) if –
 - (a) there is no service provider available; or
 - (b) the court considers that there is any other good reason for not making a direction.

The legislation provides direction on a range of issues such as communication between the court and service provider, information sharing, ability of the judge to bring the perpetrator back to court and responses to non-compliance. Many of the service pathway and stakeholder roles and responsibilities that might normally be specified in interagency protocols or memorandums of understanding are actually written into the legislation. For example, Section 51L states:

- (1) Before providing a non-violence program to a respondent, the service provider must settle in writing with the respondent the terms of attendance, which must include –
 - (a) the number of program sessions that the respondent must attend; and

³⁶ For a more detailed description of these new expectations of community-based DFV program providers, see McMaster (2013).

- (b) the place, date, and time of the first program session, and all subsequent sessions, that the respondent must attend.
- (2) The service provider must provide to the Registrar a copy of the terms of attendance that the service provider has settled with the respondent.
- (3) If a service provider is not able to settle with a respondent the terms of attendance, the service provider must notify the Registrar.
- (4) On receipt of a notice under subsection (3), the Registrar must –
- (a) settle the terms of attendance with the respondent and the service provider; or
 - (b) bring the matter to the attention of a Judge.
- (5) When a matter is brought to the attention of a Judge under subsection (4)(b), the Judge may make such further directions as the Judge thinks fit in the circumstances.

The legislation has recently been renewed again through the Safer Sooner initiative, which will include an emphasis on strengthening perpetrator referral pathways beyond the civil and criminal justice system (Ministry of Justice Tāhū o te Ture, 2017).

Peak body or dedicated capacity-building organisation

Historically, Te Kupenga – the National Network of Stopping Violence (NNSV) has performed an important member-driven, peak body role representing stopping violence services. Established in 1988, NNSV was one of the earliest peak bodies of its kind, and reflecting its bicultural nature developed an internal constitutional and accountability structure involving a set 50 percent quota for female and for Māori representation on its board, and a two-member CEO position also reflecting this partnership dynamic. However, NNSV lost significant capacity in 2013 due to financial constraints. As will be outlined below, possibly the most intensive liaison with program providers now occurs through the Ministry of Justice, as part of its auditing and quality assurance mechanisms with respect to the Code of Practice. However, as the ministry is the main funder of stopping violence services, program providers do not have

the same collective representation and voice at the NGO level that comes with NGO peak body representation.

Standards or professional practice guidelines

Ministry of Justice funded programs for protected persons, children and perpetrators are guided by the six-volume *Domestic violence service provider code of practice* (New Zealand. Ministry of Justice, 2016), first released in 2014 to provide guidance in relation to the *Domestic Violence Amendment Act 2013* (NZ), and revised the following year. The Code, explicitly framed as a “living document” is currently going through its second revision.

Standards and considerations relating to DFV perpetrator programs are spread throughout most of the Code, which as a set takes a holistic approach towards working with families who come into contact with the civil justice system due to the need to protect family members from a perpetrator’s use of violence. The six volumes of the Code focus on:

- overview and frameworks;
- practice context;
- adult safety programs/strengthening safety service (victim/survivor focused);
- children’s safety programs;
- non-violence assessment and programs (perpetrator focused); and
- resources (containing a wide range of tools, templates and resources for all three types of programs - adult victims/survivors, children and perpetrators).

Throughout these volumes, the Code serves as a detailed practice guide exploring program implementation issues, and how to implement each of the standards to an acceptable level.

Some standards are applicable to all three types of programs (working with adult victims/survivors, children and perpetrators). These are covered in volumes 1 (overview and frameworks) and 2 (practice context). Examples of the framework standards (16 overall) include:

- Programs are delivered in accordance with the contracted scope and structure.
- Invoicing reflects published fee schedules for each component of the program.

- Providers use the correct forms for reporting to the court.
- Providers will have documented processes for selecting and recruiting, approving, suspending and cancelling the approval of facilitators.

Examples of the practice context standards (10 overall) include:

- Program design and delivery are responsive to the diverse needs of the participant.
- Providers ensure that programs are grounded in a research-informed theory of change.
- Facilitators will build constructive relationships with program participants.
- Facilitators take account of risk as being non-static when designing and delivering safety programs.
- Service providers have systems and processes in place that support ongoing risk assessment.

