Joplin Higgins

Rehabilitating domestic violence perpetrators

An Australian and International Analysis and Evaluation of Men's Behaviour Change Programs

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Summary

Scope of Paper

The report focuses on domestic violence against women and children and behaviour change programs for adult men who use violence in heterosexual relationships. Men who use violence were chosen as the focus as they make up the majority of those responsible for domestic homicide and targeting this group is seen as the priority. The research was narrowed for this purpose and includes Indigenous perspectives. Culturally and Linguistically Diverse (CALD), LGBTQIA+ groups and men under 18 who use violence were not considered. Domestic violence against men was not considered. These groups could use additional and specialised research to further understand their experiences.

It is hoped this report can be used by a variety of disciplines and to inform policy addressing domestic violence, particularly interventions and programs for men who use domestic violence.

The recommendation of content for an effective Men's Behaviour Change Program in Australia was not proposed, although the current content in programs in Australia and internationally was considered throughout the report. The specific contents of a program are outside the scope of the report and expertise and will need to be informed by those qualified in behavioural science, psychology, psychiatry, criminology and adult education and taking into account the risks and needs of perpetrators and their families explored throughout the report.

Research Methods

A wide range of resources were reviewed for the report including academic journals relating to law, psychology, criminology, social science, trauma and feminism, news articles, government reports and policies, presentations and conferences, books, websites, interviews and phone calls. Research organisations such as ANROWS, Australian Institute of Family Studies and Australian Institute of Criminology were utilised. Both Australian and international programs were considered. Common search terms used in databases and search engines included:

- Alcohol related violence
- Attachment and violence
- Batterer intervention
- Batterer programs
- Behaviour change
- Biopsychosocial model and violence
- Child abuse
- Children experiencing domestic violence
- Children exposed to domestic violence

- Child protection and domestic violence
- Coordinated response to domestic violence
- Domestic abuse
- Domestic homicide
- Domestic violence
- Domestic violence and child protection
- Domestic violence and court
- Domestic violence prevention
- Domestic violence responses
- Domestic violence training
- Ecological model
- Emotional violence and abuse
- Engaging men
- Entitlement and violence
- Family violence
- Family violence and court
- Fathers who use violence
- Focused deterrence and violence
- Indigenous men's behaviour change programs
- Indigenous violence
- Intimate partner homicide
- Intimate partner violence (IPV)
- Men who use violence
- Men's behaviour change program
- Men's violence
- Parenting and violence
- Perpetrator intervention
- Perpetrator programs
- Physical violence and abuse
- Power and control
- Psychological violence and abuse
- Sexual violence and abuse
- Toxic masculinity
- Violence against women

Definitions

Attachment: The emotional bond formed between a child and caregiver, usually the mother and infant. Early attachment is thought to have significant impacts throughout a child's life and into adulthood, influencing how a person forms emotional bonds with other people later in life.

Children: Person aged between 0-18.

Coercive control: The term established by Evan Stark refers to an act or pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. Coercive control limits the persons autonomy and abuses the unequal power dynamic in a relationship. Behaviours can include limiting access to money, monitoring communication and location and isolating the victim from family and friends.

Co-parenting: Refers to post-divorce or separation parenting where both parents share responsibility and participate in the child's care and upbringing. This can include married or de-facto couples.

Domestic violence/violence: Includes acts of violence that occur between two people who have or previously had an intimate relationship and is aimed at controlling the person through fear. Behaviour includes physical, sexual, psychological and emotional abuse. Family violence extends to family members not in the intimate relationship and can include siblings and children. Terms also used include intimate partner violence or domestic abuse.

Father: A male parental figure that is present and participates in a child's life and upbringing. For the purpose of this report, it includes stepfathers.

Fathers who use violence: Fathers who perpetrate violence involving, against or in the presence of children. This includes children living in the family home, witnessing violence against their mother or experiencing the aftermath post-violence such as property damage or emergency responses to violence.

Gender: Either of the two sexes (male and female) and the range of characteristics related and differentiating between femininity and masculinity. This can be based on biological sex and identity.

Historical/intergenerational trauma: Refers to the cumulative harm of an individual or generation caused by a traumatic experience or event. It is multigenerational and often experienced by a specific, cultural, racial or ethnic group. The terms asset trauma can be transferred through generations through parenting practices, behavioural problems, violence, harmful substance use and mental health. The study of epigenetics suggests trauma may even leave chemical marks on a person's genes which is then passed through subsequent generations.

Indigenous people: People with familial heritage to groups that lived in Australia before British colonisation. This includes Aboriginal and Torres Strait Islander people. The term First Nations People may also be used.

Perpetrator: A person who carries out a harmful or illegal act. For the purpose of this report, the perpetrator refers to the person (typically male) committing violence against another person (typically female). May also be referred to as the primary aggressor or batterer.

Trauma: Trauma refers to an experience that causes overwhelming amounts of stress that exceeds the person's ability to cope or integrate the emotions involved. This can include

physical, psychological or emotional trauma. It is often prompted by a deeply distressing or disturbing event but can also involve the chronic stress of repeated events over a period of time. The repeated exposures 'add up' or cumulate.

For the purpose of this report, trauma also includes secondary trauma and vicarious trauma (trauma you may witness or exposure to upsetting details of trauma experienced by another person).

Typology: Study of or analysis or classification based on types or categories and common characteristics. Typologies are typically used in social science and psychology.

Victim: A person who is harmed or injured as a result of an event or action. For the purpose of this report, the victim is typically female and experiences physical, psychological or emotional harm or injury as a result of domestic violence.

Background

Domestic violence is a serious public issue in Australia calling for an intensive multi-agency response to victims, children and perpetrators of domestic violence. There is a need for policy to promote and balance immediate and long-term change. Statistics in Australia show at least one woman a week dies due to domestic violence.[1] Further, the murder of children in Australia by fathers usually happens when there has been a history of domestic violence.[2] The prevalence of children experiencing domestic violence is estimated to be between 4-23 per cent.[3] Targeting and correcting men's violence is one way of protecting and ensuring the safety of women and children, operating alongside criminal and health responses as well as victim services. To prevent violence there needs to be a focus on perpetrator's behaviour. Domestic violence creates "an unhealthy and toxic family environment that devastates the lives of all family members."[4] Changing perpetrators behaviour can improve circumstances for all members of the family.

Men Behaviour Change Programs (MBCP) also referred to as Batterer Intervention Programs, place accountability and responsibility for domestic violence on the perpetrator, aiming to reduce and eliminate abusive patterns of behaviour. Overall, in comparison to other developed countries, Australia's MBCP lack the intensity required for significant behaviour change. Reforms to

domestic violence has been reactive, lacking a coordinated response. Responses have been predominantly focused on crisis and post-crisis as opposed to primary and secondary prevention.

$328 million dollars in 2019 was allocated by Scott Morrison to combat domestic violence.[5] Funding was directed towards housing solutions and frontline services for women and children. The NSW Domestic and Family Violence Blueprint extended its funding to $431 million dollars in 2019-2020 however, it was unclear whether there would be any additional funding for MBCP in Australia despite the significant waitlists for programs.[6] Whilst crisis interventions are vital for immediate safety, they "are not set up to undertake the long-term work required to prevent family violence or heal its consequences."[7] Approaches currently place a significant burden on the victim, responsibility on victim services and lack perpetrator accountability. Perpetrator accountability should be a nation-wide priority.

Considering programs in other countries, particularly where programs can run over a year and operate from residential facilities, it seems Australia is not taking the role of MBCP to correct abusive behaviour seriously. This greatly hinders Australia's ability to prevent domestic violence and coercive control using MBCP. Responses to domestic violence have predominantly been from a legal perspective. Whilst the law offers a mechanism to make it clear publicly domestic violence is unacceptable and encourage a cultural shift, MBCP are an alternative to punishment and promote longer term, generational change.

The responsibility of addressing domestic violence has been largely placed with women's organisations and seen as a women's (feminist) issue.[8] Investing in MBCP relieves victim services of some of the burden of addressing domestic violence. Interventions need to be engaging with perpetrators as well as men who do not use violence to support sustained change. Prevention work is more likely to be effective when the "whole population is involved and work at all levels of society."[9] The 'not all men' argument "alleviates the majority of men from responsibility."[10] Domestic violence can be prevented and requires long-term solutions. Effective MBCP play an integral role in Australia's response to domestic violence.

What are Men's Behaviour Change Programs?

MBCP refer to group programs working with men who perpetrate domestic violence against women. They focus on enabling men to recognise domestic violence and develop strategies to stop them from using domestic violence and coercive control. Programs also look at attitudes and beliefs contributing to domestic violence and the effects on children. Hearing other men's stories

and accountability for domestic violence throughout programs can act as a motivator for change.[11]

There are a variety of programs currently operating in Australia and demand for programs is increasing,[12] with waitlists ranging from 6-8 months. Programs are facilitated by a variety of service providers on a state-by-state basis. Programs have predominantly developed unsystematically. Following the development of MBCP, states developed minimum practice standards and compliance frameworks for programs to adhere to. Most state practice standards have been developed from Victoria's *'No to Violence'* framework. Programs must comply with state standards to be accredited.

The length of programs varies, typically ranging from 12 to 20 weeks. Each session ranges from two to four hours. The longest program in Australia runs for 40 weeks, with an ongoing support group post-completion.[13] The program, Heavy METAL, explores a range of topics including abusive behaviours and their impact, basic skills to promote safety, behaviours and beliefs systems, gender roles, communication skills, emotional wellbeing and conflict resolution. The topics span over three phases. Perpetrators can repeat the program or one of the phases if required. This may occur because of feedback from the participant's partner, failure to grasp certain concepts or if the participant identifies they require further support.

Minimum practice standards outline programs that run for less than 12 weeks are viewed as less effective.[14] Research with general perpetrator populations suggests longer programs might be more effective at reducing recidivism. More frequent sessions may assist in reducing reoffending at the beginning of the program when there is an increased risk of reoffending.[15]

However, there is no clear evidence relating program length to treatment effectiveness relating to domestic and family violence perpetrators.[16] Despite this, there are other benefits associated with longer programs including:[17]

- the opportunity to monitor perpetrators.
- commence and maintain engagement particularly men with low readiness to change.
- time to work with women and children.
- tailoring of programs to individual needs.
- opportunity to revisit certain skills and topic areas within the program.

Due to the community needs, short but intensive programs may run, especially in Indigenous communities where participants are eager to return to country and life in remote locations.

Types of Programs and Frameworks

There is significant variance in the content of MBCP across states, as well as internationally. This includes the length of the program as well as the topics and skills covered, support for victims and children, inclusion of one-on-one counselling and follow up support.

Professional frameworks utilised include the Duluth model,[18] cognitive behavioural therapy (CBT), trauma informed practice, narrative therapy and motivational interviewing. Programs may take a psychoeducational, psychotherapeutic approach or a combination of both.

Programs such as the Duluth model are focused on the idea of accountability for one's actions and involve challenging beliefs, attitudes and perpetrators relationship with power and control. The model uses the power and control wheel.[19] The Duluth model also integrates a feminist approach, including content focusing on gender inequality in broader society and how it contributes to domestic violence. Addressing inequality on a broader level is one way of addressing domestic violence.[20] Domestic violence is located in a social context, focusing on unequal power relationships and men's violence as an outcome and response to gendered inequality.[21]

Dominant forms and patterns of masculinity and men's attachment to gender roles help drive violence against women.[22] Men's emotional development is thought to be influenced by the pressure to suppress their emotions and regulate how they express themselves. This attitude to 'opening up emotionally' creates a barrier when engaging with men.[23] Because the Duluth model is grounded in "learned behaviour" treating psychological problems or personality traits is not part of the process.[24] This approach is contradicted by research in relation to the trauma background of perpetrators and Cluster B personality traits.

CBT involves the consideration of psychological processes which the man grants himself permission to be violent. Programs help men identify the physiological signs, thoughts and feelings prior to incidents to prevent future violence. It also considers the underlying beliefs and thought patterns of the perpetrator that contribute to violence.[25]

Perpetrators can undertake multiple programs simultaneously to address different needs such as substance use and mental health conditions. Research suggests men who address multiple needs at the same time do better in the program.[26] Addressing multiple needs also prompted lasting change.[27] Alcohol abuse is a significant risk factor for domestic violence, highlighting the importance of addressing these vices alongside attitudes and beliefs towards women. Programs for Indigenous men in Australia have a stronger focus on culture, narrative therapy and are more likely to engage a trauma-informed approach to address the needs of participants.

Benefits of MBCP

MBCP has the potential to benefit perpetrators and victims of domestic violence and coercive control in a variety of ways. MBCP addresses the behaviour at the source and places accountability solely on the perpetrator. Many perpetrators have been found to repeat abusive behaviour in future relationships.[28] If domestic violence is corrected, this results in greater long-term safety for women and children in the relationship or future partners.

Research suggests reoffending rates post MBCP may be better than reoffending rates post-imprisonment.[29] However, some research suggests there is not a significant reduction in reoffending rates, contributing to a reluctance to fund programs. 22 studies found that perpetrators who underwent CBT or Duluth model treatment programs had a 35 per cent chance of recidivism, while perpetrators who did not undergo treatment had a 40 per cent chance of recidivism.[30] Sentences for domestic violence offences are typically short and have not shown evidence they correct abusive behaviour. MBCP are more cost-effective than prison and have the potential to reduce the health burden posed by domestic violence.

MBCP accounts for the fact women are likely to return to an abusive partner for a variety of reasons. Research outlines, it takes at least seven times for a victim to leave and not return to an abusive partner. [31] MBCP helps protect women who are not able to leave the relationship, do not have access to safety measures offered by criminal justice responses or victim services or must maintain contact with perpetrators due to co-parenting arrangements.

Research outlines 80 per cent of victims still live with or have contact with the perpetrator. This may be a result of co-parenting or returning to the relationship.[32] Another study indicated an upward of 50 per cent of women return to their partners after leaving domestic violence emergency accommodation such as shelters.[33] Victims have been reported to say, they do not wish to leave the relationship, only they want the abuse to stop.[34] Programs can additionally provide support to women and children as well as monitor perpetrators in the community that may not be monitored by police or other responses such as child protection, family court and the criminal court.

