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GENDER AND
FAMILY VIOLENCE
PREVENTION CENTRE

Evaluation of the Taskforce Early Intervention for Family Violence Program (U-Turn)

Final Report

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Abbreviations and Acronyms

AOD	Alcohol and Other Drugs
AFM	Affected Family Member
AUDIT	Alcohol Use Disorders Identification Test
BIP	Batterer Intervention Programs
CJS	Criminal Justice System
DUDIT	Drug Use Disorders Identification Test
DV	Domestic Violence
DFV	Domestic and Family Violence
FSC	Family Safety Contact
FV	Family Violence
FVIO	Family Violence Intervention Order
IPV	Intimate Partner Violence
K10	Levels of Psychological Distress (Kessler-10 Scale)
MARAM	Family Violence Multi-Agency Risk Assessment and Management Framework
MBCP	Men's Behaviour Change Program
MGFVPC	Monash Gender and Family Violence Prevention Centre
PRS	Personal Responsibility Scale
RCFV	Royal Commission into Family Violence

Data Waves and Collection Timepoints

Wave	Timepoint
Wave 1	U-Turn participant and AFM data at U-Turn commencement
Wave 2	U-Turn participant and AFM data at U-Turn conclusion
Wave 3	U-Turn participant and AFM data six-month post U-Turn conclusion
Wave 4	U-Turn participant and AFM data 14-month post U-Turn conclusion

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Acknowledgement of Country

We acknowledge the Traditional Owners of the lands on which we meet and conduct our research, and recognise that these lands have always been places of learning. We pay respect to their Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play in responding to domestic and family violence (DFV).

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1. Executive Summary

The U-Turn Program

U-Turn is a Victoria-based pilot program aimed at addressing the intersection between family violence (FV) and problematic alcohol and other drug (AOD) use for men who are alleged perpetrators and respondents on a Family Violence Intervention Order (FVIO). The need to pilot such a program was identified in the Royal Commission into Family Violence's (RCFV) report and recommendations (State of Victoria 2016, recommendations 87; 92; 93) and is supported by the wider literature identifying problematic AOD use as a key contributing and intersecting factor in FV occurrences (Freeman et al., 2015; Kraanen et al., 2010; Lipsky et al., 2010; Radcliffe & Gilchrist, 2016; Stuart et al., 2009).

TaskForce Community Agency (hereafter referred to as TaskForce) received funding from the Department of Health and Human Services (DHHS) Victoria to develop and deliver four 12-week group-based programs during 2019 and 2020 for up to fourteen men, per group, who are recent respondents on FVIOs and present with comorbid FV and problematic AOD use. This funding included a provision for the current evaluation. Program participants enter the intervention program via referrals from the local Magistrates' Court.

All referrals are assessed for risk and eligibility. Those who are ineligible for this intervention group are referred into more suitable programs or one-on-one counselling options. Those who are assessed as eligible and 'group-ready' join a three-week orientation group prior to commencing the 12-week group-based intervention program. Topics covered during the 12-week program include harm reduction; the relationship between AOD and FV; the gendered nature of FV; the impacts of violence on women, children and the community; respectful communication (post-separation); emotional regulation; and basic legal education (with regard to understanding and complying with FVIOs, including any possible variations to the FVIO).

Informed by AOD harm minimisation principles, feminist theory and a psychoeducational framework of behaviour change, U-Turn ensures that men are visible and accountable for their actions, that they have access to support, and that women and families are kept safe.

U-Turn is framed as an 'early intervention' due to the timing of the referral pathway during men's contact with the local court as part of the civil FVIO proceedings (and, where applicable, related criminal charges). A key objective of the program is to keep men who have had minimal or no prior contact with the criminal justice system (CJS) out of the system. The evaluation team acknowledges that the term 'early intervention' may not be an accurate description of the victim/survivor perspective and that victim/survivors have often experienced prolonged histories of FV by the time their victimisation attracts police and/or court interventions.

Evaluation Approach

The Monash Gender and Family Violence Prevention Centre (MGFVPC) was contracted by TaskForce to undertake the evaluation of four rounds of the U-Turn program between February 2019 and April 2021. The evaluation approach was designed in close consultation with TaskForce to ensure it captures critical and meaningful outcome measures that inform future service delivery at the intersection of men's use of FV and problematic AOD use. It examines the suitability and effectiveness of the U-Turn program in preventing subsequent FV, including breaches of FVIOs. The evaluation took a mixed-methods approach to examine program suitability and effectiveness. Data sources included surveys

and interviews with program participants and their affected family members (AFMs) along with stakeholder focus groups and interviews. Program participant and AFM data was collected at four different time points:

- Wave 1 – men's program commencement
- Wave 2 – program conclusion
- Wave 3 – six-month follow up
- Wave 4 – 14-month follow up

Program participant and AFM surveys were designed to capture women's experiences of FV (including change over time), perceptions of safety and wellbeing, along with men's self-reported AOD use, perceptions of personal responsibility and emotional wellbeing. This data was collected during Waves 1 and 2. Interview components were conducted during Waves 2, 3 and 4 to further contextualise quantitative findings. Data collection commenced in June 2019 and continued until the conclusion of the final groups and their relevant follow ups. Follow up data includes Waves 3 and 4 for Groups 1 and 2 and Wave 3 only for Groups 3 and 4 as their Wave 4 follow up data collection falls outside the evaluation timeframe.

Stakeholder focus groups and interviews were conducted after the first 12 months of the pilot program implementation. Ten stakeholders participated in this evaluation component. They represented the following service sectors: Magistrates' Court of Victoria, FV specialist services, AOD specialist services, mental health and Men's Behaviour Change Programs (MBCP). The purpose of the stakeholder component was to examine sector perceptions regarding the need for combined interventions in the FV and AOD space along with the identification of key benefits and challenges to consider when combining such interventions.

In addition to the primary data collection described above, the evaluation included access to men's court records for the 12 months following their U-Turn referral. All men gave consent for their court data to be accessed as part of their evaluation consent. The purpose of this data was to identify whether participants had subsequent court contact after being referred into the U-Turn program to examine whether U-Turn achieves the aim of keeping alleged perpetrators of FV out of the CJS.

Evaluation Participation Rates for U-Turn Participants and AFMs

A total of 35 men were referred and assessed as eligible and group-ready to commence U-Turn. Of these, 30 men who commenced the program gave consent to participate in the evaluation. Further, 14 female AFMs who were associated with U-Turn program participants through their experiences of FV in a past or current relationship agreed to participate in the evaluation. Response rates to each wave of data collection are outlined in Table 1:

Response Rates	U-Turn Participants	AFMs
Wave 1	30	14
Wave 2	25	10

Attrition rate by Wave 2 (%)	16.7	28.6
Wave 3	16	9
Attrition rate by Wave 3 (%)	46.6	35.7
Wave 4	7	3
Attrition rate 14-month follow up (%)	63.2[1]	66.7[2]

Table 1: Response Rates for Each Wave of Data Collection

Research Questions Guiding the Evaluation

The evaluation of U-Turn was guided by six overarching research questions:

1. What is the need for combined interventions?
2. What are some of the perceived benefits of combined interventions?
3. What are some of the challenges in delivering combined interventions?
4. Do combined interventions increase family safety?
5. Do combined interventions assist men in managing their AOD use and behaviour change in relation to FV?
6. Do combined interventions keep men who are subject to FVIOs out of the criminal justice system?

Questions 1 to 3 are answered using stakeholder focus groups and interview data. Questions 4 to 6 were answered drawing on U-Turn participant and AFM self-report data. Question 6 was further cross-referenced against 12-month follow-up administrative court data, which identified whether men had returned to court for subsequent FV or any other matter in the 12 months following their initial FVIO mention date.

Evaluation Findings

Evaluation findings overall support the need for combined interventions at the intersection of FV and problematic AOD use and indicate their effectiveness in increasing family safety, assisting men in maintaining behaviour change around FV and problematic AOD use, and keeping respondents on FVIOs out of the CJS. Evaluation findings further highlight some key considerations when designing and delivering combined interventions. Finally, findings identify the critical role of Family Safety Contact (FSC) in combined interventions, the wider benefits being for families, including improved co-parenting and father-child relationships where children were involved and reveal improved emotional wellbeing among U-Turn participants as well as AFMs.

Findings further highlight some limitations of program effectiveness, including persistent denial of responsibility and victim-blaming attitudes among a smaller number of program participants. While limited to a small sample size, findings indicate that outcomes may be better for program participants

[1] Attrition rate for U-Turn participants at Wave 4 is calculated out of the 19 men who participated in U-Turn Groups 1 and 2 as Groups 3 and 4 had not reached their 14-month follow-up timepoint at the time the evaluation concluded.
[2] Attrition rate for AFMs at Wave 4 is calculated out of the nine women who are associated with the men who participated in U-Turn Groups 1 and 2 as AFMs associated with men in Groups 3 and 4 had not reached their 14-month follow-up timepoint at the time the evaluation concluded.

who remained in a relationship with the AFM or were working towards reconciliation. Further, findings indicate that combined interventions, such as U-Turn, are best suited for men with limited complex needs due to the 'early intervention' nature of the referral pathways. While findings suggest the capacity to address some level of complexity present in men presenting with comorbid use of FV and problematic AOD use, the small number of participants who presented with complex needs – including chronic illicit drug use, significant trauma and mental health problems, ongoing child protection involvement, and/or repeat or prolonged experiences of housing instability – disengaged from the program and/or the evaluation.

Identifying the Need for Combined Interventions

Findings derived from stakeholder focus groups and interviews reveal the following:

- Cross-sector acknowledgement that:
    - the FV and AOD service sectors (along with other service areas, such as mental health) have historically operated in siloes, which can isolate clients and leave relevant support needs unaddressed;
    - taking a combined intervention approach is a critical step towards more holistic service responses to FV, due to the persistent intersection of FV and AOD use observed in research and practice evidence; and
    - men who use violence often have more complex needs than solely needing to address their use of abusive behaviours in an intimate or family relationship, validating the need for a more holistic approach to clients' behaviours and support needs, including combined group-based interventions.

Benefits of Combining Interventions

Overall, stakeholder interviewees believed that taking a combined approach would have clear benefits for family safety because addressing problematic AOD use in the context of FV offers an opportunity to generate behaviour change through more than one lens. This, in return, was seen as beneficial to family members affected by men's use of FV. Identifying specific benefits, stakeholders indicated that combining interventions:

- offers a more informed approach to identifying and monitoring intersecting risk factors for FV;
- contributes to growing awareness, education and skill building in each sector to equally identify, understand and adequately respond to the other aspect of presenting issues (e.g. more AOD-informed practice in FV service delivery and more FV-informed practice in AOD service delivery); and
- creates multiple entry points to interventions addressing the intersection of FV and problematic AOD use. Some clients may be more open to acknowledging support needs related to AOD use, while others are more open to addressing patterns of abuse in their relationships. Stakeholders described that, ultimately, a combined intervention approach offers multiple 'doors to the same room'.

Challenges Associated with Combining Interventions

Findings identify a number of potential challenges when designing and delivering combined interventions, including:

- Combined interventions must ensure that service providers and practitioners are acutely aware that while it is beneficial to address FV and problematic AOD use in unison where they intersect, intoxication should never be understood as a cause of FV.
- FV and AOD service providers have historically been working from distinct ideological standpoints. Combined interventions must therefore ensure expertise of both sectors in the room and an awareness of the stigma that may potentially be associated with one or the other service sector.
- Group facilitators must represent both sectors, including Men's Behaviour Change Program (MBCP) expertise and skills along with clinical AOD expertise.
- Client risk assessment can vary between sectors, with traditional MBCPs focusing on men's behaviour and related risk, with a focus on the risk they may pose to others. AOD interventions, on the other hand, tend to prioritise client needs and assess for individual risk and protective factors while taking a therapeutic approach to assessing support needs. It is therefore critical to conduct a combined risk assessment in the context of combined interventions to equally support harm minimisation around problematic AOD use.
- Ongoing professional development opportunities and continuous upskilling of both sectors was described as critical by stakeholders to ensure holistic approaches to risk identification and management, accountability and behaviour change.

Increased Family Safety

For the purpose of examining AFM's experiences of FV and their perceptions of their own and, where applicable, wider family safety, the evaluation relied on AFM data only. It was determined by the evaluation team that without AFM data to cross reference men's accounts of their use of violence, perceptions of safety cannot be validated. Further, it was deemed inappropriate to ask program participants to comment on whether their AFMs (and where applicable children) felt safer at different points of follow up, as only those experiencing FV can accurately comment on their perceptions of safety. Based on the accounts of 10 AFMs at Wave 2 and 9 AFMs at Wave 3, findings suggest that for the majority of women, experiences of FV decreased and perceptions of safety increased throughout men's participation in U-Turn and was maintained across the different points of follow up. Specifically, most AFMs reported:

- an improvement in men's use of respectful communication;
- a reduction in experiences of controlling behaviours (such as social isolation, financial control and sexual jealousy) and thus improvement in AFM's space for individual action and decision making;
- a reduction in experiences of non-physical forms of harassment (such as verbal abuse, emotional abuse, humiliation, stalking behaviours and property damage);
- a reduction in experiences of physical abuse (including threats with a weapon and threats to kill); and
- a reduction in experiences of sexual abuse (although it must be noted that only a small minority of AFMs reported some experiences of sexual abuse overall, leaving limited space for change in this type of abuse).

Maintaining Behaviour Change Around Use of FV and Problematic AOD Use

For the vast majority of U-Turn participants, alcohol was the primary and, in most cases, sole substance of concern. As a result, findings related to men's change in AOD use primarily discuss men's alcohol use. Wave 3 and 4 data collection was used to determine whether men had maintained any

achieved behaviour change related to FV and problematic AOD use, reported at Wave 2. Where available, the evaluation relied on AFM data to confirm whether behaviour AOD-related behaviour change was maintained. Due to the smaller number of AFMs participating in the evaluation, U-Turn participant data was used to identify self-reported maintenance of behaviour change in relation to AOD use only.

While men's self-reports may be more favourable with regards to their AOD and FV behaviour change, it can be noted here that where data was available from both parties, AFMs equally reported men's initial and sustained AOD and FV behaviour change in the majority of cases. Discrepancies between U-Turn and AFM accounts only emerged for two separated couples, where men reported improvement in both FV behaviours and AOD use, with AFMs reporting no improvement in the nature and extent of the FV they experienced, with one reporting ongoing concerns regarding problematic AOD use and the other being unable to comment on her ex-partner's AOD use due to limited contact. Based on the evaluation's capacity to cross reference and validate most men's self-report data where AFM data was available, it can be assumed that men's self-report data presented in the report is reliable for the majority of U-Turn participants.

As evidence of this, the majority of U-Turn participants and AFMs reported the following changes in men's AOD use in addition to the changes in FV behaviours described above:

- A reduction in AOD use (with alcohol the primary substance of concern).
- Improved insight into the impact of AOD use on their behaviour and how it affects their ability to self-regulate.
- Improved ability to moderate alcohol intake to avoid drinking to excess.
- Compliance with FVIO directions stipulating that U-Turn participants may not consume alcohol at the residence shared with the AFM and/or may not attend an AFM's residence or return to a mutual residence while intoxicated.

Further, most U-Turn participants reported an improvement in:

- their understanding of what constitutes FV;
- their understanding of how their AOD use and abusive behaviours affect other family members, including children; and
- their ability to recognise negative emotions towards their (ex)partner and, where applicable, children and self-regulate to avoid an escalation into abusive behaviours.

Where FV and AOD behaviour change was reported at Wave 2, this was sustained by the majority of U-Turn participants over time. A small number of U-Turn participants and AFMs reported occasional 'relapses' into past drinking behaviours during Victoria's prolonged household restrictions. However, overall findings suggest that despite most U-Turn families having been affected by the documented impact of COVID-19 on employment, parenting and mental health, the vast majority of U-Turn participants were able to sustain their initial FV and AOD behaviour change.

Keeping Respondents on Civil FVIOs out of the CJS

Administrative court data was available for 29 of the 30 male evaluation participants. This data reveals:

- Nine U-Turn participants had criminal charges associated with the FV occurrence that led to their current FVIO.

- Of the criminal charges finalised during the evaluation timeframe, none of the U-Turn participants ended up being incarcerated. One was sentenced to a community corrections order
- During the 12-month period since their first FVIO mention date, eight men breached their FVIO at least once (with an average of 3.8 breaches per individual, ranging from 1 to 11 breaches).
- Of those appearing for a FVIO breach, five also had other court appearances during the 12-month follow-up period, with an additional four participants without reported breaches who appeared in court for other offences during this time.

The extent to which U-Turn was able to keep male FVIO respondents out of the CJS is difficult to determine in this evaluation, as the court data is subject to a number of limitations, including a number of matters that remained unfinalised by the end of the evaluation timeframe and some FVIO breaches potentially not having been mentioned by the time the evaluation ended. In the case of the latter, this is due to the general time lag existing between the date that criminal charges are laid and the date a matter is mentioned in court, which was exacerbated by the impact of COVID-19 restrictions on court proceedings in Victoria throughout most of 2020. However, data available for the purpose of the evaluation shows that none of the U-Turn participants reappeared in court for new FV matters (e.g. additional FVIOs and/or criminal charges involving a new AFM) over the 12-month follow-up timeframe, and that almost three quarters (72.6%) of U-Turn participants did not appear in the court system for a FVIO breach during the follow-up timeframe. While a number of participants appeared for other criminal matters subsequent to their initial U-Turn referrals, some of these alleged offences may have occurred prior to men's referral to U-Turn, given the allowed timeframe of up to 12 months between charges being laid and a matter being mentioned in court, unless the matter involves a bail hearing.

Other Key Findings

The Critical Role of Family Safety Contact

Family Safety Contact (FSC) – also referred to as Partner Contact in MBCPs – emerged as a crucial component in combined interventions during stakeholder consultations. Specific findings on the FSC implementation of a FSC component include:

- FSC must form part of combined interventions addressing FV accountability in order to ensure family safety and include the voices of victim/survivors and children in the room when facilitating combined intervention programs.
- FSC should be offered via a dedicated FSC worker role. It should not be conducted by program facilitators, and it should not be allocated to other practitioners on top of their standard workload (e.g. AOD clinicians or FV practitioners working for the service provider that is delivering a combined intervention).
- FSC should therefore be funded as a dedicated role. This role should operate with a degree of flexibility around working hours to ensure FSC can be offered outside of standard service hours for AFMs with fulltime work and/or carer commitments.

These findings were further supported by AFM feedback on their utilisation of FSC. While not all AFMs made use of this aspect of the U-Turn program, the majority had some contact with the FSC worker. Contact ranged from no contact at all or initial contact at men's program commencement only to text message 'check-ins' at agreed intervals or regular telephone contact throughout the 12-week

program. Of the AFMs who utilised this support mechanism and participated in the evaluation, all described their experiences as positive and the FSC component as useful. Specifically, AFMs described the FSC support as:

- useful in having their own support option;
- helpful in understanding the U-Turn program;
- beneficial due to the FSC worker providing information about and, where relevant, referrals to other support services; and
- beneficial due to the FSC worker assisting AFMs in developing protective strategies and supporting further help-seeking where men displayed ongoing abusive behaviours.

The Critical Role of Having a Closed Feedback Loop

Stakeholder focus group findings reveal the importance of having a closed feedback loop between key organisations and service providers, highlighting that:

- information sharing must go both ways, with the program provider feeding back to the referring court whether men attended their intake sessions or not, and with the local court feeding back to the program provider whether current participants have reappeared in court or not; and
- where combined interventions form part of a wider partnership model (e.g. involving child protection, police, probation and parole), a closed feedback loop needs to be ensured between the program provider and all key program partners to ensure program participant as well as service system accountability.

Improved Co-parenting and Parent-child Relationships

While parenting and parent-child relationships were not a specified focus of the evaluation – as the U-Turn program in its current format is not specifically designed for parents or to provide parenting support and education – co-parenting and parent-child relationships were discussed by a number of U-Turn participants and AFMs during follow-up interviews. Specifically, qualitative findings suggest that where men's AOD use and use of FV improved and such improvements were maintained over time (which was the case for the majority of participants), AFMs equally reported improved co-parenting relationships and U-Turn participants reported improved relationships with their children, where applicable.

Application of U-Turn Content in Everyday Life Situations

During their Wave 2 interview component, U-Turn participants frequently spoke about the applicability of program content, especially as it relates to identifying and regulating anger and other negative emotions in their interaction with their (ex)partner as well as everyday situations. The majority of U-Turn participants reported at different follow-up timepoints that they still draw on program content frequently and at times revisit the printed program material to resolve situations they may have identified as challenging or problematic. Here, several participants emphasised that while the program content was discussed in and applied to the context of their intimate and family relationships, they tended to apply it to everyday interpersonal interactions, including when tensions arise with co-workers or clients, and during other social interactions.

