WHERE ► TO

Department of Social Services

Evaluation of telephone and online domestic violence perpetrator intervention services

**Men's Referral Service
Brief Intervention Service
Changing for Good**

May 2024

Contents

Content warning

This report contains detailed discussions and analysis of family, domestic and sexual violence, which may include descriptions of physical, emotional, and sexual abuse. Some readers may find the content distressing or triggering. Reader discretion is advised.

Support resources

Support resources are available for those affected by or who consider themselves at risk of using family, domestic and sexual violence. These are listed below.

If you or someone you know needs help, please contact one of these services:

- 1800RESPECT – 1800 737 732
- Men's Referral Service – 1300 766 491
- MensLine – 1300 78 99 78
- 13Yarn – 13 92 76
- Lifeline – 13 11 14
- Beyond Blue – 1300 22 4636.

In the case of an emergency, please call the police on Triple Zero (000).

Glossary

Acronyms and abbreviations

Abbreviation	Meaning
ABS	Australian Bureau of Statistics
AFM	Affected family member
AIHW	Australian Institute of Health and Welfare
AVO	Apprehended Violence Order
BIS	Brief Intervention Service
CALD	Culturally and linguistically diverse
CFG	Changing for Good
CRAF	Common Risk Assessment Framework
FDSV	Family, domestic and sexual violence
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual (+ minority gender identities and sexualities not explicitly included in the term LGBTIQ)
MARAM	Multi-Agency Risk Assessment and Management Framework
MBCPs	Men's behaviour change programs
MRS	Men's Referral Service
MWUVA	Men who use violence and abuse
National Plan	*National Plan to End Violence against Women and Children* (2022–2032)
NOSPI	National Outcome Standards for Perpetrator Interventions
NTV	No to Violence
OTLA	On the Line Australia
PUV	Person using violence
RCFV	Royal Commission into Family Violence
The department	Department of Social Services
TTM	Trans-Theoretical Model
VPP	Violence Prevention Program

Definitions and terminology

We recognise words, terminology and definitions may be used differently and interchangeably for different purposes and in different contexts. We have outlined the meanings of common terminology used for the purpose of this evaluation.

Family, domestic and sexual violence (AIHW 2024[1])

Family violence is a term used for violence that occurs within family relationships such as between parents and children, siblings, intimate partners or kinship relationships. Family relationships can include carers, foster carers and co-residents (e.g. in group homes or boarding residences).

Domestic violence is a type of family violence that occurs between current or former intimate partners (sometimes referred to as intimate partner violence).

Both family violence and domestic violence include a range of behaviour types such as:

- physical violence (e.g. hitting, choking, burning)
- sexual violence (e.g. rape, penetration by objects, unwanted touching)
- emotional abuse, also known as psychological abuse (e.g. intimidating, humiliating).

Coercive control is often a significant part of a person's experience of family and domestic violence and abuse. It is commonly used to describe a pattern of controlling behaviour used by a perpetrator to establish and maintain control over another person.

Sexual violence can take many forms including sexual assault, sexual threat, sexual harassment, child sexual abuse and image-based abuse.

People who use violence (AIHW 2024)

While experiences of family and domestic violence, intimate partner violence and sexual violence are diverse, these are forms of violence that are more commonly experienced by some people – such as women and children – than others. These are also forms of violence more likely to be perpetrated by men than by women.

People who use violence is an inclusive term that encompasses all those who use violence against others. The term 'people who use violence' applies for all forms of family, domestic and sexual violence and can be used to describe any person, regardless of their age, sex or other characteristics. 'People who use violence' is the preferred term for children and adolescents (aged 18 years or younger) who use violence and people in some groups or communities, where other terms such as 'perpetrator' may not always be appropriate.

Perpetrator is a term used to describe adults aged 18 years or older who use violence. Perpetrators can use any form of violence, and this violence can occur within, or outside, a family or domestic context. The term perpetrator is not used frequently in this report because it is regarded by some in the sector as stigmatising and tied to criminal justice definitions of violence.

Offender is the term used when violence has been deemed to be a criminal offence. An offender is a person aged 10 years or older who is proceeded against and recorded by police for one or more criminal offences. A person who has been proceeded against by police for family and domestic violence–related offences may be referred to as an 'FDSV offender'. People aged 10–17 may be referred to as 'youth offenders'.

The domestic violence service system for people using violence

The system dealing with people who use violence comprises several services outlined below.

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[1]https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/what-is-fdsv#definitions-used

- **Men's Behaviour Change Programs (MBCPs)** target men who have used violent or abusive behaviour, using group therapy, counselling and education to foster non-violent conflict resolution and promote accountability. These programs, often court-mandated, aim to improve family and partner safety.

- **Telephone and online services** for men who use violence offer accessible support and intervention through counselling, resources and educational materials. These services aim to help people change violent behaviours and improve relationship dynamics, often providing anonymity and flexibility in access. The programs being evaluated in this report fall into this category.

- **Government interventions (courts, police, statutory child protection and justice services)** also deal with men who use violence. They do not attempt to change behaviour, focusing instead on law enforcement, legal proceedings, family safety and rehabilitative services. They aim to protect victims, hold perpetrators accountable and provide opportunities for behavioural change and rehabilitation.

Men also reach out to psychologists, counsellors and other mental health practitioners.

National Outcome Standards for Perpetrator Interventions (NOSPI)

The National Outcome Standards for Perpetrator Interventions (national outcome standards) (Department of Social Services 2015) were endorsed by the (then) Council of Australian Governments (COAG) on 11 December 2015. The standards were developed based on extensive consultation with government and non-government sector experts.

To keep women and their children safe, perpetrators should be held to account through effective interventions that stop their violence. The national outcome standards were developed to guide and measure the outcomes achieved by perpetrator interventions across Australia.

National Risk Assessment Principles for domestic and family violence

The National Risk Assessment Principles for domestic and family violence provide an overarching conceptual understanding of risk and managing risk in the area of family and domestic violence, with the intention of keeping women and children safe. The principles do not replace existing state and territory frameworks; instead, they provide a guide for policymakers and practitioners to develop risk assessment tools and resources (Backhouse and Toivonen 2018).

Low-dose programs

The programs being evaluated are sometimes referred to as 'low-dose' interventions. This is in reference to the relatively short nature of the programs. The total number of hours or interaction service users receive in these programs is relatively low compared with other programs available, such as MBCPs.

The literature agrees that 100 hours is considered by some as a 'moderate dose', but definitions of 'low-dose' vary. In this report we refer to all programs as 'low-dose' given they include a maximum of 12 contact hours (Sperber et al. 2013).

Report summary
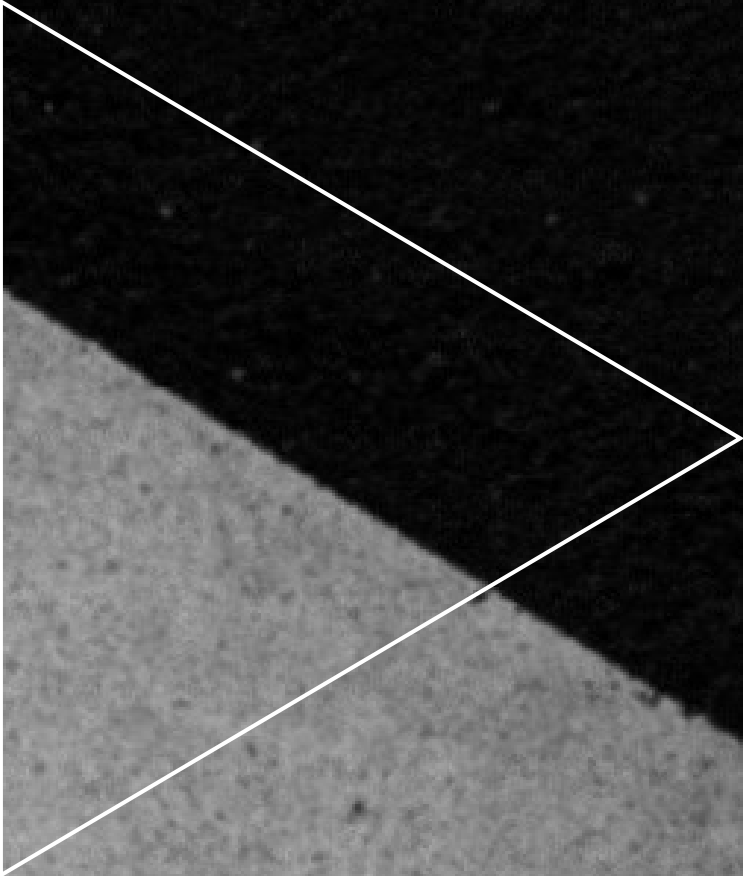
Report summary

Violence against women and children is one of the most widespread, persistent and devastating violations of human rights worldwide. In Australia, family, domestic and sexual violence (FDSV) issues, understanding how to address FDSV and ultimately prevent it from happening, has been on the national agenda for well over a decade. This requires an understanding of those who use violence and the system of services to respond to FDSV, a subset of which are designed to support users of violence through behaviour change interventions. In more recent years, there has been an increased focus and investment in men's behaviour change programs (MBCPs), which are a vital part of an integrated response to ending FDSV.

The Department of Social Services contributes funding to perpetrator intervention services including telephone- and web-based counselling and information and support services provided by No to Violence (NTV) and Lifeline. Three of the services delivered by NTV and Lifeline are:

- **NTV's Men's Referral Service (MRS):** The MRS offers a 24-hour national direct telephone and online support service for men who have used violence or controlling behaviour.

- **NTV's Brief Intervention Service (BIS):** The BIS offers a multi-session telephone-based counselling service for men who may be waiting to access a behaviour change program. It was introduced in response to elevated risks and longer wait times for MBCPs during the COVID-19 pandemic.

- **Lifeline's Changing for Good (CFG):** The CFG program is a telephone support service with 2 streams:

  - The **Post Men's Behaviour Change Program (Post-MBCP)** is designed to reinforce and maintain behavioural and attitudinal change in men who have undertaken MBCPs in the preceding 12 months. Service users receive multi-session support for up to 12 months. Men in the Post-MBCP are likely to be further along their behaviour change journey.

  - The **Violence Prevention Program (VPP)** is a 2-month telephone counselling program for men who are yet to use physical violence but who are worried their thoughts or behaviours may escalate to physical violence. A requirement of the program is that men have not used physical violence. It tends to attract men who are earlier on in their behaviour change journeys.

These services are designed as the entryway into the system for people who use violence. They support other perpetrator interventions such as MBCPs.

Overview of this evaluation

The purpose of this evaluation was to understand how the MRS, BIS and CFG services contribute, as part of the service system, to supporting men who use violence and abuse (MWUVA) to change their behaviour and improve the safety and wellbeing of affected family members (AFMs) (or, where applicable, former partners and children who do not live with them).

The evaluation scope included an assessment of the appropriateness, effectiveness and efficiency of these services. It also examined the outcomes of these services on different cohorts of men (i.e. Aboriginal and/or Torres Strait Islander men and culturally and linguistically diverse, or 'CALD', men) who use violence.

Key findings

Finding	Implementation
The sector requires a more holistic and joined-up approach to meet its aims of generational change.	**Organisations working in the behaviour change sector with MWUVA are siloed and often do not have strong linkages with other parts of the sector.** Problems often relate to information sharing: effective information sharing will help keep AFMs safer, will help with ongoing evaluations and understanding program effectiveness, and will be able to better support men's journeys of change. Better connections between police and the programs are required to ensure that referred men understand they will receive a call. Programs need to build awareness and understanding outside of their home bases in Victoria: interstate business development appears to have been lacklustre. Better conversations and connections between primary and tertiary prevention services are required to achieve change. Frontline staff have excellent insights into what could help drive change with respect to primary prevention activity. For example: • Many men are not aware that their behaviour is controlling, or of their own sense of entitlement. • Stigma and self-help (men's help-seeking behaviours) are key barriers. It will be important to include AFMs/partners in program design and for future evaluations to ensure the programs have a good outside perspective of the changes that the men are really making. • Services should acknowledge the difficulty of achieving this while allowing men to maintain a sense of anonymity, and the freedom this offers for self-reflection.
Funding arrangements impact on the extent to which these organisations can be effective.	**The programs operate in a competitive sector, which affects funding and collaboration.** Many organisations expressed the desire to collaborate better, but competitive tender processes can dissolve collaborative efforts. There is also no funding for innovation, and pilot funding is often not continued.
Reliability of data is a critical issue that needs addressing for NTV.	**The MRS and BIS are significantly limited by poor-quality data. Historical data has been collected using different methods, and large changes in numbers often reflect this.** Issues include changes to definitions, cumbersome collection processes, reporting errors and inaccurate data entry. September 2022 saw new processes for data collection implemented, but confusion about these remain among NTV staff.

Finding	Implementation
Men entering the MRS, BIS and CFG's VPP programs are generally at very early stages of their behaviour change journeys.	**Most MWUVA entering these programs are in the pre-contemplative or contemplative stages**. In other words, they are in denial about the extent of their violence or are resistant to change. Some have begun to recognise they have a problem but are yet to do anything about it. CFG's Post-MBCP program is the exception to this as men entering this program have already been through an MBCP and are more likely to have begun to move past the pre-contemplation stage.
There are substantial barriers affecting take-up and contact made to all 3 services by MWUVA.	Shame, judgement, stigma and traditional notions of independence and masculinity are substantial barriers to help-seeking among this cohort of men.
Motivations to engage these services are often extrinsic.	This means they stem from some external source such as a court mandate or fear of losing access to their partner or children. Intrinsic motivations (e.g. the desire for personal growth and self-improvement) are much less common but evident in some – especially those in the CFG VPP.

Finding	Appropriateness
These services represent 'low-dose' interventions and are unlikely to involve enough hours to create long-term behaviour change in and of themselves.	**Instead, these services should be viewed as the gateway or the top of the funnel into the service system for MWUVA in which they each play important individual roles** in crisis counselling, information provision, building motivation, encouraging ongoing engagement and developing treatment readiness. For many service users, this will be their first interaction with the system, and their experiences will be highly influential on their likely decision to seek help elsewhere. Therefore, interactions between frontline counsellors and service users are critically important. Current research identifies that for high-risk offenders, 200 or more hours of treatment reduces recidivism, while 100 hours or more reduces recidivism for moderate offenders. **These services function best as a port of entry into the service system. They are appropriate as services to encourage engagement with the sector but are less valuable as tools for long-term behaviour change.**

Finding	Appropriateness
The absence of the AFM in the risk assessment process is a key weakness in risk assessment, monitoring and response across the services.	The implications of the absence of AFM contact are multifaceted: • Services must rely on the testimony of MWUVA, when this group have been shown to minimise, deny and hide their violence. • Both the MRS and the BIS use the Victorian Multi-Agency Risk Assessment and Management (MARAM) Framework in Victoria. This tool works well when administered with the AFM but is less effective when being administered to MWUVA in isolation. • This also has an impact on the ability of frontline counsellors to correctly apply therapeutic tools in session, not knowing the extent of violence or the true level of progress of their clients. • It hobbles the ability for robust program evaluation for the same reasons as above. **By not keeping the AFM in view, the MRS, BIS and CFG have lowered the risk to their own organisations (i.e. where a MWUVA receiving counselling continues perpetration, the AFM could argue they are neglecting their responsibilities under best practice guidelines).** However, this means organisations cannot effectively manage risk, thereby pushing risk onto AFMs or the broader sector such as emergency services and other organisations including victim-survivor services.
The therapeutic approaches adopted across these programs appear to be somewhat loosely defined and are applied with a high degree of flexibility by counsellors.	This has benefits in that counsellors can respond to the diverse needs of MWUVA in the moment and build rapport with clients at the early stages of their behaviour change journey. However, it places great importance on the discretion of frontline counsellors, and therefore the need for more training and support for them. There should therefore be an explicit requirement for use of evidence-based approaches or agreed best-practice approaches for different MWUVA risk cohorts and points in the journey.
There is some duplication evident for the MRS with other national or state/territory-based services.	**Geographic duplication also occurs between the MRS and similar state-based services such as the Men's Domestic Violence Helpline in Western Australia and the DV Connect Men's Line in Queensland.** These services offer a 24-hour phone line providing support, information and referrals to callers (i.e. the same function that the MRS performs nationally). **Some duplication occurs with police referrals between the MRS and The Orange Door network in Victoria.** In Victoria, police referrals go through The Orange Door during business hours and the MRS after hours and on weekends. However, information sharing between The Orange Door and the MRS does not always occur, meaning there are instances where men are contacted by both programs, only to be told the same thing.

Finding	Appropriateness
There is low awareness of these services (or any services) available to MWUVA prior to engaging with the sector.	**Men are often not accessing services until their violence causes a personal crisis or precipitates government intervention in their lives** (e.g. criminal charges or family court interventions). From a service user perspective, there is general positive feedback indicating that the services came at the right time.
These services help bridge the geographic barriers faced by men living in regional, rural, or remote Australia	**Men living in regional, rural or remote Australia**, for whom a national call-based service helps bridge the geographical barriers they face (e.g. there may be no MBCP locally available). However, call-based services are not a direct replacement for face-to-face MBCPs, and many regional, rural, and remote service users lament the lack of services available to them locally.
For people with disability, the services are very helpful.	Those navigating mental health challenges felt safe and neurodiverse service users spoke about how the services helped them understand their neurodiversity. For those with physical disabilities, telephone counselling was especially beneficial because it removed physical barriers to access. Nonetheless there are service users with acquired brain injuries or cognitive disabilities who can find the self-reflection process required to take responsibility for their actions difficult. Some within this cohort will also be unable to comprehend basic concepts such as coercive control. It is unclear what hope we can hold for this group to change their behaviour, but it is unlikely that these low dose interventions will be enough to effect change in their lives.
For First Nations, the services were helpful but are likely to be only a small part of the solution.	**Aboriginal and Torres Strait Islander MWUVA are underrepresented in these services.** While Aboriginal and Torres Strait Islander men are over-represented in MRS and BIS relative to their population proportions, Aboriginal and Torres Strait Islander men are disproportionately represented in FDSV, implying that the services are not attracting First Nations MWUVA proportionally. **Aboriginal and Torres Strait Islander MWUVA consistently said they prefer face-to-face services**, a First Nations counsellor to speak with (and that the programs could not provide them with one), or First Nations–specific services. This offers a reason as to why Aboriginal and Torres Strait Islander MWUVA are underrepresented and why there
LGBTIQA+ participation in these services remains low, as it does across the sector in general.	**There are barriers to help seeking that are unique to LGBTIQ+ communities** including perceived lack of understanding from service providers of LGBTIQ+ issues and barriers such as stigma and fear of exclusion from their social circles or communities if other find out. **The services themselves continue to feel more targeted to straight, cisgender men.** However once men call into the services their experience can be positive. The two Gay male participants this evaluation consulted felt safe in their conversations with the services.

Finding	Appropriateness
CALD men reported feeling listened to, comfortable and safe.	**They did not perceive language proficiency or cultural background as barriers to benefiting from the programs.** However, the proportion of men who use the national Translating and Interpreting Service when contacting these services is low. Among the programs evaluated here, only the MensLine Australia website (on which the CFG VPP and CFG Post-MBCP program information is hosted) had information available in languages other than English. Instructions to access the MRS and BIS were available only in English.

Finding	Effectiveness
Overall, there are a range of positive indicators of the effectiveness of the MRS, BIS and CFG services.	**Overall, service users were much more likely to self-report a reduction in their violent, abusive or antisocial behaviours than an increase.** Large proportions of BIS service users self-reported reductions in all violence, abuse and antisocial metrics tested. Large proportions of CFG service users self-reported reductions in many metrics, especially verbal arguments and anger management. However, service users who reported the highest degrees of success in maintaining behaviour change also engaged with other services including MBCPs, specialist psychologists and other helplines. **Based on MRS program data and the online survey of service users, around 2 in 5 MRS service users are referred to other services, the bulk of which are made to other MBCPs.** This should be viewed as a relative success given the high barriers, potential for disengagement and resistance this cohort have towards behaviour change. Of those referred, just under a quarter (23%) have had multiple or ongoing contacts, and 1 in 6 (16%) have had a single contact. **Currently cold referrals are primarily used whereby the service user initiates engagement with the referred service.** Administrative burden and wait time on phones has reduced the ability of the MRS to make warm referrals. As a result, there are not yet strong links established with other services.

Finding	Effectiveness
However, some areas need further improvement to achieve intended outcomes. This is particularly around keeping service users engaged in the process.	**Three potential unintended consequences emerged in this evaluation:** • Some men in these programs have reported increases in violence, verbal abuse, controlling behaviour and other antisocial behaviours, calling into question the overall appropriateness of low-dose interventions. The literature identifies that some low-dose interventions have the potential to increase risk among lower risk men. • The positioning of the CFG VPP (1 of CFG's 2 programs) as pre-violence and distinguishing between physical and non-physical forms of violence in the VPP could support the idea that men in that program are not 'as bad' as men in other programs. This could inadvertently reinforce their inappropriate behaviours as 'normal' and 'acceptable'. • NTV staff mentioned there are men who contact intervention services (in particular, the MRS) to manipulate the system rather than wanting to change their behaviour. That is, they are attempting to deliberately use the system to achieve a better outcome at court, with child protection services or with the police. The services are aware of this and manage such situations.

Finding	Efficiency
Evidence suggests that program resources are being used to deliver flexible services to meet client needs.	**Most men surveyed had engaged in multiple sessions:** • CFG VPP clients typically received 3 to 4 sessions of counselling over 2 to 3 months. • CFG Post-MBCP clients had completed between 4 and 10 sessions. • Most BIS clients received at least 6 sessions over 2 to 3 months. • While the MRS model is not designed for ongoing contact, many men called several times over a period of up to 3 months.[2] They used the service not just for referrals but also for crisis support and counselling. As expected, for BIS and CFG service users, positive client outcomes were correlated with the number of contacts. The ideal number of sessions is likely to be highly individual, but the cap on sessions available is limiting the program's impact.
Historically, staff retention, capacity and talent have been problems for all these programs.	To retain and develop staff, these services must balance operational pressures, the need for robust clinical governance, and the needs for training that supports the personal and professional growth of counsellors. Some frontline workers expressed feeling undervalued by upper management.

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[2] It is likely that this is a sampling bias because men who were more engaged with the program were more likely to participate in the evaluation survey. However, it is currently impossible to determine the true number of sessions per caller because the anonymous nature of the MRS means repeat callers cannot be routinely recorded.

Finding	Efficiency
Access to a high-quality talent pool remains an ongoing concern in the sector.	Working with MWUVA requires a high skill level including formal training, technical expertise and good interpersonal skills.
	Vicarious trauma and direct abuse, especially for women, can take a significant emotional toll. This leads to many leaving the sector as staff seek more sustainable, long-term work elsewhere.
	Currently, training, recognition for upskilling and formal recognition of those skills are not acknowledged as well as some sector stakeholders thought they could be.

Recommendations

This evaluation has provided a range of insights into how current systems are working to support perpetrators' behaviour change journeys. This has allowed the evaluation team to develop a range of recommendations both at the overall level across the 3 programs and at the individual service level.

Some recommendations would require a significant reworking of existing contracts and approaches, while others are more easily achievable within the programs' current structures. These recommendations are presented below for the consideration of the department and service delivery teams.

Recommendations that apply to all programs	Recommendations in detail
Continue funding for all programs.	**All evaluated programs play an important role in the violence prevention system and should be continued.**
	Funding for these or similar telephone support services for MWUVA should continue. However, we make several recommendations below about how the programs could be better defined and structured to more effectively meet the government's goal of eliminating violence against women within a generation.
Make explicit the role these programs play as an entryway into the behaviour change journey for MWUVA.	**The most important role that these programs play in the system is as a low-barrier entryway into the behaviour change journey for MWUVA.**
	This evaluation found that the evidence on the potential for meaningful behaviour change via 'low-dose' telephone interventions is weak, but the role they can play in getting men into the system is important. Program staff can build trust and rapport with clients and may be able to move some men past the pre-contemplation stage to a place where they can see the need for change.

Recommendations that apply to all programs	Recommendations in detail
Better evaluation data is needed for continuous improvement of the programs and their funders.	• **For all programs, establish processes for pre- and post-engagement survey data collection** that is either automated or conducted by counsellors to collect data about participant progress. While this will be more challenging for the MRS in particular (given its anonymous nature), it would still be worth considering how this could be implemented. • **All programs require data linkages to other services** (e.g. MBCPs, alcohol and other drug services and mental health support) to enable tracking of men through the system to fully understand their progress, and to follow up on referrals. Again, this will not be possible for all calls to the MRS but should be considered where referrals – and especially warm referrals – are made. This should include the opportunity to collect recidivism data after 12, 24 and 60 months. • **For the MRS and BIS, monitor data quality over the next 6 months**. A new process for data collection was established in September 2022. Data quality should be closely monitored to ensure it is improving.
Require all programs to report on their adherence to National Outcome Standards for Perpetrator Interventions (NOSPI), or equivalent.	While there are a large number of indicators to consider as part of this – and not all will be relevant – the following headline standards (HS) would appear appropriate: • HS1: Women and their children's safety is the core priority of all perpetrator interventions. • HS2: Perpetrators get the right interventions at the right time. • HS4: Perpetrators participate in programs and services that enable them to change their violent behaviours and attitudes. • HS5: Perpetrator interventions are driven by credible evidence to continuously improve. • HS6: People working in perpetrator intervention systems are skilled in responding to the dynamics and impacts of domestic, family and sexual violence.
More investment in promoting these services is required to encourage men into the top of the funnel.	These services are creating a good 'flow-through' effect for those who enter the system. However, relative to the scale of family and domestic violence in Australia, program numbers are relatively low. A national above-the-line campaign for the MRS is recommended to build awareness and bring more MWUVA into the system. Consideration should be given to the target audience of that campaign: likely MWUVA or men at risk of choosing violence. The MRS should also be listed alongside other family and domestic violence referral numbers such as 1800RESPECT. Further promotion of BIS and CFG should also occur. This should be direct to MWUVA and could be supported by more communication and business development with other frontline services (GPs, psychologists, ambulance services, police) in all states and territories.

Recommendations that apply to all programs	Recommendations in detail
Improve sector collaboration through contracts and tender processes.	Collaboration is crucial to: • effective risk assessment, monitoring and response • better long-term behaviour change in men • better data sharing for evaluation • reducing duplication between services. Consider more collaborative tender/grant processes that encourage different organisations to work together. Provide specific funding (and where applicable, legislative change) to support collaborations between providers. This should focus on the priority areas of: • developing a secure, user-friendly data-sharing system for counsellors across the sector • developing internal processes, liaison and collaborative capacity building within organisations. Minimise competitive tensions in the sector to improve collaboration between organisations. This could be achieved by: • providing longer term contracts (although this evaluation was unable to determine an optimal contract length) or ongoing funding to reduce the frequency of competitive tension • structuring tendering processes in a way that prevents collaborating organisations competing for grants or funding • tying funding to outcomes that can only be achieved through interorganisational collaboration, such as successful tracking of MWUVA through the sector. Thoroughly review opportunities to minimise duplication of services, and ensure the different services being funded nationwide complement each other. • This evaluation found that the MRS potentially duplicates some state-based referral services for MHUVA in Western Australia and Queensland, and police referral services in Victoria. • Some of this duplication is about the market positioning of services like MensLine Australia and the MRS, and consumer confusion about the different purposes.

Recommendations that apply to all programs	Recommendations in detail
Develop a high-quality talent pool in the sector.	Consider requiring regular psychological support, guidelines around clinical governance and adequate debriefing time to handle the vicarious trauma for workers and re-traumatisation for victim-survivors working in the sector, which leads to burnout, churn and a lack of experience. Increase the length of contracts or provide ongoing funding for programs across the sector. Temporary contracts for programs mean temporary contracts for workers. Consider establishing credentialling within the sector to allow for better quality control of applicants and to provide a pathway to career development. This could include requirements around focused perpetrator intervention micro-credentials or certificates on top of existing requirements.
Design, develop and implement a national perpetrator risk assessment framework.	Currently the services are using different risk measurement and management approaches, some of which are not being used as designed. A national perpetrator risk assessment framework should be developed in consultation with the sector and across the jurisdictions to: • empower, train and support workers to apply risk assessment approaches with perpetrators • apply a consistent approach to perpetrator risk assessments across Australia • recognise the weakness of using tools designed primarily for risk assessment with AFMs in the absence of AFM contact • prevent the use of informal risk assessment tools • where appropriate, include the AFM perspective in that risk assessment. Consider including a marker for counsellor assessments of whether the perpetrator is using or likely to use the service to arm themselves to avoid taking responsibility for their actions or to present a better image to courts.
More investment in face-to-face services for Aboriginal and Torres Strait Islander men is required (e.g. MBCPs).	Not all Aboriginal and Torres Strait Islander men want a dedicated service to support behaviour change for MWUVA, but some require access to one if they want it. Currently these types of services are rare. • The MRS, BIS and CFG should continue to maintain the current standard of cultural awareness and cultural safety. Where possible, and if appropriate for individual clients, Aboriginal and Torres Strait Islander men could be referred into more appropriate face-to-face services or services delivered by Aboriginal and Torres Strait Islander counsellors, such as the Brother to Brother crisis line run by Dardi Munwurro. • Consideration should also be given to including an Aboriginal and Torres Strait Islander worker within the programs to give clients this option if they call. • Consider developing a stronger referral relationship for First Nations MRS clients to the First Nations–specific Brother to Brother crisis line.

Recommendations that apply to all programs	Recommendations in detail
More investment in services for gay, bisexual, trans and queer (GBTQ) men may be required.	**While this evaluation did not include a substantial number of GBTQ men, those who were included found the services helpful; however specialised services were believed to be more helpful.**
	Specialised services are relatively scarce therefore more investment in GBTQ specialised services may be required.
	It is important to note that the government funds a range of services supporting male victims of violence however not all services provide specialised support to GBTQ men.

Recommendations that apply to individual services	Recommendations in detail

For BIS and CFG, consider structuring contracts to prioritise ongoing engagement, referral onto other programs through more referrals and/or follow-up calls for BIS and CFG.

Given the long-term nature of behaviour change, case coordination is critical.

National case coordination for MWUVA does not currently exist and as national telephone-based services, these programs could potentially be reshaped to begin delivering this. This approach could help to alleviate the siloed and disconnected nature of MBCPs, provide a whole-of-system view that helps identify bottlenecks in the MBCP system, and provide alternative options for those unable to secure a place in a program.

A case coordinator could link clients to other relevant services, such as alcohol and other drug, homelessness, and mental health support, and conduct regular follow-up to ensure men stay the course. This model could also include a whole of family approach where services supporting perpetrators are delivered concurrently with services for AFMs. This is further explored in the recommendation that follows this.

It would also allow deeper insights into what works to support men's behaviour change, and help provide richer, more usable data for continuous improvement across the sector.

Under this arrangement, the services could continue to offer low-dose counselling and referral services and support for an ongoing behaviour change journey. However, their main roles would be to ensure MWUVA feel that someone is supporting them to change, keeping MWUVA in view of the system, and encouraging them to undertake programs where their beliefs and behaviours can be more robustly and safely challenged. This should include more emphasis on warm referrals (discussed further below) to MBCPs, counsellors or psychologists and, where possible, conducting ongoing risk assessments or evaluation exercises with clients to evaluate their behaviour change.

Case management — as distinct from the case coordination role we are proposing — is not being recommended in this report as there was not enough evidence gathered in this evaluation to support a national case management system. Case management is a comprehensive process that would likely require local service delivery and substantial coordination with local services.

While there would be potential benefits of a system like this, it could also be large, bureaucratic, or unwieldy. If case management is considered, thought should be given to leveraging the pre-existing networks and knowledge that local services have and consultation with the sector should be conducted.

Recommendations that apply to individual services	Recommendations in detail
Require BIS and CFG to attempt to contact AFMs to improve risk assessment, monitoring, response, counselling, and evaluation.	• AFM contact should be based in best-practice recommendations (e.g. ANROWS 2020), which states: 'The evidence suggests that every woman with a current or former partner involved with such a program should be offered support from the program or a partner organisation.' • How AFM contact is managed should be given careful consideration. It may be appropriate that it is managed by a separate organisation with expertise in supporting victim-survivors or at least a separate division within the organisation. • Efforts to engage client AFMs should be made, but their engagement should be voluntary (not a prerequisite of program participation). • For the MRS, AFM contact will be achievable for a limited set of clients. We suggest that partner contact be pursued but only where deemed appropriate by MRS counsellors – for example, for regular callers or those open to providing their details. • For the CFG VPP in situations where the man has not yet used physical violence, it may be appropriate to consider gaining the consent of the man before contacting AFMs. If so, this should be framed as a way of ensuring the man can get maximum benefit from their participation in the program.
For the MRS, consider structuring contracts to include providing warm referrals to other MBCPs and other parts of the sector.	The importance of warm referrals to the referral function of MRS should be recognised and embedded as a provision within contracts. • This will allow for better understanding of overall referral take-up by MRS clients and for a more co-ordinated system response to MWUVA. It will mean MWUVA are more visible, are engaged more often, and better tracked through the system.

Recommendations that apply to individual services	Recommendations in detail
Increase funding for the BIS and the CFG VPP to increase the number of sessions available.	The ideal number of sessions is likely to be highly individual, but the cap on sessions available is limiting the program's impact. • In the CFG VPP, it is recommended that the number of available sessions increase from 4 to between 7 and 12 times to allow enough time for rapport building and counselling. Across this evaluation, men's self-reported change from engaging with telephone counselling services appeared to hit a maxima at around 12 sessions. This is despite the international literature suggesting that even after this many sessions, there is still much work to do. Once completed, clients should then receive several follow-up calls as a check-in and to encourage engagement with other services. • For the CFG Post-MBCP program, men should be able to continue with the service for as long as needed. They should be followed up after completion (once in the first month, three months after that and a further three months after that) to encourage them to continue their journey of change, including via additional MBCPs and ongoing work with professionals. • For the BIS, it is recommended to extend the service following program completion. Discretion should be given to counsellors and the program about how many sessions to provide and to include follow-up calls for check-in and engagement encouragement. These follow-up calls are likely to be especially relevant for men who finish the program but are yet to begin an MBCP, and should be sustained at least until the man has begun an MBCP or other appropriate service (e.g. working with a psychologist). - At this stage there is no data on the optimal frequency of follow up calls. What is suggested here should be revisited with programs following the implementation of follow up calls to establish the ideal frequency.

Recommendations that apply to individual services	Recommendations in detail
Increase training and support for MRS, BIS and CFG counsellors.	**Consider allocating specific funding to training and better supporting staff.** • A very specific skill set is required to counsel MWUVA effectively and to address their diverse and complex needs. Counsellors consistently mentioned the need for more training and support to improve their ability to respond to clients well. This could include training in counselling practices, motivational interviewing techniques and vicarious trauma training. - There should be an explicit requirement for use of evidence-based approaches or agreed best-practice approaches for different MWUVA risk cohorts and points in service users' behaviour journeys. • Consider manualisation of clinical approaches, processes and risk assessments to provide consistency and direction to staff. While this may have some impact on flexibility, the manualisation should not be so rigid as to limit the degree to which counsellors can adapt to the different circumstances and situations. • This additional training and manualisation of processes should extend to processes and best practice to deal with service users who contact with the aim of manipulating the system (e.g. service users who call with the understanding that doing so will improve their position in the Courts).
Remove screening criteria preventing men who use physical violence from entering the CFG VPP program.	The distinction between physical violence and non-physical violence in the context of 'violence prevention' risks supporting perpetrator narratives that 'it is not violence unless it is physical'. It is also recommended that all men in the CFG VPP receive specific counselling interventions about non-physical forms of violence.
Add information to the NTV website (hosting MRS and BIS content) in languages other than English.	**This should include instructions for accessing the national Translating and Interpreting Service.** Men who contact the programs with the intention of using the national Translating and Interpreting Service is low.

Recommendations for further research	Recommendations in detail
Conduct a comprehensive audit of all FDSV perpetrator interventions to evaluate risk assessment processes, staff qualifications and counselling approaches used.	It was beyond the scope of this evaluation to seek out and list all the various programs available. However, it is apparent that the current risk assessment processes, staff qualifications and counselling approaches used can be applied inconsistently, or in an ad hoc, piecemeal manner. This comprehensive audit could aim to rank programs on the NOSPI and/or other measures of effectiveness to ensure better compliance across the sector.
Invest in further research into the skills and training of other frontline services to support behaviour change.	This evaluation heard that service users are using other frontline services to support their behaviour change journey, receive referrals or seek help at times of crisis. These include psychologists, nurses, GPs and psychiatrists. This research could also involve understanding the value of providing education on what services are available (e.g. the MRS).
Conduct research into alternative delivery models for Aboriginal and Torres Strait Islander men.	First Nations men are likely to be best served by specialised services using First Nations counsellors that allow for face-to-face interaction across metropolitan, regional, rural and remote regions of Australia (e.g. videoconferencing).

Detailed report

Introduction

Background

Family, domestic and sexual violence

Experiences of family, domestic and sexual violence (FDSV), intimate partner violence and sexual violence are diverse. But these forms of violence are disproportionately experienced by women and children and are overwhelmingly perpetrated by men (AIHW 2023).

In Australia, 1 in 4 women and 1 in 14 men have experienced physical and/or sexual violence from an intimate partner since the age of 15 (AIHW 2023, based on ABS 2021–22).

Holding perpetrators accountable has long been on the national agenda; it is a priority in the *First Action Plan of the National Plan to End Violence against Women and Children 2022–2032* (National Plan) (Department of Social Services 2023c) and was one of the 6 priorities of the Australian Government's *Third Action Plan 2016–2019* of the preceding *National Plan to Reduce Violence against Women and their Children 2010–2022* (Department of Social Services 2016).

Men's behaviour change programs

There has been a cultural shift in the understandings of men's roles in stopping violence, as highlighted by the Victorian Royal Commission into Family Violence in 2015–16 (Neave et al. 2016). This has driven increased focus and investment in MBCPs over recent years. It has become apparent that MBCPs are part of an integrated response to ending family violence rather than a standalone solution (Nicholas et al. 2020). One of the key steps towards reducing prevalence, as stated in the National Plan, is to ensure MBCPs and perpetrator interventions (such as those evaluated here) are effective. MBCPs are typically group-based interventions that work with men who use abusive and controlling behaviours, as well as their partners, ex-partners and family members. These programs aim to improve safety and wellbeing for women and children through facilitating change in perpetrator behaviour. They do this by helping perpetrators to take responsibility for their violence while also considering the risk of violence experienced by victim-survivors and their children (Vlais 2014). National outcome standards for perpetrator programs in Australia were developed in 2015 by Australia's National Research Organisation for Women's Safety (ANROWS).

Men's Referral Service, Brief Intervention Service and Changing for Good

As part of a suite of activities under the National Plan, the Department of Social Services contributes funding to perpetrator intervention services including telephone and web-based counselling, information and support services provided by No to Violence (NTV) and Lifeline (formerly delivered via On the Line Australia, OTLA).

Three of the services delivered by NTV and Lifeline are designed to support male perpetrators to change their behaviour. Each of these services are designed as interventions at the beginning of service user behaviour change journeys, they are often the entry point for service users into the service system.

- **Men's Referral Service (MRS):** national counselling, information and referral service for men who use violence and abuse to change their behaviour.

- **Brief Intervention Service (BIS):** a flexible, multi-session service to provide counselling support and referral options to assist men who have used violence to get further support. BIS focuses on providing short-term multi-sessional telephone support for men who use family violence, men who are on a waiting list for family violence support (e.g. a behaviour change program)

- **Changing for Good (CFG):** provides a one-to-one telephone counselling service for men who want to maintain respectful relationships without using violence. It includes 2 services:

    - **Post Men's Behaviour Change Program (Post-MBCP)** – a 6-month telephone counselling program that helps men continue the work they started in a men's behaviour change program.

    - **Violence Prevention Program** – a 2-month telephone counselling program for men who are worried that their thoughts and behaviours may escalate to physical violence.

A summary of the 4 services under these 3 programs is in Table 1.

Table 1: Overview of the intervention services

Service breakdown	Men's Referral Service	Brief Intervention Service	Changing for Good
Provider	NTV	NTV	Lifeline (formerly OTLA)
Period of operation	1993 – current	2020 – current	2015 – current
Number of active counsellors	9	8	5
Description of service	The MRS offers a 24-hour national direct telephone and online support service for men who have used violent and controlling behaviour. The service is customised to the client's risks and needs and may include information and advice, risk and needs assessments, development of safety plans, crisis counselling and referral to other services for further support.	The BIS was introduced in response to elevated risks and longer wait times for MBCPs through the COVID-19 pandemic. Offering a multi-session telephone-based counselling service for men who may be waiting to access an MBCP, or for whom such a service may not be appropriate, the BIS aims to enhance family wellbeing and safety through supporting people who have chosen to use violence, and achieve at least short-term change in behaviour to reduce the risk of violence, and maximise referrals to MBCPs or other services as a longer term solution.	CFG is a telephone support service designed to reinforce and maintain behavioural and attitudinal change across 2 distinct programs: 1. **The Violence Prevention Program (VPP)** is for men who are not yet using physical violence but are worried that they are at risk of doing so. 2. **Post Men's Behaviour Change Program (Post-MBCP)** is designed to reinforce the lessons men learnt through an in-person MBCP. Service users in each of these programs receive support in the form of multi-session counselling with information, referral and support services. Support is for up to 12 months for MBCP and 2 months for VPP to assist them to achieve lasting behaviour change.
Summary of service provision process	The MRS is a first point of direct client contact. In 3 states – Victoria, New South Wales and Tasmania – police referrals can be made after attending a domestic violence case. (Note, police referrals ceased in NSW at the end of 2023.) Inbound calls are received from service users or outbound calls are made to service users (if contact via police referral). Frontline counsellors will make an initial assessment of risk, make cold referral(s) to other supports/programs as needed and provide counselling. If required, follow-up call(s) may be arranged.	Referrals are received in 2 streams: via an internal referral if a man calls the MRS or via a link provided by a recognised service provider or agency. Up to 6 counselling sessions are delivered, with an option of expanding to 10 sessions if required. Referrals to other supports/programs (predominantly MBCPs) may be made and, if required, a letter of engagement provided. Allowance for non-attendance – 2 × SMS are sent and 1 × callback made.	Initial inbound approach is via a call to Lifeline's MensLine Australia through to CFG, or via an online expression of interest in response to which a CFG counsellor will make a call to the service user. The initial intake call allows a determination on suitability of VPP or Post-MBCP. • VPP – 4 phone counselling sessions every 2 weeks over 2 months, plus 1 follow-up session after the program is finished. • Post-MBCP – 12 phone counselling sessions every 2 weeks for up to 6 months, plus 1 follow-up session after the program is finished.
Mode of contact	National telephone and online support	Telephone support	Telephone support
Duration	Once-off service with optional follow-up if required	6 sessions, option to expand to 10	VPP – 4 sessions over 2 months Post-MBCP – 12 sessions (up to 6 months)
Participation	Participation is voluntary only.	Participation is voluntary only.	Participation is voluntary only.

Evaluation approach

The Department of Social Services commissioned Where*to* Research to conduct an independent outcomes evaluation of the MRS, BIS and CFG services.

Purpose

The purpose of this evaluation was to understand how these services contribute, as part of the service system, to supporting men who use violence and abuse (MWUVA) to change their behaviour and improve the safety and wellbeing of their partners and children (or where applicable former partners and children who do not live with them).

Scope

The evaluation scope included an assessment of the appropriateness, effectiveness and efficiency of these services and also examined the outcomes of these services on different cohorts of men (i.e. Aboriginal and/or Torres Strait Islander people and culturally and linguistically diverse [CALD]) people who use violence.

Ethics

Ethics approval was granted by the Victoria University Human Research Ethics Committee from 2 October 2023 to 2 October 2025. The ethics project title is: Evaluation of Men's Referral Service, Brief Intervention Service and Changing for Good.

Overview of evaluation design

A robust mixed-methods evaluation was conducted, guided by an evaluation plan that was developed in consultation with the Department of Social Services. This outlined the key evaluation questions and associated data collection framework.

Program logic development

Program logic development workshops were conducted by the Where*to* team with NTV and OTLA (now Lifeline) representatives to design the program logic and theory of change for each of the 3 services: the MRS, BIS and CFG (refer to Appendix 1).

Key evaluation questions

In considering the role that violence prevention services contributed to clients changing their behaviour, the evaluation focused on evaluation questions for the 4 domains of implementation, appropriateness, effectiveness and efficiency (Table 2).

Table 2: Key Evaluation Questions

Implementation	Appropriateness (the extent to which the program is doing the right things and fits with other programs)	Effectiveness (the extent to which the program is achieving the intended outcomes)	Efficiency (the extent to which the program uses resources well)
At what points in their behaviour change journeys are men engaging with these services and how do they find out about them? Consideration should be given to the antecedent factors that led men to engage with different services. • (for MRS) this may include examining how engagement with the service varies by channel (telephone versus webchats).	To what extent do these services adequately assess, monitor, and respond to the risk of clients committing domestic and family violence? In considering this question it is the expectation that the Service Provider consider: • To what extent do these services adequately respond to clients from diverse cultures, communities and circumstances (including but not limited to Aboriginal and Torres Strait Islander clients, clients from Culturally and Linguistically Diverse backgrounds, regional and remote communities, members of the LGBTIQA+ community, people with disability), and engage effectively with perpetrators with diverse needs? • As referral services, to what extent are men being referred to the right help at the right time? In answering this question, the Service Provider will consider the services' identification of factors that may contribute to individual client's behaviours such as substance abuse, gambling addiction, mental illness etc.; and appropriateness and timeliness of referrals to support services, including but not limited to Behaviour Change Programs. To what extent do these three services complement or duplicate each other, and other services provided by the Australian Government or State and Territory Governments?	(for MRS) To what extent are individuals engaging with services to which they are referred by the MRS, to what extent is that engagement ongoing? (for the BIS and CFG) What changes in clients' violent and/or controlling behaviours result from engagement with these services? Are these changes maintained over time? Are there any unintended consequences for clients and their family members (or current partners) from engagement with these programs (positive or negative)? (for BIS and CFG) What factors contribute to, or impede the success of clients changing behaviours? / (for MRS) what factors contribute to, or impede ongoing engagement with services designed to support changes in the behaviour? • Factors for consideration may include client demographics (including age, relationship status, cultural influences), therapeutic model/counselling approach or other aspects of the service, availability of or engagement with support services (for substance abuse, gambling addiction, mental illness, etc.), other perpetrator support services and/or the criminal justice/legal status, source of referral, and presenting behaviours/patterns. intervention strategies • Consideration should be given to identifying the most useful or essential elements of a service in supporting clients to change their violent and/or controlling behaviours.	(for BIS and CFG) How does the number of sessions and spacing of sessions completed at an individual client level relate to client outcomes? Are there any workforce issues impacting or likely to impact service delivery or opportunities to improve the use of resources? (for MRS) What proportion of clients using MRS enrol in other services and seeks out additional help?

WHERE TO

Evaluation methods

This section provides a summary of the mixed-methods

data collection, analysis and assessment methods applied in this evaluation.

Data sources icon	Data sources
📖	Document and literature review
📈	Program activity data
👥	Interviews with - Stakeholders - Service users - Frontline service staff
🥧	Online surveys - Service users - Frontline service staff

Review of documentation

A thorough review of program and related documentation was conducted to inform the evaluation design and the content of selected implementation and appropriateness evaluation components.

Literature review

A rapid literature review was undertaken of the academic and grey literature, the findings of which focused on mapping the extent of the problem, best practice service delivery and barriers and enablers to service access with respect to victim-survivors leaving family, domestic and sexual violence (FDSV) relationships. The literature review was reported separately, a summary of which is included in 'Appendix 4: Literature review'. Relevant findings are presented throughout this report.

Program data analysis

Program data was extracted and provided to Where*to* for this evaluation. It included areas such as total number of calls across time, delivered sessions and program demographics.

For CFG, the program data also included Intermediate Outcomes Measurement Instrument (IOMI) pre/post testing, which is an indicator of recidivism. Change over time in the IOMI was also analysed.

Interviews with stakeholders, frontline staff and service users

Primary qualitative research was conducted from August 2023 to February 2024, which included 34 semi-structured interviews with stakeholders, 29 interviews with service staff and 43 in-depth interviews with service users (Table 3-7).

All interviews were conducted via telephone or video call online and ran between 30 and 60 minutes.

Stakeholders

Interviews with stakeholders were conducted to understand the position and value of these programs to the sector, to other services in the sector such as police and child protection services and the perspectives of funders.

Table 3: Qualitative interview participants

Qualitative fieldwork	Number
Stakeholders	34

Qualitative fieldwork	Number
Government stakeholders	11
Peak bodies (inc. diversity peaks) or experts	5
MBCPs	11
Community health/legal services	3
Police	2
Child protection workers	1
Counselling hotlines	1

Frontline counsellors

Interviews with frontline counsellors were conducted as paired or group conversations with between *n* = 2 and *n* = 4 in each conversation. A range of topic areas were covered such as program successes and challenges, systems, processes, supports and training. These interviews were also used to, in part, validate the claims from service user interviews.

Table 4: Qualitative interview participants

Qualitative fieldwork	Number
Frontline counsellors	**18**
CFG	6
BIS	6
MRS	6

Management

Interviews with management were conducted according to the availability of management staff. This meant a group conversation was conducted for interviews with management staff for NTV while separate one-on-one conversations were conducted with CFG staff.

A range of topic areas were covered such as program successes and challenges, systems, processes, supports and training.

Table 5: Qualitative interview participants

Qualitative fieldwork	Number
Management	**11**
CFG	4
NTV	7

Service users

Interviews with service users were held via video call or telephone interview, with most participants electing to have camera off. Topics covered included self-reported behaviour change, how they came into contact with the service, barriers and enablers to contact, interaction with the counsellor.

Table 6: Qualitative interview participants

Qualitative fieldwork	Number
Service users	**43**
BIS	15
MRS	13
CFG	15

Among service users, this included a sample of:

- *n* = 14 service users with a disability
- *n* = 13 service users living in regional, rural or remote areas
- *n* = 8 CALD service users
- *n* = 1 First Nations service users
- *n* = 2 LGBTIQA+ service users.

First Nations MWUVA who have not used the services

Domestic and family violence is a significant and ongoing issue for First Nations communities. First Nations communities face many unique challenges contributing to violence such as colonisation, racism, intergenerational trauma and violence, displacement from traditional lands, the continued removal of children and high levels of incarceration. It was therefore important to include First Nations MWUVA in this evaluation.

Table 7: Qualitative interview participants

Qualitative fieldwork	Number
First Nations MWUVA	**3**
Have not used BIS, MRS or CFG services	3

Online surveys of service users and frontline staff

Primary quantitative research was conducted through online surveys with service users and frontline staff.

Service users

The questionnaire delivered to service users was designed using the IOMI, which is a validated scale for measuring recidivism among MWUVA and other metrics designed to measure prevalence of violence (detailed further below).

The survey was launched on 2 December 2023 and closed on 12 February 2024. Recruitment was conducted via email, with follow-up reminders via email and text message, and computer-assisted telephone interviewing.

The resulting survey response sample achieved is presented in Table 8.

Table 8: Online survey sample of service users (n)

Quantitative fieldwork – service users	Overall	BIS	MRS	CFG
Total sample	**131**	**56**	**44**	**31**
18–29 years	17	9	7	1
30–39 years	37	16	14	7
40-49 years	46	20	15	11
50+ years	31	11	8	12
Victoria	74	36	24	14
New South Wales	21	8	10	3
Queensland	18	4	5	9
South Australia	6	1	2	3
Western Australia	5	1	2	2
Tasmania	5	4	1	0
Prefer not to say location[3]	2	2	0	0
Disability	28	12	9	7
Regional, rural, remote areas	56	28	13	15
CALD	27	8	16	3
First Nations	5	4	1	0

Frontline counsellors

The questionnaire was delivered to frontline counsellors on 12 February and closed on 19 February.

The online survey to frontline counsellors covered: counsellor perceptions of role, impact and efficiency of the programs, internal program processes, ability to assist service users, and for MRS the proportion of callers who receive referrals.

Recruitment was conducted via email with follow-up reminders via email.

The resulting survey response sample achieved is presented in Table 9.

Table 9: Online survey sample of frontline counsellors (n)

Quantitative fieldwork – frontline counsellors	Number
Total sample	**13**
BIS	4
MRS	3
CFG	6

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[3] A broad range of service users across the 3 programs were approached to participate. However, no service users living in the ACT or NT took part in this evaluation. Both jurisdictions represent small proportions of the program users.

Intermediate Outcomes Measurement Instrument

The IOMI measures 7 domains that indicate risk of recidivism. Scores are measured in a 5-point Likert scale. Each domain is calculated by taking an average of respondents' agreement to 3 statements that indirectly link to that domain. The 7 domains are:

- **Resilience**: Capacity to recover from adversity, to move on in a positive manner or begin again. Related to individual coping skills and wider relationships and support networks.

- **Agency/self-efficacy**: Whether one can make autonomous decisions about one's own life and to make things happen in the outside world as a result.

- **Hope**: A calculation about perceived scope for positive future change. Linked to motivation and self-assessments of efficacy.

- **Wellbeing**: General or overall mental/emotional/psychological health or balance. Linked to positive self-regard and confidence.

- **Motivation to change**: Linked to positive engagement. A key focus is on internal rather than external motivation.

- **Impulsivity/problem-solving**: Lack of reflection and planning and a disregard of the consequences of behaviour. People who are highly impulsive also generally lack problem-solving skills.

- **Interpersonal trust**: Positive attitudes towards and connectedness with others. Links to notions of social capital.

The IOMI is a validated tool to measure outcomes for organisations delivering mentoring interventions to adult offenders.

It measures domains that are directly or indirectly associated with reductions in reoffending over the longer term, and that in the shorter term indicate positive changes along an offender's pathway towards an offence-free future.

