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# Standards of Practice in Domestic and Family Violence Behaviour Change Programs in Australia and New Zealand

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Domestic and family violence is a key area of concern for all professionals who work with families, with recent years seeing an expansion in the availability of intervention programs for men who perpetrate violence against women and children. This paper considers current approaches to the regulation of professional practice in this area, providing information about the changing context in which interventions are offered. The purpose of the paper is to encourage ongoing discussion about the setting of men's behaviour change program standards of practice in Australasia and to identify some key issues that require consideration.

**Keywords:** domestic violence, men's behaviour change programs, family violence, quality assurance, accreditation

**Key Points**

1. It is important that practitioners are familiar with current expectations and standards relating to work with those who are violent in their families.
2. This paper provides an overview of current work to develop standards for men's behaviour change programs in Australia and New Zealand.
3. These standards represent an attempt to improve the consistency and quality of practice in this area.
4. There is a need to carefully consider the evidence that exists to support the adoption of particular approaches to work with perpetrators.
5. There is value for family therapists to engage with the wider program sector to strengthen outcomes for families.

Questions about how the Australian community should best respond to perpetrators of domestic and family violence (DFV) have arisen frequently in recent years. The Victorian Royal Commission into Family Violence, for example, identified men's behaviour change programs (MBCPs) as the main programmatic intervention to address men's violence against women, but also heard evidence about the limitations of current MBCPs, including those that relate to variations in the assessment of appropriate participants, the content being covered, the roles and responsibilities of partner contact workers, and the duration of the intervention (State of Victoria, 2016). In short, the Royal Commission highlighted a lack of consistency in service delivery in a context in which there is a lack of compelling empirical evidence to suggest that any one type of intervention is more effective than any other. It underscored suggestions that there is a need for further reflection on the intervention models used

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with perpetrators of DFV, along with the development of quality standards and accreditation processes to guide the delivery of MBCPs across Australia (Mackay, Gibson, Lam, & Beecham, 2015).

The need to ensure that there is some consistency of practice in an area in which many different approaches to intervention are used (see Bowen & Day) is widely accepted and is consistent with a specific concern that unqualified practitioners, with little or no expertise in DFV, irresponsibly treat court-ordered referrals. For family therapists this is a key practice issue. Brown and James (2014) have, for example, reviewed the controversies that characterise work in this area in Australia, before describing key principles to guide couple and family therapists in their work with clients where DFV is an issue.

The aim of this paper is to promote further discussion about professional practice in this area by reviewing current MBCP standards of practice in Australia and identifying key issues for further work.

## Methodology

This article is based on a systematic review of English language studies on MBCPs using the Preferred Reporting Items for Systematic reviews and Meta-Analysis guidelines (PRISMA), which focus on peer-reviewed studies,[1] supplemented with a jurisdictional review of community-based MBCP sectors[2] across Australia, with overviews of other countries, including New Zealand, also included. Each jurisdiction was then reviewed through a combination of desktop review of available grey literature, Skype or telephone-based interviews with jurisdictional representatives (who were identified as in a key position of formal or informal leadership within that jurisdiction's MBP sector, and located either within government or in a non-government organisation peak body representing MBCP providers), and additional email contact with these representatives where further clarity was required.

## Standards for MBCP Delivery

Guidelines to support MBCP design and delivery were first introduced in the US in the mid-1980s, largely in response to a proliferation of new programs that followed the implementation of mandatory arrest laws for DFV (Gondolf, 1997). The general aim was to encourage providers to work in ways that more closely reflected the learnings of work carried out by victim advocates in the battered women's movement, such as helping perpetrators to understand the cycle of violence and how issues of power and control characterised their use of violence (Stover & Lent, 2014). Whilst some provided only general guidance, others clearly specified the intervention format and duration and the methods that should be used (and those that should not be), and were quickly adopted as *standards for practice* (Saunders, 2008). By 2008, at least 45 US states had developed some form of standards to regulate program practice (Maiuro & Eberle, 2008), although Arias, Dankwort, Douglas, Dutton, and Stein (2002) noted that these varied according to the means by which they were enforced or regulated. This could, for example, be through a local judicial board (e.g., in Colorado), a criminal justice body (e.g., in Iowa), or a State code agency such as public health (e.g., in Massachusetts), child protection (e.g., in Washington), or Human Services (e.g., in Illinois).