Limitations Around Program Effectiveness

While the majority of U-Turn participants and AFMs reported men's behaviour change around use of FV and problematic AOD use along with AFMs' reports of increased feelings of safety, a small number of program participants did not achieve these goals. A small number of men maintained persistent attitudes of denial and minimisation of their responsibility for their abusive behaviours along with victim-blaming attitudes. Others seemed to minimise the extent of their AOD use and/or the impact this may have had on other family members. In particular, the small number of men that did not seem to have achieved substantial behaviour change would often deflect by indicating that their (ex)partners equally engaged in problematic AOD use. These men saw this as a contributing factor towards their own use of FV rather than separating these two areas of accountability and focusing on their own personal responsibility of ensuring family safety. While limited to a small number of program participants, these findings suggest that some participants may need to develop further accountability insight and that more comprehensive MBCP work may be required. Here, an exit assessment of all U-Turn participants to facilitate further program referrals, where relevant, is recommended.

Study Limitations

While evaluation findings overall support the effectiveness of the U-Turn program in a) increasing family safety, b) assisting men to maintain their achieved AOD and FV behaviour change and c) keeping program participants out of the CJS, it must be noted that it is difficult to isolate this effect solely on men's participation in U-Turn. Of the 25 men who participated in at least two waves of data collection, 22 were engaged with at least one other support service. Support services utilised by men parallel to and often beyond their participation in U-Turn included private psychologists and psychiatrists, one-on-one AOD counselling, and Alcoholics Anonymous (AA). Further, the majority of men reported conditions on their FVIOs that prohibited them from drinking at the family home or attending the AFM's residence while intoxicated. It is therefore likely that for at least some of the U-Turn participants, their reduction in problematic AOD use and use of FV may be the result of a combination of their U-Turn participation, engagement with other support services and their FVIO conditions related to AOD consumption.

Further, quantitative findings reported throughout the final evaluation were rarely statistically significant. This may primarily be the result of the small sample size for U-Turn participants and AFMs engaged in the program and evaluation and the substantial attrition rates at different points of follow up. However, albeit not statistically significant, findings across the majority of measures reveal change in the desired direction, which should be noted as positive from a qualitative perspective.

Recommendations

Findings derived from the qualitative and quantitative data sources utilised for the evaluation of U-Turn provide guidance for future directions regarding the continuation of the U-Turn program.

Recommendation 1 – Continuation of U-Turn in Its Current Form

To offer a holistic response to respondents on FVIOs who present with comorbid FV and problematic AOD use, it is recommended that U-Turn is refunded and continued in its current format.

Recommendations 2 – Ensuring a Dedicated FSC Worker Role and Funding Allocation

To ensure adequate support to AFMs associated with male U-Turn participants, it is recommended that future U-Turn programs continue to operate with a dedicated FSC worker role. It is recommended that this role has dedicated funding attached to it when refunding the program. It is

further recommended that this role has a level of flexibility that allows the FSC worker to operate outside of standard TaskForce hours in order to meet the needs of and maximise engagement with AFMs who require outside-of-office-hours support due to fulltime work and/or carer commitments.

Recommendation 3 – Consideration of a Father-specific Group Format

Given the positive aspects noted by U-Turn participants and AFMs with individual or mutual dependent children, it is recommended that U-Turn is trialled in an additional format, specifically targeting fathers with dependent children and incorporating a greater focus on the engagement of AFMs in their roles as mothers, carers or guardians. It is recommended that such a model involves a collaborative approach with child protection to better support families where FV occurrences intersect with initial or ongoing child protection involvement.

Recommendation 4 – Exit Assessment to Identify Further Referral Needs

It is recommended that a brief exit assessment is conducted with all program participants to identify potential ongoing MBCP needs and facilitate relevant referral pathways. Exit assessment and referral decisions may be further informed by facilitators' professional judgement based on observations of persistent attitudes and beliefs around victim-blaming and denial of accountability during group facilitation.

Recommendation 5 – Extended Partnership Approach with Additional Service Sectors for Participants with Complex Needs

While the current format of U-Turn is delivered as an 'early intervention model', some referrals considered for program intake presented an accumulation of complex needs. Referrals with an accumulation of complex needs seemed to be more likely to disengage from the program and/or the evaluation. It is therefore recommended that U-Turn extends its partnership beyond the court – TaskForce partnership to include at a minimum child protection, probation and parole, and a housing support service to better support men who may require a more holistic wrap-around support to facilitate their ongoing engagement in U-Turn and related behaviour change.

2. Background

U-Turn is a Victoria-based pilot program aimed at addressing the intersection between FV and problematic AOD use for men who are alleged perpetrators and respondents on a FVIO. The need to pilot such a program was identified in the Royal Commission into Family Violence's report and recommendations (2016) and is supported by the wider literature identifying problematic AOD use as a key contributing and intersection factor in FV occurrences (Freeman et al., 2015; Kraanen et al., 2010; Lipsky et al., 2010; Radcliffe & Gilchrist, 2016; Stuart et al., 2009).

The program is delivered by TaskForce. TaskForce received funding from the Department of Health and Human Services (DHHS) Victoria to develop and deliver four twelve-week group-based programs during 2019 and 2020 for up to fourteen men, per group, who are recent respondents on FVIOs and present with comorbid FV and problematic AOD use. This funding included funding for the current evaluation. Program participants enter the intervention program via referrals from the local Magistrates' Court.

Prior to program entry, participants are assessed for risk and eligibility. Those who are ineligible for this intervention group are referred into more suitable programs. Those who are assessed as eligible and 'group-ready' join a three-week orientation group prior to commencing the 12-week group-based intervention program. Topics to be covered during the 12-week program include harm reduction; the relationship between AOD and FV; the gendered nature of FV; the impacts of violence on women, children and the community; respectful communication (post-separation); emotional regulation; and basic legal education (with regard to understanding and complying with FVIOs, including any possible variations to the FVIO).

Informed by feminist theory and behaviour change and AOD harm minimisation principles, U-Turn ensures that men are visible and accountable for their actions, that they have access to support, and that women and families are kept safe.

It should be noted that the phrase 'early intervention' in the program title 'TaskForce Early Intervention for Family Violence' refers to the timing of the criminal justice response. The program was designed as an early intervention for perpetrators who have entered the CJS for the first time or have previously had minimal contact. The evaluation team acknowledges that 'early intervention' may not be an accurate description of the victim/survivor perspective and their experiences of FV as victim/survivors often share prolonged experiences of abuse by the time their victimisation attracts police and/or court interventions.

2.1 U-Turn Program Eligibility

All men included in the evaluation had received an interim or final FVIO at the time of being referred to the U-Turn program. Respondents were referred by the Moorabbin Magistrates' Court of Victoria to the locally based AOD service provider TaskForce as part of their civil court proceedings. To be eligible for a program referral, men had to have problematic substance use identified as part of their FV perpetration. This could include respondents disclosing in court a history of substance use, court records suggesting a history of substance use based on AOD-related offending behaviour, or simply

having been intoxicated at the time of their most recent FV occurrence that led to a police and court response. As the pilot program under evaluation was designed to be an early intervention for FV, respondents were screened for additional risk factors to ensure participants met the criteria for an early intervention from a criminal justice perspective.

3. Evaluation Methodology

The Monash Gender and Family Violence Prevention Centre (MGFVPC) was contracted by TaskForce to undertake the evaluation of four rounds of the U-Turn program between February 2019 and April 2021. Disruptions caused by the COVID-19 global pandemic meant the beginning of Group 3 was delayed. Consequentially, a decision was made to run Groups 3 and 4 simultaneously.

3.1 Evaluation Approaches and Deliverables

This section outlines the evaluation questions, data collection process and different evaluation samples, made up of U-Turn program participants, AFMs and key stakeholders.

The evaluation examines the suitability and effectiveness of the U-Turn program, a combined AOD and FV intervention delivered by TaskForce. The program is aimed at preventing subsequent violence, including breaches of FVIOs. The broad approach to the evaluation is to gather information on the effectiveness of the program using surveys, interviews and stakeholder focus groups. Quantitative data is collected from program participants and AFMs at the time of men's program commencement (Wave 1) and program conclusion (Wave 2), as well as at six-month (Wave 3) and 14-month (Wave 4) follow-up points. In addition, a qualitative interview component is conducted with participants of the U-Turn program and AFMs at Wave 2, 3 and 4. Further, qualitative feedback has been captured from key stakeholders in justice, mental health, FV and AOD services to examine the need for combined interventions in the FV and AOD space, along with key benefits and challenges to consider when combining such interventions. Evaluation data collection commenced in July 2019 and was ongoing until the conclusion of Groups 3 and 4 and relevant follow ups. Follow-up data includes Waves 3 and 4 for Groups 1 and 2 and Wave 3 only for Groups 3 and 4, as their Wave 4 follow-up data collection falls outside the evaluation timeframe.

3.2 Research Questions

This evaluation draws on the following research questions:

a) What is the need for combined interventions?
b) What are some of the perceived benefits of combined interventions?
c) What are some of the challenges in delivering combined interventions?
d) Do combined interventions increase family safety?
e) Do combined interventions assist men in managing their AOD use and behaviour change in relation to FV?
f) Do combined interventions keep men who are subject to FVIOs out of the criminal justice system?

Table 2 provides an overview of the evaluation framework and maps the key evaluation questions with the relevant indicators and data sources.

Evaluation Question	Indicator	Data Source
a) What is the need for combined interventions?	Stakeholder perceptions of the need for combined interventions based on their expertise and knowledge of the intersection of DFV and AOD.	Stakeholder focus groups
b) What are some of the perceived benefits of combined interventions?	Stakeholder perceptions of the perceived benefits combined interventions based on their expertise and knowledge of the intersection of DFV and AOD.	Stakeholder focus groups
c) What are some of the challenges in delivering combined interventions?	Stakeholder perceptions of the challenges in delivering combined interventions based on their expertise and knowledge of the intersection of DFV and AOD.	Stakeholder focus groups
d) Do combined interventions increase family safety?	AFM perceptions of changes in program participants' FV and AOD behaviours and their feelings of safety for themselves and their children.	AFM data (Waves 1, 2, 3 and 4), survey and interview data
e) Do combined interventions assist men in managing their AOD use and behaviour change in relation to FV?	AFM and U-Turn participant perceptions of the ways and extent to which the combined intervention offered by TaskForce assisted men in managing their AOD use and behaviour change in relation to FV.	AFM and U-Turn participant data (Waves 1, 2, 3 and 4), including intake, survey and interview data)
f) Do combined interventions keep men who are subject to FVIOs out of the criminal justice system?	Presence or absence of U-Turn participants in court records during or subsequent to their participation in the U-Turn program.	12-month follow-up court data

Table 2: Evaluation Framework

3.3 Data Collection

Several data sources are being used as part of this evaluation. Data collection methods fall under the following categories:

- U-Turn participant and AFM data.
  - Surveys (including intake surveys with U-Turn participants administered by U-Turn intake clinicians, U-Turn participants Wave 2 surveys administered by the evaluation team, and AFM Wave 1 and 2 surveys administered by the evaluation team).
  - Interview components (Waves 2, 3 and 4, all conducted by the evaluation team).
- Group observations.
- Stakeholder focus groups and interviews.
- Administrative court data (12-month follow up for consenting U-Turn and evaluation participants).

3.3.1 Data Collection from U-Turn Participants and AFMs

Quantitative and qualitative data was collected from U-Turn participants and AFMs across four waves. Table 3 provides an overview and breakdown of the data collected at each wave.

Wave	Data Collected	
	U-Turn Participant	AFM
Wave 1 – Program commencement	Demographic data, K10, AUDIT, PRS[3]	Survey 1
Wave 2 – Program completion	K10, PRS, qualitative exit interview component*	Survey 2, qualitative interview component*
Wave 3 – Six-month follow up	Qualitative interview*	Qualitative interview*
Wave 4 – 14-month follow up	Qualitative interview*	Qualitative interview*

Table 3: Overview and Breakdown of Data Collected at Each Wave

*Where possible, qualitative data from interviews was quantified to supplement descriptive quantitative findings for reporting purposes.

3.3.1.1 U-Turn Participant Data Collection and Measures

Data Collection Process for U-Turn Participants

TaskForce staff informed U-Turn participants during their intake assessment about the evaluation and their opportunity to be involved. All men assessed as eligible for U-Turn participation were given a Participant Information Sheet, outlining the evaluation and their potential role in it. TaskForce staff collected written informed consent from all men who agreed to participate in the evaluation. Consent

[3] The PRS was only administered with Groups 3 and 4 as its use during intake assessment only commenced with these groups. In Groups 3 and 4, TaskForce administered the PRS at program commencement, participants self-administered the PRS at the halfway (six-week) program mark and the evaluation team administered the PRS at Wave 2 data collection.

covered research access to U-Turn intake data and 12-month follow-up court data along with participation in interviews at program conclusion, six and 14-month follow up.

For Wave 1 data, quantitative information was extracted from program intake assessment forms and measures administered by TaskForce (including demographic information, the Kessler 10 [K10] scale, the Alcohol Use Disorders Identification Test [AUDIT] and the Personal Responsibility Scale [PRS]).

An interview component was conducted with U-Turn participants from all groups by the evaluation team at Waves 2, 3 and 4 between October 2019 and March 2021. Wave 2 interviews with Groups 1 and 2 were conducted at TaskForce with support services on hand to minimise any adverse effects that may have arisen during the course of data collection. Due to the COVID-19 pandemic and government-directed stay-at-home orders, only a limited number of on-site interviews was possible for Wave 2 data collection with Groups 3 and 4. U-Turn program group work was permitted to continue face-to-face onsite during the pandemic. Regulations for personal protective equipment and social distancing were required during this time. Group observations were also permitted to continue during this time. Where possible, U-Turn Wave 2 data collection was conducted in person adjacent to group sessions. However, due to space restrictions and social distancing guidelines, the majority of Wave 2 data collection for Groups 3 and 4 took place over the phone.

Wave 2 interviews with male U-Turn participants were designed to canvass the experiences of participants who were asked a series of questions about FV, AOD use and individual wellbeing, and to provide any feedback relating to the program, including its content, facilitation and impact. Wave 3 and 4 interviews were shorter and covered maintenance of or changes to AOD and FV behaviours reported at the previous wave of data collection.

All interview components were audio recorded and transcribed using SmartDocs, an Australian transcription service.

Instruments and Measures

Levels of Psychological Distress (Kessler-10 Scale)

The 10-item Kessler-10 (K10) scale is a global scale that was used to calculate levels of psychological distress in mothers and fathers. The purpose was to examine change in levels of psychological distress (K10 scores) in both U-Turn participants and AFMs across the 12-week intervention.

AUDIT

The AUDIT is a scale measure consisting of 10 questions that are designed to identify problematic drinking behaviours and potential alcohol dependence. Answers to each question are scored 0, 1, 2, 3 or 4, with the exception of questions nine and 10, which have possible responses of 0, 2 and 4. Questions relate to participants' alcohol use in the past 12 months for the purpose of program intake.

The range of possible scores is from 0 to 40 where 0 indicates an abstainer who has not experienced any problems from alcohol in the past 12 months. A score of 1 to 7 suggests low-risk consumption according to World Health Organization (WHO) guidelines. Scores from 8 to 14 suggest hazardous or harmful alcohol consumption, and a score of 15 or more indicates the likelihood of alcohol dependence (moderate-severe alcohol use disorder).[4]

[4] For further information on the AUDIT, see, https://auditscreen.org/about/scoring-audit/.

Personal Responsibility Scale

The eight-item Personal Responsibility Scale is a non-validated combined AOD/FV tool developed by TaskForce and used to measure men's feelings of personal responsibility in relation to substance use and relationship quality with partners and children. Each question has a 10-point scale response (1 = *Not responsible*, 10 = *Completely responsible*).

3.3.1.2 AFM Data Collection and Measures

Data Collection Process for AFMs

All AFM surveys and interviews were conducted over the phone throughout the evaluation. At the beginning of the U-Turn program, FSC workers asked AFMs if they were interested in participating in the evaluation. If the AFM confirmed her interest, she was advised that she would be contacted again at the conclusion of the program and at six and 14-month follow ups. AFMs were also advised that they could withdraw from participation at any stage. At each wave of the evaluation, and prior to contact by Monash researchers, TaskForce FSC workers checked back in with AFMs to confirm they consented to being contacted by Monash. AFMs interested in continuing their participation provided their preferred contact times to the FSC worker who, in turn, provided this information to the Monash team. Monash researchers then arranged contact for surveys and interviews. At the conclusion of each AFM contact, researchers checked in with the AFM to gauge any distress, discomfort or safety concerns. All participating AFMs were offered a follow-up support call from the TaskForce FSC worker.

For all AFMs involved in the research, Wave 1 surveys were administered around week two of the U-Turn program and Wave 2 surveys occurred within two weeks of program conclusion. Wave 1 and 2 surveys consisted of Project Mirabal survey measures[5] (Kelly & Westmarland, 2015) and the K10 to gather information about experiences of FV and emotional wellbeing/levels of psychological distress. The specific measures administered to AFMs in the surveys included respectful communication; experiences of violence, abuse and harassment; experiences of expanded space for action (e.g. absence or presence of controlling and restricting behaviours by the abuser); and levels of psychological distress (K10).

AFM interviews included questions about relationship status and living arrangements, the protection order, (ex)partner's AOD use, wellbeing, whether/how things may have improved for themselves and their family (if relevant) since their (ex)partner or other family member's participation in the U-Turn program, feedback about the U-Turn program, and key hopes and expectations for the future.

A decision was made that the research team would interview AFMs at Wave 2 (program conclusion), regardless of whether men completed the U-Turn program or not, as long as AFMs were contactable and continued to agree to evaluation participation at the time of follow-up contact. There was only one instance over the course of the evaluation where the U-Turn participant disengaged from the program after six weeks (but an AFM was still interviewed at the time of Group 1 program conclusion).

To acknowledge AFM's increased input into the evaluation, participating women received a $25 Coles voucher at each wave of their participation in data collection.

[5] For further information on Project Mirabel see, https://projectmirabal.co.uk/.

Instruments and Measures

AFMs' Experiences of Violence and Abuse

AFM surveys consisted of Project Mirabal measures (Safety and Freedom from Violence and Abuse for Women and Children measures), including 'Respectful Communication', 'Expanded Space for Action', and 'Safety and Freedom from Violence and Abuse' measures (Kelly & Westmarland, 2015).

Respectful Communication

AFMs' experiences of respectful communication in their relationship with (ex)partners was measured using a five-item questionnaire at the beginning and conclusion of the U-Turn program. Each item was rated on a five-point Likert-type scale (1 = never, 5 = always).

Expanded Space for Action

AFMs' experiences of controlling and coercive behaviour by fathers were assessed using a 12-item questionnaire, capturing behaviours such as social isolation, financial control and sexual jealousy. Each item was rated on a five-point Likert-type scale (1 = never, 5 = always).

Safety and Freedom from Violence and Abuse

AFMs were asked questions around their experiences of harassment and other abusive acts (seven items, including behaviours such as verbal and emotional abuse, property damage or stalking), and physical and sexual violence (seven items, including threats with a weapon and threats to kill). Each item was rated on a Likert-type scale (1 = never, 5 = always).

3.3.2 Observations

The research team observed each program group at three points: beginning, middle and end. This method was used in order to gain insight into program content and how the U-Turn program was being facilitated. Observations assisted the research team in asking targeted questions around program content and experiences regarding its applicability during men's exit interviews. Observations of group facilitation were discussed with facilitators after attending individual sessions to provide feedback and inform further delivery of the program. Further program attendance in the beginning was used to introduce the evaluation and lead researchers to group and evaluation participants to establish rapport and buy-in for evaluation participation.

U-Turn program group work for Groups 3 and 4 was permitted to continue face-to-face and onsite during the COVID-19 pandemic. Regulations for personal protective equipment and social distancing were required during this time. Group observations were also permitted to continue during this time.

3.3.3 Stakeholder Interviews and Focus Groups

This project utilised semi-structured focus groups and interviews with key stakeholders. Stakeholders were given the option of participating in individual telephone interviews if they were unable or unavailable for the focus group. Key stakeholder interviews took place in person or via telephone and asked participants a range of questions based around the research questions. Topics included:

- The need for combined AOD and FV interventions.

- The challenges and benefits associated with combined interventions.
- The key requirements in delivery.
- Challenges associated with referral pathways and information sharing.

One focus group was conducted with key stakeholders in February 2020. Focus group participants were asked the same questions as key stakeholders who took part in an interview (outlined above). Focus groups ran between 60 and 90 minutes and were audio recorded. Interviews ran between 20 and 45 minutes and were also audio recorded.

All interviews and focus groups were transcribed using SmartDocs.