Twenty-four standards are specific to non-violence programs with perpetrators, covering the areas of reporting and legislative practice requirements, risk assessment and safety planning, assessments, program design and program delivery. Each standard is associated with examples of performance indicators, in the form of a quick table reference in a visual layout, in addition to considerably more detailed explorations in the course of the main text of the volumes. Many of the standards are written in a way that focuses explicitly on organisational responsibilities to deliver the program safely, in accordance with the legislation, in ways that are consistent with RNR principles, and in ways that are considered to be culturally responsive.

Compliance monitoring

The Department of Corrections has a stated goal to support community-based providers of its internally developed program to implement this program with integrity. The department is hesitant to mandate providers to perform integrity checking activities as providers are not funded to do so; however, it is working towards a culture of encouraging program providers to do so. At present, the department is directly conducting integrity checking with a small number of providers, and where programs are falling short,

is supporting these providers to improve the quality with which they implement the corrections-developed program. However, the focus more broadly is on helping to equip program providers with the skills and tools to conduct their own integrity checking. The department intends to adapt its own internal integrity monitoring template for use by program providers, with a major focus on encouraging practitioners to observe each other's practice, either live or via video recordings, to promote peer-review and reflective practice. The department's integrity monitoring template covers in detail a wide range of issues, including 17 items for facilitator training and support, five for participant selection, nine for program resources, ten for program documentation, and similar numbers of items for delivery of sessions, managing session absences, adherence to the program manual, integration of cultural considerations, adherence to the program's treatment style, adherence to therapeutic principles, therapeutic quality in facilitator skill and in change processes, responsiveness skills and facilitator behaviour that interferes with therapeutic processes.

In terms of Ministry of Justice funded programs, programs were accredited through a national approvals panel process until 2013, when this was ceased. This process has been replaced with a compliance monitoring process involving four interrelated components.

Perhaps the most unique component is the use of program invoicing to keep track of broad service delivery issues for each funded program. Unlike most other jurisdictions, in New Zealand program providers are not funded to put a certain number of participants through their program each year. Rather, program provision is segmented into particular service activities, with each activity for each client funded to a certain amount, and the provider invoicing the ministry at the end of each invoicing period depending on the overall volume of each type of service activity. The payment schedule funds particular amounts for assessments (which assumes 4 hours of face-to-face time with the perpetrator and 2 hours for preparation, reporting and administration), for the perpetrator's failure to attend an assessment session (2.5 hours), group session delivery, individual session delivery, failure to attend an individual session, failure to attend a group session and for other service activities.

As the ministry receives invoices with a detailed breakdown of the volume of each service activity, it can continuously track trends and patterns in the provider's service delivery. Through this the ministry can spot, for example, if a provider is relying entirely on group work sessions and is not making use of supplementary individual sessions to tailor the program; if all perpetrators are receiving the same length of intervention and configuration of services (violating the RNR foundations of the Code); and if an unrealistically small number of program participants are returned to court due to non-compliance with program participation conditions. Such analyses are conducted on an ongoing basis and enable the ministry to identify and focus on providers who appear not to have adapted to the expectations for service delivery that accompanied the 2013 legislative amendments. Invoice monitoring feeds into three other processes that the ministry uses to monitor compliance with the standards, conducted by a team of departmental Domestic Violence Advisors who have significant prior practice and service coordination experience in the sector:

- Monthly phone check-ins with each funded program provider.
- Monitoring visits approximately 2-3 times per year, to investigate service trends and patterns, complexities and barriers towards implementing particular standards, and developments in the local community affecting program delivery. These visits often include an audit of a small number of client files. Issues identified in relation to meeting the minimum standards are followed up with telephone contact to track progress towards resolution.
- More formal and comprehensive audits every 2 years (approximately). These audits do not focus on the full range of the standards, but rather zero in on a particular cluster of standards that the ministry believes is an issue across multiple program providers.

Providers who are in breach of the minimum standards are generally provided with a remedial notice and are given time to change their practice and demonstrate that they are meeting the standards. If they are not successful in this respect, or if the breach is particularly serious, the provider will lose its contract with the New Zealand Government.

Use of program logic and other program integrity building methods

Not unlike in Australia, workforce development issues can be a significant impediment to enhancing the quality of community-based MBCPs, and to strengthening program integrity. While New Zealand programs vary in size, a number rely predominantly on a small number of part-time staff members, providing little time or opportunity to implement program integrity building measures such as developing a theory of change or constructing a theory manual. Like Australia, in New Zealand, the development of a robust workforce is a key requirement for improving program integrity. As a whole, program integrity checking measures are rarely implemented, with relatively little peer-review of live practice or dedicated use of supervision to support program integrity.