Reliability and validity

In relation to internal reliability, one of the standard ways to estimate the degree of internal consistency is to calculate an 'alpha coefficient' for each key dimension. It is generally accepted that an alpha coefficient of around 0.70 or above indicates acceptable internal consistency. The alpha coefficients calculated for the IOMI tool's dimensions mostly fall above 0.70; however, resilience returned an Alpha of between 0.56 and 0.24.

The IOMI has strong face validity, as its design is strongly anchored in consultation and feedback from providers and other professionals who work with offenders.

Measuring change

Although the IOMI can track changes in key dimensions in participants, data generated through use of the instrument cannot be expected to speak for itself.

Positive changes measured by the instrument do not on their own establish an intervention has been effective, or even that the intervention itself generated those impacts. Therefore it is important to view IOMI results within the context of other data and evidence.

Trans-Theoretical Model to assess behaviour change

This evaluation used the Trans-Theoretical Model (TTM) to assess the behaviour change status of men. The TTM holds that behaviour change is a process with 6 stages: pre-contemplation, contemplation, preparation, action, maintenance and termination, which are outlined in

Figure 1. Relapse is not considered a stage but rather a step between termination and contemplation.

The TTM is an important tool for this evaluation to understand where MWUVA are with respect to their behaviour change journey and how the services being evaluated help them progress. Throughout this evaluation a critical lens has been applied to analyse the responses of service users who participated against what we know to be typical for each stage of change. In the context of FDSV, the TTM posits the following stages of change:

- Pre-contemplation – at this stage men are unaware that there is anything that needs to change.

- Contemplation – at the contemplation stage men are becoming aware of the need to change and are coming to grips with all the ways in which they may need to change and their implications.

- Planning – at the planning stage, change has been considered and small steps (e.g. starting a program on a non-mandatory basis) have begun.

- Action – through the action stage, change is actively underway, with some incidents of prior controlling/abusive/violent behaviour still happening but less frequently, less intensely and with enhanced reflection and remorse.

- Maintenance – change has occurred and is enduring, with no incidents occurring within the previous 12 months or longer.

Figure 1: The Trans-Theoretical Model of behaviour change
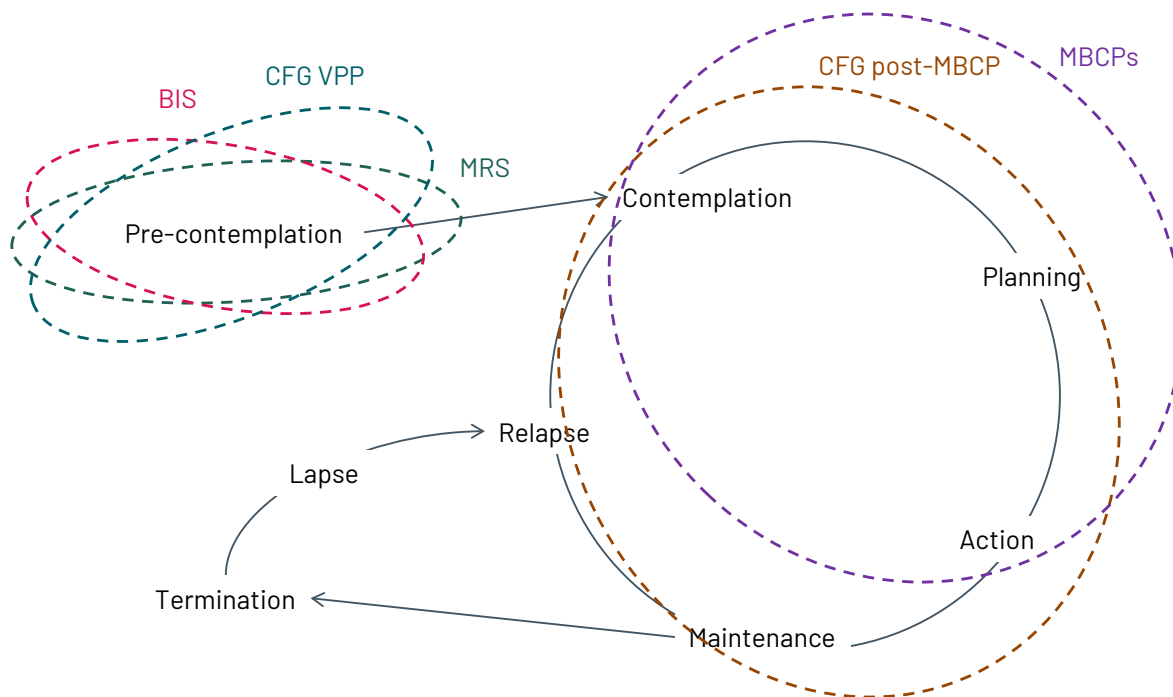
There are cognitions and cognitive distortions that denote that an individual is at different stages. These scripts are adapted from the Violence Risk Scale and developed in consultation with the clinical psychologist assisting this evaluation. Table 10 provides examples of these scripts that could be expected at each stage. The analysis uses these cognitions and cognitive distortions as indicators of change rather than simply relying on men's self-reported change. In interviews with service users, what they say is very often intended to minimise their violence and exaggerate their behaviour change. This is part of their image management – they understand violence will bring the judgement of others.

For example, a man who uses language and scripts that indicate he does not accept responsibility or shows an unwillingness to change would be deemed to be in the pre-contemplation stage.

Table 10: Example scripts at each stage of change

Stage	Cognitions / cognitive distortions examples
Pre-contemplation	*'Violence against women isn't real, it is an international conspiracy.'* *'Women lie to get access to money and kids.'*
Contemplation	*'Domestic violence is an issue in culturally diverse communities, but not my community.'*
Planning	*'I need to make a change, this isn't working for me. I have taken first steps.'*
Action	*'I have started making changes, and these are becoming more entrenched over time.'*

Stage	Cognitions / cognitive distortions examples
Maintenance	*'I have made consistent, considered and long-term (greater than 12 month) changes.'*

Readiness for change

Service users were also asked to rate their readiness to start to change when they first had contact with the service on a scale of 0 to 10 where 0 meant 'I had not thought about change at all at that stage' and 10 meant 'I realised I had a significant problem in my life, and I had already started to make changes'.

The results of this are presented as a self-reported readiness for change.

Limitations of this evaluation

There were several methodological and analytical limitations that are important to consider when interpreting the data quality and findings presented in this report. These broadly relate to the 3 broad dimensions of the ABS Data Quality Framework (ABS 2009), as detailed below.

Program data

- **Institutional environment and coherence** – Information from the MRS, BIS and CFG program data were provided for analysis, which comprised call and online activity data. The institutional environment for NTV in particular was an important consideration that influenced the reliability of MRS and BIS activity data. For example:
  - Limitations were evident in MRS and BIS historical data, which had been collected using different methods over time, and some large changes in reported metrics reflected this. Some issues include changes to definitions, cumbersome collection processes, reporting errors, inaccurate data entry and gaps/missing data points.
  - NTV advised that in September 2022 new processes for data collection were implemented and they are working towards a more consistent approach. However, some confusion about collection processes among NTV frontline staff remains.
  - A lack of testing and data sharing on referrals makes assessing the client or program outcomes from program data difficult for the purpose of evaluation. For example:
    - The MRS does not collect data from other providers about whether callers engage with the organisations they refer out to. This makes understanding the effectiveness of the MRS as a referral service difficult to ascertain from program data.
    - The BIS conducts some pre-post testing of participants but this is not comprehensive. This is referred to as the Standard Client/Community Outcomes Reporting (SCORE) data. SCORE was not able to be used in this evaluation because it began in 2023 and minimal data had been collected at the time of inception of this evaluation.
    - There is currently no systematic coding or analysis of case notes being done at either organisation. It is likely that this data could provide rich insights into both program effectiveness and men's behaviour change journey. New approaches, such as using AI analysis could prove fruitful, but are, as yet, unexplored.

Primary data collection

- **Timeliness** – Limitations with the sample of interview participants or survey respondents were experienced including:

    - Engagement with service users was limited to men who had completed one of the programs within the past 6 months because consent to participate in research and evaluation had not been obtained prior to June 2023. This meant it was difficult to make an assessment of any long-term impact of the program, and findings presented were limited to the reported short-term experiences of these participants.

    - The online surveys conducted were cross-sectional, not longitudinal; this limited our ability to understand change over time or permanent change. However, some CFG program data was provided that comprised pre-post testing of service users using the IOMI to give an indication of change over time in selected measures.

- **Coherence**[4] – There were some coherence limitations observed in the primary data collection process including:

    - Engagement was with service users and not partners/ex-partners, which meant this evaluation has had to rely on self-reported perceptions and experiences of participants. There is an empirically and clinically justified earlier assumption that the insights gained from the men is unreliable — they are likely to minimise their use of violence in self-report situations.

    - Due to constraints on how these services are set up, we were unable to engage with partners, ex-partners or other affected family members, for example, to gain broader insights of partner voices.

    - The CFG program consists of 2 streams: the VPP and the Post-MBCP. The quantitative survey was completed by a total of $n = 31$ CFG service users, including $n = 5$ Post-MBCP service users and $n = 26$ VPP service users. To avoid analysis of small sample sizes, the quantitative analysis of the CFG program looks at the CFG program overall not each stream individually.

    - There was some bias observed in the characteristics of men who participated in the evaluation. Men who participated may have been at lower risk.[5] Men considered very high risk, very pre-contemplative or men who have disengaged were less represented in the sample. It is recognised in the literature (refer to Appendix 4: Literature review) that higher risk factors make men more likely to disengage from enrolling or completing a program (Olver et al. 2011), such as having prior FDSV

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[4] The ABS Data Quality Framework describes coherence as referring to 'the internal consistency of a statistical collection, product or release, as well as its comparability with other sources of information, within a broad analytical framework and over time. The use of standard concepts, classifications and target populations promotes coherence, as does the use of common methodology across surveys. Coherence is an important component of quality as it provides an indication of whether the dataset can be usefully compared with other sources to enable data compilation and comparison.'

[5] Evaluation participants were determined to be 'lower risk' through consultation with the clinical psychologist assisting on this evaluation.

offences, having an antisocial personality, a history of criminality, non-mandated attendance, younger age, and little motivation for treatment.

- There was likely bias that men who received a better service experience were more likely to participate in the evaluation compared with those who received a service experience they felt provided little for them. If present, this bias could mean that the feedback received in this evaluation was more positive than was true for the experience of all participants. It is difficult to quantify the full extent of this bias given the evaluation cannot know the experience of those not interviewed or surveyed.

- The evaluation was affected by limited representation of selected sub-groups including:

  - Small numbers of Aboriginal and Torres Strait Islander men – the online survey received only 5 responses across the MRS and the BIS but none in CFG, interviews were conducted with 1 Aboriginal man who had used the MRS and 3 who had not had contact with any service but who had used violence.

  - Small number of LGBTIQA+ community members – the evaluation only included 2 survey responses and 2 interviews with gay men (MRS and BIS). No other LGBTIQA+ community members participated. The experience of intimate partner violence within LGBTIQA+ communities can be very specific to those communities therefore insights related to the services directly apply for the experiences of the 2 gay men only.

- Institutional environment[6] – limitations relating to the institutional environment of these programs were also observed.

  - There is a dearth of evidence in the literature on short term, call-based intervention services focused on MWUVA, meaning evidence stemming from the literature review supporting this evaluation, relies in part on literature relating to other fields that are assumed to have some comparability – for example, literature with men in corrections and the effectiveness of call-based services for people in mental distress.

  - NTV and OTLA grew very rapidly in recent years and have each experienced issues with that growth, undergoing constant change over the last several years. This has impacted on data collection within the programs.

  - The organisations running these programs were not set up for good evaluation of the programs at the time: NTV and OTLA.

    - At the time, the programs did not collect evidence of change from AFMs or others around them.

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[6] The ABS Data Quality Framework describes the institutional environment as 'the institutional and organisational factors which may have a significant influence on the effectiveness and credibility of the agency producing the statistics. Consideration of the institutional environment associated with a statistical product is important as it enables an assessment of the surrounding context, which may influence the validity, reliability. or appropriateness of the product.'

- Important evidence that could be used to support evaluation is collected in counsellor case notes but is not analysed effectively, nor structured for analysis.

Limitations are noted throughout the results and findings presented in this report to ensure interpretation is appropriately caveated where required.

Addressing limitations in this evaluation

This section outlines the methodologies employed to address the identified limitations in the program evaluation:

- **Enhanced Data Collection through Detailed Surveys:** To mitigate the limitations associated with the program data, detailed surveys were conducted with service users. This approach was designed to deepen the understanding of user experiences and outcomes, thereby enriching the data quality and reliability.

- **Interorganisational Collaboration for Data Sharing:** The issue of insufficient data sharing with other service providers was systematically addressed through structured consultations with various referrers. This initiative aimed to foster greater transparency and cooperation, facilitating a more comprehensive aggregation of data across services.

- **Incorporating Frontline Counsellor Perspectives to Mitigate Bias:** To counteract the potential self-report bias inherent in client interviews and surveys, the evaluation process actively canvassed the views of frontline service providers. This measure provided a critical balance, integrating professional insights with client feedback to present a more accurate representation of the program's impact.
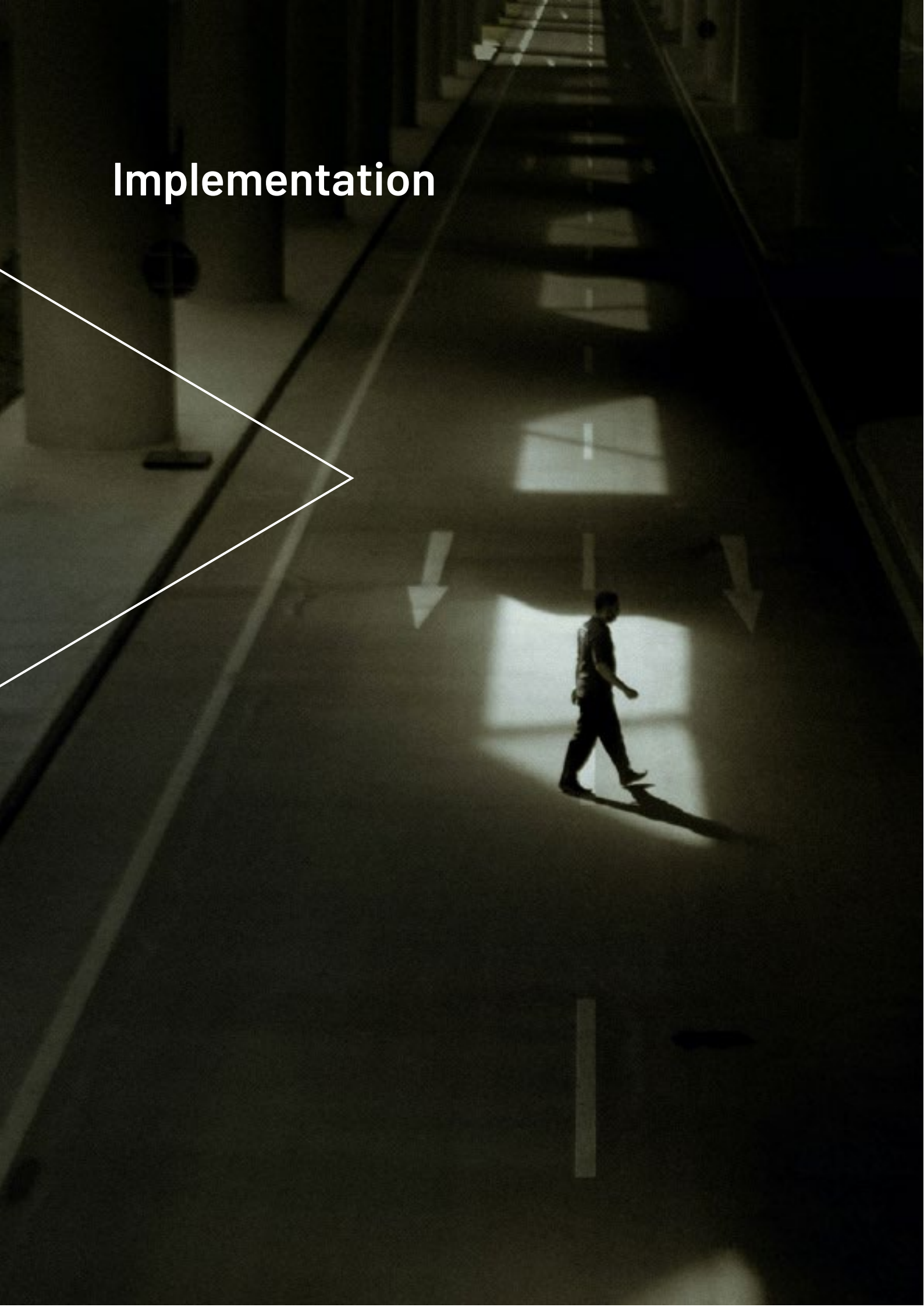
Implementation

Implementation

At what points in their behaviour change journeys are men engaging with these services and how do they find out about them?

- Consider the antecedent factors that led men to engage with different services.
- (For the MRS) this may include examining how engagement with the service varies by channel (telephone versus webchats).

Implementation key findings

- Each service plays its own role in supporting men's behaviour change journeys. Most men entering the MRS, BIS and CFG programs are at very early stages. Consultations with frontline counsellors and analysis of cognitive distortions show the vast majority are pre-contemplative or contemplative and so are in denial of the extent of their violence and are resistant to change.
    - CFG's Post-MBCP program is the exception to this. Men entering this program have already been through an MBCP and are more likely to have begun to move into and even past pre-contemplation.
- Service users' self-reported readiness to, or progress of, change tended to be greater than the demonstrated level of change, which is consistent with the literature that has consistently found men are likely to use image management to minimise or under-report their violence.
- A range of antecedent factors were evident as both barriers and drivers to men's engagement with services.
    - Barriers: Shame, judgement and stigma are significant barriers to help-seeking among this cohort of men.
    - Drivers: Motivations to engage these services are often extrinsic (stem from some external source e.g. court mandate, fear of losing access to a partner or children). Intrinsic motivations (e.g. the desire for personal growth and self-improvement) are much less common but evident in some. The literature shows intrinsic motivation is strongly correlated with treatment readiness.
- Telephone (not online chat) is the dominant mode of contact for these services.

Integration is a key challenge across the sector

While there are some notable exceptions, the behaviour change sector is lacking good and effective connections between its component parts. The lack of integration between the different services that intersect with MWUVA means that some MWUVA can slip through the cracks, some are more easily able to evade attempts to support their behaviour change journeys, and some are able to keep repeating violent behaviours with new partners. It also means that the sector is not optimised for learning about what works to encourage MWUVA to begin a journey of behaviour change, and what is required to see this journey through to the end.

The significance of primary prevention in motivating potential clients to initiate contact is a crucial part of preventing FDSV. Many individuals may not recognise that their actions are controlling or that they have an ingrained sense of entitlement. Effective dialogue between primary and tertiary prevention sectors is crucial; frontline staff can provide invaluable insights into strategies that could enhance demand for behaviour change programs. This evaluation did find that some primary prevention organisations have begun employing staff with backgrounds in tertiary prevention, but the examples were relatively sparse.

Moreover, fostering a better understanding and connection between police and intervention programmes is essential to ensure that referred men are aware they will receive follow-up calls, as evidenced by the differing approaches in Tasmania and New South Wales.

Challenges related to information sharing persist; however, effective information exchange is vital for enhancing the safety of AFMs, improving programme evaluation, understanding effectiveness and supporting men's journeys of change.

The importance of including AFMs or partners in future evaluations – and potentially in future programmes – is acknowledged. It is crucial to balance this inclusion with the maintenance of anonymity for the men involved, as this anonymity facilitates self-reflection and engagement in the programme.

Funding arrangements

The absence of sustained, secure funding markedly impedes the capacity of organisations to develop and refine their programmes over time.

The competitive nature of the sector exacerbates barriers to collaboration. NTV, Lifeline and other sector stakeholders (e.g. MBCPs) interviews showed that despite a widespread aspiration for enhanced collaboration, the introduction of competitive tendering frequently undermines these collaborative initiatives.

Additionally, the pursuit of improved collaboration necessitates further funding, and in turn imposes additional burdens on already significant workloads. There is also a conspicuous lack of funding for innovation, with pilot projects rarely receiving ongoing support, and a prevailing risk aversion that stifles creative endeavours.

Furthermore, while NTV assumes the functions characteristic of a peak body, it lacks the corresponding funding, prompting other organisations to question the value it provides, thereby intensifying the sector's challenges.

Roles of the programs

All evaluated programs play an important part in the violence prevention system, specifically as an entry point for men first entering the behaviour change sector. The MRS has a relatively long history for services in this space, starting in 1993. CFG began more recently in 2015 while the BIS began more recently again, in 2020. The evolution of these programs has been during a time of increasing focus on FDSV in Australia. The literature review (refer to Appendix 4: Literature review) highlighted many national, state and territory plans and policies that have focused on FDSV priorities. National plans have been focusing on FDSV for over a decade through the *National Plan to Reduce Violence against Women and their Children 2010–2022*

(Department of Social Services 2016) and the current *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services 2022).

State and territory governments have also focused on a range of FDSV strategies and transformations in support services. For example, in the wake of the Victorian Royal Commission, the FDSV sector witnessed substantial transformations, including the introduction of the Multi-Agency Risk Assessment and Management Framework (MARAM) and the establishment of The Orange Door, aimed at enhancing family violence support services.

Within all the national, state and territory FDSV strategies and plans, there is a focus on perpetrator accountability through access to programs and services to address behaviour change. This coincides with the establishment of the MRS, BIS and CFG services.

Men's Referral Service

The MRS is a 24-hour national gateway into the service system, the functions of which include crisis counselling[7] (but not crisis response), information provision and making referrals. Men contacting the MRS are often interacting with the FDSV service sector for the first time, and for these men, it is a crucial first step towards change – the importance of which cannot be understated.

Men reported that their interactions with the MRS were very helpful in locating the appropriate programs, helping them understand their situation and/or receiving crisis support, with many reporting positive experiences. Rather than being a once-off event, some men call multiple times over several months as they navigate their situation.

'[Before I engaged MRS] I knew I wasn't doing that great, but I didn't know what was going on and I saw a few counsellors earlier but because I didn't know what I needed they weren't helpful. I needed direct help with what was happening right now. When my wife said I was controlling, the MRS was a great help because I was finally able to get help for that. Beforehand I just didn't know what to seek help for.' – MRS/BIS service user, male, Victoria

'Finding the right help and the help I needed was the barrier. Once I found that help, I was able to work on what I needed to.' – MRS/BIS service user, male, Victoria

'The MRS gave me that thing where I am not missing something that could be an unhealthy thought and you can call any time. The times I called I needed assistance in the moment. There was too much going on for me at the time to save it all up and discuss in a single session at a later time.' – MRS/BIS service user, male, Victoria

The MRS also benefits other services such as police, courts and child protection workers by providing vital information. For example, educating men about the implications of a Family Violence Safety Notice can prevent further violations, thereby aiding the police in reducing risks. Similarly, by explaining legal procedures and options, the MRS helps men better prepare for the legal process, streamlining their navigation through the system.

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[7] Crisis counselling provides immediate, short-term psychological support to help individuals cope with acute emotional distress after traumatic events. The MRS provides crisis counselling but will speak with emergency services (most often police) if crisis response is required. An example of when response is required would be if the service user discloses an immediate intent to harm their partner or themselves.

'The judge said talk to the MRS, they'll find out what you need and send you in the right direction, as opposed to, you just need to change your behaviour because you're ... this or that.' – MRS service user, male, Victoria

'I see these services as extremely beneficial when the people are engaged with them. They're an amazing support because it's something that we as police can't do. So, to have support agencies in there that provide the time and money to try and change people's behaviour is fantastic. I personally see the massive benefit in these programs and, yes, the more of these the better for me because that will mean that the people are getting seen sooner, and the problem might stop sooner as well because we do get a lot of recidivism in the family violence space. If we can put some support in early then that's going to minimise that as well.' – Recently retired Senior Sargeant, Victoria Police

Brief Intervention Service

The objectives of the BIS are preparing men for behaviour change and keeping them engaged while they wait to start an MBCP. At the time of its introduction, MBCPs had waitlists of up to 18 months, which was clearly unacceptable for those who needed support to begin a behaviour change program immediately. BIS also sought to overcome the anticipated physical distancing restrictions arising as a result of the COVID-19 pandemic, and therefore to offer support while in-person men's behaviour change (MBC) group sessions were not available.

At the time of this evaluation, not every MBCP had significant wait times, some were able to accept men immediately, some cap the total number of men that can be enrolled, while some do put men on a waitlist.

The BIS caters to men who are at the pre-contemplative stage in their behaviour change journey. Men participate voluntarily and are either awaiting entry into an MBCP, do not find group suitable (e.g. they are too pre-contemplative, suffer from social anxiety or live remotely where there may not be face-to-face programs available).

'I rang and ...I was surprised that they answered. So that was important. It was there when I needed it. Whereas there's a delay for men's behaviour change and, obviously, there's massive delay to see any sort of psychology or counselling these days, there's just such wait, like a couple of months' delay.' – MRS service user, male, Victoria

'The MRS counsellor, she referred me on to the Brief Intervention Service whilst I was put on the wait list for the men's behaviour change program.' – BIS service user, male, CALD, New South Wales

The BIS offers up to 10 telephone counselling sessions for MWUVA and aims to begin the process of behaviour change. Given this relatively small number of sessions, for most men, the BIS was seen as very helpful but only a small part of their overall change.

Changing for Good Violence Prevention Program

The CFG VPP is designed for men who have not committed physical acts of family violence but have concerns that their feelings, attitudes, and behaviours may lead to physical violence or have significant relationship problems. The VPP provides support to help strengthen all relationships in service users lives.

According to stakeholder and service user feedback, the men who enter this program are typically more motivated to change and often seek out help themselves. However, again, for

most men this is the first time they have engaged with services to address their behaviours. The VPP is therefore also very early in the journey of behaviour change.

The current evidence base suggests that it is unlikely that 4 sessions will be able to prevent violence. Current research identifies that for high-risk offenders, 200 or more hours of treatment reduces recidivism, while 100 hours or more reduces recidivism for moderate offenders (Borseth et al. 2023; Sperber et al. 2013). Rather, the VPP works as a good entry way into the system by offering men a start on their behaviour change journey and referral onto other services where the bulk of the change is likely to occur.

'We get people who volunteer themselves, so we have a very high level of cooperation, disclosure and being prepared to be challenged. I'm actually shocked at how deep some people are prepared to be challenged. They often appreciate the fact that someone will stand up to them. We've got a relatively great cohort that come to us; they're probably the easier end of what happens in men's behaviour change groups.' – CGF frontline counsellor

Changing for Good Post-MBCP

The Post-MBCP is intended to consolidate the learnings from MBCPs. It follows then that men joining the Post-MBCP are generally — though not always — further progressed in their behaviour change journey. Although the evidence is somewhat limited given the low participation rates, and subsequently low sample numbers, the language these men used in interviews was more likely to be expressive of the contemplation, planning or action phases of the TTM, rather than the pre-contemplation stage. While men tend to be further progressed, they are not usually at the maintenance stage of behaviour change. Most men who have completed an MBCP still need more work, and many are still in the early stages.

The program is voluntary and is for those who have completed an MBCP, meaning service users have already spent considerable time discussing their behaviours and understanding key concepts through these programs. MWUVA who are more engaged in the process and have found the MBCP useful appear more likely to choose to participate in this follow-up program: they are beginning to see changes, and are enthusiastic to continue the journey and avoid slipping back into old ways.

The longer term nature of the program (6 months) is useful the men because ongoing support after an MBCP is not generally available, and other supports (e.g. counsellors/psychologists) may incur significant costs.

'The stigma I first held, I didn't want to believe that I was abuser, that I had emotionally abused wife, didn't want to be shamed, post the MBCP I felt less stigma, gone through a positive experience, and felt like my behaviours were changing, I felt like I had made a lot of progress but feared that I would lose it. The good work I had done would fade away without more practice, more learning and accountable.' – Man with autism, BIS, Post-MBCP, CFG.

Engagement with services

Service engagement activity

Stakeholders and service users reflected that extended wait times for MBCPs have long been a feature of program delivery.

Historical MRS and BIS activity data shows a steady increase when the service began, then a stabilising in engagement in engagement levels over time. We note that NTV has advised of limitations with its activity data, with fluctuations in call numbers evident in 2022 attributed to system changes to the way these metrics are reported. For the CFG program, service usage has steadily increased over time.

Demographics across the 3 programs

Participant demographics across the 3 programs are remarkably similar. Service users are almost all male, are typically aged between 30 and 49 years old and – broadly in line with population statistics, are more likely to live in a metropolitan area.

- CALD men and Aboriginal and Torres Strait Islander men make up a significant proportion of service users.

    - CALD: 25% of MRS and 23% of BIS service users identify as CALD, while 15% of CFG service users were born in a foreign country.[8] For MRS and BIS, these statistics are broadly in line with population proportions, while CALD men appear to be under-represented in CFG service users.

    - Aboriginal and Torres Strait Islander: 3.25% of MRS service users, 5.25% of BIS service users and 4% of CFG service users are Aboriginal and Torres Strait Islander men.[9]

    - Further detail on CALD and Aboriginal and Torres Strait Islander representation is discussed in *Appropriateness*.

- Victoria has the highest engagement in all 3 programs (MRS: 65% of total service users; BIS: 61% of service users; CFG: 39% of service users in the last reporting period), followed by New South Wales and Queensland. This is in part a result of greater investment in the sector in Victoria and natural population proportions between the states. It could also be because both NTV and CFG are Victorian-based organisations and are less well known outside of Victoria. This could indicate a need for increased interstate promotional activity.

Program contact modes

The MRS offers both telephone and online chat as a mode of contact, but the online chat has remained a very small part (2.23% of the total contacts) of the service. Phone calls are by far the more frequently used method of contact.

The BIS and CFG, by comparison, do not offer online chat.

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[8] CFG collects 'country of birth' which is a subset of the CALD definitions used by MRS and BIS which also include linguistic diversity. This is the likely explanation as to why CFG has a substantially smaller proportion of CALD service users represented in the data.

[9] Aboriginal and Torres Strait Islander people represent 3.2% of the Australian population but only 1% of the Victorian population where a disproportionate number of MRS and BIS clients live. On face value this represents an over-representation, however, Aboriginal and Torres Strait Islander people are much more likely to be involved in FDSV therefore based on the likelihood of use of FDSV among Aboriginal and Torres Strait Islander men, they should be viewed as under-represented in these services. For more detail see *Appropriateness*.

Point of entry and behaviour change

The literature review (Appendix 4: Literature review) identified that to have the best chance of success, men need to be ready to change before they engage with a program. Most MWUVA do not seek treatment willingly, and those who do often do so because they are required to by the legal system. Even among those who are mandated to attend treatment, many discontinue prematurely, especially during their initial attempts. The literature review uncovered certain predictors that make men more likely to disengage from enrolling or completing a program (Olver et al. 2011). These predictors include having an antisocial personality, a history of criminality, non-mandated attendance, younger age, and little motivation for treatment. The strongest predictor of non-completion was having prior family and domestic violence offences.[10]

Self-referring to treatment for FDSV can be daunting, even for a man who genuinely wants to change. Motivation to change is a critical factor in assessing the impact of therapy, especially in the context of MWUVA interventions. For change to occur, the person must be ready, willing and capable of making changes.[11] 'Ready' signifies the belief that change is essential and a priority; 'willing' refers to the preparedness for change; and 'able' relates to having the self-efficacy and belief in one's ability to make and sustain the changes (Viets et al. 2002).

Service users' stages of change

By using the TTM to critically analyse the service user interviews, it is evident that almost all men starting the MRS, BIS and CFG VPP programs are at very early stages of their behaviour change journeys: the vast majority are pre-contemplative or contemplative. They use language that expresses externalising of their issues, avoidance of responsibility for their actions, and a lack of any need for change.

'What happened was I split with my wife, and she said she wouldn't let me see the children unless I did the course. You know it was absolute bull****. So, I did it just to assist her mental ill health and to keep her happy.' – Pre-contemplative man, BIS service user, Victoria

This is supported by frontline staff at the services who can see that despite making the effort to reach out to the service, many of those calling in are still at the pre-contemplation stage, meaning they don't really see a need to change but are beginning to appreciate that things may not be as good as they could be.

'We've got more pre-contemplative men than contemplative men. A lot of men think that they are contemplating change. But as soon as they start the process, they realise they're not there yet. So, a lot of men actually are at that pre-contemplative stage where there's a lot of things that they're actually not really willing to change, there's a lot of pushing blame onto the partner and they're feeling blamed and punished as well.' – BIS frontline staff

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[10] Notably, characteristics such as the type of violence, controlling behaviours, depression or anxiety, anger problems, alcohol use (excluding abuse), and childhood maltreatment were not correlated with non-completion (Olver et al. 2011).

[11] There are other substantial barriers impacting service user ability to be 'ready, willing and able' such as literacy level and comprehension capacity. Men with intellectual disabilities and acquired brain injuries often fall into this category.

That stated, there are some important qualifications to make:

- Men entering the MRS are most likely to be in pre-contemplation. Some will only recently have had government intervention in their lives. For example, police may have issued a Family Violence Safety Notice, child protection services may have visited their house, or they may have been mandated to attend an MBCP. These interventions often give rise to extrinsic motivations to change.

- Men entering the BIS often come through the MRS but may have had some time to better comprehend their situation. They may have had important seeds planted in their interaction with an MRS counsellor that have moved them slightly deeper into the pre-contemplation stage.

- Notably, the source of their referral into the program – according to counsellors – correlates somewhat with their preparedness for change:

  - Some men enter the intervention services of their own volition after finding out about services via an online search. This group are usually deeper into their pre-contemplation or the beginning stages of contemplation. This is more typical for CFG service users but is also true for the other intervention services.

  - All 3 programs are voluntary and service users cannot be court-mandated to attend. However, those referred to the programs via an intervention order, the police or courts often make contact begrudgingly and tend to be more pre-contemplative. This is evidenced in the low proportion of answered calls[12] through this avenue.

  - Those referred to the MRS through the police and how this correlates to answered calls also depends on the state and the police processes around referrals. Answered call outcomes are highest in Tasmania (40% where the service user has already been in contact with the Safe at Home program[13] before the call is made); Victoria follows that (9%). New South Wales has the lowest rate of successful call outcomes (7%) relative to the number of referrals.

- Men entering the (pre-physical violence) VPP within the CFG program are somewhat more aware that there is a problem than men entering the MRS or BIS and are worried about the potential of their behaviours. Most are likely to be at the pre-contemplation stage, and some are potentially into contemplation. Often these men will seek out the program through their own research, frequently after a conversation with their partner.

- Men entering the Post-MBCP within the CFG program have completed an MBCP and are likely to be further progressed again. Some are still in the contemplation stage, and some are at each of the planning, action and maintenance stages. Where a man has progressed to

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[12] Answering a call/case includes the delivery of a service or a reasonable and appropriate attempt to deliver a service.

[13] Safe at Home is Tasmania's integrated criminal justice response to family violence. It involves a range of services working together to address the risk and safety needs of victim-survivors and children and hold perpetrators accountable. It utilises a pro-intervention policy to address family violence, complemented by a human services approach to support recovery and change. It is funded by the Tasmania Department of Justice. The Australian Government also provides funding for Safe at Home via *Keeping Women Safe in their Homes*.

depends on how successful the MBCP has been for them, how many times they have completed an MBCP, and whether they have other channels such as psychologists or counsellors through which to work on themselves. Even those who have completed an MBCP and who enter the Post-MBCP program are entering with work to do. This program is not only about 'maintenance'; it is part of an ongoing journey.

Service user self-reported stage of change

In the online survey, service users were asked to rate their readiness to start to change when they first had contact with the service on a scale of 0 to 10 where 0 meant 'I had not thought about change at all at that stage' and 10 meant 'I realised I had a significant problem in my life, and I had already started to make changes'. Figure 2 shows that men in the CFG program are much more likely to rate themselves as a 7-10 than men in the other services. Over half (58%) of the CFG service users in this evaluation rated themselves this way. This is followed by men in the MRS and BIS, where two fifths (41%) rated themselves a 7-10.

It is very important to regard these self-reported results with careful judgement. Numerous clinical studies (e.g. Helfritz 2017) have shown that self-reported data from men using violence are not entirely reliable. These men are likely to use image management to minimise their violence or to under-report their violence based on rational or situational (e.g. relationship) characteristics. Many in this cohort would likely have an interpretation of the language used that differs from the TTM stages of change model. 'Readiness' as defined by men when completing the survey may just mean willingness.

When these survey results were cross-referenced against the qualitative interviews, there was a notable discrepancy between self-reported figures and demonstrated change. Most men are pre-contemplative, and very few had made any change before calling any of the services.

Figure 2: Readiness for change
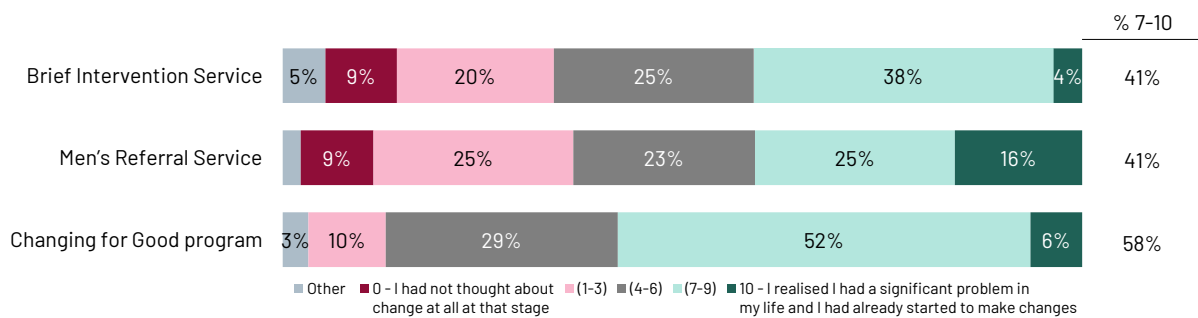
Source: A7d. On a scale of 0 to 10, how ready were you to start to change, when you first had contact with the service?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 28 in Appendix 5 to see the full data breakdown for this figure.

Antecedent factors that led men to engage with services

A range of antecedent barriers and drivers to men's engagement with services were identified through this evaluation.

Barriers

Participating in an MBCP often brings up substantial emotional barriers. The literature review (Appendix 4: Literature review) and interview findings found that people grappling with the decision to engage with these services often contend with profound discomfort, shame and unease. While physical and logistical hurdles are typically minimal, the psychological barriers run deeper, often intertwined with self-perception and societal norms rather than arising solely from program advertising or accessibility issues. However, there is an opportunity to alleviate some of these barriers by assuring men that a program is safe and relevant for them, irrespective of whether they have a history of physical violence.

Foremost among these barriers is the internal sense of shame and guilt harboured by prospective participants. Many express profound shame for their behaviour, perceiving it as incongruent with their self-image, which can hinder their willingness to engage with a program. This deep-seated shame often dissuades or delays participation as these men grapple with the prospect of recounting and confronting their regrettable actions.

'I'm a pretty reflective kind of person, so I never thought I'd be in this situation. It was pretty shocking to me and stressful.' – MRS service user, male, Victoria

Another significant obstacle is the fear of embarrassment and judgement from counsellors. This fear manifests in 2 distinct ways: first, the apprehension of being open and vulnerable about one's regrettable and shameful actions, and second, the stigma surrounding seeking help, particularly for men who may view it as a sign of weakness. The fear of appearing weak or being perceived as a 'lesser man' perpetuates the reluctance to seek assistance, with many men preferring to handle their issues independently.

Some men entering the services (especially MRS and BIS) have intellectual disabilities or acquired brain injuries making comprehension of the concepts discussed difficult and sometimes impeding ability to take responsibility. NTV staff highlight that this is common among service users coming from Corrections. NTV staff estimate that approximately 40% of clients referred through Corrections have an intellectual disability or acquired brain injury.

Many participants also struggle with cognitive distortions, wherein they wrestle to reconcile their actions with their self-perception and sense of identity. Many men see themselves as a good person, with a self-perception as someone who isn't violent or cruel — even as someone who is happy and supportive. Entering a program or seeking help for using violence creates an internal conflict, which, compounded by a fear of judgement, inhibits their willingness to engage with a program.

Moreover, there is also a misconception among some BIS and MRS service users that these intervention services are only suitable for those who have committed physical violence. While this points to a fundamental misunderstanding of what constitutes FDSV, it also further deters participation among those who may, for example, be using controlling behaviours, but not physical violence, or who have only used physical violence 'once'. In many instances, this cognitive distortion not only inhibits men from participating once a problem is identified, it inhibits men from considering seeking help before reaching crisis point (often following the breakdown of the family). Frontline counsellors at the BIS indicate that almost all service users they consult with are using controlling behaviours and that only after the AFM resists or fights back that physical violence begins.

It's important to note that conversations with counsellors highlighted that while not all service users have been physically violent, *all* are using controlling behaviours. Some literature (Boxall et al. 2022) has shown that in many cases the first physical act of violence is a homicide, yet the man has used credible threats and stalked their partner to cause fear and maintain control. This emphasises the importance of getting all men using controlling behaviours into these programs before their 'authority' is challenged in a way that causes them to snap.

There is also a sense of guilt among certain men who perceive themselves as less severe offenders and fear that they are using resources that could benefit others who may need it more or are more aggressive than them. This misunderstanding underscores the need for clearer communication about the services offered and that they cover all forms of violence. This would be consistent with the definition of 'violence against women' as defined in the glossary for the National Outcome Standards for Perpetrator Interventions and the United Nations Declaration on the Elimination of Violence against Women that says:

'The term "violence against women" means: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".' – Department of Social Services 2015

Anxiety surrounding describing complex thoughts and emotions poses a significant barrier for some people. The prospect of discussing sensitive topics such as emotional regulation and gender equality can be intimidating, particularly in a one-on-one counselling setting.

Drivers

It appears that most men seeking assistance from MBCPs find themselves motivated by various external factors. Among these is the fear of 'losing their family', a powerful motivator driving them to seek help. Whether it's the threat of losing access to their children or the desire to salvage their marriage, the prospect of family disintegration propels many men to reach out to an MBCP for support or eagerly await the phone call they expect to receive.

While this acts as a powerful motivator it is also predicated, in part, on the idea of women, children and families as possessions of men and speaks to the entitlement that many of these men continue to demonstrate when they reach out to intervention services.

'My wife told me on the phone what was going on and, for me, the risk of losing everything was so great that being open and honest by getting the help I needed was the most important thing I could do.' – MRS/BIS service user, male, Victoria

Also, for some men, the prospect of securing accommodation through the MRS[14] or through a referral to other accommodation services serves as a significant incentive. Facing homelessness due to intervention orders or post-incarceration circumstances, the immediate necessity of shelter becomes a driving force in their decision to engage with an MBCP. The suddenness of the upheaval from the family following a crisis event and the shock that sinks in at the breakdown of their family life and home leaves men feeling aimless, lacking purpose and

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[14] NTV also runs a separate program called the Men's Accommodation and Counselling Service (MACS), which provides accommodation and counselling to men who cannot go to their home due to their use of family violence. The MACS only operates in Victoria.

direction. Being referred to an MBCP offers them a semblance of structure and a path forward amid the chaos.

Punitive measures play a role in motivating participation, particularly when court orders mandate program attendance to an MBCP (the programs being evaluated aren't mandated by court but may be used as entry pathways into MBCPs, which can be). The fear of legal repercussions and the desire to move past the crisis moment drives men to commit to the program, viewing it as a means to avoid further penalties and restart their lives. Also, some men perceive attending these programs as a strategic move to improve their standing in the eyes of legal authorities and child protection services. Whether motivated by a desire to appear more favourable to magistrates or to gain a better understanding of the legal processes unfolding in their lives, the pursuit of self-interest can be a compelling factor in seeking assistance.

> *'Typically, there is an external motivator: there has been a family violence incident, they have been told to call [by] the magistrate or they have seen our number on the paperwork after being issued an order (that's the most common the open line), sometimes it's the partner saying, 'Hey, look, unless you pull your head in I am leaving' or the partner has just left.' – MRS frontline staff*

'A lot take up the referral to start with because it often impacts the outcomes that they're going to get from court. So, thinking about the court situation, they could go in and say that they've sought counselling, and they're getting referrals and they're speaking to support agencies from a behavioural change point of view. From a punishment point of view, I would say a lot would do it to at the start.' – Retired member of Victoria Police

Intrinsic motivations for seeking help are less common but are nonetheless a factor for some men. For some, the desire for personal growth and self-improvement is a driving force. The shock of experiencing serious consequences, such as police involvement in their home life, can serve as a wake-up call, prompting men to reassess their behaviour and strive for positive change. Others are motivated by a sense of responsibility and a desire to make amends for past wrongs, recognising the impact of their actions on their partner and children. Despite the inability to change the past, these men seek redemption and closure through the commitment to reform and improve themselves. A very small proportion of men expressed that the shock of confronting their own behaviour was an impetus to seek help.

There is a clear evidence base that intrinsic factors are much more powerful than extrinsic factors as a source of motivation and intrinsic motivations correlate with treatment readiness. This is because intrinsic motivation can change a person's perceptions of self and guide them towards long-term behaviour change (Harpine 2015).

Drivers for the Violence Prevention Program over other services

The VPP has a unique strategy for overcoming the shame that many men feel about their behaviours: its name. The term 'violence prevention program' is appealing to men who might be exhibiting violent behaviours, especially those that are non-physical, because many of these men do not see their actions as 'violence', and do not self-identify as violent men. The stigma of being involved in a program for violent men is much higher than taking part in a program with a name that doesn't directly accuse them of being violent.

However, while the name of the program is an effective tool for getting men to enrol, it also carries a significant risk of collusion. It might suggest a softening of the reality of their

behaviours. To counteract this, it's vital that the program includes strong content that clearly defines violence in all its forms. While this may be addressed on an ad hoc basis already, there is no formal documentation or manualisation of the process of how or when to address this. This ensures men understand the full spectrum of violent behaviours and the impact they have, effectively addressing the serious nature of their actions within the safe, initial appeal of the program name.

Appropriateness

Appropriateness

Appropriateness: the extent to which the program is doing the right things and fits with other programs.

Appropriateness key evaluation questions

To what extent do these services adequately assess, monitor and respond to the risk of clients committing FDSV? In considering this question it is the expectation that service providers consider:

- To what extent do these services adequately respond to clients from diverse cultures, communities and circumstances (including but not limited to Aboriginal and Torres Strait Islander clients, clients from CALD backgrounds, regional and remote communities, members of the LGBTIQA+ community, people with disability) and engage effectively with perpetrators with diverse needs?

- As referral services, to what extent are men being referred to the right help at the right time? In answering this question, service providers will consider the service's identification of factors that may contribute to a client's behaviours such as substance abuse, gambling addiction or mental illness; and appropriateness and timeliness of referrals to support services, including but not limited to behaviour change programs.

To what extent do these 3 services complement or duplicate each other and other services provided by the Australian Government or state and territory governments?

Appropriateness key findings

- These services represent 'low-dose' interventions and are unlikely to be enough to create long-term behaviour change in isolation. However, as the top of the funnel into the service system for MWUVA they each play an important role in building motivation, encouraging ongoing engagement and developing treatment readiness. Service users' experiences with these services will be highly influential about whether they then go on to seek help elsewhere.

- Current research identifies that for high-risk offenders, 200 or more hours of treatment reduces recidivism, while 100 hours or more reduces recidivism for moderate offenders.

- An evaluation of these programs should therefore be realistic about what long-term behaviour change, if any, can be achieved in the limited sessions available (single session in the MRS, 6 to 12 in the BIS, 4 sessions in the CFG VPP, and 12 sessions in the CFG Post-MBCP).

- Current processes for risk assessment adopt formal and informal risk assessment tools. Both the MRS and the BIS use the MARAM, while the CFG program uses the IOMI, Standard Risk Cues and the 'Family Violence Risk Assessment' (developed internally).

- These services have a significant gap in ability to assess, monitor and respond to risk of clients committing FDSV because they have no visibility of the AFM.

    - By not keeping the AFM in view, the MRS, BIS and CFG have lowered the risk to their own organisation (e.g. risk involved in responding to AFM emergencies).

- However, this means organisations cannot effectively manage risk, thereby pushing risk onto AFMs or the broader sector (e.g. emergency services and other organisations such as victim-survivor services).

- Current internal AFM arrangements conflict with the need for keeping users/partners/families safe (as noted as best practice by the National Outcome Standards for Perpetrator Interventions [NOSPI] and the National Risk Assessment Principles for FDSV).

- There are also challenges with using the MARAM to appropriately support risk assessment in the absence of contact with AFMs. The MARAM works well as a risk assessment tool when administered to the AFM and the MWUVA but is less effective when being administered to MWUVA in isolation.

- Therapeutic approaches across these programs are loosely defined. Counsellors apply them with a high degree of flexibility.

- While most service users say the services came at the right time, there is very low awareness of these services (or any services) available to MWUVA before engaging with the sector. This means men are often not accessing services until their violence causes a crisis for them.

- There is some complementation and duplication evident for the MRS with other national or state/territory-based services including:

  - The Orange Door in Victoria

  - the Men's Domestic Violence Helpline in Western Australia

  - DV Connect in Queensland

  - national services provided by MensLine Australia, 1800RESPECT and Lifeline.

- The services are not attracting First Nations MWUVA proportionally.

  - Given Aboriginal and Torres Strait Islander people represent 1% of the Victorian population where a disproportionate number of MRS and BIS clients live there appears to be an over-representation of Aboriginal and Torres Strait Islander men using these services. However, Aboriginal and Torres Strait Islander men are disproportionately represented in FDSV to a degree that vastly outweighs this.

- These call-based services are important resources for Aboriginal and Torres Strait Islander men but are only a small part of the solution.

  - Many Aboriginal and Torres Strait Islander men consulted for this evaluation preferred face-to-face services for a better ability to connect and build trust. This is likely to contribute to the relatively low participation rates.

  - However, in-person services also have their own challenges for Aboriginal and Torres Strait Islander men – for example, racism from other participants and a distrust of government services stemming from historical injustices.

  - Not all Aboriginal and Torres Strait Islander men will want face-to-face interaction and so providing flexible options (e.g. call-based services) is important. But it is crucial to have Aboriginal or Torres Strait Islander representation within the services for men to feel welcomed. Feedback from service users was that the representation

is currently below expectations, with Aboriginal and Torres Strait Islander service users unable to speak with an Aboriginal or Torres Strait Islander counsellor. The programs do not currently have Aboriginal and Torres Strait Islander counsellors available.

- CALD men reported positive experiences overall: they felt listened to, comfortable and safe. Despite not having their cultural identity explicitly addressed, they did not perceive language proficiency or cultural background as barriers to benefiting from the programs. However, there's a need for more research to better understand the challenges facing CALD men who choose not to engage.

- LGBTIQA+ participation in domestic violence services remains low due to a perceived lack of understanding from service providers and barriers such as stigma and fear of exclusion. Police misidentification of the perpetrator and victim is another barrier. Existing services are often not tailored to the unique needs of LGBTIQA+ people.

- People with disability are likely to rate the programs as effective, attributing their positive experience to supportive counsellor interactions, which create a safe space for open discussion and self-exploration. This is particularly beneficial for those navigating mental health challenges or neurodiversity. Telephone counselling is especially beneficial for those with physical disabilities, removing barriers to access.

Current process for risk assessment

The intervention goals of the MRS, BIS and CFG services are multipronged (Table 11), with risk assessment and mitigation a common goal across all.

Table 11: Intervention goals of the MRS, BIS and CFG

Service	Intervention goals
MRS	- Risk assessment and mitigation - Initial provision of information and advice - Crisis counselling - Referral
BIS	- Risk assessment and mitigation - Treatment readiness enhancement **Then, if risk is LOW and treatment readiness is in the PLANNING, ACTION or MAINTANENCE stage of change:** - Behavioural change (attitude change and skill rehearsal) - Processing (with a goal to enhance insight) - Referral

Service	Intervention goals
CFG VPP	• Risk assessment and mitigation • Treatment readiness enhancement **Then, if risk is LOW and treatment readiness is in the PLANNING, ACTION or MAINTANENCE[15] stage of change:** • Behavioural change (attitude change and skill rehearsal) • Processing (with a goal to enhance insight) • Referral
CFG Post-MBCP	• Risk assessment and mitigation • Consolidation and planning • Referral

Current processes for risk assessment adopt formal and informal risk assessment tools. Both the MRS and the BIS use the MARAM to assess risk, while CFG uses the Family violence risk assessment, IOMI and Standard Risk Cues (Table 12).

Table 12: Current process for risk assessment, monitoring and response

Service	Formal risk assessment tools	Frequency
MRS	• Person using violence (PUV) MARAM assessment tool	• Each contact using the NTV client management system
BIS	• PUV MARAM assessment tool	• Each contact using the NTV client management system
CFG	• Family violence risk assessment (an informal tool developed internally based on the IOMI) • IOMI • Standard Risk Cues	• Family violence risk assessment conducted at intake • IOMI is administered specifically during intake and on completing the program • Standard Risk Cues in every session

PUV = person using violence

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[15] The planning stage is where change has been considered and small steps have been taken (e.g. starting a program on a non-mandatory basis). The action stage is where change is underway, with some incidents of prior abuse/violence still happening but less frequently, less intensely, and with enhanced reflection and remorse. The maintenance stage is where change has occurred and is pervasive and enduring, with no incidents of abuse or violence within the past 12 months.

Ability to assess, monitor and respond to risk with no visibility of the affected family member

The first headline standard of the NOSPI is that: *Women and their children's safety is the core priority of all perpetrator interventions* (Department of Social Services 2015).