3.3.4 Court Data

All U-Turn participants who participated in the wider evaluation gave consent for the research team to access their 12-month follow-up court data from the day of their initial FVIO mention date, where a U-Turn referral was made. The purpose of this data was to identify whether or not participants had subsequent court contact after being referred into the U-Turn program to determine if U-Turn achieved the aim of keeping alleged perpetrators of FV out of the CJS. Court data included the following information:

- Whether criminal charges were associated with the initial FVIO matter.
- Whether U-Turn participants returned to court for new FV matters (including breaches of the original FVIO as well as new FV matters against another AFM).
- Whether U-Turn participants returned to court for other criminal matters (including AOD-related offending behaviour as well as any other crimes).

3.4 Data Analysis

3.4.1 Quantitative Analysis

For the purpose of analysing the quantitative evaluation data, we use descriptive statistics and paired samples t-tests to analyse the Taskforce data. Paired samples t-tests were employed to analyse change in survey responses between Waves 1 and 2.[6,7] This analytic technique allows researchers to test whether there is a difference in mean scores for individuals between the time points. We use the 95% confidence threshold whereby a p-value ≤0.05 denotes statistical significance.[8] This means that we can have confidence that any statistically significant differences are not due to chance, with a 5% margin of error. Given the small sample sizes in both the male and female groups, caution should be taken when making causal claims based on the paired samples t-tests. Despite the limitation in the statistical power of the analyses, non-statistically significant findings still contribute meaningful insights into the experiences of U-Turn participants and AFMs within this study. Results from the

[6] Due to the small sample of Wave 2 AFM participants, t-tests were unable to be performed on all scales. Where t-tests were not able to be computed, descriptive statistics are presented instead.

[7] The *Personal Responsibility Scale* items were administered in an additional wave to male participants. These results are also reported in the findings.

[8] For ease of reading, we have footnoted p-values for the paired samples t-tests throughout this report.

paired samples t-tests are presented in tables and graphs throughout this section of the report to show the change in mean scores over time, regardless of their statistical significance.

3.4.2 Qualitative Analysis

The qualitative data was analysed using thematic analysis in NVivo software. Themes for analysis were developed by the evaluation team based on stakeholder, U-Turn participant and AFM responses, with relevance to the evaluation research aims and questions and prevalence of issues within the relevant literature. Transcripts were uploaded to NVivo and coded according to the developed themes and subthemes. NVivo is a qualitative analysis tool which assists research in organising and structuring data to produce thematic reports which are then analysed to develop research findings and outcomes. The NVivo coding process enables researchers to determine the prevalence of each theme within and across transcripts, facilitating rigorous and robust conclusions that can be drawn from detailed qualitative data. Each U-Turn program participant and AFM was allocated a Participant/AFM number. These numbers are used throughout the report when presenting quotes that demonstrate specific findings. The use of numbers within the report allows the qualitative data to be presented in a way that maintains U-Turn participant and AFM anonymity.

Where possible, qualitative data from interviews was quantified to supplement descriptive quantitative findings for reporting purposes. Quantifiable data collected from AFM interviews includes responses regarding the maintenance of men's improved FV and AOD and parenting behaviours. Quantifiable data collected from U-Turn program participant interviews includes (but is not limited to) information about FVIO conditions, living arrangements at the time of the FV incident and police removal from the home.

3.5 Evaluation Samples

3.5.1 U-Turn Participants

Thirty males who had previously committed DFV participated in the baseline Wave 1 survey and intake assessment. Half of the sample were Australian born (50.0%) and none of the sample reported having a refugee status (see, Table 4). The average age of the sample was 43.1 years old. The majority of the sample was employed (53.3%) and living with family (40.0%). Over three-quarters of the sample (76.6%) had at least one child. Less than one-third of the sample reported being the primary caregiver of and/or living with their child(ren) (23.3%).

	Freq. (%)	Mean	SD
Age		43.1	10.9
Employment Status			
Employed	16 (53.3)		
Unemployed	5 (16.7)		
Other	8 (26.7)		
Overseas Born			
Yes	10 (33.3)		
No	15 (50.0)		
Refugee Status			
Neither	16 (53.3)		
Permanent visa	2 (6.7)		
Living Arrangements			
Family	12 (40.0)		
Friends	3 (10.0)		
Alone	2 (6.7)		
Other	6 (20.0)		
Number of Children		1.68	1.35
0	2 (6.7)		
1	12 (40.0)		
2	8 (26.7)		
3	1 (3.3)		
5	1 (3.3)		
6	1 (3.3)		
Primary Caregiver/Live with Child(ren)			
Yes	7 (23.3)		
No	17 (56.7)		

Table 4: Male Demographic Information

3.5.2 Affected Family Members (AFMs)

Fourteen AFMs consented to participation in the evaluation and were asked a series of questions in order for the evaluation to gather demographic information about the sample. More than half of the sample (57.1%) reported being born overseas (see, Table 5). None of the sample identified as Aboriginal and/or Torres Strait Islander. Over one-third of AFMs were employed (35.7%) and almost half of AFMs had a trade certificate (42.9%). AFMs were also asked if they identified as someone with a disability, with only five responding and four stating that they did not have a disability. Almost half of the sample reported that they were married to the person named on their FVIO (42.9%), while the remainder of the sample were separated from the named person (28.6%), or the named person was a current partner (14.3%) or casual partner (7.1%). Almost two-thirds of the sample lived separately from the named person on their FVIO (64.3%), while the remainder of the sample lived with the named person (35.7%).

	Freq. (%)
Employment Status	
Employed	5 (35.7)
Unemployed	3 (21.4)
Home duties	2 (14.3)
Studying	3 (21.4)
Carer	1 (7.1)
Educational Attainment *Primary school*	1 (7.1)
Up to year 10	3 (21.4)
Senior school/year 12	2 (14.3)
Trade certificate	6 (42.9)
Bachelor's degree	2 (14.3)
Overseas Born	
Yes	8 (57.1)
No	6 (42.9)
Aboriginal and/or Torres Strait Islander Status *Yes*	0 (0.0)
No	14 (100.00
Relationship with Named Person on FVIO	
Married	6 (42.9)
Separated	4 (28.6)
Current Partner	2 (14.3)
Casual Partner	1 (7.1)
Parent	1 (7.1)
Living Arrangements	
Living together *Living separately*	5 (35.7) 9 (64.3)
Disability[9]	
Yes	1 (20.0)
No	4 (80.0)

Table 5: Female Demographic Information

The majority of the sample reported having children (92.9%; n=13; see, Figure 1), with all but two AFMs (85.7%; n=12) identifying that their children were from the relationship with the named person on their FVIO (see, Figure 2). The majority of AFMs had two children (46.2%) and reported that the children lived with the named person all of the time (46.2%).

[9] Please note that only five AFMs responded to this question.

Figure 1: Total Number of Children Reported by an AFM (n=11)

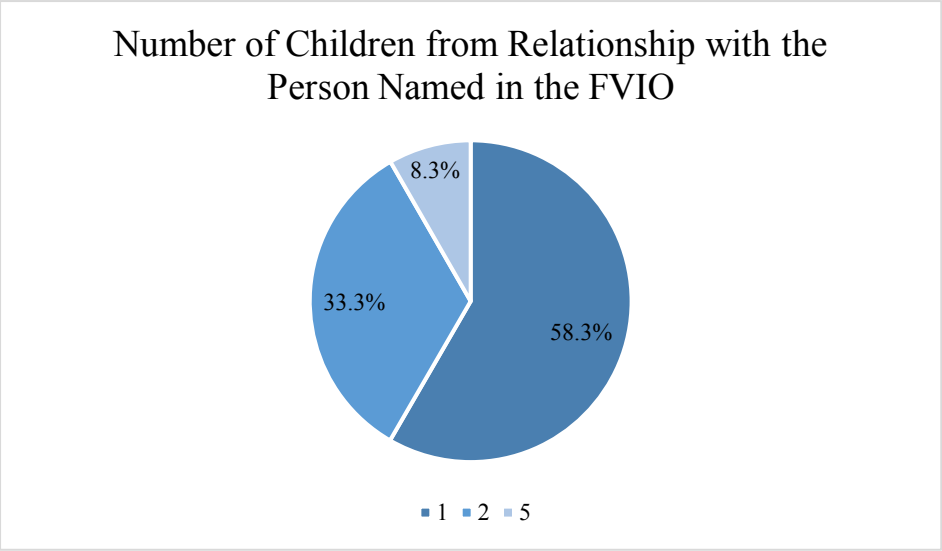
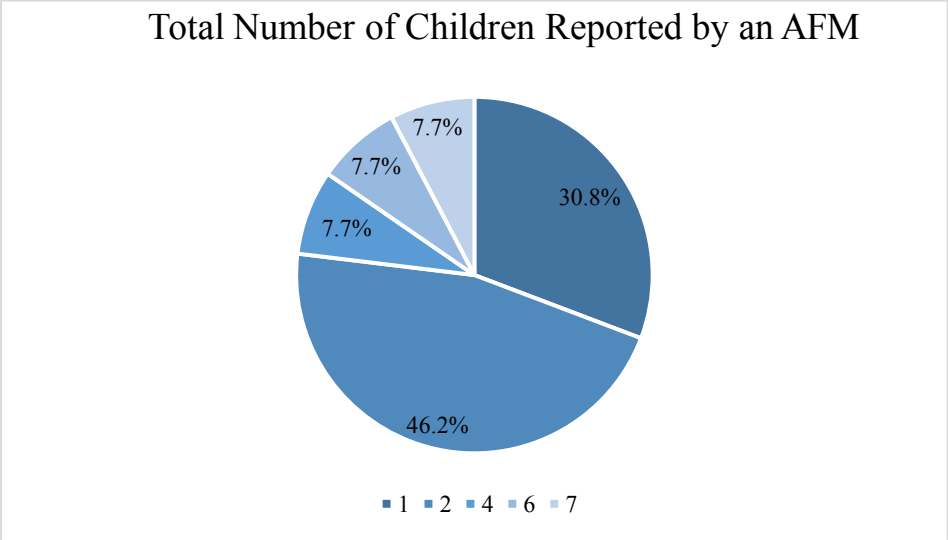


Figure 2: Number of Children from Relationship with the Person Named in the FVIO (n=10)



3.5.3 Key Stakeholders

Overall, ten key stakeholders participated in the evaluation. These included a range of different services and represented the following sectors: Magistrates' Court of Victoria, FV, AOD and MBCP.

3.6 Evaluation Limitations

3.6.1 Limitations Related to Recruitment

This study has several methodological limitations. Recruiting AFMs for this evaluation proved challenging, particularly with regards to retention of AFMs over the duration of the program and into the follow-up periods. It is well documented that recruitment of vulnerable and hard-to-reach

populations has its challenges (e.g. see, Liamputtong, 2007; Thummapol et al., 2019). Literature identifies that recruiting vulnerable populations can be both challenging and time consuming (Liamputtong, 2008). It involves building a sense of trust with research participants, communication, negotiating and mutual respect (Roper & Shapira, 2000), and challenges can affect research participation and retention. To overcome these challenges, it has been noted that there are a number of procedures that can employed, such as managing research participant expectations, emphasising the benefits of research participation and outlining all confidentiality clearly at the outset (Thummapol et al., 2019). While the research team had procedures in place to initiate contact with women, and worked closely with the FSC worker around AFM participation in the evaluation, only ten women (out of the original fourteen) took part in both Waves 1 and 2 – nine in the six-month follow up and three (out of a possible five) in the 14-month follow up. As some women did not have regular contact with TaskForce, follow-up contact relied on the research team for a small number of AFMs. Researchers attempted numerous phone calls with AFMs in an attempt to maximise retention rates, yet these did not always prove successful. Conversely, when AFMs were connected and had regular contact with TaskForce, they were able to pass on preferred times to make contact, which was a more successful approach.

Along with this, there was a change in staff at TaskForce during the recruitment of AFMs. Initially, the person acting in the FSC worker role was employed in a part-time role specifically to do this work. This practitioner had greater flexibility in following up with women; both around FSC and women's involvement with the evaluation. For Group 2 of U-Turn, the FSC worker role was allocated to a TaskForce AOD clinician who fulfilled this role in addition to their existing clinical caseload and during TaskForce opening hours, which likely impacted on capacity and flexibility around establishing and maintaining FSC.

Finally, it needs to be noted that the Monash evaluation team was only able to speak with women who had and were engaging with some form of FSC, as access to AFMs was facilitated through FSC workers. This means that no qualitative data was collected from AFMs who chose not to engage with FSC workers. Consequently, no outcome comparisons can be drawn between AFMs who utilised FSC support and those who did not as AFM data is limited to women who at least initially engaged in FSC.

3.6.2 Limitations Related to Data

There are several key limitations to the survey component of the evaluation. Firstly, the small sample sizes lack the statistical power needed for inferential and predictive methods. Thus, they limit the generalisability of the findings presented in this report and make it difficult to establish correlational claims between variables. The attrition rates across the different waves of data collection show that this is a difficult population to reach and work with. Given the relatively small AFM sample size in Wave 2 (n=10), analyses were unable to establish a statistical picture of those participants for some items. We therefore incorporate a greater focus on AFM experiences and perceptions in the qualitative findings sections based on follow-up interviews with AFMs at different timepoints.

Secondly, the use of some scales, which have been used in prior evaluations of FV intervention programs but have not been tested for validity and reliability, requires the interpretation of findings with caution. Thirdly, some U-Turn participants may have provided socially desirable answers to

questions around their behaviour towards their (ex-)partner. The evaluation therefore draws on AFM data to answer these questions where available.

Lastly, some U-Turn participants and AFMs may report that their circumstances have positively improved for reasons not captured within the scope of this study. Specifically, the majority of U-Turn participants and some AFMs accessed other types of support and interventions over the course of the evaluation, including psychiatrists, psychologists, one-on-one AOD counselling and AA. Many further had FVIO conditions that stipulated restrictions around their AOD use. It is therefore impossible to determine whether specific improvements reported by U-Turn participants and AFMs are the result of their participation in U-Turn, the conditions prescribed on their FVIO, their involvement in other support services and mechanisms or a combination of these factors. However, it is noteworthy here that qualitative findings presented later on in this report suggest that some U-Turn participants and AFMs link an improvement in U-Turn participant behaviour directly to their participation in the U-Turn program.

4. Findings: Quantitative Data Analysis

This section provides an overview of survey response rates and present quantitative findings derived from U-Turn participant and AFM data at different points of data collection. U-Turn participant findings include alcohol use, psychological wellbeing, personal responsibility and aspects of housing stability. AFM findings include perceptions and experiences of U-Turn participants' respectful communication; space for action; experiences of non-physical, physical and sexual abuse; and feelings of safety. Results from six and 14-month follow ups as well as 12-month court follow-up data are also presented.

4.1 Survey Response Rates

A total of 35 men were referred and assessed as eligible and group-ready to commence U-Turn. Of these, 30 men who commenced the program gave consent to participate in the evaluation. Only one man who declined participation in the evaluation commenced and completed the U-Turn program. The remaining four who declined participation in the evaluation also did not commence the U-Turn program as they failed to attend or engage in the three orientation sessions leading up to the 12-week program. Findings reported hereafter are based on the 30 program participants who commenced U-Turn and agreed to participate in the evaluation.

Table 6 shows the number of U-Turn program participants and AFMs and the survey response rates across each time point. Of those program participants who participated in the evaluation, eight did not complete all 12 sessions. 25 U-Turn participants completed an exit assessment, which represents a 16.7% attrition rate. A further 14 female AFMs who were associated with the U-Turn program participants through their experiences of FV agreed to participate in a separate Wave 1 survey. Ten of these AFMs went on to complete the second wave, which represents a 28.6% attrition rate (see, Table 6).

Additional follow ups were conducted six months and 14 months after the U-Turn program ended. A total of 25 participants completed the six-month follow up, which comprised nine AFMs and 16 U-

Turn participants. These response rates represent a 35.7% and 46.6% attrition rate respectively from initial contact with AFMs and U-Turn participants. At the 14-month follow up, three AFMs and seven U-Turn participants provided information.

Over time, the attrition rate of participants across both groups from the point of initial contact to the 14-month follow up may be due to a combination of factors, including the lack of face-to-face contact between participants and researchers, competing demands in the lives of individuals affected by FV, and the enduring impacts of the COVID-19 pandemic. It is important to note that it is not uncommon for research with highly vulnerable and hard-to-reach populations to encounter high attrition rates, especially when relying on telephone follow-up contact as the mode of data collection (Meyer et al. 2019a; Meyer et al. 2019b; Day et al. 2019). Families previously or currently affected by FV often face a variety of demands on top of everyday life, including trauma, housing stress, financial hardship and the need to comply with regulatory interventions. As a result, making time for research participation can play a subordinate role.

	Males	Females
Total completed Wave 1	30	14
Total completed intake and exit/Wave 2	25	10
Attrition rate Wave 2 (%)	16.7	28.6
Men who completed Waves 1 and 2 but did not attend all program sessions	8	-
Total completed six-month follow up (Wave 3)	16	9
Attrition rate Wave 3 (%)	46.6	35.7
Total completed 14-month follow up (Wave 4)	7	3
Attrition rate Wave 4 (%)	63.2[10]	66.7[11]

Table 6: Survey Response Rates

4.2 Male Results

4.2.1 Alcohol Use

U-Turn participants were asked at program intake if they had consumed alcohol in the last year. All but one participant stated they had (96.7%). Of those that reported consuming alcohol, the majority stated they did so at least four times per week (40.0%; see, Figure 3). Further, 43.7% of the sample reported having six or more drinks on one occasion at least weekly (see, **Error! Reference source not found.**).

[10] Attrition rate for U-Turn participants at Wave 4 is calculated out of the 19 men who participated in U-Turn Groups 1 and 2 as Groups 3 and 4 had not reached their 14-month follow-up timepoint at the time the evaluation concluded.

[11] Attrition rate for AFMs at Wave 4 is calculated out of the nine women who are associated with the men who participated in U-Turn Groups 1 and 2 as AFMs associated with men in Groups 3 and 4 had not reached their 14-month follow-up timepoint at the time the evaluation concluded.

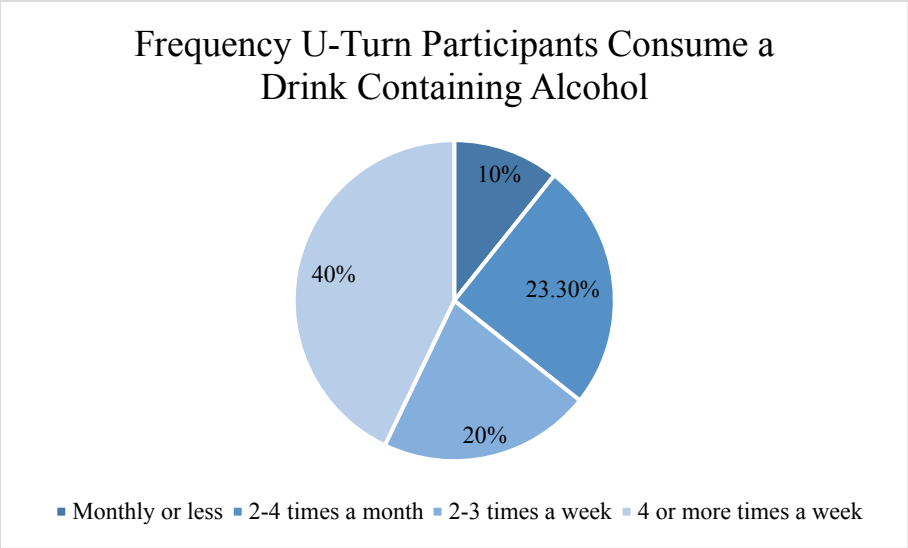


Figure 3: Frequency U-Turn Participants Reported Consuming Alcohol (n=28)

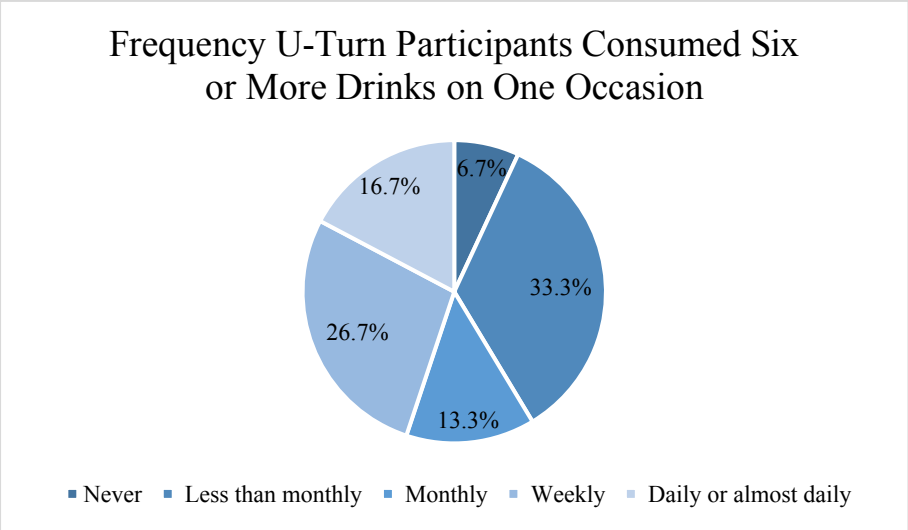


Figure 4: Frequency U-Turn Participants Reported Having Six or More Drinks on One Occasion (n=29)

U-Turn participants were also asked about the extent to which they engaged in binge drinking behaviours (e.g. consuming six or more standard drinks on one occasion). Over half of the sample (56.7%) reported binge drinking behaviours at least monthly. The majority of these drank six or more standard drinks on one occasion at least weekly. However, the majority of participants advised that neither they nor someone else had ever been injured because of their drinking (60.0%), with the remaining sample stating either they or someone else had been injured because of the U-Turn participants' drinking in the past year (3.3.%) or historically (33.3%).