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Two basic categories of standards exist: (a) *mandatory standards*, with or without accompanying legislation, to which programs are required to adhere as a condition of being funded and/or licensed to operate; and (b) *voluntary standards*, where there is little or no inducement to comply. Boal and Mankowski (2014) have, however, noted that current requirements surrounding compliance vary widely with suggestions that, in some cases, voluntary standards may be more likely to be followed than mandatory standards; perhaps because particular voluntary standards are very well known (Arias et al., 2002). They also describe the difficulties faced by MBCP providers in meeting standards, which commonly relate to finding qualified facilitators, (inadequate) funding, meeting training requirements, high workloads, establishing and maintaining collaborations, accommodating diverse participant needs, conflict between central and local standards, and perceived gaps between the standards and evidence-based practice.

## Concerns About the Content of Standards

The main critiques of MBCP standards have come from those who have questioned the scientific basis for their inclusion (e.g., Austin & Dankwort, 1999). Holtzworth-Munroe (2001) made this point over 15 years ago when she argued that research data simply did not validate many of the assumptions underlying the standards that were in place at the time. These included the assumption 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 (including the idea that conjoint treatment is never appropriate). This is largely because there is still no clear empirical evidence that one type of intervention works any better than any other (Mackay et al., 2015). Related to this are arguments that the adoption of standards limits innovation (Austin & Dankwort, 1999), prohibit practice that might be beneficial for specific populations (Holtzworth-Munroe, 2001), and generally inhibit program development strategies that involve implementing the findings from evaluation research (Boal & Mankowski, 2014).

The critical question, however, is whether the introduction of program standards does indeed achieve the overarching goal of improving program performance and enhancing victim safety. Formative evaluations that consider this specific issue are rare. However, Boal and Mankowski (2014) did compare the characteristics and practices of 74 different programs delivered across the state of Oregon (US) at three time points between 2004 and 2008 – before and after standards were adopted. Their analysis suggested that (across all programs) the use of mixed gender group co-facilitation did increase over time (by 14%), and that program length increased by approximately 12 weeks. However, other practices (such as co-ordination with community partners) did not change. They were unable to relate these program changes to any observable change in the safety of women and children. In Australia, a significant additional issue is the ability of the non-government sector to comply with program standards in a context in which the resources required to do this are often limited and the demand for services is high.

In summary, whilst development of standards has been generally welcomed, the process used to develop standards and, in some circumstances, their restrictive nature has been the subject of some criticism (Bennett & Vincent, 2001). There are also

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important threshold issues to consider. 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) should improve confidence that compliant programs will be more effective. Setting a lower standard, on the other hand, should mean that fewer services fail to reach a minimum level of delivery. The introduction of program standards should also lead to greater transparency about those interventions that are available and, as Arias et al. (2002) have argued, facilitate a process by which those with varying interests and particular mandates can work together. They also have the potential to legitimise the need for specialised DFV knowledge, training, and intervention approaches.

## MBCP Standards in Australia and New Zealand

What follows is an overview of MBCP program standards across Australasia. An important caveat to this, however, is that it only reflects work underway at the time of writing and this is an area that is evolving quickly, with policy and funding initiatives regularly released or under development. Indeed, there have, for example, been minimum standards/professional practice guideline revisions for community-based MBCP work in both Victoria and Queensland, and a compliance framework and monitoring mechanism developed for Western Australian MBCP providers in relation to their recently revised professional practice guidelines.