While all the intervention services being evaluated here support this outcome, none have visibility of AFMs or an AFM worker within their services. Comparing the lack of AFM visibility with the NOSPI headline standard and how the MARAM risk assessment tool is best administered, there is a substantial gap in the ability of the service to reliably assess, monitor and respond to risk of clients using FDSV. Services understanding of risk depends on the counsellor's ability to elicit truthful information or intuit risk through their conversations with service users.

The services must rely on the testimony of MWUVA to understand the extent of their violence despite the fact MWUVA often minimise or hide that violence. While there are some methods for getting around this (such as listening for typical cognitive distortions or asking for the assessments from other around them: e.g. 'What does it say on your intervention order?' or 'What your partner say happened?'), they are nowhere near fool proof.

NTV and Lifeline outlined that including AFM contact in these services:

- involves significant time and resources

- provides the organisation more information about risk and therefore places more responsibility on it to respond

- includes legal implications – for example, if the man engages and gets the counsellor to contact the partner so she can engage and be supported or provide insights and feedback, this could be considered a breach

- could affect the counsellor–client relationship – for example, maintaining confidentiality and the freedom this offers for self-reflection, and the ability to build rapport if the man knows he is the focus

- decreases the attractiveness of the service to MWUVA, who feel safer knowing that it is entirely confidential.

The importance of visibility of the AFM in these interventions is highlighted in the ANROWS National Risk Assessment Principles for Domestic and Family Violence, which states that:

'... a victim's perception of their own risk of experiencing future violence is not sufficient by itself to accurately determine severity or incidence of violence. However, there is significant consensus across the literature that it is important to consider the victim's own assessment as at a minimum, they can provide information relevant to their safety management.' (ANROWS, n.d.))

Standards 1.4 and 1.5 of the New South Wales Practice Standards for Men's Behaviour Change Programs require that: (1.4) *services prepare victims and children for the participation of their family member in an MBCP* and (1.5) *that services complete individual safety plans for victims and children*. While these services are not accredited MBCPs, both the BIS and CFG do attempt to achieve behaviour change with men.

By not keeping the AFM in view, MRS, BIS and CFG have lowered the risk to their own organisation (e.g. risk involved in responding to AFM emergencies). However, this means

organisations are unable to effectively manage risk thereby pushing risk onto AFMs or the broader sector (e.g. emergency services and other organisations such as victim-survivors services). Current internal AFM arrangements conflict with the need for keeping users/partners/families safe.

Without a partner contact, staff in all services have concerns about their ability to respond to risk. Table 13, Table 14 and Table 15 show agreement among frontline workers with statements about risk at each service:

- Two counsellors at the BIS strongly disagreed that the service effectively works together at every opportunity to identify, keep sight of and engage with MWUVA. Qualitative interviews indicated that this primarily related to the fact there was no AFM contact and that teams within the organisation were siloed.

- One counsellor at the MRS strongly disagreed and 2 CFG counsellors disagreed that the service shares relevant information about MWUVA and victim-survivors with other services wherever possible to reduce the risk to victim-survivors.

'It is important to have an AFM worker within the team as there are clients that live at home with their partner and in some cases without any orders in place, and they need to see if they require supports as well.' – Frontline counsellor

This is not to suggest that the only way to include AFM visibility is to directly contact partners from the programs themselves or that AFM contact is itself without downsides. These are discussed in the section *Challenges and opportunities for AFM contact into the future* below.

Table 13: Agreement with risk statements – BIS frontline counsellors (BIS has a total of 8 counsellors, 6 of whom responded)

Risk statement	Total agree	Total disagree + unsure
The Service shares relevant information about perpetrators and victim-survivors with other services wherever possible to reduce the risk to victim-survivors	6	0
The Service intervenes swiftly as soon as an instance of violence is identified in ways that stop their violence	6	0
The Service effectively works together at every opportunity to identify, keep sight of and engage with perpetrators	4	2

Source: A10. Please indicate the extent to which you agree or disagree with the following statements about the service.
Base: Frontline workers: Brief Intervention Service, unweighted, n = 6.

Table 14: Agreement with risk statements – MRS frontline counsellors (MRS has 9 counsellors, 3 of whom responded)

Risk statement	Total agree	Total disagree + unsure
The Service shares relevant information about perpetrators and victim-survivors with other services wherever possible to reduce the risk to victim-survivors	2	1
The Service intervenes swiftly as soon as an instance of violence is identified in ways that stop their violence	3	0
The Service effectively works together at every opportunity to identify, keep sight of and engage with perpetrators	3	0

Source: A10. Please indicate the extent to which you agree or disagree with the following statements about the service.
Base: Frontline workers: Men's Referral Service, unweighted, n = 3.

Table 15: Agreement with risk statements – CFG frontline counsellors (CFG has 5 counsellors, 4 of whom responded)

Risk statement	Total agree	Total disagree + unsure
The Service shares relevant information about perpetrators and victim-survivors with other services wherever possible to reduce the risk to victim-survivors	1	3
The Service intervenes swiftly as soon as an instance of violence is identified in ways that stop their violence	3	0
The Service effectively works together at every opportunity to identify, keep sight of and engage with perpetrators	4	0

Source: A10. Please indicate the extent to which you agree or disagree with the following statements about the service.
Base: Frontline workers: Changing for Good program, unweighted, n = 4.

Challenges of and opportunities for including AFMs into risk assessments

Challenges

There are several challenges and risks associated with including AFMs in risk assessments with these services.

Given the nature of telephone-based counselling services, there is a potential risk of coercion when a victim-survivor is required to provide updates or assessments regarding incidents of violence. The privacy and security of the communication channel are essential to ensure that victim-survivors can speak freely without external pressure.

Service users may experience significant shame and discomfort when discussing acts of violence. This discomfort could be exacerbated by the knowledge that their disclosures might be shared with their AFMs, potentially leading to disengagement from the services.

Many victim-survivors no longer maintain contact with the perpetrator and may have legal restrictions such as personal protection orders that make any form of contact inappropriate. Legal constraints and the potential for re-traumatisation must be carefully considered to protect the wellbeing and security of victim-survivors.

The Multi-Agency Risk Assessment and Management Framework (MARAM) identifies alternative methods for managing these risks, such as enhanced information sharing with specialised victim-survivor services. It is crucial to consider these alternatives, as there are inherent risks associated with AFM involvement, including the potential disengagement of men who use violence due to negative perceptions related to AFM engagement.

Opportunities

There are several suggestions outlined below that address some of the challenges and risks associated with including AFM in risk assessments. These suggestions do not eliminate risk but may assist in reducing risk.

- Establishing or engaging a separate organisation to manage interactions with AFMs can improve service outcomes. This entity should maintain regular and robust information sharing protocols with the primary telephone intervention service. Such an arrangement ensures consistent and secure communication, enhancing the overall service integrity.

- Implementing a framework to determine the appropriateness of initiating AFM contact is crucial. This framework should include legal considerations to ensure all contact adheres to applicable laws and regulations. Criteria should be clearly defined to assess when and how AFM contact should be proposed, safeguarding the interests and rights of all parties involved.

- To mitigate the risk of coercion, phone calls with AFMs and MWUVA should be carefully coordinated. For example, ensuring that these calls occur simultaneously while requiring that both parties are in separate rooms during the risk assessment to reduce the potential for coercion and enhance the safety and efficacy of the assessment process.

Therapeutic approaches are not well defined in services

Service providers are clear that supporting staff to use their discretion and expertise on a case-by-case basis is important. Further, flexibility of approach is also seen as important by service providers. Given this, manualisation and standardisation of intervention approaches is limited.

Counsellors are trained in delivering services, but the nature of this training and the capacity of workers is not clear nor explicit. Frontline counsellors (in interview) and service providers (in documentation) were quick to use therapeutic terminology (e.g. 'strengths-based approaches') that was not well grounded in the international evidence base and often did not match the context or client need. Also, some of the more specific strategies outlined lacked a clear evidence base for use with these populations, which creates a risk dynamic. One service provider, for example, asserted that they provide information about trauma and the brain, which is an action that can enhance risk given the low-intensity/low-dosage of these

interventions. It has the potential to arm people using violence with content with respect to not taking responsibility for their own behaviours due to being in fight or flight (which is a common cognitive distortion for this client group).

Lack of program fidelity[16] therefore is a major finding, with an apparent lack of understanding on the part of counsellors about what was happening in these sessions and how they were being delivered. The narrative styles also seem to suggest a commitment to micro-skills, Rogerian values (empathy, congruence and unconditional positive regard) and a willingness to discuss power and gender.

> *'Developments in theory and typology of family violence have not in my view been adequately integrated into our practice (e.g. Johnson's typology of abuse/conflict). We do not adequately distinguish between abuse that is based in a pattern of power and control and conflict that is more situationally based. We require more training in counselling practices. Lots of other services have presented to our team, which has been great for knowledge of the sector. We have received a lot of training in risk management and diversity concerns, but not a significant amount of time has been spent on developing motivational interviewing skills and working with cognitive patterns that justify and support violent behaviour. In addition, this is a space where we meet both mandated (court, police, CP), coerced (requiring courses or counselling to access children, being asked by their partners) and voluntary clients. Each has differing levels of motivation and requires different responses.' – NTV frontline counsellor*

While many service users responded positively to the therapeutic content, the literature states there are risks of doing 'too much, too soon', especially where there is no AFM visibility. Some risk of violence use can be driven up due to:

- perceptions of third-party endorsement (i.e. from a counsellor) and empowerment of particular behaviours (even if this is misunderstood)

- the AFMs holding enhanced hope of change and shifting their own safety behaviours as a result

- the experience of shame (which can increase occurrences of violence to combat internal incongruence).

Given this risk and given the programs are attempting behaviour change with the men, there is ample justification for better AFM visibility.

Table 16 summarises the therapeutic approaches used by each intervention service.

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[16] Fidelity is defined as the extent to which an intervention follows a program model.

Table 16: Summary of therapeutic approaches by intervention service

Men's Referral Service	Brief Intervention Service	Changing for Good
Invitational narrative approach used.	Invitational narrative approach used. Other approaches used: • motivational interviewing • communication style – identified as combative/resistant/aggressive/threatening • micro-counselling skills.	Counsellors mostly use an invitational narrative approach. Other approaches used: • health coaching[17] • motivational interviewing • psychoeducation.

Referrals to the right help at the right time

All 3 programs make referrals to assist men to change their violent behaviours. When appropriate, they will make referrals to MBCPs, other social services or programs such as local psychologists, alcohol and other drug (AOD) programs and homelessness services.

Service users participating in qualitative interviews suggested the services men are referred to are appropriate, can meet their behaviour change needs and, when the man follows them up, are critical to their journey of change.

Several BIS and Post-MBCP service users talked favourably about the program but even more favourably about their psychologist, with whom they'd been able to make more significant progress through a series of intensive sessions where they were challenged to a greater extent. This highlights where these programs fit within a broader journey of change for many men – an initial (and often reluctant) foray.

Timing of engagement

Service user survey data in the Figure 3 shows a majority of service users across all programs believe their interaction with the service came 'at the right time' (63% BIS; 54% MRS; 55% CFG), but many believe it should have come earlier.

This was also evident in the qualitative interviews where service users spoke about how they would have preferred the service came earlier but that it took a crisis for them to realise they had a problem or to motivate them to do something about it.

> *'Changing for Good opened the door to some ideas around some of my behaviours, but I discovered that sometimes people may need to learn things, and sometimes they're just not ready. And I've had to do a lot of learning, since I've done that course. And it's become a lot clearer that my behaviours are totally wrong, dysfunctional, and harmful to other people.' – Service user, CFG, Brisbane*

Very small proportions of BIS and CFG service users indicated that the service came at the right time but felt they needed a different service (Figure 3).

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[17] Health coaching works by giving people the confidence, knowledge, and skills to become active participants in their own care and achieve their self-identified health goals (Better Conversation, n.d.).

Figure 3: Right help at the right time
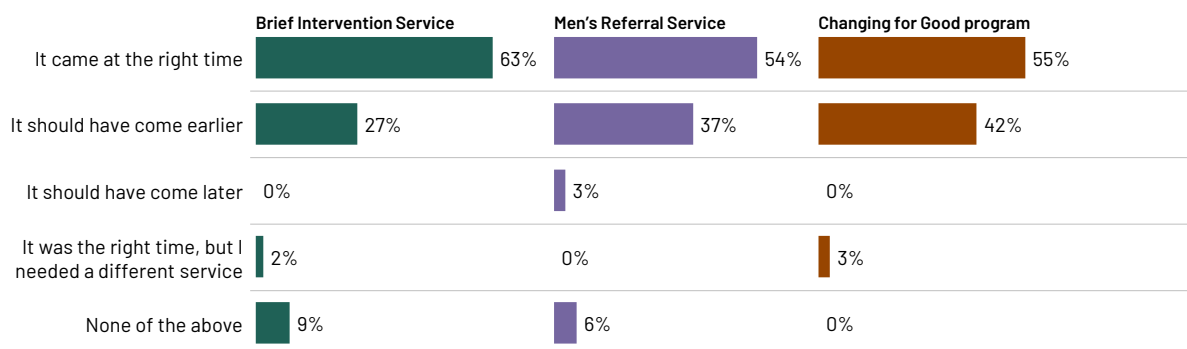
	Brief Intervention Service	Men's Referral Service	Changing for Good program
It came at the right time	63%	54%	55%
It should have come earlier	27%	37%	42%
It should have come later	0%	3%	0%
It was the right time, but I needed a different service	2%	0%	3%
None of the above	9%	6%	0%

Source: A5. A4MRS. Which of the following best describes your interaction with the service?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=35; Changing for Good program, unweighted, n=31.

Refer to Table 29 in Appendix 5 to see the full data breakdown for this figure.

Awareness of the supports for men who use violence and abuse

There appears to be low awareness of the supports available to MWUVA until an intervention is made or crisis occurs.

Service users reported not knowing what supports were available for MWUVA before they first engaged these services. This cohort prefer information to be provided to them.

Men first become aware of each program in very different ways (Figure 4). This influences the profile and character of service users in each program and the emotional, psychological and behaviour change states within which they enter.

- MRS: Men often hear about this service through some form of government intervention in their lives such as: police attending their house, being issued a family safety notice, intervention order or apprehended violence order; a magistrate giving them the phone number; or via statutory child protection services. In addition, in some jurisdictions the MRS responds to police referrals after attending an incident; as such, these men can be in very escalated states.

- BIS: Men are referred into the program via the MRS or, as of 2023, directly via an online referral process. Most often, men call the MRS seeking assistance and are referred into the BIS program. Men can be aware of the BIS before making the call. As described in Figure 4 they hear about it through a court, magistrate, police or emergency services.

- VPP CFG: Men often discover the VPP CFG program online after searching it out themselves. This means the men entering the program have already put in more effort and are likely to be more motivated to change. Men who have used physical violence in the past are excluded, which makes the client profile less extreme. Men who are extreme in their use of other forms of violence are unlikely to put in the effort to search out this program.

- Post-MBCP CFG: Men entering this program almost always receive a referral from an MBCP they were attending.

Figure 4: Source of program awareness

	Brief Intervention Service	Men's Referral Service	Changing for Good program
A court or magistrate	21%	34%	0%
The police or emergency services	18%	16%	3%
An advertisement online	2%	7%	29%
Online search	2%	5%	23%
Mensline	2%	0%	23%
My partner at the time	4%	7%	3%
Child protection / other family support	7%	2%	0%
A mental health professional	7%	0%	0%
An advertisement on social media	4%	2%	3%
A friend	2%	5%	3%
A family member	4%	2%	3%
From a correction officer	2%	7%	0%
Men's Referral Service	5%	2%	0%
From a MBCP clinic facilitator	4%	0%	3%
Orange Door	5%	0%	0%
Through an AOD service	4%	0%	0%
I saw a flyer	0%	2%	3%
Advertisement in person	0%	0%	3%
Lawyer	2%	0%	0%
Other	4%	5%	0%
Don't know	4%	5%	0%

Source: A7c. How did you first hear about the [PROGRAM]?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.
Note: Labels under 1% have been removed for clarity.

Refer to Table 30 in Appendix 5 to see the full data breakdown for this figure.

This low awareness of programs speaks to a broader issue of how these services are marketed and how secondary prevention works for each. The lack of awareness of options available for MWUVA means that men often reach out after their violence becomes so significant that it causes a crisis for them.

In many of the service user interviews MWUVA indicated significant barriers to help-seeking and taking initiative to resolve personal issues. Despite the profound issues affecting their personal lives they were simply not looking for help.

Receiving the right help

The reported reasons why men call these services are listed in Figure 5. Many men call services for behaviours related to anger management, physical violence or controlling behaviours. 'Verbal arguments' can often reflect an effort on the part of service users to minimise their violence. It is likely that at least some of the men claiming to be seeking assistance for verbal arguments in fact require assistance for some form of domestic violence. The qualitative interviews also reflected this minimisation of violence.

Figure 5: Behaviours men sought assistance for when calling services
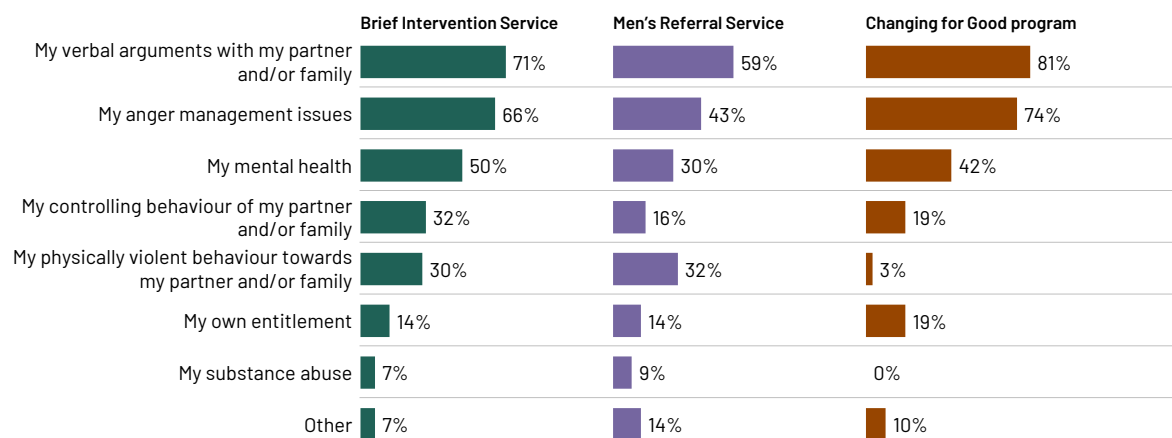
	Brief Intervention Service	Men's Referral Service	Changing for Good program
My verbal arguments with my partner and/or family	71%	59%	81%
My anger management issues	66%	43%	74%
My mental health	50%	30%	42%
My controlling behaviour of my partner and/or family	32%	16%	19%
My physically violent behaviour towards my partner and/or family	30%	32%	3%
My own entitlement	14%	14%	19%
My substance abuse	7%	9%	0%
Other	7%	14%	10%

Source: A18. What type of behaviours did you speak with the [PROGRAM] for? Please select all that apply
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Refer to Table 31 in Appendix 5 to see the full data breakdown for this figure.

Many of the men contacting these services are experiencing other significant problems in their lives. Figure 6 indicates that high proportions of service users are experiencing difficulties with mental health, housing, employment and physical health, among other issues.

Program counsellors are aware of the complex needs of men calling their services. They aim to prioritise the immediate needs of safety, while also balancing what behaviour change is possible while other co-occurring issues are present. In some cases, counsellors will try to address other major issues in service users lives if that is likely to help reduce their violent behaviours. This could be psychoeducation for a man with poor mental health or assistance in communication and reading social cues for a man with autism.

'The Brief Intervention Service was incredible. The work I did with the counsellor helped me understand social cues and my own emotions. Because of my autism I struggle with that and that has been a huge problem for me my entire life. I am better able to communicate with my wife, extended family and friends. It has totally changed who I am.' – Man with autism, BIS, Post-MBCP and CFG.

Figure 6: Self-reported issues for service users (total of 'big problem' + 'problem')
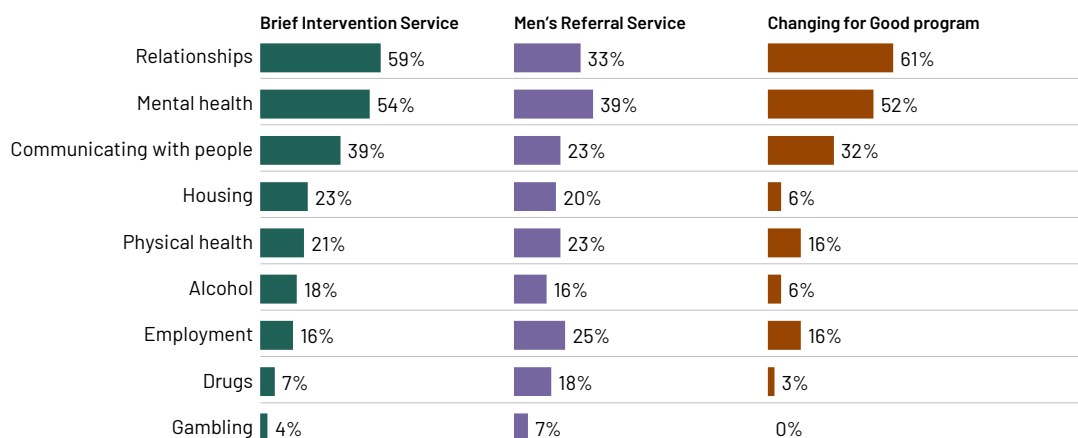
	Brief Intervention Service	Men's Referral Service	Changing for Good program
Relationships	59%	33%	61%
Mental health	54%	39%	52%
Communicating with people	39%	23%	32%
Housing	23%	20%	6%
Physical health	21%	23%	16%
Alcohol	18%	16%	6%
Employment	16%	25%	16%
Drugs	7%	18%	3%
Gambling	4%	7%	0%

Source: A12. Please indicate whether the problems below are a big problem for you or no problem for you. Please answer all of the questions and remember that there are no right or wrong answers.
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Refer to Table 32 in Appendix 5 to see the full data breakdown for this figure.

Overall, men who engaged with these programs claim to have experienced improvements with many of the other issues in their lives Figure 9 shows that many service users report reductions in AOD use, gambling and problems with mental and physical health.

At the same time, issues with housing and employment increased significantly for some men. The services being evaluated are designed for addressing FDSV (not other issues) and so should not be evaluated against improvements or declines in other issues. It does appear, however, that they can adequately assess when those other issues are a significant problem and make relevant referrals. Issues with employment and housing (except for the MRS, which has the MACS[18]) are likely to be outside of the control of these organisations.

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[18] As is outlined above, NTV also runs a separate program called the Men's Accommodation and Counselling Service (MACS) which provides accommodation and counselling to violent men in Victoria.

Figure 7: Changes in behaviour/issues since making contact with the BIS
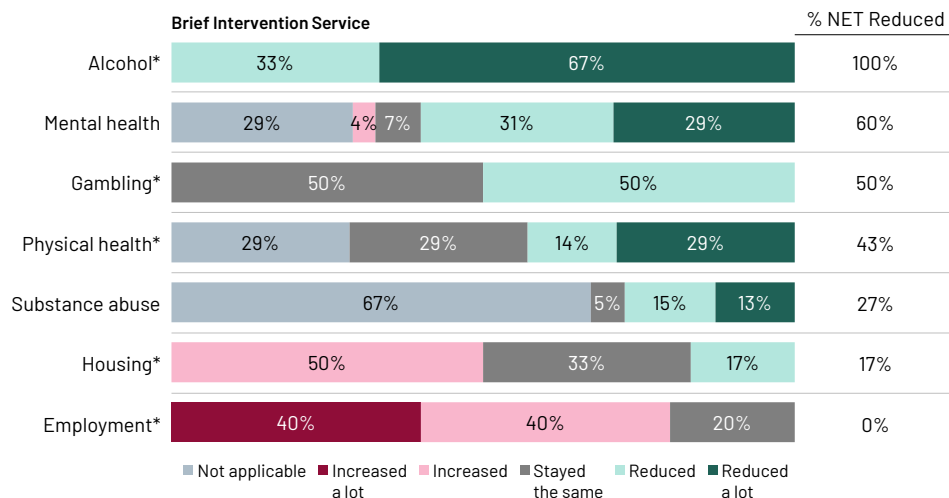
Brief Intervention Service — % NET Reduced

Category		% NET Reduced
Alcohol*	33% Reduced / 67% Reduced a lot	100%
Mental health	29% Not applicable / 4% Increased / 7% Stayed the same / 31% Reduced / 29% Reduced a lot	60%
Gambling*	50% Stayed the same / 50% Reduced	50%
Physical health*	29% Not applicable / 29% Stayed the same / 14% Reduced / 29% Reduced a lot	43%
Substance abuse	67% Not applicable / 5% Stayed the same / 15% Reduced / 13% Reduced a lot	27%
Housing*	50% Increased / 33% Stayed the same / 17% Reduced	17%
Employment*	40% Increased a lot / 40% Increased / 20% Stayed the same	0%

Legend: Not applicable | Increased a lot | Increased | Stayed the same | Reduced | Reduced a lot

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Brief Intervention Service
Base: Brief Intervention Service, unweighted, n=56.
Note: Labels less than 3% have been removed for clarity.*low sample size, n ≤ 7.

Refer to Table 33 in Appendix 5 to see the full data breakdown for this figure.

Figure 8: Changes in behaviour/issues since making contact with the MRS
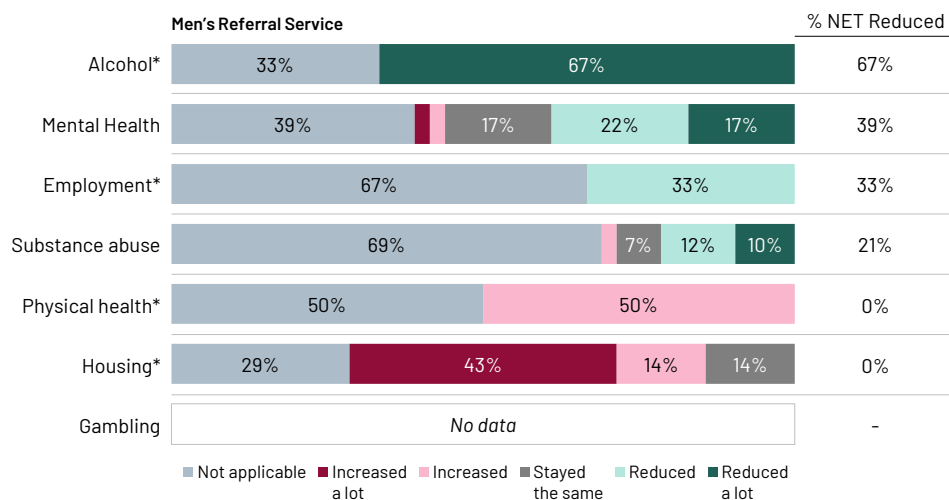
Men's Referral Service — % NET Reduced

Category		% NET Reduced
Alcohol*	33% Not applicable / 67% Reduced a lot	67%
Mental Health	39% Not applicable / Increased a lot / 17% Stayed the same / 22% Reduced / 17% Reduced a lot	39%
Employment*	67% Not applicable / 33% Reduced	33%
Substance abuse	69% Not applicable / 7% Stayed the same / 12% Reduced / 10% Reduced a lot	21%
Physical health*	50% Not applicable / 50% Increased	0%
Housing*	29% Not applicable / 43% Increased a lot / 14% Increased / 14% Stayed the same	0%
Gambling	No data	–

Legend: Not applicable | Increased a lot | Increased | Stayed the same | Reduced | Reduced a lot

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Men's Referral Service
Base: Men's Referral Service, unweighted, n=44.
Note: Labels less than 3% have been removed for clarity.*low sample size, n ≤ 7.

Refer to Table 34 in Appendix 5 to see the full data breakdown for this figure.

Figure 9: Changes in behaviour/issues since making contact with the CFG program
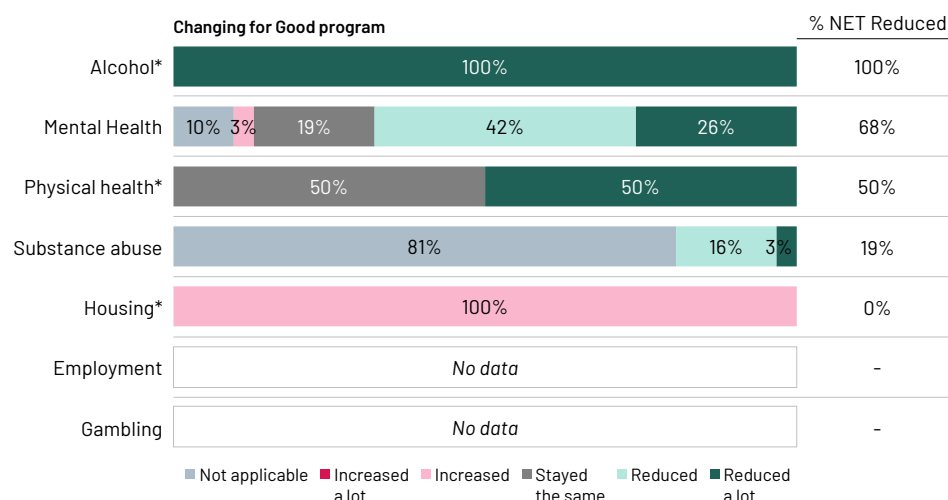
Changing for Good program

		% NET Reduced
Alcohol*	100%	100%
Mental Health	10% / 3% / 19% / 42% / 26%	68%
Physical health*	50% / 50%	50%
Substance abuse	81% / 16% / 3%	19%
Housing*	100%	0%
Employment	No data	-
Gambling	No data	-

Legend: ■ Not applicable ■ Increased a lot ■ Increased ■ Stayed the same ■ Reduced ■ Reduced a lot

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Changing for Good program
Base: Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.*low sample size, n ≤ 2.

Refer to Table 35 in Appendix 5 to see the full data breakdown for this figure.

Fit with other programs

The role of 'low-dose' interventions and crisis support services

Each service intervention in isolation is unlikely to be enough to create behaviour change without further support, but they still play an important respective role in the system.

As part of this evaluation, a literature review was conducted before primary data collection began. In relation to the role of these services the literature made several key points:

- There is a direct relationship between dose and recidivism in that a higher dosage of treatment is associated with reduced recidivism. Current research identifies that for high-risk offenders, 200 or more hours of treatment reduces recidivism, while 100 hours or more reduces recidivism for moderate offenders (Borseth et al. 2023; Sperber et al. 2013).

- Short-term interventions addressing the perpetration of FDSV are unlikely to reduce recidivism for high-risk offenders but may assist in building motivation to engage in longer term intervention, where ambivalence or a lack of accountability deem a violent man unsuitable.

- To effectively engage men who present with low treatment readiness and make the most of their willingness to participate, intake and assessment workers play a crucial role in helping them progress towards taking further action along the change continuum.

It is also important to view the MRS differently from the BIS and CFG. The literature review (Appendix 4: Literature review) highlighted several reasons why crisis-based call lines are important. While the MRS is not strictly a crisis call line, many men who call do so in crisis or with high levels of emotional distress. In those instances, the call becomes less about referral and more about de-escalation and immediate counselling support. Interviews with service users showed this was because the MRS:

- provided a confidential environment

- is easily accessible regardless of geographical location

- has no screening or entry assessments

- includes the freedom to initiate and end the call at any time

- uses person-centred, collaborative problem-solving support approaches.

These services represent the top of the funnel for men entering the service sector early in their behaviour change journey (often the first interactions with the sector). As such, service users' experiences will highly influence whether they then go on to seek help elsewhere.

An evaluation of these programs should therefore be realistic about what behaviour change, if any, can be achieved in the limited sessions available (single session in the MRS, 4 sessions in the CFG VPP, 6 to 10 in the BIS). The real benefit of these services is to prepare men for MBCPs, to keep them engaged and to set them up for success with further treatment.

The bulk of the behaviour change in any man will most likely occur in an MBCP after many more hours than these programs (MRS, BIS and the CFG VPP) can provide.

The place for telephone-based and other non-face-to-face services

Telephone conversations circumvent many of the practical obstacles involved with face-to-face counselling. Many men noted that the telephone service was highly convenient, and, for many, the only viable option given their rural/regional location. First, telephone services can be accessed from anywhere, offering more flexibility in finding a time around work and life schedules because it eliminates the need for travel. It also streamlines the process of speaking to a counsellor, potentially resulting in greater attendance per session. Not having to expend energy on even minor tasks like planning a route, considering departure times, parking and fuel means that the experience is straightforward and accessible.

More broadly, the primary value of non-face-to-face services lies in its ability to substantially address one of the largest barriers men encounter when participating in the program. While not a perfect solution, non-face-to-face interactions drastically reduce the emotional barriers that men experience when discussing regretful, shameful behaviour, as well as the stigma associated with the belief that men don't openly discuss their feelings, emotions and problems. MWUVA are highly concerned about feeling judged, and this concern is heightened at the thought of sitting face to face with another person. A phone conversation avoids the potential for seeing a judgemental reaction on another's face, ultimately creating a less uncomfortable environment and reducing the friction associated with starting.

This is demonstrated in the reasons men gave about why they preferred the BIS and CFG over traditional face-to-face group-based work:

'Because [group-based work] is an embarrassing and humiliating experience.' – BIS service user, male

'It seemed less intense and less stigmatised. And more accessible/quicker to start.' – BIS service user, male

'I didn't want to associate with men like me.' – BIS service user, male

Some — and in this evaluation the sample tended towards those who have done ongoing work with a psychologist who was able to challenge them more deeply — feel that face-to-face

interactions allow for a stronger sense of rapport, trust, and confidence in being understood. Nonetheless, men with this view are in the minority. Most men in this study reported that telephone communication is their preferred approach and do not feel that they miss out on any benefits or learning opportunities via telephone. Moreover, most men feel that counsellors excel at forming rapport, building trust, and creating a safe and comfortable environment – although sometimes, for BIS and CFG service users after an initially negative experience with an intake counsellor (which is different to the counsellor that delivers the program content). As a result, almost all of them believe that their initial concerns about embarrassment and judgement were unfounded because rapport was built over the session.

'Convenience. I don't have to travel somewhere to do it. I don't have to sit in a waiting room for 10 minutes while somebody else is finishing up. I don't have to do all that sort of stuff. I find it a lot more convenient.' – CFG service user, male

'The key barriers for my clients accessing counselling services are limited money, limited time, their work schedules and perhaps wanting to be more anonymous (thus why they choose telehealth). Many of my clients are employed, and even then they have seen counsellors face to face previously but felt their experiences were not successful.' – CFG frontline counsellor

While these services are delivered one-on-one, this does not make them unique. There are other MBCPs that are delivered over video call, and some FDSV services that focus on MWUVA offer one-on-one pre-group sessions.

Complementation and duplication

A decentralised system with many front doors

There are various entry points into and pathways through the sector. Men can either:

- call the MRS (or any other national helpline) and receive a referral to an MBCP (either locally or over video call)
- seek entry into the BIS or CFG VPP
- seek out an MBCP themselves, complementing their treatment with other supports (e.g. behaviour change, AOD, gambling support).

Apart from a court-mandated attendance at an MBCP, there is no standardised approach to engaging with services; men often pick and choose their own way through. Each service has its own intake process, meaning the man must tell his story afresh at each point. This creates a new barrier each time and introduces opportunities to disengage.

It is important to note here that not all men can access services that treat their diverse needs; for example, men living in remote Australia with low digital literacy may not have access to an MBCP. This is explored in more detail in the 'Response to other dimensions of diversity' section of this report.

Complementation between the services

The MRS, BIS, and CFG provide complementary interventions for MWUVA without duplication between them.

- The MRS operates as a crisis counselling service, offering immediate, single-session interventions tailored to immediate risk, information provision and referral.

- The BIS offers a multi-session model, designed to bridge the gap for men waiting to enter a Men's Behaviour Change Program (MBCP) or for whom MBCPs are not suitable. The BIS ensures these men remain engaged in the system, helping them prepare for the process of behaviour change and reducing the immediate risk of violence.

- CFG VPP, on the other hand, provides a more approachable service for men to seek help from without the stigma of admitting to use of FDSV.

- The CFG Post-MBCP focuses on long-term support and reinforcement of behaviour change and learning achieved through completion of an MBCP. It and provides ongoing support for men post-MBCP to ensure lasting behavioural changes. Each service addresses different stages and levels of risk, ensuring a comprehensive approach without overlapping roles .

Geographic duplication of the Men's Referral Service

Despite being a national service, MRS callers continue to skew heavily towards Victoria and, to a lesser extent, New South Wales and Tasmania (**Figure 10**). There are reasons for this: the Royal Commission in Victoria has resulted in more funding being invested in FDSV, meaning the sector is better set up and able to uncover and respond to FDSV, but also, both NTV and CFG are based in Victoria, and the limited reach could arise from a lack of interstate business development.

Figure 10: Average monthly cases delivered by state compared with population statistics
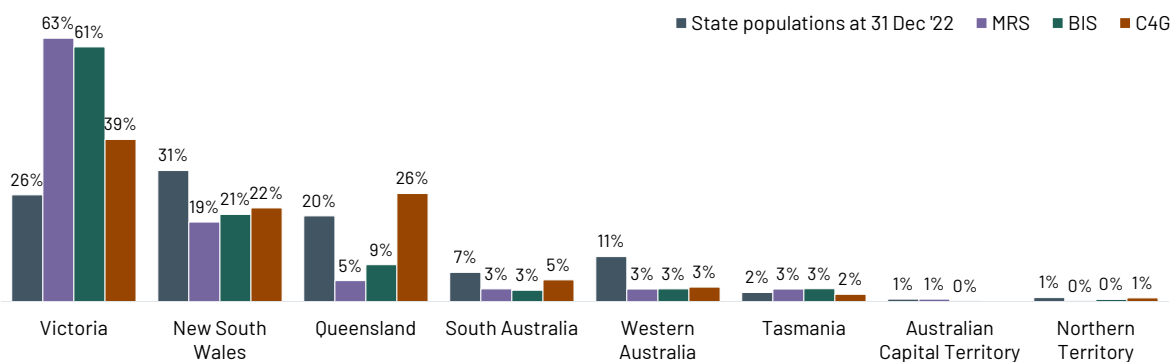
Source: MRS#5 - Number of inbound Men's Referral Service calls/cases answered. Answering a call/case includes the delivery of a service or a reasonable and appropriate attempt to deliver a service.

Refer to Table 36 in Appendix 5 to see the full data breakdown for this figure.

Geographic duplication occurs between the MRS and similar state-based services such as The Men's Domestic Violence Helpline in Western Australia and the DV Connect Men's Line in Queensland by.

These services offer a 24-hour phone line providing support, information, and referrals to callers (i.e. the same function that MRS performs nationally).

There are other national services and other specific state-based services that serve different functions to the MRS but are sometimes used for the same purposes by callers. These include:

- MensLine Australia – information and referral service for men with family and relationship concerns, including men experiencing domestic violence

- 1800RESPECT – a national counselling, information and support service for people impacted by domestic, family and sexual violence

- Lifeline – the largest national crisis support line in Australia.

Men will occasionally call these services for assistance with their use of FDSV. At the same time men will sometimes call the MRS for family and relationship matters, which is strictly more the domain of MensLine Australia.

There are some important distinctions to make about these services.

- **MensLine Australia**: a men's mental health and broader counselling service for men with relationship concerns. MensLine Australia also covers family violence but isn't a focused on behaviour change. MensLine Australia refers men to CFG for men requiring more ongoing support for family violence.

- Police referrals are made to the MRS, not MensLine Australia. They are likely to respond to much higher risk men than MensLine Australia. MensLine Australia also markets itself better (by investing in promotion online and through the positioning of the service as a support for men rather than focusing on their use of violence – as is the case for NTV), meaning they better attract men seeking out assistance.

- **Lifeline Crisis Support** has much broader audience and will encounter men who have used violence often via their help-seeking about their mental health.

- **1800RESPECT** is a national sexual assault, domestic family violence counselling service, therefore it focuses more on victim-survivors.

- The **Men's Domestic Violence Helpline** in Western Australia and **DV Connect MensLine** in Queensland are both state-specific services providing support for people who are experiencing domestic violence, and men using violence. Given the names include the term domestic violence, it is possible some violent men will not see this as relevant to them and would be more interested in the MRS.

Duplication of police referrals between the Men's Referral Service and The Orange Door in Victoria

Across Victoria, New South Wales[19] and Tasmania, the MRS responds to police referrals. Broadly this means when police attend an FDSV incident in the state, they put the offender's details into a system, which the MRS can access and use to call him. This is very helpful to police as it assists the offender understand his situation, for example, by explaining the rules of intervention orders so he does not breach or to manage housing and suicide risk in the immediate aftermath. Details about this process can be found in the appendix of this report.

As is outlined in Table 17, in Victoria, The Orange Door handles police referral calls from 9 am to 5 pm Monday to Friday. The MRS handles these calls after hours and on weekends.

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[19] Police referrals to the MRS in New South Wales ended at end of 2023. However, at the time of data collection, the police referrals in New South Wales were still in place.

Table 17: MRS police response by jurisdiction

Jurisdiction	Operating hours
Victoria	**Mon–Fri, 9 am – 5 pm** • Police referrals: handled by The Orange Door • Open line: Men can call at any time **After hours and on weekends** • Police referrals: handled by the MRS • Open line: Men can call at any time
New South Wales	**24 hours, 5 days a week** • Police referrals: handled by the MRS • Open line: Men can call at any time
Tasmania	**24 hours, 5 days a week** • Police referrals: handled by the MRS • Open line: Men can call at any time

Information sharing between The Orange Door and the MRS does not always occur, meaning there are instances where The Orange Door services are not sure whether the MRS has contacted the man or not. Subsequently, The Orange Door will often follow up with men who enter the system after hours or on weekends when they come back on shift, only to find the man has already spoken with the MRS and has been referred to other services.

This was reflected in the qualitative interviews with service users, who indicated they were contacted by both The Orange Door and the MRS after an incident, and by sector stakeholders, who indicated they were aware of the same.

The impact of being contacted twice is not necessarily a negative for the man because further conversations may encourage engagement, but that is not the intent and it does mean an unnecessary duplication of contact to the same man between the 2 agencies. The key difference between the MRS and The Orange Door is that the latter coordinates with the AFM, meaning they have a clearer understanding of risk.

'So the court did recommend to my wife to coordinate with The Orange Door and the police must have put a referral in for me. Because about a week later Orange Door rang me and I did an assessment with them. And they said, 'Well, we would have recommended you the exact same thing [as what MRS recommended]. So, you're on the right course.'' – MRS service user, male, Victoria

'We work very closely with The Orange Door in Victoria, but that can be a bit tricky as well. We know there is that space there in our programs where we should be thinking about the AFM and that loop in with The Orange Door, which we would definitely like to see more conversations around.' – NTV management

Response to other dimensions of diversity

Aboriginal and Torres Strait Islander men in the services

Limited sample size

This evaluation achieved the following:

- BIS: *n* = 4 surveys completed with First Nations men.
- MRS: *n* = 1 survey completed with a First Nations man; *n* = 1 qualitative interview.
- CFG: no interviews with First Nations men.
- *n* = 3 qualitative interviews with First Nations men who have used violence in the past but have not used these services.

Domestic and family violence is a significant and ongoing issue for First Nations communities. Colonisation, structural racism, intergenerational trauma and violence, displacement from traditional lands, the continued removal of children and high levels of incarceration have all played a substantial role in this problem for First Nations people.

This is a small sample size but is complemented by program data, interviews with First Nations experts and interviews with people working in the sector to provide a more rounded view of the place of these services for First Nations people.

Representation of First Nations callers

Program data shows that there are disproportionate numbers of Aboriginal and Torres Strait Islander men contacting FDSV intervention services.

- For the MRS, Aboriginal and Torres Strait Islander men represent an average of 3.25% of their contacts per month (Figure 11).
- For the BIS, Aboriginal and Torres Strait Islander men represent an average of 5.25% of their client base per month (Figure 11). For the CFG program, Aboriginal and Torres Strait Islander men represent an average of 4% of their clients for the yearly reporting period (Table 18).[20]
- Given Aboriginal and Torres Strait Islander people represent 1% of the Victorian population[21] where a disproportionate number of MRS and BIS clients live there appears to be an over-representation of Aboriginal and Torres Strait Islander men using these services.[22]

However, Aboriginal and Torres Strait Islander men are disproportionately represented in intimate partner violence to a degree that vastly outweighs this, implying that the services are not attracting First Nations MWUVA proportionally. For example, First Nations women were 27 times more likely to be hospitalised for assault, an 16% of First Nations people aged 15 or older reported they were a victim of either physical or threatened physical harm in the previous year, which implies the services are not apparent.

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[20] CFG data is organised as aggregate results per financial year.
[21] Australian Bureau of Statistics (1 July 2022), Australia: Aboriginal and Torres Strait Islander population summary, ABS Website, accessed 9 August 2023.
[22] Aboriginal and Torres Strait Islander people represent 3.2% of the Australian population.

Figure 11: Percentage of Aboriginal and Torres Strait Islander cases – MRS and BIS

Source: MRS#15 Aboriginal and Torres Strait Islander status – Number of cases overall by Aboriginal and Torres Strait Islander status (%)
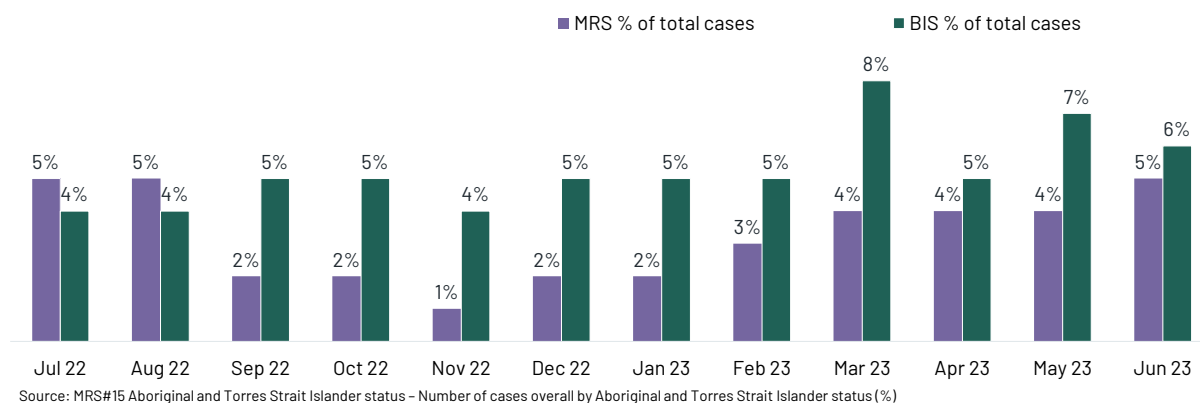
Refer to Table 37 in Appendix 5 to see the full data breakdown for this figure.

Table 18: Number of Aboriginal and Torres Strait Islander cases (July 2022 to June 2023) – CFG

CFG clients: Indigenous status	Number	Percentage
Aboriginal but not Torres Strait Islander origin	15	3%
Both Aboriginal and Torres Strait Islander origin	4	<1%
Neither Aboriginal nor Torres Strait Islander origin	450	89%
South Sea Islander	1	<1%
Not stated	33	7%
Total	**503**	**100%**

The Aboriginal and Torres Strait Islander service users consulted for this evaluation indicated they were broadly satisfied with their experiences. Table 19 shows that 3 of 4 Aboriginal and Torres Strait Islander BIS service users who completed the survey indicated the service performed well or very well in catering to the cultural and language needs of Aboriginal and Torres Strait Islander men. One rated the service 'poor' in this regard. The one MRS service user consulted indicated the service performed 'well'.

Table 20 indicates that Aboriginal and Torres Strait Islander men also believed that the BIS was effective in addressing the reasons they called it for. Three of 4 survey participants indicated it was 'very effective' or 'effective'. However, one indicated it was ineffective.

For the MRS, the same participant who indicated the MRS performed well in catering to the cultural and language needs of Aboriginal and Torres Strait Islander men also said it was ineffective for the reason he called it for.

'I have had some good yarns in the past with the Men's Referral Service before I went back to jail last year.' – First Nations man, MRS service user

'They've been pretty good.' – First Nations man, BIS, open ended response to quantitative survey

Table 19: Rating of performance of the BIS and MRS in catering to the cultural and language needs of Aboriginal and Torres Strait Islander men (n)

Measure	BIS	MRS
Total well (very well + well)	3	1
Total poor (very poor + poor)	1	0

Source: Service user survey. A25. How well did the service cater to your cultural/language needs as an Aboriginal or Torres Strait Islander person? (n)
Base: Aboriginal and Torres Strait Islander men (n = 5)

Table 20: Effectiveness of the BIS and MRS in addressing the reason it was contacted (among Aboriginal and Torres Strait Islander men)

Measure	BIS	MRS
Total effective (very effective + effective)	3	0
Total ineffective (very ineffective + ineffective)	1	1

Source: Service user survey. A18a – And how effective was the service is addressing the reason you were contacting the service for? (n)
Base: Aboriginal and Torres Strait Islander men (n = 5)

The literature review and consultations with service users and experts identified substantial barriers to help-seeking and behaviour change for Aboriginal and Torres Strait Islander men which are addressed by these services. These included:

- lack of access to face-to-face services for those living in rural and remote areas, and the limited availability locally

- reluctance to engage with services in close-knit communities because people they know may work at those services

- racist and discriminatory language/behaviours from other men in mainstream, group-based MBCPs.

> *'I know people [working in government services] that have said they had real bad things. Like workers being racist to them and things like that.' – First Nations man, MRS service user*

> *'Within the [domestic violence] sector in Alice Springs there's … such a lack of support to men who use violence and such, and there's really an agreement, that people going to prison doesn't really help.' – Aboriginal women's refuge*

However, these services are only a small part of the solution for FDSV for Aboriginal and Torres Strait Islander men and, for many, these services are unlikely to be appealing. In Table 20 (previous page), 2 survey participants indicated the service was ineffective for the reasons they called it for.

Consistent feedback from stakeholders, experts and First Nations MWUVA highlighted the preference for face-to-face conversations, which were reported to instil better connection,

trust and, ultimately, behaviour change[23]. Many stakeholders also spoke about the benefits of wraparound services that treat the whole family as a better approach to FDSV for First Nations communities, especially where the partners would both like to remain together.

'The humanistic nature to behaviour change is really important, even more so for mob. We always talk about connection, and it's important to connect to clients and the workers and et cetera. But I think even more so when it comes to First Nations, not only is it really vital, but it often takes longer to actually make those connections, and probably a lot of that is because of the historical distrust and the different things that come out there as well. But also I think there's probably a massive lack of awareness that violence being a behaviour, but also that change is possible as well.' – First Nations FDSV expert

'In person is always best for our mob. I know for me I didn't take much in over the phone and felt like I was talking to a robot or something. Seeing someone's face is better. I have heard some mob say that even Zoom is better than on the phone because at least you are still seeing other people.' – First Nations man, who has used violence in his relationships, no connection to MRS, BIS or CFG

'Some of the services are good but don't really fit for us brothers because we are different to white fellas in some ways, like some of the things we need might be different to what a white fella needs. Over-the-phone I don't reckon really works.' – First Nations man, who has used violence in his relationships, no connection to MRS, BIS or CFG

'You need to look at each other in the eyes. We on the phone, there's no spiritual connection whatsoever. Just a verbal I can tell you whatever I want, how I want and there's no accountability. There's probably no effective change that's going to happen with these services as they aren't face to face.' – Former facilitator of First Nations MBCPs

Other barriers that make these intervention services less attractive include language barriers for men living in community, preference for local services for those living in community (so long as they know their conversations will remain confidential and they do not know people working in the local service) and preference for First Nations–specific services (e.g. the Brother to Brother phone service for Aboriginal men delivered by Dardi Munwurro[24]) over mainstream services (if that is not available, then at least speaking with a First Nations counsellor). Aboriginal or Torres Strait Islander representation within the service was regularly mentioned by the First Nations men interviewed as important to feeling welcome. However, none of the First Nations men who called any of the services were able to get through to one.

Phone-based services will work for some Aboriginal and Torres Strait Islander men but not for all. They are part of the mix of service options that are required to address FDSV but are likely to be a small part of the overall solution.

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[23] This provides some explanation as to why the services are not attracting First Nations MWUVA proportionally. As explained in this section, Aboriginal and Torres Strait Islander people represent 1% of the Victorian population where a disproportionate number of MRS and BIS clients live. However, Aboriginal and Torres Strait Islander men are disproportionately represented in FDSV to a degree that vastly outweighs this.

[24] The Brother to Brother crisis line provides phone support for Aboriginal men who need someone to talk to about relationship issues, family violence, parenting, drug and alcohol issues or who are struggling to cope for other reasons.

'It would be a bit better if there was someone who done this behaviour change stuff but in a cultural way, like being out on Country having a yarn about better ways to handle our anger and stuff. Most white fellas' services don't fit with our mob and that's why not many brothers go to those services. Some brothers are really ashamed about the things that they do to their missus but feel weak in their heart to admit that to a stranger.' – First Nations man who has used violence in his relationships, no connection to MRS, BIS or CFG

'More [Indigenous workers] make me feel more comfortable having a yarn. I get that sometimes I will have to work with non-Indigenous workers and that is fine, I am used to it, but it would be helpful for me to see more Aboriginal brothers and sisters working at services.' – First Nations man, MRS/BIS service user, open ended response to quantitative survey

'Aboriginal men often feel worried asking for help from a non-Indigenous program or service because we feel that the staff might not understand our cultural background and things that sometimes have happened to us in our past.' First Nations man who has used violence in his relationships, MRS/BIS service user, open ended response to quantitative survey

'I have seen that many services for domestic violence over the years and I am still doing the exact same thing. The only time I go to services now is when I have to [court mandated]. When services read my history, I reckon they just put me in the too-hard basket and not try to help as much as they should.' – First Nations man, MRS service user

Culturally and linguistically diverse backgrounds

CALD Australians[25] make up roughly a quarter (23%) of the population. The annual average monthly service users of the BIS and MRS reflect the same proportion as the population. Notably, CFG has a lower (15%) representation of CALD service users (Figure 12), but this is likely due to a narrower definition of CALD for this specific program. The CFG program defines CALD users as being born overseas, while the BIS and MRS define CALD as service users who speak a language other than English at home.