4.2.2 Psychological Wellbeing

U-Turn participants' psychological wellbeing was measured at intake and the exit assessment utilising the *Kessler 10 Psychological Distress* scale (n=24)[12]. As can be seen in Figure 5, there was no statistically significant difference in scores between the Wave 1 (Mean = 2.08; SD = 0.99) and Wave 2 (Mean = 1.82; SD = 0.82). However, the decrease in mean scores between Waves 1 and 2 suggests that U-Turn participants experienced slightly less psychological distress at the exit assessment following completion of the U-Turn program. Between the intake and exit assessments, U-Turn participants' feelings of psychological stress decreased from being felt 'a little of the time' to being felt almost 'none of the time'.

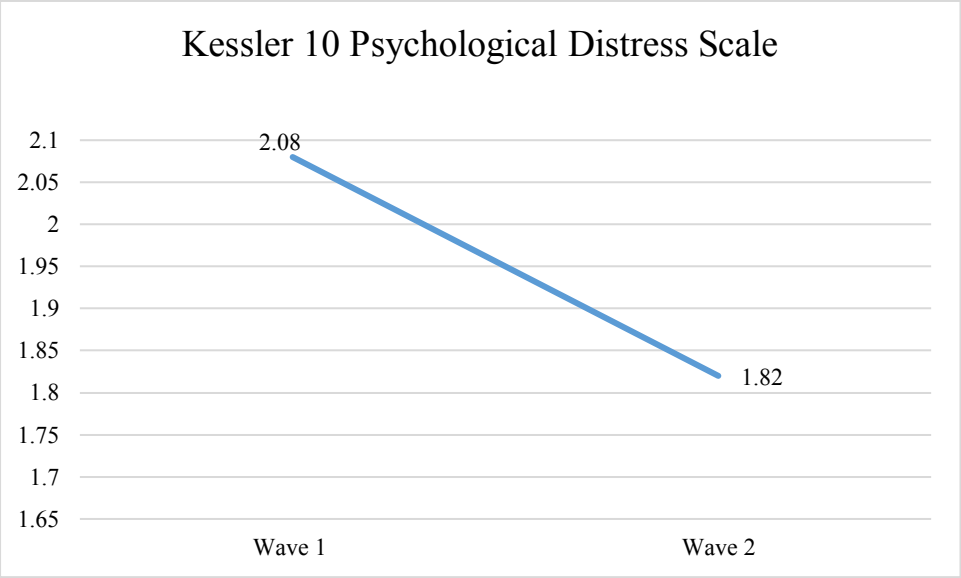


Figure 5: U-Turn Participants' Psychological Wellbeing Measured by the Kessler 10 (n=24)

4.2.3 Personal Responsibility

U-Turn participants in the final two Groups (3 and 4) were also asked to answer a series of questions at intake (Wave 1), at program midpoint (6 weeks) and at exit data collection (Wave 2) that sought to measure their feelings of personal responsibility towards their behaviour, particularly as it pertained to their relationships with their partners and children (where applicable). As can be seen in Table 7, feelings of responsibility to all questions – except '*I am ultimately responsible for my choices and behaviour*', '*I am responsible for my choice to use drugs and/or alcohol', and 'Anger is an emotion; violence is a chosen behaviour*' – decreased between the intake and midpoint assessments, before the mean score across most items increased again by Wave 2. The reduction in mean scores at the midpoint assessment across the three items could be reflective of participants selecting more socially desirable answers at program intake and exit because the survey was administered by a dedicated interviewer at those timepoints. The midpoint decrease may be a reflection of men acknowledging lower levels of responsibility for their actions and behaviours when self-administering the scale at program midpoint. However, a notable exception to this observation was in response to the items '*I*

[12] Missing data for this measure exists as some U-Turn participants did not complete this scale at Waves 1 or 2.

am ultimately responsible for the FVIO' and '*I am responsible for my choice to use drugs and/or alcohol*', whereby the mean score had decreased for the first measure by the midpoint assessment then dropped slightly more by Wave 2 data collection. For the second measure, the mean score had increased slightly by the midpoint assessment but dropped below the mean score recorded at intake. It is therefore unclear what role social desirably answer selections at Wave 1 and 2 may have played as no clear pattern of a lower midway score compared to Waves 1 and 2 scores emerged across patterns.

Non-parametric t-tests[13] were conducted to determine if there were significant differences in feelings of personal responsibility towards each item across the three time points. As shown in Table 7, no items were statistically significant.

	Intake (Wave 1)		Midpoint		Exit (Wave 2)	
	Mean	SD	Mean	SD	Mean	SD
I am ultimately responsible for my choices and behaviour	9.50	0.97	9.60	0.70	9.60	0.84
Changing my behaviour is a matter of choice, consistency and discipline	9.60	0.70	9.22	1.09	9.80	0.42
I am responsible for my current life circumstances	9.10	1.29	8.80	2.39	9.10	1.29
I am ultimately responsible for the FVIO	8.50	1.43	7.70	3.43	7.60	3.10
I am responsible for my choice to use drugs and/or alcohol	9.70	0.95	9.78	0.67	9.50	1.08
Anger is an emotion; violence is a chosen behaviour	9.40	1.35	9.56	0.88	9.60	0.84
I am responsible for the current state of my relationship with my children	9.00	1.58	8.86	1.86	9.14	1.57
I am responsible for the current state of my relationship with my (ex)partner	8.30	2.00	7.89	2.57	8.80	1.62

Table 7: Mean Scores and T-test Results Comparing U-Turn Participants' Feelings of Personal Responsibility Across All Three Time Points

4.2.4 Importance of Housing for Perpetrators Excluded from the Home

At the exit interview (n=25), U-Turn participants were asked a series of questions about their living situations and how the FVIO had impacted their living arrangements. As shown in Figure 6, the majority of U-Turn participants were living with the AFM at the time of the DFV incident (n=21; 84%). Two U-Turn participants (8%) were not, one participant's living condition was unknown (4%) and one was missing from the data.

[13] Wilcoxon Sign tests were run when the difference of each paired sample was not normally distributed.

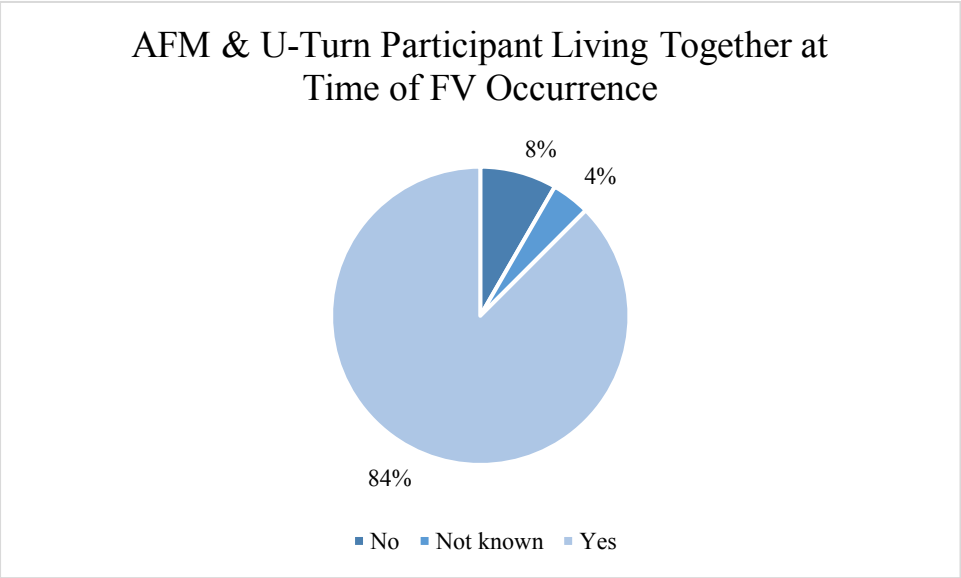


Figure 6: Percentage of Participants Living Together at the Time of the Domestic and Family Violence (DFV) Incident (n=25)

However, following the DFV incident, police removed most of the respondents from the home. Specifically, Figure 7 shows that over 70% (72%; n=18) of U-Turn participants were removed from the home for the safety of the victim/survivor. Only two U-Turn participants were temporarily removed without an exclusion condition being included on the FVIO application. These U-Turn participants were temporarily removed from the home for the purpose of police interviewing or a mental health assessment (n=2). Of all the U-Turn participants who were removed from the home by police, two-thirds (66.7%; n=12) were subject to an extended exclusion condition once the application was mentioned in court.

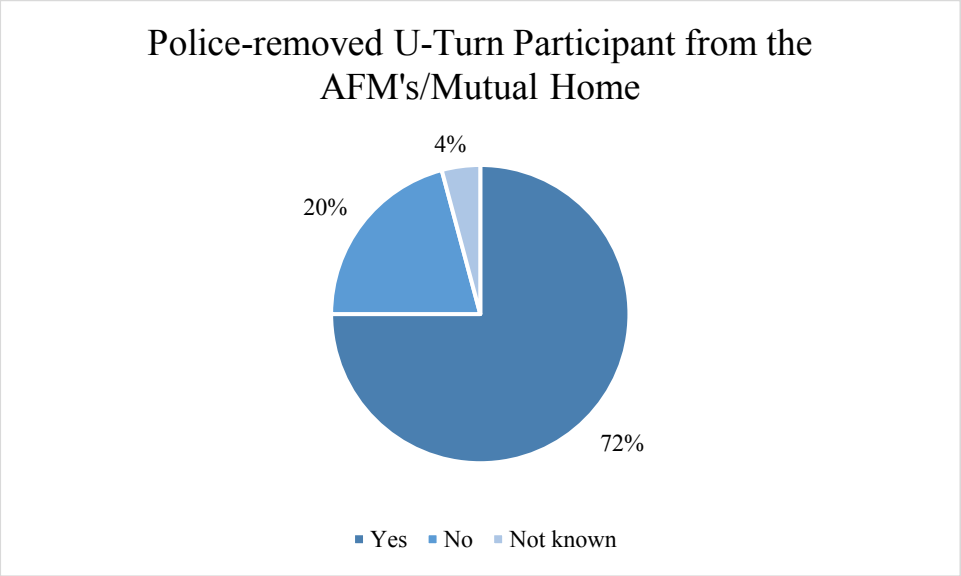


Figure 7: Percentage of U-Turn Participants Removed from the Home by Police Officers (n=25)

Ten U-Turn participants who completed the exit interview were able to cohabitate with conditions as stipulated by the courts (40%; see, Figure 8). Of the 25 men who completed the exit interviews, 17 (68%) further had a condition included on their FVIO that stipulated restrictions around their AOD use. Stipulations included requirements that men cannot be intoxicated in the home shared with the AFM, and/or cannot attend the AFM's residence (where not residing together) intoxicated.

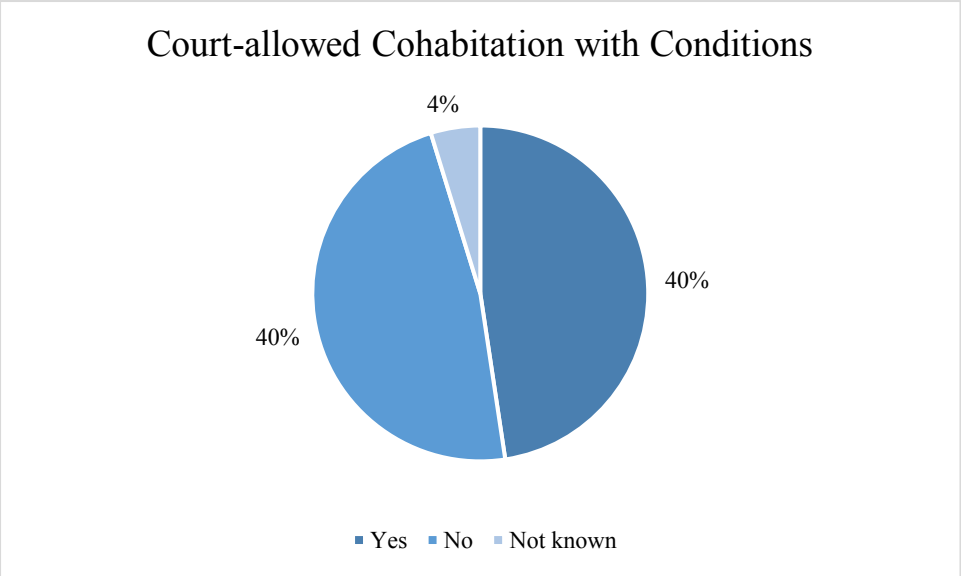


Figure 8: Percentage of U-Turn Participants Who Had a Court-stipulated Cohabitation Condition (n=25)

4.3 AFM Results

4.3.1 Respectful Behaviours

The sample size to conduct paired t-tests for AFMs' perceptions that the named person in their FVIO was respectful towards them in their communication was small (n=9). Additionally, the reported respectful behaviours scale at Wave 1 (n=14) and Wave 2 (n=9) was not normally distributed. As such, the non-parametric t-test conducted did not yield sufficient statistical power and was statistically non-significant. As shown in Figure 9, there was an increase in AFMs' perceptions that the named person in their FVIO was respectful towards them when comparing the mean scores of the seven AFMs who completed the Wave 1 (Mean = 3.39; SD = 1.12) and Wave 2 surveys (Mean = 3.82; SD = 0.60). In other words, AFMs perceived that the named person in their FVIO was more respectful at Wave 2 of the survey.

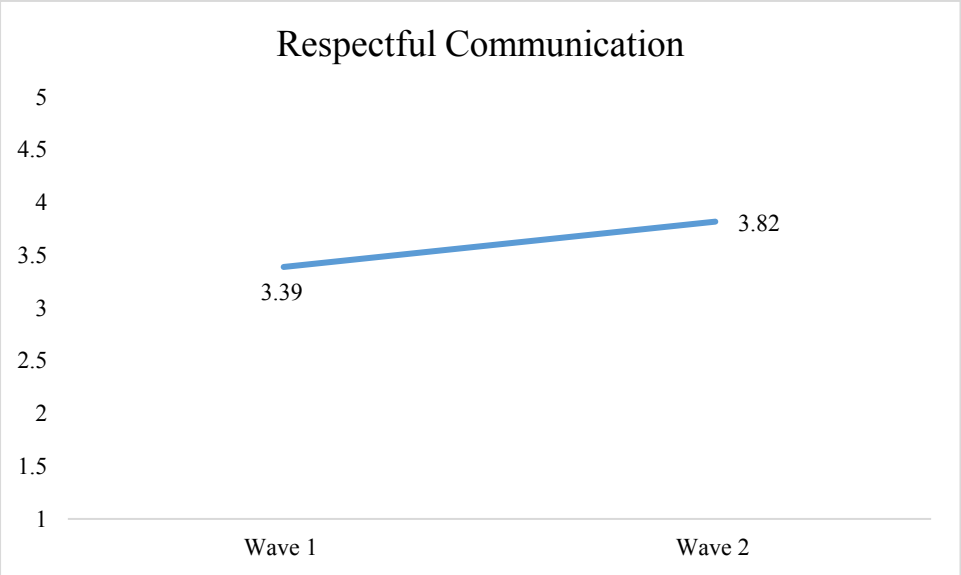


Figure 9: AFMs' Perceptions That the Named Person in Their FVIO Was Respectful at Wave 1 (n=14) and Wave 2 (n=9)

4.3.2 Space for Action/Controlling Behaviours

AFMs were asked a series of items across Waves 1 and 2 to ascertain the extent to which they experienced controlling behaviours. The sample size to conduct paired t-tests for AFMs' perceptions that the named person in their FVIO was controlling towards them was small (n=8). Additionally, the reported controlling behaviours scale at Wave 1 (n=14) and Wave 2 (n=9) was not normally distributed. As such, the non-parametric t-test conducted did not yield sufficient statistical power and was statistically non-significant. As shown in Figure 10, there was a decrease in perceived controlling behaviours when comparing the mean scores of the 14 AFMs who completed the Wave 1 survey (Mean = 2.40; SD = 0.87) and the eight AFMs who completed the Wave 2 survey (Mean = 1.60; SD = 0.45). In other words, AFMs perceived that the named person in their FVIO was less controlling at Wave 2 of the survey (see, Figure 10).

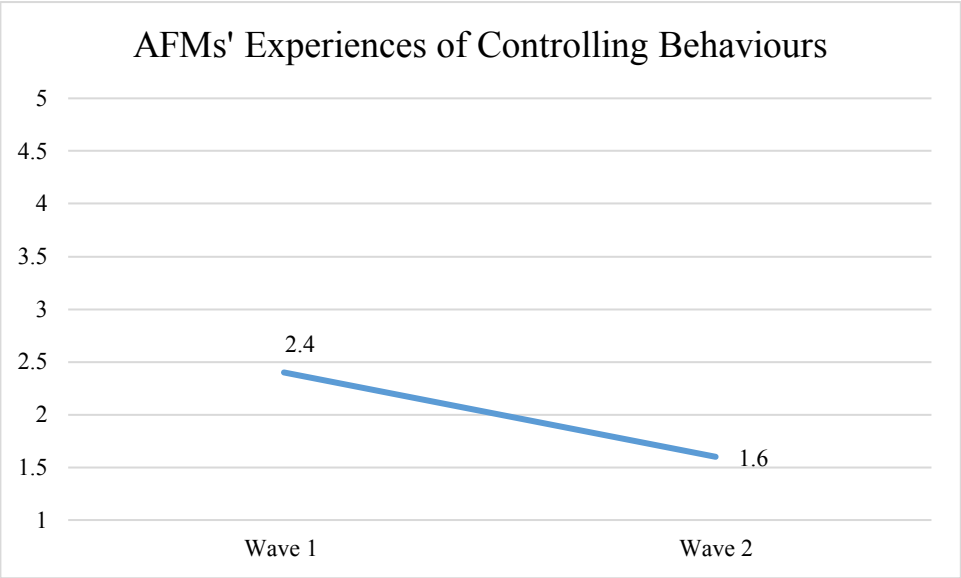


Figure 10 AFMs' Reported Experiences of Controlling Behaviours at Wave 1 (n=14) and Wave 2 (n=9)

4.3.3 Non-physical Harassment

The sample size to conduct paired t-tests for AFMs' experiences of non-physical harassment was also small (n=9), and the reported non-physical harassment scale at Waves 1 and 2 was not normally distributed. Thus, a non-parametric t-test was conducted to examine if there was a statistically significant difference between AFMs' experiences of non-physical harassment at Waves 1 and 2. Results of the test indicate that experiences of non-physical harassment were statistically significantly lower at Wave 2 when compared to Wave 1.[14] This finding suggests that men's participation in U-Turn may have contributed to men reducing the frequency of their non-physical forms of harassment towards the AFM (see, Figure 11).