The aim then is not to keep abreast of all of these developments, but to highlight some of the similarities that exist nationally in how MBCP practice is developing. Community program standards in only four of Australia's eight States and Territories (Victoria, Queensland, New South Wales, Western Australia) are considered, as well as in New Zealand. The MBCP sectors in the other jurisdictions were considered too small to warrant separate consideration.[3]

### Victoria

Victoria saw the fastest growth in the MBCP field in the mid-late 1980s and early 1990s. Until 2013, Victoria had Australia's only funded peak body or network dedicated to capacity-building and still has the largest number of funded program providers and program sites.[4] Approximately two-thirds of current funding is available through the Department of Health and Human Services, with the remainder through the justice system. Justice-funded referrals are split between those arising through the civil system (where 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 in a community-based MBCP) and through the Department of Justice, which funds community-based MBCP providers to work with those on Community Corrections Orders who are deemed to be at 'low risk'. The number of 'hard' mandates to attend has increased substantially, and now makes up over half of all referrals. The statewide telephone referral service for men who perpetrate DFV – the Men's Referral Service – has also been a significant source of referrals for over 20 years.

At the time of writing, there were approximately 20 different providers who offer programs across 40 sites. Two programs are delivered in languages other than English (Vietnamese and Arabic), with a third focusing specifically on men from South Asian countries (delivered in English). It is estimated that there are three Aboriginal-specific

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MBCPs, run either by Aboriginal community controlled organisations or by a community health service. A small number of other programs specific to culture or geographical development are in the concept or development phase, with one program also offered to gay and bisexual men who perpetrate DFV. Victorian community-based MBCPs generally provide approximately 12–20 group work sessions which follow one or two sessions of individual assessment. The Department of Justice funded programs have some limited additional capacity to supplement group work with individual sessions when indicated.

Several recommendations of the Victorian Royal Commission into Family Violence relate to 'new ways of working' to strengthen MBCP practice, in part through diversifying the nature and contexts in which these programs run, and through adopting some evidence-based practices from the offender rehabilitation literature (see Day, Chung, O'Leary, & Carson, 2009). Some significant new funding is being directed at these areas, although the lack of a sufficiently sized and skilled workforce of MBCP practitioners is a major constraining factor. The Victorian Government has created a dedicated agency – Family Safety Victoria – to oversee the implementation of the Commission's 227 recommendations.

No To Violence, incorporating the Men's Referral Service (NTV), has existed as a peak body for Victorian MBCP providers for approximately 20 years and performs a significant role in policy development, training and professional development, and to some extent research. NTV developed the first minimum standards for MBCP work in Australia, which were published in 1996. These were subsequently revised 10 years later, and are currently undergoing their second review. The initial standards were developed following concern from Victorian MBCP practitioners that some programs were not sufficiently rigorous in terms of safety and accountability. The 2006 update considered the available MBCP evaluation literature, however, consultations with program providers and practitioners in the field was the main basis for the revisions. A revised set of minimum standards has recently been published.

A 'self-regulatory' monitoring framework was also introduced with the 2006 update of the standards; membership of NTV was a prerequisite for an NGO to be eligible for Victorian Government funding and, to be a member of NTV, the NGO needed to declare that it met the minimum standards. NTV also established a complaints mechanism whereby any member of the public could register a complaint against a program provider in relation to non-compliance with the minimum standards, although the number of complaints has been low.

### Queensland

The MBCP sector in Queensland is currently undergoing significant reform. However, Queensland MBCPs first developed in the late 1980s, with the field experiencing rapid development in the first half of the 1990s before growth in the number of State-funded programs slowed. As of 2014, Queensland had approximately 20 MBCPs, with two-thirds funded by the State Government, and just under one-third relying on Commonwealth funds, and one program funded by a mining company (Monsour, 2014). At least one Aboriginal and Torres Strait Island-specific MBCP is run in Queensland (in Rockhampton), with further programs and initiatives in the State's far north.