Foundational training for practitioners

There is no competency-based foundational training for DFV perpetrator program practitioners in New Zealand.

Professional development and community-of-practice activities

The significant reduction in NNSV's capacity has curtailed the extent of professional development and community-of-practice activities for community-based providers in New Zealand. Together with the lack of foundational training, this represents a major gap for this jurisdiction. The Ministry of Justice is seeking to organise monthly webinars and other accessible professional development options focusing on particular areas of the Code of Practice and particular practice issues, and some of the larger stopping violence service providers are organising training of their own for the field. The need for creativity in professional development activity is particularly pertinent given that community-based MBCPs rely predominantly on a part-time and casual workforce. Unlike their counterparts in corrections who are more likely to be working full-time and to have the capacity and organisational support to attend blocks of training for several days at a time, casual and part-time practitioners might only be working a few hours or a day or two per week. In this context, online learning and webinars focusing on

particular practice dilemmas are examples of the professional development creativity that might be required.

The introduction of the significant changes in funder expectations of program providers in 2014 demonstrates the importance of professional development activities and support for program providers to adapt and make the most of the changes to enhance the quality of their practice.

Knowledge transfer and exchange

The New Zealand Family Violence Clearinghouse, based at the University of Auckland, provides significant support for knowledge transfer and exchange in DFV policy and practice at a national level, including with respect to perpetrator interventions. It performs similar knowledge transfer and exchange functions to ANROWS in Australia, though it is not involved in commissioning research.

England and Wales

Domestic violence perpetrator programs initially formed in the UK in the late 1980s, influenced largely by the Duluth model. In 1992 a National Practitioners Network formed, which started to meet approximately 6-monthly as a “bottom-up” process for programs and practitioners to share ideas, dilemmas and innovations.³⁷ Respect UK formed in 1992 as a member representative peak body for UK programs (Phillips, Kelly, & Westmarland, 2013).

Until 2005, community-based domestic violence perpetrator programs (DVPPs) in the UK worked very closely with the Probation Service, and often worked with a mixture of criminal justice system mandated and non-mandated sources of referrals. However, the decision by the Probation Service to internally run its own DVPPs in 2005 commenced a significant split, with community-based and Probation-run DVPPs diverging in quite different directions (Phillips et al., 2013). The UK is known for implementing one of the most thorough accreditation processes for DFV perpetrator programs, which will be the focus of this jurisdictional review.

³⁷ The Network ended in 2010.

Characteristics of the community-based MBCP field

Approximately 60 organisations provide DVPPs in the UK. Two-thirds are Respect members, with roughly half having achieved accreditation and the remainder at some point in the process of working towards accreditation. Providers range in size, from the largest offering approximately 14 groups per week to those who offer only one.

A significantly higher proportion of referrals into UK programs – approximately two-thirds – arise through child protection and family law systems than in Australia. With respect to the family law systems, the Children and Family Court Advisory and Support Service is a major source of referrals. Relatively few referrals arise through the justice system, given that the Probation Service runs its own programs internally, and given that Domestic Violence Protection Orders were only first rolled out across England and Wales in 2014.

Guiding legislation and action plans

While Wales has some additional domestic violence-related legislation compared to England, both countries share in common the following:

- *Serious Crimes Act 2015* (UK), Section 76, notable for creating the new offence of “coercive or controlling behaviour in an intimate or family relationship”; and
- *Domestic Violence, Crime and Victims Act 2004* (UK), amended in 2012.

The main UK action plan focusing on DFV – *Ending violence against women and girls strategy 2016–2020* (United Kingdom Home Office, 2016) – includes a significant section on strengthening criminal justice system responses to perpetrators, though it makes no mention of DVPPs or behaviour change.

Peak body or dedicated capacity-building organisation

Respect UK is one of the most notable peak bodies for DFV perpetrator program providers on a global scale. In addition to its focus on setting standards and accrediting program providers, Respect undertakes significant volumes of activity in specialist training of perpetrator intervention practitioners, policy development and research (including active participation and support in the Project Mirabal and RE-PROVIDE projects), and runs two telephone-based services for male perpetrators and victims/survivors of DFV respectively. Respect is a very active member of the WWP EN and is known for its pioneering work to build service system capacity to respond to young people who use adolescent violence in the home or dating violence.