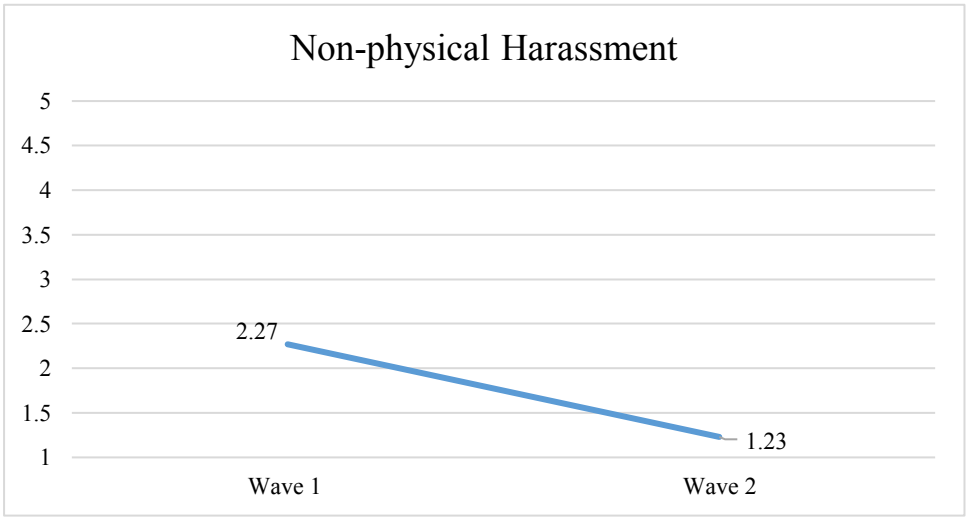


Figure 11: AFMs' Reported Experiences of Non-physical Harassment at Wave 1 (n=14) and Wave 2 (n=9)

[14] (Z = -2.68, p<0.01)

4.3.4 Physical Abuse

AFMs were asked a range of questions pertaining to their experiences of physical abuse by their (ex)partner. AFMs reported rarely experiencing each type of abuse at Wave 1. At Wave 2, AFMs reported that experiences of physical abuse had ceased altogether. Non-parametric t-tests were conducted across each item at both waves but did not yield any statistically significant results. This is likely due to the small sample size that completed both waves of surveys (see, Figure 12).[15]

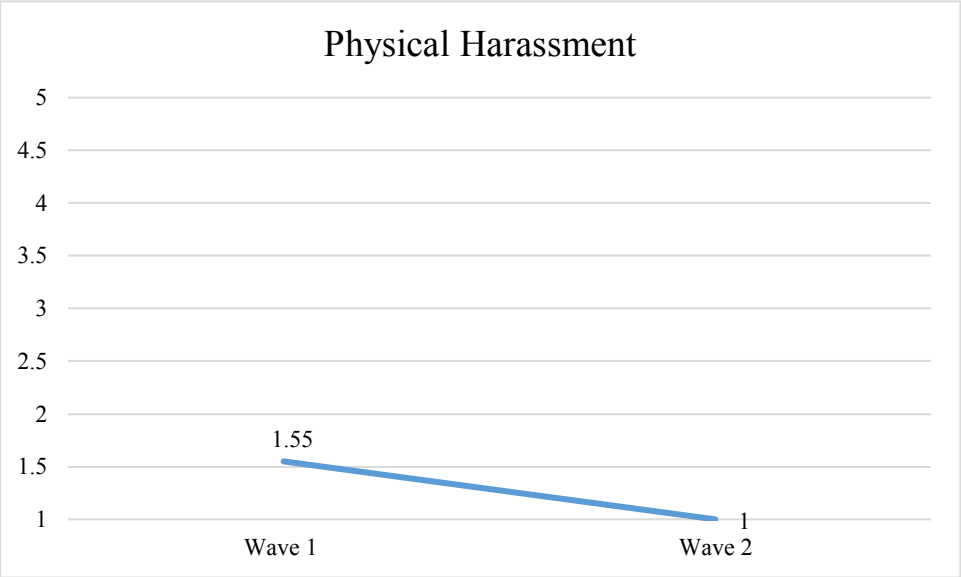


Figure 12: AFMs' Reported Experiences of Physical Harassment at Wave 1 (n=14) and Wave 2 (n=8)

4.3.5 Sexual Abuse

The sample size to conduct paired t-tests for AFMs' experiences of sexual abuse was small and the reported sexual abuse item at Wave 1 (n=14) and Wave 2 (n=7) was not normally distributed. As such, the non-parametric t-test conducted did not yield sufficient statistical power and was statistically non-significant. Overall, AFMs reported limited experiences of sexual abuse, with two AFMs (14.3%) reporting that 'sometimes' they had been made to do something sexual that they did not want to do. The remainder of the sample had either 'hardly ever' (14.3%) or 'never' (71.4%) been unwillingly made to do something sexual.

4.3.6 Feelings of Safety

The sample size to conduct paired t-tests for AFMs' feelings of safety was small (n=8) and the feelings of safety item at Waves 1 and 2 was not normally distributed. As such, the non-parametric t-test[16] conducted did not yield sufficient statistical power and was statistically non-significant. As shown in Figure 13, there was no change in AFMs' feelings of safety when comparing the mean scores of the eight AFMs who completed the Wave 1 (Mean = 3.25; SD = 1.04) and Wave 2 (Mean = 3.25; SD = 1.04)

[15] The sample size for questions 1 and 2 was (n=6), for questions 3 and 4 was (n=7), and for question 5 was (n=8).
[16] Wilcoxon Sign tests were run when the difference of each paired sample was not normally distributed.

surveys. Given the general improvements in men's behaviour reported by AFMs, the lack of change in AFMs' feelings of safety between Waves 1 and 2 may suggest that AFMs already felt relatively safe at Wave 1 due to the protective measures put in place via their FVIO and men's engagement with a behaviour change program.

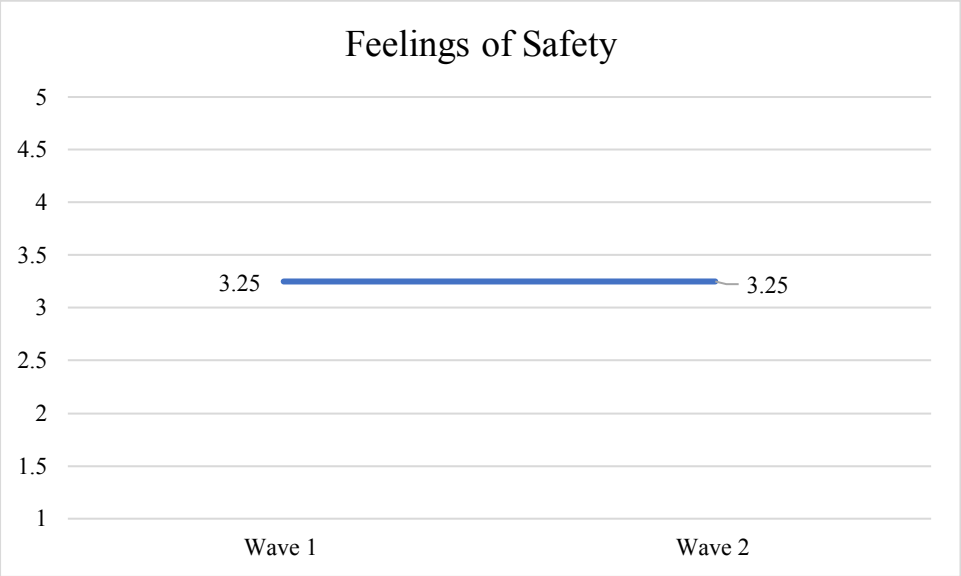


Figure 13: AFMs' Reported Feelings of Safety at Wave 1 and Wave 2 (n=8)

4.4 Six-month Follow Up

U-Turn participants and AFMs involved in the evaluation were invited to participate in six-month follow-up interviews (Wave 3). The primary purpose of this follow up was to ascertain AFM and U-Turn participants' current perceptions of men's AOD use, use of FV and experiences of co-parenting where children were involved, as well as whether any change identified at Wave 2 data collection (program conclusion) was maintained.

Quantitative data gathered from the six-month follow-up interviews across the three domains of FV, AOD use and co-parenting was based on AFM reports, apart from where AFMs were unable to comment due to having no contact with the U-Turn participant at the time of data collection or where AFMs did not participate in Wave 3 data collection. Where AFM data was unavailable, U-Turn participants' data was used, *with the exception of data on FV behaviours*. That is, if an AFM did not complete the six-month follow up, this field was left blank. However, male U-Turn participants' self-reports were used in relation to AOD use and co-parenting in the absence of AFM data.

The first two questions of the six-month follow up interview confirmed with AFMs whether there had been an improvement in their relationship with the male participant at the time of program conclusion and, where applicable, whether this improvement had been maintained. Where the AFM did not participate, responses were not obtained from U-Turn participants. Nine AFMs responded to these first four questions. Of those, seven advised that there had been an improvement in their relationship with the U-Turn participant, and that this improvement had been maintained. It must be noted that

the two AFMs who did not respond to this question did so because, as they advised, they had not had any contact with the male participant and thus no ongoing relationship with the U-Turn participant.

The second set of questions confirmed with U-Turn participants and AFMs whether the U-Turn participant had reduced or ceased consuming alcohol (or other drugs, where applicable) at program conclusion, and whether any changes reported at Wave 2 had been maintained at Wave 3. Based on a combination of AFM accounts and U-Turn self-reports, we have responses to these questions for 17 U-Turn participants at their six-month follow up. Of these, 14 AFMs and/or U-Turn participants reported the U-Turn participant had reduced/ceased alcohol and/or drug consumption and maintained it. One AFM stated they were unsure due to limited contact, and a further two AFMs reported that they did not know, due having no ongoing contact with the U-Turn participant. Of these, three AFMs were unsure – the evaluation is unable to comment on the AOD use of one U-Turn participant at Wave 4 as the corresponding U-Turn participant did not participate in a six-month follow-up interview, while the other two U-Turn participants reported deterioration in their drinking behaviours. The final series of questions confirmed with U-Turn participants and AFMs whether or not there had been an improvement in co-parenting arrangements or men's overall relationships with their children at the time of program conclusion, and whether any reported change at the time had been maintained by Wave 3 data collection. Nine individuals reported that there had been an improvement and it had been maintained. Four participants stated that they did not have any children, a further two stated that they had sole custody, one advised that their children were adults, and one stated that they were unsure.

The majority of AFMs and U-Turn program participants reported improvements to FV behaviour, AOD use and co-parenting maintenance at their six-month follow-up interviews. While this overall improvement was reported, a small number of AFMs and U-Turn participants did discuss some deterioration in men's drinking behaviour at different follow ups (see, sections 5.1.1.1 and 5.1.2.1). Where this was the case, AFMs and/or men primarily linked this to the impact of prolonged COVID-19 restrictions on Victorian households at the time (see, section 5.4.5).

4.5 14-month Follow Up

A 14-month follow-up interview was also completed with U-Turn participants (n=7) and AFMs (n=3).[17] This survey served as an additional 'check-in' to ascertain whether sustained behaviour change reported at Wave 3 had been further maintained in relation to FV, AOD use and co-parenting.

As with the quantitative data gathered from the six-month follow-up interviews, quantitative data extracted from Wave 4 interviews are, where possible, based on AFM reports. Where an AFM did not provide this information (due to non-completion of follow up or no knowledge of the U-Turn participant's current situation or behaviours), U-Turn participant data was used, *with the exception of data on FV behaviours*.

Of the three AFMs who participated in Wave 4 data collection, one reported still feeling unsafe as there had been no improvement in her ex-partner's behaviour at Waves 2, 3 or 4 data collection. One AFM reported that while there had been some conflict in recent months associated with Victoria's extended household restrictions, and the family having been 'locked down' together for an extended

[17]In one follow up, both the AFM and the U-Turn participant provided responses.

period of time, overall the U-Turn participant had maintained some behaviour change. The third AFM reported that improvements noted at Waves 2 and 3 had been maintained for her partner.

Regarding alcohol and/or drug consumption, seven participants (three AFMs and four U-Turn participants) responded to the question. The three AFMs reported that improvements regarding AOD use reported at Waves 2 and 3 had been maintained by men. Three U-Turn participants further affirmed that they had maintained their reduction in or abstinence from AOD consumption reported at Waves 2 and 3. Only one U-Turn participant stated that they had not been able to maintain the improvement in their own alcohol and/or drug use reported at Wave 3. This participant linked his relapse at six months to COVID-19 and at 14 months to the loss of his father.

The final question asked AFMs and U-Turn participants if any improvements in their co-parenting relationships reported at Wave 3 had been maintained. Seven participants (three AFMs and four U-Turn participants) responded to this question, with four stating that positive change had been maintained. One participant stated that change reported at Wave 3 had not been maintained. The final two participants reported that they did not have children.

The majority of AFMs and U-Turn program participants reported that initial improvements to FV behaviour, AOD use and co-parenting had been maintained, during their 14-month follow-up interviews. Few AFMs and U-Turn participants referred to a deterioration in men's behaviour, primarily around AOD use and co-parenting/parenting (see, sections 5.1.1.1 and 5.1.2.1). Similar to findings reported for six-month follow ups, where a deterioration in behaviours was reported, AFMs and/or men primarily linked this to the impact of prolonged COVID-19 restrictions on Victorian households at the time (see, section 5.4.5).

4.6 Court Analyses

In addition to the data collected as part of the U-Turn program, court data was also obtained for consenting U-Turn participants (n=29[18]). Participants' first court mention for their FVIO ranged from 16 January 2018 to 16 June 2020, and the finalisation dates ranged from 16 January 2018 to 23 March 2021.[19] Four participants' FVIOs were finalised in court on the day of the first mention. The remaining participants had FVIO finalisations ranging from 30 days to 1256 days (approximately three years and five months) after their first mention (Mean=219.85 days).

Nine U-Turn participants had criminal charges associated with their FVIO matter (31%).[20] Eight participants had recorded FVIO breaches, ranging from one to 11 breaches (27.6%; Mean=3.9). Five of these participants also had other court appearances during the 12-month period since their first FVIO mention, with an additional four participants who had no reported breaches but had appeared in court for other offences (27.6%). Three participants were indicted on alcohol-related offences, three participants had court appearances for stealing offences – including aggravated burglary – two participants had a combination of charges, including assault, threats to harm, criminal damage charges and/or dangerous/careless driving offences. The final participant breached their bond. While there are limitations to using court data to determine whether U-Turn was able to keep FVIO respondents

[18] All 30 evaluation participants consented for their court data to be accessed and analysed. However, the court was unable to retrieve data for one of the participants as his name did not yield any results in the court data base.
[19] One participant's finalisation date is scheduled for 6 August 2021.
[20] The court data are based on information from 29 participants.

out of the CJS (e.g. time lag between offences occurring, charges being laid and matters being heard in court), the above findings suggest that the majority of U-Turn participants did not enter the CJS in the context of their FV offending behaviour. None of the U-Turn participants reappeared in court for new FV matters (e.g. additional FVIOs and/or criminal charges involving a new AFM) over the 12-month follow-up timeframe. Almost three quarters (72.4%) of U-Turn participants did not appear in the court system for a FVIO breach during the follow-up timeframe. While some appeared for other criminal matters since their initial U-Turn referrals, some of these alleged offences may have occurred prior to men's referral to U-Turn given the allowed timeframe of up to 12 months between charges being laid and a matter being mentioned in court for all non-FV matters, unless the matter involved a bail hearing.

5. Findings: Qualitative Data Analysis

5.1 Men's Behaviour and Behaviour Change

5.1.1 Men's AOD Use – Both Self-reports and AFM

The majority of men acknowledged substantial histories of self-reported chronic binge drinking, some alcohol dependence, and, to a lesser extent, some other drug use during the qualitative interview components. For the majority of U-Turn participants, alcohol constituted the primary drug of concern. It is important to note that because most men ceased or reduced their alcohol intake prior to commencing the U-Turn program, and because several men had court orders stipulating restrictions around their alcohol intake and drinking habits, it is difficult to establish a causal relationship between participation in U-Turn and participants' decreased intoxication and decreased abusive behaviours where these previously occurred predominantly in the context of alcohol misuse. Nevertheless, improvements are reported here, particularly where these were sustained at six and 14-month follow ups. It is also noteworthy that some participants – both men and AFMs – attribute these improvements explicitly, at least in part, to men's participation in U-Turn.

5.1.1.1 Current/Ongoing AOD Use

Some form of current and continued consumption of alcohol was common among U-Turn participants, with very few participants reporting abstaining from alcohol consumption entirely. However, where AOD use, particularly alcohol consumption, was current and ongoing, this was predominantly discussed in the context of improved drinking behaviours, such as drinking less, as illustrated by the following examples:

> Prior to this event, I would have drunk every night and I would be drinking [to] excess every night. Now I would be lucky if I'd drink to excess once a week. (Exit Interview, P12 Group 2)

> I still buy alcohol, but I've slowed down. (Six-month follow up, P5 Group 1)

> I still enjoy a drink, but I drink a lot less now. (14-month follow up, P4 Group 1)

While no participant reported increased AOD consumption, a minority of participants reported no change or a temporary relapse into their previous drinking behaviour. For example:

> Probably had a bit of a crack in the last two weeks, but before that, the month before that, I was – well, a couple of months before that I wasn't really drinking at all very much. (Exit Interview, P14 Group 2)

> I certainly drink with my friends on the weekend, and I'd had glasses of wine over dinner. I'm certainly a drinker, and certainly enjoyed alcohol with friends. Then after that my drinking habits have been, I guess I would say pretty similar, especially through COVID, and maybe not that much else to do, you know, having a drink at home. But I don't think that there has been a substantial change in my drinking habits. (Exit Interview, P31 Group 3)

> This unfortunately hasn't changed. Now he drinks every day but not as much. Before, he drank more but less often. Every day he finds an excuse to drink. (Exit Interview, AFM4 Group 1)

> The last eight months […] I probably drank a bit more yeah [because …] I had my father die. (14-month follow up, P14 Group 2)

5.1.1.2 Overall Improvement in AOD Use

The majority of U-Turn participants reported improved AOD behaviours, primarily in the form of drinking less, as the above section (5.1.1.1) on current and ongoing AOD use highlights. Some participants also expressed improvements in their awareness of where and when they consume alcohol, how this impacts others, and when to stop. This was articulated by both participants and AFMs:

> So, what has changed since that all occurred is that again, I'm no longer drinking in private. And she's fully aware of when I do consume alcohol. And at this stage, for the past few months, it's been both of us doing it, typically on a Friday and a Saturday night, and it will involve sharing a bottle of wine, or sharing a bottle of champagne. (Exit Interview, P27 Group 3)

> I have noticed that he will have one or two and will go, "You know what, that's enough for now." Whereas, I know previous to that incident last year, he just didn't know how to say, "No. That's enough." So for me, that's a massive step. (Six-month follow up, AFM5 Group 1)

> [The U-Turn program] certainly helped me […] to understand how other people feel as well, so – and yeah, well, you know, [how they are impacted] by the drinking behaviour. I actually drink a lot less now. (14-month follow up, P4 Group 1)

For some participants, improvements in AOD behaviours were at least partially attributable to other service engagement, such as rehabilitation services and AA:

> I was heavily dependent on the substance. I was using 24/7 for a period of a year. Since December the 2nd, I went into a rehab and I've been clean since then. (Exit Interview, P29 Group 3)
>
> [Name] hasn't had a drink for eight months. "I don't think he would have been able to do this without U-Turn or AA – AA meetings are also very important to him now." (Six-month follow up, AFM3 Group 1)
>
> Things have come a long, long way, […] I'm still going to AA […] I haven't touched a drop of alcohol, not one little bit […] I don't feel like a drink anymore. (14-month follow up, P3 Group 1)

The above quotes from P3 and AFM3 illustrate that improvements were reported by both partners. In this evaluation, similar feedback on changes to AOD use reported by (ex)partners was common where both parties participated in the evaluation. This highlights the critical role of including the voices of AFMs in program evaluations where possible to maximise the reliability of self-report data collected from program participants.

Identifying engagement with other AOD services is relevant here as it a) highlights the wider support needs of men with comorbid AOD use and use of FV, and b) limits the evaluation's ability to isolate effects of behaviour change and attribute improvements in AOD use to U-Turn specifically. However, our findings suggest an overall reduction in AOD use, particularly alcohol consumption, among participants who engaged in U-Turn. It is particularly noteworthy that these improvements were sustained at six and 14-month follow-up interviews by the majority of participating men and AFMs. Only one male U-Turn participant who participated in a six and 14-month follow-up interview reported a deterioration in drinking behaviours. At the six-month follow up, he indicated that the deterioration was related to the impacts of COVID-19 on his current situation. At the 14-month follow up he described ongoing problematic alcohol use, which he described as a coping response to a death in the family.

5.1.2 Men and AFM Accounts of Men's Use of FV

To identify men's use of FV and related behaviour change, the evaluation primarily relies on AFM reports, where available. Where AFMs did not participate in the evaluation, men's data is used to identify potential improvements. While AFMs predominantly reported an overall improvement in their experiences of FV – reflecting the quantitative findings reported in section 4.3 – some also reported continued abusive behaviours. Ongoing abusive behaviour was primarily reported by AFMs who had separated from the U-Turn participants and involved the instrumentalisation of friends, family, neighbours or children to facilitate ongoing surveillance of the AFM along with other controlling behaviours.

Most male evaluation participants demonstrated some reflection and insight into their (past) abusive behaviours, with some displaying ongoing denial and victim-blaming attitudes. This is discussed below in relation to limitations around men's acknowledgement of personal responsibility. Ultimately, we see some ongoing forms of abusive behaviours, but, overall, the qualitative data suggests that women who participated throughout the evaluation felt safer at the time of their exit, six and 14-month follow-up interviews.