Funding levels in these programs is modest, with most programs funded for less than the equivalent of a full-time staff member. However, new funding is being

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released, which should result in an expansion of the number of programs available, and their geographical coverage. Historically, partner contact work has not been supported, with the expectation that program providers should find funds from other sources to conduct this work (despite it being an essential requirement of the current practice standards; Monsour, 2014).

Major referrers to MBCPs are probation and parole, child protection, the Magistrates' Courts, DV Connect Mensline, family law solicitors, internal referrals from larger relationship services based agencies, and police active referrals (Monsour, 2014). Recent reforms have seen designated DFV practitioners being placed as part of family support services although, to date, this does not appear to have strengthened their capacity to engage with perpetrators and provide referrals to MBCPs. Similarly, the 'Walking with Dads' initiative involves specialist perpetrator engagement practitioners working in child protection across five trial sites, matched with funding for the development of new MBCPs in these locations to promote safe parenting capacity for DFV perpetrators. A recent initiative has been to increase the number of referrals from civil protection order proceedings in 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 participation in a MBCP or equivalent individual counselling).

The Queensland Professional Practice Standards stipulate a minimum program length of 32 hours, with most programs around 32–40 hours' duration spread over 13–16 weeks. Whilst 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 have been available for quite some time.

The *Not Now, Not Ever* report, led by the former Australian Governor-General Quentin Bryce, 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). These have informed the Queensland Domestic and Family Violence Prevention Strategy 2016–2026, which is currently in the Second Action Plan 2016–2019.[5] This second action plan includes strategies to expand the number of perpetrator intervention services to enable them to respond to more perpetrators and engage new services (including where high-risk teams are being rolled out as part of an integrated service response). It also calls for the review and updating of the current Professional Practice Standards; broadening the scope to include individual counselling, culturally appropriate approaches to Aboriginal and Torres Strait Islander clients, young offenders and the provision of information to respondents appearing at court. It highlights the need to develop a quality assurance framework and audit process to ensure ongoing compliance with these initiatives. The current professional practice standards were first developed in 1997, and updated in 2007. They were developed through a program provider driven, 'bottom up' process, and did not reference relevant literature.

### New South Wales

Whilst a handful of MBCPs were available in the 1990s, State Government funding in NSW was not available until 2015, when significant funding for four pilot sites was released. At the time of writing, nine providers were registered to provide programs across 18 different sites. Most of these programs are in the Sydney region and

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along the eastern seaboard, although coverage across other areas is expanding as more funding becomes available.

The responsibility for minimum standards and compliance monitoring processes rests with the NSW Department of Justice. These were first launched in 2012 and proved contentious as program providers, who at that stage received no State Government funding, were required to comply with minimum standards in order to obtain referrals from State Government authorities and services. The minimum standards document has recently been revised and updated, with new standards introduced, consideration of children's needs strengthened, and more emphasis given to collaboration with partner agencies, cultural adaptiveness, and the Risk Needs Responsivity (RNR) framework as a guiding philosophy for program design and delivery. The RNR framework is a differentiated case management model that is widely used by correctional services to allocate services on the basis of assessed risk of re-offending (see Day et al., 2009).

A practice guide was also commissioned by the NSW Department of Attorney General and Justice to accompany the standards (NSW Department of Attorney General and Justice, 2012). This provides detailed advice about how providers can meet each of the standards at 'acceptable' and 'optimal' levels. This is Australia's only detailed practice guide[6] and, at approximately 280 pages, contains detailed information about program tools and templates that program providers can download and adjust for use in their local setting. Adapted from guidelines developed by the UK peak body for perpetrator intervention programs, UK Respect, it contains one of the few tools available to assist MBCP providers to determine when it might be safe and appropriate to offer, or refer to, couple counselling work in the context of DFV. The tool specifies a number of specific requirements for couple counselling to be considered a safe option, with examples of some of the identified indicators of behaviour change reproduced in Table 1.