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[25] The Australian Bureau of Statistics use several variables to measure Cultural and Linguistic Diversity of Australia. The CALD Australians mentioned here refers to the proportion of Australians who speak a language other than English at home.

Figure 12: Representation of CALD service users in each program
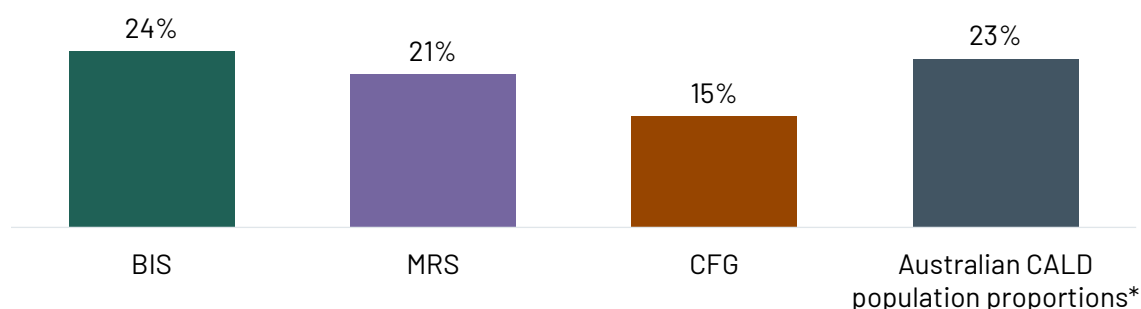
Source: Program data MRS#13 CALD | Program data BIS#8 CALD | Program data CFG not born in Australia | Australian Bureau of Statistics (20 September 2022), Cultural diversity of Australia, ABS Website, accessed 29 September 2023.
Note: CFG CALD data represents those born overseas which is a different definition than BIS, MRS, and the 'Australian CALD population proportions' which refer to the proportion of Australians who speak a language other than English (LOTE) at home.

Refer to Table 38 in Appendix 5 to see the full data breakdown for this figure.

Men from CALD backgrounds reported positive experiences with their respective services. In terms of their overall perceptions of their experience as CALD people, they share similar sentiments with most service users. They expressed that their experience was characterised by feeling genuinely listened to, comfortable and safe. According to many CALD men in the research, their background and diversity was not specifically addressed by program staff, but this didn't worry them. Feeling comfortable and welcomed, they did not perceive their accent or level of English proficiency as obstacles to getting all they could from the programs. They did not feel that their cultural identity created any tension or barrier between themselves and the services. This was further supported by the quantitative findings that showed 59% of CALD men felt that the services catered to their cultural/language needs well, while only 4% rated the services 'poor' on this dimension.

'The only extra thing they could have done would be to ask for a translator, but to be honest I really didn't need it.' – CALD MRS service user

'I never even thought about how my background might impact the sessions. But I felt there was so much opportunity to explain myself and my background. I felt understood and listened to, which helped me break down my fundamental understanding of masculinity.' – CALD MRS service user

Figure 13: Rating of how services cater to the cultural and language needs of CALD service users
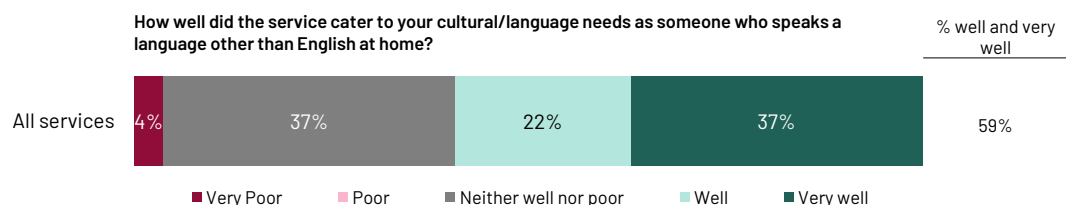
Source: A25 - How well did the service cater to your cultural / language needs as someone who speaks a language other than English at home?
Base: Speak a language other than English at home, unweighted, n=27.

Refer to Table 39 in Appendix 5 to see the full data breakdown for this figure.

While the research highlights positive results among CALD service users, there is a gap in understanding the challenges that may exist for CALD men who chose not to take part in the programs. Further research to understand the impact of language and cultural barriers would be beneficial given the current literature, which highlights the challenges that exist when it comes to language.

Although research is scarce in family violence telephone and online interventions for CALD men, research has highlighted that it is crucial to offer clear information in a person's native languages about how and where they can access support (Murray et al. 2022). Findings from Murray et al. (2022) indicate that among a sample of websites for mental health support, none offered forums, web chat or email services in languages other than English. Only a few with telephone counselling services provided information on accessing the national Translating and Interpreting Service; however, the instructions to access this service were available only in English. Among the programs evaluated here only the MensLine website (on which the CFG VPP and CFG Post-MBCP program information is hosted) had information available in separate languages. Further, Straiton et al. (2014) found that men, in general and especially those from non–English speaking backgrounds, especially foreign-born men, were more likely to have unequal access to mental-health treatment based on their needs. As mentioned, men are hesitant to seek help due to beliefs centred around masculinity; foreign-born men are likely to face added barriers such as language difficulties. In considering the lack of non-verbal cues when communicating over the phone, CALD MWUVA may face additional issues when accessing phone support.

Case study #1: Ahmad, 42, new migrant from Syria, referred onto an MBCP by the MRS

Ahmad, a 42-year-old new migrant from Syria, embarked on a journey to Australia with his wife and 2 children, seeking refuge from the war that ravaged their homeland.

Life in Australia brought about significant changes for Ahmad's family, particularly for his wife, who found a new sense of independence through employment at a local opportunity shop. This job not only provided her with her own income but also opened doors to new friendships and a social life outside the home.

However, Ahmad's traditional views on family dynamics led him to exert control over his wife's finances, movements, and social interactions, a practice that increasingly became a source of conflict between them. The tension escalated when his wife began to spend more time outside the home, embracing her newfound independence and social circle, which Ahmad viewed as a challenge to the status quo.

The situation reached a boiling point one evening when his wife returned home later than expected. An argument ensued, during which Ahmad chose to strike his wife. In response, she called the police, leading to Ahmad being issued an intervention order.

Faced with legal consequences, Ahmad was mandated to attend an MBCP. With the assistance of the Men's Referral Service and the aid of an interpreter, Ahmad was directed to an Arabic-specific MBCP located on the opposite side of Melbourne, a journey that required him to drive for 45 minutes to attend. Through the interpreter, the MRS also explained some of the legal implications of FDSV in Australia to Ahmad.

Participating in the MBCP proved to be a challenging experience for Ahmad. It confronted him with the stark differences between his expectations of family roles and the reality in Australia. The program forced Ahmad to reflect on his behaviour and the impact of his actions on his

family. Yet, even after completing the program, Ahmad struggled to reconcile with the idea that the Australian government could intervene in personal family matters, particularly regarding the control over family finances, including his wife's earnings.

The case studies presented are not based on any single individual. Rather, they are an amalgamation of narratives, themes, and attitudes that emerged consistently through qualitative interviews with service users. Whereto Research have synthesised these elements to construct representations that accurately reflect the experiences of some of the men we interviewed. Importantly, none of the case studies correspond to any one person. Furthermore, the names, ages, and other details presented in the case study heading are fictional.

Regional and remote communities

Men from regional and remote communities, comprise a significant proportion of service users for all programs. Program data for the BIS and MRS show that the proportion living outside of the major cities is broadly in line with population proportions.

- Those living in 'Inner regional Australia' are slightly over-represented compared with 'Outer regional Australia' in NTV data.

- The CFG program does not collect detailed remoteness data in the same way. However, data collected from survey responses shows that those living in 'regional', rural and remote Australia represent close to 4 in 10 (39%) CFG service users.

For MWUVA living outside metropolitan Australia, these call-based services are an important resource, they provide access to support nationally regardless of location. Some regional, rural and remote areas will have no access to local MBCPs and while some may join video call–based programs many will not.

Behaviour change programs and mental health services delivered via telephone cater to various barriers faced by men residing in regional and remote areas. A significant advantage is granting access to services that might not be locally available. Telephone counselling bridges the gap for those lacking nearby counsellors or psychologists, saving them the logistical hassle and extra expenses associated with travel.

Figure 14: Location of MRS and BIS service users (program data)
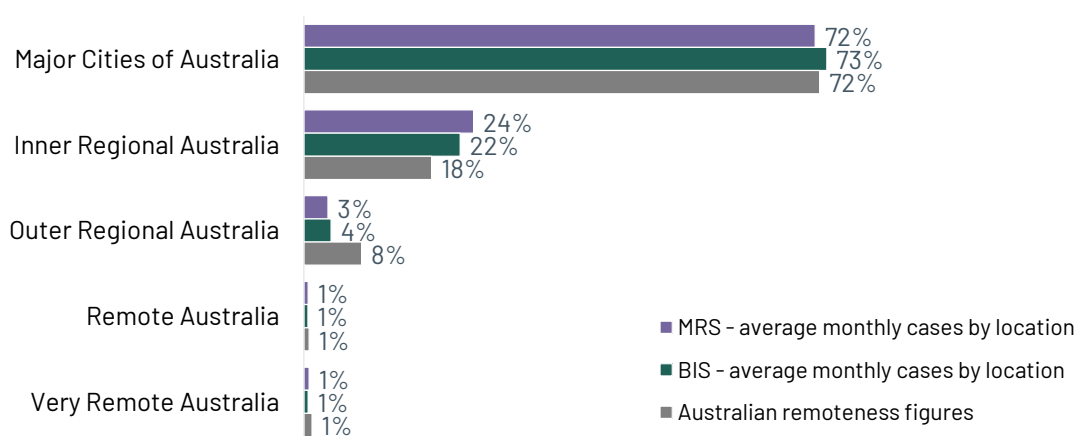
Source: MRS#14 Region – number of cases overall by region | Source: BIS Number of clients overall by location

Refer to Table 40 in Appendix 5 to see the full data breakdown for this figure.

Figure 15: Location of service users (survey data)
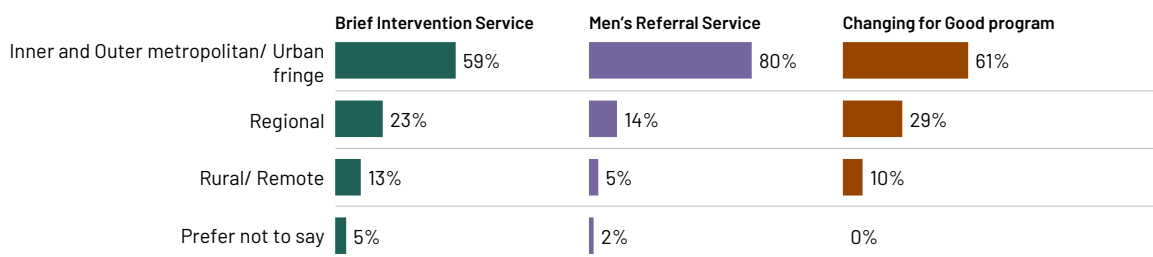
	Brief Intervention Service	Men's Referral Service	Changing for Good program
Inner and Outer metropolitan/ Urban fringe	59%	80%	61%
Regional	23%	14%	29%
Rural/ Remote	13%	5%	10%
Prefer not to say	5%	2%	0%

Source: A31. Which of the following best describes where you live?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Refer to Table 41 in Appendix 5 to see the full data breakdown for this figure.

Moreover, telephone services offer a more comfortable and less daunting platform for men to engage with professionals, especially in small towns where seeking face-to-face assistance may heighten feelings of embarrassment or discomfort due to community visibility. Privately accessing support from one's own home enhances the sense of security and confidentiality.

Service users living in regional, rural, and remote Australia believe the services are effective in addressing the reasons they called them for. Figure 16 shows the overall effectiveness of all 3 interventions cross-tabulated by location (metro compared with regional, rural, remote). We see that service users from regional, rural, and remote Australia rated the effectiveness of the service highly (80% 'very effective' or 'effective'). Ratings of service effectiveness did not significantly differ between service users from regional, rural, and remote areas and those living in metropolitan Australia (77% 'very effective' or 'effective').

Figure 16: Effectiveness of services combined: metro compared with regional, rural and remote

	Very ineffective	Ineffective	Neither	Effective	Very effective	% effective and very effective
Metro	3%	8%	11%	40%	37%	77%
Regional + Rural + Remote	3%	3%	15%	38%	43%	80%
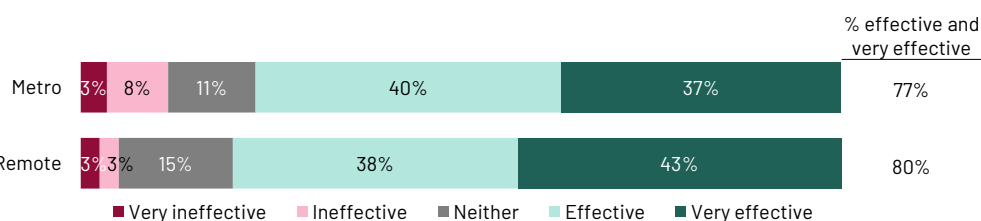
Source: A18a. And how effective was the service is addressing the reason you were contacting the service for?
Base: Metro, unweighted, n=87; regional, unweighted, n=40.

Refer to Table 42 in Appendix 5 to see the full data breakdown for this figure.

Some non-metropolitan men identify a specific barrier: hesitance towards answering calls originating from outside their local area. They are accustomed to disregarding calls from distant cities, given their perceived lack of personal relevance, leading to instances where they inadvertently miss calls from their respective programs.

In addition, call-based services are not a direct replacement for face-to-face MBCPs, and many regional, rural, and remote service users lament the lack of services available to them locally.

'But being in a rural area was very, very tough. Sorry, the [regional] services [that] were there, they were great … But when you're stuck an hour away from anything can't really get that face-to-face assistance that was needed. I still need help, I still need to go through an MBCP, but it's been a long, slow process because I live in a rural area.' BIS service user, male

LGBTIQA+ community

Participation in FDSV services among LGBTIQA+ communities is notably low, despite the significant prevalence of intimate partner violence in these communities.

Within the programs, according to program data:

- In the past 6 months, *n* = 4 have presented as trans or gender diverse. This represents 0.12% of all contacts in that period.

- The BIS has no trans or gender diverse service users on record.

    - Neither service provided records of sexual orientation to Where*to*. However, consultations with frontline counsellors indicate it is extremely rare to speak with GBTIQ+ service users.

- The CFG program asks sexual orientation (heterosexual, gay or bisexual) and has no men indicating they are gay or bisexual men from July 2022 to March 2023.

The 'Private Lives 3' report (Hill et al. 2021) on the health and wellbeing of LGBTIQA+ people in Australia highlights that more than 4 in 10 participants (41.7%) have experienced abuse in an intimate relationship. Yet, the use of helplines and services remains minimal.

One of the critical challenges is the misidentification of victim-survivors and perpetrators by police, who often default to assuming the man is the person using violence. This approach overlooks the nuanced and gendered nature of violence within LGBTIQA+ relationships, where the more masculine presenting person is not always the offender.

Several barriers contribute to the low usage of these services by LGBTIQA+ people:

- a perception that existing services do not cater to their specific needs

- concerns that service providers may not understand the unique dynamics of their relationships

- MBCPs are predominantly designed with heterosexual men in mind, making them less relevant for gay and transgender men

- stigma and shame, particularly around dating transgender women, can exacerbate the reluctance to seek help

- a recognition that disrespect towards women is often intertwined with homophobia

- a fear of being misunderstood or unwelcome by facilitators who may not grasp their specific issues

- a heightened sensitivity in the LGBTIQA+ community to subtle cues of exclusion or unwelcomeness

- concerns about being ostracised from close-knit community networks, especially in rural areas, if they disclose using violence.

When it comes to service delivery, there is a critical need for training to understand the complex power dynamics, intra-community discrimination, racism, and gender dynamics within LGBTIQA+ communities. Discrimination and misunderstandings within the community, such as between gay men and transgender men, further complicate service provision.

Consultations with sector stakeholders and experts indicate that although there's a desire for support, the scarcity of LGBTIQA+ specific behaviour change services limits options. Programs like 'Proud Partners' show behaviour change programs can occur, with lower levels of violence and a focus similar to MBCPs but tailored for LGBTIQA+ people. However, such programs are small, infrequent and cannot meet the widespread demand.

In the absence of accessible, inclusive services, LGBTIQA+ people often disclose intimate partner violence in settings like AOD services or general psychological sessions, where the support provided is inconsistent and depends on the training of the service provider.

This gap in support and understanding means that many in the LGBTIQA+ community continue to experience and use violence in their relationships with little to no intervention, underscoring the urgent need for more inclusive, informed and accessible FDSV services.

People with disability

People with physical or mental disabilities, as well as those with neurodiversity, express a notably high level of positivity towards the programs. Most service users with disabilities found their programs effective (92% in BIS; 78% in MRS; 86% in CFG – Figure 17).

Various factors contribute to the perceived effectiveness and positive experiences across people with different disabilities. The supportive and empathetic nature of counsellor interactions plays a significant role. Counsellors create a comfortable environment, particularly through attentive listening, ensuring service users feel heard, which is crucial for people facing mental health challenges or navigating neurodiversity. Providing a non-judgemental space where service users can openly discuss challenging psychological aspects in the context of their condition fosters a sense of safety and promotes progress towards behaviour change. For instance, people dealing with schizophrenia find it essential to address behaviour change while considering their specific circumstances.

Furthermore, counselling sessions offer an opportunity for men to delve into self-exploration and gain a deeper understanding of their psyche, adding value to their experience. Psychoeducation provided during sessions allows them to learn about their cognitive processes, which many find stimulating and motivational. Some people, following recent discussions with psychologists, either discovered they were on the autism spectrum or suspected they might be, finding counselling sessions valuable for further exploration.

For those with physical disabilities, telephone counselling proves beneficial by eliminating physical barriers associated with face-to-face interactions, such as travel. Being able to receive calls in their homes offers personalised ways to manage physical comfort, enhancing their overall experience.

'It's sometimes physical disabilities that we deal with, but most of the time, it's mental health or it's acquired brain injuries. The most common would be acquired brain injuries, and people who have bipolar or schizophrenia. I think is a quite common cohort we work with.' – Frontline MRS counsellor

Figure 17: Service effectiveness among users with disability or a chronic health condition

		% Total effective and very effective	
Service users with a disability or chronic health condition		Disability or health condition	No disability or health condition
Brief intervention Service	8% Ineffective / 42% Effective / 50% Very effective	92%	84%
Men's Referral Service	11% Ineffective / 11% Neither / 56% Effective / 22% Very effective	78%	60%
Changing for Good program	14% Neither / 43% Effective / 43% Very effective	86%	88%

■ Very ineffective ■ Ineffective ■ Neither ■ Effective ■ Very effective
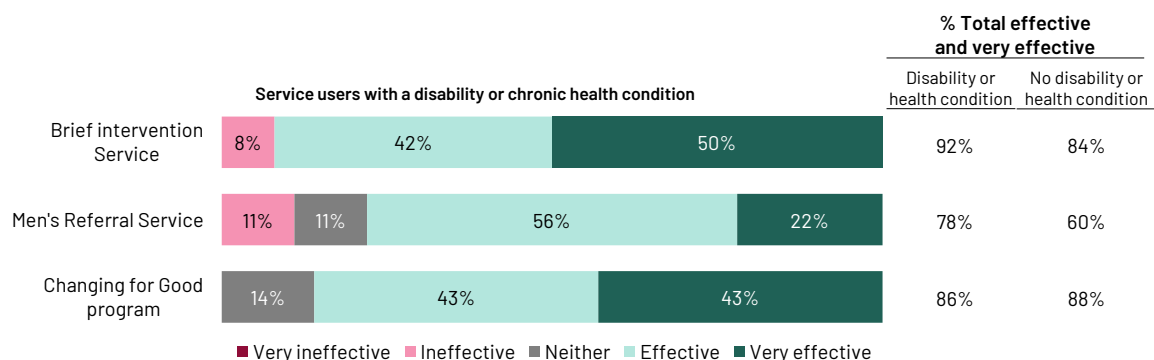
Source: A18a. And how effective was the service is addressing the reason you were contacting the service for?. A32 - Are you a person living with disability or chronic health conditions?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 43 in Appendix 5 to see the full data breakdown for this figure.

> *'Yes, obviously travelling long distances is difficult for me. I have to do a lot, living where I do [regionally], but, you know, getting in and out of my car is difficult with the disability now. Going into the city for me is about a half-day experience. So this kind of service would be really beneficial for me if I had to access it again.' – CFG service user, male, physical disability*

> *'The BIS counsellor, he was a really good listener. In the first couple of sessions, he created a lesson plan for each session. He would approach it in a way that I could learn it, my way. His way of thinking just worked; he would walk me up to the gate then let me work it out. He helped me understand social cues and empathy in a way I never had explained to me before. I've become more empathetic; I'll never master it, but I am much better than I was 6 months ago. I deal with situations much better. I am a lot calmer and as such I can deal with conflict a lot better.' – BIS service user, male, autism*

> *'I need more supports. I have changed a lot, but there is a lot to go. This will be something I need to work on for the rest of my life, but I am excited to do that and feel positive about the future.' – CFG Post-MBCP service user, autism*

Case study #2: David, 46 years, recently acquired physical disability, substance abuse, referred to an MBCP by the MRS

David, 46 a family man, faced a life-altering challenge when a back injury rendered him unable to work. The physical pain and loss of his role as a provider led him down a path of heavy drinking, creating a growing rift between him and his family. The situation reached a critical point when he awoke one morning to his wife's revelation that he had hit her in a drunken state the night before. Shocked by his actions and the threat of his wife leaving, David realised the urgent need for change.

In his search for support, David contacted the MRS, which directed him to an MBCP and enrolled him in the BIS. They also connected him with Alcoholics Anonymous, offering a comprehensive support system to address his alcoholism and its underlying issues.

Appreciating the call-based nature of the BIS due to his mobility issues, David ceased drinking and began to uncover and confront the reasons behind his alcohol dependency and its devastating impact on his family. Despite his initial trepidation about the MBCP, fearing the presence of more violent individuals or those with prison backgrounds, David found the positive experiences with the BIS encouraging for his journey ahead.

As he prepared to start the MBCP, David was aware of his partner's scepticism about the depth of his change. He understood that rebuilding trust would be a slow and challenging process but remained committed to transforming his life for the better. David's story is one of confronting personal demons, embracing support, and the ongoing journey towards healing and change within a family.

The case studies presented are not based on any single individual. Rather, they are an amalgamation of narratives, themes, and attitudes that emerged consistently through qualitative interviews with service users. Whereto Research have synthesised these elements to construct representations that accurately reflect the experiences of some of the men we interviewed. Importantly, none of the case studies correspond to any one person. Furthermore, the names, ages, and other details presented in the case study heading are fictional.

Effectiveness

Effectiveness

Effectiveness: the extent to which the program is achieving the intended outcomes.

Effectiveness key evaluation questions

(For the MRS) To what extent are individuals engaging with services to which they are referred by the MRS and to what extent is that engagement ongoing?

(For the BIS and CFG) What changes in clients' violent and/or controlling behaviours result from engaging with these services? Are these changes maintained over time?

Are there any unintended consequences for clients and their family members (or current partners) from engaging with these programs (positive or negative)?

(For the BIS and CFG) What factors contribute to or impede the success of clients changing behaviours? (For the MRS) What factors contribute to or impede ongoing engagement with services designed to support changes in the behaviour?

- Factors for consideration may include client demographics (including age, relationship status, cultural influences), therapeutic model/counselling approach or other aspects of the service, availability of or engagement with support services (for substance abuse, gambling addiction, mental illness, etc.), other perpetrator support services and/or the criminal justice/legal status, source of referral and presenting behaviours/patterns.

Consideration should be given to identifying the most useful or essential elements of a service in supporting clients to change their violent and/or controlling behaviours.

Effectiveness key findings

- Based on MRS program data and the online survey of service users, around 2 in 5 MRS service users are referred to other services, the bulk of which are made to MBCPs. Of those referred, just under a quarter (23%) have had multiple or ongoing contacts, and 1 in 6 (16%) have had a single contact.
  - There are circumstances in which it is not appropriate to provide a referral (e.g. crisis counselling, response to risk, information provision), and sometimes it is not possible to refer on (e.g. if a man is intoxicated, drug-affected or overly abusive towards counsellors).
  - Cold referrals are currently used, whereby the MRS service user initiates engagement with the referred service themselves. The ability for MRS services to make warm referrals has been limited because there are not yet strong links established with other services.
- Service user survey respondents for all programs reported overall reductions in self-reported violent behaviours.
  - Note that these are low-dose programs, and it is difficult to attribute all this change to the programs alone.
- Service users who had the most success in maintaining behaviour change also engaged with other services: MBCPs, specialist psychologists, other helplines.
- Three potential unintended consequences emerged in this evaluation:

- Some men in these programs have reported increases in violence, verbal abuse, controlling behaviour and other antisocial behaviours.

- The potentially collusive name of the VPP and how distinguishing between physical and non-physical forms of violence in the VPP could reinforce the idea that men in that program are not 'as bad' as men in other programs. The streaming of non-physical and physical violence types reinforces a false dichotomy that has been identified as an important unintended consequence for further consideration.

- Many men who contact intervention services, in particular the MRS, do so looking to manipulate the system rather than wanting to change their behaviour. That is, they are attempting to deliberately use the system to achieve a better outcome at court, with child protection services or with police. The services are aware of this and manage such situations.

- Several impediments were identified, reflecting multifaceted challenges men face in engaging with behaviour change services or in acknowledging, taking responsibility for and ultimately changing their violent behaviours. These include:

  - systemic barriers such as long wait times or over subscription for MBCPs in limited locations

  - misalignment between court assessments requiring MBCP participation and treatment readiness

  - the impact of traditional male gender roles and associated stigma on men's reluctance to seek psychological help

  - cognitive impairments and language or cultural barriers, which can complicate engagement with services

  - limited interventions that are culturally sensitive and appropriate, especially for First Nations men and those from CALD backgrounds.

Overall, the success of these programs is not necessarily in effecting behaviour change in service users but tailoring multipronged services and keeping service users engaged in the process, fostering positivity and ensuring men follow up referrals to longer term programs.

Extent of engagement with services to which men are referred by the MRS

Referrals are a core part of the MRS service and a key reason why men make contact. The interaction between the MRS and a caller can be the first and only time the sector has to engage with these men. Before this interaction the actions of the man can be completely hidden to the sector, and if the man disengages, then he may not call back for years, if at all.

The MRS does not collect data on what proportion of men follow up referrals they provide. Men are given a 'cold referral' whereby the MRS provides the man with the referral and lets him engage with the service himself. There is currently no liaison between the provider and receiver of the referral (most frequently an MBCP).

For the BIS and CFG, referrals are an important but smaller component of the programs.

The impact of no case coordination on sector engagement

Through sector consultations and service user interviews, it became clear there are currently no system to follow men through their behaviour change journey and ensure individual cases achieve the change required. This means that engagement with the sector and the extent to which behaviour change occurs is decided by the service user attempting that behaviour change. This leaves multiple points at which disengagement can occur. Often men will complete only one (e.g. court mandated) MBCP and not go on to seek any further assistance. Despite, as is previously mentioned in this report, the current literature states that 200 hours of behaviour change is required for high-risk individuals and 100 hours for moderate risk (Sperber et al. 2013) to reduce recidivism rates. If behaviour change has not occurred in the MBCP, then there is no reason to assume the MWUVA will not go on to use violence again (either against his current partner/family or against a new partner/family).

This suggests a need for a case coordination role to follow men through the system and ensure they stay engaged, provide some ongoing behaviour change support and consultation, complete the programs they set out to, re-enrol if required and seek out other supports (e.g. clinical psychologist support, AOD/housing/gambling programs) to support their behaviour change work.

Men's Referral Service referral pathway success

This evaluation has sought to provide insight on the success or otherwise of the referral pathway from the MRS into other services. The data below show that the MRS is creating a 'flow through' effect within the sector.

Figure 18 shows 2 in 5 (43%) MRS service user respondents to the survey claim to have been referred to other services by the MRS. This proportion of referrals should be viewed as a success by the MRS.

While 57%[26] of callers not receiving a referral may seem high, it is important to note that sometimes it will not be appropriate to provide a man with a referral (e.g. crisis counselling, response to risk, information provision) and sometimes it will not be possible (e.g. if a man is intoxicated, drug affected or overly abusive towards counsellors). Furthermore, frontline counsellors estimate approximately 50% of callers are not genuinely interested in behaviour change (this is explained under Unintended consequences see Figure 30).

Six in 10 (57%) claim to have not been referred on or don't know, 14% claimed to have been referred to multiple services and 30% claim to have been referred to a single service. From there, just under a quarter (23%) have had multiple or ongoing contacts, and 1 in 6 (16%) have had a single contact. Of those referred, only 5% have had no contact at all.

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[26] This aligns with program data aligns with NTV program data on total proportion of callers referred onto other services: from July to December 2023, NTV had an average of 56% who did not receive a referral.

Figure 18: Referral pathway process
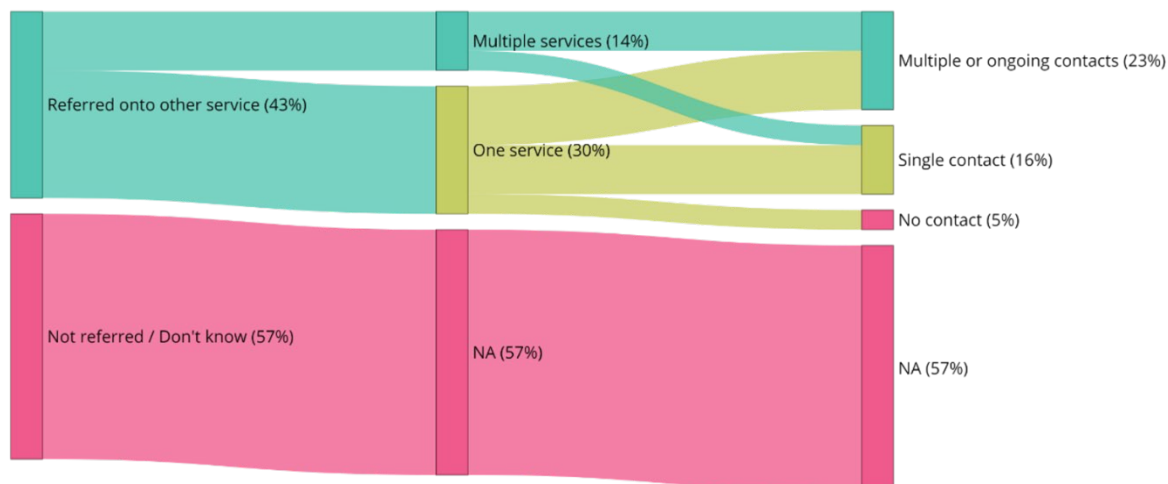
Refer to Table 44 in Appendix 5 to see the full data breakdown for this figure.

These data show that among those referred onto other services by the MRS, 91%[27] go on to have a single or multiple contacts with the service they were referred to.

Some of those who have had no contact with the service they were referred to will simply have lost the motivation or courage to change and will be lost to the system forever, others may call back months or years later and ask for the same referral again then go onto take up that referral. This is part of their behaviour change journey for MWUVA.

Figure 19 shows that a large majority of those provided a referral were to an MBCP (74%). One in five (21%) received one to an AOD service. Five per cent of referrals were to the BIS.

Figure 19: Proportion of MRS service users referred to other service
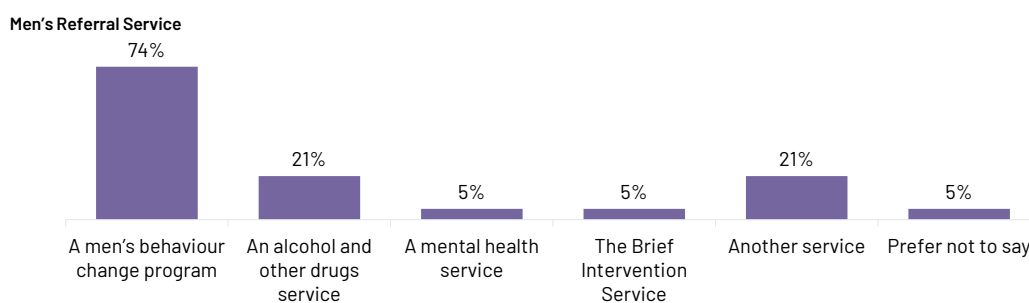
Refer to *Table 45* in Appendix 5 to see the full data breakdown for this figure.

'I've got to give the MRS props. At the end of the day, it referred to me on to a men's behavioural change program, which has ultimately been a positive. At the time, I didn't feel that it was like it was individualised to me but, but at the same time, I can't fault what the resulting positive outcome was.' MRS service user, male, Victoria

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[27] Calculation of the proportion of those who followed up a referral from MRS: 39% (multiple + single contacts) / 43% (proportion of MRS callers provided a referral) *100 = 91%.

Warm referrals

The MRS does not currently conduct 'warm referrals', which would include informing the target service that they have referred a man to them. A warm referral might also include ongoing liaison about whether the man engaged in the program/service he was referred to.

Instead, men are given a 'cold referral', which involves providing the man with the referral and letting him engage with the service himself. There is currently no liaison between the referrer and the service about referrals.

Frontline staff and management at NTV expressed a desire to move towards a model where warm referrals are part of the model, but this would need to be funded accordingly because it would mean extra administration and liaison.

There was agreement within the sector (speaking with MBCPs and the MRS) that warm referrals would be a better approach because they allow for better tracking of the man through the system and mean there is likely better information sharing between services. For the man trying to seek help, navigating this sector can be frustrating; he often must retell his story each time, and there is no follow-up after he reaches out.

This approach would have the benefit of improved risk management for the AFM by keeping the man in view throughout his journey, providing better data for evaluation of services and ongoing improvement, and reducing the prevalence of men dropping out of their behaviour change journey.

'The Men's Referral Service is heavily reliant on the service system to which we are the front door. Many of the services and issues raised in my responses (AOD, Mental Health, Housing … i.e. intersectionality and case management) are not available for most men. Equally, where these services are available, MRS does not seem to have strong links to them or the ability to make warm referrals. Men often feel like they are bouncing from service to service, and there is a way to go in the men's sector to make genuine multiagency risk management a reality. This also contributes to the need for men to tell their story over and over, a practice we have sought to leave behind in the women and children's sector.' – NTV frontline counsellor

Brief Intervention Service and Changing for Good contributions to engaging with other services

The BIS and CFG also contribute to this flow through in a slightly different way; by providing a positive and motivating counselling experience, men are more likely to continue with their behaviour change journey with other services. For men who are awaiting an MBCP the BIS and CFG keep them engaged in the system and prepare them for what is to come in the MBCP—this reduces drop out.

The data below (Figure 20) show that among BIS service users who took part in the online survey, 16% went on to complete an MBCP, 27% are yet to start but intend to, and 25% have no intention of completing an MBCP. 14% started an MBCP but did not finish. Among CFG service users, 26% have completed an MBCP, 29% are yet to start but intend to, and 29% have no intention of completing an MBCP. 10% started an MBCP but did not finish.

Providing referrals is not the key function of the BIS and CFG, they only provide referrals when asked or at the discretion of the counsellors. However, attendance and engagement in long-

term men's behaviour change should be a key objective of these programs, as it is through longer term programs that MWUVA will have the greatest opportunity for meaningful change.

Figure 20: Engagement with MBCPs among BIS and CFG service users
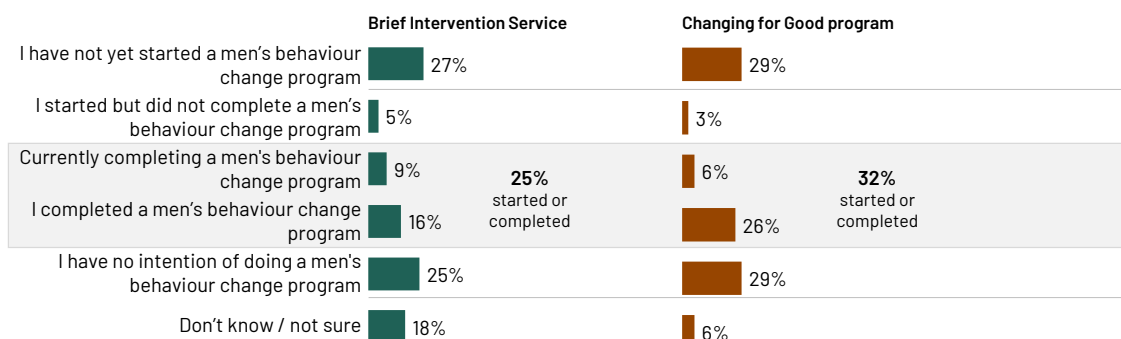
	Brief Intervention Service	Changing for Good program
I have not yet started a men's behaviour change program	27%	29%
I started but did not complete a men's behaviour change program	5%	3%
Currently completing a men's behaviour change program	9%	6%
I completed a men's behaviour change program	16%	26%
I have no intention of doing a men's behaviour change program	25%	29%
Don't know / not sure	18%	6%

25% started or completed (Brief Intervention Service)

32% started or completed (Changing for Good program)

Source: A13. Following your interactions with the [PROGRAM], which of the following apply to you?
Base: Brief Intervention Service, unweighted, n=56; Changing for Good program, unweighted, n=31.

Refer to Table 46 in Appendix 5 to see the full data breakdown for this figure.

Despite the fact that many men enrolled in the CFG VPP see themselves as less violent than other MWUVA and are keen to make a distinction between themselves and in their words the 'really bad guys', 29% went on to complete an MBCP. This should be viewed as a success. The fact that men in the VPP have engaged with an MBCP shows that the VPP contributes to a 'flow through' effect too.

Profile of men who disengage

The literature review (Appendix 4: Literature review) found certain predictors that make men more likely to disengage from enrolling or completing an MBCP (Olver et al. 2011). The strongest predictor of non-completion was having prior FDSV offences. Other predictors include having an antisocial personality, a history of criminality, non-mandated attendance, younger age and little motivation for treatment.

Notably, characteristics such as the type of violence, controlling behaviours, depression/anxiety, anger problems, alcohol use (excluding abuse) and childhood maltreatment were not correlated with non-completion (Olver et al. 2011).

'I don't think my circumstances meet the requirements of the program.' – CFG service user, male

'Didn't know that was the next appropriate step.' – CFG service user, male

In the survey of service users, those who indicated they did not have any intention of doing an MBCP were asked an open-ended question of why. These responses were then categorised and coded. The results in Figure 21 show the most common response type was that service users felt 'well equipped' (and therefore an MBCP was not seen as relevant to them). This was especially so for those who completed the CFG program, with 4 in 5 (78%) CFG service users who had no intention of completing an MBCP citing this as a reason. Interestingly, those who did not plan on attending an MBCP, after having engaged with CFG, were more likely than those in the BIS to say it was not relevant for them than because they 'had not committed domestic violence'.

'I thought about doing a group thing, but I felt quite well after speaking with the counsellor and I didn't feel a need to.' – CFG service user, male

'They got in contact with me, but I feel like I didn't need to do it because I see a counsellor and he said to me that I do not need to do the men's behaviour change program. You have suffered narcissistic abuse, and we should just keep doing this.' – CFG service user, male

This is perhaps concerning because we know almost all men engaging in these intervention services are engaged in some form of violence, but the name of the VPP and the fact that one is ineligible by using physical violence implies that non-physical violence is not violence (this is explored in depth in the Unintended consequences section). While this evaluation made no attempt to quantitatively measure service users' understanding of the definition of domestic violence, qualitative interviews showed a tendency for service users think of domestic violence as exclusively physical violence.

'I didn't know I could do it after that; the behaviour hasn't occurred since doing the BIS. If I lapse back into something dodgy, I will use it. The BIS has done its job at this stage.' – BIS service user, male

This demonstrates the importance of a more connected sector that can follow men through their behaviour change journey and intervene when and if they disengage.

Figure 21: Reasons why service users do not intend to do an MBCP (open-ended coded responses)

	Brief Intervention Service	Changing for Good program
I feel well-equipped (tools/knowledge/etc.)	21%	78%
Addressing behaviours alternatively (councilor / other program)	21%	22%
It was not relevant for me as I never committed domestic violence	7%	22%
Its not necessary for me / issue isn't going to happen again	14%	11%
Program scheduling didn't suit my responsibilities - work/parenting	14%	0%
Can't be bothered	7%	0%
I am doing the program	7%	0%
I'm currently not in a relationship	7%	0%
I addressed concerning behaviours post program	0%	11%
It fulfilled my court requirements	7%	0%
Will contact again if I am in need of further help	7%	0%
I didn't know I could do it	7%	0%
If I lapse back into bad behaviour I will do it	7%	0%
Other	14%	0%

Source: A16A - Why do you have no intention of doing a men's behaviour change program?
Base: Those with no intention to do a MBCP, unweighted BIS n=14, unweighted, CFG n=9.

Refer to Table 47 in Appendix 5 to see the full data breakdown for this figure.

Case study #3: Mike, 35 years, very physically violent, MRS service user

Mike, a 35-year-old man, has always known violence, it has been an ever-present feature of his life. He had a difficult upbringing marked by years of witnessing his father's physical violence and severe psychological abuse towards his mother and his own interactions with statutory child protection, juvenile detention and time spent moving between foster homes.

By the time he had reached adulthood, Mike found himself entrenched in destructive patterns of alcoholism and violence. As the years went on, he had multiple partners all of whom he had been violent toward.

On one occasion, an argument escalated into Mike choking his partner, which the neighbours heard and called the police. Mike was removed from the property and issued a Family Violence Safety Notice. Mike was provided with the details for the Men's Referral Service by the police. Not knowing what else to do Mike called the MRS who explained that if he re-enters the family home he will be in breach of the Family Violence Safety Notice. The MRS helped Mike to find a solution to his immediate housing needs and he believed he could go stay with a friend.

He called back the next day and was very upfront about his violent behaviour, and asked the MRS counsellor what they can do to 'fix it'. Mike harboured scepticism about the possibility of his ability to change, assuming that any psychologist or counsellor would say he required a significant and long-term overhaul of his mindset and behaviour. He was not prepared to enter into such a commitment which he saw as belittling and embarrassing. In his mind, he merely sought quick tips and strategies to temper his anger. Eventually, Mike thought it worth giving the MBCP a shot.

However, his hopes for a quick fix were dashed when the MRS recommended he join a multi-week MBCP. Disheartened by the commitment required, Mike dismissed the idea, convinced that it overstated the severity of his situation and fearing judgement. Rationalising that he couldn't spare the time for such a long-term endeavour, Mike chose to forgo the opportunity.

The case studies presented are not based on any single individual. Rather, they are an amalgamation of narratives, themes, and attitudes that emerged consistently through qualitative interviews with service users. Whereto Research have synthesised these elements to construct representations that accurately reflect the experiences of some of the men we interviewed. Importantly, none of the case studies correspond to any one person. Furthermore, the names, ages, and other details presented in the case study heading are fictional.

Changes in violent behaviours

To evaluate service user behaviour change, this report triangulates several data points including service user survey data, service user interviews, interviews with frontline counsellors and interviews with MBCPs. As is outlined in the 'Limitations of this evaluation' section of this report, MWUVA tend to overestimate their change progress and minimise their violence, therefore a critical lens must be applied to all self-reported data and various data sources must be cross-checked.

Changes in violent behaviours overall and comparison of the services

At the overall level, service users in this evaluation were more likely to self-report a reduction in violent behaviours than an increase.

Online survey data shows that these services are creating some positive behaviour change in service users. Service user survey respondents reported declines in behaviours they sought to address when they first had contact with the service, especially verbal arguments (78% of BIS and 84% of CFG service users reported a reduction) and anger management (78%, 94%), but also including the use of physical violence, controlling behaviour, anger, entitlement and poor mental health. As Figure 22 shows:

- Large proportions of BIS service users self-reported reductions in all metrics.

- Large proportions of CFG service users self-reported reductions in many metrics, especially verbal arguments and anger management. As physical violence should preclude service users from the CFG VPP, many indicated 'not applicable'.

- MRS service users reported reductions in behaviours, but with less interaction with the service the overall proportion of men indicating they had seen positive behaviour change was lower than for other services.

Figure 22: Total reductions in behaviours or problem since first contact with service ('reduced a lot' + 'reduced')

	Brief Intervention Service	Men's Referral Service	Changing for Good program
My **physically violent behaviour** towards my partner and/or family	47%	36%	23%
My **verbal arguments** with my partner and/or family	76%	55%	84%
My **controlling behaviour** of my partner and/or family	53%	33%	45%
Problems with my **mental health**	60%	39%	68%
Problems with my **substance abuse**	27%	21%	19%
Problems with my **own entitlement**	45%	32%	52%
Problems with my **anger management**	78%	48%	94%
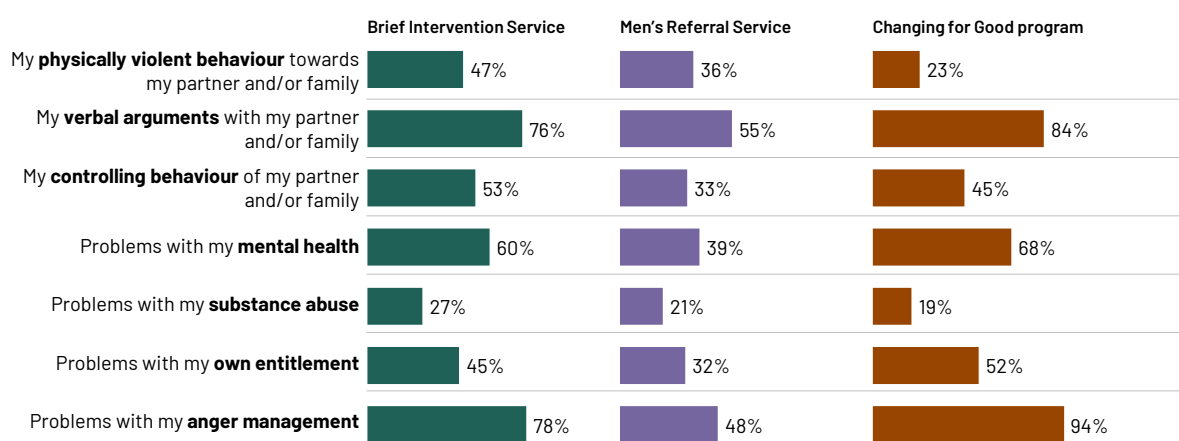
Source: A19. Have the behaviours you sought to address when you first had contact with the service changed?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Refer to Table 48 in Appendix 5 to see the full data breakdown for this figure.

Men were generally very positive about their experiences, often discussing internal changes, emotional regulation, mindfulness and an improved awareness of their own body language. They spoke about gaining a new language to articulate their feelings, allowing them to resolve conflicts more effectively. Most men accepted at least some responsibility for their actions; only some blamed others completely. Many recognised that 'I need to change', and most acknowledged they 'still have work to do'.

> *'I don't think I necessarily understood what my behaviours were doing, or I didn't listen to her. I have a tendency to avoid things and not accept responsibility for the things that I have been doing.' – Service user, CFG*

Many service users had a good experience in reaching out for help and spoke about how that gave them confidence to seek help again in future. They reported almost no negative feedback, indicating that the programs are not discouraging men from continuing to engage with the sector.

In the survey, service users were asked to rate how effective the service was in addressing the issue they contacted it for. The results are shown in Figure 23. More than 8 in 10 BIS (86%) and CFG (87%) respondents said the program was 'very effective' or 'effective' in addressing their reason for contacting the service. This was lower for the MRS, where 64% said it was 'very effective' or 'effective'.

Figure 23: Service effectiveness in addressing their reason for contact
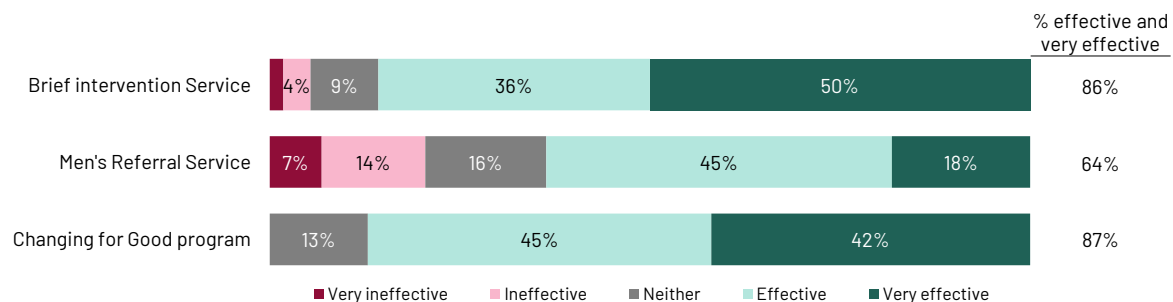
% effective and very effective

Service	Very ineffective	Ineffective	Neither	Effective	Very effective	% effective
Brief intervention Service	4%		9%	36%	50%	86%
Men's Referral Service	7%	14%	16%	45%	18%	64%
Changing for Good program			13%	45%	42%	87%

■ Very ineffective ■ Ineffective ■ Neither ■ Effective ■ Very effective

Source: A18a. And how effective was the service is addressing the reason you were contacting the service for?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 49 in Appendix 5 to see the full data breakdown for this figure.

Survey respondents described in their own words how things been in the relationship with their partner or former partner lately (in the preceding month), revealing mixed experiences. Some reported it is going well or that things had improved, while for others the relationship had worsened, or they had separated, or had no ongoing contact (e.g. due to an intervention order) (Figure 24).

Figure 24: Relationship with partner or former partner
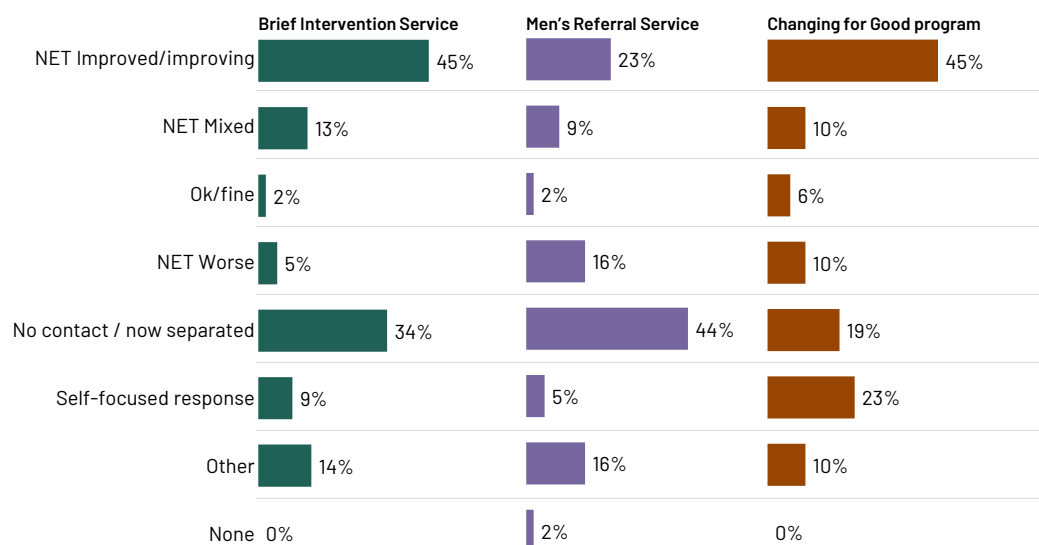
	Brief Intervention Service	Men's Referral Service	Changing for Good program
NET Improved/improving	45%	23%	45%
NET Mixed	13%	9%	10%
Ok/fine	2%	2%	6%
NET Worse	5%	16%	10%
No contact / now separated	34%	44%	19%
Self-focused response	9%	5%	23%
Other	14%	16%	10%
None	0%	2%	0%

Source: A18b. In your own words, how have things been in the relationship with your partner/former partner lately (in the last month)?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=43; Changing for Good program, unweighted, n=31.

Refer to Table 50 in Appendix 5 to see the full data breakdown for this figure.

Survey responses from frontline workers indicated broad agreement that the clients benefit from the services and model meaningful behaviour change (Figure 25).

Figure 25: Reason for engaging with the service

	Brief Intervention Service	Men's Referral Service	Changing for Good program
Clients benefit from the services you provide	79%	55%	88%
Clients demonstrate meaningful behaviour change during the program	70%	45%	97%
Your clients exactly fit the description of men using violence or who are at significant risk of using violence	92%	70%	78%
Your clients are genuinely interested in changing their behaviour when they begin the program	58%	N/A	89%
Your clients are genuinely interested in changing their behaviour when they finish the program	71%	N/A	89%
Your clients are genuinely interested in changing their behaviour when they call the MRS	N/A	50%	N/A

Source: A11a. Please enter a percentage in response to the question below using a 0-100% scale.
Base: Frontline workers: Brief Intervention Service, unweighted, n=3; Men's Referral Service, unweighted, n=1; Changing for Good program, unweighted, n=3.

Refer to Table 51 in Appendix 5 to see the full data breakdown for this figure.

Counsellors in multi-session programs noted significant change in the way men present between initial engagement, a few sessions in and by the end of the program.

Their ability to be reflective about their own behaviour increases and their awareness of the impacts of the behaviour on others has increased. The ability to understand their own triggers and to take evasive actions (e.g. going for a walk) also increased.