5.1.2.1 Current/Ongoing Use of FV

While men primarily noted that their intimate and family relationships were going well, some AFM interviews suggest that there remain some persistent issues alongside the reported improvements. For example, a separated AFM reported ongoing controlling behaviours persisting at both the six and 14-month follow-up interviews:

> Since the police removed him, after the last assault, he has not been living at these premises. There is a two-year good behaviour bond on him … he's not allowed here, and he has adhered to that, as in he hasn't physically been here, but he has still continued his controlling behaviours from afar […] he has been working his magic legally, et cetera, and using his financially controlling things still, as he has always done […] that hasn't changed. (Six-month follow up, AFM12 Group 1)

> The people that are his friends around here are watching me, I know they are, and my movements are monitored. And as far as the financial stuff, the games that he played originally where he cut off the electricity, the gas, the internet and everything else along with it – all of the insurances et cetera. He can't do that a second time, because it's done, so the scope of works there has finished. But he did play games with whatever little funding he's sent to me – maintenance. He volunteered to do that, and then did it intermittently, but then, in one of the court cases we managed to get that mandated, so that has kind of solidified that process. (14-month follow up, AFM12 Group 2)

Another separated AFM highlighted the way in which co-parenting and the hand-over of children provided an avenue for ongoing abusive behaviour:

> Handover is meant to be 8:00pm on a Sunday night. They get dropped home at 10:30am, 1:00pm, 5:00pm, but for the whole year not once did they get home at 8:00pm and the day before the Sunday they both start school for the whole new year, here they rock home at quarter to ten at night. And I'm texting at 8:30 going, like, call [AFM's son] at 8:30 to say, "Where are you? Are you running late?" […] And I hear [former partner] in the background go, "Tell your mother I'll drop you home at midnight. Ha ha ha ha ha." (Six-month follow up, AFM25 Group 3)

Comparatively, her ex-partner's account of his behaviours towards her since participation in U-Turn was substantially more positive:

> I've adjusted the way that I communicate because I was being antagonistic in the way that I was communicating. I was trying to get a result from that. I was trying to create – I was trying to cause pain. So I was being an arsehole basically.

> So what I've learnt from I suppose time and also from the U-Turn program is that it's just to be communicating in that way is counterproductive, it might make me feel better for that 20 minutes after I've sent the email but then I've got a lot of remorse after that. So for me it was just better to look at, okay, what's the objective that I'm – what's my objective from sending this email because we can only communicate via email. Thank god […] I'd look at the email and say, okay, will this achieve my objective or is it just – am I just doing it to try and hurt her? So that's certainly from learnings from U-Turn and also a bit of time. You know, I've calmed down. (Exit Interview, P25 Group 3)

While the above quote suggests insight into some aspects of past abusive behaviours, cross-referenced AFM data reveals ongoing abusive and controlling behaviours in other areas. This variation in accounts reported by men and AFMs highlights the importance of including AFM voices in evaluations of perpetrator interventions (Westwood et al., 2020) to overcome men's data limitations associated with socially desirable self-reports and/or an attempt to manipulate systems, including service and evaluation providers. While most AFM and U-Turn participant accounts captured in this evaluation suggest improvements in men's behaviour, men typically reported more positive reflections on their level of behaviour change, while AFMs continued to identify ongoing problem behaviours in some instances.

5.1.2.2 Overall Improvement in FV

Overall improvements were reported in the form of a cessation of violent or abusive behaviours, as well as men's improved ability to manage emotions and communicate more effectively and respectfully. In line with the quantitative data presented in section 4.3, interviews with AFMs revealed physical and/or sexual abuse had ceased in most cases and emotional and verbal abuse along with property damage had substantially decreased. Improvements in (ex)partners' behaviours were reported by AFMs in exit interviews along with six and 14-month follow ups:

> I can see lots of good changes in his behaviour, but as I said, again, we don't live together. He understands when we see each other he can't be the same, like violent or abusive, because then I won't see him. (Exit Interview, AFM2 Group 1)

> Yes – he is much calmer and doesn't react strongly to things any more. He has started to think before he says or does things and there is now more understanding that he needs to show respect. There have been no abusive behaviours. (Exit Interview, AFM4 Group 1)

> He improved. He is improved really good. He quite calm, yeah. If it's compared with two years ago, yes, he improve. (Six-month follow up, AFM29 Group 3)

> He has come just an incredibly long way and a lot of it is because he now understands that when he is stressed, he can talk through it. He knows how

> to talk through it without getting all agro and riled up and all the rest of it. He knows how to talk through things, which is fantastic. He just – yeah, is a completely different person. (14-month follow up, AFM5 Group 1)

Men also reported improvements in their own behavior and, in particular, their capacity to manage emotional tension when it arises. For example:

> I just keep my calm. Even with my kids I just keep my calm now as much as I can […] and if I think things are going to escalate, I'll exit the property and go […] I've really tried hard on that. It's good. And I do keep calm a lot now. (Six-month follow up, P6 Group 2)

> I've honestly learnt to calm down a lot more and just not contribute to escalating tensions and things like that. And just being more aware of the moment, of how in the past I would have reacted, and thinking about when I've yelled, and how it's just useless wasted of energy, and yeah, just trying to be positive. (Exit Interview, P11 Group 1)

These accounts highlight the importance of the U-Turn component that is focused on emotional and behavioural self-regulation, which several participants still referred to as useful at their 14-month follow-up interview. In addition to improvements in FV and abusive behaviours, U-Turn participants reported an improved understanding of what constitutes FV:

> Definitely the bits towards what is abuse. Like, I just thought physically, pretty much. I learned a lot more about yelling and screaming and all that, slamming doors, and how it affects them. Like I ask my wife, and she said "Yeah it does", where I didn't realise it scared her a little bit […] I just thought abuse was physical, pretty much. (Exit Interview, P10 Group 1)

> The videos that we watched, I guess the secondary, the nature and energy of the home life and the extensive effects it can have – like family violence on the children. And just the different types of family violence that a child can be subjected to. So it made me more aware, and just [to] constantly just keep checking myself. Be aware of the situation, be aware of if I'm doing something I'm maybe not aware of. And just listen a bit more. (Exit Interview, P34 Group 3)

While there were some reports of ongoing abusive behaviours by a small number of AFMs, overall improvements in behaviours were reported by both men and AFMs. Men also reported a better understanding of what constitutes FV and greater awareness of the impact of their behaviours on others. This shift in understanding was directly linked by some participants to U-Turn program content. Findings presented here therefore suggest increased awareness and an overall reduction in abusive behaviours, which was maintained at both six and 14-month follow-up interviews by those who reported improvements at program exit.

5.1.3 Intersection of AOD Use and FV

For U-Turn participants in this evaluation, the use of FV was closely tied to the use of AOD. As noted in section 5.1.1, on men's AOD use, the majority of participants used alcohol as the primary drug of concern. For the majority of men in the U-Turn program, their drinking behaviours changed, either after initial police or court contact or as they entered the U-Turn program. Alongside reduced substance use, both AFM and U-Turn participants reported a reduction in FV and improved family relationships. These findings suggest that for many men in the U-Turn program, the use of FV is closely linked to problematic AOD use (primarily in the form of excessive alcohol intake). This is further supported by the following quotes from male U-Turn participants:

> I think I've just realised that all my problems – whenever my problems have occurred, they've been when I've been drinking as well. And I can't think of a time when the police have been called or anything like that when both of us haven't been drinking. Basically, I've realised that alcohol's probably the root of most of my problems. (Exit Interview, P11 Group 1)

> I blamed her for everything. But now I can actually admit to it. If I wasn't drinking – because I said to my wife, [name], "If I wasn't drinking none of this would have happened." I said that's what's made me change to I actually don't drink anymore. (Exit Interview, P3 Group 1)

In discussing incidents of FV, including specific incidents that led to police or court involvement and engagement in U-Turn, AFMs often reported that AOD use was a factor:

> He would often get blind drunk and then lie about it. I'd be able to smell the alcohol on him and he'd say he hadn't been drinking but I was going crazy. (Exit Interview, AFM26 Group 2)

> [At the time of the incident that led to police involvement] We'd had dinner together; we'd share one bottle of wine and then my husband continued to drink whisky. He consumed over half a bottle of whisky. (Exit Interview, AFM12 Group 2)

> [At the time of the incident that led to police involvement] He started hitting the alcohol a bit more harder [sic] than [usual] […] I think he just got a bit jealous and he had a bit of a drink and then he showed up here and that's when it escalated. (Exit Interview, AFM6 Group 2)

Women generally described (ex)partners as calmer, better in interaction, and less angry when they were not drinking. Equally, men tied their anger and aggression to intoxication. There were some differences in how men and AFMs reflected on the intersection between AOD use and FV and abusive behaviours, with some men more focused on discussing drinking together with their (ex)partner when acknowledging their own alcohol use, suggesting both parties engaged in problematic AOD use. This is discussed in greater detail under findings relating to ongoing denial of responsibility displayed by some men during the evaluation in section 5.1.4.1.

5.1.4 Limitations Around Acknowledgment of Personal Responsibility

Overall, findings reported here suggest an improvement in most U-Turn participants' behaviours and AFMs' experiences of safety. However, the data also reveal some persistent problem behaviours. For some men there is ongoing denial, minimisation and deflection of accountability. For these participants, more comprehensive MBCP work may be required to generate substantial and lasting personal responsibility.

5.1.4.1 Men's Reflections That Indicate Denial of Problematic AOD Use

The majority of U-Turn participants acknowledged their AOD use as problematic to some extent. However, a small number of men reflected this in ways that indicated denial and minimisation of their AOD use. For example:

> My drinking's not that bad, it's not bad at all. Compared to lots of people that I know. (Exit Interview, P20 Group 2)

> There's other conditions [of bail] like not to be under the influence of alcohol in her presence and it's all right for her but blah-blah-blah, so I'm drinking zero alcohol beers. Only drank light beer anyway, so it wasn't really anything – so this whole drug and alcohol dependent thing, like it's been an interesting exercise to see how some others live, but doesn't really apply to me at all, but it's been interesting. (Exit Interview, P33 Group 3)

5.1.4.2 Men's Reflections That Indicate Denial of Their Use of FV

Mirroring the findings in relation to problematic AOD use, the majority of U-Turn participants acknowledged their use of FV to some extent. While some denial and minimisation was observed in relation to problematic AOD use, these tactics appeared to be more common in relation to men's acknowledgement of their use of FV. This included denial and/or minimisation of the use of FV altogether, its impact on others, and/or what men may define or acknowledge as FV in the first place:

> I'm the exception to the people that you talk to […] I'm pretty sure that everybody there, except myself, was there [in the U-Turn program] because they'd been naughty boys […] I didn't deserve to be there […] I realise I am the exception, not the norm. I'm the good guy. (Exit Interview, P30 Group 3)

> We had an altercation. I've never hit her in me [sic] life, or anything like that, but anyhow, she decided that she'd leave, so she walked out on me […] She said [to the police] that I pushed her out of the shed, and I said I just restrained her or removed [her] from the shed. There's no fighting or anything like that. And that was like six months beforehand […] She didn't have a date or anything […] They [the police] said, "Well, on the second occasion that you grabbed her by the back of the head and pushed her to

> the floor," I said, "No, I didn't. She just fell to the floor." And I've never hit her in me [sic] life. (Exit Interview, P14 Group 2)
>
> She tends to say wild things when she's drunk and stuff, and she calls the police and says I did things that I just didn't do. (Exit Interview, P11 Group 1)
>
> It was just a verbal fight, it wasn't anything physical. (Exit Interview, P29 Group 3)

As illustrated above, limitations around men's acknowledgements of personal responsibility were expressed in various ways. This included, for example, denial of FV behaviour entirely (particularly in ways that suggest the AFM was lying or exaggerating), a failure to recognise what constitutes FV through reinforcing gender roles or minimising non-physical forms of abuse, and a lack of reflection on the way in which behaviours impact others.

5.1.4.3 Victim-blaming

Alongside the persistent attitudes of denial displayed by some men were continuing attitudes of victim-blaming. These were most commonly expressed by men describing the AFM as abusive or provocative, or suggesting that the AFM was the one with problematic AOD use, revealing persistent perceptions of mutual responsibility among some U-Turn participants:

> Her manner of conversation is very to provoke and I buy it. (Exit Interview, P12 Group 2)
>
> She always tried to have a fight with me, always. (Exit Interview, P20 Group 2)
>
> I shouldn't be saying this, but through a lot of that stuff, it was her doing the pushing the buttons all the time, still pushing the buttons now, still, to get a reaction from me. I told the police, "This is what happened," they said, "That's right, that's exactly what happened." She pushed me, pushed me, pushed me, pushed me; she knew the thing was coming up, she pushed, pushed, pushed, pushed, bang. That's what happened. And you know, ripping out rose bushes, pulling out eleven trees, you know, cutting up me [sic] clothes – I didn't go run to the police. (Exit Interview, P14 Group 2)
>
> I can recognise more readily now and I remind her like if she's been drinking and, "Well look, you know, three's your limit, darling, you know. If you go and have five, that's ridiculous. And any more than that, look out. You change. Your personality changes." (Exit Interview, P33 Group 3)

While U-Turn participants and AFMs overall reported improvements to AOD use and FV behaviours, the persistence of attitudes that deflect personal responsibility among some participants highlights the need for more work to be done in generating men's insights into personal responsibility to support meaningful and lasting behaviour change.

5.1.5 Parenting and Parent-child Relationships

While not a specific focus of the U-Turn program – which targets men who are fathers as well as those who are not – parent-child relationships and co-parenting often came up in interviews with AFMs and men. Both AFMs and U-Turn participants equally reported improved parent-child and co-parenting relationships where improvements around AOD use and FV behaviours were reported overall. As the following participants explain:

> Co-parenting has been phenomenal, and it's even gotten to a point where his co-parenting skills with his ex-girlfriend, who is also the mother of his eldest child, that has improved so much, because he knows now that – you know, he can say stuff to her as a co-parent, and it's not offensive and it's not aggressive and it's not anything else; it's just him discussing the needs of his child with the child's mother, and that they can do it together as a team. (14-month follow up, AFM5 Group 1)

> After I – my baby born in April – after that he become more responsible, yes, and some support more give [sic] from U-Turn. So from all of that he stopped drinking and he becomes responsible for – to the family. (Exit Interview, AFM28 Group 2)

As these quotes illustrate, AFMs spoke positively about co-parenting at both exit and follow-up interviews. It is significant that these improvements appear to have been maintained after the conclusion of the U-Turn program. While the majority of participants suggested improvements in this space, a small number of AFMs also highlighted the way in which co-parenting and handover presented an opportunity for further abuse and control (see, section 5.1.2.1), particularly where parties shared co-parenting responsibilities post-separation. These findings suggest that co-parenting and relationships between U-Turn participants and children improved alongside wider improvements observed in this evaluation, highlighting the value of AOD and FV-focused interventions in improving family life more broadly.

5.1.6 The Role of Other Parallel Interventions and Service Engagement

Twenty-two out of 25 men were engaged with other help-seeking services such as AOD services (including AA and individual AOD counselling), mental health services (including private psychologists), and housing support services, either prior to or in parallel with the U-Turn program. Some participants also expressed a desire for future service engagement, such as couples counselling and parenting interventions. As alerted to under study limitations (section 3.6.1), the common combination of men's broader help-seeking, U-Turn engagement and regulatory conditions around AOD consumption on their current FVIO makes it difficult to attribute any behavioural change to a single external factor or intervention. Anecdotally, it appears that the U-Turn participants with extensive other engagement, such as a regular commitment to AA work and attendance, seemed to display greater insight around personal responsibility, the impact of their behaviour on other people and restoration of harm they inflicted on others.

5.1.6.1 FVIO Conditions Mitigating Known Risk Factors

As described in Section 4.2.4, 68% of men who participated in Wave 2 data collection were subject to a condition on their FVIO that stipulated they were not to drink at home and not to return home intoxicated, where residing with the AFM. Where separated, these conditions stipulated that men were not to attend the AFM's residence intoxicated (where contact and attending the AFM's residence were permitted). From the court perspective, this condition recognises the link between AOD use and FV. Men's accounts suggest that such conditions can be a motivating factor for some men to avoid being intoxicated around their (ex)partners and, where applicable, children:

> I'm still not allowed to drink around the kids, I'm not allowed to appear at the house drunk, so I've decided not to drink at the house. (Exit Interview, P5 Group 1)

> I'm not allowed to drink at the house. So yeah, if I want to drink I have to go camping or go stay at a mate's house or go out fishing, whatever. So yeah – but it's only a weekend thing now. Yeah. I don't get actually drunk. Whereas I was drunk every day. (14-month follow up, P10 Group 1)

For these participants, FVIO conditions appears to have influenced their AOD behaviours. This reduction in alcohol consumption, particularly around the AFM, is significant given the intersection of AOD use and FV. However, it is unclear whether current FVIO conditions related to AOD use only have a short-term deterrent effect or may assist long-term change in AOD use. The evaluation is therefore unable to determine whether AOD use may deteriorate once the intervention order/relevant AOD condition is no longer in place. Overall, findings suggest – albeit anecdotally – that U-Turn participants undertaking parallel/wrap-around service engagement demonstrated greater improvements in relation to both AOD use and FV behaviours.

5.2 U-Turn Feedback

5.2.1 Content

Feedback on program content, which was observed by AFMs as well as men, was overwhelmingly positive. Participants revisiting program content and reflecting on their knowledge and skills acquired through U-Turn at six and 14-month follow ups suggest that U-Turn has had a lasting effect on many of them:

> Some of the – just the exercises. Yeah, like breathing exercises and just cool out, yeah, instead of getting straight to angry, just – yeah. That helped out a fair bit in that way. (14-month follow up, P10 Group 1)

> I've learnt at the program how to defuse it and, you know, how to control my emotions. So that helped. As I said, it helped me a lot, this program. Yeah, I definitely use the tools that I got from the actual program. Yeah. All the time. Every day. (14-month follow up, P4 Group 1)

> Well, he still mentions that course. When he's stressed he says, "I remember in the course I had to do this," or, "They said I should do this, this or this." […] He still remembers all of it. He still has the book that [they] gave him and he'll look through that occasionally. But I know that when he's really stressed, he automatically reverts back to that [the book]. (Six-month follow up, AFM5 Group 1)

> Yes, of course there are many things, but one of the things which I really visualise every day, more or less, is that [emotional] thermometer which that visualisation in myself, it being my office, it being my house, anywhere I am, in the train probably, somebody does something, when I apply that, it makes me a lot calmer. (Exit Interview, P16 Group 2)

> I've learnt how to breathe now because that's one thing with the box breather thing which has helped me a lot. Even when I'm driving sometimes I do that now. (Exit Interview, P3 Group 1)

The experiences and reflections from both AFMs and U-Turn participants demonstrate the applicability of tools and skills acquired through U-Turn, such as box breathing and the emotional thermometer, used to support self-reflection and self-regulation. It is further noteworthy that alongside the overall improvement in FV and abusive behaviour (section 5.1.2.2), these specific tools were identified by some program participants as useful for managing behaviour and emotions more broadly in everyday interactions.

5.2.2 Facilitators

Feedback on the program's facilitators was exclusively positive. The key elements highlighted here were using respectful engagement, explaining program content and making content accessible through its presentation/illustration – as demonstrated by these participants:

> They are sympathetic, nonjudgmental, articulate. They were both very, very, very, very good. I can't say I enjoyed coming here but they have made it very much easier. (Exit Interview, P12 Group 2)

> I enjoyed [facilitator name] and [facilitator name]'s work and enthusiasm and their – how courteous and they're in an environment where we're having a lot of trouble. So I was really happy [with] the way they expressed themselves and that's what we need. We need kindness in these situations. We need smiles. We need support. Yes, [they] are fantastic. I really liked [facilitator name]. I think he's a champion bloke. No, I was really happy with their delivery of the program. (Exit Interview, P26 Group 3)

> They were very kind and decent and polite, and respectful. (Exit Interview, P30 Group 3)

The above reflections from program participants highlight the importance of respectful engagement with court users and other populations that often share experiences of stigmatisation and social exclusion.

5.3 Affected Family Member (AFM) Support

5.3.1 Family Safety Contact (FSC)

Over the duration of the U-Turn trial and evaluation, FSC was provided by three different workers, including one externally contracted FSC worker with hours specifically dedicated to this role and two workers whose primary roles were AOD clinicians at TaskForce. In the latter two examples, the clinicians provided FSC for different U-Turn rounds in addition to their AOD clinician role. These clinicians were limited to providing FSC during their normal clinician hours and without additional time allocation. The externally contracted FSC worker, however, had the benefit of allocated hours to a dedicated FSC worker role and the flexibility of providing FSC after hours (e.g. outside of AOD clinical hours) where AFMs requested after-hour contact due to work or childcare commitments.

Once FSC was established with AFMs, the same worker would aim to provide ongoing support to allocated clients (where AFMs requested ongoing contact) to ensure client-worker rapport and 'continuity of care'. The nature and extent of FSC was client-led, with uptake of FSC being optional and clients being able to determine whether they wanted ongoing contact for the duration of their (ex)partner's participation in the program and, if yes, how frequently and in what format they wished to be contacted by the FSC worker. FSC therefore varied across AFMs from weekly to monthly contact, with some AFMs requesting FSC check-ins via text message, whereas others scheduled regular phone appointments with their FSC worker.