Domestic violence does not cease once the relationship does. Separation is a high-risk time for victims and children. A study by Catherine Humphreys emphasised the "absent presence" of perpetrators in the lives of children who had experienced domestic violence, highlighting the multiple ways the "shadow of the perpetrator of violence continued to be cast over the lives of children and their mothers, even following separation."[35] Humphrey's research found fathers

who use violence often had poor parenting skills resulting from entitlement, self-centred attitudes and controlling behaviour.[36] They also were more likely to overuse physical discipline and have a poor understanding of child development.[37] Despite the history of domestic violence, children in separated families were still having time with their fathers. The types of abuse were not systematically recorded however involved hospitalisation, incidents of serious physical and sexual violence, stalking and highly controlling tactics of abuse.[38]

77 per cent of mothers reported one or more of their children were mainly living with their father who used violence on a shared care, full-time basis or having substantial over-night care unsupervised.[39] Typically men continue to have contact with their children or move on to new families. With interventions focused on separation and not correcting men's behaviour, this is of significant concern for children who are still having frequent contact with fathers who use violence. The ongoing presence of the father after separation demonstrates the need to develop interventions for all members of the family to keep women and children safe. Early intervention is extremely important for children's short and long-term outcomes.

Programs that correct abusive behaviour effectively offers greater protection for children who have contact with abusive fathers. The occurrence of other forms of child maltreatment with domestic violence is high.[40] Co-occurrence of maltreatment and domestic violence provides an opportunity for programs to address both issues simultaneously. The role of fatherhood can be a motivating factor for fathers who use domestic violence and want to be better parents to their children. Some programs operating in Australia are specifically for fathers including Caring Dads.

Current responses to abusive fathers are less focused on correcting the behaviour and rather aims to separate them from their families and limit time with children,[41] to protect and isolate them from further violence. Solutions to domestic violence cannot only be focused on women leaving violent relationships. In practice, the research suggests this is not what is occurring and places a significant burden on victims and victim services. Responses to domestic violence need to explore other alternatives that corrects the behaviour rather than depending on victims and children to be able to leave the relationship safely. MBCP that are effective will reduce the harm to women who remain in contact with perpetrators, either in an intimate or co-parenting relationship as well as children who have a relationship with their father. Programs are essential to eradicating domestic violence long-term and preventing the transmission of trauma as a result of abuse. Only funding crisis responses will not be enough to prevent or eliminate men's violence.

MBCP as Part of a Coordinated Response

Court mandating of programs

In Australia, MBCP are usually court referred or participants can self-refer. Men are often referred to the program once they have been charged with a criminal offence. In the USA, BIP are court mandated and completion of the program and participants' engagement can influence sentencing and imprisonment. For MBCP to be effective in Australia, programs need to be exist in a strong community coordinated system, including consistent criminal justice responses that promote accountability for the perpetrators actions.

There has been a push for intervention prior to domestic violence reaching the severity of criminal charges.[42] Engaging with perpetrators needs to begin early. This could be achieved by increasing men's awareness and motivation to seek help for violent behaviour.[43] However, men who have been court ordered to programs have demonstrated a statistically better outcomes than men who were not court ordered.[44]

Referrals may also be made through the Family Court, Local Court or state child protection services. Groups can operate on a rolling basis, where participants can join at any time or have a fixed start and end date.

Judicial officers responsible for referring perpetrators to MBCP in Australia have expressed they have limited access to information on programs available and previous completion of programs by perpetrators.[45] Access to an in-depth history of the perpetrators pattern of offending is also limited.[46] Research by ANROWS has indicated knowledge on programs is not unform across jurisdictions and there is difficulty in staying up to date on perpetrator programs and their availability.[47]

For Indigenous perpetrators, the Koori court provides a therapeutic style of punishment to involve the Indigenous community to achieve better outcomes than simple punishment.[48] Elders hear cases alongside the magistrate and assist in counselling perpetrators and victims and advise on support services and solutions.[49] The Koori court is able to be used when the perpetrator has taken responsibility and pled guilty to the offence. The court recently implemented the Umalek Bait (Koori Family Violence and Victims Support Program). Domestic violence offences can now be heard in the Koori court and a specialist family violence practitioner, male and female workers to work with women and the perpetrators of violence. Strong Indigenous leadership and voices has led to better outcomes than other jurisdictions with a high demand for accountability and action.[50] The court has employed careful case management and court officers are familiar with the history of the perpetrator.[51] Referrals can be made by the court to MBCP relevant to

Indigenous men, accounting for domestic violence in the context of the ongoing effects of colonisation, intergenerational trauma and substance abuse.

Focused deterrence

The Australian Crime Commission has recently released a paper on three years of research focusing on the application of focused deterrence in Australia for domestic violence perpetrators. The prevalence of domestic violence has not decreased and calls for a different criminal justice approach. Traditional responses do not appear to be deterring perpetrators and places a burden on victims to report to police.

The most common criminal response to perpetrators is domestic and family violence protection orders (DFVPO). Protection orders are available across all states and apply nationally, however there are significant variations in language, scope of behaviours and relationships covered, conditions, breaches, penalties, information and local law enforcement practice.[52] These variations all have implications for enforcement of DFVPO. The research outlined practitioners felt victims lacked adequate support to report DFVPO breaches and that perpetrators were not taking breaches seriously.

Whilst these may be useful in severe cases of domestic violence, where the victim and perpetrator no longer have ongoing contact, they are not always suitable in situations where a relationship is maintained, such as co-parenting arrangements. Domestic violence can continue post-separation and parents are required to maintain some level of contact to effectively co-parent. Solutions focusing on eliminating contact with the perpetrator may not be viable in all situations.

Focus deterrence is a criminal justice led response, integrating criminal punishment and key stakeholders of social services and departments in the local area. It has been used in multiple countries to target crime. The use of 'focused deterrence' begun in Boston in the 1990s as a response to youth gun violence.[53] Focused deterrence utilises the strategic use of the law and offers intensive support to perpetrators who want to change their behaviour. Fairness and respect is extremely important to focused deterrence engagement with perpetrators.

There are several components that are fundamental to focus deterrence including:[54]

- identification of a specific crime problem
- the establishment of an interagency group involving local agencies
- detailed analysis of data on perpetrators

- direct communication with targeted individuals to notify them they are being monitored, inform them of consequences and highlight action taken against other perpetrators
- improving victim and perpetrator access to support services and offering support to perpetrators to help change their behaviour
- drawing on the full suite of legal actions available to stop offending

Focused deterrence relies on sanctions viewed as "swift and certain" and requires the provision of social services before legal action,[55] relying on partnership and change at all levels of the systems involved.[56] To be effective, focused deterrence requires a "timely, targeted and graduated response."[57] In a review of focused deterrence it was argued focused deterrence works "better than anything else out there."[58] Intervention matches the intensity of risk, placing perpetrators on a tier of offending. However, all perpetrators receive some level of response. Data and information sharing is utilised in the approach. Law enforcement and respective agencies take "ownership" of the problem,[59] relieving some of the burden on victims.

In North Carolina, USA, focused deterrence has been used to reduce domestic violence with substantial results. North Carolina has been the first community to use the strategy to target domestic violence. Perpetrators at risk of killing their partners have been confronted with a strong message "if they didn't stop abusing their partners, police would pursue them relentlessly and impose severe penalties, including long-term prison sentences."[60] The stern threat was additionally met with offers to support these men with whatever they needed to stop their abuse. Support included counselling, employment and treatment for addiction. North Carolina saw a significant reduction in intimate partner homicide and injuries related to domestic violence offences.[61] Funding has been allocated to implement the approach in other communities. Due to the similarities in patterns of offending in the USA and Australia,[62] it has been argued there is compelling evidence Australia could benefit from a focused deterrence approach.[63]

Data indicates a small proportion of domestic violence perpetrators are responsible for a disproportionate number of incidents.[64] A perpetrator typically reoffends within a five-year period after their first offence, with the majority of offending taking place within the four-week period after being charged with their first offence. This suggests targeting specific perpetrators within this period would assist in reducing incidences more effectively rather than trying to address singular offences. Preventing one incident can assist in preventing future reoffending.[65] Targeting specific perpetrators would additionally assist in establishing a pattern of domestic violence and coercive control rather than applying an incident-based approach. Focused deterrence can be tailored to the individual community and hence suitable for regional, rural and remote areas as

well as Indigenous communities. For focused deterrence to be effective, messages received by the community, victim and perpetrator must be consistent. The perpetrator must be matched with the right treatment and intervention to prevent future offending.

Whilst Australia wide, a harsh approach has not been taken towards domestic violence, Bourke has embraced a similar model referred to as 'Justice Reinvestment.'[66] The town has been known for its high levels of domestic violence. Local indigenous community leaders, police and support services were brought together to help men at risk of offending address underlying issues contributing to family violence. This could include trauma counselling, drug and alcohol rehabilitation or mentoring.[67] Between 2015 and 2017 domestic violence assaults reduced by 39 per cent.[68] The success of the programs has been attributed to the ability to see perpetrators as individuals capable of rationality and redemption and the fostering of deep, community led collaboration.[69] Treatment could be tailored to the needs of the individual.

For a focused deterrence model or Justice Reinvestment approach to be applied in other areas in Australia, it would be vital to ensure support programs are adequately resourced, comprehensive and targeted to specific offender types. Long waitlists or a 'one size fits all' approach to MBCP could limit the effectiveness of focused deterrence. MBCP would play an important role if focused deterrence was implemented in Australia. The approach would need to operate alongside other initiatives. Whilst negative consequences are increased and the benefits associated with violent behaviour are decreased, this will not result in the elimination of violence for all offenders. Motivators for domestic violence are complex and can include control/dominance, expression of negative emotions, communication difficulties, alcohol and drug use, trauma and mental health issues.[70] Support is offered for perpetrators, however they are still required to take full accountability for their behaviour. Focused deterrence is a well-researched strategy worthwhile trialling in Australia and could only be implemented if intensive support for perpetrators was readily available.

Support and safety of women and children

MBCP offer a way to further engage and support victims and children and monitor their safety, ensuring they are visible to agencies involved with the perpetrator. Motivation for men to change will often be focused on getting back together with their partner and parenting. However, women during and at the completion of programs were hesitant to trust the changes made and whether change could be sustained.[71]

Recovery for women and children who have experienced domestic violence needs to be supported and specialised. Programs need to consider the level of contact and intervention offered to

women and children and that domestic violence is underreported by victims. A recent research report by ANROWS highlighted that lack of partner contact by MBCP can lead to some perpetrators using their participation in the program to engage in further domestic violence against victims.[72] Partner contact requires intensive resources and is often a secondary priority for service providers. In Australia there is a lack of consistency in practices and interventions as well as limited awareness of existing standards for those who have contact with partners of participants.[73] This can jeopardise the safety of women and children as there is a possibility of heightened risk when the participant is in or has completed a MBCP.[74] There are positive benefits associated with partner contact even if the perpetrator disengages in the program or there is no change in behaviour and attitudes.[75]

Research suggests the need for better integration of services for children.[76] Responses to women and children helps mitigate the impact of experiencing domestic violence. Therapeutic responses that work with both the mother and child are thought to be beneficial.[77] There are several factors that can reduce the impact of domestic violence on children, including the relationship with their mother or primary carer and "whether the child receives an adequate response/treatment following the domestic and family violence." Current responses to children who have experienced domestic violence include:[78]

- Mother-child focused therapy and playgroups
- Counselling
- Group therapy
- Play and art-based therapy
- Story telling
- Movement activities
- Home visits
- Education workshops for parents

Responses to children and victims of participants in MBCP requires careful consideration. It is important for services to be child-centred, tailored to the child's individual need and family context, integrated collaboratively with adult services and work holistically with the child's support networks and community.[79]

Typologies and the Motivation of Perpetrators

Health services, victim organisations, police and courts commonly use screening tools and risk assessments to assist in safety planning and establishing the risk of imminent and escalating

violence. A risk assessment tool commonly used is DOORS.[80] Risk assessment and screening tools assist practitioners in 'predicting' or assessing the likelihood of a perpetrator committing similar abuse in the future or the escalation of violence.[81] It is important the perpetrators risk of offending is proportionate to the level of intervention received.[82] Typologies are not as commonly used by practitioners in Australia, however, there is an increasing space to integrate the use of typologies into future practice including prevention, beneficial treatment, behaviour change programs and legal decision making. It may additionally assist and support risk assessment of perpetrators by looking at them through a typology lens.

Australia appears to be following a different direction comparatively with international jurisdictions and has resisted categorising perpetrators and utilising behavioural and psychological science and typologies. Research on why some men are abusive towards women and what drives the behaviour has halted, limiting the development of effective treatment programs.

The research by Mary Cavanaugh and Richard Gelles suggests not all perpetrators are alike.[83] Cavanaugh and Gelles alongside other practitioners have separated perpetrators into a variety of categories. Ignoring this evidence risks rendering treatments ineffective and puts women and children at risk of further violence. More effective assessment, identification and intervention better protects victims. Programs targeted at specific types of perpetrators as well as their circumstances and risk factors, are more likely to be effective if the approaches and curricula modalities address the problematic behaviours, motivation and underlying causes.[84]

A study by the Australian Institute of Criminology emphasised the resistance of practitioners in the field of domestic violence to use typologies.[85] Stakeholders included service delivery staff, police officers, legal representatives and community corrections staff. This is in contrast to other types of crimes such as sexual offences, where sexual offender programs adopt a cognitive behavioural approach and have rigorous assessment and screening tools to determine a perpetrators risk and motivations.[86] Overall, none of the practitioners interviewed in the study said they were using typologies in their practice.[87] Reasons included the individual nature and complexity of domestic violence matters, ability for the behaviour to change over time, lack of acceptance by the court and inconsistency with their roles.[88] Practitioners reported using their intuition, clinical judgement and practical experience.[89]

Lack of consideration of evidence-based research and the failure to further develop existing research limits a holistic understanding of domestic violence. This prevents the multi-disciplinary, thorough and consistent approach required to effectively address domestic violence.

Research by key practitioners has introduced several types of categories of perpetrators. Some categories may overlap or have similar features. Developing "profiles" and identifying patterns of

behaviour and motivation behind behaviour assists in developing specific programs and treatment best suited to the perpetrator and their characteristics. Perpetrators can be distinguished in a variety of ways including childhood victimisation, personality traits and attitudes towards women.[90] Targeting perpetrators more effectively has the potential to reduce recidivism and prompt partner safety.