Standards or professional practice guidelines

Respect developed its first iteration of minimum standards in 2004. These were updated to form *the Respect Standard* (Respect UK, 2017) in 2008, which was updated again in 2012 and most recently in late 2017.

Respect UK's approach is based on an outcomes framework specifying, in broad terms, what all DFV perpetrator interventions (not only MBCPs) should work towards. These outcomes were written to apply to a range of general and specific perpetrator cohorts, including use of relationship violence by young people, and working with female perpetrators. The outcomes – and the whole Respect accreditation system – is applicable to innovations in perpetrator interventions beyond MBCP provision, such as intensive case management, specialist DFV fathering interventions, conjoint work on DFV perpetration with other risk-related behaviours (e.g. alcohol and other drug use or mental health issues) and others.

The five broad outcomes are:

- reduction in perpetrator's violent and abusive behaviour;
- increase in survivor's safety, wellbeing and freedom;
- improvement in children's wellbeing and safety;
- improvement in multi-agency work; and
- effective targeting of interventions.

Each outcome is described in detail by the framework, with associated key outcome indicators. Ten principles of safe and potentially effective perpetrator interventions form another foundation of the accreditation system (Respect, 2017).

The Respect Standard (Respect UK, 2017) is organised into five sections: management of the organisation; intervention delivery; diversity and equality; multi-agency work; and an innovation framework providing guidance on testing new innovations in perpetrator interventions. Fourteen headline standards exist across these five categories, with each headline standard divided into a number of "evidence-level standards" outlining the types of evidence that the provider needs to demonstrate in order to meet the headline standard. Guidance is also provided in relation to most of these evidence-level standards to assist providers on how to collect the evidence.

The Respect Standard (Respect UK, 2017) is written succinctly, and is explicitly designed to focus provider attention on how to demonstrate compliance through an accreditation process. The structure is unique in that the standards have been written with the specific accreditation system associated with those standards in mind. Furthermore, the standards are written broadly to maximise their relevance to a wide range of perpetrator interventions, including those that focus on particular cohorts not usually addressed through MBCP delivery, and those that use different approaches to MBCPs (e.g. intensive one-on-one case management). Detail is provided through practice guidance and specific examples of how each standard can be demonstrated.

No reference is made to the evidence base or use of research literatures to inform the standards in the standards document.

Compliance monitoring

Due to the intensity of the full accreditation process, Respect is available to support program providers to become accreditation ready. For example, one requirement of the accreditation application pack³⁸ is that all group work activity with perpetrators over the past 6 months be either video- or

³⁸ The application pack can be downloaded from <http://respect.uk.net/what-we-do/accreditation/>.

audio-recorded to enable assessors to analyse a sample of this activity. Respect has trained a significant number of independent assessors to conduct accreditation audits. Each audit is conducted by two assessors, focusing on:

- a desktop analysis of almost 30 types of policies, procedures or other forms of documentary evidence;
- an analysis of client files (using a detailed template covering approximately 35 items);
- interviews with permanent and sessional DVPP facilitators, partner contact workers, the practice manager and the agency CEO; and
- group observation analysis guided by a checklist.

Assessors are provided with a detailed workbook containing a range of templates, tools and procedural information to conduct the audits; and a clear list of roles, responsibilities and expectations for both the assessor and Respect. The auditing process is intensive and can take many weeks or months, with detailed feedback provided to the program provider throughout the process. Program providers need to renew the accreditation process every 3 years for accreditation to remain current. There are no mechanisms for monitoring program compliance with the accreditation standards in between the 3-yearly re-accreditation processes.

The intensity of the accreditation process resulted in Respect introducing a two-tiered accreditation process in 2012. A Safe Minimum Practice (SMP) assessment was developed as step one towards full accreditation, to provide confidence that an organisation's practice is considered safe, with sufficient risk assessment and risk management processes in train. SMP assessments focus on a limited range of issues related to the safe provision of practice, and need to be renewed annually to remain valid.

Both the SMP assessment and full accreditation process are entirely voluntary – no direct consequences will occur to UK program providers who decide not to undergo either process. However, accreditation has been important to assure referrers and the public about the status of DVPPs, and with the cutback in social services funding over the past few years, full accreditation appears to have helped particular program providers to avoid funding cuts (Blacklock, 2014).