**TABLE 1**

Examples of Indicators of Behaviour Change (Adapted from the NSW Department of Attorney General and Justice, 2012, pp. 240–241)

| |
|---|
| Has there been a sufficient period without violence to indicate a change in pattern and an acceptably low risk of him again using physical, sexual, emotional, social, financial and other forms of violence, or of him introducing new forms of violence? |
| Does he understand that she might never feel totally safe in the relationship, and might therefore retain some degree of hyper-vigilance of signs that he might use violence again. Similarly, does he understand that in situations where he might raise his voice tone or express ordinarily acceptable levels of frustration, moodiness or anger, that she might feel some level of fear that he is moving closer to using violence again? Does he accept this, and the need for him to show some care in these expressions, even though he might not be at risk in these situations of using violence again? |
| Does he understand and acknowledge the impacts of his violence on his victims and on the children it may have effected? In so far as there are discrepancies between his idea of these impacts and the views of others such as his partner, can these be safely discussed with him? |
| Does she [the victim] believe that she is now safe to argue with the client, to confront difficult issues and to express anger towards him and that she can do so without fear? |

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The NSW Department of Justice operates a registration process, whereby program providers seeking to be accredited (and to receive referrals from government authorities and services) undergo a detailed application process that requires them to provide a narrative to explain how they will meet every standard, as well as to provide documentary evidence of supporting policies and procedures.[7] No monitoring or auditing activities occur until re-registration is required which is, in part, a pragmatic consequence of the lack of MBCP capacity within the NSW Government to conduct ongoing audits.

### Western Australia

The MBCP sector in WA has existed for at least 25 years. Throughout much of this time, a small number of providers (two to four) have delivered MBCPs across multiple sites. Currently, four providers are contracted by the State Government to provide programs over approximately 12 locations, mostly in Perth. There are few programs offered in rural and remote regions.[8] Funding for MBCPs has been mainly through the Department of Communities and the Department of Corrective Services. Most programs include about 26 sessions of group work activity and some also offer additional individual sessions. Innovations in MBCP program provision include a residential MBCP,[9] and a joint MBCP and substance abuse intervention program.

Until recently, Western Australia had six specialist family violence courts feeding referrals into MBCPs, which have now been replaced by a new model that manages family violence offenders in mainstream courts through a dedicated family violence list process. The Western Australian Government has also recently announced plans to develop a mandatory referral pathway for perpetrators into MBCPs arising through civil justice system protection order processes.

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.[10] SFV assisted with the development of WA'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 has investigated the possibility of developing an accreditation framework for provider compliance in relation to the State's professional practice standards for MBCP work.

Initially developed in 2000, and updated in 2015, the *Practice Standards for Perpetrator Interventions*[11] focus on five headline standards, worded the same as the NSW minimum standards. These are associated with 31 individual standards, which also draw heavily from the NSW standards.[12] The standards are written to be as minimally prescriptive as possible, and there is no current system for compliance monitoring.

### New Zealand

In New Zealand, Ministry of Justice funded programs for protected persons, children, and perpetrators are guided by a six-volume Domestic Violence Service Provider Code of Practice that was first released in 2014 to provide guidance in relation to the Domestic Violence Amendment Act 2013, 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 manuals and the Code serves as a detailed practice guide


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exploring program implementation issues, and discussion of how to implement each of the standards to an acceptable level. For example, 24 standards cover 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 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 guiding legislation.

## Discussion

Domestic and family violence is clearly an area of significant interest for every practitioner who works with families. In response to recent reviews and inquiries, there has been an unprecedented focus in Australia on both describing and prescribing the interventions that should be made available to those who perpetrate this type of violence. Generally, the current standards offer little support for approaches that focus solely on understanding and changing unhealthy family dynamics, or that conceptualise DFV as arising out of the interacting behaviours of two or more people within a family as a result of deficient communication patterns (see Neidig, 1984; Nicholls, 2007). The overarching goal of MBCPs that comply with current standards is thus not to identify and change communication patterns, but rather to facilitate the understanding of how the (implicit and explicit) societal sanctioning of men's power and control over women promotes behaviour that leads to violence (e.g., financial control, intimidation, minimisation and denial, male privilege, isolation) and to provide participants with the skills to act differently. Importantly, the goal of intervention is not only to bring about individual change, but also to support a multi-agency approach to women's safety that is more closely linked to the judicial system (see Babcock, Green, & Robie, 2004). Current standards help to specify how these goals might be achieved.