Figure 1: Examples of typology categories[91]

Typology	Groupings
Johnson[92]	• Coercive control • Violent resistance • Situational violence • Separation instigated violence • Mutual violent control
Langhinrichsen-Rohling[93]	• Power and control • Self-defence • Jealously • Communication difficulties • Expression of negative emotions • Retaliation • Other
Holtzworth-Munroe and Stuart[94]	• Family only offenders • Dysphoric/borderline offenders • Generally violent/antisocial offenders
Jacobson and Gottman[95]	• Cobra offenders – heart rate decreases during violent episodes. Severely antisocial, they demonstrate criminal traits and are more emotionally abusive. Female partners are less likely to leave, Motivated by desire for immediate gratification. • Pit-bulls – heart rate increases during violent episodes. Women appear less intimidated by these types of offender. Motivated by fear of losing their partner and are emotionally dependent on them.
Dorthy Stucky Halley[96] (2017)	• Entitlement-based motive • Survival-based motive • Sadistic-based motive

Certain personality traits have been closely linked with domestic violence. Consideration of the traits of perpetrators correlated with domestic violence, alongside other risk factors, provides an opportunity to better assess perpetrators and their current and future behaviour. Studies have demonstrated a link between Cluster B personality traits including narcissistic, borderline, anti-social and histrionic traits and increased anger, aggression and violence.[97] In a study of men imprisoned for domestic homicide, one third of the men displayed borderline traits.[98] This study was further support by research by Hamberger and Hastings, finding that 88 per cent of perpetrators evaluated presented with schiziodal/borderline, narcissistic/antisocial and dependent/compulsive personality traits.[99]

Violence may serve a varying function depending on the personality traits present. Violence associated with anti-social traits was identified as primarily instrumental in comparison to borderline traits where violence appeared to be more emotionally driven.[100] This suggests violence associated with borderline traits could be reduced with elements of the program targeting emotional regulation, interpersonal effectiveness and distress tolerance as opposed to programs focused solely on psychoeducation. A study on feminist-cognitive behavioural and process-psychodynamic treatments demonstrated men with dependent personalities had better outcomes in process psychodynamic groups and those with anti-social traits had better result in the CBT groups.[101] Research of rehabilitation programs of perpetrators of all types show poor results unless they are matched with appropriate treatment.[102]

Identification of borderline traits among perpetrators could offer a broader research and evidence base to work with in the development of programs. For example, dialectical behavioural therapy (DBT) has demonstrated effectiveness in treating borderline personality disorder and used in mental health treatment. Some perpetrators could be argued to have similar characteristics to those with the symptoms of borderline personality disorder including sudden and explosive anger, unstable and intense relationships, impulsivity, frantic efforts to avoid real or imagined abandonment, low self-esteem, substance abuse and inability to regulate and cope with intense emotions.[103] Borderline personality disorder and its correlation with trauma,[104] further supports the use of trauma informed practice when rehabilitating some perpetrators. With further application and research, treatments for borderline personality disorder may be transferable and effective for some types of perpetrators.

Alongside certain personality traits, research has outlined most perpetrators have demonstrated attitudes and beliefs consistent with male privilege and entitlement.[105] The different factors contributing to domestic violence and coercive control emphasises the need to draw together a

variety of disciplines and approaches to develop programs that address all the relevant contributing factors to the perpetration of domestic violence and coercive control.

Trauma Informed Practice

Trauma informed practice is an approach to delivering human services, care and treatment based on the principles of physical and emotional safety, choice, collaboration, trustworthiness and empowerment.[106] It requires an understanding and recognition of the presence of trauma symptoms and the role trauma can play in a person's life and their development.[107] Research has begun to demonstrate a link between adverse childhood experiences (ACEs) and perpetration of domestic violence. For perpetrators, two consistent developmental experiences have been identified: experiencing domestic violence as a child and experiencing physical or sexual abuse as a child.[108] The CDC-Kaiser Permanente Adverse Childhood Experiences Study is one of the largest investigations of childhood trauma and later-life health and well-being.[109] Over 17,000 participants receiving physical health exams completed confidential surveys regarding their childhood experiences and current health status and behaviours. A score was then determined by the person's experience of 10 childhood events. The events included parental substance abuse, family separation, physical, sexual and emotional abuse, neglect and imprisonment of a parent. The higher the ACE score, the higher risk of experiencing a range of physical and mental illnesses as well as poor social and educational outcomes.

The ACE study draws together an understanding of developmental psychopathology and attachment theory.[110] Policy addressing the prevention of ACEs is likely to reduce a significant number of chronic health conditions. Prevention of ACEs may also provide an opportunity to prevent future domestic violence through early intervention and targeting at-risk groups. The measurement of a person's ACE score can be used in health, education and therapeutic settings to target interventions best suited to an adult or child. The impact of trauma on brain development including sense of self, social skills, emotional regulation and impulsivity has been well founded.[111] The research of ACEs and potential impact on adult outcomes and behaviour, results in trauma being relevant in the rehabilitation of perpetrators of domestic violence.

The link between higher ACE scores and the perpetration of domestic violence is supported by research by Christian Mar and Laura Voith.[112] Voith's research demonstrated a clear link between aggression and trauma.[113] Men in behaviour change programs with trauma backgrounds may have developed a belief that "the world is unsafe and those who care for you are untrustworthy

and unreliable," growing up feeling powerless and thus use violence to regain control and feel empowered in their intimate relationships.[114] In additional research Voith highlights a perpetrator who is "abused in childhood may suffer from distortions in brain development, leading to poor attachment, underdeveloped emotion regulation and higher levels of impulsivity. His compromised regulatory systems may lead to unhealthy coping mechanisms in adolescence and adulthood such as drug and alcohol abuse."[115] This is further supported by Lundy Bancroft's research, considering the family in which children grow up as "usually the strongest influence."[116] Bancroft highlights that studies have found nearly 50 per cent of abusive men have been raised in a home where either their father or stepfather was abusive.[117] The strong link between childhood trauma and the perpetration of domestic violence in adulthood emphasises the need for a multi-disciplinary and trauma informed approach to rehabilitating perpetrators and researching effective interventions. Whilst not all individuals who have experienced childhood trauma will go on to perpetrate domestic violence themselves, the link between childhood trauma and domestic violence cannot be ignored when developing treatment.

Research indicates individuals who engage in aggression have a low awareness of their internal states, low tolerance for emotional arousal and underdeveloped skills needed to identify emotions in oneself and others.[118] Dutton further supports the impact of trauma on domestic violence, highlighting the biggest childhood contributors to abusiveness were all related to some type of unresolved grief or attachment trauma.[119] Dutton found that 45 per cent of perpetrators assessed met the research criteria for PTSD and exhibited elevated levels of chronic trauma symptoms,[120] further supporting the relevance of trauma informed practice to domestic violence perpetrators.

The presence of trauma impacts the effectiveness and development of programs. Trauma intervention requires the use of a bottom-up approach to the brain.[121] The Duluth model commonly used, as well as CBT, both use a top-down approach, psychoeducation models utilising the higher parts of the brain. This could render programs solely using these approaches ineffective for participants with unresolved trauma. A bottom-up approach involves intervention addressing the physiological elements involved with trauma "triggers" and hyperarousal[122] before progressing to the higher parts of the brain involved in attachment, emotions, behaviour, thinking and learning.

Whether the intensive trauma therapy required to progress to psychoeducational models utilised in programs can be completed in a group setting is questionable. The presence of trauma may alter the delivery of the program. Group therapy is not generally recognised as the first treatment option for trauma due to the lack of one-on-one attention and inability to discuss experiences in depth in a group setting. This may result in one-on-one therapy for participants prior to commencing a group program or co-occurring with group work to ensure the process is more

effective. Trauma informed practices have been supported by Dorthy Stucky Halley for survival-based batterers where is entitlement-based batterers are thought to benefit more from their beliefs and behaviour being "un-learned." Processing and understanding trauma experiences requires "an environment where one can feel safe to explore past experiences."[123]

Trauma informed practice enables the understanding and consideration of minority groups overrepresented in domestic violence research. Groups who have experienced significant trauma include Indigenous Australians and defence and military personnel. Incidence of domestic violence in Indigenous communities is reported to be "higher in comparison to the same types of violence in the Australian community as a whole."[124] Exploring trauma assists in ensuring programs are relevant to Indigenous men and their experience with intergenerational trauma, dispossession, colonisation and forced removal from families and culture as well as non-Indigenous Australian's that may have experienced trauma. Additionally, studies on defence personnel post-deployment have revealed exposure to combat is a risk factor for violence both within and outside the family home.[125] Responses to combat such as hyperarousal, hypervigilance, disproportionate aggressive reactions and increased irritability are thought to contribute to the perpetration of domestic violence within defence force personnel.[126]

The Family Peace Initiative, providers of a BIP in the USA, additionally identified increased ACE scores among program participants in comparison to the rest of the population.[127] The information obtained from the ACE study and its use as an assessment tool, can assist in targeting early intervention to prevent domestic violence, as well as assist in developing more effective programs for current perpetrators that address some of the underlying causes of the pattern of behaviour. Considering current research on domestic violence and at-risk groups, it is important that trauma is considered in the development of programs and screening for post-traumatic stress disorder (PTSD), complex PTSD and developmental trauma such as ACEs takes place.

Judith Siegel's research has stressed the importance of incorporating neuroscience and its understanding of trauma and emotional regulation into programs. Neuroscience has been used within the treatment of PTSD, substance abuse and borderline personality disorder. Siegel's research found high comorbidity rates among these diagnoses and the strong representation of these disorders in perpetrators of domestic violence.[128] The presence of these disorders would require the treatment to consider the disorder present and the role it may play in the perpetration of domestic violence and coercive control. John Persampiere has further supported a neuropsychological understanding of domestic violence. His assessment of perpetrators indicated they displayed poor executive functioning and impulsivity.[129] This would shift effective treatment

away from a solely educational approach and require programs to consider the neurological functioning of perpetrators.

Attachment theory, first developed by John Bowlby, has additionally provided another perspective that can be applied to domestic violence and coercive control. Research on attachment has indicated a link between attachment insecurity and domestic violence. A secure parent-child relationship is critical for children to develop "working models of interpersonal relationships."[130]

A study involving court ordered perpetrators found perpetrators displayed high levels of insecure attachment and were overly dependent on their partners compared to non-violent men.[131] Disorganised attachment, one of the insecure attachment styles, has been strongly correlated with borderline personality organisation.[132] Treating attachment trauma and its contribution to domestic violence may support perpetrators in reducing the use of violence long-term. The theory may also offer an explanation as to why separation is such a high-risk period for victims. The escalation in violence "may be a form of protest behaviour directed at the victim and precipitated by perceived threats of separation or abandonment."[133]

Understanding perpetrators experience of trauma or personality traits does not function as an excuse or defence for domestic violence, rather the evidence and research can be used to target and increase accuracy of assessment for MBCP, map and predict future behaviour and risk and develop more intensive programs.

The safety of women and children should always be the priority. Perpetrators, regardless of their trauma history need to take responsibility and be held accountable for their behaviour and its impact on their family. A psychological assessment alone will not be sufficient. Assessment of perpetrators needs to include the context in which the pattern of abuse occurs in, past behaviour, socio-cultural and environmental factors.[134] This allows an assessment beyond the criminal justice system. The criminal justice system is limited in its ability to capture the presence of patterns of domestic violence and coercive control due to its incident-based approach.[135]

It is vital exploring the potential of traumatic experiences of the perpetrator in this assessment does not inhibit accountability and ownership of their current behaviour. MBCP must balance holding the perpetrator to account and reintegrating them safely. Engaging men in ways that are shaming or humiliating is not often effective, with feelings of shame, fear and guilt acting as barriers and provocative of defensive reactions from men.[136] Men participating in MBCP often arrive with a sense of shame and denial. [137] These factors will need to be addressed in the program and may be a turning point for some men if managed well.[138] One single approach will not be sufficient for all men, as it is clear there are variations in their psychology and neurology, motivations, attitudes and beliefs and trauma history.

Behaviour Change Model

Behaviour change has typically been researched in public health, addiction and medicine. 6 stages of behaviour change have been recognised.[139] These include:

1. Precontemplation – person is not thinking about changing and are not interested in any kind of help. Do not see they have a problem.
2. Contemplation – more aware of their personal consequences of their behaviour and spend time considering the problem.
    a. Contemplation of pros and cons of modifying their behaviour.
    b. In the contemplation stage people are more willing to receive information about their behaviour.
3. Preparation/determination – people have a commitment to make the change and begin to gather information.
4. Action/willpower – the stage where people believe they have the ability to change their behaviour and are actively involved in taking steps to change their behaviour by using a variety of different techniques. This stage generally occurs for 6 months.
5. Maintenance – successfully avoid any temptation to return to previous habits. Plan for follow up and discussion on coping with relapse. Post 6 months to 5 years.
6. Relapse/termination – this stage involves the resumption of old behaviours. The trigger for the relapse will need to be reassessed alongside motivations and barriers. Stronger coping strategies will need to be put in place to minimise the risk of termination.