'I feel from the feedback from working with my clients – they have been able to show insight into their harmful behaviours, have an understanding of the impacts this had on the effective family members and was able to explore new strategies. However, as a BIS worker we only hear from the clients themselves we work with – we never get to hear from the AFMs and how effective it has been for their journey of change.' – BIS frontline counsellor

Anecdotal evidence suggests that those completing the BIS are at least a few sessions ahead when they do get to a group MBCP program. One MBCP facilitator commented that men who join the program after having completed the BIS don't have the 'hard edge' that first-time service users normally do.

'They were never challenging me so that I was in a worse place when I left the call. Not judging what's going on or anything. But if I said something bad, they were like 'oh, hang on, let's just chat about the way you worded that'; that could come across poorly. Like it was gentle challenging, I guess. But not something that pushed me into a worse place. I always ended up in a better place at the end of the call.' – MRS service user, male, Victoria

'I feel like the Men's Referral Service was great for helping me understand what's going on and to discuss details of what control and [domestic violence] that kind of thing is. The Brief Intervention Service really helped me understand myself and my emotions. It was very helpful for those reasons. And I would definitely would have been in a much worse place without it.' – MRS/BIS service user, male, Victoria

Qualitative interviews with service users were consistent with the data above. Men were generally very positive about their experience with the services and were keen to explain how much change had occurred as a result. However, those same men used language that indicated they were still pre-contemplative. Almost all men couched their violence in the circumstances (financial stress, work pressures and, for some, their partner's poor mental health) and were reluctant to accept responsibility for their actions completely.

When asked about what their partner would say about their violence, many acknowledged that their partner would not see all the changes they have made.

Frontline workers feel similarly about the impact they notice in the men they treat. Table 21 shows that frontline workers rate the effectiveness of the programs in creating behaviour change as effective or very effective. Table 22 shows they believe the services are meeting or exceeding their goals.

Table 21: Frontline counsellor rating of effectiveness in creating behaviour change

Response	BIS	MRS	CFG
Total effective (effective + very effective)	**4**	**3**	**3**
Very effective	2	0	1
Effective	2	3	2
Neither	1	0	0
Ineffective	0	0	0
Very ineffective	0	0	1
Unsure	1	0	0

Source: A11B. Effectiveness of the [SERVICE] in creating behaviour change.
Base: BIS, unweighted, n = 6; MRS, unweighted, n = 3; CFG program, unweighted, n = 4.

Table 22: Frontline counsellor belief that the service is achieving its goal

Response	BIS	MRS	CFG
Total exceeding (exceeding + strongly exceeding)	**3**	**1**	**2**
Strongly exceeding that goal	1	0	2
Exceeding that goal	2	1	0
Meeting that goal	2	2	2
Falling short of that goal	1	0	0
Falling well short of that goal	0	0	0

Source: A3. To what extent do you believe that [SERVICE] is achieving its goal?
Base: BIS, unweighted, n = 6; MRS, unweighted, n = 3; CFG program, unweighted, n = 4.

However, there was still a long way to go for some of these men. In their open-ended responses to the survey, service users continued to demonstrate externalisation, cognitive distortions, and denial.

'I got charged with assaulting my daughter – which was a bogus charge.' MRS service user, male, Queensland

'Victoria Police dragged me out of bed on the fake accusation I was being abusive. In actual fact I was asleep, and it appears my girlfriend did all this so she could send my granddaughter whom I have raised for years, to my stepson's house. I still receive no help in fact I would say your system is painting a target on my back.' MRS service user, male, Victoria

Changes in violent behaviours among Brief Intervention Service users

Historically, the BIS has not done pre-post testing[28] of service users but began collecting SCORE data[29] in 2023, but at the time of this evaluation not enough data had been collected for proper analysis. In the view of this evaluation, this is a key weakness of the ability of this evaluation to correctly measure effectiveness, and even more importantly, how its own methods and approaches can be improved over time.

Figure 26 provides a detailed summary of self-reported changes in behaviour among service users of the BIS.

A substantial portion of service users reported reductions in harmful behaviours, with 47% noting a decrease in physically violent behaviour towards partners or family, 53% indicating reduced controlling behaviour, 78% observing improvements in anger management.

Notably, the data also shows minimal reports of increased behaviours across the measured categories, with mental health issues being the only area where a small percentage (4%) reported worsening conditions. This could indicate either genuine improvement or a reluctance to admit to negative behaviour changes.

This was supported through the qualitative interviews with service users who indicated they were better able to express feelings, use of tools such as traffic light system, being aware of physical indicators of escalating anger in their body and, understanding trauma in themselves and their partner.

While the self-reported data from BIS service users indicates a positive trend in behaviour modification, it is important to interpret these findings within the context of self-reporting limitations. The propensity for individuals to under-report negative behaviours or overstate progress necessitates a cautious analysis of the effectiveness of the BIS program in achieving sustained behavioural change.

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[28] Pre and post testing is a research methodology used to evaluate the effectiveness of programs by comparing results measured before and after an intervention. In this case pre post testing would assess readiness for change, engagement with services, the degree of attitudinal or behaviour change or any other attribute these services are attempting to influence.

[29] Participation means organisations must record client outcomes, known as Standard Client/Community Outcomes Reporting (SCORE) reporting. A SCORE assessment for a client should be recorded at least twice. Once in the intake assessment and once in the final counselling session. It is expected that, where practical, organisations collect outcomes data for at least 50% of participants.

Figure 26: Self-reported changes in behaviour among BIS service users
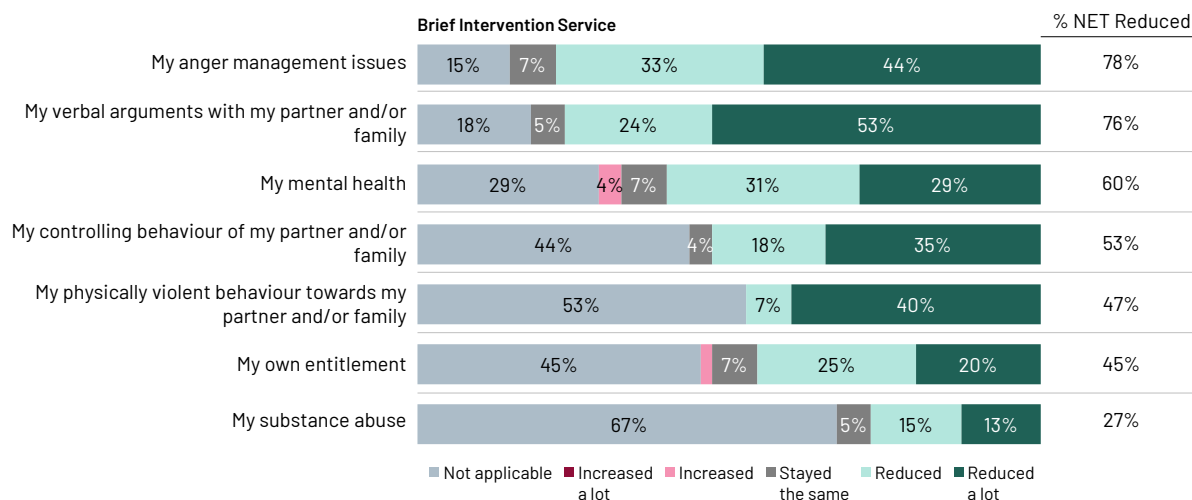
Brief Intervention Service

		% NET Reduced
My anger management issues	15% | 7% | 33% | 44%	78%
My verbal arguments with my partner and/or family	18% | 5% | 24% | 53%	76%
My mental health	29% | 4% | 7% | 31% | 29%	60%
My controlling behaviour of my partner and/or family	44% | 4% | 18% | 35%	53%
My physically violent behaviour towards my partner and/or family	53% | 7% | 40%	47%
My own entitlement	45% | 7% | 25% | 20%	45%
My substance abuse	67% | 5% | 15% | 13%	27%

Legend: Not applicable ■ Increased a lot ■ Increased ■ Stayed the same ■ Reduced ■ Reduced a lot

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Brief Intervention Service
Base: Brief Intervention Service, unweighted, n=56.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 52 in Appendix 5 to see the full data breakdown for this figure.

'The BIS counsellor was probably the best counsellor I've ever had, he helped me to connect with my emotions. I've always been very rational and detached from them. He helped me recognise what was going on for me, to reconnect with my feelings. Being able to feel things and respond through that.' – MRS/BIS service user, male, Victoria

'The programs helped me understand how my communication was controlling and that helped me understand how that must have been for her. That realisation and that understanding only came from the targeted help I received through these programs. In that sense the general counselling I was receiving was a complete failure because I didn't know what I was dealing in with.' – BIS service user, male, Victoria

Case study #4: Brad, 37 years, initially reluctant to attend a court-mandated MBCP, used the BIS while he waited for a place in an MBCP

Brad, a 37-year-old man, found himself in a heated disagreement with his wife, during which he made threatening remarks. Brad's wife, fearing for her and their children's safety, promptly called the police, resulting in Brad's removal from their home and the issuance of a Family Violence Safety Notice. Brad always had the sense that he is committed to being a dedicated provider for his family and was caught off guard by the fast turn of events, harbouring resentment towards his wife for involving the authorities rather than resolving the matter as a family.

Subsequently, the court mandated Brad to attend an MBCP, leading him to reluctantly participate in a Brief Intervention Service while awaiting placement. Feeling out of place among individuals whom he perceived as being 'actual' and 'frequent' perpetrators of violence, Brad struggled to reconcile his self-image as a law-abiding citizen with the reality of his situation. Despite his initial reluctance, he complied with the program's requirements.

Throughout the program, Brad encountered a supportive and non-judgemental counsellor who provided him with a safe environment to address his emotions and behaviour. Gradually, Brad began to recognise the benefits of the program, learning practical techniques to manage his anger, including controlling his breathing and disengaging from confrontational situations. While Brad felt the program helped him in becoming a better man, and he accepted responsibility for his life moving forward, he continued to harbor resentment towards his wife for what he perceived as an overreaction, exacerbated by the ongoing intervention order that hindered any prospects of reconciliation. Upon completing the program, Brad felt equipped to handle future conflicts in a safer and more constructive manner, having gained control over his anger and frustration levels. However, he remained bitter about his family's reluctance to afford him a chance at redemption, feeling unable to prove his genuine desire for change to them. Despite these challenges, Brad recognised the value of the program in fostering personal growth and enhancing his ability to navigate difficult situations.

The case studies presented are not based on any single individual. Rather, they are an amalgamation of narratives, themes, and attitudes that emerged consistently through qualitative interviews with service users. Whereto Research have synthesised these elements to construct representations that accurately reflect the experiences of some of the men we interviewed. Importantly, none of the case studies correspond to any one person. Furthermore, the names, ages, and other details presented in the case study heading are fictional.

Changes in violent behaviours among Changing for Good service users

The CFG program is a much smaller program and is much better set up for evaluation with the use of the IOMI to measure progress after completing the program.

Figure 27 outlines the self-reported changes in behaviour among service users of the CFG program. Notable findings include an 84% reported reduction in verbal arguments with partners or family, with 39% of service users reporting this had reduced a lot. In all, 94% of service users noted improvements in anger management. Given men in the VPP are precluded from the program if they have used violence, a high proportion say that physical violence is not applicable.

Again, the qualitative interviews with service users supported the quantitative data below. Many CFG service users spoke about a sense of achievement and confidence that they can

change after having gone through the program, but also spoke about how a lot of the change was internal. For the men, this internal change felt momentous but was not always evident to partners. The connection to the counsellor and the use of Rogerian values (empathy, congruence and unconditional positive regard) (although not service users' words) helped them connect and feel heard. Many men said that they were now able to verbalise their feelings, walk away from arguments when they notice they are becoming frustrated or angry and better self-regulate.

Some areas, such as physical violence and substance abuse, were much less relevant to men in the CFG program, with only 23% and 19% of service users reporting reductions, respectively.

The relatively high percentages of service users reporting improvements, especially in anger management and verbal arguments, could reflect a genuine positive impact of the CFG program.

While the CFG program appears to have facilitated some positive behavioural changes among its service users, a critical analysis is necessary to account for the potential discrepancy between self-reported improvements and actual behaviour change, particularly given the likelihood of service users minimising negative behaviours and overstating their improvements.

Figure 27: Self-reported changes in behaviour among CFG service users
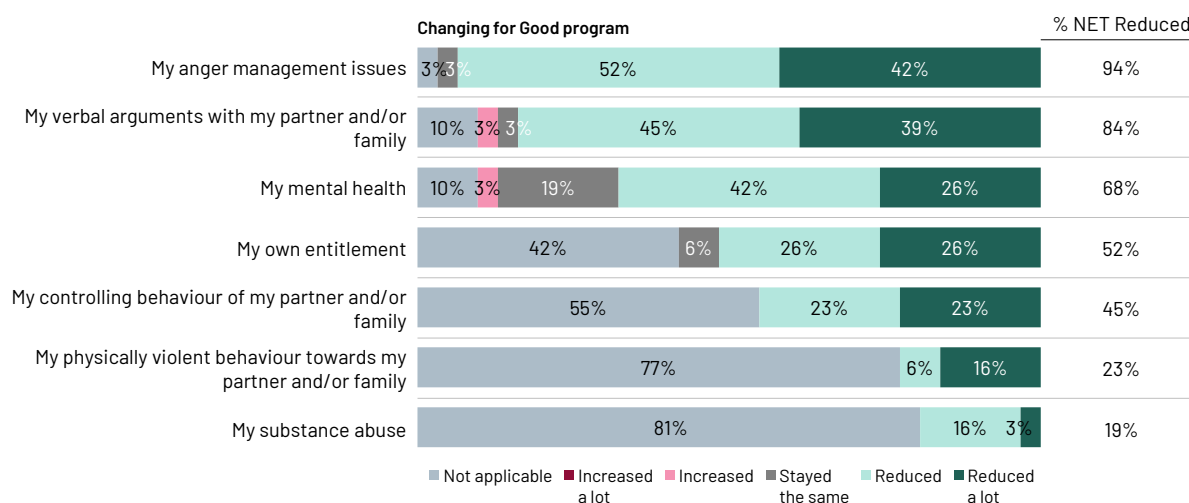
Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Changing for Good program
Base: Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 53 in Appendix 5 to see the full data breakdown for this figure.

Those who had been through the CFG Post-MBCP demonstrated the most dramatic change. Having been through an MBCP and many other touchpoints along the way, Post-MBCP service users had built many hours of work. This was evident in the way they spoke in the qualitative interviews and in their open-ended responses in the service user quantitative survey. This cohort spoke in terms that aligned with the maintenance phase of the TTM. They were aware of the limits of their work but also excited about the chance to improve them. They were committed to long-term behaviour change and one acknowledged that 'the work will never end'.

'I completed the first men's behaviour change program and found it enormously beneficial. I felt I still had more to learn and wanted to stay accountable so signed up for Changing for Good.' – Service user, CFG, Queensland

'I got everything I need from this service and even started seeing a marriage counsellor afterwards. I'm not a threat of perpetrating violence against my partner, but I needed to change my attitude to counselling, which I was brought up to see as a sign of weakness. You opened the door to a new way of life and I'm grateful.' – CFG service user, male

Case study #5: John, 49 years, recently retrenched, feels emasculated by his partner becoming the primary breadwinner, spoke with the CFG

John, a 49-year-old man, found himself in a challenging situation after losing his job, which he had held for the past 2 decades. With his professional identity stripped away, John struggled to find a sense of self-worth and purpose and felt an increasing financial strain from unemployment.

Over the weeks, John noticed a pattern emerging – he was becoming increasingly short-tempered and irritable, particularly towards his wife. He resented the burden of increased household responsibilities due to his wife becoming the primary breadwinner and felt his frustration and agitation began to escalate. This culminated in a situation where he felt unable to control his outbursts and was shouting at his wife. Afterwards, his wife said the relationship was at a crossroads and that she did not feel safe around him.

John's wife suggested that he seek professional support and after a quick search online, John reached out to MensLine Australia, who directed him to the CFG program. Despite feeling apprehensive initially that the program was not for men like him, John was reassured by the program's focus on preventing violence. He acknowledged that while he hadn't crossed the line of physical violence yet, his escalating anger and frustration were cause for concern.

John participated in 4 counselling sessions through the CFG program. The counsellors provided him with a safe space to explore his emotions and challenges without judgement. They equipped him with practical tools, including breathing exercises, to help manage his anger and frustration in moments of heightened tension.

Following the completion of the program, John felt a sense of optimism about his ability to control his emotions however, also felt a sense of insecurity that he could fall back into old habits. John still grapples with occasional outbursts and lingering doubts about his progress. He feels frustrated by his job prospects and he feels his wife 'pushes his buttons' but has noticed a decrease in the frequency and intensity of his anger episodes.

The case studies presented are not based on any single individual. Rather, they are an amalgamation of narratives, themes, and attitudes that emerged consistently through qualitative interviews with service users. Whereto Research have synthesised these elements to construct representations that accurately reflect the experiences of some of the men we interviewed. Importantly, none of the case studies correspond to any one person. Furthermore, the names, ages, and other details presented in the case study heading are fictional.

Changes in violent behaviours among Men's Referral Service users

The data presented in Figure 28 reveals the overall positive impact that service users reported since engaging with the MRS. While the MRS will not be the root of this behaviour change, it is an important part of understanding how effective the referral process is in assisting men to access services to help change their behaviours.

Notably, a significant portion of service users reported reductions in harmful behaviours, with 36% indicating a decrease in physically violent behaviour towards partners or family, 33% reporting reduced controlling behaviour and 48% observing improvements in anger management.

However, this data also underscores areas of concern where behaviours have not only persisted but, in some instances, increased. Two per cent of service users reported an increase in physically violent behaviour, and another 2% noted a substantial escalation. Similarly, controlling behaviour and anger management issues saw increases in 7% and 10% of respondents, respectively. A total of 12% experienced significant worsening in anger management.

Figure 28: Self-reported changes in behaviour among MRS service users
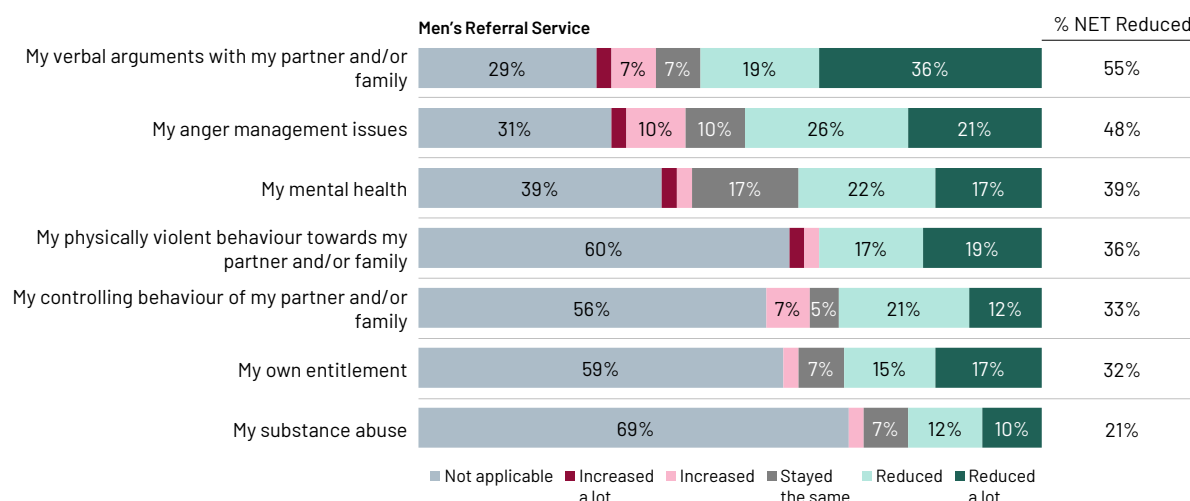
Men's Referral Service	Not applicable	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	% NET Reduced
My verbal arguments with my partner and/or family	29%	7%		7%	19%	36%	55%
My anger management issues	31%	10%		10%	26%	21%	48%
My mental health	39%			17%	22%	17%	39%
My physically violent behaviour towards my partner and/or family	60%				17%	19%	36%
My controlling behaviour of my partner and/or family	56%		7%	5%	21%	12%	33%
My own entitlement	59%			7%	15%	17%	32%
My substance abuse	69%			7%	12%	10%	21%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Men's Referral Service
Base: Men's Referral Service, unweighted, n=44.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 54 in Appendix 5 to see the full data breakdown for this figure.

Qualitative interviews showed that for men engaging the MRS, change occurred because of their interactions with MBCPs or private counsellors/psychologists. Although men sometimes received crisis counselling from the MRS, change did not occur through this interaction. Rather, change came through taking up the referral; the more common benefit was the referral onto other services.

Men contacting the MRS present with a range of issues, many of which are factors linked to increased likelihood to disengage (Olver et al. 2011). This makes behaviour change for this cohort more difficult and their journey though the sector more varied. Many men call for crisis support and do not receive referrals.

The value of other supports to men seeking change

Many service users participating in MBCPs aren't engaging with them in isolation; rather, they often have prior experience with similar programs focused on improving marriages or parenting, and many have had ongoing discussions with psychologists for years. This interconnectedness complicates the evaluation of these programs since they occur within a broader context of therapeutic engagement.

The accumulated experience of attending counselling sessions prior to engaging in MBCPs appears to confer certain benefits. Familiarity with discussing one's thoughts and emotions, as well as establishing a meaningful rapport with a counsellor, are cited as significant factors. Over time, men may find that the perceived barriers to seeking help (e.g. shame or fear of judgement) diminish as they become more accustomed to the process. This sentiment is echoed by program coordinators overseeing longer term men's behaviour change initiatives. They observe that men often arrive at their programs having already completed introductory stages of counselling. This suggests that prior counselling experience may facilitate a smoother transition into MBCPs and contribute to a more receptive mindset among service users.

Are these changes maintained over time?

It is difficult to answer the question of long-term change without access to longitudinal data. However, many service users indicated their own hesitancy about maintaining behaviour change over time without access to ongoing support.

The question of maintaining changes over time cannot be answered conclusively, but qualitative responses from service users indicate that further support is critical to long-term behaviour change. Without this, many felt concerned about their ability to maintain what changes they had been able to achieve.

Unintended consequences

There are three potential unintended consequences of these service interventions.

- Some men in these programs have reported increases in violence, verbal abuse, controlling behaviour and other antisocial behaviours, calling into question the overall appropriateness of low-dose interventions.[30]

- The positioning of the VPP as pre-violence and how distinguishing between physical and non-physical forms of violence in the VPP could reinforce the idea that men in that program are not 'as bad' as men in other programs. This could inadvertently reinforce their inappropriate behaviours as 'normal' and 'acceptable', both of which are counterproductive outcomes given the intention of these programs.

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[30] Overall, the total number of men that reported increases in violence, verbal abuse, controlling behaviour and other antisocial behaviours was relatively low and these may have been driven by other external factors affecting that individual. External factors could be driving this increase in violence, but it does still demonstrate low-dose interventions are unable to manage those external factors. And that for some men the interventions will not work.

- The fact that some men call the intervention services looking to consciously manipulate the system. For example, a man may have an upcoming Court attendance and has been told by his lawyer that he will receive a better outcome if he engages the BIS and shows the court he is attempting to change. He may therefore engage the BIS with no intention to change. The services are aware of this and indicate they are able to identify it reasonably well.

Impact of low-dose interventions on low-risk men

Through the online survey, a small proportion of men ($n = 5$) across all services indicated their negative behaviours had increased since they first had contact with the service.

Small proportions (4%) indicated their anger management issues and verbal arguments had increased. Smaller proportions again (2%) indicated their controlling behaviour, entitlement and physical violence had increased since contacting the service.

Figure 29: Summary of behaviour change across all service interventions
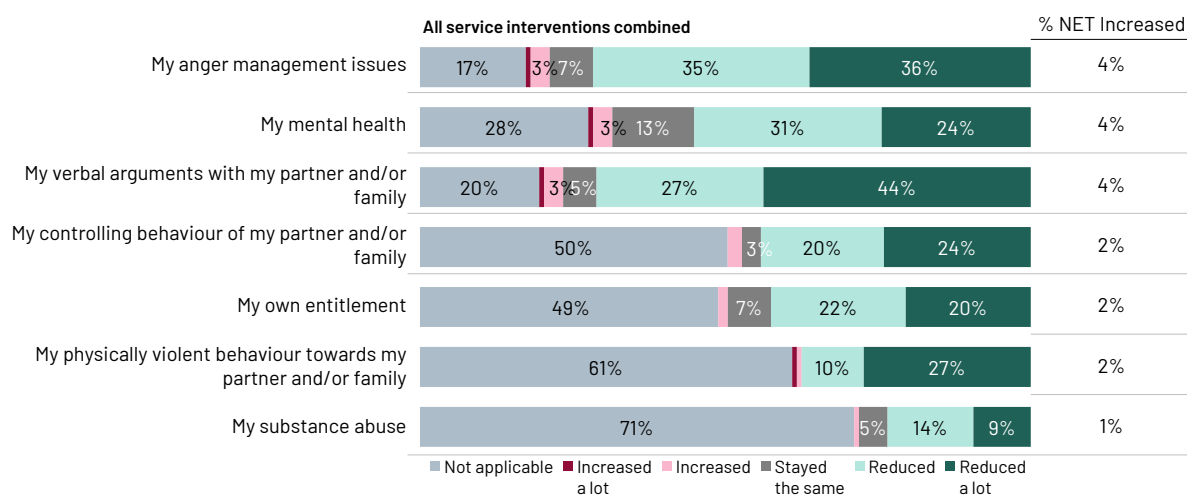
Source: A19. Have the behaviours you sought to address when you first had contact with the service changed?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 55 in Appendix 5 to see the full data breakdown for this figure.

There are many factors that could explain these increases (many of which are outside the control of these service interventions) however, this does speak to a prominent concern among forensic psychologists about the potential for harm that low-dose interventions could pose to low-risk MWUVA that fit a particular profile. Forensic psychologists believe that for MWUVA, the risk of violence can increase with interventions (McEwan et al. 2015).This may be due to:

- perceptions of third-party endorsement (from counsellors) and empowerment of particular behaviours (even if this is misunderstood)

- the AFMs holding enhanced hope of change and shifting their own safety behaviours as a result

- the experience of shame (which can increase occurrences of violence to combat internal incongruence).

Qualitative interviews showed that there was one man who had come out of the 4 CFG VPP sessions with the belief that he was the victim. He attributed this belief to his interactions with

CFG VPP. Many more interviews with other programs showed men with violence supporting narratives and cognitive distortions that positioned them as victims. However, it was not clear that the interactions with the service reinforced these beliefs.

'My ex accused me of domestic violence and the Changing for Good program kind of allowed me to realise that there's kind of 2 sides to things and it's probably more the other way around. Not me being abusive.' CFG service user, male, Queensland

'I need to have a tough conversation with my wife (now separated) about her drinking and abuse of others and I need it to be brokered, so that it doesn't get abusive and give substance to another AVO. I need help to manage and maintain boundaries around someone I deeply care for and will no longer tolerate her below the line behaviours when drinking.' MRS service user, male, New South Wales

While the overall number of men who report increases in violence, abuse or negative behaviours are small (2-4%), they are also likely to be higher in reality as there is image management underway in these self-report data. This does beg the question of how much FDSV among service users is acceptable in these programs, and the degree to which we should willing to tolerate potentially creating more violence in the lives of the few if it reduces violence for the many.

Positioning of the CFG VPP

CFG's VPP is designed for men who have not yet used physical violence in their relationships. If physical violence is detected, this precludes the man from participating.

The marketing of the VPP is one of its key strengths. As discussed elsewhere in this report, there is significant shame, embarrassment, and stigma in admitting to using physical violence in relationships. The VPP circumvents that shame barrier of admission to FDSV by allowing men to enter believing they are yet to use violence or to 'prevent' themselves from using violence because, in their mind's, violence is only physical violence or that non-physical forms of violence is not as bad. This idea is something that came through quite clearly in the qualitative interviews: men see the VPP to stop something bad from happening.

The name of the program is therefore a major drawcard for service users and has contributed to engaging men who would otherwise not see FDSV services as relevant for them (despite the fact they will almost always will be).

That said, labelling the intervention as 'violence prevention' while still accepting people who are using non-physical violence could be construed as collusive and potentially reinforcing violence-supporting scripts.

Under the National Plan, the definition of violence against women includes non-physical forms:

'The National Plan's definition of "violence against women" is aligned with the United Nations Declaration on the Elimination of Violence Against Women (1993), which defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".'

Distinguishing between physical forms and non-physical forms could have unintended consequences. In the qualitative interviews with service users, we saw that men who had been through the CFG VPP were still interested in the distinction between themselves and physically

violent men. This has the potential to impact on their own understanding of violence and taking responsibility for their violence and, subsequently, their engagement with supports such as MBCPs in an ongoing way. It is important to note that the latter issue is a concern among those working in the sector (e.g. clinical leads, MBCP facilitators) rather than something that came out of conversations with service users.

'I have a lot of concerns. My concern is that it implies that physical violence is domestic violence and everything else isn't domestic violence. And that they've got a scale in their mind of serious violence versus not serious. And that coercive control isn't considered domestic violence because it's violence prevention. And it's for only men who haven't used physical violence. So, men have used all other forms of tactics of use are being recommended to do a violence prevention program. I'm very, very concerned about the language that I've used. I do wonder whether they've used that language to increase the number of men who take up support because that's the language of men. But then you're colluding with that belief.' – Sector stakeholder

Attempts to manipulate the system

Many men who call intervention services are not interested in behaviour change. This is especially true for the MRS where, as shown in Figure 30, frontline counsellors indicate that only half (50%) of MRS callers are genuinely interested in change when they call. The same number (50%) are attempting to deliberately use the system to achieve a better outcome at court, with child protection services or with police. Service users mentioned that while they were never mandated to attend these programs, sometimes magistrates would suggest them. Lawyers might mention that completing them would be looked upon favourably by the courts in deciding custody arrangements or dividing assets for example.

'It's not necessary – the court is aware and happy with what I'm currently doing and what I did with the BIS. It fulfills the requirements I have.' – BIS service user, male

The proportion of men interested in abusing the system is less in the BIS and less again in CFG, substantially so, where the proportions interested in using the services to achieve better outcomes for themselves are 38% and 15% respectively.

'The other hand is the one that the man that's using the smoke screens, and you can tell from what he's not saying, and by your own risk assessment that there's a lot happening behind the scenes there. it doesn't feel like they're calling our service to make changes.' – MRS frontline counsellor

'[This type of person], they're used to manipulating the system, the family, their partner and then they use that to get what they want. And [they believe] they're the victim.' – MRS management

According to MRS frontline counsellors, some of these men believe they will be able to achieve a better outcome with the courts, statutory child protection or police if they can put their narrative (e.g. that they are the victim, that the children are only safe with them, or that the allegations against them never happened) into the system early. In interview, frontline counsellors were aware of this and said that it was typically not difficult to identify.

Figure 30: Proportion of clients interested in changing their behaviour (average %)
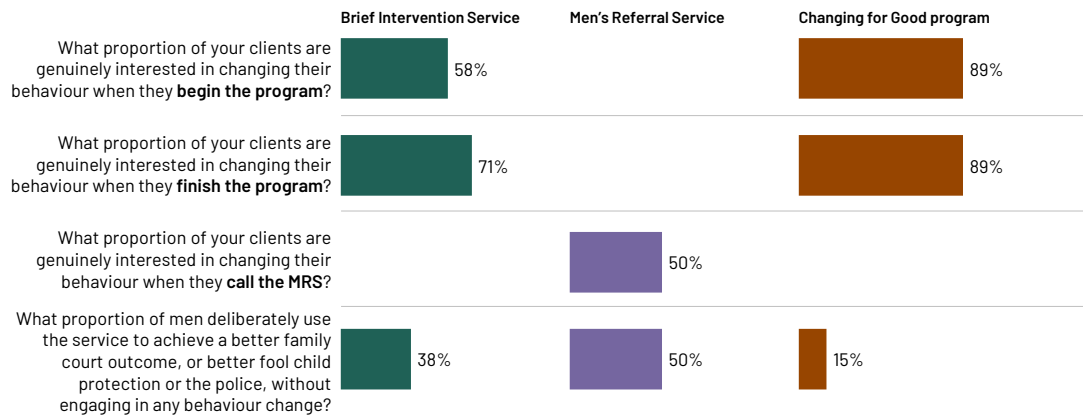
	Brief Intervention Service	Men's Referral Service	Changing for Good program
What proportion of your clients are genuinely interested in changing their behaviour when they **begin the program**?	58%		89%
What proportion of your clients are genuinely interested in changing their behaviour when they **finish the program**?	71%		89%
What proportion of your clients are genuinely interested in changing their behaviour when they **call the MRS**?		50%	
What proportion of men deliberately use the service to achieve a better family court outcome, or better fool child protection or the police, without engaging in any behaviour change?	38%	50%	15%

Source: A11a. Please indicate the relative proportions for the questions below.
Base: Frontline workers: Brief Intervention Service, unweighted, n=6; Men's Referral Service, unweighted, n=3; Changing for Good program, unweighted, n=4.

Refer to Table 56 in Appendix 5 to see the full data breakdown for this figure.

Efficiency

Efficiency

Efficiency: the extent to which the program uses resources well.

Efficiency key evaluation questions

(For the BIS and CFG) How does the number of sessions and spacing of sessions completed at the individual client level relate to client outcomes?

Are there any workforce issues impacting or likely to impact service delivery or opportunities to improve the use of resources?

(For the MRS) What proportion of clients using the MRS enrol in other services and seek out additional help?

Efficiency key findings

- Most men surveyed had engaged in multiple sessions:
    - Most CFG clients typically received 2 to 4 sessions of counselling over a period of 2 to 3 months.
    - Most BIS clients received at least 6 sessions over 2 to 3 months.
    - While the MRS model is not designed for ongoing contact, men often called up to 4 times; the period of engagement ranged from one day to 2 to 3 months.

- For survey respondents of the BIS and CFG services, there was a higher correlation between selected positive client outcomes and greater number of contacts:
    - There was a high level of agreement that the service was effective for those who had made contact at least 3 times; almost all respondents (96%) who had experienced 7 to 12 contacts felt the service was effective.
    - There was also a high level of self-reported reductions in physical violence, controlling behaviour, verbal arguments and anger management for those who attended 7 to 12 sessions.

- Several service process and workforce issues were identified where improvements and greater efficiencies could be gained:
    - Administrative tasks such as data collection takes up a significant proportion of time (up to 30% for the BIS). For the MRS and BIS in particular, poor-quality program activity data is being collected or reported, with inconsistent definitions and collection systems currently operating (refer to the 'Limitations of this evaluation' section).
    - There are complex challenges faced by frontline staff including balancing the need for robust clinical governance, professional development and operational pressures (e.g. call demand).
        - This creates challenges with staff recruitment and retention, capability and resilience to adapt to the needs of a changing sector.
        - Some frontline workers expressed feeling undervalued by upper management, highlighting a lack of understanding of the complexity and time-consuming nature of providing high-quality counselling support.

- Access to a high-quality talent pool remains an ongoing concern in the sector. The inability to offer full-time positions results in a reliance on casual roles, leading to a significant turnover as staff seek greater long-term stability and security elsewhere.

Historically, leadership challenges at both NTV and OTLA (now Lifeline) have created difficulties for these programs. While new leadership has been installed at both organisations, some issues remain for frontline workers at NTV, who would like more supervision, training and support. These issues may resolve over time as new leadership settles.

Number and spacing of sessions

Most men engaged in a range of 4 to 12 sessions with their counsellor. Service users in the CFG programs typically received 4 sessions of counselling. Service users in the BIS received between 6 and 10 sessions. While the MRS model is not designed for ongoing contact, men often call 3 or more times (Table 23).

Table 23: Total number of contacts with services (MRS, BIS and CFG)

Number of contacts	BIS	MRS	CFG
1 to 2 times	9%	41%	6%
3 to 4 times (or more for MRS)	13%	59%	48%
5 to 6 times	34%	N/A	29%
7 to 12 times	36%	N/A	16%
More than 12 times	9%	N/A	0%

Source: A2 – And how many times have you spoken with a counsellor from the [PROGRAM]?
Base: BIS, n=56, MRS, n = 44, CFG, n = 31, unweighted.

Sessions typically occurred according to frequency defined by each program (weekly for the BIS, every 2 weeks for the CFG VPP, the MRS is single session model where users called in according to need) although flexibility was provided to accommodate individual circumstances such as fluctuating work schedules. Broadly, service users appreciated the good flexibility of the service used, but some expressed concerns over session scheduling, where they had long work hours or unpredictable schedules. There appears to be an opportunity to enhance flexibility further to cater to such unique situations. Many service users believed that weekly sessions struck the right balance, allowing adequate time for reflection and implementation of learned strategies without losing momentum or allowing the teachings to fade from memory. However, there were differing opinions on session frequency, with some suggesting a more intensive initial week of 2 sessions followed by spaced-out subsequent sessions. Others advocated for longer intervals between sessions to extend the program duration, providing them with greater confidence in their ability to enact lasting change over a longer period.

Figure 31 shows the period of service engagement for each service. Most men in the BIS (54%) reported being engaged with the program over the full period of 2 to 3 months. This is also true for the CFG program; 7 in 10 (71%) service users were engaged for 2 to 3 months. The typical engagement period for the MRS is much more mixed, with 1 in 5 (20%) engaged for a day only, 1 in 6 (14%) engaged for a week, a further third (32%) engaged for a month, and a quarter (25%) engaged for 2 to 3 months.

Figure 31: Period of service engagement
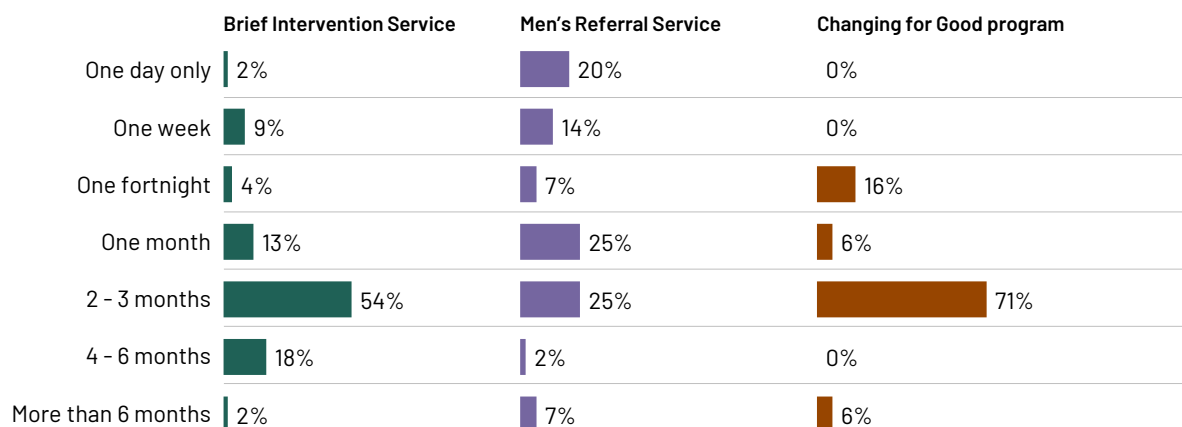
	Brief Intervention Service	Men's Referral Service	Changing for Good program
One day only	2%	20%	0%
One week	9%	14%	0%
One fortnight	4%	7%	16%
One month	13%	25%	6%
2 - 3 months	54%	25%	71%
4 - 6 months	18%	2%	0%
More than 6 months	2%	7%	6%

Source: A3. Over what period of time did you speak with your counsellor from the [PROGRAM]?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Refer to Table 57 in Appendix 5 to see the full data breakdown for this figure.

Despite the variation in engagement frequency and period, almost all service users expressed a desire for more sessions, feeling that the allocated number were not enough. This was especially true for CFG VPP (with only 4 allocated sessions) but was also true for the BIS. While the MRS is a single session model, many men got a lot of value out of calling multiple times. Experience of the Post-MBCP was different however, with men who used the service felt the length of the program was one of its key strengths.

The enjoyment, rewards and perceived benefits of the sessions fuelled this desire, particularly among the programs with fewer sessions allocated. Many highlighted the importance of building rapport with their counsellor, noting that 4 sessions felt insufficient to build a sense of trust, which may take 2 to 3 sessions. While acknowledging the value of the provided sessions, service users doubted the ability to achieve significant behaviour change within a timeframe of 4 to 6 sessions. A larger number of available sessions would likely mitigate these issues.

This is evidenced by cross-tabulating survey responses for the number of times a participant spoke with a counsellor against how effective they felt it was in addressing the reason they initially made contact. Agreement with the effectiveness of the service was greater with multiple contacts; of survey respondents who had contacted the service 7 to 12 times, almost everyone (96%) felt it was effective (Figure 32).

Figure 32: Effectiveness of services by amount of contact with services (BIS and CFG)
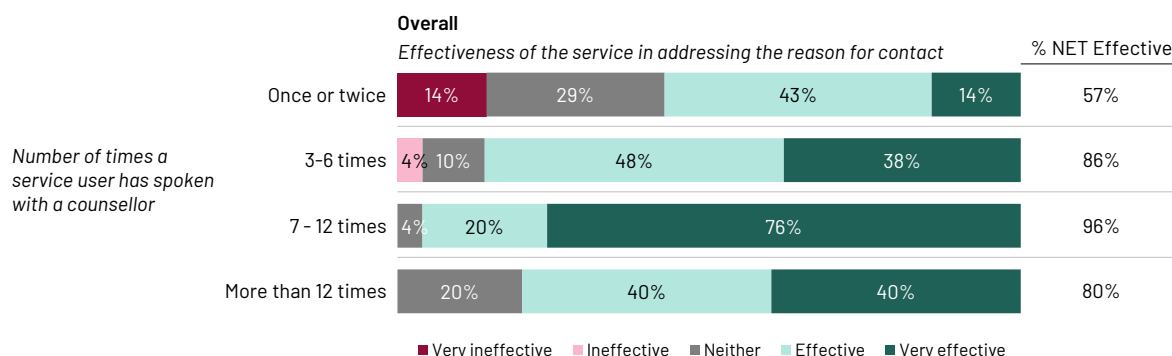
Overall
Effectiveness of the service in addressing the reason for contact

Number of times a service user has spoken with a counsellor	Very ineffective	Ineffective	Neither	Effective	Very effective	% NET Effective
Once or twice	14%		29%	43%	14%	57%
3-6 times		4%	10%	48%	38%	86%
7 - 12 times			4%	20%	76%	96%
More than 12 times			20%	40%	40%	80%

■ Very ineffective ■ Ineffective ■ Neither ■ Effective ■ Very effective

Source: A2. And how many times have you spoken with a counsellor from the [PROGRAM]? A18a. And how effective was the service is addressing the reason you were contacting the service for?
Base: Brief Intervention Service, unweighted, n=56; Changing for Good program, unweighted, n=31.
Note: Labels less than 3% have been removed for clarity.

Refer to Table 58 in Appendix 5 to see the full data breakdown for this figure.

We also see a similar correlation between the number of sessions attended and self-reported reductions in physical violence, controlling behaviour, verbal arguments, and anger management. Service users who attended 7 to 12 sessions were more likely to report reductions in these metrics compared with service users who received fewer sessions (Table 24).

Table 24 shows that service users who have used the programs more than 12 times see less reduction in antisocial/ FDSV behaviours relative to those who attended 7-12 sessions. While on face value this may appear to suggest that there is no value in attending more than 12 sessions there are reasons to show this is not the case.

Service users reporting to have contacted the services more 12 times are exceeding the formal number of sessions the programs were designed for. There are several reasons this might occur which are likely to have an impact on service user ability to achieve behaviour change. The additional contacts could have been:

- half sessions,
- failed calls where the service user recalls a session, or
- check ins for service users which counsellors deemed high risk or who had difficulty understanding the content.

These are factors which cannot be accounted for within the survey data. Instead to answer the question of how many sessions is the ideal number, it is best to defer to the literature which states that to reduce recidivism risk, 100 hours is required for moderate-risk men and 200 hours is required for high-risk men (Borseth et al. 2023; Sperber et al. 2013).

'It didn't go long enough; it takes 2 or 3 weeks to get to know you and then there was only one session left. Good idea to have service but not long enough to be effective.' – CFG service user, male, New South Wales

'My problems generated through decades worth of suffering. I have not had an easy life. So, these are long-term scars. So, I need a long-term solution. And 20 weeks is a short-term solution if you see my point.' – BIS service user, male, Victoria

Table 24: Reduction of behaviours by amount of contact with services (BIS and CFG)

Behaviour change	1 to 2 times	3 to 6 times	7 to 12 times	More than 12 times
My physically violent behaviour towards my partner and/or family	29%	37%	**44%**	40%
My verbal arguments with my partner and/or family	57%	80%	**88%**	60%
My controlling behaviour of my partner and/or family	43%	49%	**52%**	60%
To get assistance for my mental health	71%	59%	**72%**	40%
To get assistance for my substance abuse	29%	24%	**24%**	20%
My own entitlement	43%	51%	**44%**	40%
Anger management for me	71%	86%	**83%**	80%

Source: A2 – And how many times have you spoken with a counsellor from the [PROGRAM]? A19 Have the behaviours you sought to address when you first had contact with the service changed?
Base: BIS, unweighted, n = 56; CFG program, unweighted, n = 31. 1 to 2 times, n = 5, 3 to 6 times, n = 26,7 to 12 times, n = 20, More than 12 times, n = 5.

'Sessions were engaging, there was not enough of them. Had to "wing it" after final session, was not a good time.' – CFG service user, Queensland, male

'Time constraints can be difficult. Sometimes I need more than 4 sessions just to get that smaller program really moving in the right direction. So, you know, I often wish I had 6 sessions with people, but we are constrained by funding as to what we can offer.' – CFG frontline counsellor

'You need time to practise their strategies and skills, and even if you do prepare them in session with case scenarios, or roleplay, you're preparing them for resistance. But how long it takes them to practise that successfully? It might not be between one session and the next. It may take several sessions.' – BIS counsellor

Despite these reservations about the number of available sessions, service users recognised the program's positive impact on their lives, citing a better understanding of their emotions and triggers, along with practical strategies to manage anger. The acquisition of coping strategies such as walking away, deep breathing and self-rating anger levels contributed to a sense of confidence in the program's effectiveness and a general feeling of optimism that they could handle themselves differently in the future gave service users confidence that some behaviour change had taken place.

Heading into the program, expectations play a significant role in shaping service users' perceptions. These expectations serve as an anchor, influencing how people feel about the program. For some, the knowledge that they were entering a 4- or 6-week program lessened the daunting nature of the task ahead. It's less intimidating to commit to something over the course of a month rather than over 3 months. Conversely, the information provided on the program's website may set expectations for a longer duration. For example, someone entering the BIS program might read up to 10 sessions then only receive 6. Upon learning that they would only receive a shorter program, some service users felt they weren't getting the full benefit

WHERE TO

available. Establishing in the first session, or in the intake call, the total number of calls available and that service users are entitled to the full number of sessions might lead to better outcomes. However, unfulfilled expectations could encourage service users to seek further help through other programs or alternative avenues, such as seeking assistance from a psychologist.

Data collection

Administration tasks including data collection, setting expectations, explaining the process, assessing risk and so on takes up a significant proportion of the call time for the MRS and the BIS, but this data is not being collected or reported in a consistent or reliable way. This is a significant inefficiency.

Counsellors report spending 15 to 20 minutes of a 30- to 40-minute call with data collection and explaining house rules. The time spent collecting the data on the phone is therefore significant, and MRS management have confirmed that, historically, there has been inconsistency in how data is collected, how attributes are defined and how it is all reported.

'As an open line [MRS] counsellor, we only have, like, 30 to 40 minutes on the call. It's very time limited because we need to explain the confidentiality statement, we need to do the demographics, we need to explain what the service is about. We need to put in ground rules before the actual session starts. We need to do risk assessment, then, like, by the time I do the demographics, explain what the service is about, ask if they want to engage, it's already, like, 15 to 20 minutes in. And then this leaves no time for the actual session.' – MRS counsellor

We've got the data collection system, which does the data analysis. We started using that this year. So the whole organisation had to be trained on that. And so we have a couple of super users, myself and another guy on the other team, who's also in a way supporting people with that side of things in terms of how we collect data, how we store that, so that it's all in alignment with reporting to DSS and all of that. So we've had some challenges in that journey.' – BIS counsellor

'And then that comes with, you know, needing to invest in systems and processes for data capture, and then consistent practice, and then, you know, those that data extraction and data analytics, and, you know, our data integrity has been a work in progress. You know, we've sort of been building the plane as we fly it, I think, is the analogy people use today. So, you know, DSS are very much aware of that, and they've been, you know, walking with us, as we continue to improve our data integrity and our system and process.' – NTV management

Figure 33 shows the frontline counsellor estimate of how much time they spend on administration tasks. For the BIS, it's 30% of their time; for the MRS, it's 17%. Much of this will go to compiling case notes, debriefing, oversight and so on, but a considerable portion also goes to data collection.

Figure 33: Approximate proportions of time dedicated to activities
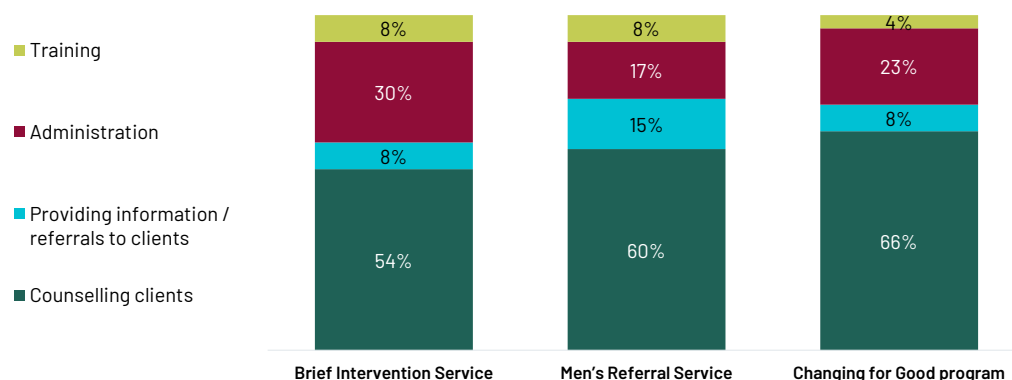
Training

Administration

Providing information / referrals to clients

Counselling clients

	Brief Intervention Service	Men's Referral Service	Changing for Good program
Training	8%	8%	4%
Administration	30%	17%	23%
Providing information / referrals to clients	8%	15%	8%
Counselling clients	54%	60%	66%

Source: A11AA. approximate proportions of time that you dedicate to the following activities?
Base: Frontline workers: Brief Intervention Service, unweighted, n=6; Men's Referral Service, unweighted, n=3; Changing for Good program, unweighted, n=4.

Refer to Table 59 in Appendix 5 to see the full data breakdown for this figure.

Workforce issues

The sector workforce

Sector stakeholders have highlighted that the sector talent pool and on-the-job pressures are key issues for the workforce of people working with MWUVA, impacting on retention, hiring, capability and resilience in the sector.

Skill level and potential for credentialling

Regarding the sector talent pool, the skill level required for frontline counselling work with MWUVA is very high, necessitating formal training and technical expertise (a degree in social work, psychology, counselling, etc.) alongside good interpersonal skills to navigate complex personalities and entrenched misogynistic attitudes and respond in the moment feeling informed and confident of their choices. Some in the sector have spoken about the need for better credentialing to allow for better quality control of staff across the sector, which would also facilitate clearer career pathways and opportunities for progression. Sector stakeholders also mentioned that the job conditions are unattractive to potential workforce entrants, with many roles offering poor job security (positions are often casual, with the possibility of running out of funding), poor remuneration and poor conditions, given the nature of the clientele and conversations with them.

The experience of working with MWUVA

On-the-job pressures are broad and multifarious. In a field where resources and time can be scarce, the operational demands of services often compete against clinical governance of staff for attention. Time to properly debrief following difficult interactions is critical to staff wellbeing and their longevity in the sector. Where operational demands take precedence, this leads to burnout and turnover. The ever-present risk of vicarious trauma complicates this further, with one sector stakeholder mentioning that the risk of this is 'not if but when', leading people often to leave the sector to take a break and recover. For female staff, this vicarious trauma is amplified, as men will often use their abusive behaviours on female staff, with this being often worst for women from non-English speaking backgrounds. In addition, staff with

lived experience are often not completely healed from their past traumas and can become triggered in their work, this group needs more support to ensure they can continue to contribute in the sector safely. It is often burnout from the emotional toll of the work rather than workload that leads to people exiting the workforce.

None of this directly describes the work environments of NTV or Lifeline (or formerly OTLA) but the sector workforce in general. This evaluation heard from NTV management that staff retention is an issue and that some who leave simply need 'a break' from work with MWUVA. CFG counsellors mentioned that the work is difficult and there could be more opportunity and time for debrief to allow for proper emotional processing of the conversations.

Challenges at NTV and CFG

NTV conceded it had experienced significant staff turnover in recent years but that staff remained committed to working with MWUVA as the solution to FDSV. NTV said that people often seek them out as a sector employer and that they sometimes have staff return to work with them. CFG frontline counsellors spoke about the need for more 'bums on seats' because the demand for these services is only growing.

Leadership changes and staff satisfaction

Historically, leadership challenges at both NTV and OTLA (now Lifeline) have created difficulties for these programs. While new leadership has been installed at both organisations, some issues remain at NTV. These issues may resolve over time as new NTV leadership settles.

Management at NTV conceded that, in the past, the organisational structure has been inefficient, involving multiple layers of management with limited communication between teams.

This has impacted on frontline counsellors, who mentioned feeling disconnected from management and sometimes undervalued. Their work is complex and time-consuming, and recent instability has meant reduced supervision and support, and rostering changes. These issues were identified at the time of this evaluation and were intended to be addressed.