Managing the accreditation system is proving a resource intensive process for Respect. The organisation was patient in introducing the system in the late 2000s in order to ensure that it had the capacity to support program providers to become accreditation-ready, to recruit and train accreditors (both initial training and yearly update training), and to in other ways to manage the system.

Foundational training for practitioners and professional development

While the UK does not have competency-based foundational training for DVPP practitioners, Respect runs a number of training courses in DVPP delivery. These are not as extensive as the two current Graduate Certificate programs in Australia; however, they are run more frequently.³⁹

Knowledge transfer and exchange

Respect has close research-based relationships with Durham University and the University of Bristol, and as such has developed partnership capacity to become involved in primary research related to the DVPP field. Respect also produces occasional briefing papers and engages in other network development activities that bring forth elements of knowledge transfer and exchange.

Scotland

Scotland, which has a separate criminal justice system infrastructure and approach to the rest of the UK, sought to develop a new approach to working with DFV perpetrators in the 2000s. This was part of an overall review of offending behaviour programs to change the relatively high imprisonment rates in Scotland compared to other Western European nations (Macrae, 2014). The development of the Caledonian System approach resulted from this push. Core to the approach's development was a focus on embedding criminal justice system work with men in an integrated context involving strong victim/survivor services as well as children's and young people's support and advocacy work. The development

³⁹ See <http://respect.uk.net/training/> for details.

of the approach was overseen by the Justice Department, the Equality Unit of the Scottish Government and the Scottish Accreditation Panel for Offender Programmes. As such it was positioned as a core whole-of-government strategy to address DFV rather than an initiative somewhat “siloed” through Justice. This degree of interdepartmental coordination and cooperation in the development of an offender program located in the justice/corrections system is quite unusual. It has resulted in the implementation of the Caledonian System being strongly victim-/survivor- and children-focused in addition to its focus on offenders, which again is quite rare for DFV perpetrator programs run in this context. This integrated focus was strengthened through the parallel development of Scottish policies and frameworks to better address the rights and needs of children, which had a substantial influence on the development of the Caledonian System. The Scottish Parliament’s adoption of a gender-based focus on DFV in 2000 also helped to lay the groundwork for this integrated approach (Macrae, 2014).

The Scottish Government’s Accreditation Panel for Offender Programs accredited the men’s component of the program in 2009. The panel decided not to attempt to accredit the women’s and children’s services parts of the program as it did not have the expertise; however, re-accreditation of the program will include these two components. This will be one of the first times, on an international scale, that a corrections/justice-based accreditation panel will include accreditation of women’s and children’s support components alongside the offender-based intervention. The panel will be led by Professor Elizabeth Gilchrist, Academic Head of Criminology and Psychology at the University of Worcester. The program has been adopted in 13 of Scotland’s 32 local government areas, with rollout to other areas of the country uncertain at this stage, pending future Scottish Government budgetary decisions. A recent evaluation of the program was broadly supportive of its effectiveness (Ormston, Mullholland, & Setterfield, 2016), and is creating some positive momentum for possible future expansion.

The program accepts referrals for men convicted of DFV crimes who are considered to be at moderate to high risk (with a focus on the high-risk end of this continuum). Lower risk men are not eligible for the program and are streamed

into an alternative case management approach. The program is implemented by local government authorities, which provides unique context because they are more localised and de-centralised than the much larger state-based government departments that implement corrections programs in other jurisdictions. The approach was designed with potential application outside of the criminal justice context in mind. To date, the program is being implemented in one such context, through the Safer Families Program in Edinburgh that accepts referrals mainly through the child protection system, with expectations being made of men to participate via a children’s court or multi-agency case conference. This version of the program is almost identical in nature and structure to the program delivered through the justice system, though it has been piloting an additional 8-week fathering and DFV module for men who might not agree to participate in the full program, but where work on their behaviour and fathering has been recommended through case conferencing. This 8-week program is, theoretically at least, seen as a stepping stone to try to motivate participants to transition into the full program.