The length of MBCP less than 26 weeks would not align with the time it takes most types of behaviour to shift. The stages of change model has been applied to other interventions such as Alcoholics Anonymous, [140] health behaviours, mental health and bullying intervention and produced more effective outcomes in comparison to programs not tailored to the stage of change of the participant.[141] The model suggests that "interventions are more likely to reduce resistance, facilitate treatment engagement and progress and produce behaviour change when interventions are individualised and matched to variables such as stages of change" rather than applying the same intervention to all perpetrators.[142]

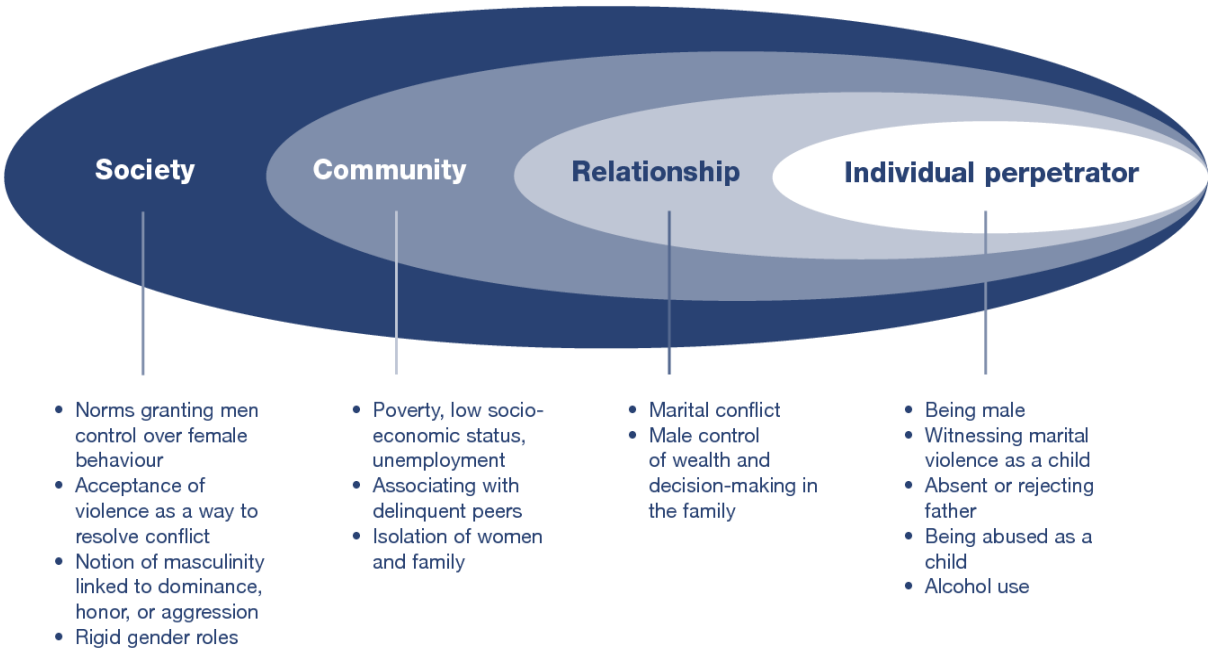
Ecological and Biopsychosocial Frameworks

Multi-faceted chronic illnesses now dominate deaths in our society as opposed to infectious diseases. Many do not follow a simple "cause and affect association," requiring a different approach to prevention and treatment.[143] Similarly, domestic violence involves the "complex

interplay of factors."[144] One causal link cannot be established. Theories of violence have been influenced by psychology, sociology, criminology and feminist ideology.[145] Any theory or explanation must be able to account for why individual men are violent and why women are so often the target.[146] Any approach used to understand domestic violence needs to integrate both socio-cultural factors and psychopathology.[147] A complete understanding of domestic violence will require considering factors on multiple levels.[148]

An ecological framework is the most used framework to understand violence. It proposes that violence is a result of factors operating at four different levels. These include individual, relationship, community and societal.[149] An ecological framework has been used to target primary, secondary and tertiary interventions of domestic violence and to form a more holistic understanding of the factors that impact perpetration. The model encourages collaboration between stakeholders when addressing domestic violence and allows all disciplines and their role and understanding of domestic violence to be considered.

Figure 2: Ecological Framework



Heise, Ellsberg & Gottemoeller (1999, p. 8), adapted from Heise (1998)

Similarly, to the ecological framework, a biopsychosocial (BPS) model, the term first established by Grinker in 1954, proposes the interaction of factors in the understanding of health, psychology and illness.[150] This has allowed practitioners to examine how biological, psychological and social elements interrelate with one another,[151] and deliver treatment accordingly.

Domestic violence could benefit from the application of a BPS perspective. It enables the consideration of an interplay of factors and examination of risk factors without absolving the perpetrator of responsibility for his actions. For example, biologically, there has been a link established between testosterone and aggression, serotonin levels and impulsivity and alcohol consumption.[152] Whilst violent and abusive behaviour is not itself a disorder there are several disorders and personality traits associated with the likelihood of the type of behaviour.[153]

Alcohol has been found to be involved in 65 per cent of domestic violence incidents.[154] Treatment of substance abuse has greatly reduced offending without directly addressing domestic violence in treatment.[155] Programs that target both substance abuse and domestic violence have reduced recidivism rates further.[156] Additionally, the use of selective serotonin reuptake inhibitors (SSRIs) has also seen the reduction in "depressed mood, rejection sensitivity, impulsive behaviour, self-destructive behaviour and hostility towards others" as well as angry mood.[157] Despite these findings, it is important domestic violence is not simply pathologized and an integrated perspective such as a BSP approach occurs. This would enable the consideration of biological influences alongside other factors influencing domestic violence such as social and cultural attitudes and gender inequality. It is evident from the research explored there are a range of factors that influence domestic violence. A BPS and ecological perspective allows those responding to domestic violence from a variety of disciplines to draw together all these factors and explore how their influence on domestic violence can be used to assess perpetrators and develop effective treatment. The perspectives keep the perpetrator in focus, as well as women and children in the delivery of treatment. How these factors can be drawn together can be seen in the following figures.

Figure 3: Biopyschosocial perspective

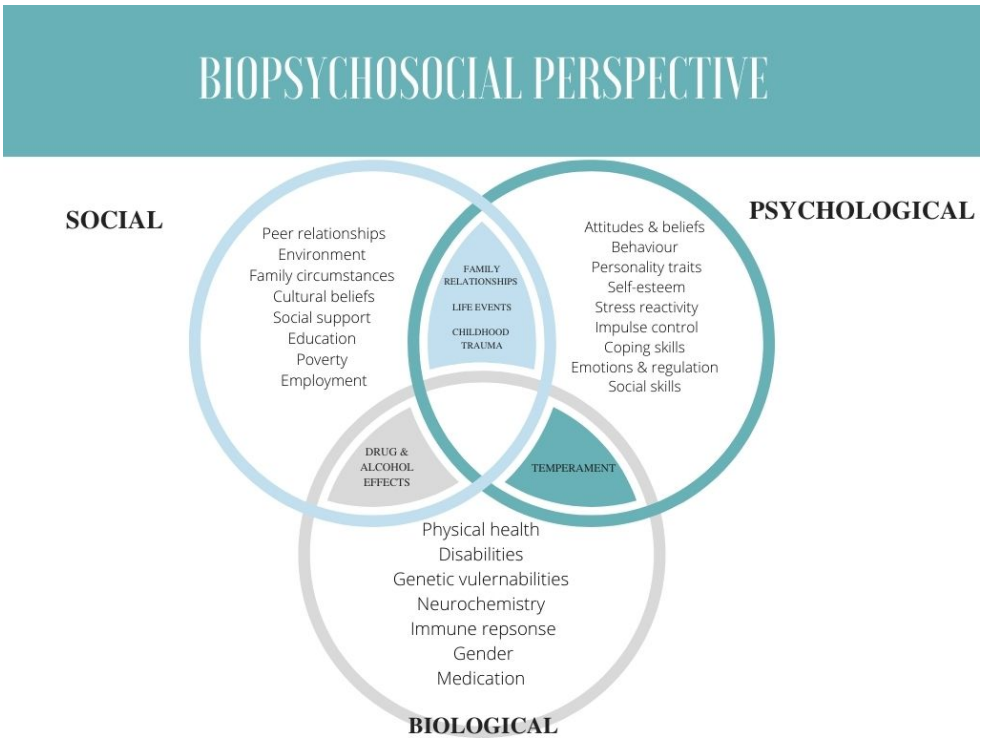
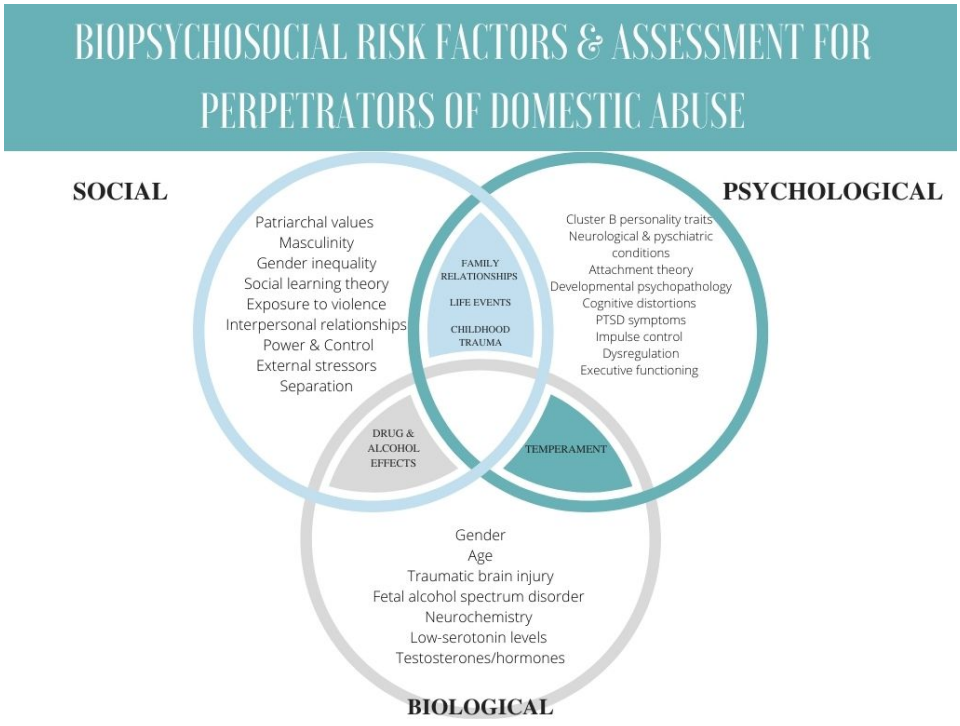


Figure 4: Biopsychosocial risk factors and assessment for perpetrators of domestic violence



Staff and Qualifications

Qualifications required for MBCP facilitators is mixed. Facilitators can come from a range of backgrounds and disciplines. Staff are often recruited from social work, psychology and counselling. 40 per cent of facilitators require an undergraduate degree in a human services field and a specific length of experience or training in the domestic violence field. 15 per cent require a post-graduate qualification and one third of states did not have specific educational requirements but did require training and experience in the domestic violence sector.[158] Graduate Certificate in Men's Behaviour Change Individual and Group-work Interventions is now offered and designed for practitioners wanting to facilitate programs. Lack of specialist training, particularly working with perpetrators has been recognised in research, as well as consistent language across jurisdictions. [159] Police responding to domestic violence do not have specialised training even though domestic violence is the majority of their work.[160] This has previously been described as the "front-desk lottery."[161] Victims reporting domestic violence may be met with a police officer who is extremely experienced and passionate about domestic violence work or an officer that dismisses the risk and their concern.[162] The lack of training, under-resourcing and high volume of work of police prevents appropriate application of legislation, referral to support services such as MBCP and the ability to protect women and children. Research suggests current issues compromising the safety of women and children is not a result of the legislation but its implementation.[163] Without adequately trained and resourced frontline staff, the ability to establish a pattern of domestic violence and coercive control is diminished and those requiring referral to MBCP are unlikely to be identified or investigated.

In their evaluation of their MBCP, Uniting Care outlined academic programs were failing to provide many facilitators with the skills and training to work with groups as well as sufficient knowledge and understanding of domestic violence.[164] This has also been highlighted in the in organisational capacity and development, with few staff trained to work with men who use violence particularly in relation to their parenting. Practitioners recognised working with fathers was skilled work and they felt ill prepared to do so.[165] Further, working with fathers who use violence is not a core learning skill in qualifications for social workers or human service professions. More collaboration between practitioners across multiple agencies was emphasised.[166]

Difficulty in accessing training and workforce development was also highlighted in the No to Violence Listening Tour report.[167] Uniting Care also outlined retention difficulties and lack of

availability of counsellors to refer to that were experienced in working with domestic violence. Changeover of staff further made relationships with stakeholders difficult. High standards of supervision of facilitators was also outlined as important to programs and their delivery but made difficult by the lack of qualified staff with relevant training and experience in the domestic violence sector.

The importance of the inclusion of both genders was highlighted in Uniting Care's report as well as in the minimum standards for each state. Co-gendered facilitation was considered necessary unless there was a problem in more regional and rural areas obtaining facilitators of both genders with appropriate qualifications.

Some programs have staff employed to work with the victims and children of perpetrators involved in the program. For example, KWY's Family Hub in South Australia provide every member of the family with a worker to help meet their individual needs. Other service providers may partner with women's support services in the area and practice a cross-collaboration approach, running a program for women alongside the MBCP.

Treatment programs for perpetrators as opposed to education programs such as the Duluth model, would require clinicians to deliver MBCP. In the USA, treatment programs require group facilitators to hold clinical degrees.[168] This would shift current employment requirements of service providers and would require more intensive knowledge and skills specific to domestic violence. Practitioners in the field typically only specialise in working with perpetrators or victims, not both.[169] This creates a silo effect and does not align with the current research that highlights the complexity of families impacted by domestic violence.[170]

For MBCP to be effective and responsive to perpetrators, the thorough training of staff is important. Facilitators play a key role in providing a safe space for men to change their violent behaviour, building a professional relationship based on trust and respect and maintaining engagement and motivation to change. This needs to occur whilst challenging men's beliefs, attitudes and understanding of domestic violence and preventing collusion between participants.

Training that does not include the multiple factors that have been consistently linked to domestic violence such as trauma, substance abuse, attitudes towards power and control and attachment theory risk misunderstanding perpetrators, their pattern of behaviour and all members of the family.[171] Training recommended includes the requirement of cross training of staff, different types of domestic violence, screening for mental health conditions and substance abuse and trauma theory.[172]

Challenges for MBCP

MBCP face a variety of challenges in the domestic violence sector. Services are fragmented and often do not align with policy intent and implementation. With such limited funding in comparison to the extent of domestic violence, victim advocates have demonstrated concern funding used for MBCP is taking up much needed resources away from women and children without clear evidence of effectiveness. Currently there is no clear evidence of what stops men's violence against women.[173]

Engaging perpetrators is difficult, with dropout rates and non-completion of programs an issue for service providers. This is partially addressed with programs being court mandated. Spending longer time in the program has been found to enhance the likelihood of positive outcomes,[174] emphasising the importance of maintaining participation and engagement of perpetrators. Perpetrators who did not complete treatment have been found to be more likely to murder their partner.[175] Emerging research has suggested effective programs include BPS assessments and address key risk factors that undermine treatment success.[176] Further, higher ACE scores were found to be negatively associated with program completion and number of sessions attended.[177] Engagement in programs could be addressed by developing programs that are more relevant to perpetrators individual needs and address known risk factors.