All frontline counsellors surveyed at both the BIS and the MRS feel confident in their understanding of their roles and key responsibilities (Table 25 and Table 26). They also believe in their service's effectiveness in assisting service users. However, there is reportedly room for improvement in human resources and support structures. Furthermore, across both service interventions, only 5 staff agreed that there are the right supports and training in place to allow them to achieve the key responsibilities of their roles.

NTV has tried to play the role of a peak body for the sector without being funded for it. While many stakeholders have valued having a peak body, this has meant that funds that would have otherwise gone to capacity building and supporting staff have instead gone to its peak body function.

Recent leadership changes were reported by management to be a positive step at the organisation, expected to bring fresh air, energy, and a focus on improving management efficiency.

'Developments in theory and typology of family violence have not, in my view, been adequately integrated into our practice ... We require more training in counselling practices.' – NTV frontline counsellor

Table 25: Understanding of systems and where to get assistance (BIS)

Level of understanding	Total agree	Neither	Total disagree
I understand my role and my key responsibilities	6	0	0
I feel there are the right supports and training in place to allow me to achieve the key responsibilities of my role	3	1	2
If I have a question, I can find the answer in a reasonable timeframe	4	2	0
The HR processes are well established	2	2	2
I understand the IT systems and how to use them	5	1	0
The service assists the intended service users to improve their behaviours	5	1	0

Source: A5 – To what extent do you agree or disagree with the following statements?
Base: BIS, unweighted, n = 6.

Table 26: Understanding of systems and where to get assistance (MRS)

Level of understanding	Total agree	Neither	Total disagree
I understand my role and my key responsibilities	3	0	0
I feel there are the right supports and training in place to allow me to achieve the key responsibilities of my role	2	0	1
If I have a question, I can find the answer in a reasonable timeframe	2	1	0
The HR processes are well established	0	1	2
I understand the IT systems and how to use them	3	0	0
The service assists the intended service users to improve their behaviours	3	0	0

Source: A5 – To what extent do you agree or disagree with the following statements?
Base: MRS, unweighted, n = 3.

At CFG, the program has experienced its own challenges and leadership changes. In 2021, the CEO of OTLA at the time resigned on short notice after it was discovered that false data had been reported to DSS. OTLA had an interim CEO for several years.

After a new permanent CEO was appointed, they began reorienting OTLA away from a commercial focus to a community focus and elevated the importance of clinical governance and better communication within the organisation. This was reported by staff to be a very positive step for culture and performance.

OTLA has now been acquired by Lifeline, a move seen as positive by management and staff. This amalgamation is supposed to streamline referrals of men calling into Lifeline's existing helplines requiring behaviour change.

Table 27 shows that, in the CFG program, there's a strong understanding of roles and responsibilities. Questions are answered promptly, suggesting good access to information. IT systems are understood. And all believe in the ability of the service to help users change their behaviour. However, it appears that some counsellors would prefer more support and training.

'We rarely have training, and we need more family violence-based training and regularly. In my previous family violence job, we had at least one or 2 training day events, whereas here we have none, other than the initial training when you start the program, which is quite basic. Also, we have less opportunities to debrief these days, as again we are being asked to focus on intakes in between our sessions. There used to be a strong emphasis on self-care, but that seems to have dissipated and intake is now the priority.' – CFG counsellor

Table 27: Understanding of systems and where to get assistance (CFG program)

Level of understanding	Total agree	Neither	Total disagree
I understand my role and my key responsibilities	4	0	0
I feel there are the right supports and training in place to allow me to achieve the key responsibilities of my role	2	2	0
If I have a question, I can find the answer in a reasonable timeframe	4	0	0
The HR processes are well established	2	2	0
I understand the IT systems and how to use them	4	0	0
The service assists the intended service users to improve their behaviours	4	0	0

Source: A5 – To what extent do you agree or disagree with the following statements?
Base: CFG program, unweighted, n = 4.

Conclusions

Conclusions

This evaluation has assessed many aspects of implementation, appropriateness, effectiveness and efficiency of the MRS, BIS and CFG services. This provides valuable insights into understanding how these services contribute, as part of the service system, to supporting MWUVA to change their behaviour and improve the safety and wellbeing of their partners and children.

The role and value of the services

Each of these services are playing a very important role in the sector, but the role they are playing is less about achieving significant and long-term behaviour change and more about providing a low-barrier entryway into a challenging behaviour change journey for individuals with serious behavioural and psychological issues. While the services appear to be able to support a long-term behaviour change process, they are not, in and of themselves sufficient. The value they provide Australian society stems from their ability to engage with MWUVA in a comfortable and non-judgemental setting, less burdened by the shame and guilt that usually accompanies their actions, help them understand the need to change, and get the further help they need.

Long-term behaviour journey for MWUVA is likely to take 2 years or more, and involve interactions with a range of different services and professionals. This evaluation reinforced a plethora of other findings that show that those who engage with multiple services progress significantly faster compared with those who do not.

Strengths of the services

The key strengths of the services all support the role that they play in the sector. All 3 services appear to have highly committed frontline staff who believe in the work they do, and the changes they can help enable.

Delivered by NTV, the MRS offers an anonymous, low-barrier crisis line for men who are concerned about their behaviour and need to find a service that can help them. A significant proportion of callers have experienced a recent crisis — they have had a police or child protection intervention, or an argument with their partner — and require information and counselling on what steps they need to take next. Just under half (43%) receive a referral to another service, and around a quarter (24%) have multiple or ongoing contact with the organisations to which they are referred. Many men call the MRS multiple times over a period of several months to 'check their understanding' of a situation or get advice and counselling, and in this sense, the MRS plays a useful role in introducing MWUVA to the counselling process, and reducing their barriers to further interactions with the sector.

Also delivered by NTV, the BIS offers a multi-session (typically between 6 and 12) telephone counselling service for men who are yet to have started a group MBCP. In practice, much of the work that happens in BIS sessions appears to be around rapport and trust building, but the service does attempt to challenge MWUVA's thinking to the degree that is possible given the setting and the limited scope. Participants in this evaluation generally had positive things to say about their relationship with their counsellor – although often this was after a rocky start. Men typically enter the BIS via a referral from the MRS, or from emergency services or the court system. Some are undoubtedly using the service to appear (before courts) like they are making

change when in fact they are not. Although the MWUVA included in this evaluation who had used the service almost universally found the BIS helpful, it's important to note that those who had experienced the most behaviour change had all engaged with other services (e.g. a private psychologist or MBCP) to which they ascribed the majority of their change. The key strength of the BIS is its ability to get MWUVA started on their behaviour change journey in a non-threatening way.

The CFG VPP has a key strength in that it markets itself as being for men who have not used physical violence. This opens the service up for those who do not identify as MWUVA. A clear strength of the VPP is that it provides a service that many men enter of their own volition, usually after having searched for help. The key strength of the CFG Post-MBCP is that it provides men who have completed an MBCP and would like to continue their behaviour change journey an opportunity to do that. It is completed over a longer period too meaning men feel they have enough time to achieve change during the process.

Key issues with the services

This evaluation has identified several key issues with the way these services are delivered. This includes:

- Not well known – None of the programs are particularly well known, and they appear to have a Victorian bias that may stem from where they are headquartered.

- Not keeping AFMs in sight – Keeping AFMs safe is, as articulated in several best practice standards the most important function of MBCPs. While it certainly increases the difficulty and risks involved from an organisational perspective, avoiding this important function means that they are externalising their risk to the broader sector. It also means that counsellors are reliant on perpetrator perspectives and self-report and cannot verify what they are hearing from service users. At a fundamental level, this means they could be misled about the amount of behaviour change occurring and are less able to challenge perpetrator cognitions/cognitive distortions effectively. While it makes sense for the MRS not to have visibility of the AFM, as the service is anonymous and not specifically designed to provide support over multiple sessions, this is not the case for either the BIS or CFG.

- Non-standardised therapeutic approaches – To the degree that the services claim to be acting as behaviour change programs, the therapeutic approaches being used are not generally recognised as best practice. Staff lack training in motivational interviewing techniques and rely on narrative approaches. The lack of standardisation means that effectiveness is more reliant on the skills of individual counsellors rather than a well-defined program.

- Data collection and data quality – While frontline staff complain that too much time is taken up in collecting data, the data available for use in program evaluation and ongoing improvement is sparse. The CFG program collects pre-post measurement (via the IOMI) and the BIS now uses SCORE data, but none of the programs use high-quality risk tools to assess and manage their clients. While there is likely to be much useful information embedded in case notes, there are no approaches to utilise this for ongoing improvement (e.g. AI analysis). Data quality problems have particularly impacted NTV, although these appear to be somewhat resolved.

- Notably, the referrals these services make are 'cold' — they do not make an introduction or share any case notes, nor do they follow-up with either the services or the individual to ensure that a referral has been taken up.

- Data sharing, coordination, and follow-up – When a service user completes their program or disengages, there is no follow-up from any of the services. Indeed, despite strong support for 'warm referrals' referrals to other services are 'cold referrals'. The result of all this is the sector is losing sight of MWUVA, potentially increasing risk for AFMs or future partners of the man, as well as losing the opportunity to support the behaviour change journey of their clients. Although in Victoria, MARAM is meant to solve some of these issues and provide a channel through which to share data, there is opportunity to consider the accuracy of the risk assessments the MARAM can provide when it is delivered to MWUVA while not including the AFM.

- Organisational issues – Both organisations have been plagued by a range of significant leadership and organisational issues, such as high staff turnover over the recent past. While these appear to be resolving, with new leadership at NTV and Lifeline taking over the CFG service, there is likely to be fresh energy directed to resolve these.

Appendices

Appendix 1: Program logic documentation

Program Logic – Changing for Good

Program need
Almost 2.2 million Australian adults have been victims of physical and/or sexual violence from a partner since the age of 15, with women nearly three times more likely to have experienced partner violence than men (Australian Bureau of Statistics, 2016). The most significant underlying driver of family violence is gender inequality between men and women (Our Watch, 2015). To achieve change in violent attitudes and beliefs, interventions are required that make men accountable and responsible for their actions, enhance women and children's safety and monitor men's use of coercive control, abuse and violence as well as the risk they pose to partners/ex-partners and children (Day et al, 2019; Kelly & Westmarland, 2015).

Program objectives
Changing for Good (CFG) aims to reduce the prevalence and impact of violence in our community through increasing men's emotional literacy, improving their emotional regulation and coping skills, and helping them to positively contribute to family life and the community.

Inputs

People
Specialist counsellor training in:
- FDSV
- Working with vulnerable groups
- Cultural sensitivity
- Change neuroscience

Specialist counsellor experience in working with men who choose to use violence

Specialist marketing and communication practitioners with experience in social marketing, outreach and engagement
Dedicated counsellors to deliver this service

Frameworks and policies
Quality Management Framework which includes:
- Clinical Governance Framework
- Counselling Framework
- Health Information Policy
- Data Governance Framework
- Code of Conduct
- Risk Management Framework
- Client's Rights and Responsibilities

Activities

1. Service entry
24/7 self referral via CFG page on MensLine website.

Recommendations from family violence support services, police and MBCPs via inbound referral form.

MensLine referral.

2. Intake, Assessment and Planning
Intake and Assessment Officers conduct intake and initial IOMI.

If eligible, the Officer will make appointments for the client for the relevant program.

If the Officer identifies imminent or immediate risk of suicide, client will be transferred to a counsellor for immediate support, safety planning and escalate to emergency services if needed. The client will be referred back to the Intake Officer once safety is confirmed.

3. Counselling and support
Violence Prevention program
Eligibility: Men who haven't perpetrated physical acts of family violence but have concerns about their feelings, attitudes, and behaviours; are at risk of perpetrating family violence; have a significant relationship problem.

Structure: Fortnightly, 40-minute sessions.

Timeframe: 2 months (4 sessions) and a postvention session.

Post-Men's Behaviour Change program
Eligibility: Men who are not currently using physical violence and have completed a MBCP in the last 12 months.

Structure: Fortnightly, 40-minute sessions

Timeframe: 6 months (12 sessions) and a postvention session

Both programs are tailored depending on the issues presented by the client and the outcomes they have agreed to work towards

Topics covered include developing healthy relationships, improving communication, problem solving and dealing with conflict, emotional regulation and self-awareness, personal growth and change

4. Referrals
Link clients with family violence support services, community support services, psychological support services as appropriate

5. Case notes
Document accurate case notes

7. Evaluation and outcomes
Follow-up after 6 weeks after the completion of the program for post intervention. Client may re-engage for further support.

8. Marketing
Targeted marketing campaigns including:
- Website updates, including evidence informed psycho-educational information
- Campaign-based landing pages
- Awareness raising, promotional and communication campaigns

Target outreach to family violence support services, police and MBCP organisations, coordinators, and service delivery staff

Outputs

Number of self-referrals

Number of recommendations from family violence support services, police, MBCPs and their providers

Number of intake and assessment sessions conducted

Number of structured counselling sessions delivered over either:
- 2 months (4 sessions), or
- 6 months (12 sessions)

Number of referrals made to other support providers

Total interactions by category – e.g., total clients entering, waitlisted, completed, did not complete

Comparison of IOMI assessment completed at intake and last sessions

Number of postvention follow up sessions delivered

Number of Client Experience Surveys completed

Number of out of hour crisis support sessions provided for participants via MensLine

Examples of promotion and outreach collateral developed, and campaigns delivered

Number of family violence support services, police, MBCPs and other providers engaged with

Program reports delivered as agreed with DSS

Short-term Outcomes
(Immediate: 0–12 months)

Men who participate in the Violence Prevention Program do not resort to using violence

Men report changes in violence supporting narratives and thinking

Empathetic client management helps clients to emotionally regulate

Callers understand independent self-management of stressors/triggers, distress and anger to keep themselves and others safe

Clients feel connected to ongoing follow-up support and stable at follow-up

Increased awareness and uptake of CFG counselling service

Improved understanding of cohort's mental and behavioural problems

Medium-term Outcomes
(Intermediate: 12 months – 2 years)

Meaningful behaviour change motivated by focusing on the humanistic perspective unconditional positive regard and meaningful relating

Client strengthens relationship with family based on respect and effective communication, ensuring partner and children's health

Client improves awareness of self and others, communication, thinking and social skills

Reduced use of violence, coercive control, abuse and harassment

Program impacts
(Long-term outcomes: 2 years +)

Men choose not to use violence in their relationships

Men improve coping skills and positively contribute to families and the community

Reduced impact of violence in our community

Increased client choice and opportunity to live a meaningful, satisfying and purposeful violence-free life

Community members feel safe from experiencing violence

Theory of change statement
Changing for Good helps men who are concerned they will use violence or who have recently completed a Men's Behaviour Change Program to continue to strengthen all relationships in their lives – intimate relationships, family, parenting, friendships or work colleagues.

Men who are worried their thoughts and behaviours will lead to violence will learn the tools to be proactive in developing respectful and healthy relationships.

Men who've completed a Men's Behaviour Change Program will learn to consolidate and maintain the strategies they learned.

Counselling sessions will focus on what the client wants to achieve, and progress will be measured along the way. Under the umbrella of the MARAM framework (Victorian Government), the sessions will use the principles of the Duluth model (Pence et al, 1993), dissonance theory and health coaching.

Our Intermediate Outcomes Measurement Instrument (IOMI) uses outcome measures developed in the UK (Ministry of Justice, UK, 2019) which is designed to measure change in relationship to seven dimensions across 21 questions.

Our intake and assessment process will respond to individual needs, our referral system will help clients access other services as needed, and our 24/7 MensLine service will provide immediate crisis support.
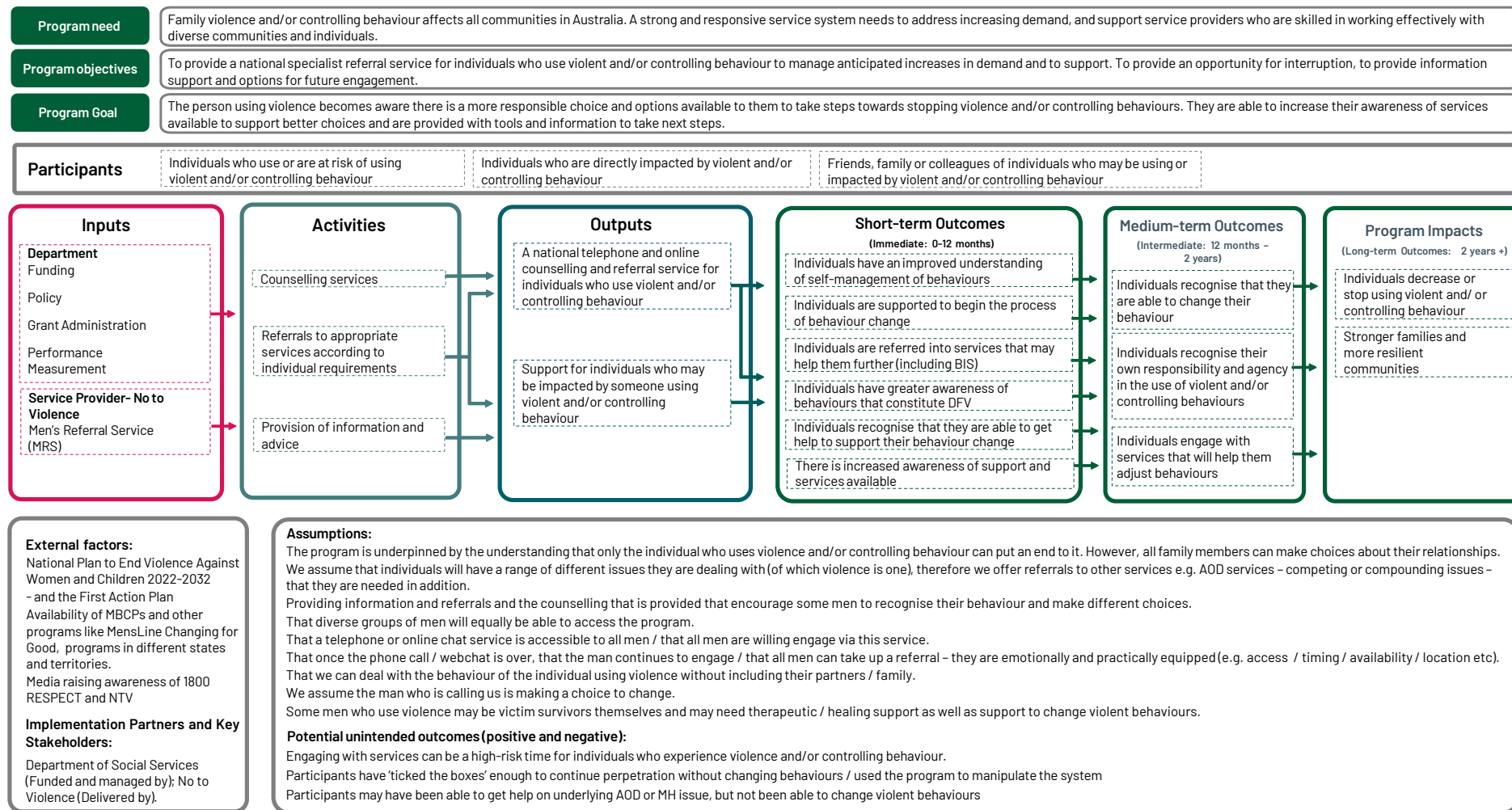
Refer to Program Logic – Changing for Good program in Appendix 5 to see the full data breakdown for this figure.

Program Logic – Men's Referral Service

National Perpetrator Intervention and Referral Service - MRS

Program need	Family violence and/or controlling behaviour affects all communities in Australia. A strong and responsive service system needs to address increasing demand, and support service providers who are skilled in working effectively with diverse communities and individuals.
Program objectives	To provide a national specialist referral service for individuals who use violent and/or controlling behaviour to manage anticipated increases in demand and to support. To provide an opportunity for interruption, to provide information support and options for future engagement.
Program Goal	The person using violence becomes aware there is a more responsible choice and options available to them to take steps towards stopping violence and/or controlling behaviours. They are able to increase their awareness of services available to support better choices and are provided with tools and information to take next steps.

Participants

- Individuals who use or are at risk of using violent and/or controlling behaviour
- Individuals who are directly impacted by violent and/or controlling behaviour
- Friends, family or colleagues of individuals who may be using or impacted by violent and/or controlling behaviour

Inputs

Department
Funding

Policy

Grant Administration

Performance Measurement

Service Provider- No to Violence
Men's Referral Service (MRS)

Activities

Counselling services

Referrals to appropriate services according to individual requirements

Provision of information and advice

Outputs

A national telephone and online counselling and referral service for individuals who use violent and/or controlling behaviour

Support for individuals who may be impacted by someone using violent and/or controlling behaviour

Short-term Outcomes
(Immediate: 0-12 months)

Individuals have an improved understanding of self-management of behaviours

Individuals are supported to begin the process of behaviour change

Individuals are referred into services that may help them further (including BIS)

Individuals have greater awareness of behaviours that constitute DFV

Individuals recognise that they are able to get help to support their behaviour change

There is increased awareness of support and services available

Medium-term Outcomes
(Intermediate: 12 months – 2 years)

Individuals recognise that they are able to change their behaviour

Individuals recognise their own responsibility and agency in the use of violent and/or controlling behaviours

Individuals engage with services that will help them adjust behaviours

Program Impacts
(Long-term Outcomes: 2 years +)

Individuals decrease or stop using violent and/or controlling behaviour

Stronger families and more resilient communities

External factors:
National Plan to End Violence Against Women and Children 2022-2032 - and the First Action Plan
Availability of MBCPs and other programs like MensLine Changing for Good, programs in different states and territories.
Media raising awareness of 1800 RESPECT and NTV

Implementation Partners and Key Stakeholders:

Department of Social Services (Funded and managed by); No to Violence (Delivered by).

Assumptions:
The program is underpinned by the understanding that only the individual who uses violence and/or controlling behaviour can put an end to it. However, all family members can make choices about their relationships.
We assume that individuals will have a range of different issues they are dealing with (of which violence is one), therefore we offer referrals to other services e.g. AOD services – competing or compounding issues – that they are needed in addition.
Providing information and referrals and the counselling that is provided that encourage some men to recognise their behaviour and make different choices.
That diverse groups of men will equally be able to access the program.
That a telephone or online chat service is accessible to all men / that all men are willing engage via this service.
That once the phone call / webchat is over, that the man continues to engage / that all men can take up a referral – they are emotionally and practically equipped (e.g. access / timing / availability / location etc).
That we can deal with the behaviour of the individual using violence without including their partners / family.
We assume the man who is calling us is making a choice to change.
Some men who use violence may be victim survivors themselves and may need therapeutic / healing support as well as support to change violent behaviours.

Potential unintended outcomes (positive and negative):
Engaging with services can be a high-risk time for individuals who experience violence and/or controlling behaviour.
Participants have 'ticked the boxes' enough to continue perpetration without changing behaviours / used the program to manipulate the system
Participants may have been able to get help on underlying AOD or MH issue, but not been able to change violent behaviours
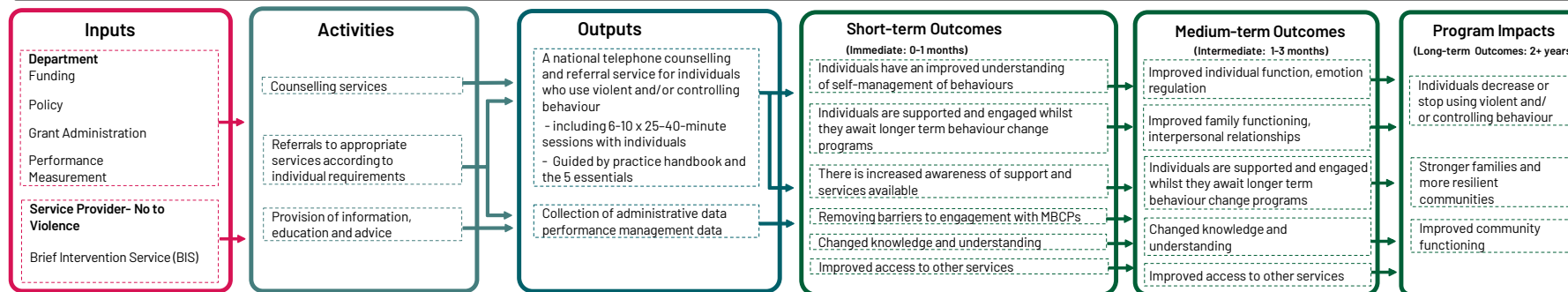
Refer to Program Logic – Men's Referral Service in Appendix 5 to see the full breakdown for this figure.

Program Logic – Brief Intervention Service

National Perpetrator Intervention and Referral Service - BIS

Program need	Family violence and/or controlling behaviour affects all communities in Australia. A strong and responsive service system needs to address increasing demand, and support service providers who are skilled in working effectively with diverse communities and individuals.
Program objectives	To provide a national specialist referral and counselling service for individuals who use violent and/or controlling behaviour to support and strengthen the service system for individuals who use violent and/or controlling behaviour. To 'keep the man in view' while they wait to engage with a MBCP, preparing them for and supporting individuals into MBCPs. Providing some behaviour change support to those in regional rural and remote areas in the absence of available MBCPs.
Program Goal	Individuals acknowledge and / or stop their violent and/or controlling behaviour and take accountability for their actions.

Participants	Individuals who use or are at risk of using violent and/or controlling behaviour.

Inputs	Activities	Outputs	Short-term Outcomes (Immediate: 0-1 months)	Medium-term Outcomes (Intermediate: 1-3 months)	Program Impacts (Long-term Outcomes: 2+ years)
Department Funding Policy Grant Administration Performance Measurement **Service Provider- No to Violence** Brief Intervention Service (BIS)	Counselling services Referrals to appropriate services according to individual requirements Provision of information, education and advice	A national telephone counselling and referral service for individuals who use violent and/or controlling behaviour – including 6-10 x 25-40-minute sessions with individuals – Guided by practice handbook and the 5 essentials Collection of administrative data performance management data	Individuals have an improved understanding of self-management of behaviours Individuals are supported and engaged whilst they await longer term behaviour change programs There is increased awareness of support and services available Removing barriers to engagement with MBCPs Changed knowledge and understanding Improved access to other services	Improved individual function, emotion regulation Improved family functioning, interpersonal relationships Individuals are supported and engaged whilst they await longer term behaviour change programs Changed knowledge and understanding Improved access to other services	Individuals decrease or stop using violent and/or controlling behaviour Stronger families and more resilient communities Improved community functioning

External factors:

National Plan to End Violence Against Women and Children 2022-2032 - and the First Action Plan
Availability of MBCPs and other programs like MensLine Changing for Good, programs in different states and territories.
Media raising awareness of 1800 RESPECT and NTV

Implementation Partners and Key Stakeholders:

Department of Social Services (Funded and managed by); No to Violence (Delivered by).
State and territory governments (victim counselling services per state)
MBCPs
Mental health and AOD services
DFSV Sector who support behaviour change and victim survivors
Courts – magistrates and principal registrars
MACS – Men's accommodation and counselling services & other accommodation providers

Assumptions:

The program is underpinned by the understanding that only the individual who uses violence and/or controlling behaviour can change to end the violence and control. However, all family members can make choices about their relationships.
We assume that individuals will have a range of different issues they are dealing with (of which violence is one), therefore we offer referrals to other services e.g., AOD services – competing or compounding issues – that they are needed in addition
Providing information and referrals and the counselling that is provided that encourage some men to recognise their behaviour and make different choices
That diverse groups of men will equally be able to access the program
That a telephone service is accessible to all men / that all men are willing engage via this service
That we can deal with the behaviour of the individual using violence without including their partners / family
We assume the man who is calling us is making a choice to change (may be forced to by system / want to manipulate courts / want to vent / want to change partners' behaviours
Some men who use violence may be victim survivors themselves, and may need therapeutic / healing support as well as support to change violent behaviours (not consciously built into the program – bt something we do need to be more mindful of it)
We assume that the man is willing to change, and that his motivation for change is stable
That men will be able to access a MBCP

Potential unintended outcomes (positive and negative):

Engaging with services can be a high-risk time for individuals who experience violence and/or controlling behaviour.
Some men may use the service to manipulate the court system (e.g., custody)
Men feel they have enough (they are 'fixed' by the end of the service, and don't continue engagement with MBCPs / don't need a longer-term program.

Refer to Program Logic – Brief Intervention Service in Appendix 5 to see the full data breakdown for this figure.

Appendix 2: Program processes

Men's Referral Service

MRS program process

Step	Action (Order of actions in steps 1 through 9 is not linear, they can change according to immediate need of caller)
1	Receive call/make call
2	Call connects
3	House keeping • Explain the service • Ground rules • Confidentiality statement Demographics
6	Risk assessment
7	Make cold referral(s) to other supports/programs (predominantly MBCPs) across the sessions • No follow-up with man or programs about whether they have taken up that referral. Idea of cold referral is that it empowers the man to take charge of his own journey.
8	Counselling
9	If required: Make time to call service user back
10	Exit call
11	Case notes entered for call

MRS police response

MRS is a national open line for men to call into but in Victoria and Tasmania,[31] the MRS receives police referrals after attending a family or domestic violence case.

The table below outlines how and when the open line and police referrals work.

Police referrals into the MRS vary by jurisdiction and are impacted by police policies around how they respond.

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[31] Police referrals to MRS ceased in New South Wales in 2023.

Jurisdiction	Police referral function	Operating hours

Victoria	• Police attend DV incident.
	• Inform the man that they may receive call from MRS.
	• Police provide the man with a card with support numbers including MRS.
	• Police enter details of incident into the system (L17 in Vic).
	• MRS counsellors receive a notification.
	• Counsellors look at the risk of making the call, for example:
	  - perhaps incarcerated so can't call
	  - if notes indicate risk to AFM then do not call
	  - intervention order may or may not be in place.
	• The call from MRS after a police incident generally occurs within 24 to 48 hours after the incident has occurred.
	• Depending on case notes, counsellors may use discretion to assess for safety and wait to give man chance to deescalate. As they may be engaging with other frontline services or are in a very agitated emotional state that is only likely to escalate with a further invention from MRS.
	• MRS send text to man to inform of call.
	• MRS make call to man.
		Mon–Fri, 9 am – 5 pm
		• Police referrals: handled by The Orange Door.
		• Open line: Men can call in at any time.
		After hours and on weekends
		• Police referrals: handled by MRS.
		• Open line: Men can call in at any time.

Tasmania	• MRS become involved at a later stage of the man's journey through the system, MRS service users have already had contact with a DV service (Stay at Home) • Stay at Home will have already explained what MRS is. • Often the man has had multiple engagements with Government services (police, support services, statutory child protection, etc.) and they are more engaged, and understand the process better. • This means there is better call back rates in Tasmania (although not necessarily better outcomes).	24 hours, 5 days a week • Police referrals: handled by MRS. • Open line: Men can call in at any time.

Brief Intervention Service

Up to 10 BIS sessions are available for counselling that are developed from the content from the first 2 weeks of an MBCP. Trained family violence counsellors use discretion and flexibility for content delivery and the tools that will work best for a client and what is agreed to work on.

As such service tends to be much more tailored. Uses motivational interviewing and engagement narrative approach.

Step	Action (Note on steps 1 through 5 – referrals to other supports/programs (predominantly MBCPs) are made across sessions)
1	Referral received in counsellor inbox
2	Counsellor calls to book for intake call > book intake: This may include an unplanned session which will include step #3 actions
3	Intake call made • Explain program and answer questions (e.g. this is not a replacement for an MBCP) • Limited confidentiality and mandatory reporting process – if required • Check if BIS referral information is correct. • Explore man's narrative, contain story telling, and assess the reason for call. • Risk assessment • Set clear goals Book first session
4	Deliver (up to) 10 sessions via telephone • Option to expand to up to 10 if required Client may exit at any point which is beyond counsellor control
5	If do not attend a meeting: • Send 2 x SMS • Call back once If no response: Client is sent an SMS message that they are to be exited from the BIS program and inform them they can reengage with BIS program in the future.
7	Exit from program • If client requests: a letter of engagement is sent • Exit and safety planning form part of the final session Secondary point of a referral as a closing of program – Where to from here for you.

Changing for Good – Lifeline

Step	Action (Note on steps 4 through 5 – referrals to other supports/programs are made throughout)
1	Initial inbound approach • Call into MensLine Australia 24/7 phoneline; or, Complete EOI form online > CFG call the man
2	Intake • Determination made on suitability of VPP or Post-MBCP If not suitable then exited (e.g. using violence)

Step	Action (Note on steps 4 through 5 – referrals to other supports/programs are made throughout)
3	**VPP** or **Post–MBCP**
4	**VPP** 4 phone counselling sessions every 2 weeks 2-month phone counselling program. **Post–MBCP** 12 phone counselling sessions every 2 weeks 6-month support counselling program.
5	One follow-up session after the program is finished.
6	Exit

Process if a man does not attend session with CFG

If a consumer misses 2 consecutive counselling appointments, they are exited from the program and the case/interaction is closed within CRM and documented accordingly.

If a consumer does not respond to 3 attempted calls, they are also exited from the program and the case/interaction is closed within CRM and documented accordingly.

Stage	Action
Intake and Assessment	Counsellors attempt to call the consumer by phone, if a consumer does not respond to 3 attempted calls, they are sent an SMS to notify of attempted contact and request to contact the service within 24hrs. The case is closed in Dynamics, with external referrers notified if applicable. If the consumer makes contact post-closure, the case is reopened, and normal intake procedures follow.
Initial Counselling Appointments	After Intake is completed, consumers are sent an email with all upcoming appointments and times. Including Counsellor they will be working with. Consumers receive automated appointment reminders a day before the session. If the first appointment call goes unanswered, an SMS is sent, and another call attempt is made. If both calls remain unanswered, the session is forfeited. A missed session prompts an email advising the consumer to notify us in advance for rescheduling. If a consumer misses 2 consecutive sessions without responding to email requests, they are exited from the program.

Stage	Action
Consumer Missing Appointments During Participation:	If a client misses one session, we follow up with a voicemail, SMS, and email to reschedule.
	If the client misses 2 sessions in a row, a final email is sent, explaining the program closure and they can contact us if they have any further questions (example email can be provided).

If client wants to contact CFG counsellor outside of scheduled times

Process is as follows:

- Man calls into MensLine Australia.

- MensLine Australia then send call to intake.

- Intake then call client back to reschedule a time.

Process for risk assessment

Men's Referral Service

Assessment	Detail
Process	Risk assessment is conducted at start of call. Often, as he tells his story.
	MRS conduct risk assessment. Clients' narrative can be inconsistent with information on hand for counsellor and as such the counsellor will use the techniques associated with curiosity and promote self-reflection, such as asking:
	What would your partner say about what happened?
	Seek to clarify the conditions on the intervention order or family safety notice and often man will read the description of events (police account) it includes.
	MRS does not have access to information sharing until a referral into MACS or BIS is completed: L17 Family Violence Portal, Central Information Point (CIP) etc.
	If risk is high enough: will go to CIP and request information about a client using the information sharing scheme and receive a report from police, child protection services and Corrections.
	Unable to do information sharing with other organisations or do call backs due to volume of calls and not funded for it.
	Information sharing cannot be performed for anonymous callers.
Formal risk assessment tools	PUV MARAM assessment tool as used in NTV client management data base.

Brief Intervention Service

Assessment	Detail
Process	Counsellor can review police notes in portal (e.g. L17, ARP).
	Staff member responsible for risk will contact the initial referrer if available to check if aware of any elevated risk.
	Line management process applies – discuss with line manager and then engage referrer as needed to confirm or inform of risk and risk level
	Counsellor will seek to understand where he is, how he is, what is going on.
	Risk assessment completed during intake conversation (static and dynamic risk) and ongoing informal assessments (dynamic) are completed throughout the (up to) 10 sessions, based on what that man is saying.
	If significant risk is detected to self, partner, family, community (e.g. line of conversation is very negative, cannot see a path forward and disengages). Complete risk check with line manager according to NTV process and if needed escalate according to identified risk
	If applicable will:
	• call Triple Zero (000)
	• call women's service
	• call child protection services.
Formal risk assessment tools	PUV facing risk assessment completed at each service delivery in BIS program.

Changing for Good

Assessment	Detail
Standard Risk Cues (In Every Session)	During each session, Team Members ask a set of standard risk assessment questions.
	These questions, selected for relevance, are seamlessly integrated into the conversation using a narrative approach, unless explicit concerns or disclosures prompt direct inquiry.
	Standard Risk Cues evaluated in all sessions include:
	Risk to client: Y/N
	Risk of Family Violence (FV): Y/N
	Risk to Person of Concern: Y/N
	Are Children Involved: Y/N

Assessment	Detail
Family Violence Risk Assessment during Intake	A distinct set of questions provided alongside the IOMI assessment at the intake phase.
	Encompasses aspects such as gender of the other party, relationship of concern, type of family violence, presence of the perpetrator, safety concerns, history of violence, contact orders, concerns about the relationship, type of abuse, direction of violence, safety of the victim, pregnancy, ability to maintain safety, availability of weapons, completion of MBCP (Men's Behaviour Change Program).
IOMI	Administered specifically during intake and upon completion of the program.
Dynamic Risk Assessment	Conducted continuously in all counselling sessions.
	Involves ongoing evaluation and adaptation based on the evolving circumstances, progress, and disclosures of the individual.
	Includes responses to standard risk cues and other relevant factors observed during counselling sessions.
	All risk assessments completed during intake, including standard risk cue questions, IOMI, and Family Violence Risk Assessment, are used to inform dynamic risk assessments.
	Aims to provide real-time insights and inform immediate interventions to enhance safety and support.
Static Risk Assessment	Occurs at specific points, during the initial intake session and program completion.
	Based on information collected during the initial intake, incorporating:
	IOMI (Intimate Partner Violence Risk Assessment).
	Family Violence Risk Assessment.
	Initial risk cue questions.
	Offers a fixed analysis of risk factors at these designated time points.
	Provides a baseline measurement and is valuable for assessing changes over time.
	The counsellor is equipped with this risk assessment and other pertinent information in advance of the initial counselling session.

Challenges with the MARAM and other risk assessment processes

As per the Royal Commission into Family Violence Report and Recommendations (2016, p. 19):

The Victorian Risk Assessment and Risk Management Framework (referred to as the Common Risk Assessment Framework, or the CRAF), introduced in 2007, was the first framework of its kind in Australia and was one of the foundational elements of the Victorian family violence reforms implemented in the mid-2000s. One of the strengths of the system to date has been that police must conduct the CRAF-based risk assessment at family violence incident scenes.

The CRAF provides a solid basis for assessing and managing the risk of family violence, but it needs to be revised in order to redress concerns about and barriers to its effective implementation. The Victorian Government has announced that the CRAF will be reviewed. This review should be completed by the end of 2017 to ensure that the foundations are laid for the introduction of the Commission's recommended Support and Safety Hubs. The next iteration of the CRAF should include weighted indicators to allow practitioners to determine whether the level of risk is low, medium or high, to help guide the risk management response. It should also include evidence-based risk indicators specific to children.

Then, from 2016, Monash University undertook a review of the CRAF to create what is now more commonly referred to as the Multi-Agency Risk Assessment and Management Framework (the MARAM), and there has been a recent recommendation from ANROWS to either nationalise this framework or another evidence-based framework to support national best practice and coherence federally.

There are some challenges in using the MARAM and its sister tools from other jurisdictions, as these tools do not provide a formalised risk rating (low, medium/moderate or high risk). Other tools, such as the Spousal Assault Risk Assessment and Violence Risk Scale support the provision of scores which align with different risk ratings that are validated using recidivism data. This then supports the tailoring of program dosage based on risk rating, which is important from 2 perspectives.

- The first is that it supports the dedication of limited resources towards cases where the risk is higher or highest. Second, and most importantly, this manages the risk of placing low risk clients into higher dosage programs than they require, which then enhances their risk of recidivism – particularly when placed in group programs. It also manages the risk of placing high-risk clients in lower dosage interventions than appropriate and enhancing their risk through doing so (for the reasons outlined above).

- The second is that factors included in the MARAM and its sister tools tend to be easily assessed in conversation with victim-survivors but are harder to assess through interviews with people who use violence (who are likely to minimise or deny the more serious and risk promoting aspects of their violence). This means that – even if ratings were obtained – they would likely be diluted by the impacts of impression management and self-report.

Effective risk management tools take time to administer and the limited scope of interaction that counsellors have with service users means that a high proportion of consult time is taken up with building rapport and trust, leaving less room for more challenging conversations.

Therapeutic approach

Therapeutic approach used by programs

There is a lot of flexibility within the programs about which therapeutic approach is used.

Men's Referral Service (MRS)	Brief Intervention Service (BIS)	Changing for Good (CFG)
Invitational narrative approach	Invitational narrative approach Other approaches used: Motivational interviewing, Communication style – identified as combative/ resistant/ aggressive/ threatening, Micro – counselling skills.	Counsellors mostly use invitational narrative approach. Other approaches used: Health coaching, Motivational interviewing, Psychoeducation.

Session focus for CFG

CFG is currently working on setting up more stringent rules around what needs to be achieved in each session. The current approach is listed below.

- Counsellors within the program tailor their approach to meet each participant at their unique starting point, recognising the varying levels of readiness for change.

- The collaborative establishment of session objectives are done on the onset, considering the diverse backgrounds and experiences each participant brings to the program. Sessions unfold with a flexible structure that facilitates the identification and awareness of contributing factors and beliefs. This approach encompasses addressing challenges, observing progress, fostering reflection, providing validation, and facilitating learning.

- The key elements of the session focus incorporate both a trauma-informed and a narrative approach. Primary objectives include building rapport, addressing identified behaviours, engaging in psychoeducation about the Cycle of Violence, considering the perspectives of others, including children, and challenging negative beliefs towards others.

- Counsellors additionally aim to equip service users with better understanding of themselves through concepts such as Attachment theory, the Cycle of Violence, Trauma and the Brain, cognitive behavioural therapy (CBT), and metaphorical explanations of anger. The overarching goals focus on increasing self-efficacy, self-confidence, and fostering consistency in changing antisocial behaviours, ultimately encouraging full responsibility for the client's behaviour.

- Homework assignments involving readings or reflections are flexible, acknowledging the dynamic nature of goals that may shift based on changing circumstances. This approach ensures personalised and adaptive support, tailoring the counselling experience to the unique journey and needs of each participant in the program.

Appendix 3: Journey maps

Overview of the journey

Key
🙂 **Emotional state:** key emotional reactions to customer touchpoints.
Divergence point: Moments that change the course of the journey
Key Moment that matters: Moments that are highly impactful

	Crisis event	**Aftermath**	**Awareness of program**	**Consideration**	**First contact**	**First session**	**Subsequent sessions**	**Final session**	**Week after**	**6-12 months**
Doing	• Use of violence • Argument • Police attend • Family violence safety notice/IVO/AVO issued • Removal from property	• Seeking accommodation • Reaching out for support • Reflecting on event	• Recommended a service/program by a friend, acquaintance, corrections, Police or Magistrate. • Google searched for a MBCP.	• Assessing the pros and cons. • Building up the courage to reach out	• Overcoming fear • Calling the service • Going through assessment • Sharing their story	• Sharing their story • Building an understanding of how sessions work • Getting a read on the counsellor	• Developing an understanding of emotions • Learning strategies and tips for managing anger • Developing ability to use words to express complex feelings • Bringing these lessons into their lives	• Revisiting lessons and progress • Receiving recommendations and referrals for additional services • Take home worksheets	• Trying to remember strategies for controlling emotions • Implementing learnings into daily life and relationships.	• Looking for additional counselling services • Maintaining a healthy, stable life – work, home, relationships
Feeling	Intense anger and/or frustration at partner and situation.	**Divergence point: Intervention orders preventing access to family and home results in different drivers and attitudes to participation** Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.	Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house Desperate for a path forward (unless court ordered)	**Divergence point: Court order vs self-initiated will change readiness to change and drivers to participate** Rollercoaster of hopeful and optimistic to shameful embarrassed and skeptical	Feeling they are in the right place and without being judged. Apprehension about effectiveness, fear about being judged but generally positive about taking the step	Feeling comfortable, safe and free of judgement to share their story Comforted and safe by counsellor's support and manner **Divergence point: Feeling too challenged and risking drop out**	Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events	Confidence that progress has been made **Divergence point: Feeling that sufficient behaviour change has occurred**	Feel alone again and unsupported. Doubting that the program was long enough.	General sense of assuredness that they are better than they used to be Feeling alone and still in need of support due to lack of additional counselling

Thinking	• Dangerous thinking, victim blaming, etc. E.g.
	  • 'My partner is being ridiculous.'
	  • 'She's the violent/abusive one.'
	  • 'Why don't they see my side of the story?'
		• Reflecting on the crisis event
		• How did it get to that point?
		• What do I do now?
		• How do I get my life/wife/children/house back?
			• I have no direction and no alternatives.
			• Something has to change
				• Maybe I can be a better man
				• Will this even work? Can I change?
				• I don't want to be judged
				• Is this really for guys like me?
					• Are they going to judge me?
					• How is this going to work?
						• Open & receptive to advice.
						• This is great that someone will listen to me
							This is great, someone is listening to me
							
							I'm learning what I need to learn to handle my outbursts
								• I've made a lot of progress.
								• I have tips and strategies now to handle my emotions
									• I'm alone again
									• I can't trust that I can remember everything they taught me
									• That ended abruptly – there is still much more to learn.
										• It's a long process, one step at a time
										• I am better at controlling my anger/emotions
										• More sessions would have been good.
										• This is still something I am learning about.

WHERE TO

Overview of the BIS journey

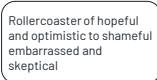|	Crisis event	Aftermath	Awareness of program	Consideration	First contact	Waiting for a program	First session	Subsequent sessions	Final session	Week after	6-12 months
Doing	• Use of violence • Argument • Police attend • Family violence safety notice/IVO/AVO issued • Removal from property	• Seeking accommodation • Reaching out for support • Reflecting on event	• Recommended about the MRS by a friend, acquaintance, corrections, Police or Magistrate. • Google searched for a MBCP.	• Assessing the pros and cons. • Building up the courage to reach out	• Overcoming fear • Calling the service • Going through assessment • Sharing their story	• Hoping the program will work • Trying to piece life together for sense of normality (i.e. new routine, new living arrangements)	• Sharing their story • Building an understanding of how sessions work • Getting a read on the counsellor	• Developing an understanding of emotions • Learning strategies and tips for managing anger • Developing ability to use words to express complex feelings • Bringing these lessons into their lives	• Revisiting lessons and progress • Receiving recommendations and referrals for additional services • Take home worksheets	• Trying to remember strategies for controlling emotions • Implementing learnings into daily life and relationships.	• Awaiting or participating in additional counselling • Maintaining a healthy, stable life – work, home, relationships
Feeling	Intense anger and/or frustration at partner and situation.	Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.	**Divergence point: Intervention orders preventing access to family and home results in different drivers and attitudes to participation** Desperate for a path forward (unless court ordered)	Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house Rollercoaster of hopeful and optimistic to shameful embarrassed and skeptical	**Divergence point: Court order vs self-initiated will change readiness to change and drivers to participate** Apprehension about effectiveness, fear about being judged but generally positive about taking the step	Feeling they are in the right place and without being judged. **Divergence point: Long waits for program placement can reduce motivation.** Losing a bit of drive and motivation. Frustrated by wait times	Feeling comfortable, safe and free of judgement to share their story Comforted and safe by counsellors' empathy and manner **Divergence point: Feeling too challenged and risking drop out**	Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events	Confidence that progress has been made	**Divergence point: Those not going on to a MBCP are more likely to feel isolated, alone and nervous about repeat behaviour** Apprehensive about being alone and regressing, but sense of assurance awaiting future program	General sense of assuredness that they are better than they used to be. Confidence to step into continual programs

Thinking	• Dangerous thinking, victim blaming, etc. E.g.
	  – 'My partner is being ridiculous.'
	  – 'She's the violent/abusive one.'
	  – 'Why don't they see my side of the story?'
		• Reflecting on the crisis event
		• How did it get to that point?
		• What do I do now?
		• How do I get my life/wife/children/house back?
			• I have no direction and no alternatives.
			• Something has to change
				• Maybe I can be a better man
				• Will this even work? Can I change?
				• I don't want to be judged
				• Is this really for guys like me?
					• Are they going to judge me?
					• How is this going to work?
						• I need this program to start so I can move forward	• Open & receptive to advice.
							• This is great that someone will listen to me
								• This is great, someone is listening to me
								• I'm learning what I need to learn to handle my outbursts
									• I've made a lot of progress.
									• I have tips and strategies now to handle my emotions
										• I'm alone again
										• I can't trust that I can remember everything they taught me
										• I'm looking forward to additional programs
											• It's a long process, one step at a time
											• I am better at controlling my anger/emotions
											• I'm feeling ready and excited for the next program
											• This is still something I am learning about.

Overview of the MRS journey

	Crisis event	Aftermath	Awareness of program	Consideration	First contact	Referred to other services	Call backs
Doing	• Use of violence • Argument • Police attend • Family violence safety notice/IVO/AVO issued • Removal from property	• Seeking accommodation • Reaching out for support • Reflecting on event	• Recommended a MRS by a friend, acquaintance, corrections, Police or Magistrate. • Google searched for a MBCP.	• Assessing the pros and cons. • Building up the courage to reach out	Receives call or makes call • Overcoming fear • Calling the service • Going through assessment • Sharing their story • Referral to other services	• Weighing up path forward (i.e. psychologist, other men's behaviour change programs	• Monitoring emotional state • When noticing a regression, calling the MRS as a safety net for an outlet or for advice
Feeling	Intense anger and/or frustration at partner and situation.	**Divergence point: Intervention orders preventing access to family and home results in different drivers and attitudes to participation** Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.	Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house Desperate for a path forward.	**Divergence point: Court order vs self-initiated will change readiness to change and drivers to participate** Rollercoaster of hopeful and optimistic to shameful embarrassed and skeptical	Feeling they are in the right place and without being judged. Apprehension about effectiveness, fear about being judged but generally positive about taking the step	Slight sense of assurance that they are in the system, have options and some sense of control	Concern around regressing, but feeling supported by MRS being a phone call away

Thinking	• Dangerous thinking, victim blaming, etc. E.g.
	  – 'My partner is being ridiculous.'
	  – 'She's the violent/abusive one.'
	  – 'Why don't they see my side of the story?'
		• Reflecting on the crisis event
		• How did it get to that point?
		• What do I do now?
		• How do I get my life/wife/children/house back?
			• I have no direction and no alternatives.
			• Something has to change
				• Maybe I can be a better man
				• Will this even work? Can I change?
				• I don't want to be judged
				• Is this really for guys like me?
					• Are they going to judge me?
					• How is this going to work?
					• I'm open to advice
						• Hoping for a call
						• What services do I need?
							• I can use the MRS as a safety net if I ever slip up
							• I have a free resource that will listen to me
							• I can make progress in a non-linear way.

Overview of the CFG VPP journey

	Crisis event	Aftermath	Awareness of program	Consideration	First contact	First session	Subsequent sessions	Final session	Week after	6-12 months
Doing	• Frustration and anger increasing to a tipping point • Argument with partner • Reaching the brink of physical violence.	• Partner breaking through that something has to change. • Reflecting on the crisis event and recent mood • Ruminating on past trauma	• Calls MensLine Australia • Has been recommended a service/program by a friend, acquaintance or partner. • Has google searched for a men's behaviour change program.	• Assessing the pros and cons. • Building up the courage to reach out	• Overcoming fear • Calling the service • Going through assessment • Sharing their story	• Sharing their story • Building an understanding of how sessions work • Getting a read on the counsellor	• Developing an understanding of emotions • Learning strategies and tips for managing anger • Developing ability to use words to express complex feelings • Bringing these lessons into their lives	• Revisiting lessons and progress • Receiving recommendations and referrals for additional services • Take home worksheets	• Trying to remember strategies for controlling emotions • Implementing learnings into daily life and relationships.	• Looking for additional counselling services • Maintaining a healthy, stable life – work, home, relationships

Feeling

- Knowing there is a program specifically catered for men who have not committed physical violence is highly encouraging
- Rollercoaster of hopeful and optimistic to shameful embarrassed and skeptical
- Feeling they are in the right place and without being judged.
- Feeling comfortable, safe and free of judgement to share their story
- Confident that progress has been made
- General sense of assuredness that they are better than they used to be

- Intense anger and/or frustration at partner and situation.
- Fearful of the loss of family and home. Disappointed and regretful
- Ashamed and nervous about the initial interaction and having to discuss relationship troubles/ violence.
- Apprehension about effectiveness, fear about being judged but generally positive about taking the step
- Comforted and safe by counsellor's support and manner
- Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events
- Feel alone again and unsupported. Doubting that the program was long enough.

Divergence point: Feeling too challenged and risking drop out

| **Thinking** | • My partner is being ridiculous
• Why don't they see my side of the story? | • How did it get to that point?
• What do I do now?
• I don't want to scare my partner
• I don't want to be this angry anymore | • Something has to change
• Looking for paths forward | • Maybe I can be a better man
• Will this even work? Can I change?
• I don't want to be judged
• Is this really for guys like me? | • Are they going to judge me?
• How is this going to work? | • Open and receptive to advise.
• This is great that someone will listen to me | • This is great, someone is listening to me
• I'm learning what I need to learn to handle my outbursts | • I've made a lot of progress.
• I have tips and strategies now to handle my emotions | • I'm alone again
• I can't trust that I can remember everything they taught me
• That ended abruptly – there is still much more to learn. | • It's a long process, one step at a time
• I am better at controlling my anger/emotions
• More sessions would have been good.
• This is still something I am learning about. |

Appendix 4: Literature review

The value of short ('low-dose') interventions in facilitating behaviour change in the family and domestic violence space.

Introduction

Although family and domestic violence is not a new social problem, over the past few decades there has been an increase in public awareness and a growing consensus that something needs to be done to address the issue. At both national and international levels, governments in most developed countries have focused on improving policies and adopting initiatives designed to reduce the occurrence of family and domestic violence, provide support to victim-survivors and children, and to hold perpetrators to account (Devaney 2014). There has been a cultural shift in the understandings of men's role in stopping violence, as highlighted by the recent Victorian Royal Commission into Family Violence (Neave et al. 2016).