The aim of this paper is to promote discussion among the professional readership of this journal about current approaches to intervention in an area that is characterised by disagreement (and perhaps disengagement) in an administrative and practice context that is evolving rapidly. The setting of practice standards raises important issues for family therapists, in relation to clarifying how they can meet community expectations about what constitutes and appropriate therapeutic response to violence. For example, 'couples therapy' is one approach that is not endorsed in many of the standards currently in place across Australia, with Brown and James (2014) recommending that family therapists should ensure that men who use violence should 'complete a program about taking responsibility for their violence *before* working with them in couples' therapy' (p. 180, italics added for emphasis). This advice is not reflected in current standards of practice in the DFV sector, nor are there any mechanisms to determine whether (or not) it is being followed or, indeed, whether violence in families reduces or increases as a consequence.

It may be that readers of this article will conclude that the current standards are too prescriptive and have unjustifiably disenfranchised family therapists from working with families who experience violence. This, however, is not our position. In our view, this is an area where the risk of iatrogenic intervention is particularly high and

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there is an overarching responsibility not to increase risk of further harm. Whilst we draw attention to the need to develop a much stronger evidence-base (about the relative effectiveness and potential harms of different types of intervention), before any particular approach can be endorsed, we see an overarching need to promote greater consistency of practice. We suggest that it is particularly important that both perpetrators and victims of violence (and indeed the wider community) have a clear understanding about the type of service that they can expect to receive should violence occur. However, there is also a need to consider the evidence underpinning each of the current standards before determining whether they should be compulsory (in circumstances where compliance can be shown to improve safety) or voluntary (when there are grounds to expect that they might be helpful).

At the same time, whilst some practitioners may see the setting of standards as intrusive (and even, at times, counter-therapeutic), engaging in the ongoing development of standards may help to inspire them to shape effective and accountable practice. For example, the distinction between supporting a moral imperative versus enabling an ethical striving to cease violence opens up the possibility for wonderful collaborations in this complex field of work (Alan Jenkins, personal communication). More broadly, we suggest that there is a need for all of those who practise in this area to reflect carefully on their underlying theory of DFV and how they understand the process of behaviour change, and to consider ways in which they can learn from others who have experience in the field. It seems self-evident, for example, that the experience of family therapists can add value to the way in which psycho-education providers work with perpetrators of violence, just as the experience of these professionals in helping perpetrators to recognise how coercive control occurs in a context in which power and control over women is socially sanctioned can assist family therapists to work in ways that effectively communicate how responsibility for violence will always lie with the perpetrator. There has, for example, been considerable acknowledgement in some therapeutic and systems-informed fields of DFV as a social problem, through the application of socio-cultural frameworks centred on an analysis of power.

Indeed, in Australia, narrative therapeutic practice through the work of Alan Jenkins, Michael White and others has provided a foundation for the development of both group-based and individual work with perpetrators in the men's behaviour change field (e.g., Jenkins, 1990, 2009). Much like modern Duluth-based dialogical processes where work with perpetrators is informed by Freire's (1970) approach towards *conscientisation*, narrative practices critique psycho-educational approaches that attempt to use the facilitator's power to instil new beliefs in clients. Narrative practice posits that men's behaviour change program work is most effective when men are invited, through careful and respectful processes, to identify the beliefs and ideas from which violent and controlling behaviours stem. And further, to explore the impacts of these beliefs and ideas on family members, on their own ethical strivings to be the best man/partner/father they can be, and on their roles and responsibilities within their community (Augusta-Scott, 2006; Jenkins, 1990, 2009). There is, in addition, rapidly growing interest in engaging with correctional models of offender rehabilitation (specifically through the matching of the assessed level of risk to the intensity of intervention).