Research has suggested the need for a 'follow up' or maintenance program for MBCP to extend and maintain their effectiveness and provide support following the completion of the program. This would assist in monitoring outcomes post the program and contribute to evidenced based practice in the area.

Effective case management and initial assessment is extremely important to MBCP. Perpetrators are likely to have co-existing issues alongside domestic violence and coercive control including substance abuse, mental health conditions, employment and housing. Managing the risk of perpetrators and prioritising the safety of women and children is fundamental to MBCP. There is concern MBCP may contribute to the risk of women and children, promoting a false sense of belief among partners of perpetrators that behaviour will cease.[178]

MBCP have been regarded as complex and are required to meet a large variety of needs, requiring multi-skilled practice by facilitators and the ability to appropriately refer. Delivery in smaller and more regional, rural and remote communities is expensive in terms of staffing and travel.[179] Programs may not always be suitable for perpetrators including those in same-sex relationships, high risk perpetrators, those with psychopathic traits and from culturally diverse backgrounds.

Along with other services in the domestic violence sector, funding is limited for MBCP. This means the evaluation of programs and the follow up on reoffending rates is not always possible, limiting the evidence available. Funding is often for short periods and does not allow for communities to build trust in established programs. It is argued long-term investment in programs is critical to allow them to become adequately established in the community and particularly for Indigenous communities, short and medium funding structures do not support the process of the healing journey.[180] Due to the lack of research in Australia, it is unclear what the value MBCP has in the domestic violence sector as well as the factors contributing to an effective program. Evaluation of programs is important to make decisions about their quality or worth, improve programs, generate knowledge and to gain knowledge to whether the program can be repeated effectively elsewhere.[181]

A strong evidence base is fundamental in ensuring the government and the community can make informed decisions in the investment of programs. WHO has developed a handbook that can assist organisations and individuals to collect information about domestic violence prevention programs.[182] Additionally, men who have completed programs have often been reluctant to participate in research.[183]

Programs cannot be accurately compared due to the differences in evaluation. It would be more effective to have a unified approach to programs and their assessment rather than the current fragmentation that exists in Australia.

Currently, Australia relies on international research, such as research completed on UK programs.[184] Whilst Australia and the UK have several similarities, this is concerning given the significant difference in population size, geography and the needs of regional and remote communities.

Australian Context

Program Providers

There are a large range of service providers that facilitate MBCP in Australia. These include religious organisations, community organisations, Relationships Australia centres, health providers and Indigenous organisations. Programs may be state or federally funded, self-funded or supported through charitable donations. A total of 70 different programs could be found to be operating across Australia. This was based on researching programs listed on government websites and police, Mensline, No to Violence and the Men's Behaviour Change Network as well as contacting service providers via telephone and email. Programs may only operate for a certain period and then have to cease due to the availability of funding.

Evaluation of the effectiveness of each program is limited. Information on the maintenance of non-abusive behaviour over time is also minimal due to the lack of follow up. Research predominantly focuses on the completion of the program as opposed to change in participants behaviour.[185] It is unclear from the research whether group-based programs or individual counselling is more effective in achieving outcomes.[186] In Australia and internationally, there appears to be minimal obligation to evaluate current programs. Traditional program models such as the Duluth model, CBT and feminist socio-cultural approaches continue to be used despite conflicting research on effectiveness.[187] Programs have been subject to little development since beginning in the 1970s.[188] This is despite the significant research on the variety of patterns of violence, profiles of perpetrators and the multitude of consistent risk factors that have been linked to domestic violence. Research that has taken place could be argued to currently be ignored in many current programs offered to perpetrators.

NSW Department of Communities and Justice released a seven-page evaluation summary of four MBCP in the state. The Minimum Behaviour Standards for Men's Domestic Violence Behaviour Change Programs outlines that:

Program providers will be required to collect data to contribute to an evidence base for the effectiveness of the behaviour change programs in accordance with minimum data set outlined in the practice guide.

It is understood from contacting the Department of Communities and Justice there is more data available due to the requirement for services to provide data, however this is not accessible to the public due "requirements to preserve confidentiality and privacy of potentially identifying information held in our data."[189]

There was inconsistency in the amount of information on programs available on the service provider's websites. Typically, the service provider would outline the length of the program, some of the topics addressed and how to receive more information or be assessed for the program. The framework or approach employed by the program or its success rate was commonly not outlined.

Some websites had brochures which contained more information. However, there were several programs that provided minimal information. These providers were emailed and called to attempt to obtain more information. General questions included the length of the program, referral process and qualifications of facilitators. Some staff were able to outline the programs approach and framework.

MBCP in Australia are arguably very fragmented and lack transparency. There is a lot of difficulty in finding critical information on the programs and being able to effectively decide its suitability for a perpetrator. There was also difficulty in locating all the programs in one place. Some information was also out of date, with changes to the names of programs and service providers.

As evidenced by the figure in the appendix, there is extremely limited data for programs across Australia or information on their outcomes following the program in the short and long term. In a NSW study by the Department of Communities and Justice, four unidentified MBCP were assessed.[190]

- 69 per cent of participants from provider 1 indicated they behaved less threateningly and/or violently towards their ex/current partner.
- 78 per cent of participants from provider 2 rated their progress as 7 or 8 out of 10 (where 0 is no progress and 10 is complete progress) on their reduction or cessation of violence and abuse.
- 86 per cent of current or ex-partners from providers 3 and 4 reported a perceived reduction in physical and sexual violence among participants.

The information outlined in the summary does not assist in establishing the effectiveness of different approaches used by MBCP or the impact of programs on reoffending rates post-completion.

Indigenous Programs

Indigenous women are disproportionately affected by domestic violence in Australia.[191] However, not all perpetrators of domestic violence against Indigenous women are Indigenous men. Abuse is perpetrated by a variety of men from different backgrounds, cultures and economic positions.[192] There are significant barriers for Indigenous people reporting domestic violence. These include fear of contributing to increasing incarceration rates of Indigenous men, child removal and being isolated from community.[193] Historical trauma experienced by Indigenous families has resulted in significant distrust of government initiatives. Indigenous women experiencing domestic violence have stressed in research they do not want their partners or children's fathers to go to prison, only that they want the abusive behaviour to stop. This may contribute to victims concealing domestic violence, not wanting to contribute to high Indigenous incarceration rates or further separation and displacement of family members.[194] Reuniting families is a significant priority for Indigenous people.[195] Indigenous communities disagree with the argument domestic violence is driven by gender inequality and support the notion domestic violence is multi-causal.[196] Whilst individuals drive domestic violence intervention, Indigenous communities argue country should be at the centre of all domestic violence initiatives.[197]

Substance abuse, neurological disability and mental illness are associated with the severity of family violence among Indigenous people and ability to access services.[198] Incarceration could be avoided by using diversionary options such as MBCP. Acquired brain injuries and Foetal alcohol spectrum disorder has also been associated with offending among the Indigenous population.[199] Domestic violence has also featured as a significant reason for the over-representation of Indigenous children and young people in out of home care (OOHC).[200] Indigenous communities support a one family/one judge approach that responds to the unique nature of domestic violence with one judge handling all criminal domestic violence cases and related family issues such as custody, visitation and civil protection orders.[201]

Programs have been developed specifically for Indigenous men, taking in to account cultural differences, the impacts of colonisation, dispossession and the Stolen Generation on Indigenous families. Modelling of healthy relationships and the ability to pass on parenting and child rearing skills as a result of the Stolen Generations has also been cited as a challenge facing Indigenous families.[202] Programs typically utilise a trauma informed approach. Indigenous culture considers health as holistic, with a focus on social and emotional wellbeing. Programs often follow this holistic view, promoting healing and cultural strengthening.[203] Case management of participants in programs should reflect the holistic approach of Indigenous culture and promote safety and cultural competency. Cultural health approaches used by Indigenous services undertake work with the whole family and include focusing on the healing of women and children. This approach is useful addressing the needs of victims and children.

KWY, providing services across Adelaide North, implements a holistic and trauma informed therapeutic approach. They work with the whole family of participants in there MBCP. Narrative therapy is used alongside emotional regulation, empathy and the effects of trauma on the brain. Participants must own and take responsibility for their behaviour.

It is important programs are developed in partnership with Indigenous communities and consultation takes place. Colonisation has had a significant impact on gender roles. In comparison to Indigenous culture, western values give less weight to the position of women, Indigenous women typically sharing equal rights and responsibility with men to provide a safe and healthy environment for women and children.[204] Indigenous presence in the delivery of services has been argued as fundamental to program effectiveness.[205]

Ngarra Jarranounith Place is a program in Victoria specifically for Indigenous men. The program operates as a residential program. The men stay for 16 weeks in a residential house in Melbourne whilst completing the program. A Koori elder lives on site. Three furnished houses were provided

by Collingwood Football Club to support the program.[206] Participants must complete the Men's Healing and Behaviour Change program first, as well as successful completion of a medical detox or alcohol and other drugs rehabilitation if required. A family engagement and safety worker additionally work alongside the women and children of the perpetrator. Programs also involve cultural and healing activities and collaborate with local elders to deliver the program. The increase in residential programs has been supported by practitioners in Victoria, where men could still work and participate in the community but with close monitoring and programs.[207] Residential programs would allow women and children to stay within their homes safely without having to flee. Few Indigenous programs have been formally evaluated,[208] making it difficult to determine whether residential programs produce better results. It is important when assessing Indigenous programs, Indigenous communities are involved to ensure adequate understanding and evaluation.

Indigenous women do not view crisis intervention as a long-term solution to domestic violence.[209] Whilst crisis interventions remain important for immediate safety, new approaches focusing on building on structures of strength, resilience and healing of Indigenous communities serve the needs of communities more appropriately.[210] In studies undertaken, Indigenous women did not discuss domestic violence in the context of gender inequality or coercive control. They more greatly associated domestic violence with alcohol and social conditions.[211] The Duluth model was not seen as appropriate for Indigenous communities as they did not view gender equality as the root cause.[212] They key elements needed for Indigenous programs include community ownership of programs, a focus on men's healing, holistic approaches and facilitation of cultural needs of participants to support healing.[213]

International Context

United States of America

The USA typically refers to behaviour change programs as Batterer Intervention Programs (BIP). Similarly, to Australia, programs vary in length and approach with some programs running for up to 52 weeks. Most referrals are made through the criminal justice system.[214] Typically programs adopt a feminist analysis of domestic violence.[215]

USA also lacks reliable research on the range of BIP available.[216] A review of BIP effectiveness in 2013 produced mixed results in whether the programs reduce reoffending rates.[217] Studies on traditional intervention programs including those based on gender themes or CBT, show approximately half of BIPs are more effective than a no treatment control condition in preventing

reoffending.[218] This was supported by criminal justice data, finding that men who had been court ordered to attend BIP were 56 per cent less likely to produce another charge.

There is minimal evidence to suggest one traditional approach should be favoured over another, however more intensive treatment (longer programs) were found to be more effective.[219] Due to the demand of the criminal justice system, programs were often expanded before there was the opportunity to evaluate their effectiveness.[220] Programs have not been able to develop in accordance with current research and evidence, unlike other treatment such as psychotherapy for mental health conditions.

Denver, Colorado

The majority of domestic violence services in Denver, Colarado are located in one building. Multi-disciplinary teams are used to treat perpetrators. Perpetrators are categorised into different levels of risk and the intensity of treatment is matched with the perpetrators risk. Assessments on the risk of perpetrators are repeated throughout the program and treatment intensity can be changed to coincide with a change in risk. Colorado aim for participants is to meet competencies rather than participating in the program for a set period. On average, level A participants completed 24 weeks, level B completed 35 weeks and level C 37 weeks.

There is a huge importance placed on information sharing and cross-collaboration between disciplines. The treatment is court ordered and the judge makes a sentencing decision once the course is completed. The facilitators of the course are therapists and make the initial assessment. Therapists make recommendations to the judge on the length of time the perpetrator should remain in the program.

The Family Peace Initiative, Kansas

The Family Peace Initiative, run by Dorthy Stuckey Halley and Steven Halley, offers a trauma-focused batterer intervention program. The program runs for a minimum of 26 weeks, including an initial assessment, orientation class and 24 weekly group sessions. Topics covered within the curriculum include:

- Adverse Childhood Experiences
- The River of Cruelty

- Integrity and Accountability
- The Shadow
- The Golden Shadow
- Negotiation and Fairness
- Trust and Partnership
- Parenting with Respect
- Sexual Respect
- Battering Motive
- Guilt and Shame

A review by court services found that 81 per cent of those who completed the Family Peace Initiative Program in a five-year time frame were not charged with another crime and did not have another protection order placed against them in that county.[221] In comparison to recidivism rates of other programs, the rate is a high standard.

Other USA Studies

The Brooklyn study indicated BIP can impact positive change however requires consistency of messages throughout the community, a quality program, good assessment, psychoeducational group modality and long enough to create sustained impact.[222] The use of probation monitoring and counselling completion has been found to significantly lower recidivism.[223]

A study on victim-orientated treatment in Washington focusing on changing beliefs, attitudes and behaviour through empathy and education as well as emotional engagement that changes the focus from blame and judgement found participants who attended the program were least likely to reoffend (12 per cent) and had a high compliance rate (64 per cent). Rearrests of participants of a program in Florida were found to be half in comparison to those who did not complete the program.[224]

A Chicago study was able to assess BIP on a broader level. 30 programs were included in the study. The participants who completed a program were found after 2.4 years to have a recidivism rate of 14 per cent, in comparison to 34 per cent for non-participants.[225] This success rate was further supported by a study done in Massachusetts.[226]

Europe

England

MBCP in England have been predominantly influenced by the Duluth model. Prior to 2005, community-based perpetrator programs worked with probation service. Now Probation Services runs its programs internally.[227] The UK have a strict accreditation process for perpetrator programs, with 60 organisations providing programs across the country.[228] Respect UK is the peak body for perpetrator programs.