Holding perpetrators accountable was one of the 6 priorities of the *Australian Commonwealth Government's Third Action Plan 2016–2019*, of the *National Plan to Reduce Violence against Women and their Children 2010–2022* (Department of Social Services 2016) and remains a priority in the First Action Plan of the *National Plan to End Violence against Women and Children 2022–2032* (Department of Social Services 2022). Both the current and previous national plans articulated that to keep women and children safe from violence, it is essential to maintain a focus on perpetrators and hold them accountable for their actions. This removes the burden of responsibility from women to keep themselves and others (i.e. children) safe. Similarly, the current National Plan aims to end violence within a generation by addressing its root causes through prevention, identifying high-risk individuals for early intervention, providing comprehensive response services, and supporting victim-survivors in their recovery and healing journey (Department of Social Services 2022).

The *First Action Plan 2023–2027* (Department of Social Services 2023c) serves as a blueprint for the initial 5-year push towards achieving the goals of the National Plan. It outlines the initial scope of activities, delineates areas of action and responsibility concerning outcomes, and elucidates the strategy for translating the commitments outlined in the National Plan into concrete actions. The plan focuses on 4 domains: Prevention, Early Intervention, Response, and Recovery and Healing. The Australian federal, state and territory governments pledge to implement 10 specific actions:

1. Promote gender equality and tackle the root causes of all types of gender-based violence, including efforts to reshape community attitudes and norms related to family, domestic and sexual violence.

2. Enhance the national information foundation by striving for consistent terminology and monitoring and evaluation frameworks, and by bolstering the collection and sharing of data and evidence.

3. Strengthen and expand the capabilities of mainstream and specialised workforces to provide high-quality services, activities, and programs across the 4 domains, customised to address the distinct needs of all victim-survivors.

4. Enhance the capacity of support services and systems for victim-survivors, ensuring they offer trauma-informed, interconnected, and coordinated responses that facilitate long-term recovery, health, and wellbeing.

5. Reinforce systems and services to hold individuals who engage in violence accountable and offer opportunities for those at risk of using violence or who have used it to change their behaviour, with the goal of safeguarding the safety and wellbeing of current and potential victim-survivors.

6. Enhance efforts to prevent and address sexual violence and harassment across all contexts, spanning the National Plan's 4 domains.

7. Collaborate in a formal capacity with Aboriginal and Torres Strait Islander communities to ensure that policies and services are culturally sensitive, asset-based, trauma-informed, and responsive to the needs of these communities, aligning with the objectives of the Aboriginal and Torres Strait Islander Action Plan.

8. Create and implement age-appropriate programs across all 4 domains, informed by insights from children and young people, that are culturally secure, designed to intervene early in addressing behaviours that support violence, and facilitate recovery and healing from trauma.

9. Enhance the responsiveness of law enforcement and the justice system to better support victim-survivors by providing trauma-informed, culturally secure support that promotes safety and wellbeing while holding those who commit violence accountable.

10. Improve access to short-term, medium-term and long-term housing for women and children experiencing violence, including those residing in institutional settings, and support women in remaining in their own homes if they choose to do so.

In addition to this Action Plan, further guiding plans have been launched in 2023 which further highlight the need for perpetrator accountability. These plans include the *Aboriginal and Torres Strait Islander Action Plan to End Violence against Women and Children* (Department of Social Services 2023), which was developed in close collaboration with the Aboriginal and Torres Strait Islander Advisory Council on family, domestic and sexual violence. This specialised plan acknowledges the significantly elevated rates of family, domestic and sexual violence faced by Aboriginal and Torres Strait Islander women; the *First Action Plan 2023–2027 Activities Addendum* (Department of Social Services 2023b), which outlines specific activities to implement each action detailed in the *First Action Plan and Outcomes Framework* (Department of Social Services 2023d), which links the actions and activities being undertaken with the aim to eliminate gender-based violence in one generation; and the Theory of Change (Department of Social Services 2023e), which explains how and why change is expected to occur.

Within all of the above-named guiding plans to end gender-based violence, there is a focus on perpetrator accountability through access to programs and services to address behaviour change. The Outcomes Framework (Department of Social Services 2023d) highlights that one of the primary outcomes of the National Plan is that individuals who engage in violence must take responsibility for their actions and cease their aggressive, coercive and abusive conduct.

The National Outcome Standards for Perpetrator Interventions (NOSPI) (Department of Social Services 2015) highlighted the need to maintain outcome standards for perpetrator interventions. While these standards are not mandatory, they represent a considerable endeavour to promote the adoption of more efficient and uniform interventions throughout all Australian jurisdictions. In essence, it aimed to establish guidelines that encourage the implementation of effective approaches to address perpetrator behaviour consistently across the country. It noted that interventions needed to the comprehensive approach to perpetrator interventions prioritises the safety of women and children, delivers timely and accountable interventions, fosters behavioural change through programs, relies on evidence-based improvements, and ensures that professionals are skilled in addressing domestic, family and sexual violence dynamics.

Many perpetrator interventions are underpinned by feminist theories of masculinity. In the realm of family and domestic violence research, the exertion of power and control, particularly against women, is a key aspect of gender inequality. Programs designed for men who perpetrate family and domestic violence aim to challenge harmful expressions of masculinity and dismantle hegemonic constructions of gender (Jewkes et al. 2015). Holland et al. (2018) reflected on a NTV conference (National Working with Men to Tackle Family Violence Conference 2017) where it was highlighted that 'toxic masculinity,' characterised by violence, sexual dominance, status, and aggression, is at the core of a culture that normalises sexism and enables family violence. To address this issue, challenging 'toxic masculinity' or 'hegemonic masculinity,' which perpetuates harmful notions of masculinity, becomes crucial in working with perpetrators (Jewkes et al. 2015). Holland et al. (2018) concluded that while there was variation in therapeutic frameworks drawn upon to inform perpetrator interventions, critical feminist analysis was an underlying and inherent component across most of the programs.

Men's behaviour change programs

The prioritisation of holding perpetrators accountable has driven increased investment in MBCPs in recent years. Since Victoria's Royal Commission into Family Violence, it has also become more evident that MBCPs are part of an integrated response to ending family and domestic violence, rather than a standalone solution (Vlais et al. 2020). MBCPs are typically group-based interventions that work with both men who use abusive and controlling behaviours, as well as their partners, ex-partners, and family members. These programs aim to improve safety and wellbeing for women and children through facilitating change in perpetrator behaviour by helping them to take responsibility for their violence, while simultaneously considering the risk of violence experienced by victim-survivors and their children (Vlais 2014).

When considering MBCPs, it is important to consider the Duluth Model, which is the most common employed approach. The Duluth model is described as psycho-educational and gender-driven, with some elements of cognitive behavioural theory incorporated (Day et al. 2009). It focuses on collaboration across justice and community service systems, using a feminist lens to address masculine and feminine norms, gender power relations, and the impact of gender inequality (Wilczynski et al. 2012). Participants take responsibility for their behaviour during the 12- to 18-week group-based program, which includes discussions and role-play. Research on the Duluth model's efficacy has shown mixed results, and it has faced criticisms. Some argue that it does not adequately address individual differences and complexities, neglecting issues like colonisation's impact on Aboriginal and Torres Strait Islander men (Holland et al. 2018). Additionally, the model has been criticised for its shallow and non-individualised treatment and its limited consideration of mental health or substance abuse as contributing factors to violence (Corvo et al. 2009; Day et al. 2009).

Duluth-based MBCPs often incorporate cognitive behavioural therapy (CBT), viewing family and domestic violence as a result of psychological dysfunction (Holland et al. 2018). CBT is effective in treating various psychological issues like anxiety and anger management (Hoffman et al. 2012). In CBT-based family violence intervention, therapists adopt a psychotherapeutic approach and work together with perpetrators to identify and change thought processes contributing to violent behaviour, teaching new skills for emotional regulation and explore healthy communication (Grealy et al. 2012; Mackay et al. 2015). The distinction between CBT and Duluth model groups has become less clear, as many programs adopt a combined model underpinned by feminist theories of power and control with interventions for anger control, stress management, and improved communication skills (Babcock et al. 2004).

Research indicates that MBCPs can be effective in promoting positive outcomes for both the perpetrators and the victim-survivors of family and domestic violence. These programs have shown positive results in various areas, including increased communication and parenting skills, improved interpersonal relationships, greater empathy, accountability of abusive behaviour, improvements in self-control, and decreased aggression and abuse (O'Connor et al. 2021). MBCPs play a significant role in holding perpetrators accountable for their actions and helping them understand the impact of their violence on others. By addressing the root causes of violent behaviour and providing tools to manage stress and develop healthier coping strategies, these programs can contribute to breaking the cycle of violence (O'Connor et al. 2022).

MBCPs are the most common used interventions to address men's violent behaviours in the context of family and domestic violence; however, behaviour change, in general, can be challenging even in ideal circumstances. For instance, research into various self-improvement interventions, such as sun protection, exercise, or quitting smoking, showed that despite moderate-to-large intentions to change, the actual behaviour change tends to be only small-to-medium (Webb and Sheeran 2006). Since MBCPs are frequently court-ordered, not all participating men may have a strong intention or willingness to change. Additionally, studies have indicated that treatment programs for family and domestic violence may not lead to significant reductions in recidivism beyond the effects of imprisonment (Babcock et al. 2004). Considering these findings, it is essential to approach MBCPs, and any other form of perpetrator intervention, with realistic expectations and recognise that achieving behaviour change, especially in the context of family and domestic violence, can be a complex process.

It is essential to note that the effectiveness of MBCPs may vary depending on several factors, such as program design, participant engagement, the severity of the violence, and the availability of ongoing support post-program (Smith et al. 2009). A man's readiness to change, particularly for court-mandated perpetrators, further influences program efficacy. Positive outcomes in these programs require participants to demonstrate willingness to change and take responsibility for their behaviour and attitudes (McMurran 2002). Evaluating and improving MBCPs is an ongoing process to ensure they continue to meet the needs of participants and contribute to the safety and wellbeing of families affected by domestic and family violence.

There has been some recent emerging research around the use of 'invitational narrative' approaches to improve engagement for men in MBCPs. Wendt et al. (2019) highlight that invitational and narrative practices prioritises individual stories and unique backgrounds of men, instead of relying on broadly applicable generalisations, renders this approach a potentially potent method for fostering profound and enduring transformation. The methods focus on the promotion of critical awareness and active involvement with men to cultivate their perspectives on power, ethics, and fairness. It is assumed that with adept and thoughtful facilitation, men involved in intimate partner violence can independently develop their own notions and commitments related to non-violence and the inequities resulting from the subjugation of others. Wendt et al. (2019) concluded that invitational narrative approaches, due to their focus on in-depth and context-rich discussions, require a significant investment of time and resources; they offer the potential for achieving lasting and sustainable change in men who engage in intimate partner violence. It is noted that there is only limited evidence of the use of invitational narrative approaches to date.

MBCPs are now considered one type of intervention to address family and domestic violence, but not the only one. The Royal Commission into Family Violence highlighted that perpetrator interventions in Victoria were limited in breadth and variety, with MBCPs being the most common. There has been implementation of other types of perpetrator interventions, such as

case management programs, brief telephone services and additional pilot programs, meaning that there are various pathways for perpetrator intervention (Vlais et al. 2020). There is little research to date evaluating the efficacy of these alternate intervention pathways for perpetrators.

Motivation to change

Most perpetrators do not seek treatment willingly, and those who do often do so because they are required to by the legal system. Even among those who are mandated to attend treatment, many discontinue prematurely, especially during their initial attempts. Self-referring to treatment for family and domestic violence can be daunting, even for a man who genuinely desires to change. Reaching out for help can feel overwhelmingly difficult, leading to most family and domestic violence cases and their consequences going unnoticed and unaddressed (Mbilinyi et al. 2023). When considering the help-seeking behaviours of perpetrators, Andrews et al. (2001) indicated that less than one-third of men experiencing psychological distress seek assistance from mental health professionals. While we need to be careful about conflating men's violent behaviour and psychological disorders, this highlights the importance of acknowledging the numerous missed opportunities for society to intervene and provide men with the necessary help and support to put an end to their abusive behaviours. Accordingly, when considering engagement for perpetrators, most treatment programs mainly assist individuals who have been legally mandated to undergo treatment. Consequently, a substantial portion of family and domestic violence research has centred on interventions for court-mandated perpetrators, leading to a disproportionate focus on post-incident analysis rather than early intervention or prevention strategies (Mbilinyi et al. 2023).

Motivation to change is a critical factor in assessing the impact of therapy, especially in the context of perpetrator interventions. For change to occur, an individual must be ready, willing, and capable of making changes. 'Ready' signifies the belief that change is essential and a priority, 'willing' refers to the preparedness for change, and 'able' relates to having the self-efficacy and belief in one's ability to make and sustain the changes (Viets et al. 2002). Most perpetrators tend to be rational and have reasons to justify their denial of harm and resistance to change. These reasons may include a desire to avoid sanctions and disapproval resulting from being caught perpetrating, lessen feelings of guilt and shame about their behaviour, or pursue significant life changes (McMurran 2002). Therefore, motivation to change, or lack of, are rational responses to circumstance and is therefore considered a dynamic construct. In psychological practice, these reasons are referred to as cognitive distortions that support, endorse and promote the use of violence. In criminology, these are referred to as 'guilt neutralisation' strategies.

McMurran (2002) categorised motivation into 2 factors; external (extrinsic) and internal (intrinsic). External motivation is influenced by outside conditions like social pressure, reinforcement, and punishment. It tends to diminish once external control is removed. In contrast, internal motivation stems from within the individual and is not reliant on external factors. It is more likely to persist even when external controls are removed. Internal motivation arises when individuals pursue valued goals or seek to avoid aversive emotions like guilt or shame. Internally driven motivation is considered a more reliable and significant predictor of long-term change and maintenance (McMarrun 2002).

In the treatment of family and domestic violence offenders, motivation to change is challenging for male perpetrators. Many of them exhibit an underlying sense of entitlement to use abuse and control, and they often fail to acknowledge the harmful impact of their behaviour on their victimised partners and children (Heward-Belle 2016). As outlined above, in most

cases, men may be required to attend behaviour change programs as part of a court order or legal intervention. Legal consequences can serve as a motivator for participation. There are further motivators including parenting and family roles, relationship improvement and personal growth. The below will focus primarily on mandatory requirements and fatherhood as motivators for change, as these 2 constructs are the most common explored in literature.

Although limited in research, there is some evidence to suggest men may self-refer to an intervention program based on self-reflection, even if they haven't demonstrated violent behaviour but fear their potential for it (NTV 2005 as cited in Holland et al. 2018). Others are encouraged by family members, relatives, or housemates. Some seek help on the advice of professionals, like lawyers, to avoid legal consequences (NTV 2005 as cited in Holland et al. 2018). Men who engage in these programs due to involvement and encouragement from those they cohabitate with can be described as driven by a 'social mandate' (Holland et al. 2018) which is form of extrinsic motivation.

Motivated by being mandated

Family and domestic violence is a criminal offence, and often, community correction orders and parole orders include mandatory perpetrator interventions (Hoffart and Clarke 2004). For many mandated men, therapeutic intervention is perceived as a form of punishment rather than a counselling and support mechanism (Gondolf 2002). Research on the effectiveness of mandated treatment has shown mixed results. Some early studies indicate that self-referred men make better progress in reducing violence compared with court-referred men (DeMaris and Jackson 1987) while others suggest that court-referred men are more likely to benefit from treatment (Farabee et al. 1998). Studies have also found differences in attrition rates and psychological problems between voluntary and court-mandated participants, notably that self-referred men had more serious psychological problems and accordingly were more likely to withdraw from treatment and further perpetrate against their partners (Gondolf 2002). A more recent study by Gondolf et al. (2004) in North America evaluated the effectiveness of mandatory perpetrator intervention programs and argued that there are indications these programs can have a positive impact on the future behaviour of perpetrators. Overall, there appears mixed evidence as to the effectiveness of treatment when it is mandated.

Motivated by fatherhood

Research on family and domestic violence indicates a gendered pattern, with a significant prevalence of male-to-female perpetrated intimate partner violence (Devries et al. 2013; Garcia-Moreno and Watts 2011). In many cases, this translates into father-to-mother violence, as most households affected by family and domestic violence have children living in them (Kaukinen et al. 2016; McDonald et al. 2006; Mouzos and Makkai 2004). The exposure of children to family and domestic violence has garnered increased attention over the past 2 decades, with studies highlighting high exposure rates and the negative impact on children's short- and long-term development and wellbeing (Kaukinen et al. 2016; Kitzman et al. 2003). Research has examined how fatherhood and the father–child relationship can serve as motivating factors in other various behaviour change contexts, including health-related interventions (Lubans et al. 2012). Regarding family violence, father may be motivated to regain contact with their children, or where contact is still maintained, to improve the father–child relationship.

A Canadian study on the 'Caring Dads' program revealed positive outcomes from a parent-specific approach as a motivator. The program utilised motivation-enhancing, psychoeducation, cognitive-behavioural, and collaborative case management interventions. It was designed for fathers who had abused or exposed their children to family and domestic

violence and was offered as a community-based individual and group intervention program (Scott and Lishak 2012). A similar study was conducted more recently in Queensland, Australia using the 'Caring Dads' program. Like the original program, this program focused on tapping into the motivation of wanting to be a 'good father' to encourage participation and behaviour change (Hine et al. 2022). Additionally, it employed motivational interviewing techniques to enhance engagement in the program. The findings suggested that it is useful to consider the father–child relationship as a motivational tool, and similarly, that promoting improved wellbeing for adult and child victim-survivors of family and domestic violence during initial stages of intervention, is beneficial in the overall intervention process (Hine et al. 2022).

Meyer (2018) concluded that understanding perpetrator's desires to maintain or rebuild relationships with their children may motivate them to commit to behaviour change. Supporting them to recognise the impact of their behaviour on their children's wellbeing and development during the early stages of engagement with support services, may facilitate the necessary commitment to the behaviour change process. Similarly, Holland et al. (2018) highlighted the benefits of using the parental relationship in early intervention stages, namely that it can be used to facilitate a point of 'buy in' and a reference point for fathers to gain insight into the severe impacts of their abuse. Holland et al. (2018) highlights the importance of using the father–child relationship with careful balance. Facilitators must be aware of the risk the perpetrator poses to their partner/ex-partner and children, while also demonstrating a degree of understanding and empathy towards the perpetrator.

Barriers to intervention, access and completion

While research has shown that certain interventions for perpetrators can be effective within a coordinated community response, one of the biggest challenges lies in the limited reach of these programs, as they only touch a fraction of the male population who would benefit from such interventions (Campbell et al. 2010). There are numerous barriers to perpetrators seeking and accessing help at both an individual and societal level.

Help-seeking behaviour

Literature has long suggested that men avoid seeking help for their violent behaviours due to associated perceptions of weakness and fragility. Abusive men often feel embarrassed, humiliated, and ashamed to seek assistance. Campbell et al. (2010) conducted a study where 38% of men admitted they were too embarrassed to seek help, and some men expressed feeling embarrassed and ashamed when their partners sought help for problems in their intimate relationship. Earlier studies have explored the influence of traditional male gender role attitudes on men's help-seeking behaviours. Men who adhere to traditional attitudes about masculinity, such as the belief that men should not express emotions or show concern for others, were less likely to seek psychological help (Good et al. 1989; Blazina and Watkins 1996).

A recent study by Brassard et al. (2023) explored the various profiles of men who sought help for their abusive behaviours. The findings indicated that men who tended to use minor forms of intimate partner violence were more likely to seek help earlier for their violence or violence-related difficulties (e.g. experience depression post separation), or before their violence escalated into more severe forms. Further, Morgan et al. (2014) found that men were more likely to seek informal support from their family and/or friends, and there next most likely source of support was from their family doctor. The anecdotal reports of men in this study indicated that generally they were open to discussing their abusive behaviours when raised by their family doctor; however, that this often did not occur, and this may have increased the men's reluctance to seek help.

Help-seeking behaviour of men may also be impacted by their cultural background. Researchers have highlighted the emphasis on different aspects of the male gender role varies across racial and ethnic groups (Vogel et al. 2011). While there may be some overlap in traditional values of how a man 'should be,' the intensity and prominence of these expectations can differ among different ethnic groups (Wester 2008). Some research has explored the cultural differences in the United States and identified that European American, African American, Asian American, and Hispanic American men may share similarities and differences in their expression of the masculine gender role and these expressions may impact their feelings of self-stigma and attitudes towards seeking counselling (Lane and Addis 2005; Wester 2008). Stigma is considered to play a significant role in the help-seeking process, and it can vary across cultural groups and accordingly impact cultural norms (Coker 2015).

For Aboriginal and Torres Strait Islander men, help-seeking for family and domestic violence can be hindered by various factors, including feelings of shame related to the violence, fear of retaliation, pressure to maintain the family unit due to cultural and family expectations, tolerance of violence in the community, limited service availability, inadequate responses to help-seekers, concerns about confidentiality in close-knit communities, and challenges posed by cultural and language barriers (Carlson and Farrelly 2009). A study into help-seeking for Aboriginal men who were also experiencing mental illness concluded that when Aboriginal men discussed their stress with their peers, seeking support and advice, their peers often discouraged them, emphasising the need to be 'strong' as culturally acceptable and normative behaviour (Isaacs et al. 2013). As a result, these men were hesitant to be perceived differently and continued to conform to this notion of strength.

Of note was a recent study in Australia which considered the testimonials of men who were engaging in an MBCP, to explore their perceptions of how future men could supported to recognise their abusive behaviour and seek help at an earlier stage (Forsdike et al. 2021). The study highlighted the importance of 'turning points' in motivating men to seek help prior to their engagement with the justice system. Carlsson (2012) suggests that 'turning points' in a person's life, particularly regarding the cessation of criminal behaviour, may not result from a single, definitive act or event, but rather may develop gradually over time. These turning points are shaped by specific changes that gradually push a person towards the process of desisting from criminal behaviour, which is often a nonlinear journey. Further, Forsdike et al. (2021) found that participants highlighted the significance of external factors, such as family support and peer testimonials, in encouraging personal introspection and the active pursuit of assistance. Participants made a clear distinction between voluntarily following advice from others and being compelled to make changes. Those in the study expressed that if change was imposed and removed from their control rather than being suggested, they would resist it.

Further, when considering ways to improve help-seeking behaviour for men, Thomson et al. (2013) designed a social marketing campaign which focused on help-seeking behaviour for family violence as a 'strength' rather than a perceived weakness. This method was based on the principle that men were less likely to seek help in relation to family violence due to associated perceptions of weakness and masculinity. The research identified effective messages that encouraged self-reflection while preserving traditional views of masculinity. This information was used to create a successful campaign promoting help-seeking as a sign of strength, leading to a high demand for a local perpetrator service (Thomson et al. 2013).

Intervention commencement barriers

In addition to obstacles of help-seeking behaviours, there appears impediments to engagement in and completion of interventions. At the individual level, many perpetrators who

attend assessment interviews to engage with MBCPs are deemed unsuitable. Perpetrators seeking access to programs are evaluated in line with the minimum standards set by their jurisdiction. For instance, in Victoria, Australia, perpetrators are assessed according to the *Family and Domestic Violence Protection Act 2008* (Vic) (s 129(3), considering factors such as character, personal history, language skills, disabilities, psychiatric or psychological conditions, alcohol or drug problems, and any other relevant matters. Often, men who were deemed unsuitable for program entry were referred to external services such as one-to-one counselling or case management (NTV 2018).

Holland et al. (2018) conducted a Practice Inquiry that reviewed several MBCPs in Victoria. They explored barriers to access and factors that hindered completion of the program from practitioner's perspectives. At the individual level, mental health and substance use were considered responsivity factors that prohibited group commencement. Trauma history was further considered a factor which may have impacted a man's ability to take accountability for their behaviour and subsequently impacted their engagement in treatment. Trauma history is also considered an impediment during the intervention program, as symptoms may be regularly activated due to the nature of the content. Aligning with their findings was the conclusions from Taylor et al. (2020) who reviewed the UnitingCare MBCPs in Queensland, which indicated that personal factors such as transience, homelessness, substance use, mental health and treatment readiness impacted suitability for program.

At the system level, research highlights the tensions between the court system and treatment readiness. Specifically, courts were seen to determine a perpetrator's suitability for MBCPs without conducting an appropriate assessment (Holland et al. 2018). This often resulted in practitioners having to refer perpetrators back to court in attempts to seek variations to their Orders. Where this was not granted, this left providers with the challenge of accommodating disruptive or unprepared men in their group sessions. Treatment readiness is considered an integral part of program suitability, as a lack of treatment readiness can often result in treatment interfering behaviour (e.g. disruptiveness) for the group and individual (Holland et al. 2018).

Oversubscription to programs is a common service gap identified within perpetrator interventions. In the context of substance use, research on mixed-gender populations have shown that shorter waiting times for treatment are associated with increased retention in both ambulatory and inpatient settings (Addenbrooke and Rathod 1990; Claus and Kindleberger 2002). MBCP services face challenges in accommodating men immediately, leading to possible negative consequences for those seeking help whether voluntarily or court-mandated (Holland et al. 2018). Delays in program availability may deter men from engaging in MBCPs, and court-mandated clients may have to wait for months before joining a program, raising concerns about women's and children's safety during this time. A study conducted interviews with frontline professionals involved in delivering the UnitingCare MBCP which revealed one common theme impacting program delivery; insufficient funding to meet the community demand for these programs, as reported across various occupations in the study (Taylor et al. 2020). Anecdotal accounts from perpetrators and victim-survivors in the same study yielded similar sentiments, namely that wait times tended to impact follow through of program engagement. It is noted that the research into the impact of wait times on family violence perpetrator interventions and engagement is limited.

Lastly, as aforementioned, Aboriginal and Torres Strait Islander men have difficulty seeking help. Gallant et al. (2017) argued that programs aimed at Aboriginal and Torres Strait Islander men should address various power constructs and acknowledge the impacts of colonisation on their social and emotional wellbeing. Understanding and addressing the effects of colonial

power are essential for the individual and collective healing journey of Aboriginal and Torres Strait Islander men and their communities. There are some apprehensions related to the cultural appropriateness of mainstream perpetrator interventions for Aboriginal and Torres Strait Islander perpetrators. Langton et al. (2020) concluded that there were several obstacles to the effectiveness of legal and support services for Aboriginal and Torres Strait Islander men who commit family violence include inadequate funding for long-term, evidence-based programs aimed at changing men's understanding of family violence and providing culturally relevant support. Additional challenges involved the systemic neglect of these men in some agencies, improper identification and support for those dealing with mental health or substance issues, and neurological disabilities, as well as a lack of familiarity and training among service providers and related agencies regarding the nuances of family violence, especially concerning the cultural significance of family within Aboriginal and Torres Strait Islander communities.

Similarly, Taylor et al. (2020) concluded that the most common existing programs, designed on an American model, might not fully address the cultural needs of First Nations men. The lack of research and development of First Nations responses to family and domestic violence was acknowledged, and significant funding and investment were identified as priorities for developing culturally responsive programs. Similarly, questions were raised about the cultural appropriateness of current MBCPs designs for CALD, and the need for tailored content and access to interpreters to cater to diverse ethnicities in migrant populations in Australia. The success of working with CALD men seemed to be linked to their level of enculturation into the dominant Australian culture, mainly based on English language proficiency (Taylors et al. 2020).

Disengagement from interventions

A meta-analysis of 144 studies on offender treatment revealed certain predictors that make men more likely to disengage from enrolling or completing a program (Olver et al. 2011). These predictors include having an antisocial personality, a history of criminality, non-mandated attendance, younger age, and little motivation for treatment. The strongest predictor of non-completion was having prior family and domestic violence offences. Notably, characteristics such as the type of violence, controlling behaviours, depression or anxiety, anger problems, alcohol use (excluding abuse), and childhood maltreatment were not correlated with non-completion (Olver et al. 2011).

In addition to above, anecdotal accounts from Taylor et al.'s (2020) study identified that the completion of the program by men was affected by further factors such as work hours, substance use issues, lack of transportation, homelessness, and personal situations. Lack of motivation and the belief that they didn't need the program were also identified as barriers to completion. Facilitators found it valuable to check in on the men when they missed a session as it provided insights into the challenging life situations they were dealing with. Similar to these conclusions are findings by Morrison et al. (2018) which indicated that from the perspective of professionals, there were 6 key challenges associated with fostering behavioural change in men who engage in violence: (a) societal acceptance of intimate partner violence, (b) hypermasculine beliefs, (c) emotional issues, (d) exposure to violence during childhood, I concurrent mental health problems, and (f) tendencies towards denial, downplaying, and shifting blame. Accordingly, it can be assumed that men undergoing treatment are faced with a complex array of underlying and entrenched problems and treatment would need to be multifaceted and consider approaches that target such needs. It is argued that the cognitive-behavioural framework adopted in current MBCPs does not consider such complexities and underlying trauma (Arvidsson and Caman 2022; Gadd and Jefferson 2007).

It is acknowledged that much of the above information pertains to barriers to engagement with MBCPs specifically. As alternate family and domestic violence interventions are in their infancy, there is little evidence exploring the limitations to engagement in these interventions. It is arguable that similar demographic and systemic characteristics may impact on a perpetrators ability to engage in supplementary interventions; however, dependent on the type of intervention (e.g. using motivational techniques) and the mode of access (e.g. telephone counselling) there may be some benefits to alternative programs.

Alternative and supplementary brief interventions

Risk Need Responsivity model

In order to understand the application of brief family violence interventions, it is important to understand the Risk Need Responsivity (RNR) approach. The RNR framework developed by Andrews and Bonta, also known as the 'what works' approach, is a set of principles for effective intervention with offenders (Andrews and Bonta 2010). The principles are as follows:

- **Risk:** interventions should be tailored based on the level of risk posed by the offender. High-risk and low-risk offenders should not be mixed in the same intervention group, as their treatment needs and potential for reoffending may differ significantly.

- **Needs:** It is important to identify and address criminogenic needs or dynamic risk factors that are directly linked to the person's offending behaviour. Criminogenic needs refer to specific factors that contribute to criminal behaviour and are subject to change through intervention. These dynamic risk factors may include issues such as substance abuse, antisocial attitudes, lack of problem-solving skills, impulsive behaviour, and poor coping mechanisms.

- **Responsivity:** To make the intervention program responsive to the individual's motivational possibilities and patterns, life situation, cultural context, and other individual factors. This approach recognises that each person is unique, and their motivations, life circumstances, and cultural background play a significant role in shaping their behaviour and responses to intervention.

The RNR model recognises the importance of tailoring interventions to the unique characteristics and needs of each offender, thereby increasing the likelihood of successful outcomes and reducing the risk of reoffending. The RNR model addresses family and domestic violence by focusing on personal dysfunction and criminogenic risk factors, such as substance abuse and unemployment, that contribute to the perpetrator's behaviour (Holland et al. 2018).

The risk principle involves 3 main elements: targeting 'higher risk offenders, providing intensive treatment to them, and avoiding intensive treatment for lower risk offenders (Andrews and Bonta 2010). The question of why interventions can have different effects on high-risk and low-risk offenders has been a subject of inquiry. The answer lies in understanding the risk factors associated with offending behaviour. Studies consistently show that antisocial attitudes, associates, personality, and a history of antisocial behaviour are strong predictors of criminal behaviour (Andrews and Bonta 1998). Other risk factors include substance abuse, family dynamics, education and employment (Gendreau et al. 1996).

When considering the characteristics of high-risk and low-risk offenders, high-risk offenders typically exhibit antisocial attitudes, associates and personalities, along with a significant criminal history and potential substance abuse problems. Conversely, low-risk offenders tend to display more prosocial behaviour, hold steady jobs, maintain positive family and social relationships, and have fewer criminal tendencies and substance abuse issues (Lowenkamp

and Latessa 2004). Accordingly, Lowenkamp and Latessa (2004) suggest that exposing lower risk offenders to higher risk offenders in intensive programs may have negative consequences. This exposure can potentially reinforce antisocial attitudes and beliefs through negative social learning. Essentially, low risk offenders may be taught more about abusive behaviours. Additionally, placing lower risk offenders in intensive programs could disrupt their prosocial networks and opportunities. The applicability of the risk principle to specialised populations, like family violence perpetrators, remains a question for further exploration.

There has been an abundance of research into the risk principle and its validity. Andrews and Dowden (1999), identified that programs that follow the risk principle, targeting higher risk offenders, were found to reduce recidivism by 19%. Conversely, programs that did not adhere to the risk principle and mix high- and low-risk offenders were associated with a 4% increase in recidivism rates. Similarly, a study by Bonta et al. (2000) focusing on intensive rehabilitation supervision revealed a 20% reduction in recidivism for higher risk offenders who received more intense supervision, but a 17% increase for lower risk offenders. Another study by Lowenkamp and Latessa (2005) examined adult halfway house participants and found that intensive programs were effective for higher risk offenders, leading to recidivism reductions of 10 to 30%, but for lower risk offenders, most of these programs resulted in increased recidivism rates.

Based on the risk principle, it is therefore arguable that short-term interventions may not have a significant impact on high-risk offenders' future behaviour. Accordingly, to effectively address family and domestic violence along with other problematic behaviours, a variety of treatment options with different intensities/dosage should be made available to perpetrators (McEwan et al. 2015). In considering what constitutes dosage, most literature posits that a higher dosage of treatment is associated with reduced recidivism rates. Specifically, current research identifies that for high-risk offenders, 200 or more hours of treatment reduced recidivism, while 100 hours or more reduced recidivism for moderate offenders (Sperber et al. 2013). These findings provide valuable guidelines for administering treatment.

It is important to note that there are some cautions raised towards the implementation of the RNR model in the family and domestic violence realm. The evidence base for RNR primarily comes from correctional systems, focusing on reducing re-offending based on proxy measures like lower reconviction rates (Polaschek 2016). For family and domestic violence, simply stopping physical violence may not be sufficient to address all impacts. Interventions with the social context (e.g. family) are still in their early stages in the community. Family violence programs may require additional change targets beyond those associated with reducing reconviction, such as addressing masculinity-based belief systems and rigid gender roles (Polaschek 2016). Combining approaches that address both gender attitudes and personal factors is recognised as valuable in addressing family and domestic violence (Neave et al. 2016).

Considering the above, it is arguable that short-term interventions addressing the perpetration of family and domestic violence are unlikely to reduce recidivism for high-risk offenders. Alternatively, short-term interventions may look to support perpetrators in alternative ways. This may include building motivation to engage in longer term intervention, where ambivalence or a lack of accountability deem a perpetrator unsuitable for MBCP it may aid to shift perspective, and it may act as a deterrent from violence in a crisis (e.g. crisis support services).

The Trans-Theoretical Model

The Trans-Theoretical Model of Change, also known as the Stages of Change Model, offers a relevant framework for intake and assessment in the context of family and domestic violence (Prochaska and Di Clemente 1984). This model describes the process of change as individuals

move through stages, including pre-contemplative, contemplative, preparation, action and relapse and maintenance.

In the context of family and domestic violence, a man in the pre-contemplative stage may not recognise the need for behavioural change. He may minimise, justify, excuse, or externalise blame for his abusive actions and be unwilling to take responsibility for the problem (Day et al. 2009). They tend to avoid acknowledging their high-risk behaviours and underestimate the benefits of changing while overestimating the costs. Many people remain in this stage for an extended period, and some seek therapy due to pressure from others, such as friends, family, employers, or legal requirements (Prochaska and Levesque 2002; Prochaska et al. 1992).

In the contemplation stage, individuals intend to act within the next 6 months but have not done so yet (Prochaska and Levesque 2002). People in this stage are more aware of the benefits of changing, but they also recognise the challenges and drawbacks. They may lack knowledge about how to change and what specific steps to take. This stage can last for an extended period, with some individuals remaining stuck in contemplation for years (Prochaska and Levesque 2002). In the contemplation stage, making a commitment to change is crucial. Effective interventions at this stage include educational programs that raise awareness of the impacts of violence and controlling behaviours on victim-survivors. Group discussions that offer feedback, social comparison, and self-re-evaluation are also considered valuable in facilitating change (Day et al. 2009).

In the preparation stage, individuals are ready to act soon. They may be exploring various change strategies and have a plan of action, such as joining recovery groups or seeking support (Scott 2004). They are prepared to engage in action-oriented rehabilitative programs (Prochaska and Levesque 2002).

During the action stage, individuals have made specific and observable changes in their lifestyles within the past 6 months. In the context of criminal offenders, the criminal justice system follows a zero-tolerance policy (Prochaska and Levesque 2002).

The maintenance stage involves individuals working to prevent relapse and using change processes less frequently than in the action stage. They are more confident in sustaining their changes and this stage can last for a few months or even a lifetime (Prochaska and Levesque 2002).

People seeking an MBCP often fall into the pre-contemplation or contemplation stage (Holland et al. 2018). In a study involving 292 males attending family and domestic violence counselling, Levesque et al. (2000) found that 24% were in the pre-contemplative stage, 63% were in the contemplation/preparation stage, and only 13% were in the action stage. This suggests that many men in family violence groups may not be ready for change, which can hinder progress. The Duluth and CBT models may assume individuals are in the action stage and ready to change, but a significant percentage of men in these programs may lack genuine motivation to make changes (Eckhardt et al. 2008). A study conducted in Australia of 414 adult male prisoners found that treatment was more effective in reducing anger when individuals had a higher level of treatment readiness at the beginning of the intervention (Williamson et al. 2003). Further, Scott and Wolfe (2003) yielded results of a study on male perpetrators which indicated that men in the contemplation and action stages showed greater positive progress compared with men in the pre-contemplative stage. Perpetrators in the pre-contemplative stage reported less abuse than those in the contemplative and action stages; however, partners of perpetrators in the pre-contemplative stage reported experiencing greater abuse than the perpetrators themselves reported, suggesting a possible role of denial in their behaviour (denial being a common indicator of the pre-contemplation stage).

To effectively engage men who present with low treatment readiness and make the most of their willingness to participate, intake and assessment workers play a crucial role in helping them progress towards taking further action along the change continuum. Motivational discussions become essential during this early stage to facilitate effective communication between the client and the worker within this model (Holland et al. 2018). By supporting perpetrators to make a commitment to their change journey, this will likely increase internal motivation which was found to have greater impacts than external motivation, as aforementioned.

Motivational interviewing

Offenders with the highest risk for serious recidivism are often perceived as the least motivated to change (McMurran 2002). As mentioned earlier, motivation is often considered a barrier to seeking help and remaining engaged in treatment. Accordingly, for those with low motivation to address their behaviour, they would likely benefit from engaging in a process that supports an increase in motivation. Motivational Interviewing (MI) was created to assist individuals in resolving ambivalence and making a commitment to change (Miller 1983). It is a person-centred approach that helps individuals resolve ambivalence about behaviour change by strengthening their own motivation and commitment to change.

MI incorporates various change processes, including empathy, discrepancy development, avoidance of argumentation, utilisation of resistance, and support of self-efficacy (Miller and Rollnick 2002, as cited in Austin et al. 2011). The counsellor establishes a warm and understanding relationship with the client through empathy. Discrepancy development involves highlighting the inconsistency between a person's behaviour and their broader goals (Miller and Rollnick 2002, as cited in Austin et al. 2011). An example of this is emphasising the contrast between a cherished value (e.g. spending time with family), and their recent criminal behaviour, leading to their imprisonment. To avoid defensiveness, the counsellor refrains from arguing for the non-violent side directly (Miller and Rollnick 2002, as cited in Austin et al. 2011). Instead, resistance is explored to understand the client's reluctance to change. Last, MI aims to boost the client's self-efficacy, instilling confidence in their ability to succeed in making positive changes (Miller and Rollnick 2002, as cited in Austin et al. 2011). Through this process, perpetrators are supported to move through the stages of change (e.g. from precontemplation to preparation), meaning they are likely to obtain enhanced outcomes during and after intervention programs.

Accordingly, MI can serve as a valuable brief intervention for perpetrators of family and domestic violence. Research into the offender population has highlighted the benefits of MI. A systematic review by McMurran (2009, as cited in Austin et al. 2011) on MI with offenders found preliminary evidence to suggest that MI can be effective with offenders. Further, Anstiss et al. (2010) conducted a New Zealand study that showed MI with medium-risk offenders increased their motivation to change and reduced the risk of recidivism. More recently, Austin et al. (2011) concluded that MI can enhance offender motivation to change by supporting them to focus on their goals and the impact of their behaviour.

In the context of family and domestic violence, a literature review conducted by Soleymani et al. (2018) concluded that high rates of failure to attend and attrition in perpetrator interventions highlight the need for early motivational enhancement. MI was considered beneficial as a prelude or preparation for intervention, as it can enhance motivation, readiness to change, treatment involvement, and session attendance. Further research supports the effectiveness of MI as a stand-alone treatment for stopping violence (Schumacher et al. 2011) and as a brief intervention to encourage additional change/help-seeking (Mbilinyi et al. 2011). For instance, a

study by Kistenmacher and Weiss (2008, as cited in Soleymani et al. 2018) involved 28 family violence perpetrators randomly assigned to either an MI group or a control group. The MI group received 2 sessions with a therapist, focusing on reducing ambivalence using MI techniques. Results indicated that participants who received MI attributed their violence more to internal factors compared with the control group and were in a better position to commit to the change process.

Similarly, a study by Mbilinyi et al. (2011), a telephone-delivered motivational enhancement therapy (MET) intervention called the 'Men's Domestic Abuse Check-Up' was evaluated. The aim was to engage untreated perpetrators who use alcohol or drugs in a brief conversation to assess their behaviour's and consider options. The study involved 124 men randomly assigned to receive the MET intervention (single telephone counselling session) or a control group. Results at one-month post-treatment suggested that MET was likely effective in reducing short-term abusive behaviour, increasing motivation for seeking treatment, and correcting inaccurate beliefs about family and domestic violence and substance use prevalence. A follow-up study by Mbilinyi et al. (2023), evaluated the impacts of 2 MET sessions and findings indicated that using MI had the potential to directly reduce recidivism. In Crane and Eckhardt's (2013) study with 82 abusers of their intimate partners, participants with lower readiness to change who received a brief motivational enhancement session showed improved treatment attendance and compliance compared with those who did not receive the session.

Taken together, evidence suggests that employing MI as a pre-intervention tool for the offender population has benefits. More specifically, although research is in its infancy, applying brief interventions using MI for family violence perpetrators has demonstrated enhanced engagement in treatment, and in some instances, a reduction in abusive behaviours.

Crisis telephone services

In addition to the use of telephone services to improve motivation as described in the above studies, telephone support can also be provided in the frame of brief crisis support. Telephone crisis support services have been established globally to offer assistance and support to individuals facing crisis situations. These support services commonly prioritise identifying and assisting individuals in crisis, as life stressors combined with pre-existing conditions (e.g. mental health) can lead to fatal outcomes (Gould et al. 2016). The crisis state is seen as time-limited and intense, making resolution inevitable. The challenge for individuals in crisis and those around them is to mobilise resources to address the situation adaptively (Turley 2013).

Data on mental health service utilisation indicates that men who seek help for mental health issues use telephone crisis support services at rates similar to other forms of psychological assistance (Australian Institute of Health 2012; Machlin et al. 2014). Telephone crisis support services may be appealing to males due to several reasons, including the provision of a confidential environment, easy accessibility regardless of geographical location, absence of screening or entry assessments, the freedom to initiate and end the call at any time, and the utilisation of person-centred, collaborative problem-solving support approaches (Feo 2012; Hunt et al. 2018).

While there is limited data on the effects of telephone crisis support for perpetrators of family violence, it is worthwhile to consider the impacts of telephone crisis support for suicidal men as a comparative. Much of the literature surrounding suicide as a crisis highlights the 'pre-suicidal state'; that is the transient period of vulnerability experienced by individuals after trauma or significant stress, and people are overwhelmed by their situation and feel helpless to address it (Turley 2013). Crisis intervention is a collaborative approach that aims to reduce anxiety, contain overwhelming emotions, enhance coping skills, and expand a person's internal

resources and external support. It involves acknowledging distress, understanding the personal significance of the crisis, and helping individuals re-evaluate their options and available resources (Turley 2013). This time-limited strategy is focused on addressing immediate concerns and assisting people in managing difficult life experiences and transitions. The urgency of the crisis may increase openness to exploring and trying new approaches to handle the situation (Turley 2013).

Crisis interventions for suicidal individuals are based on Shneidman's (1996, as cited in Turley 2013) understanding that intense emotional pain is central to most suicidal crises. The primary goal is to listen to and address this pain, which increases the chances of achieving safer outcomes. Therefore, communicating with a helpline professional may aid in acknowledging the hurt and developing a safety plan to manage. Further, telephone crisis support services typically refer callers on for ongoing support (Hunt et al. 2018).

In considering the above in the context of family and domestic violence, crisis telephone support is likely to follow the same principles. Much like intervening during the 'pre-suicidal state', telephone crisis support for perpetrators may provide intervention in the 'pre-violent state'. A man fuelled with intense emotion and considering the prospect of violence, may benefit from removing himself and calling for support. This aligns with the time-out method; a strategy often taught in perpetrator programs as a temporary interruption technique (Wistow et al. 2017). The intervention is a brief behavioural strategy that creates a safe space for reflection and interrupts the thoughts fuelling violence.

There is conflicting evidence on the efficacy of the time-out method for preventing family and domestic violence. Wistow et al. (2017) found that the 'time-out' method when employed as an interruption strategy yielded positive outcomes for perpetrators and victim-survivors. On the contrary, Babock and Potthoff (2021) concluded that distraction strategies, like taking a time-out, might not effectively reduce physiological arousal in perpetrators. Instead, intervention strategies addressing mindfulness, physiological soothing, distorted cognitions, and rumination were identified as more impactful in decreasing negative physiological arousal in this context. Thus, adopting Babock and Potthoff's (2021) framework, the role of a family and domestic violence telephone crisis support worker could be twofold; the space can aid as a time-out technique by encouraging a perpetrator to remove himself from the situation while simultaneously the support worker could engage in challenging cognitive distortions which may increase the risk of violence. This may include focusing on the consequences of violent behaviour and similarly supporting the man to regain control of his emotional experience.

In Australia, helplines provide support for various social and emotional issues (Trail et al. 2002). This includes suicide and crisis intervention (e.g. Lifeline), broader mental health support (e.g. Beyond Blue), tailored support for men (e.g. MensLine), and specific issues such as sexual assault and family violence (e.g. 1800-RESPECT). A study conducted by Trial et al. (2022) explored men's use of various crisis hotlines in Australia including Lifeline, Beyond Blue and MensLine. Men in the sample, regardless of helpline use, had similar demographic profiles, except that helpline users were slightly younger and more likely to be unemployed. Those using helplines were also more inclined to have previously sought help from mental health professionals, indicating they sought multiple forms of support to manage their distress. Men highlighted the importance of the nature and quality of interactions with helpline counsellors, valuing kindness, support, and care. The helplines' immediacy and accessibility were highly valued as a support service for managing acute distress.

There is currently a national hotline in Australia called Men's Referral Service which aids as a central point of contact for men taking accountability for their abusive behaviours. The hotline supports men through providing telephone counselling, information, and referrals to

appropriate support services. In Victoria, the MRS receives referrals from various sources, including Victoria Police, concerned individuals such as family and friends, a man himself and other service providers (NTV 2021). Support can be anonymous, and MRS pledges to provide a respectful, non-shaming environment to assist the men they support. The MRS works closely with other supports such as crisis accommodation for perpetrators, with the aim of enhancing safety and wellbeing for victim-survivors (NTV 2021). Similarly, the MRS refers a significant portion of perpetrators to the MBCPs. In Victoria in the 2015–16 financial year, the MRS referred 983 men to MBCP's (Holland et al. 2018). There is a lack of literature in telephone crisis support for family violence perpetrators, therefore making it difficult to definitively conclude whether this form of support has yielded positive outcomes for men and victim-survivors.

Post-MBCP support – maintenance

The above has largely focused on the implementation of brief interventions prior to engagement with MBCPs. Although scarce in literature, there is some commentary around the possible benefits of 'low-dose' maintenance type programs following the conclusion of the mainstream MBCP. In the UnitingCare study conducted by Taylor et al. (2020), there was a strong theme expressed in the MBCP service system regarding the need for an ongoing maintenance program to support the progress of men who have completed the program. Many participants, partners, and ex-partners emphasised the importance of consolidating learning, achieving deeper insights, and sustaining positive changes.

A large study by Brown et al. (2016) supported the idea of an immediate positive shift in attitudes after completing the program. The study involved over 300 men and partners from various programs across Australia, with follow-ups conducted over a 2-year period. The findings showed a significant reduction in violent behaviour right after the program, and these positive changes were maintained and further reduced in the subsequent one and 2 years. Conversely, the study also revealed that men found maintaining these changes difficult and felt that their successes were precarious. Interestingly, many of the men sought therapy and counselling post-program and continued with it throughout the 2-year follow-up period. This highlights the importance of men continuing their journeys of change and having access to support services to sustain their progress.

The findings from the above study align with theories relative to the risk principle of the RNR model; that is, that for effective behaviour change to occur the right dosage needs to be provided. Similarly, McEwan et al. (2015) emphasise the importance of the flexibility to provide treatment options with varying intensities and dosages. They argued that this enabled a more comprehensive and responsive approach to addressing family and domestic violence and problematic behaviours among perpetrators, ultimately increasing the chances of promoting positive behavioural changes and reducing recidivism rates. Further, the integration of a maintenance program in essence corresponds to the final stage of the Trans-Theoretical Model of behaviour change, the maintenance stage (Prochaska and Levesque 2002). Implementing a post treatment intervention would enable practitioners to continue to support men to implement strategies learned in the intensive program such as MBCP, provide ongoing review of challenges/ barriers of implementation, and similarly act as a space of case management. Ongoing case management may increase the safety of victim-survivors by ensuring they remain linked in with a professional network post-intervention.

Individual versus group interventions

There have been conflicting views related to group versus individual interventions for perpetrators of family and domestic violence. Interventions for perpetrators, such as MBCPs,

are commonly conducted in group settings, which some argue to be effective in influencing attitudinal and behavioural change. Group therapy reduces social isolation and allows for role-play, feedback, and confronting existing beliefs (Labriola et al. 2008). Anecdotal feedback from perpetrators who participated in domestic violence perpetrator programs in United Kingdom indicated that they appreciated the group format as it facilitated change through input from both facilitators and other men (Kelly and Westmarland 2015). Being held accountable by peers and exploring alternative ways of being men were crucial aspects of group therapy's effectiveness. The interview data supported this model, acknowledging the challenge, direct communication, and the need to embrace vulnerability.

On the contrary, studies suggest that individual or individualised interventions for family violence perpetrators may be more effective in reducing recidivism compared with group-based programs (Murphy and Meis 2008). Individualised treatment allows tailoring to each individual's motivation levels and readiness to change, which can lead to better outcomes. Some argue that group therapy may not adequately address individual needs and may hinder engagement for less motivated offenders. Research has primarily focused on group models, neglecting the potential benefits of individual treatment formats. Dutton and Corvo (2006) advocate for identifying and treating the psychology of abusive behaviour as the most effective intervention. Day et al. (2009) support the notion that interventions matched to individual offender needs are likely to be more effective.

It is therefore essential to uncover interventions that work for different cohorts of perpetrators, as they are not a homogenous group. Recognising the diverse needs of perpetrators, some may benefit from group engagement, while others may require individual counselling. Intake and assessment are crucial in identifying the most appropriate intervention for each individual (Holland et al. 2018). In practice, a combination of both individual and group therapy can be beneficial for offenders. Individual therapy can address individualised needs and underlying issues, while group therapy can complement individual work by providing additional opportunities for skill-building, social learning, and peer support. The selection of therapy format should be based on a comprehensive assessment of the individual's needs, risk, and treatment goals, aligning with the RNR framework.

Telephone and online interventions

There has been some earlier commentary around the benefits of telephone interventions as a therapeutic intervention. This mode of access, along with the online platform, is easily accessible to individuals who may have limited mobility, live in remote areas, or have transportation challenges (Campbell et al. 2018). Similarly, clients can attend therapy sessions from the comfort of their own homes, reducing the need for travel and making scheduling more flexible. Online and telephone therapy can facilitate continued support for clients who may have difficulty attending regular in-person sessions due to travel, work, or other commitments. The possibility of providing therapy remotely benefits underserved populations, like individuals with agoraphobia, anxiety, or limited access, who can 'see' therapists without physically being present in a clinic (Bouchard et al. 2000).

There is substantial evidence to support the benefit of telepsychology services in settings such as mental health. A systematic review of videoconferencing in psychotherapy found that clinicians generally had high satisfaction with the method and used it for various therapeutic formats with diverse populations (Backhaus et al. 2012). A subsequent meta-analysis described telepsychology as effective in achieving various clinical outcomes, including reducing unnecessary hospitalisations and improving symptoms and functioning (Hilty et al. 2013). The meta-analysis also provided evidence for telepsychology's effectiveness in diagnosing across

age groups, ethnicities, and settings, and its similarity to in-person care and assessment in terms of outcomes.

The use of telepsychology in forensic psychology was not well-known until recently. A survey found that approximately 35% of forensic evaluators used videoconferencing for psycho-legal evaluations, mainly assessing violence risk and adjudicative competencies (Batastini et al. 2020). The benefits included reduced court costs and shorter wait times for evaluates, but concerns were related to assessment challenges and technical difficulties. Forensic practitioners' perceptions of telepsychology varied, with some recognising its potential benefits, while others had concerns about technical issues and rapport building (Benhard et al. 2021).