One of the most challenging aspects of regulating MBCP practice is the setting of criteria for when a particular standard (or indeed program) can be considered to the 'evidence-based'. This is a term first used in health-care settings in the early 1990s to

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describe a particular approach to medicine (Rycroft-Malone, Seers, Titchen, Harvey, Kitson, & McCormack, 2004), but it was quickly imported into other areas of human service delivery (e.g., Gendreau, Smith, & Thériault, 2009), with different agencies subsequently developing their own thresholds for assessing whether (or not) a particular practice qualifies as evidence-based; with some applying a more rigorous standard than others (Mihalic & Elliott, 2015). In the criminal justice arena, for example, these judgements are often made by the strength of outcome research that is available.

The University of Maryland Scientific Methods Scale (Sherman, Gotfredson, MacKenzie, Eck, Reuter, & Bushway, 1998), which was originally developed to assist US congress select effective crime prevention initiatives, is a good example of this approach. The scale classifies evaluation studies according to five levels of methodological quality; with legislation enacted in some US States that now requires local agencies to compile inventories of evidence-based practices and only implement those which are included (Wanner, 2018). This has not been the approach adopted by the MBCP providers in Australasia, given the absence of any robust evidence base to demonstrate that practice does lead to behavioural change. Nonetheless, implicit in this policy is the idea that evidence should be collected that can inform such decision making.

An additional, but nonetheless, also important issue going forward is practitioner training. There is very little foundational training for MBCP practitioners available across Australia, although a graduate certificate is available in Victoria and is to be introduced in NSW. Further, this training is rarely taken up by practitioners working outside of the specialist MBCP sector and so does little to influence the DFV practices in broader family therapy contexts. These programs aim to equip practitioners with the skills to work competently and safely with those who perpetrate DFV, but are limited in their capacity to offer training in a range of different therapeutic modalities.

Our conclusion from this review, however, is that more work is needed to provide evidence to support the key assumptions about violence and behavioural change that underpin different approaches to MBCP practice if standards of practice are to significantly improve the safety of women and children who experience DFV in Australasia.

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## Endnotes

[1] The initial search yielded 11,304 hits. After duplicates were removed (N = 1,120), titles and abstracts were screened and 269 studies were considered potentially relevant. Full-text articles were then accessed. Key words used in the initial search included variations of: domestic violence and abuse, intimate partner violence and abuse, spouse violence and abuse, batterer, and were cross-referenced with terms such as program, evaluation, treatment, intervention and therapy.

[2] The term 'sector' is used here with caution. 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.

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[3] The Australian Capital Territory Government funded only one agency to provide a community-based MBCP, with this program still in establishment phase at the time of writing. Only one MBCP existed in the Northern Territory that is run by a community-based provider. The South Australian Government is in a consolidation phase with respect to community-based MBCP provision and, at the time of writing, is conducting consultations with the sector towards a more consistent approach and to develop the state's first official minimum standards. The Tasmanian Government funded one provider of community-based MBCP work across three sites.

[4] At the time of writing, approximately 3,500 places were funded for Victorian MBCP work – however, this is likely to increase with additional funding released in 2018.

[5] These documents can be obtained from https://www.communities.qld.gov.au/gateway/end-domestic-family-violence/dfvp-strategy

[6] See http://www.crimeprevention.nsw.gov.au/domesticviolence/Pages/MiniStandardsforMen'sBehaviour/Support_for_program_providers.aspx

[7] Approximately 20 different documents are required overall as part of the application.

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

[9] See https://www.communicare.org.au/Accomodation-Services/communicare-breathing-space.html

[10] See sfv.org.au

[11] See https://www.dcp.wa.gov.au/CrisisAndEmergency/DFV/Documents/2015/PracticeStandardsforPerpetratorIntervention.pdf

[12] 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".

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