Characteristics of the approach

The Caledonian System is a 2-year intervention, given the focus on working with high-risk perpetrators and an underlying ethos of working towards secondary desistance goals of significant changes in the perpetrator’s identity, lifestyle, social milieu and general approach to taking responsibility in life. All three components of the program – women’s, children’s and men’s – work in a highly integrated fashion, with developments in any one component often influencing work in the others. The women’s service is flexible, responsive and proactive in terms of identifying and addressing the risk and support needs that partners have as a result of the perpetrator’s use of violence. It generally involves a combination of telephone and face-to-face support, determined by the woman in terms of what she needs at different points in time. The recent program evaluation recommended, however, that more shape and structure be given to the women’s service, to ensure a greater level of consistency and transparency to external stakeholders in terms of the different aspects of what’s provided (Ormston et al., 2016).

The role of Caledonian children's services workers is not to have direct contact with children in all cases, but rather to perform systems coordination and navigation roles to support the child's needs being met through the nationwide Getting it Right for Every Child framework. The children's worker's role is largely to ensure that the child's experience of DFV is taken into account by other services and professionals in their work with the child in various spheres of the child's and family's life. The above-mentioned evaluation recommended that the Caledonian System explore opportunities for children's service workers to work more directly with children in a wider variety of circumstances than what has been the case.

The men's program consists of three main phases. After initial eligibility and suitability assessment, an initial pre-group phase of 14-20 sessions occurs that focuses on establishing a therapeutic relationship with the perpetrator. This initial phase:

- invites men to discuss their experiences of the justice system and to explore their expectations of the program;
- uses personal construct theory to assist men to identify their personal belief systems, identity and who they would like to be;
- introduces cognitive-behavioural change techniques for men to take responsibility for their behaviour, attitudes and emotions;
- explores issues of power and control, and the social construction of masculinity and gender-based entitlement;
- identifies barriers towards progressing through the program, including shame; and
- begins the process of scaffolding perpetrator efforts to develop their personal plans, focusing on good life goals and how they want to change through the program (Macrae, 2014).

The group work phase consists of six modules over 26 weeks, titled:

- Lifelong Change;
- Responsibility for and to Self;
- Responsibility within the Relationship;
- Sexual Respect;
- Men and Women; and
- Children and Fathering.

Each participant works on further developing their personal plan at the end of each group work module. The final maintenance phase is less structured and can be delivered in either one-to-one or group work contexts. The emphasis is on preparing the participants to further develop their personal plan (an ongoing process) and to put it into practice in a self-directed way in the spirit of lifelong learning.

Guiding legislation and action plans

Equally safe: Scotland's strategy for preventing and eradicating violence against women and girls, released in 2014 and updated in 2016 and 2018 (Scottish Government, & Convention of Scottish Local Authorities, 2018), is the key policy document driving DFV programs such as the Caledonian System. The plan, and a commitment to DFV perpetrator program funding and development, has bipartisan support in the Scottish Parliament, enabling a progressive agenda and a positive political and civil society outlook towards this work. The plan's development has helped to continue the positioning of the Caledonian System approach as a whole-of-government initiative that equally prioritises working with victims/survivors, children and men.

The key legislation relevant to DFV is the *Domestic Abuse Act 2011* (Scotland); however, the Act does not include mention of perpetrator programs. The Scottish framework for supporting positive outcomes and meeting the rights for children and young people – Getting it Right for Every Child – has been instrumental in the development of the Caledonian System approach, and in providing a basis for the work of the children's component of the program.

Peak body or dedicated capacity-building organisation

The initial development of the Caledonian System was accompanied by a Caledonian National Implementation Group jointly established by the Justice Department and the Equality Unit of the Scottish Government. This group was established to provide the foundational training and to support local government authorities to establish the programs in the trial sites. Although the implementation

group continued to meet, and there has been ongoing training to new workers and some facilitation of inter-site liaison, its terms of reference did not include a role in detailed oversight of the delivery of the program in the different sites. The 2016 evaluation report, however, has led to significant interest from the Scottish Government in implementing the report's recommendations and considering options for the future "expansion" of the program. This is leading to new terms of reference for the implementation group, and the creation of a Caledonian development team consisting of a coordinator and two full-time equivalent positions, made up of experienced practitioners and managers from the various hubs.

Standards or professional practice guidelines

As the Caledonian System is a consistent approach with a detailed program theory and operational manuals, there is not a need for a separate layer of standards or guidelines.