Further, grey literature by Vlais and Campbell (2020) highlighted that there is limited evidence into the effectiveness of telepsychology services for family violence intervention. They identified a single paper published by NTV (NTV; 2018) which argued that while online platforms could potentially enhance men's future participation in in-person MBCPs (i.e. serve as a motivational tool), they should not replace in-person sessions. Regarding MBCPs delivered via videoconferencing, NTV concluded that they may have limitations due to potential technical requirements, safety concerns in cases of perpetrators living with their victim-survivors, and effectiveness issues related to group dynamics, lack of face-to-face interaction, and disclosure of violent behaviour in a virtual context. Evaluations in the effectiveness of online and telephone interventions for family violence perpetrators is lacking.

The therapeutic relationship

Despite the lack in review in the context of family violence, it is worth considering the importance of the therapeutic relationship in perpetrator interventions. Many psychotherapy models emphasise the importance of the therapeutic alliance; the collaborative and trusting relationship between a therapist and their client (Johnson and Wright 2002). It is a crucial aspect of psychotherapy and counselling, as it significantly influences the effectiveness of the therapeutic process. Lambert and Barley (2001) emphasise the significance of the therapist-client relationship in achieving successful therapy and facilitating behavioural or mindset changes in clients. They highlight the importance of factors like rapport building, trust, empathy and understanding, positive bond and agreement on goals.

There is a dynamic interaction between verbal and non-verbal cues in the therapeutic alliance (Guzman et al. 2014). In traditional face-to-face therapy, non-verbal cues, such as facial expressions, body language, and tone of voice, play a crucial role in conveying emotions, understanding clients' feelings, and establishing rapport. These cues help therapists gauge the client's level of comfort, engagement, and emotional state, allowing for more nuanced and empathetic responses (Guzman et al. 2014). In telephone and online support, the lack of non-verbal cues can make it difficult for therapists to fully grasp the client's emotional experiences and may hinder the development of a strong therapeutic alliance. It may be challenging to interpret subtle emotional cues, leading to potential misunderstandings or misinterpretations during sessions (Mehta et al. 2020). This would appear more frequently in telephone support given online support mostly allows for the observation of a person's presentation. Despite these challenges, therapists can employ various strategies to strengthen the therapeutic alliance during telephone and online support including reflecting back verbal information.

Aboriginal and Torres Strait Islander and CALD people

When considering Aboriginal and Torres Strait Islander people, there has been minimal exploration of their use of telephone and online services, particularly in the scope of family and

domestic violence. In the context of mental health support for Aboriginal and Torres Strait Islander people, research highlights that Aboriginal and Torres Strait Islander people experience a disparity in accessing mental health services compared with their burden of disease (Garvey. 2008). Factors such as living in rural and remote areas, limited availability of appropriate services, cultural inappropriateness, and stigma surrounding treatment-seeking contribute to the challenges they face in accessing mental health support. Regarding treatment via online support, Povey et al. (2016) found that applying a culturally sensitive approach would need to consider the need to localise and adapt content for different regions, communities, and languages as an essential component of support. They suggest this could be achieved through consultative and collaborative approaches to ensure the content is relevant and effective for its target audience.

Similarly, Puszka et al.'s (2016) study identified that Aboriginal and Torres Strait Islander participants expressed significant concerns about the security of personal data stored in e-mental health tools. The potential risks stem from e-mental health tools recording sensitive information and facilitating rapid online transmission. Historical and ongoing government intervention in the lives of Aboriginal and Torres Strait Islander people and challenges in de-identifying client information in close-knit communities further exacerbate security concerns within this population group (Puszka et al. 2016). Although a focus on online support, these findings are predominately transferable to telephone support; Aboriginal and Torres Strait Islander people may fear the preservation of their privacy and similarly telephone support may need to be adapted to regions.

Scarce in research is the use of family violence telephone and online interventions for CALD individuals, particularly men. Research has highlighted that it is crucial to offer clear information in individuals' native languages about how and where they can access support (Murray et al. 2022). Findings from Murray et al. (2002) indicated that among a sample of websites for mental health support, none offered forums, web chat or email services in languages other than English. Only few with telephone counselling services provided information on accessing the national Translating and Interpreting Service; however, the instructions to access this service were available only in English. Further, Straiton et al. (2014) found that men from non–English speaking backgrounds, especially foreign-born men, were more likely to have unequal access to mental-health treatment based on their needs. As aforementioned, men are hesitant to seek help due to beliefs centred around masculinity, and foreign-born men are likely to face additional barriers, such as language difficulties. In considering the lack of non-verbal cues when communicating over the phone, CALD people may face added interference when accessing telephone support.

Conclusion

This review evaluates the effectiveness of alternative and/or additional interventions to MBCPs for perpetrators of family and domestic violence, including those interventions considered brief or 'low-dose'. It concludes that while brief interventions may not be sufficient on their own to address behaviour change, they play a vital role in enhancing treatment engagement and fostering accountability. Pre-intervention treatments, incorporating motivational techniques, have been found to improve engagement. Post-treatment interventions help sustain changes as well as supporting men to continue gaining a more profound and comprehensive understanding of their behaviour. Brief interventions can serve as crisis management and interrupt the act of family and domestic violence and provide referral pathways to additional support services. Accordingly, these interventions enhance the safety and wellbeing of victim-survivors. The flexibility of service delivery (e.g. telephone and online support) is likely to reach

a greater number of men who require intervention, including those who are awaiting MBCPs. It is noted that telephone and online support presents with some limitations; however, it is arguable that the benefits outweigh the limits. Brief interventions are therefore valuable in a network of behavioural interventions and should be considered when addressing the treatment needs of men who use family violence.

Appendix 5: Full data for figures

Listed below is the full data breakdown for each figure in the report.

Table 28: Full data for Figure 2: Readiness for change

Response	BIS	MRS	CFG
NET 7-10	**5%**	**2%**	**3%**
0 – I had not thought about change at all at that stage	5%	2%	3%
1 + 2 + 3	9%	9%	0%
4 + 5 + 6	20%	25%	10%
7 + 8 + 9	25%	23%	29%
10 – I realised I had a significant problem in my life and I had already started to make changes	38%	25%	52%
Other (please specify)	4%	16%	6%

Source: A7d. On a scale of 0 to 10, how ready were you to start to change, when you first had contact with the service?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 29: Full data for Figure 3: Right help at the right time

Response	BIS	MRS	CFG
It came at the right time	63%	54%	55%
It should have come earlier	27%	37%	42%
It should have come later	0%	3%	0%
It was the right time, but I needed a different service	2%	0%	3%
None of the above	9%	6%	0%

Source: A5. A4MRS. Which of the following best describes your interaction with the service?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=35; Changing for Good program, unweighted, n=31.

Table 30: Full data for Figure 4: Source of program awareness

Source heard about services	BIS	MRS	CFG
A court or magistrate	21%	34%	0%
The police or emergency services	18%	16%	3%
An advertisement online	2%	7%	29%
Online search	2%	5%	23%
Mensline	2%	0%	23%
My partner at the time	4%	7%	3%
Child protection / other family support	7%	2%	0%
A mental health professional	7%	0%	0%
An advertisement on social media	4%	2%	3%
A friend	2%	5%	3%
A family member	4%	2%	3%
From a correction officer	2%	7%	0%
Men's Referral Service	5%	2%	0%
From a MBCP clinic facilitator	4%	0%	3%
Orange Door	5%	0%	0%
Through an AOD service	4%	0%	0%
I saw a flyer	0%	2%	3%
Advertisement in person	0%	0%	3%
Lawyer	2%	0%	0%
Other	4%	5%	0%
Don't know	4%	5%	0%

Source: A7c. How did you first hear about the [PROGRAM]?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 31: Full data for Figure 5: Behaviours men sought assistance for when calling services

Behaviour	BIS	MRS	CFG
My verbal arguments with my partner and/or family	71%	59%	81%
My anger management issues	66%	43%	74%
My mental health	50%	30%	42%
My controlling behaviour of my partner and/or family	32%	16%	19%
My physically violent behaviour towards my partner and/or family	30%	32%	3%
My own entitlement	14%	14%	19%
My substance abuse	7%	9%	0%
Other	7%	14%	10%

Source: A18. What type of behaviours did you speak with the [PROGRAM] for? Please select all that apply
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 32: Full data for Figure 6: Self-reported issues for service users (total of 'big problem' + 'problem')

Behaviour	BIS	MRS	CFG
Relationships	59%	33%	61%
Mental health	54%	39%	52%
Communicating with people	39%	23%	32%
Housing	23%	20%	6%
Physical health	21%	23%	16%
Alcohol	18%	16%	6%
Employment	16%	25%	16%
Drugs	7%	18%	3%
Gambling	4%	7%	0%

Source: A12. Please indicate whether the problems below are a big problem for you or no problem for you. Please answer all of the questions and remember that there are no right or wrong answers.
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 33: Full data for Figure 7: Changes in behaviour/issues since making contact with the BIS

Behaviour change	Alcohol*	Mental health	Gambling*	Physical health*	Substance abuse	Housing*	Employment*
Total reduced (reduced + reduced a lot)	**100%**	**60%**	**50%**	**43%**	**27%**	**17%**	**0%**
Increased a lot	0%	0%	0%	0%	0%	0%	40%
Increased	0%	4%	0%	0%	0%	50%	40%
Stayed the same	0%	7%	50%	29%	5%	33%	20%
Reduced	33%	31%	50%	14%	15%	17%	0%
Reduced a lot	67%	29%	0%	29%	13%	0%	0%
Not applicable	0%	29%	0%	29%	67%	0%	0%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Brief Intervention Service
Base: Brief Intervention Service, unweighted, n=56.
Note: Low sample size, n ≤ 7.

Table 34: Full data for Figure 8: Changes in behaviour/issues since making contact with the MRS

Behaviour change	Alcohol*	Mental health	Employment*	Substance abuse	Physical health*	Housing*	Gambling
Total reduced (reduced + reduced a lot)	**67%**	**39%**	**33%**	**21%**	**0%**	**0%**	**-**
Increased a lot	0%	2%	0%	0%	0%	43%	-
Increased	0%	2%	0%	2%	50%	14%	-
Stayed the same	0%	17%	0%	7%	0%	14%	-
Reduced	0%	22%	33%	12%	0%	0%	-
Reduced a lot	67%	17%	0%	10%	0%	0%	-
Not applicable	33%	39%	67%	69%	50%	29%	-

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Men's Referral Service
Base: Men's Referral Service, unweighted, n=44.
Note: Low sample size, n ≤ 7.

Table 35: Full data for Figure 9: Changes in behaviour/issues since making contact with the CFG program

Behaviour change	Alcohol*	Mental health	Physical health*	Substance abuse	Housing*	Employment	Gambling
Total reduced (reduced + reduced a lot)	100%	68%	50%	19%	0%	-	-
Increased a lot	0%	10%	0%	81%	0%	-	-
Increased	0%	0%	0%	0%	0%	-	-
Stayed the same	0%	3%	0%	0%	100%	-	-
Reduced	0%	19%	50%	0%	0%	-	-
Reduced a lot	0%	42%	0%	16%	0%	-	-
Not applicable	100%	26%	50%	3%	0%	-	-

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Changing for Good program
Base: Changing for Good program, unweighted, n=31.
Note: Low sample size, n ≤ 2.

Table 36: Full data for Figure 10: Average monthly cases delivered by state compared with population statistics

State	BIS	MRS	CFG	State populations at 31 Dec '22
Victoria	61%	63%	39%	**26%**
New South Wales	21%	19%	22%	**31%**
Queensland	9%	5%	26%	**20%**
South Australia	3%	3%	5%	**7%**
Western Australia	3%	3%	3%	**11%**
Tasmania	3%	3%	2%	**2%**
Australian Capital Territory	0%	1%	-	**1%**
Northern Territory	0%	0%	1%	**1%**

Source: MRS#5 - Number of inbound Men's Referral Service calls/cases answered. Answering a call/case includes the delivery of a service or a reasonable and appropriate attempt to deliver a service.

Table 37: Full data for Figure 11: Percentage of Aboriginal and Torres Strait Islander cases – MRS and BIS

Months	BIS	MRS
Jul 2022	4%	5%
Aug 2022	4%	5%

Months	BIS	MRS
Sep 2022	5%	2%
Oct 2022	5%	2%
Nov 2022	4%	1%
Dec 2022	5%	2%
Jan 2023	5%	2%
Feb 2023	5%	3%
Mar 2023	8%	4%
Apr 2023	5%	4%
May 2023	7%	4%
Jun 2023	6%	5%

Source: MRS#15 Aboriginal and Torres Strait Islander – Number of cases overall by Aboriginal and Torres Strait Islander (%)

Table 38: Full data for Figure 12: Representation of CALD service users in each program

	CALD proportion
Australian CALD population	**23%**
BIS cases	24%
MRS cases	21%
CFG case	15%

Source: Program data MRS#13 CALD | Program data BIS#8 CALD | Program data CFG not born in Australia | Australian Bureau of Statistics (20 September 2022), Cultural diversity of Australia, ABS Website, accessed 29 September 2023.
*Note: CFG CALD data represents those born overseas which is a different definition than BIS, MRS, and the 'Australian CALD population proportions' which refer to the proportion of Australians who speak a language other than English (LOTE) at home.

Table 39: Full data for Figure 13: Rating of how services cater to the cultural and language needs of CALD service users

Response	All services
Total well (well + very well)	**59%**
Very Poor	4%
Poor	0%
Neither well nor poor	37%

Response	All services
Well	22%
Very well	37%

Source: A25 - How well did the service cater to your cultural / language needs as someone who speaks a language other than English at home?
Base: Speak a language other than English at home, unweighted, n=27.

Table 40: Full data for Figure 14: Location of MRS and BIS service users (program data)

Location	BIS	MRS	Australian remoteness figures
Major Cities of Australia	73%	72%	**72%**
Inner Regional Australia	22%	24%	**18%**
Outer Regional Australia	4%	3%	**8%**
Remote Australia	1%	1%	**1%**
Very Remote Australia	1%	1%	**1%**

Source: MRS#14 Region – number of cases overall by region | Source: BIS Number of clients overall by location

Table 41: Full data for Figure 15: Location of service users (survey data)

Location	BIS	MRS	CFG
Inner and Outer metropolitan/ Urban fringe	59%	80%	61%
Regional	23%	14%	29%
Rural/ Remote	13%	5%	10%
Prefer not to say	5%	2%	0%

Source: A31. Which of the following best describes where you live?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 42: Full data for Figure 16: Effectiveness of services combined: metro compared with regional, rural and remote

Response	Metro	Regional/ Rural/Remote
Total effective (effective + very effective)	**77%**	**80%**
Very ineffective	3%	3%
Ineffective	8%	3%
Neither	11%	15%

Response	Metro	Regional/Rural/Remote
Effective	40%	38%
Very effective	37%	43%

Source: A18a. And how effective was the service is addressing the reason you were contacting the service for?
Base: Metro, unweighted, n=87; regional, unweighted, n=40.

Table 43: Full data for Figure 17: Service effectiveness among users with disability or a chronic health condition

Response	BIS	MRS	CFG
Total effective (effective + very effective) – no disability or health condition	**84%**	**60%**	**88%**
Total effective (effective + very effective) – disability or health condition	**92%**	**78%**	**86%**
Very ineffective	0%	0%	0%
Ineffective	8%	11%	0%
Neither	0%	11%	14%
Effective	42%	56%	43%
Very effective	50%	22%	43%

Source: A18a. And how effective was the service is addressing the reason you were contacting the service for?. A32 - Are you a person living with disability or chronic health conditions?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 44: Full data for Figure 18: Referral pathway process

Pathway	All services
Referred onto other services	43%
Not referred or don't know	57%
Referred to multiple services	14%
Referred to one service	30%
Multiple or ongoing contacts	23%
Single or no contact	16%

Source: A13i. Have you been referred to other services? A14i. Which service(s) were you referred to? A15i. Have you been in contact with the service(s) you were referred to?
Base: A13i, n=44; A14i, A15i: n=19.

Table 45: Full data for Figure 19: Proportion of MRS service users referred to other service

Services referred to	MRS
A men's behaviour change program	74%
An alcohol and other drugs service	21%
A mental health service	5%
The Brief Intervention Service	5%
Another service	21%
Prefer not to say	5%

Source: A14i. Which service(s) were you referred to?
Base: Men's Referral Service, unweighted, referred to services, n=19.

Table 46: Full data for Figure 20: Engagement with MBCPs among BIS and CFG service users

MBCP engagement	BIS	CFG
Total started or completed a men's behaviour change program	**25%**	**32%**
I have not yet started a men's behaviour change program	27%	29%
I started but did not complete a men's behaviour change program	5%	3%
Currently completing a men's behaviour change program	9%	6%
I completed a men's behaviour change program	16%	26%
I have no intention of doing a men's behaviour change program	25%	29%
Don't know / not sure	18%	6%

Source: A13. Following your interactions with the [PROGRAM], which of the following apply to you?
Base: Brief Intervention Service, unweighted, n=56; Changing for Good program, unweighted, n=31.

Table 47: Full data for Figure 21: Reasons why service users do not intend to do an MBCP (open-ended coded responses)

Source heard about services	BIS	CFG
I feel well-equipped (tools/knowledge/etc.)	21%	78%
Addressing behaviours alternatively (councillor / other program)	21%	22%
It was not relevant for me as I never committed domestic violence	7%	22%
Its not necessary for me / issue isn't going to happen again	14%	11%
Program scheduling didn't suit my responsibilities - work/parenting	14%	0%
Can't be bothered	7%	0%
I am doing the program	7%	0%
I'm currently not in a relationship	7%	0%
I addressed concerning behaviours post program	0%	11%

Source heard about services	BIS	CFG
It fulfilled my court requirements	7%	0%
Will contact again if I am in need of further help	7%	0%
I didn't know I could do it	7%	0%
If I lapse back into bad behaviour I will do it	7%	0%
Other	14%	0%

Source: A16A - Why do you have no intention of doing a men's behaviour change program?
Base: Those with no intention to do a MBCP, unweighted, BIS n=14, unweighted, CFG n=9.

Table 48: Full data for Figure 22: Total reductions in behaviours or problem since first contact with service ('reduced a lot' + 'reduced')

Behaviour change	BIS	MRS	CFG
My physically violent behaviour towards my partner and/or family	47%	36%	23%
My verbal arguments with my partner and/or family	76%	55%	84%
My controlling behaviour of my partner and/or family	53%	33%	45%
My mental health	60%	39%	68%
My substance abuse	27%	21%	19%
My own entitlement	45%	32%	52%
My anger management issues	78%	48%	94%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 49: Full data for Figure 23: Service effectiveness in addressing their reason for contact

Response	BIS	MRS	CFG
Total effective (effective + very effective)	**86%**	**64%**	**87%**
Very ineffective	50%	18%	42%
Ineffective	36%	45%	45%
Neither	9%	16%	13%
Effective	4%	14%	0%
Very effective	2%	7%	0%

Source: A18a. And how effective was the service in addressing the reason you were contacting the service for?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 50: Full data for Figure 24: Relationship with partner or former partner

Response	BIS	MRS	CFG
NET Improved/improving	45%	23%	45%
NET Mixed	13%	9%	10%
Ok/fine	2%	2%	6%
NET Worse	5%	16%	10%
No contact / now separated	34%	44%	19%
Self-focused response	9%	5%	23%
Other	14%	16%	10%
None	0%	2%	0%

Source: A18b. In your own words, how have things been in the relationship with your partner/former partner lately (in the last month)?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=43; Changing for Good program, unweighted, n=31.

Table 51: Full data for Figure 25: Reason for engaging with the service

Client behaviour	BIS	MRS	CFG
clients benefit from the services you provide	79%	55%	88%
clients demonstrate meaningful behaviour change during the program	70%	45%	97%
your clients exactly fit the description of men using violence or who are at significant risk of using violence	92%	70%	78%
your clients are genuinely interested in changing their behaviour when they begin the program	58%	–	89%
your clients are genuinely interested in changing their behaviour when they finish the program	71%	–	89%
your clients are genuinely interested in changing their behaviour when they call the MRS	–	50%	–

Source: A11a. Please enter a percentage in response to the question below using a 0-100% scale.
Base: Frontline workers: Brief Intervention Service, unweighted, n=3; Men's Referral Service, unweighted, n=1; Changing for Good program, unweighted, n=3.

Table 52: Full data for Figure 26: Self-reported changes in behaviour among BIS service users

Behaviour change	Total reduced (reduced + reduced a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My anger management issues	**78%**	0%	0%	7%	33%	44%	15%
My verbal arguments with my partner and/or family	**76%**	0%	0%	5%	24%	53%	18%
My mental health	**60%**	0%	4%	7%	31%	29%	29%
My controlling behaviour of my partner and/or family	**53%**	0%	0%	4%	18%	35%	44%
My physically violent behaviour towards my partner and/or family	**47%**	0%	0%	0%	7%	40%	53%
My own entitlement	**45%**	0%	2%	7%	25%	20%	45%
My substance abuse	**27%**	0%	0%	5%	15%	13%	67%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Brief Intervention Service
Base: Brief Intervention Service, unweighted, n=56.

Table 53: Full data for Figure 27: Self-reported changes in behaviour among CFG service users

Behaviour change	Total reduced (reduced + reduced a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My anger management issues	**94%**	0%	0%	3%	52%	42%	3%
My verbal arguments with my partner and/or family	**84%**	0%	3%	3%	45%	39%	10%
My mental health	**68%**	0%	3%	19%	42%	26%	10%

Behaviour change	Total reduced (reduced + reduced a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My own entitlement	**52%**	0%	0%	6%	26%	26%	42%
My controlling behaviour of my partner and/or family	**45%**	0%	0%	0%	23%	23%	55%
My physically violent behaviour towards my partner and/or family	**23%**	0%	0%	0%	6%	16%	77%
My substance abuse	**19%**	0%	0%	0%	16%	3%	81%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Changing for Good program
Base: Changing for Good program, unweighted, n=31.

Table 54: Full data for Figure 28: Self-reported changes in behaviour among MRS service users

Behaviour change	Total reduced (reduced + reduced a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My verbal arguments with my partner and/or family	**55%**	2%	7%	7%	19%	36%	29%
My anger management issues	**48%**	2%	10%	10%	26%	21%	31%
My mental health	**39%**	2%	2%	17%	22%	17%	39%
My controlling behaviour of my partner and/or family	**36%**	2%	2%	0%	17%	19%	60%
My physically violent behaviour towards my partner and/or family	**33%**	0%	7%	5%	21%	12%	56%
My own entitlement	**32%**	0%	2%	7%	15%	17%	59%

Behaviour change	Total reduced (reduced + reduced a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My substance abuse	**21%**	0%	2%	7%	12%	10%	69%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed? – Men's Referral Service
Base: Men's Referral Service, unweighted, n=44.

Table 55: Full data for Figure 29: Summary of behaviour change across all service interventions

Behaviour change	Total increased (increased + increased a lot)	Increased a lot	Increased	Stayed the same	Reduced	Reduced a lot	Not applicable
My anger management issues	**4%**	1%	3%	7%	35%	36%	17%
My mental health	**4%**	1%	3%	13%	31%	24%	28%
My verbal arguments with my partner and/or family	**4%**	1%	3%	5%	27%	44%	20%
My controlling behaviour of my partner and/or family	**2%**	0%	2%	3%	20%	24%	50%
My own entitlement	**2%**	0%	2%	7%	22%	20%	49%
My physically violent behaviour towards my partner and/or family	**2%**	1%	1%	0%	10%	27%	61%
My substance abuse	**1%**	0%	1%	5%	14%	9%	71%

Source: A19. Have the behaviours you sought to address when you first had contact with the service changed?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 56: Full data for Figure 30: Proportion of clients interested in changing their behaviour (average %)

Client behaviour	BIS	MRS	CFG
What proportion of your clients are genuinely interested in changing their behaviour when they begin the program	58%	-	89%
What proportion of your clients are genuinely interested in changing their behaviour when they finish the program	71%	-	89%
What proportion of your clients are genuinely interested in changing their behaviour when they call the MRS	-	50%	-
What proportion of men deliberately use the service to achieve a better family court outcome, or better fool child protection or the police, without engaging in any behaviour change.	38%	50%	15%

Source: A11a. Please indicate the relative proportions for the questions below.
Base: Frontline workers: Brief Intervention Service, unweighted, n=6; Men's Referral Service, unweighted, n=3; Changing for Good program, unweighted, n=4.

Table 57: Full data for Figure 34: Period of service engagement

Period of time	BIS	MRS	CFG
One day only	2%	20%	0%
One week	9%	14%	0%
One fortnight	4%	7%	16%
One month	13%	25%	6%
2 - 3 months	54%	25%	71%
4 - 6 months	18%	2%	0%
More than 6 months	2%	7%	6%

Source: A3. Over what period of time did you speak with your counsellor from the [PROGRAM]?
Base: Brief Intervention Service, unweighted, n=56; Men's Referral Service, unweighted, n=44; Changing for Good program, unweighted, n=31.

Table 58: Full data for Figure 32: Effectiveness of services by amount of contact with services (BIS and CFG)

Response	1 to 2 times	3 to 6 times	7 to 12 times	More than 12 times
Total effective (effective + very effective)	**57%**	**86%**	**96%**	**80%**
Very ineffective	14%	0%	0%	0%
Ineffective	0%	4%	0%	0%

Response	1 to 2 times	3 to 6 times	7 to 12 times	More than 12 times
Neither	29%	10%	4%	20%
Effective	43%	48%	20%	40%
Very effective	14%	38%	76%	40%

Source: A2. And how many times have you spoken with a counsellor from the [PROGRAM]? A18a. And how effective was the service is addressing the reason you were contacting the service for?
Base: Brief Intervention Service, unweighted, n=56; Changing for Good program, unweighted, n=31.

Table 59: Full data for Figure 33: Approximate proportions of time dedicated to activities

Activities	BIS	MRS	CFG
Training	54%	60%	66%
Administration	8%	15%	8%
Providing information / referrals to clients	30%	17%	23%
Counselling clients	8%	8%	4%

Source: A11AA. approximate proportions of time that you dedicate to the following activities?
Base: Frontline workers: Brief Intervention Service, unweighted, n=6; Men's Referral Service, unweighted, n=3; Changing for Good program, unweighted, n=4.

Program logics

Program Logic – Changing for Good program

Program need

Almost 2.2 million Australian adults have been victims of physical and/or sexual violence from a partner since the age of 15, with women nearly three times more likely to have experienced partner violence than men (Australian Bureau of Statistics, 2016). The most significant underlying driver of family violence is gender inequality between men and women (Our Watch, 2015). To achieve change in violent attitudes and beliefs, interventions are required that make men accountable and responsible for their actions, enhance women and children's safety and monitor men's use of coercive control, abuse and violence as well as the risk they pose to partners/ex-partners and children (Day et al, 2019; Kelly & Westmarland, 2015).

Program objectives

Changing for Good (CFG) aims to reduce the prevalence and impact of violence in our community through increasing men's emotional literacy, improving their emotional regulation and coping skills, and helping them to positively contribute to family life and the community.

1. **Inputs:**

- People

  - Specialist counsellor training in:

    o FDSV

- o Working with vulnerable groups
- o Cultural sensitivity
- o Change neuroscience
  - Specialist counsellor experience in working with men who choose to use violence
  - Specialist marketing and communication practitioners with experience in social marketing, outreach and engagement
  - Dedicated counsellors to deliver this service
- Frameworks and policies
  - Quality Management Framework which includes:
  - o Clinical Governance Framework
  - o Counselling Framework
  - o Health Information Policy
  - o Data Governance Framework
  - o Code of Conduct
  - o Risk Management Framework
  - o Client's Rights and Responsibilities

2. **Activities:**

1. Service entry
   - 24/7 self referral via CFG page on MensLine website.
   - Recommendations from family violence support services, police and MBCPs via inbound referral form
   - MensLine referral

2. Intake, Assessment and Planning
   - Intake and Assessment Officers conduct intake and initial IOMI
   - If eligible, the Officer will make appointments for the client for the relevant program.
   - If the Officer identifies imminent or immediate risk of suicide, client will be transferred to a counsellor for immediate support, safety planning and escalate to emergency services if needed. The client will be referred back to the Intake Officer once safety is confirmed

3. Counselling and support
   - Violence Prevention program
     - Eligibility: Men who haven't perpetrated physical acts of family violence but have concerns about their feelings, attitudes, and behaviours; are at risk of perpetrating family violence; have a significant relationship problem.
     - Structure: Fortnightly, 40-minute sessions
     - Timeframe: 2 months (4 sessions) and a postvention session
   - Post-Men's Behaviour Change program

- Eligibility: Men who are not currently using physical violence and have completed a MBCP in the last 12 months.

- Structure: Fortnightly, 40-minute sessions

- Timeframe: 6 months (12 sessions) and a postvention session

    - Both programs are tailored depending on the issues presented by the client and the outcomes they have agreed to work towards

    - Topics covered include developing healthy relationships, improving communication, problem solving and dealing with conflict, emotional regulation and self-awareness, personal growth and change

4. Referrals

    - Link clients with family violence support services, community support services, psychological support services as appropriate

5. Case notes

    - Document accurate case notes

7. Evaluation and outcomes

    - Follow-up after 6 weeks after the completion of the program for post intervention. Client may re-engage for further support

8. Marketing

    - Targeted marketing campaigns including:

        - Website updates, including evidence informed psycho-educational information

        - Campaign-based landing pages

        - Awareness raising, promotional and communication campaigns

- Target outreach to family violence support services, police and MBCP organisations, coordinators, and service delivery staff

3. Outputs:

- Number of self-referrals

- Number of recommendations from family violence support services, police, MBCPs and their providers

- Number of intake and assessment sessions conducted

- Number of structured counselling sessions delivered over either:

    - 2 months (4 sessions), or

    - 6 months (12 sessions)

- Number of referrals made to other support providers

- Total interactions by category – e.g., total clients entering, waitlisted, completed, did not complete

- Comparison of IOMI assessment completed at intake and last sessions

- Number of postvention follow up sessions delivered

- Number of Client Experience Surveys completed

- Number of out of hour crisis support sessions provided for participants via MensLine

- Examples of promotion and outreach collateral developed, and campaigns delivered

- Number of family violence support services, police, MBCPs and other providers engaged with

- Program reports delivered as agreed with DSS

4. Short-term Outcomes:

- Men who participate in the Violence Prevention Program do not resort to using violence

- Men report changes in violence supporting narratives and thinking

- Empathetic client management helps clients to emotionally regulate

- Callers understand independent self-management of stressors/triggers, distress and anger to keep themselves and others safe

- Clients feel connected to ongoing follow-up support and stable at follow-up

- Increased awareness and uptake of CFG counselling service

- Improved understanding of cohort's mental and behavioural problems

5. Medium-term Outcomes:

- Meaningful behaviour change motivated by focusing on the humanistic perspective unconditional positive regard and meaningful relating

- Client strengthens relationship with family based on respect and effective communication, ensuring partner and children's health

- Client improves awareness of self and others, communication, thinking and social skills

- Reduced use of violence, coercive control, abuse and harassment

6. Program Impacts:

- Men choose not to use violence in their relationships

- Men improve coping skills and positively contribute to families and the community

- Reduced impact of violence in our community

- Increased client choice and opportunity to live a meaningful, satisfying and purposeful violence-free life

- Community members feel safe from experiencing violence

Theory of change statement

Changing for Good helps men who are concerned they will use violence or who have recently completed a Men's Behaviour Change Program to continue to strengthen all relationships in their lives – intimate relationships, family, parenting, friendships or work colleagues.

Men who are worried their thoughts and behaviours will lead to violence will learn the tools to be proactive in developing respectful and healthy relationships.

Men who've completed a Men's Behaviour Change Program will learn to consolidate and maintain the strategies they learned.

Counselling sessions will focus on what the client wants to achieve, and progress will be measured along the way. Under the umbrella of the MARAM framework (Victorian Government),

WHERE TO

the sessions will use the principles of the Duluth model (Pence et al, 1993), dissonance theory and health coaching.

Our Intermediate Outcomes Measurement Instrument (IOMI) uses outcome measures developed in the UK (Ministry of Justice, UK, 2019) which is designed to measure change in relationship to seven dimensions across 21 questions.

Our intake and assessment process will respond to individual needs, our referral system will help clients access other services as needed, and our 24/7 MensLine service will provide immediate crisis support.

Program Logic – Men's Referral Service

Program need

Family violence and/or controlling behaviour affects all communities in Australia. A strong and responsive service system needs to address increasing demand, and support service providers who are skilled in working effectively with diverse communities and individuals.

Program objectives

To provide a national specialist referral service for individuals who use violent and/or controlling behaviour to manage anticipated increases in demand and to support. To provide an opportunity for interruption, to provide information support and options for future engagement.

Program goal

The person using violence becomes aware there is a more responsible choice and options available to them to take steps towards stopping violence and/or controlling behaviours. They are able to increase their awareness of services available to support better choices and are provided with tools and information to take next steps.

Participants

- Individuals who use or are at risk of using violent and/or controlling behaviour

- Individuals who are directly impacted by violent and/or controlling behaviour

- Friends, family or colleagues of individuals who may be using or impacted by violent and/or controlling behaviour

-

  1. **Inputs:**

- Department

  - Funding

  - Policy

  - Grant Administration

  - Performance Measurement

- Service Provider – No to Violence

  - Men's Referral Service (MRS)

  2. **Activities:**

- Counselling services

- Referrals to appropriate services according to individual requirements
- Provision of information and advice

3. Outputs:

- A national telephone and online counselling and referral service for individuals who use violent and/or controlling behaviour
- Support for individuals who may be impacted by someone using violent and/or controlling behaviour
- Individuals are supported to begin the process of behaviour change

4. Short-term outcomes (immediate: 0-12 months):

- Individuals have an improved understanding of self-management of behaviours
- Individuals are supported to begin the process of behaviour change
- Individuals are referred into services that may help them further (including BIS)
- Individuals have greater awareness of behaviours that constitute DFV
- Individuals recognise that they are able to get help to support their behaviour change
- There is increased awareness of support and services available

5. Medium-term outcomes (intermediate: 12 months – 2 years):

- Individuals recognise that they are able to change their behaviour
- Individuals recognise their own responsibility and agency in the use of violent and/or controlling behaviours
- Individuals engage with services that will help them adjust behaviours

6. Program impacts (long-term outcomes: 2 years +):

- Individuals decrease or stop using violent and/ or controlling behaviour
- Stronger families and more resilient communities

External factors

- National Plan to End Violence Against Women and Children 2022-2032
  - and the First Action Plan
- Availability of MBCPs and other programs like MensLine Changing for Good, programs in different states and territories
- Media raising awareness of 1800 RESPECT and NTV
- Implementation Partners and Key Stakeholders:
- Department of Social Services (Funded and managed by); No to Violence (Delivered by)

Assumptions

- The program is underpinned by the understanding that only the individual who uses violence and/or controlling behaviour can put an end to it. However, all family members can make choices about their relationships

- We assume that individuals will have a range of different issues they are dealing with (of which violence is one), therefore we offer referrals to other services e.g. AOD services – competing or compounding issues – that they are needed in addition

- Providing information and referrals and the counselling that is provided that encourage some men to recognise their behaviour and make different choices

- That diverse groups of men will equally be able to access the program

- That a telephone or online chat service is accessible to all men / that all men are willing engage via this service

- That once the phone call / webchat is over, that the man continues to engage / that all men can take up a referral – they are emotionally and practically equipped (e.g. access / timing / availability / location etc)

- That we can deal with the behaviour of the individual using violence without including their partners / family

- We assume the man who is calling us is making a choice to change.

- Some men who use violence may be victim survivors themselves and may need therapeutic / healing support as well as support to change violent behaviours

Potential unintended outcomes (positive and negative)

- Engaging with services can be a high-risk time for individuals who experience violence and/or controlling behaviour

- Participants have 'ticked the boxes' enough to continue perpetration without changing behaviours / used the program to manipulate the system

- Participants may have been able to get help on underlying AOD or MH issue, but not been able to change violent behaviours

Program Logic – Brief Intervention Service

Program need

Family violence and/or controlling behaviour affects all communities in Australia. A strong and responsive service system needs to address increasing demand, and support service providers who are skilled in working effectively with diverse communities and individuals.

Program objectives

To provide a national specialist referral and counselling service for individuals who use violent and/or controlling behaviour to support and strengthen the service system for individuals who use violent and/or controlling behaviour. To 'keep the man in view' while they wait to engage with a MBCP, preparing them for and supporting individuals into MBCPs. Providing some behaviour change support to those in regional rural and remote areas in the absence of available MBCPs.

Program goal

Individuals acknowledge and / or stop their violent and/or controlling behaviour and take accountability for their actions.

- Participants have 'ticked the boxes' enough to continue perpetration without changing behaviours / used the program to manipulate the system

Participants

- Individuals who use or are at risk of using violent and/or controlling behaviour.

   1. **Inputs:**

- Department
   - Funding
   - Policy
   - Grant Administration
   - Performance Measurement

- Service Provider- No to Violence
   - Men's Referral Service (MRS)

   2. **Activities:**

- Counselling services
- Referrals to appropriate services according to individual requirements
- Provision of information and advice

   3. **Outputs:**

- A national telephone counselling and referral service for individuals who use violent and/or controlling behaviour
   - including 6-10 x 25–40-minute sessions with individuals
   - Guided by practice handbook and the 5 essentials
- Collection of administrative data performance management data

   4. **Short-term outcomes (immediate: 0–12 months):**

- Individuals have an improved understanding of self-management of behaviours
- Individuals are supported and engaged whilst they await longer term behaviour change programs
- There is increased awareness of support and services available
- Removing barriers to engagement with MBCPs
- Changed knowledge and understanding
- Improved access to other services

   5. **Medium-term outcomes (intermediate: 12 months – 2 years):**

- Improved individual function, emotion regulation
- Improved family functioning, interpersonal relationships
- Individuals are supported and engaged whilst they await longer term behaviour change programs
- Changed knowledge and understanding
- Improved access to other services

   6. **Program impacts (long-term outcomes: 2 years +):**

- Individuals decrease or stop using violent and/ or controlling behaviour

- Stronger families and more resilient communities

- Improved community functioning

External factors

- National Plan to End Violence Against Women and Children 2022-2032

    - and the First Action Plan

- Availability of MBCPs and other programs like MensLine Changing for Good, programs in different states and territories.

- Media raising awareness of 1800 RESPECT and NTV

Implementation Partners and Key Stakeholders

- Department of Social Services (Funded and managed by); No to Violence (Delivered by).

- State and territory governments (victim counselling services per state)

- MBCPs

- Mental health and AOD services

- DFSV Sector who support behaviour change and victim survivors

- Courts – magistrates and principal registrars

- MACS – Men's accommodation and counselling services & other accommodation providers

Assumptions

- The program is underpinned by the understanding that only the individual who uses violence and/or controlling behaviour can change to end the violence and control. However, all family members can make choices about their relationships.

- We assume that individuals will have a range of different issues they are dealing with (of which violence is one), therefore we offer referrals to other services e.g., AOD services – competing or compounding issues – that they are needed in addition

- Providing information and referrals and the counselling that is provided that encourage some men to recognise their behaviour and make different choices

- That diverse groups of men will equally be able to access the program

- That a telephone service is accessible to all men / that all men are willing engage via this service

- That we can deal with the behaviour of the individual using violence without including their partners / family

- We assume the man who is calling us is making a choice to change (may be forced to by system / want to manipulate courts / want to vent / want to change partners' behaviours

- Some men who use violence may be victim survivors themselves, and may need therapeutic / healing support as well as support to change violent behaviours (not consciously built into the program – but something we do need to be more mindful of it)

- We assume that the man is willing to change, and that his motivation for change is stable

- That men will be able to access a MBCP

Potential unintended outcomes (positive and negative)

- Engaging with services can be a high-risk time for individuals who experience violence and/or controlling behaviour.

- Some men may use the service to manipulate the court system (e.g., custody)

- Men feel they have enough (they are 'fixed' by the end of the service, and don't continue engagement with MBCPs / don't need a longer-term program.

Journey maps

Overview of the journey

1 Crisis event

Doing:

- Use of violence

- Argument

- Police attend

- Family violence safety notice/IVO/AVO issued

- Removal from property

Feeling:

- Intense anger and/or frustration at partner and situation.

Thinking:

- Dangerous thinking, victim blaming, etc. E.g.

  - 'My partner is being ridiculous.'

  - 'She's the violent/abusive one.'

  - 'Why don't they see my side of the story?'

Emotional State:

- Angry

2 Aftermath

Doing:

- Seeking accommodation

- Reaching out for support

- Reflecting on event

Feeling:

- Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.

Thinking:

- Reflecting on the crisis event

- How did it get to that point?

- What do I do now?

- How do I get my life/wife/children/house back?

Emotional state:

- Concerned

Divergence point:

- Intervention orders preventing access to family and home results in different drivers and attitudes to participation

3 Awareness of program

Doing:

- Recommended a service/program by a friend, acquaintance, corrections, Police or Magistrate.
- Google searched for a MBCP.

Feeling:

- Desperate for a path forward (unless court ordered)

Thinking:

- I have no direction and no alternatives.
- Something has to change

Divergence point:

- Court order vs self-initiated will change readiness to change and drivers to participate

Key moment that matters:

- Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house

4 Consideration

Doing:

- Assessing the pros and cons.
- Building up the courage to reach out

Feeling:

- Rollercoaster of hopeful and optimistic to shameful embarrassed and sceptical

Thinking:

- Maybe I can be a better man
- Will this even work? Can I change?
- I don't want to be judged
- Is this really for guys like me?

Emotional state:

- Concerned

Divergence point:

- Court order vs self-initiated will change readiness to change and drivers to participate

5 First contact

Doing:

- Overcoming fear
- Calling the service
- Going through assessment
- Sharing their story

Feeling:

- Apprehension about effectiveness, fear about being judged but generally positive about taking the step

Thinking:

- Are they going to judged me?
- How is this going to work?

Emotional state:

- Anxious

Key moments that matter:

- Feeling they are in the right place and without being judged.

6 First session

Doing:

- Sharing their story
- Building an understanding of how sessions work
- Getting a read on the counsellor

Feeling:

- Comforted and safe by counsellor's support and manner

Thinking:

- Open & receptive to advice.
- This is great that someone will listen to me

Emotional state:

- Happy

Divergence point:

- Feeling too challenged and risking drop out

Key moments that matter:

- Feeling comfortable, safe and free of judgement to share their story

7 Subsequent sessions

Doing:

- Developing an understanding of emotions
- Learning strategies and tips for managing anger
- Developing ability to use words to express complex feelings
- Bringing these lessons into their lives

Feeling:

- Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events

Thinking:

- This is great, someone is listening to me
- I'm learning what I need to learn to handle my outbursts

8 Final session

Doing:

- Revisiting lessons and progress
- Receiving recommendations and referrals for additional services
- Take home worksheets

Feeling:

- Confidence that progress has been made

Thinking:

- I've made a lot of progress.
- I have tips and strategies now to handle my emotions

Emotional state:

- Very happy

Divergence point:

- Feeling that sufficient behaviour change has occurred

9 Week after

Doing:

- Trying to remember strategies for controlling emotions
- Implementing learnings into daily life and relationships.

Feeling:

- Feel alone again and unsupported. Doubting that the program was long enough.

Thinking:

- I'm alone again
- I can't trust that I can remember everything they taught me
- That ended abruptly – there is still much more to learn.

10 6-12 months

Doing:

- Looking for additional counselling services
- Maintaining a healthy, stable life – work, home, relationships

Feeling:

- General sense of assuredness that they are better than they used to be

Thinking:

- It's a long process, one step at a time
- I am better at controlling my anger/emotions
- More sessions would have been good.
- This is still something I am learning about.

Emotional state:

- Very happy or unhappy

Overview of the BIS journey

1 Crisis event

Doing:

- Use of violence
- Argument
- Police attend
- Family violence safety notice/IVO/AVO issued
- Removal from property

Feeling:

- Intense anger and/or frustration at partner and situation.

Thinking:

- Dangerous thinking, victim blaming, etc. E.g.
    - 'My partner is being ridiculous.'
    - 'She's the violent/abusive one.'
    - 'Why don't they see my side of the story?'

Emotional state:

- Angry

2 Aftermath

Doing:

- Seeking accommodation
- Reaching out for support
- Reflecting on event

Feeling:

- Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.

Thinking:

- Reflecting on the crisis event
- How did it get to that point?
- What do I do now?
- How do I get my life/wife/children/house back?

Emotional state:

- Concerned

3   Awareness of program

Doing:

- Recommended about the MRS by a friend, acquaintance, corrections, Police or Magistrate.
- Google searched for a MBCP.

Feeling:

- Desperate for a path forward (unless court ordered)

Thinking:

- I have no direction and no alternatives.
- Something has to change

Divergence point:

- Intervention orders preventing access to family and home results in different drivers and attitudes to participation

4   Consideration

Doing:

- Assessing the pros and cons.
- Building up the courage to reach out

Feeling:

- Rollercoaster of hopeful and optimistic to shameful embarrassed and sceptical

Thinking:

- Maybe I can be a better man
- Will this even work? Can I change?
- I don't want to be judged

- Is this really for guys like me?

Emotional state:

- Concerned

Key moment that matters:

- Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house

5 First contact

Doing:

- Overcoming fear
- Calling the service
- Going through assessment
- Sharing their story

Feeling:

- Apprehension about effectiveness, fear about being judged but generally positive about taking the step

Thinking:

- Are they going to judge me?
- How is this going to work?

Emotional state:

- Anxious

Divergence point:

- Court order vs self-initiated will change readiness to change and drivers to participate

6 Waiting for a program

Doing:

- Hoping the program will work
- Trying to piece life together for sense of normality (i.e. new routine, new living arrangements)

Feeling:

- Losing a bit of drive and motivation. Frustrated by wait times

Thinking:

- I need this program to start so I can move forward

Divergence point:

- Long waits for program placement can reduce motivation.

Key moment that matters:

- Feeling they are in the right place and without being judged.

7 First session

Doing:

- Sharing their story
- Building an understanding of how sessions work
- Getting a read on the counsellor

Feeling:

- Comforted and safe by counsellors' empathy and manner

Thinking:

- Open & receptive to advice.
- This is great that someone will listen to me

Emotional state:

- Happy

Divergence point:

- Feeling too challenged and risking drop out

Key moment that matters:

- Feeling comfortable, safe and free of judgement to share their story

8 Subsequent sessions

Doing:

- Developing an understanding of emotions
- Learning strategies and tips for managing anger
- Developing ability to use words to express complex feelings
- Bringing these lessons into their lives

Feeling:

- Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events

Thinking:

- This is great, someone is listening to me
- I'm learning what I need to learn to handle my outbursts

9 Final session

Doing:

- Revisiting lessons and progress
- Receiving recommendations and referrals for additional services
- Take home worksheets

Feeling:

- Confidence that progress has been made

Thinking:

- I've made a lot of progress.
- I have tips and strategies now to handle my emotions

Emotional state:

- Very happy
- Confidence that progress has been made

10 Week after

Doing:

- Trying to remember strategies for controlling emotions
- Implementing learnings into daily life and relationships

Feeling:

- Apprehensive about being alone and regressing, but sense of assurance awaiting future program

Thinking

- I'm alone again
- I can't trust that I can remember everything they taught me
- I'm looking forward to additional programs

Emotional state:

- Anxious

Divergence point:

- Those not going on to a MBCP are more likely to feel isolated, alone and nervous about repeat behaviour

11 6–12 months

Doing:

- Awaiting or participating in additional counselling
- Maintaining a healthy, stable life – work, home, relationships

Feeling:

- General sense of assuredness that they are better than they used to be. Confidence to step into continual programs

Thinking:

- It's a long process, one step at a time
- I am better at controlling my anger/emotions
- I'm feeling ready and excited for the next program
- This is still something I am learning about

Emotional state:

- Very happy or anxious

Overview of the MRS journey

1 Crisis event

Doing:

- Use of violence

- Argument

- Police attend

- Family violence safety notice/IVO/AVO issued

- Removal from property

Feeling:

- Intense anger and/or frustration at partner and situation.

Thinking:

- Dangerous thinking, victim blaming, etc. E.g.

- 'My partner is being ridiculous.'

- 'She's the violent/abusive one.'

- 'Why don't they see my side of the story?'

Emotional state:

- Angry

2 Aftermath

Doing:

- Seeking accommodation

- Reaching out for support

- Reflecting on event

Feeling:

- Fearful of the loss of family and home. Isolation from network and support. Confused and directionless. Vulnerable.

Thinking:

- Reflecting on the crisis event

- How did it get to that point?

- What do I do now?

- How do I get my life/wife/children/house back?

Emotional state:

- Concerned

Divergence point:

- Intervention orders preventing access to family and home results in different drivers and attitudes to participation

3 Awareness of program

Doing:

- Recommended a MRS by a friend, acquaintance, corrections, Police or Magistrate.

- Google searched for a MBCP.

Feeling:

- Desperate for a path forward.

Thinking:

- I have no direction and no alternatives.

- Something has to change

Emotional state:

- Unhappy

Key moment that matters:

- Hearing about the program at the right time and by the right source i.e. trusted friend or police upon losing house

4   Consideration

Doing:

- Assessing the pros and cons.

- Building up the courage to reach out

Feeling:

- Rollercoaster of hopeful and optimistic to shameful embarrassed and sceptical

Thinking:

- Maybe I can be a better man

- Will this even work? Can I change?

- I don't want to be judged

- Is this really for guys like me?

Emotional state:

- Hopeful then concerned

Divergence point:

- Court order vs self-initiated will change readiness to change and drivers to participate

5   First contact

Doing:

- Receives call or makes call

- Overcoming fear

- Calling the service

- Going through assessment

- Sharing their story

- Referral to other services

Feeling:

- Apprehension about effectiveness, fear about being judged but generally positive about taking the step

Thinking:

- Are they going to judge me?
- How is this going to work?
- I'm open to advice

Emotional state:

- Anxious

Key moment that matters:

- Feeling they are in the right place and without being judged.

6 Referred to other services

Doing:

- Weighing up path forward (i.e. psychologist, other men's behaviour change programs)

Feeling:

- Slight sense of assurance that they are in the system, have options and some sense of control

Thinking:

- Hoping for a call
- What services do I need?

Emotional state:

- Happy

7 Call backs

Doing:

- Monitoring emotional state
- When noticing a regression, calling the MRS as a safety net for an outlet or for advice

Feeling:

- Concern around regressing, but feeling supported by MRS being a phone call away

Thinking:

- I can use the MRS as a safety net if I ever slip up
- I have a free resource that will listen to me
- I can make progress in a non-linear way.

Emotional state:

- Anxious then happy

Overview of the CFG VPP journey

1 Crisis event

Doing:

- Frustration and anger increasing to a tipping point
- Argument with partner
- Reaching the brink of physical violence.

Feeling:

- Intense anger and/or frustration at partner and situation.

Thinking:

- My partner is being ridiculous
- Why don't they see my side of the story?

Emotional state:

- Angry

2 Aftermath

Doing:

- Partner breaking through that something has to change.
- Reflecting on the crisis event and recent mood
- Ruminating on past trauma

Feeling:

- Fearful of the loss of family and home. Disappointed and regretful.

Thinking:

- How did it get to that point?
- What do I do now?
- I don't want to scare my partner
- I don't want to be this angry anymore

Emotional state:

- Concerned

3 Awareness of program

Doing:

- Calls MensLine Australia
- Has been recommended a service/program by a friend, acquaintance or partner.
- Has google searched for a men's behaviour change program.

Feeling:

- Ashamed and nervous about the initial interaction and having to discuss relationship troubles/ violence.

Thinking:

- Something has to change

- Looking for paths forward

Key moment that matters:

- Knowing there is a program specifically catered for men who have not committed physical violence is highly encouraging

4   Consideration

Doing:

- Assessing the pros and cons.

- Building up the courage to reach out

Feeling:

- Rollercoaster of hopeful and optimistic to shameful embarrassed and sceptical

Thinking:

- Maybe I can be a better man

- Will this even work? Can I change?

- I don't want to be judged

- Is this really for guys like me?

Emotional state:

- Concerned

5   First contact

Doing:

- Overcoming fear

- Calling the service

- Going through assessment

- Sharing their story

Feeling:

- Apprehension about effectiveness, fear about being judged but generally positive about taking the step

Thinking:

- Are they going to judge me?

- How is this going to work?

Emotional state:

- Anxious

Key moment that matters:

- Feeling they are in the right place and without being judged.

6   First session

Doing:

- Sharing their story
- Building an understanding of how sessions work
- Getting a read on the counsellor

Feeling:

- Comforted and safe by counsellor's support and manner

Thinking:

- Open and receptive to advise.
- This is great that someone will listen to me

Emotional state:

- Happy

Divergence point:

- Feeling too challenged and risking drop out

Key moment that matters:

- Feeling comfortable, safe and free of judgement to share their story

7   Subsequent sessions

Doing:

- Developing an understanding of emotions
- Learning strategies and tips for managing anger
- Developing ability to use words to express complex feelings
- Bringing these lessons into their lives

Feeling:

- Empowered and optimistic about controlling their feelings and actions. Difficulty admitting fault and reliving past events

Thinking:

- This is great, someone is listening to me
- I'm learning what I need to learn to handle my outbursts

8   Final session

Doing:

- Revisiting lessons and progress
- Receiving recommendations and referrals for additional services
- Take home worksheets

Feeling:

- Confident that progress has been made

Thinking:

- I've made a lot of progress.
- I have tips and strategies now to handle my emotions

Emotional state:

- Very happy

9 Week after

Doing:

- Trying to remember strategies for controlling emotions
- Implementing learnings into daily life and relationships.

Feeling:

- Feel alone again and unsupported. Doubting that the program was long enough.

Thinking:

- I'm alone again
- I can't trust that I can remember everything they taught me
- That ended abruptly – there is still much more to learn.

Emotional state:

- Concerned

10 6-12 months

Doing:

- Looking for additional counselling services
- Maintaining a healthy, stable life – work, home, relationships

Feeling:

- General sense of assuredness that they are better than they used to be

Thinking:

- It's a long process, one step at a time
- I am better at controlling my anger/emotions
- More sessions would have been good.
- This is still something I am learning about.

Emotional state:

- Very happy

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