Project Mirabal refers to a report done in 2015 on MBCP in the UK. It looked at what extent programs are effective and their contribution to a coordinated community response. Project Mirabal did not identify the outcomes of specific programs, rather the overall outcome of programs in Europe. Programs tended to take on a pro-feminist, CBT or psychodynamic approach.[229] A 2004 study of a court mandated program adopting a psychoeducation pro-feminist approach indicated in the 11 month follow up period completers were alleged to have committed fewer offences than dropouts of the program.[230] Other studies on UK programs indicated small differences in recidivism when comparing those who completed the program and those who dropped out.[231]

One program indicated an initial increase in self-reported abusive behaviour which then declined gradually. Female partners of the participants in the program reported a decrease in abuse and there was significant psychological improvement of the perpetrators, women and children involved in the program.[232] Police, social workers and a women and children's worker were all involved in the program which spanned over 42 weeks. The evaluation of the program was thorough assessing women and children alongside the perpetrator. This study provides additional factors that can be considered when evaluating programs.

Scotland

Scotland's predominant program for domestic violence perpetrators is the Caledonian System. It was developed in response to high imprisonment rate, comparatively to other western nations. It formed part of a government wide strategy to reduce domestic violence and provides a comprehensive theory manual to ensure consistency across the delivery of the program. The manual was developed utilising contributions from a variety of disciplines. An evaluation of the program indicated key areas for improvement whilst assessing the current outcomes. The system

implements an integrated approach to addressing domestic violence, providing a court ordered programme for men and support for women and children that emphasises the effective collaboration and information sharing with other services. Cases could be returned to court if the perpetrator was not suitable for the program. The program takes on an 'ecological' model of behaviour, examining the influence of various factors on domestic violence. This includes social stereotypes about gender roles and individual circumstances in men's lives that may have contributed to abuse such as their own exposure to violence and use of alcohol and drugs.[233] Regular client liaison meetings typically take place once every three weeks, with the safety of women and children the first priority. The program is targeted at moderate to high-risk perpetrators.

The men's program spans over two years, providing 14 one to one sessions, 26 group sessions and one-on-one sessions repeated post-group work to assist maintenance of the reduction of domestic violence. Assessment and psychometric testing is conducted at the beginning and end of the program.

Many perpetrators (81 per cent) had problems with alcohol when commencing the program.[234] Post the program, the proportion of participants with alcohol problems reduced by almost half.[235] Evidence indicated men who completed the program posed a lower risk to partners and children at the end of the program.[236] Those assessed as high-risk reduced from 26 per cent to 8 per cent and moderate risk fell from 62 per cent to 32 per cent. Participants classed as low risk increased from 12 per cent to 60 per cent.[237]

Norway

Advocates for domestic violence victims have argued violence is driven by gender inequality. This has been supported by campaigns in Australia such as 'Change the Story.'[238] However, this may be contradicted by domestic violence in Nordic countries. Norway ranks in the top four countries for gender equality.[239] The index considers health, education, economic opportunity and political opportunity. Despite this, Norway and other Nordic countries still appear to have a disproportionate amount of domestic violence.[240] The feminist framework significantly contributes to understanding domestic violence, however, the research on Nordic countries suggests other factors could contribute to domestic violence. Consideration of gendered factors alone is not sufficient.

The ATV program in Norway incorporates elements from CBT, emotion focused therapy, trauma focused therapy and psychodynamic therapy. Themes such as power, safety, control and gender stereotypes are incorporated into the program. Similarly, to Scotland, the program considers

broader factors that could contribute to domestic violence including depression, anxiety, trauma specific reactions, attachment and substance abuse. There is not a set timeframe for completion of ATV. Rather the length is tailored to the needs of the perpetrator in collaboration with their individual therapist. On average the participants spend 10 months in treatment.

Research on perpetrators who dropped out of programs in Norway indicated the longer time in treatment enhanced the of positive outcomes.[241] Identifying the reasons for early dropouts is important however difficult to identify.

Israel

Israel takes a different approach to intervention programs, opting for a residential program for perpetrators. Two studies have been conducted on the therapy provided at the facility Beit Noam, as well as the results from an assessment report. The program coincides with a court order, banning men from their family homes. The program aims to address the core problem of domestic violence, men's behaviour. Sessions are conducted in the evening and men go to work during the day. Men are additionally responsible for the maintenance of the house, challenging gender stereotypes in a practical way. The residential stay allows the behaviour of the men to be observed in a social setting and can assist in targeting interventions.

Six types of groups are conducted including interpersonal relations, cognitive self-control, development of self-awareness, a parenting group addressing the child witnesses of violence and a follow up group.[242] The parenting group helps perpetrators address their own experiences of violence as children and their own children's, with many of the participants exposed to violence in childhood.[243] Time within the program could be extended if required to meet the participants needs. To assess outcomes of the program, probation officers were utilised. Victims, practitioners and probation services all reported the program had been successful in dealing with physical violence perpetrated by participants.[244] Each woman indicated a decrease in violence including "no longer being assaulted or threatened, no longer felt afraid and men made an effort to control their anger."[245] However, women did report the occasional use of verbal abuse. Beit Noam offers an integrative approach to intervention. Having men stay at a designated facility aligned with court orders could be seen to enhance the safety of women and children and minimise disruption by having them remain within the family home.

Fathers who use Violence

The Convention of the Rights of the Child recognises children's right to live free from violence, including violence within the home.[246] The negative impact of domestic violence and coercive control on children has been well founded,[247] and in some cases has prompted the removal of children from the care of their parents due to the physical and psychological harm caused by domestic violence. In some states, exposure to domestic violence is recognised as a form of child abuse and subject to mandatory reporting. Mandatory reporting may prevent mothers reporting violence to relevant authorities due to the fear of their children being removed from the family home. Removal risks significantly disrupting the child's relationship with both parents.

Services such as child protection have had difficulty engaging with fathers who use violence, neither engaging with them as a risk or resource.[248] Attention has not often been given to violent fathers, rather the focus has been on mothers 'failure to protect' and the willingness to separate from the perpetrator despite the increased risk of violence, homelessness and the continuation of violence after separation.[249] If the fathers domestic violence is not addressed, this will significantly impact the mothers ability to parent. The presence of domestic violence also impacts decisions relating to parenting in the Family Court.

Engaging fathers rather than criticising mothers for their 'failure to protect' places the responsibility of a child's wellbeing and development back on the perpetrator. Framing domestic violence as a parenting choice of fathers simultaneously provides a starting point to motivate and engage participants in programs. Despite father's inability to understand the harm caused to children by domestic violence and little evidence to suggest fathers who use violence "make good or even adequate fathers," fathering is where men have demonstrated the most motivation to change and has often been a key turning point.[250]

Research in child development has stressed the impact domestic violence can have on children. This has been found to extend to coercive control, with children often used tactically to perpetrate harm and control over victims.[251] Post-separation, children may be used to continue to coercively control partners and has been seen to intensify the pattern of behaviour post separation.[252] When conflict between parents is frequent, intense and poorly resolved, it puts children's mental health and long-term outcomes at risk.[253] A study by Professor Eamon McCroy found children experiencing domestic violence have been found to exhibit the same hypervigilance as veterans exposed to combat,[254] highlighting the severe impact for children experiencing domestic violence. This is further supported by Megan Mitchell, the National Children's Commissioner, reporting domestic violence as a significant risk factor for youth suicide.[255]

Children may develop maladaptive coping mechanisms to reduce the impact of domestic violence. These can include self-protective behaviours such as dissociation, mediating arguments, hiding or absconding from the family home. Siblings may attempt to protect younger children from the violence.[256] Children have described feelings of fear, anxiety, powerlessness as well as experiencing symptoms such as insomnia, headaches and stomach pains.[257] Domestic violence further impacts children's ability to form attachments and healthy relationships in adulthood.[258]

The *Family Law Reform Act 1995* (Reform Act) provided the first clear statutory recognition in Australian Family Law of the importance of family violence as an issue to be considered in parenting decisions. The court could be argued to now play a significant role in child protection, making its understanding of domestic violence and coercive control vital. The importance of the court in these types of matters is reinforced by the lack of investigation by state child protection authorities into allegations of domestic violence, minimal consideration of all elements of domestic violence in family reports and the highly powerful and discretionary decision-making roles of judges.[259]

Whilst parenting capacity is not explicitly recognised in Section 60CC, parent history and the quality of children's relationship with each parent is, under Section 60CC (3). Parenting capacity can be defined as the ability to "recognise and meet the infant's changing physical, social and emotional needs in developmentally appropriate ways and to accept responsibility for this."[260]

Sedgley and Sedgley[261] recognised the importance of parenting capacity and the effect the wellbeing of a parent has on children. The major issue in the case included whether the disadvantages of ordering continued contact where the was a history of family violence and the adverse effect such an order may have on the primary carer's capacity and thus the children, may outweigh the potential advantages of the children maintaining a relationship with the father. It was found the behaviour of the father caused "great stress" for the mother, impacting her well-being and parenting. The impact on the nature of the relationship with the children's mother and siblings was considered, as well as the need for "peace and tranquillity" in the mother's home. This was considered as a more "compelling need" for the children, emphasising the need for stability and security, healthy attachment, minimal conflict and nurturing parenting within the home the child lives in.

Domestic violence can significantly impact the parent-child relationship and parenting capacity. The occurrence of domestic violence does not support the best interests of the child and their need to form healthy relationships with their parents for physical and psychological development. Child psychiatrist, Dr Bruce Perry, highlights that when a child's caregivers are unresponsive or

threatening, the attachment is disrupted and the child's ability to form any healthy relationships during his or her life may be impaired.[262] Parenting deficits have been closely associated with domestic violence and high conflict.[263] Conflict between parents has been associated with poor parent-child relationships as well as use of harsher parenting techniques and less emotional availability for children.[264] Women who experience domestic violence are more likely to use physical punishment to discipline their children.[265] Perpetrators may directly or indirectly undermine the mother-child relationship as a form of control and abuse. This may worsen and continue post-separation.[266]

Children are particularly vulnerable to the impacts of domestic violence due to their dependency on caregivers for survival and the critical periods of development present throughout childhood. This is supported by research on children's neurobiological functioning and how it is disrupted by domestic violence.[267] They are often regarded as 'silent' victims,[268] with their experiences largely unheard. The deeming of children as 'witnesses' is beginning to be challenged, as they are no longer seen as passive bystanders but deeply engaged in what occurs in the family environment.[269] This extends to the harm experienced as a result of domestic violence. Environment has a powerful influence on how a child develops,[270] with the risk of severe psychological harm for children experiencing domestic violence.

The chronic nature of domestic violence and its creation of ongoing fear and tension jeopardises children's healthy development. The fear response experienced by children can become almost automatic, leaving them in a state of constant hyperarousal, long after incidents of domestic violence have ceased.[271] This can impact a range of outcomes including academic performance. Children learn best when they experience a sense of safety and protection. If the attachment to the primary carer is disrupted the children's brain will become more focused on survival, impacting their future learning and ability to grow and thrive.[272] Children may never see their parent harmed, yet can be significantly impacted by the atmosphere domestic violence creates within the home.[273]

The most beneficial action a court can take for children is to cease the exposure to domestic violence and support the protective parent in establishing safety and promoting recovery from abuse.[274] Currently, mechanisms to protect children form domestic violence focus on limiting contact with their father. This results in children having an inconsistent relationship with their father and potentially without a reliable and beneficial father figure in their lives. If no contact with the children's father is ordered, children lose the opportunity to have both parents in their lives. Addressing the behaviour of fathers who use violence would help support children having a safe and meaningful relationship with both parents.

The ongoing stress experienced by victims inhibits attachment, with the focus of parents on surviving rather than connecting with their children.[275] Time and energy is diverted away from the child to minimise abuse. Abusive partners often insist their needs come first, parents focusing attention on the perpetrator, away from their children.[276] Additionally, the overwhelming stress experienced by victims has been seen to impact the use of appropriate parenting methods.[277] Parents who are experiencing trauma, such as domestic violence may be too emotionally unstable or inconsistent to offer their child the comfort and protection required for secure attachment.[278] Secure attachment is fundamental to children's long-term outcomes, resulting in children with reduced socio-behavioural problems, improved language and school readiness compared to children exposed to insensitive parenting and a history of insecure attachment.[279] A supportive relationship with at least one stable and committed adult caregiver assists children in building resilience and recover from domestic violence.[280] It is detrimental to children to risk secure attachment with their primary caregiver. Children are reliant on their caregivers for physical and emotional care, medical care, safety and behaviour management.[281] Domestic violence effects the sense of safety of children within the home and with their primary caregiver. Children as a survival mechanism may attach more strongly to the perpetrator against the other parent to minimise the abuse against themselves,[282] further disrupting the relationship with the victim. As a result of these impacts, domestic violence and coercive control has been regarded as an "assault on the caregiving system."[283] The challenges for victims of domestic violence do not cease with the relationship does indicating the importance of addressing the behaviour and holding perpetrators to account on the impact domestic violence has on children.

Programs targeting fathers often used the 'Safe and Together' model.[284] The Caring Dads program also accounts for perpetrators role as fathers. Uniting Care highlighted in their program, fathers were motivated to participant with their focus of wanting to be a better father and gain access to their children.[285] Caring Dads is a 17-week family group intervention program for fathers who have neglected their children or exposed them to family violence.[286] The program has a high retention rate and has been shown to have a positive impact on co-parenting, reduce risk of children's exposure to domestic violence and increase fathers to recognise the impact of domestic violence on children.[287]

Studies have demonstrated abuse does not end when the relationship between the perpetrator and the victim breaks down.[288] It is likely father's will still have some contact with their children post-separation. Court proceedings can also be used to continue coercive and controlling behaviour. Programs teach men they "cannot abuse or disrespect their children's mother without also hurting the children."[289] Fathers also have a fundamental role in their children's attitudes

towards gender and experiences of masculinity. In particular, the father son relationship is "an important mediator for how dominant forms of masculinity are passed on and maintained within the family and society more broadly."[290]

Research by Donald Dutton found one of the biggest contributors to domestic violence was related to childhood trauma.[291] This has been consistently supported throughout research. Engaging fathers can help prevent risk factors for abuse and break the cycle of intergenerational trauma. Programs have begun to consider the link between alcohol abuse and domestic violence, integrating parenting intervention into residential alcohol abuse treatment for fathers.[292] This approach has assisted father's staying in treatment for longer periods of time. Some MBCP may only choose to work with fathers and those who have contact with their children.