While some of the FSC workers also worked as U-Turn facilitators at different points in time, none of them acted as a FSC worker related to a group they facilitated. Facilitator and FSC worker roles were kept separate from AOD clinicians who were only providing FSC for U-Turn groups they did not facilitate. This forms an important aspect of FSC in men's behaviour change work and ensures that behaviour change with men who use violence is separated from the safety and support provided to AFMs (Chung et al., 2020). FSC workers and U-Turn facilitators engaged in regular discussions of safety concerns and risk monitoring and management practices based on information on risk emerging during group facilitation and/or FSC. The close interaction and information exchange, as it relates to potential risks to clients and their families, forms a critical aspect of perpetrator monitoring and risk management and follows good practice in MBCP delivery (Westwood et al., 2020; Chung et al., 2020; Smith et al., 2013).

5.3.1.1 Limitations Around Family Safety Contact Data

There are some limitations to the discussion of FSC. FSC workers at TaskForce kept records detailing whether women did or did not want FSC and, where they did want contact, how often they would like this to be. They also recorded successful contacts as well as contact attempts – however, detail about the nature and quality of the contact was not systematically captured. It should be noted that there was no directive regarding the nature of contact notes to be kept by FSC workers. As this role was undertaken by different TaskForce and external staff at different times of the evaluation, the nature

and extent of contact notes made available to the evaluation team therefore varied. As a result, no conclusive links can be drawn between the nature and extent of FSC and AFM outcomes reported here. However, findings reported hereafter highlight the critical value of dedicated FSC work, and future program evaluations should ensure a systematic and standardised collection of FSC data.

5.3.2 Feedback

When asked about the utilisation and usefulness of the offered FSC, AFMs who took up and engaged with the FSC worker spoke very positively about their experiences:

> Yes, I did. I spoke with [name], who was fabulous. (Exit Interview, AFM12 Group 2)

> Oh, it's always good to be able to talk things through. (Exit Interview, AFM26 Group 2)

> Yeah, it's helpful and good. (Exit Interview, AFM29 Group 2)

One woman spoke very positively about specific recovery and self-care methods offered by the FSC worker, including a strategy for automatically indexing email from her ex-partner to a separate folder so the decision to read his emails was made by her when she felt ready:

> Fantastic. Unreal. Especially at the start. Can't thank [name] enough […] probably for the first three to four months, yeah some really handy tools that she gave me to use. And some references to look – like gaslighting and grey rock method. And with her advice to make the emails just go to a box so you don't actually see them. And when I'm in the right frame of mind – so that it wasn't interrupting my work, weekly – so some really handy hints to move forward as well so it was good. (Exit Interview, AFM25 Group 2)

Some AFMs reported an additional positive benefit from receiving information from the FSC workers about the content and objectives of the U-Turn program and whether the participant connected to them was attending. FSC workers did not disclose detailed information about U-Turn participants or breach any confidentiality but were able to provide some context and assurance to AFMs:

> She just explained everything, just made me feel better […] because you don't know what's going on on the other side […] Just for her to explain it and what the objective was and just to have someone to talk to […] it was just what it was about, what the program was about, because I didn't really know much about it. So there was a bit of hope there, you know. (Exit Interview, AFM3 Group 1)

> [Name] rang me regularly. She was brilliant, absolutely brilliant. There were times throughout the thing where I'd be having a rough day and it just would coincide with [name] giving me a call. If there were any hiccups along the way where I thought, "He's struggling with this particular part of it", I'd make a note of it and [name] would give me a call and she'd be like, "We

> might mention that to the coordinators there and see if they can pop something in the course about it." […] She was very careful not to breach any confidence but she also kept me updated in a way that made me feel like I was confident that the right things were being done, that he was turning up, that he was actually participating and that sort of stuff. (Exit Interview, AFM5 Group 1)

Where AFMs expressed frustration in response to FSC or dissatisfaction in general, it was largely due to circumstances beyond the remit of the FSC support and generally took one of the forms described below:

1. FSC counselling services were deemed to be not as useful when relations between the parties were dominated by financial, property and legal disputes which impacted on feelings of safety and security.
2. When another support service engaged by the AFM was not able to provide the support the AFM needed to achieve feelings of safety and security.
3. When co-parenting arrangements impacted on feelings of safety for their children.

One woman with whom the team had follow-up contact with up to 14 months expressed frustrations aligning with categories one and two outlined above. In her exit interview, she spoke about her belief that she needed to install surveillance cameras to deter her husband (who was prohibited from coming to their house under conditions included on their FVIO). This AFM felt as though she was being surveilled at his behest by their neighbours. She felt unsafe and dissatisfied with external services she had sought assistance from to secure her safety, as no assistance with installing physical safety measures to her home was provided. When the team spoke with her again at the 14-month follow up, she reported ongoing financial stresses related to a property dispute and drawn out court processes. At the conclusion of the follow up, she was asked if she would like the FSC worker to follow up with her to discuss some of the disclosed ongoing issues and concerns. At that time, she said:

> No, let's just leave it. Look, I've gone through that loop with [name] […] and yeah, it doesn't achieve anything. I mean, yes, it's lovely to talk to somebody, but it doesn't actually – I have to just focus now on […] getting through this next stage, yeah. (14-month follow up, AFM12 Group 2)

For this woman, safety, financial stability, growing debt and concerns about housing stability were a priority. This finding is consistent with previous research on victim/survivors' perceptions of justice which found that women frequently correlate justice with safety and security (Maher et al., 2018; McGowan & Elliott 2019; McCulloch et al., 2020). While AFMs who engaged in FSC overwhelmingly valued the support, some also realised that it has its limitations in situations where ongoing safety concerns are present. For these women, 'talking' or counselling are often secondary on their priority list because they continue to be unsafe and in crisis in their current context.

Another separated AFM whom the evaluation team interviewed at program commencement, conclusion and six-month follow up was satisfied with the FSC support provided through TaskForce but expressed frustrations with external services and challenges associated with shared parenting arrangements and ongoing safety concerns for her children. This couple had been separated since the time of the incident that lead to the U-Turn program referral and had utilised mediation to develop a parenting plan. While the parenting plan stipulated the U-Turn participant's abstinence from AOD use

(in this case specifically illicit drug use) during time spent with his children, nature, frequency and timing of drug testing requirements were not explicitly stated in the parenting plan, and the informal nature of parenting plans would not have provided the AFM with mechanisms to enforce his drug testing compliance. This AFM described ongoing tensions around shared parenting arrangements and a sensation of helplessness around ensuring her ex-partner's sobriety during time spent with the children and when commuting with children in the car to facilitate handover. At the time of the exit interview, the AFM highlighted the need for access to information about Family Law proceedings to formalise parenting arrangements that may better assist AFMs in protecting their children and child support to ensure adequate and consistent financial support to raise mutual children:

> It was girlfriends that said sign up to child support pretty much straight away. If someone hadn't told me that I wouldn't have gotten into that system and, yeah, probably more about the steps to take family law wise and financially I suppose. (Exit Interview, AFM25 Group 2)

The above experiences highlight that where AFMs are subject to ongoing family law matters (including property settlements and shared parenting arrangements), patterns of abuse, power and control are often ongoing and may persist throughout and beyond men's engagement in relevant intervention programs.

5.3.3 AFMs' Other Help-seeking/Service Engagement

A significant proportion of AFMs who accessed FSC through the U-Turn program were also engaged in other help-seeking. Two women reflected on their experiences with Orange Door,[21] with one describing her experience as unsatisfying as she perceived the service contact as unable to increase her safety, while another woman noted, 'There was […] group called Orange Door […] A lady – that was fantastic' (Exit Interview, AFM25 Group 2). When asked about any help-seeking from other services at the time of their (ex)partners' engagement with U-Turn, some AFMs also reported receiving assisted accommodation and housing support through various services.

The most common form of help-seeking among AFMs was accessing counselling and parenting support services. One woman spoke about seeing a private psychologist, but noted that the prohibitive cost put it out of her reach (14-month follow up, AFM12 Group 2). Another woman reported accessing a community-based counselling service (Exit Interview, AFM28 Group 2). One

[21] The Victorian Government Orange Door website describes the Orange Door as follows:
'The Orange Door is a free service for adults, children and young people who are experiencing or have experienced family violence and families who need extra support with the care of children. You should contact The Orange Door if: someone close to you is hurting you, controlling you or making you feel afraid – such as your partner, family member, carer or parent(s); you are a child or young person who doesn't have what you need to be OK; you are worried about the safety of a friend or family member; you need more support with the care of children, e.g. due to money issues, illness, addiction, grief, isolation or conflict; you are worried about the safety of a child or young person; you need help to change your behaviour and stop using violence in your relationships.' ('What is the Orange Door', accessed 8 April 2021, https://orangedoor.vic.gov.au/what-is-the-orange-door).

woman specifically highlighted the positive impacts on co-parenting following the U-Turn program, as well as her family's plan to seek additional family counselling:

> He is now very open to hearing my feedback and following my suggestions. It's like talking to a different person! […] In the past [name] used to say I was a terrible mother and undermine things that I said. He's trying really hard to be a better dad. We've also got family counselling scheduled at Better Place once the restrictions are lifted – I hope that helps too. (Six-month follow up, AFM3 Group 1)

Another AFM spoke about being prompted to seek additional support for family members affected by someone with problematic AOD use by a friend:

> I never had time. I'd been a single mum with four kids for a long, long time, so I never went to a support group, but this year, actually, I did go. My friend, who has a son with a drug addiction, she invited me and we went together. (Exit Interview, AFM2 Group 1)

5.3.4 Summary of Affected Family Member (AFM) Support

Women who engaged with the FSC that was offered as part of the U-Turn program primarily described the support they received as positive. Women who described the engagement as positive but noted no positive impact of the FSC on their safety and/or wellbeing were found to be in situations beyond the remit of the FSC support. These situations, as outlined above, primarily reflected the reality of separated couples where men continued to use ongoing contact associated with settling shared assets and/or co-parenting mutual children as a platform for their abusive behaviours. These findings suggest that FSC is useful towards women's empowerment and the development of immediate protective strategies. However, additional and, at times, long-term support may be required for women who have ongoing contact with an abusive ex-partner, for example, due to prolonged family law matters, as this offers an ongoing platform for coercive control and other forms of abuse, also noted in other research on victims' post-separation experiences (Meyer & Stambe, 2020; Douglas, 2018; Easteal et al., 2018). As illustrated in this section, this can have lasting adverse effects on an AFM's ability to commence the recovery process and, where applicable, adequately protect dependent children from ongoing exposure to risk and potential harm.

5.4 Complex Needs

A small number of the overall U-Turn participant population discussed complex needs, raising implications around service delivery. While the U-Turn program already combines two areas of high-risk behaviours, including problematic AOD use and use of FV, the underlying complex risk factors experienced by some program participants highlight the need for more holistic support mechanisms required by some men with comorbid AOD and FV use. It is important to note here that U-Turn was designed as an early intervention for men with little or no historical involvement with the CJS and those who were assessed as 'program ready' by the U-Turn provider. The majority of referred men therefore presented with limited or no complex needs. However, a small number reported

involvement with child protection, past criminality, underlying trauma, housing (in)stability, culturally specific needs, mental health concerns and other forms of addiction (e.g. gambling, sex addiction).

5.4.1 Child Safety Concerns

A small number of U-Turn participants (n=4) discussed their involvement with child protection (Department of Health and Human Services [DHHS]). This involvement varied between participants, including instances of children being placed in the care of the DHHS and instances of supervised contact with children. For other AFMs and U-Turn participants, welfare and safety concerns identified for their children were predominantly documented through the naming of children on the FVIO, including restrictions on contact between U-Turn participants and their children. Some U-Turn participants explicitly described their desire to regain or increase contact and time spent with children as a motivating factor for accepting the U-Turn referral at court and participating in the 12-week program.

5.4.2 Criminality

A minority of U-Turn participants (n=7) discussed contact with the CJS. Offences/charges included resisting arrest, assault, breaches of FVIOs, breaches of other court orders, property damage and driving without an alcohol interlock. Two participants were serving community service hours at the time of data collection. Additionally, three participants shared past incarceration experiences, suggesting a criminal history beyond the 'early intervention' aim pursued by U-Turn. Two of the three participants with past incarceration experiences completed the U-Turn program. While both continued to report positive impacts and experiences at the six-month follow-up interview, they were uncontactable at the time of the 14-month follow-up interviews. It is therefore important to consider whether U-Turn may be unsuitable for people with complex needs beyond comorbid AOD and FV use. In its current format and funding model, U-Turn is not set up to support ongoing engagement with men with criminal histories and/or other significant complex needs. In order to do so, it may require integration into a more holistic service system response to FV (also highlighted in section 5.1.6).

5.4.3 Underlying Trauma

While participants were not specifically asked about underlying trauma, six U-Turn participants reflected on the connection between past traumatic experiences and their use of AOD. For most of these participants, experiences related to childhood trauma, including abuse and parental intimate partner violence. Although some participants also described the role of trauma (e.g. loss of a loved one) experienced during adulthood:

> I was one of the Royal Commission cases, so the last five, six years have been very confronting for me, facing things I – not necessarily forgot about, but I just put in the back of my head. […] I think alcohol is actually – is my demon and is one thing I find really hard to stop. If I'm by myself and I got a call in, that's it, I'm going for a drink. (Exit Interview, P6 Group 2)

> I had a stepfather who was an arsehole and I had – my dad was an arsehole as well – because I never had a dad. I want my kids to have a dad […] I don't actually believe in god because of all the things that happened to me in the past and I don't believe in that but I do believe in a higher power, like there's something out there. Something happened to me at the [local pub] because I was sitting there where I used to drink every day and I was on my second beer and something come over me and he said to me, "[Name], you cannot drink anymore because you've got to give it up." So, the first thing I did I rang my mum, "I need help." I went over to my mum's house and mum said, "You're most welcome to live here on the condition there's no drinking." I said, "Okay, mum, I'm going to start AA the next day." The next day was my first AA meeting at [location name]. It's probably one of the best things I've ever done. (Exit Interview, P3 Group 2)

> I had a year and a half clean before I started using again, and the trigger was my best friend actually drowned. So I started just gradually using marijuana again just to cope, I guess. It was a coping mechanism. Didn't know how to deal with the situation and that gradually got more and more the – my tolerance went up. So using more and more. (Exit Interview, P34 Group 3)

5.4.4 Housing Stability

A very small number of men reported historical experiences of housing instabilities and homelessness. While this was the minority, given the early intervention nature of the U-Turn program for most participants, a larger number of men reported temporary housing instabilities as the result of their use of FV and related FVIO. As noted in section 4.2.4, 70% of U-Turn participants were removed from the home at the time of police intervention, with 40% having been subject to an extended exclusion condition once the FVIO application was mentioned in court. This observation, combined with the wider observation that the utilisation of exclusion conditions on FVIOs have become more common over the past five years/since the RCFV, raises implications for men's referrals into intervention programs as the result of their court interaction. For many of these referrals, temporary housing instability may be a reality and, if left unassessed and unaddressed, may create barriers to men's readiness to engage in the intervention, potentially creating an increased risk of non-compliance with FVIO conditions more broadly (Day et al., 2019).

5.4.1 COVID-19

Very few men deteriorated in their behaviour, as illustrated in sections 4.4 and 4.5. Where this was the case, AFMs and/or men linked this to the impact of COVID-19 restrictions. The observation that the majority of U-Turn participants maintained reported behaviour change as it relates to AOD use, FV and co-parenting, is important. Research has shown that COVID-19 and related household restrictions have had significant effects on many families, including job loss, financial stress, mental health problems, increased alcohol consumption and an increase in FV (Boxall et al., 2020; Pfitzner et al., 2020; VicHealth, 2020). In the Australian context, many of these household impacts were

particularly felt by Victorian families, with Victoria having been subjected to the strictest and longest lockdown conditions as the result of COVID-19. In line with this, the majority of program participants and AFMs reported that COVID-19 had some negative effects on their family and household. For vulnerable families, such as those involved in U-Turn, to maintain the improvements men had achieved in the form of reduced AOD use and reduced FV at the time of program exit throughout the impact of COVID-19 should, therefore, be noted as particularly positive.

A small number of participants indicated that COVID-19 restrictions had limited their access to ongoing supports such as family counselling and AA. Similarly, some participants reported delays in progression of court matters (including FVIO variations, child protection and family law matters), delaying participants' ability to visit children or have unsupervised contact even where program completion and behaviour change had been achieved according to men as well as AFMs.

Participants also reported limited access to family supports, social connections, feelings of isolation, and pressure and stress related to having children studying from home. All of this reflects wider challenges experienced by the Victorian community during lockdown.

In addition to the small number of significant reports of ongoing abusive behaviour unrelated to COVID-19 impacts (reported in section 5.1.2.1), a small number of AFMs also reported some challenges relating to the stress of COVID-19 restrictions. However, in these examples AFMs report positively on how these situations were managed:

> The only time he got angry and upset was about two months ago – when his AA meetings were cancelled because of COVID. I wasn't scared though. I asked him to leave and he did. He's been fine since the meetings re-started online. (Six-month follow up, AFM3 Group 1)

> There was a time there where he got really stressed about trying to – he was missing the normality that was having his son over here – well, having both of his sons here together at the same time and being able to do stuff together as a cohesive family group because of the coronavirus restrictions in place and then … he was working ridiculously long hours, pretty much seven days a week and not getting a lot of rest, so – and I know myself, if I'm incredibly tired, I get incredibly stressed out. And that's what happened. He's so stressed, like he wasn't thinking clearly. And to be honest, I can't even remember why – what he said, but it was something so stupid and I remember saying, "You don't know. It's not okay. It's not okay for you to do that." And just saying, "It's not okay," it made him really stop and he apologised and he said, "I'm so sorry. I really didn't mean that." He said, "And I don't even know why I said it." And so we sat down and we discussed about what was going on … 12 months ago, trying to communicate that to him, it would've ended in a massive argument. Whereas, now there's no arguing. There is discussion, lots of discussion, but no arguing, which is good. (Six-month follow up, AFM5 Group 1)

Some participants raised financial stress, reduced work hours and job loss experienced by both participants and AFMs:

> I haven't had any work since November last year. And yeah, just getting to see my kid, like I haven't seen him at all, so – it's been really stressful, this Covid thing for me with all the stuff that's going with my family and my child. (Exit Interview, P26 Group 3)

> I was going to say, up and down, like everyone I suppose. When you're stuck in confined space 24/7. There's a lot more arguments, I suppose, than usual. But that's just normal. And with a daughter that's – yeah, hitting the terrible two's and three's now, that was – yeah, there's some tempting days there, but yeah. Had to deal with it. (14-month follow up, P10 Group 1)

Some participants also spoke about the positive impacts of restrictions such as spending more time with family or receiving more work as a result of working in industries that picked up during the Victorian lockdown. Again, these positive accounts mirror the way in which restrictions have impacted the wider Victorian community:

> I actually think that it actually helped our relationship even more because we see each other a lot more now. (Six-month follow up, P4 Group 1)

> I think better financially than I've ever been, because just work – my boss has just been supplying us a lot of work. (Exit Interview, P34 Group 3)

Participants who reported improved AOD and FV behaviour at program exit appeared to maintain change despite being impacted by COVID-19 restrictions. For vulnerable families, such as those involved in U-Turn, this is particularly noteworthy, given the well-documented escalation of FV and other intersecting risk factors across households during the pandemic.

6. Stakeholder Focus Group Findings

For the purpose of this evaluation, the research team conducted interviews with key stakeholders identified by the funding body and developers of the U-Turn program. Ten stakeholders representing the DHHS/Family Safety Victoria, TaskForce, Moorabbin Justice Centre, and the men's behaviour change, mental health and AOD service sector participated across one focus group and four interviews. Interviewees were asked to comment on a range of open-ended questions, addressing the following themes:

- The need for a combined approach to comorbid use of FV and problematic AOD use.
- The timing of funding and trialling combined group-based interventions.
- Key considerations (or ingredients) when combing interventions.
- The role of partner/FSC.
- Situating combined interventions in different service sectors.
- Offering combined interventions in residential AOD treatment.
- Voluntary versus mandatory program referral and participation.

The identified themes are discussed in detail below.