The comprehensive theory manual includes, in part, an analysis of relevant literatures, and references to support the underlying assumptions of the program, key concepts, and the main program structure and features. For example, the evidence used to provide a rationale for the nature and design of the 14 pre-group sessions is made transparent through the theory manual. The manuals also stipulate some practices in terms of minimum frequency of external supervision, and the requirement for providers to enable opportunities for reflective practice. This involves the stipulation that each month at least part of one group session is recorded and viewed by program management within a reflective practice ethos – however, the degree of occurrence of this is not monitored. Managers are also required to provide debriefing in relation to each group session within 2-3 days of the session.

Compliance monitoring

As stated above, there has been no systematic oversight of the trial sites, although the Justice Department has kept a role in data collection from the trial sites. The evaluation reported in 2016 (with evaluation activity commencing the year prior) has provided an important check concerning how the program has been implemented, with recommendations

for strengthening integrity in some areas. Unfortunately, significant data-gathering limitations constrained the ability of the evaluation to provide hard quantitative data to back up the qualitative finding that the program appears to be successful in working towards important safety outcomes for victims/survivors (Ormston et al., 2016).

One of the recommendations of the evaluation that is being implemented is that there should be a designated data collector, with sufficient practitioner-based experience, to provide program integrity checks in terms of live observations, something which was lacking in the initial phase of the roll-out.

Use of program logic and other program integrity building methods

The Caledonian System evaluation, which included a significant process evaluation component involving a range of qualitative research methodologies, found that the program was being implemented in the way that it was meant to, consistent with the program's theory of change, conceptual underpinnings and specifications in the program manuals (Ormston et al., 2016). While it is difficult to definitively ascertain the relative contributions of different factors helping to build and maintain program integrity for the intervention, these factors have included the following:

- A series of detailed program manuals, with separate manuals for the program's theoretical foundations, men's program, women's service and children's service. The theory manual addresses in detail how the program weaves together a strong gender-based, feminist lens influenced by Duluth multi-agency systemic responses that put women's and children's safety and advocacy at the core, and evidence-based practice from the corrections literature on how to tailor programs to individual offenders through the RNR framework and strengths-based approaches.
- Contributions to the theory manual made both by criminal justice social workers and corrections forensic psychologists, creating the need to deliberately integrate these two perspectives on the work in a way that provides sufficient conceptual clarity to practitioners. The theory manual also outlines the rationale and key objectives of all components of the approach, including the women's and children's service. The detailed operational manuals further

articulate the theoretical underpinnings, frameworks and strategic objectives of their respective areas of work, in addition to specifying operational practice.

- The initial training provided to practitioners across the program sites occurring as a collective endeavour, rather than through disparate trainings. This generated a common understanding of the different components of the program, including the importance of the pre-group assessment and case management sessions and the second-year maintenance program.
- The innovative context of the approach – a sense of creating something new together – and the program’s multiple accountabilities to Scottish Government frameworks focusing on the needs of women, children and the rehabilitation of men, rather than to the justice-based accreditation panel only.

A new process is being developed to strengthen program integrity by addressing some of the areas highlighted in the evaluation, including providing greater shape and delineation to some aspects of the women’s service, and exploring the extension of the children’s service to involve more direct contact and work with children (in addition to the current advocacy and service coordination/navigation role). This process will involve, as mentioned above, the recruitment of practitioners and managers across many of the trial sites to join, on a part-time basis, a centralised team with responsibility for strengthening the Caledonian System based on the evaluation findings. The team, in addition to liaising and consulting with the program sites to address these issues, will be developing an options paper for the Scottish Government on how to expand the program to work in additional contexts (e.g. its adaptation for work with lower risk men and its use in a prison-based setting). Following a recommendation from the evaluation, the program manuals will also be rewritten. While the extensive detail in the manuals appeared important to ensure that the initial development of the approach was done consistently across the trial sites, and have been extensively used as intended by practitioners, the evaluation found a need to compress the detail and writing in the manuals.

Foundational training for practitioners

An initial 6-day group work training program is provided by the Scottish Ministry of Justice for all Caledonian System practitioners involved in the men’s program component. The delivery of one such program per year is sufficient to cover all new practitioners and to grow the workforce required for the current scale of the Caledonian System rollout. Two 3-day trainings per year are also provided for practitioners engaged in the case management component of the program, which includes the 14 pre-group sessions. It is intended for refresher trainings to be conducted for practitioners every 2-3 years; however, at present these are conducted less frequently.

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