There is a lack of children's perspective in the delivery of MBCP. Programs that have engaged with fathers who use violence have shown promising results so far, although research is in its early stages.[293] Correcting father's behaviour is vital to maintaining the safety of children still in contact with their father, assists in building meaningful and positive relationships between fathers and their children, and supports co-parenting between the mother and the father without domestic violence and coercive control. Lack of engagement with fathers who use violence does not account the relationship children maintain with their father despite the domestic violence present. It is rare for parents to cease all contact when they are required to co-parent children and is only ordered by the court in the most severe cases of domestic violence. Failing to effectively rehabilitate fathers who use violence and continuing to use no contact orders as the only resource to protect children, risks leaving children 'fatherless.' It would be more beneficial to children's wellbeing, safety and long-term development to correct father's behaviour where possible and promote positive parenting skills and healthy attachment with their children. Children's safety needs to be the first priority when determining whether a healthy father-child relationship can be achieved.

Findings

MBCP face a variety of challenges that need to be considered and managed. Current MBCP in Australia are unlikely to address domestic violence long-term. The length of the programs and intensity is inadequate to correct the level of offending present and lacks the use of current research and evidence. Domestic violence needs to move beyond a legal response. Criminal punishment is important if Australia considers utilising strategies such as focused deterrence but the criminal justice system has to work in parallel with other interventions. Responsibility should not only be placed on victim services and women's organisations. It is critical to engage with perpetrators to holistically address domestic violence, stop the cycle and target domestic violence before it occurs.

Increased funding for programs is paramount to ensure vital funds are not taken away from victim services offering immediate safety to women and children. The wants and needs of women must be considered in program development and implementation. Solutions focused on victims separating from the perpetrator cannot be the only response. Some women have highlighted they do not want to leave their partner, only they want the violence to stop. Women's perspectives and voices should not be silenced. Victim's agency and empowerment needs to be supported in all circumstances.

Children are particularly vulnerable due to their developmental needs. They can be significantly impacted by domestic violence and endure a range of negative consequences. This has been emphasised by the ACE study and numerous practitioners. Despite this vulnerability, children also offer a space for early intervention that could shift their potential trajectory and promote long-term positive outcomes.

MBCP are significantly fragmented, varying from state to state and across service providers. Australia's approach lacks coordination of programs as well as consistent messages that operate alongside domestic violence campaigns, early intervention and education in schools. Scotland provides an excellent example of the coordination of media campaigns with the introduction of their coercive control laws, ensuring the message was consistent across all platforms.[294] The minimum standards developed by states for MBCP has not offered an adequate solution to the lack of consistency present.

More research in the area, particularly relevant to Australia is needed to determine the length and types of programs that are most effective for perpetrators. The 'one size fits all' approach and belief all perpetrators are the same is not sufficient and nor supported by current research. To

develop evidence-based practice in MBCP more evidence is required, as well as the implementation of evidence that is currently available. Common factors in programs that link to desirable outcomes is missing from research. Increased funding is necessary to adequately assess program delivery and participant outcomes. Evaluation of programs needs to be consistent if programs and their outcomes are going to be accurately compared. Evaluation of programs requires a set framework.

There are consistent risk factors for domestic violence that have appeared throughout multiple studies with a strong link found between gender, substance use, exposure to violence and abuse as a child and adult perpetration of domestic violence These risk factors do not appear to be addressed in many of the programs offered. Programs that have been successful such as the Family Peace Initiative Kansas address these common risk factors. There are multiple disciplines and jurisdictions that can be applied to domestic violence. It is important not to discount any of these disciplines.

Indigenous people and their communities have varying needs that must be considered in the development of programs. The current research calls for a trauma informed approach for both Indigenous and non-Indigenous Australians. Whilst it appears a trauma informed approach to domestic violence is embraced for Indigenous programs as well as addressing substance abuse, this is somewhat disregarded when developing mainstream programs despite the research indicating consistent links between domestic violence, trauma and substance abuse and increased effectiveness of programs addressing adverse childhood experiences. A trauma informed approach is relevant for all interventions and its inclusion in programs would benefit both Indigenous and non-Indigenous Australians. The current ignorance of common variables amongst perpetrators in fear of diminishing accountability and responsibility is neglectful to both perpetrators and victims and undermines the development of effective programs. The aim to hold perpetrators to account cannot discount a psychological and neurological analysis of perpetrators. Typologies of perpetrators that have been developed are not being utilised in practice. The integration of a biopsychosocial and ecological perspective and assessment would enable the delivery of programs to consider the perpetrator holistically, the level of risk they pose to women and children and the appropriate treatment.

Domestic violence is a multi-determined problem. It is impossible to establish one cause from the current research. This calls for multiple agencies and disciplines to coordinate their response, share knowledge and the responsibility of addressing perpetrators' behaviour. Fields such as psychology, law, criminology and sociology have all contributed to the understanding of domestic violence. Programs need to consider and address the multiple factors that contribute to domestic violence if they are going to be effective. With consideration of consistent risk factors and

correlations throughout domestic violence research, the sector can draw from a larger evidence base. Drawing upon multiple sources of knowledge can assist in "bridging the research and practice divide."[295]

Educational models such as the Duluth model and CBT, whilst providing a fundamental starting point, do not appear to be working alone to rehabilitate perpetrators. These models ignore many of the other risk factors prevalent in domestic violence research. A perpetrator may present with a variety of issues, requiring more intensive treatment and assessment. A purely educational model does not account for this. The adequate training of practitioners and frontline staff will be important to referral to programs and their delivery. A shift from education-based programs to intensive treatment will require qualified clinicians with experience in domestic violence and thorough understanding of perpetrators, victims and children. Frontline staff such as police, need to take a greater role in investigating domestic violence perpetrators and referring them to relevant support rather than relying on victims to report abusive behaviour. Identifying perpetrators and victims of domestic violence requires a different investigatory approach than other crimes and may require different questions to be asked. Some victims may not recognise domestic violence and the risk perpetrators pose. Increased training in domestic violence will help both victims and perpetrators access relevant treatment and support.

Domestic violence has been predominantly viewed as a criminal justice issue when it is clear a multi-agency response is required. It extends far beyond a legal problem and can be understood as a personal, social and public health challenge for Australia and internationally. Programs need to be remodelled to reflect this and aim for long-term outcomes for families. Information sharing between agencies needs to increase to ensure a comprehensive and safe response to perpetrators.

Judicial mechanisms can mandate treatment and prompt initial engagement however, it is not the only response required. MBCP has developed minimally since their beginning in the 1970s, this contrasts with other treatments such as mental health intervention that has developed alongside research. The biopsychosocial and ecological approach would allow interventions to address domestic violence comprehensively and prevent any individual risk factors and needs being unaccounted for. Addressing men's behaviour with effective treatment is paramount for the long-term safety of women and children.

Recommendations

1. Comprehensive assessment of perpetrators integrating a biopsychosocial and ecological approach to domestic violence. The program must match the perpetrators needs and account for their pattern of offending. Both the perpetrator and victim should be asked the same questions regarding the perpetrator to reduce the risk of misinformation and underreporting by the participant in the program. An assessment for programs needs to take into consideration:
    - Pattern of domestic violence and coercive control
    - Types of abuse
    - Level of risk
    - Attitudes and beliefs
    - Motivation to change
    - Psychological typology
    - Psychiatric conditions
    - Relationship status
    - Family relationships including contact with their partner or ex-partner
    - Contact with children
    - Parenting practices
    - Trauma history (ACE questionnaire)
    - Substance use
    - Employment
    - Education
    - Cultural and religious needs
2. Consistent evaluation of programs assessing outcomes and indicators of change pre- and post-program with follow up at 6 months, 1 year, 2 year and 5 year. This would enable programs to be evaluated effectively, consistently and monitor perpetrators and their progress. This would also enable the safety of women and children to be managed throughout the program and post-completion. Evaluation would include:
    - Police reports and reoffending rates
    - Risk assessment of victim and children
    - Level of fear assessment of victim and children
    - Victim self-report of incidences and pattern of abuse
    - Participant self-report of incidences and pattern of abuse
    - Attitudes and beliefs of participant
    - Indicators of change of participant

- Any other relevant government agency data including police, criminal court, family court, children's court, child protection, victim services, education and health departments.
- Stress reactivity of participant
- Attachment style of participant
- Impulse control of participant
- Emotional regulation of participant
- Participants who dropped out of the program
- Self-reported reasons for incompletion
- Outcomes in comparison to participants who completed the program
- Contact with children
- Parenting practices

3. Involvement of the victim and perpetrator in assessments for the program and evaluation post-completion.
4. All agencies in contact with the victim and perpetrator would be required to share information on patterns of offending. This includes the police, criminal court, family court, children's court, child protection, victim services, education and health departments.
5. Cross-agency practice standards for collecting and sharing information, fostering trust and collaboration across the domestic violence sector and the implementation of MBCP.
6. Specific legislation and training that facilitates information sharing and adherence to privacy laws. Information sharing would focus on perpetrators pattern of abuse and risk to women and children, with the safety of the victim as the priority.
7. Development of programs to include current evidence and research. This would involve a shift from solely educational programs to intensive treatment programs for perpetrators. The current evidence and international programmes highlight educational frameworks such as the Duluth model alone are not able to effectively meet all the needs of the perpetrator or take into consideration the multiple factors contributing to domestic violence. Further, the Duluth model is not applicable or supported by Indigenous perpetrators or their communities. All programs would be required to implement a trauma informed approach for both Indigenous and non-Indigenous perpetrators, women and children.
8. Implementation of a biopsychosocial and ecological frameworks in the assessment and delivery of programs. This would reduce the lack of consideration of common risk factors correlated with domestic violence and ensure intervention is targeted and matched to the perpetrator.

9. Programs in Australia to be a minimum of 52 weeks with consideration of the perpetrators needs and risk and ability to extend the length of treatment if necessary. This would include the consideration of residential treatment consistent with Israel and Ngarra Jarranounith Place in Victoria, allowing for more intensive treatment, the delivery of services in one location and prevention of services operating as silos. It would also support greater safety for women and children as perpetrators could be ordered to stay at the residential facility and women and children could stay within the home.
10. A whole integrated system and government approach in the delivery of treatment and programs and the use of multiple government agencies. Community services and non-government agencies would not be depended on to deliver programs. Program delivery and funding would be the responsibility of government departments.
11. Aligned with recommendations by ANROWS,[296] a central register of MBCP and their availability would be established. This would enable streamlined reporting and build on the evidence of effectiveness of specific interventions for perpetrators and enhance judicial knowledge of programs.
12. All jurisdictions implement a consistent approach to domestic violence and coercive control. This would include shared definitions and language and focusing on perpetrator accountability rather than placing responsibility on victims to protect themselves and their children from domestic violence.
13. Ability of all courts (family, criminal and children's court) to order completion of a MBCP and treatment and sentence perpetrators accordingly if they do not complete the program or engage. This would help bridge the jurisdictional gap that exists between the family, criminal and children's court.
14. Perpetrators in contact with the court would be seen by the same judge or magistrate so continuity is maintained throughout their matter and allowing judicial officers to gain an in-depth knowledge and pattern of offending and enhancement of case management.
15. Multi-disciplinary teams and clinicians involved in the assessment, delivery and evaluation of treatment.
16. Specific content should be included in programs for fathers (including stepfathers) who use violence on the effects of domestic violence on children and healthy parenting practices.
17. Contact with partners and children throughout and post program completion. Adequate resources and funding would be required for service delivery and the development of minimum practice standards for contact with partners and children.
18. Intensive voluntary programs available for women alongside perpetrator programs. This would ensure intervention, promote recovery and empowerment of victims and ensure

they are visible throughout the perpetrator program as well as consideration of their needs and perspective.

19. Specialised treatment for children of fathers who use violence. This would include mandatory referral for children to a trauma informed program that is individualised, developmentally appropriate and focuses on secure attachment to the non-offending parent. There is extensive research on the negative outcomes for children who have experienced domestic violence. Children who experience domestic violence are at risk of perpetrating abuse in adulthood as well as being victims themselves. This would ensure the reduction of the impact of childhood trauma, promote recovery, support early intervention and keeps children of fathers who use violence visible. Programs for children would be trauma informed, tailored to their individual needs and consideration of the co-occurrence of domestic violence with other forms of child abuse and neglect. A model similar to the LINKS program trialled could be used. LINKS delivers trauma-focused, evidence-based support and involves a multidisciplinary team including mental health clinicians, Indigenous mental health clinician, occupational therapist, speech pathologist, psychiatrist and customer service officer. The program has had significant results for children who have experienced complex trauma in OOHC.[297] Utilising complex trauma interventions takes into consideration domestic violence is likely to co-occur with other types of child maltreatment.
20. Availability of programs for women and children and contact with partners regardless of perpetrators engagement and completion of the program.
21. Integration of MBCP with a focused deterrence strategy. Focused deterrence has demonstrated substantial results when applied to domestic violence perpetrators. This would strengthen an interagency response to domestic violence, reduce reoffending, promote safety, and prompt participation in programs by perpetrators who want to change. Harsher criminal punishment would promote greater immediate safety for women and children, particularly if perpetrators are sentenced to longer imprisonment. Focused deterrence balances immediate responses to domestic violence as well as long-term change in domestic violence offending. Focused deterrence can be tailored to suit the needs of the community making it applicable to regional, rural and remote communities in Australia.
22. Indigenous programs need to include collaboration with Indigenous elders and the community to ensure treatment is:
    - Community ownership of programs
    - Focus on men's healing

- Holistic approaches
- Facilitation of cultural needs of participants to support healing

23. Coordination of treatment with campaigns and primary and secondary responses to domestic violence. Programs cannot operate in isolation, messages need to be consistent across all interventions and campaigns addressing domestic violence.
24. Cross training of staff delivering programs and the establishment of competencies for domestic violence practice proposed by Stover and Lent (figure 6). Training would include regular 'refreshers' to include new developments in research. Staff relevant to making referrals to MBCP and recognising domestic violence would also require increased training including:
    - Police
    - Correction officers and parole officers
    - Legal representatives, judicial officers and judges
    - Child protection caseworkers
    - Health practitioners and paramedics
    - Education and childcare practitioners
    - Advocacy and support services

Figures

Figure 5: MBCP Programs in Australia

Service Provider	Location	Program Name and Length	Evaluation
Baptist Care Family and Counselling Services	New South Wales – Bankstown, Campbelltown, Penrith, Tuggerah.	Facing Up 2.5-hour sessions for 20 weeks	Information unavailable
Manning Support Services	New South Wales – Taree, Forster, Glouster.	Taking Responsibility 18 weeks	Information unavailable
North East MBCP	New South Wales - Albury		Information unavailable
Liberty Domestic and Family Violence Specialist Services	New South Wales – Port Macquarie	Engage2Change 4 Individual counselling sessions 12 weeks	Information unavailable

CatholicCare Wilcannia Forbes	New South Wales – Wilcannia, Forbes	2.5 hour sessions for 18 weeks	Information unavailable
Men and Family	New South Wales – Lismore, Tweed Heads	MEND 3-hour sessions 32 weeks Participants are asked to commit to 8 weeks at a time.	Information unavailable
Settlement Services International	New South Wales - Fairfield (Arabic), Toongabbie (Tamil)	Building Stronger Families Voluntary program for men who have come to Australia from overseas 16 weeks	Information unavailable
Relationships Australia	New South Wales - Bathurst - Blacktown - Hunter - Illawarra - Lake Macquarie - Macquarie park - Maitland - Northern Beaches - Parramatta - Penrith - Sydney CBD	Building Stronger Families Taking Responsibility	Information unavailable
Relationships Australia Canberra and Regions	New South Wales – Wagga Wagga	Taking Responsibility for Respectful Relationships 18 weeks	Information unavailable
Kempsey Families Inc.	New South Wales – Kempsey, Nambucca Valley, Coffs Harbour	Engage2Change	Information unavailable

Anglicare	New South Wales – Parramatta, Nowra, Ulladulla	STOP Twice per week 11 weeks	Information unavailable
Catholic Care	New South Wales - Fairfield	Choosing Change 15 weeks	Information unavailable
Warrina DFV Specialist Services	New South Wales – Coffs Harbour	Engage2Change	Information unavailable
Housing Plus	New South Wales - Orange	20 weeks	Information unavailable
Mission Australia Central and Far West NSW	New South Wales - Broken Hill - Dubbo - Orange - Walgett - Central and Far West	50 hours of group sessions	Information unavailable
Centacare New England North West	New South Wales – Tamworth and Gunnedah	Disrupting Family Violence 20 weeks	Information unavailable
Catholic Care NT	Northern Territory – Darwin, Tiwi Islands, Wadeye	24 weeks 1.5-hour modules Engages a woman safety worker	Information unavailable
Tangentyere Council	Northern Territory - Alice Springs	MBCP 16 weeks 2-hour sessions Psycho-educational approach	Information unavailable
Holyoake	Northern Territory - Alice Springs		Information unavailable
Relationships Australia Queensland	Queensland - Spring Hill	Stopping Family Violence 18 weeks	Information unavailable
Centacare	Queensland - Gold Coast		Information unavailable

Uniting Care	Queensland Ipswich West Moreton Marcoochydore Gympie Caboolture Moreton Bay	Men Stopping Violence Program Men Choosing Change /Walking with Dads 16 weeks 2-hour sessions	Approximately half the women interviewed said their sense of safety had increased and they thought the program had contributed towards this. The full report can be found here.[298]
YFS	Queensland - Logan	Responsible Men 16 weeks	Information unavailable
North Queensland Domestic Violence Resource Service		MenTER (men towards equal relationships) 2 sessions a week for 7 weeks	Information unavailable
Brisbane Domestic Violence Service		Men's Domestic Violence Offender Program 27 weeks Duluth program Men's Domestic Violence Education Program 10 weeks	Information unavailable
The Centre for Women and Co.	Queensland - Logan	Disrupting Family Violence	Information unavailable
Better Relationships Org	Queensland - Strathpine, Buranda, Stafford, Riverview, Booval, Inala, Clontarf, Caboolture,	Living without Violence 18 weeks	Information unavailable

	Underwood, and Cleveland		
Helem Yumba Healing Place	Queensland - Central Queensland	Male Behaviour Change Program 3 phases	Information unavailable
Anglicare Victoria	Victoria Bayswater Box Hill Lilydale	MBCP 20 weeks Caring Dads 17-week program Fathers must be having some contact with their children and an incident in the last 6 months Program goes for 4-6 months	Evaluation of the Caring Dads program found positive changes in knowledge, awareness, attitudes and behaviour among some fathers who completed the program. However, it also found that some fathers who complete the program do not change sufficiently and their contact with their families should continue to be monitored. A full evaluation can be found here.[299]
Bethany Community Support	Victoria - Geelong and Warranmbool	Men's Behaviour Change Program	Information unavailable
Centre for non-violence	Victoria	Making aMENds	Information unavailable
CAFS	Victoria	No to Violence 18 weeks	Information unavailable
Dardi Munwourro (Strong Spirit)	Victoria	Men's Healing and Behaviour Change program	Information unavailable

		- Aboriginal men - Group meets fortnightly Ngarra Jarranounith Place 16 weeks Post support for up to 18 months Must complete Men's Healing and Behaviour Change Program fist	
Djerriwarrh health services	Victoria - City of Melton Moorabool Shire	Men's Behaviour Change Program	Information unavailable
Family Life	Victoria - Sandringham Frankston	20-week program	Information unavailable
Gateway Health	Victoria - Wangaratta Wodonga Victoria - Myrtleford	MBCP Two streams: Complete case management then group program Group is 2 hours every week Psychoeducation approach	Information unavailable
Relationships Australia Victoria	Victoria	MBCP 20 weeks	Information unavailable
Heavy METAL	Victoria - Hallam	40 weeks Delivered in three phases.	Information unavailable Documentary of the program and

			participants experience can be found here.[300]
Relationship Matters	Victoria – CBD Frankston Williamstown Wyndham	MBCP 20 weeks	Information unavailable.
Peninsula	Victoria - Frankston	Men Exploring Non-Violent Solutions 20 weeks 2 hours per session	Information unavailable
DPV	Victoria	20 weeks	Information unavailable
Link Health and Community	Victoria	MBCP 20 weeks Followed by support group	Information unavailable
Grampians Community Health	Victoria - Ararat Rural City Northern Grampians Shire Horsham Rural City	20 weeks education discussion group	Information unavailable
Latrobe Community Health	Victoria - Morwell Warragul Sale	20 sessions CHOICES is a similar educational program. It is especially for Koorie men runs over 16 weeks from our sites in Bairnsdale and Morwell.	Information unavailable
MDAS	Victoria - Mildura Swan Hill Kerand	TIME OUT	Information unavailable

	Robinvale		
Victorian Aboriginal Health Service	Victoria - Fitzroy		Information unavailable
Star Health	Victoria - Port Phillip, Stonnington, Bayside, Kingston and Glen Eira.	20 weeks program 2 hours per session	Information unavailable
Nexus primary health	Victoria	20 weeks 2 hours per session Short term counselling to support men until they engage in the MBCP	Information unavailable
Sunraysia Community Health Services	Victoria	20 weeks 2 hours per session	Information unavailable
Sunbury Community Health Centre	Victoria - Sunbury	20 weeks 2 hours per session	Information unavailable
Yarra Valley Community Health	Victoria		Information unavailable
Gippsland Lakes Community Health	Victoria - Lakeside Entrance Bairnsdale		Information unavailable
Kildonan UnitingCare	Victoria		Information unavailable
VACCA	Victoria		Information unavailable
Brophy	Victoria		Information unavailable

SalvoCare Eastern	Victoria - South Gippsland Bass Coast Shires		Information unavailable
Anglicare SA	South Australia - Hindmarsh Christies Beach	Dad's moving towards Responsibility 12 weeks 2-hour sessions Follow up support Can attend the group more than once Individual counselling throughout and after the group	Information unavailable
Relationships Australia South Australia	South Australia - West (Hindmarsh) Outer West (Port Adelaide) South (Marion) North (Salisbury) North (Elizabeth) Riverland (Berri) City (Frome Street)	Back on Track: A Men's Group for Positive Change 12 weeks	Information unavailable
KWY	South Australia - Adelaide North	For Aboriginal Families Accountability, Responsibility to Change Program Trauma-informed and therapeutic practice 2 days per week for 3 weeks (double sessions per day) 1 day per week for 6 weeks Short programs due to the transience of the	Information unavailable

		community in Port Augusta Metro Adelaide 12 weeks Elders do cultural activities.	
OARS	South Australia - Adelaide	Moral Reconation Therapy 26 weeks Safe Relationships 12 weeks CBT based.	Information unavailable
Catholic Care Tasmania	Tasmania		Information unavailable
Relationships Australia	Tasmania	Men Engaging New Strategies Individual counselling followed by a group program that runs for 10 weeks. Program runs for 20 – 24 weeks in total	Information unavailable
Relationships Australia Western Australia	Western Australia	24 weeks	Information unavailable
Centre Care	Western Australia Perth Joodalup Mirrabooka	Men Choosing Respect 2-hour weekly sessions	Information unavailable

		Educational program 5 one on one sessions 24 weeks	
Anglicare WA	Western Australia	Changing Tracks 24 weeks	Information unavailable
Communicare	Western Australia	Safer Communities Program Both men and women	Information unavailable
Nintirri Centre	Western Australia		Information unavailable
Men's Out Reach Service	Western Australia - Broome	Change Em Ways Program 8 weeks 3 days a week; 9-2pm Follow up phase – 1 visit per month for 5 months Strong Women, Strong Families Runs alongside men's program Children's Program focused on nurturing cultural, social and emotional wellbeing through bush play.	Information unavailable
Relationships Australia Canberra		16 weeks 2.5-hour sessions	Information unavailable
Everyman		12 weeks Home visits when appropriate	Information unavailable

		Helps with access to accommodation	
Domestic Violence Crisis Service	Room for Change	9-12 months 8 week emerge program 20 week men's behaviour change group 17 week caring dads group Access to accommodation whilst completing the program	Information unavailable
	South Australia, Western Australia and the Northern Territory (cross border region of Central Australia)	The Cross Border Indigenous Family Violence Program Four weeks 54 hours in total	Higher reoffending rates in Northern Territory in comparison to South Australia and Western Australia

Figure 6: Competencies for Domestic Violence Practitioners

Proposed Standards for Domestic Violence Providers

Carla Stover and Kimberly Lent, 'Training and Certification of Domestic Violence Service Providers: The need for a national standard curriculum and training approach' (2014) 4 (2) *Psychology of Violence* 117, 121-122.

Provider Type	Competencies	Acquisition
General for all providers	Knowledge 1. History of DV and the battered women's movement 2. Theory of power and control in relationships 3. Theory of empowerment	1. Minimum of 180 hours (or 12 credits of coursework/training focusing on competency achievement in the areas outlined (didactics, role plays etc in an educational

	4. Understanding of the different types of abuse (physical, sexual, psychological, economic etc.) 5. Understanding of the impact of violence on health outcomes (mental and physical) 6. The impact of DV on child development and parenting 7. The co-occurrence of substance abuse, mental health problems and child maltreatment with DV 8. The role of trauma in families impacted by DV (e.g. victim, children and perpetrators) 9. Confidentiality rights of clients and limits of confidentiality 10. Framework behind batterer intervention programs 11. Understanding of current knowledge of batterer subtypes/typologies and impact on potential treatment 12. Familiarity with community agencies involved with DV prevention and intervention, mental health services and substance abuse treatments 13. Legal aspect of DV (e.g. protective and restraining orders etc) Skills 1. Effective communication with clients and within networks	setting with expert faculty trainers)

	2. Ability to professionally interact between provider spheres 3. Assessment of batterer's violence history of, power and control behaviours and risk/lethality 4. Safety plan development and implementation 5. Implementation of proper coping mechanisms and self-care Attitudes 1. Awareness of the complex relationship between victims, batterers and children 2. Acknowledgement that families may want to stay together and hope for change/recovery (e.g. stake in effective batterer intervention treatment) 3. Openness to understanding the dynamics, difficulties and issues within each individual case	
Advocates and batterer interventionists (psychoeducational group leaders not treatment providers)	Knowledge in addition to above 1. DV shelter specific policies and procedures 2. Batterer intervention program curriculum Skills in addition to above 1. Screening of victims (adults and children) and batterers for trauma, mental health, substance abuse and power and control dynamics. 2. Facilitate psychoeducational or	1. Completion of basic 180 competency training outlined above 2. Minimum of 2,000 hours of practical experience. Including an initial period of direct observation and gradual transition to independent functioning. Must work with DV victims, perpetrators and child witnesses. With at least 25% of experience with each population type 3. Minimum of 3 hours of continuing education per

	support groups related to DV 3. Ability to refer clients to outside services when needed (case management, financial assistance, trauma, mental health or substance abuse treatment) 4. Court and legal advocacy related to DV **Attitudes** 1. Understanding of the client's individual rights within their relationship and in seeking services, acceptance of client's experience and wishes 2. Recognition that client's issues may fall outside the realm of advocacy/batterer interventionists skills	year focusing on current updates in DV intervention and knowledge
Clinicians	**Knowledge in addition to above** 1. DV assessment approaches and tools 2. Best practices in treatment and intervention for DV for each member of the family. 3. Understanding of the court-mandated treatment system as applicable to the profession **Skills** 1. Assess appropriateness for various intervention approaches and whether contact/sessions with family are appropriate and safe 2. Ability to implement best practice treatments for individuals and families	1. Completion of the basic 180-hour competency training outlined above 2. Graduate coursework relevant to assessment and treatment for family violence (e.g. impact of violence on child development, lethality assessment, comprehensive assessment of families including trauma, substance abuse, mental health issues and family dynamics) 3. A minimum of 2,000 hours of supervised/postgraduate field experience that includes supervised work with both batterer and victim (adult and child) populations. At least 25% of experience must be with each population type. 4. Professional licensure

	(including children) impacted by DV 3. Effective relationships and communication with DV advocates, batterer programs, courts, child protection and other providers who may be involved with the family Attitudes 1. Openness to meeting and assessing each individual involved in the family as appropriate 2. Acknowledgement that individualised intervention that meets the needs of a specific case/family is needed	5. Subsequent CEU for discipline e.g. social work, psychology) on most up to date research and interventions for DV (minimum of 3 per year)

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