6.1 The Need for a Combined Approach to Comorbid Use of Family Violence and Problematic Alcohol and/or Other Drug Use

We asked focus group participants to describe their views around the need for taking a combined approach to FV and problematic AOD use in group-based interventions. All participants felt that due to the persistent intersection of FV and AOD use observed in research and practice evidence, taking a combined intervention approach is an important step towards a more holistic service responses to FV. Participants highlighted the reality that the two service sectors (along with other service areas, such as mental health) have historically operated in siloes, which can isolate clients and leave relevant support needs unaddressed. Here, interviewees emphasised that interventions addressing FV need to take a holistic approach to individual and family needs, rather than dissecting individuals and human behaviour into different characteristics and behaviours, which need to be addressed separately by different service providers. Instead, interviewees felt that taking a combined approach acknowledges that individuals often have more complex needs than solely needing to address the use of abusive behaviours in their relationships, and that by bringing FV and AOD-focused interventions together, a more holistic approach to clients' behaviours and support needs is offered.

6.1.1 Perceived Benefits of Combining Interventions

Overall, interview participants believed that taking a combined approach would have clear benefits towards family safety as addressing problematic AOD use in the context of FV offers an opportunity to generate behaviour change through more than one lens, which in return was seen as beneficial to family members affected by men's use of FV.

Some interviewees further discussed the circumstance that police and court statistics clearly indicate the involvement of primarily alcohol – and, to some extent, other drugs – in FV occurrences that come to the attention of law enforcement. Further, AOD sector representatives stated that FV is certainly overrepresented in client populations accessing AOD services, including female clients who primarily disclose a history of victimisation and male clients who have frequently been identified as a perpetrator of FV and at times other forms of violence. While interviewees clearly stated that the presence of AOD use should never be seen as a cause of FV, it needs to be acknowledged as a contributing factor, especially with regards to the escalation of violence in frequency and severity. Interviewees therefore welcomed the consideration of combined interventions while also flagging some challenges and potential pitfalls to consider.

6.1.2 Perceived Challenges Associated with Combining Interventions

A number of potential challenges were raised across interviews, including the challenge associated with FV and AOD service providers at times working from different ideological standpoints, the need to ensure expertise of both sectors in the room when combining interventions, and the stigma that may potentially be associated with one or the other service sector. The latter will be discussed in greater detail when considering where combined interventions may be best situated, sector-wise.

One of the identified key challenges to address when combining interventions was the approach to client work in FV/MBCP and clinical AOD interventions. Interviewees from both sectors highlighted that there are, traditionally, differences in client work. While both sectors have an awareness of the intersection of FV and AOD use, each sector takes a different approach to client work. FV interventions/MBCPs traditionally focus on men's behaviour and related risk in the wider context of family and community life, and create accountability work in this wider context. Further, FV-focused MBCPs tend to focus on social structural factors (including gender inequality, male privilege and patriarchy) as key drivers for abusive behaviours. AOD-focused interventions on the other hand tend to operate from a client-centred, therapeutic approach that examines AOD use and related behaviours as the result of individual factors and experiences rather than the wider family or social structural context. As a result, MBCPs tend to conduct risk assessments that examine the perpetrator's social and family context to estimate the risk he may pose to others. Family members are therefore assessed around their risk of harm rather than the support they may be offering to the perpetrator engaging in behaviour change. AOD interventions, on the other hand, tend to prioritise client needs and assess for individual risk and protective factors, while taking a therapeutic approach to assessing support needs. As a result, the traditional ideological standpoints of these two sectors may clash. However, in the context of this evaluation, interviewees strongly felt that the AOD sector has become more FV informed, and that the FV sector is becoming more open to approaches that address intersectionality around perpetrator risk factors and support needs. While an ongoing need for upskilling the AOD sector in FV-informed practice and upskilling the FV sector around the core intersecting issues – such as AOD use and mental health issues, especially in individual client work – was voiced by a number of interviewees, participants were optimistic that combined group-based interventions are ready to overcome these challenges by bringing together expertise from both areas in the development and delivery of combined interventions.

6.2 The Timing of Funding and Trialling Combined Group-based Interventions

We asked interviewees why a shift towards trialling combined interventions is only just emerging at this particular point, although the research and practice evidence regarding the overlap of FV and problematic AOD use has been present for over a decade. In response, some interviewees emphasised they had been having conversations around the need for combined interventions for at least a decade. Overall, interviewees reiterated that both service sectors have been operating in siloes, partly due to ideological differences but mostly due to siloed approaches to funding service delivery. The majority of interviewees felt that the timing had been right and the right champions had come together when U-Turn was conceptualised, developed and funded. This role of champions driving service and sector reforms around responses to FV overall was strongly emphasised by those involved in the initial development of the U-Turn program.

6.3 Key Considerations (or Ingredients) When Combing Interventions

Interviewees identified a number of key considerations – or 'ingredients' – when developing and implementing combined group-based interventions. Some have been addressed above – such as the need to combine expertise in the development and delivery of combined interventions, rather than letting one or the other sector 'just run with it'. Interviewees strongly felt that program developers must either have expertise, skills or qualifications in both MBCP design and/or delivery, and that clinical AOD work, or program developers, must come together from both sectors to take a joint approach to development and delivery. Interviewees who were familiar with the U-Turn program described the service provider currently offering the program as 'fortunate enough' to have relevant staff members with expertise, skills and qualifications that were relevant to both sectors, but acknowledged that this is unique. As a result, all interviewees acknowledged that this cannot be expected as the status quo, and that partnership approaches are therefore required during the development as well as the delivery phase of combined interventions.

Other 'key ingredients' discussed by interview participants include the role of theoretical underpinnings informing combined approaches, DFV-informed risk assessment, ensuring a closed feedback loop, program content, and facilitator skills and qualifications.

6.3.1 Theoretical Framework/Underpinnings

Despite the support for a more holistic approach to generating behaviour change at the intersection of FV and AOD use, interviewees all emphasised the need to have a feminist framework underpinning any form of MBC work, including combined interventions. A gendered understanding of FV – including control, manipulation and coercion – was seen as crucial when working with men who use FV, regardless of other co-occurring risk factors. Further, some interviewees highlighted the need for a harm minimisation framework, which the majority of interviewees supported both in relation to problematic AOD use and FV. All interviewees agreed that family safety needs to be a key criteria when combining interventions, and that a harm-minimisation approach towards changing the impact of FV as well as men's AOD use on (ex)partners, children and other family members would therefore form a useful contribution to a gendered analysis.

Further, interview findings suggest that a therapeutic, or trauma-informed, approach to understanding men's use of violence needs to form part of the framework for combined interventions. Due to levels of childhood trauma observed in FV perpetrator and AOD client populations, several interviewees discussed the need for a trauma-informed understanding of the impact of childhood trauma on men's behaviour (including the use of violence as well as problematic AOD use). This has further been highlighted under some of the key considerations around program content, discussed further below.

6.3.2 FV-informed Risk Assessment

In line with the emphasis on FV-informed practice in combining interventions, interviewees highlighted the need for FV-informed intake and risk assessment processes. Findings support the

conclusion that risk needs to be assessed in relation to men referred for intake into combined interventions as well as their immediate environments, including former or current partners and other family members affected by their use of FV. Further, risk needs to be understood as dynamic and something that requires regular reassessment during program participation. Interviewees emphasised that where combined interventions are delivered by an AOD or other service provider, providers need to ensure that initial and subsequent risk assessments are FV focused and informed, and guided by an understanding of the complexities of FV, including its various forms, impact and the use of manipulation and image management among many perpetrators of FV. In the Victorian context, the current rollout of the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) plays a crucial role here – although it is acknowledged that not all states and territories have transitioned to the use of standardised FV screening and risk assessment tools across all services sectors, including AOD services.

6.3.3 Feedback Loop

In the context of information exchange between key stakeholders relevant to combined intervention approaches, some interviewees highlighted that similar to any MBCP following good practice and minimum standards, combined intervention programs must ensure a closed feedback loop. In the context of U-Turn, this was described as the information sharing between the referral agency (local magistrates court) and the service provider conducting intake assessment and delivering the program. It was emphasised that information sharing around referral pathways, referral uptake, risk assessment, program drop out and subsequent court responses needs to go both ways to ensure the program provider is aware of all expected referrals; the court remains aware of all program uptake (including referrals that were assessed as ineligible, referrals that declined program uptake and referrals that dropped out after initial commencement of the program), and the program provider remains updated on any subsequent court responses to men remaining in and dropping out of the program. Notably, referring court and program providers described this element as crucial in keeping perpetrators of FV in view of key stakeholders and holding them accountable for their behaviour, while equally holding referral agencies and service providers accountable for information sharing around program availability, uptake, drop out or completion, plus related court contact.

6.3.4 Program Content

In relation to program content, the majority of interviewees agreed that a combination of different content areas is required when taking a combined intervention approach. Beyond ensuring a gendered analysis of abusive behaviours and addressing such behaviours as a personal, relationship and – where applicable – parenting choice, interviewees equally agreed that substantial content around AOD use is crucial. Here, interviewees discussed the need to incorporate content on the underlying drivers for AOD use as well as how AOD use interacts with men's use of violence. Findings suggest that it is therefore equally important to cover triggers of AOD use to generate an understanding among program participants of why and when, for example, they individually engage in AOD use, and to include content on how AOD use may affect the use and choice of violent behaviours, including how different stages of problematic AOD use (e.g. stages of intoxication, stages of withdrawal) may contribute to the use and escalation of violence.

As discussed under the theoretical framework underpinning combined interventions (section 6.3.1), interviewees further discussed the level of childhood trauma often present in men with comorbid FV and AOD use. Some interviewees, therefore, raised the need to incorporate sessions on the family of origin for program participants to make the relevant connection between potential trauma experienced over the course of a life, subsequent coping responses (including problematic AOD use) and their use of abusive behaviours in their own family relationships. Similar to addressing the intersection of FV and AOD use, interviewees emphasised that childhood trauma needs to be understood and addressed as a contributing factor to generate behaviour change, but it should never be seen as an excuse for the use of violence in adulthood.

6.3.5 Facilitators

As covered under findings discussed around the need for combined sector expertise in the development and delivery of combined interventions, interviewees strongly felt that facilitators need to incorporate expertise in FV, MBCP facilitation and clinical AOD work into a combined intervention delivery. As highlighted earlier on in the findings, the U-Turn program provider was unique in that one of the program developers and facilitators held qualifications, expertise and experience in MBCP and clinical AOD service delivery. As it cannot be expected that this is the case across service providers which may consider the development and delivery of a combined group-based intervention, it is important to have a combination of facilitators that bring together expertise in FV, MBCP delivery and clinical AOD work. This combination is crucial to ensure combined interventions offer content that is relevant to the use of FV along with problematic AOD use and its interconnectedness. Further, combined facilitation skills and expertise are important to ensure the voices of women and children are always present and the program and its facilitation to maintain focus on the overarching goal of increasing victim and family safety.

6.4 The Role of Partner/Family Safety Contact in Combined Interventions

Further in relation to including the voices of victims and children in the room when facilitating combined intervention programs, interviewees discussed the importance of FSC. Interviewees agreed that FSC should form a crucial component of all perpetrator-focused intervention programs so as to ensure family safety, provide support and referral pathways to AFMs, and hold program participants accountable through regular check ins with those affected by their abusive behaviours. There was consensus that the quality and extent of FSC varied across MBCPs throughout Australia. However, interviewees believed it is a core component when delivering perpetrator interventions and should equally be prioritised in combined interventions. In this context, interviewees noted that the varying quality and extent of FSC among other programs occurs for several reasons, including a lack of dedicated funding for this role and, at times, a lack of priority placed on this component of perpetrator interventions. Interview participants emphasised that in order to do this component adequately, funding needs to be allocated to a dedicated FSC worker role – whether this is a role allocated within the program provider's agency or externally contracted for this particular purpose.

As addressed earlier in this report, in the particular context of U-Turn the FSC was provided by an externally contracted FV practitioner in Group 1 of the program. For the duration of Group 2, the contracted FV practitioner was unavailable. As a result, the FSC role was filled by one of the service provider's AOD clinicians on top of her usual work and case load. The AOD clinician filling the role for Group 2 had less capacity and flexibility in initiating and maintaining FSC with AFMs due to her usual workload and being limited to clinical AOD work office hours. In Group 2, the service provider and evaluation team noticed decreased uptake of FSC along with evaluation participation by AFMs. While this may partly be the result of varying needs among AFMs across program groups, it does suggest that FSC work may be done more efficiently and effectively in a dedicated role that offers greater flexibility around contact hours and frequency. There was consensus among those who discussed the importance of this FSC role that it should always be provided by a practitioner external to the program facilitation team and never by a program facilitator – regardless of whether the role was allocated internally or externally. This ensures the ability to maintain clear and ethical boundaries between practitioners working directly with men as perpetrators and practitioners providing support to AFMs.

Interviewees further noted that FSC work in combined interventions should equally provide AFMs with support around regaining and maintaining family safety, as well as offering relevant referral pathways. Here, interviewees discussed that where a combined intervention is situated somewhat determines the nature of support available to AFMs. While interviewees agreed that any relevant referral pathways can be initiated for AFMs to meet their individual needs (e.g. around immediate safety, housing stability, counselling, support for children), referral pathways made via the Orange Door were described as 'clunky' and inefficient at times. Internal referrals were seen as timelier and more streamlined, although limited to the support offered by the program service provider. In the case of U-Turn, the service provider is able to offer AOD-related support to AFMs, should women disclose their own problematic AOD use. In the case of U-Turn Groups 1 and 2, no such disclosures were made and any referrals were therefore made externally to other support services via the Orange Door where relevant.

Some interviewees noted that if a combined program was situated with a FV service provider, this would offer the benefit of internal access to counselling and recovery support for AFMs. On the other hand, these interviewees also noted that situating the program with a FV service provider requires external referrals to an AOD service provider where male program participants benefit from one-on-one clinical AOD work in addition to, or in preparation for, their group participation. This point is further discussed in the next section.

6.5 Situating Combined Interventions in Different Service Sectors

Interviewees were asked to reflect on whether there is a rationale for situating combined interventions in a particular sector, or whether one sector may be better placed to lead such interventions than another. Overall, interviewees did not feel that one sector was necessarily better placed to lead or offer combined intervention programs than another. As discussed during the key ingredients for combined interventions section, interviewees felt that one of the key elements to successfully developing and delivering such interventions is to bring together expertise from both sectors and ensure co-facilitation by practitioners that brings together qualifications, skills, expertise and experience around FV, MBCPs and clinical AOD work. As noted under the discussion of the role of

FSC, interviewees further raised the issue that where a program is situated to some extent determines referral pathways and direct access to different types of support for program participants and AFMs.

In addition to aspects around where to situate combined interventions, the issue of potential stigma associated with one or the other service sector was raised by a number of interviewees. These interviewees argued that in the context of male FV violence perpetration and comorbid problematic AOD use, men who come in contact with police or courts may be more open to the idea of accessing support via an AOD as opposed to FV service provider. As some interviewees conveyed, '*Even the employed, middle class men may be quite comfortable acknowledging that they frequently drink two bottles of wine whereas they may be less forthcoming about their abusive behaviours*'. Interviewees therefore believed that situating a combined intervention with an AOD service provider may offer access through a door that is attached with less stigma and reluctance to engage. A smaller number of interviewees further discussed whether it may be beneficial to fund a more 'independent' sector or community service provider that draws on expertise from the AOD and FV sector, but is not associated with the stigma of either area of required support. Interviewees emphasised that regardless of where an intervention is situated, bringing together relevant expertise was a key criteria, and, where this can be assured, funding community organisations known for providing more general community and family welfare services may be able to minimise the stigma associated with FV perpetration as well as problematic AOD use. Interviewees agreed that in any scenario, the aim was to offer '*multiple access points to getting men into one and the same room'*, meaning that the final destination is a MBCP, which employs a gendered framework while acknowledging and addressing intersectionality in relation to FV perpetration. Overall, there was consensus that if funding future service providers to offer combined interventions, these could be situated in either sector or based with community organisations separate to the FV and AOD service sector as long as the key ingredients of combined experience, expertise and facilitation skills from FV, MBC and AOD work are adhered to.

One noteworthy benefit of the current U-Turn program being situated with an AOD service provider is the internal access to one-on-one clinical AOD work for referred men who may need AOD-related support prior or parallel to their participation in the U-Turn group format. This may be in the form of parallel one-on-one support or initial one-on-one work while supporting a referred client towards group readiness for an upcoming program group. If combined programs are situated in other service sectors, additional AOD-related support would require an external service referral, which may increase the risk of men's disengagement after their initial referral uptake and intake assessment process – unless there is close collaboration between service providers along with a closed feedback loop to avoid clients falling through 'referral gaps' as a result of their additional support needs. This, along with the referral pathways available for AFMs discussed above, highlights the need for combined interventions to form part of integrated – or, at the very minimum, closely coordinated – holistic service responses to minimise client disengagement.

6.6 Offering Combined Interventions in Residential AOD Treatment

Given the emerging approach to funding and delivering combined group-based interventions that address FV and problematic AOD use, we asked interviewees whether they had a view on offering combined, group-based interventions in longer-term residential AOD treatment settings (e.g.

residential rehabilitation facilities as opposed to shorter-term detoxification facilities). Views among interviewees were mixed, with some raising concerns around how such group-based interventions would be offered in settings that often support both female and male clients and clients who may have experienced and/or used FV. These interviewees noted that careful consideration should be given on how to provide group-based interventions in settings where residents include a broad range of clients without singling out or further stigmatising some residents.

However, some interviewees were generally supportive of extending combined interventions situated with the AOD sector to residential support settings. These interviewees felt that there was a clear need to address FV in these settings due to the substantial known overlap of problematic AOD use and FV among clients accessing AOD support services. Interviewees felt that residential rehabilitation settings would therefore be a suitable environment to extend available onsite support services to MBCPs addressing the intersection of FV perpetration and problematic AOD use.

6.7 Voluntary Versus Mandatory Program Referral and Participation

Interviewees were asked to share their views regarding referral pathways into combined group-based interventions. While some were equally supportive of voluntary and mandatory referral pathways, AOD sector representatives, in particular, felt that voluntary participation is likely going to be more beneficial than court-mandated program attendance. This was specifically framed around addressing problematic AOD use. Interviewees had fewer concerns around mandating MBCPs, but felt that behaviour change around AOD use requires an initial motivation to change, which was described as less present in court-mandated populations. However, other interviewees felt that there is sufficient evidence to suggest that AOD as well as FV-focused interventions have demonstrated significant levels of effectiveness in mandated populations, thus arguing that with skilled motivational interviewing at program intake, referred clients should develop a readiness to change regardless of their initial referral pathway.

6.8 Summary

Focus group findings identify a shift in readiness for combined group-based interventions addressing FV and AOD use among key stakeholders from justice, FV service/MBCP providers, and AOD and mental health services. Interview participants unanimously identified a clear need for combined interventions due to the substantial overlap of FV perpetration and problematic AOD use. While representatives from all areas felt that both sectors needed to invest in further upskilling to ensure a FV and AOD-informed development of future group-based interventions, interviewees equally felt that both sectors had already made substantial improvements in terms of developing a clearer understanding of intersectionality and, especially in the AOD sector, an increasingly FV-informed approach to client work.

While interviewees felt that either sector would be well placed to offer future combined interventions, strong emphasis was placed on the need to ensure a gendered framework, combined with a harm minimisation approach and clinical AOD expertise, regardless of where combined interventions are

situated. Further, findings clearly highlight the need to ensure combined expertise from the AOD and FV/MBCP sector in the development of combined interventions as well as their delivery through qualified, skilled co-facilitators. The combination of expertise, experience, qualifications and skills in the development and delivery of combined interventions was seen as crucial in order to ensure that programs offer a balance of accountability work, harm minimisation and education with the ultimate goal of increasing the safety of AFMs.

Findings further highlight the importance placed on the FSC component of perpetrator interventions. Interviewees strongly emphasised the need for adequate resourcing of dedicated FSC worker roles across programs. Findings regarding the FSC worker component along with where programs may best be situated further highlight the need for integrated service systems. Where referral pathways for additional support to program participants as well as AFMs require the involvement of external support services, a close coordination of referrals and service uptake, along with relevant information exchange that keeps victims and perpetrators in view, is crucial. In the longer term, preliminary focus group findings further support findings from a number of other FV program evaluations and clearly point towards the need to transition to fully integrated service responses to FV in order to minimise the risk of victims and perpetrators falling into service and referral gaps as the result of multiple referral pathways across different service sectors.

7. Recommendations

Findings presented throughout this report support the need for and benefits of combined interventions in addressing the support needs of men presenting with comorbid use of FV and problematic AOD use. Further, findings highlight the benefits of the specific U-Turn intervention for program participants as well as AFMs. While the U-Turn program appears to be overall effective in achieving its aims, findings also indicate room for improvement. The following recommendations are informed by the qualitative and quantitative findings presented throughout this report and provide directions regarding the future delivery of the U-Turn program.

Recommendation 1 – Continuation of U-Turn in Its Current Form

To offer a holistic response to respondents on FVIOs who present with comorbid FV and problematic AOD use, it is recommended that U-Turn is refunded and continued in its current format.

Recommendations 2 – Ensuring a Dedicated FSC Worker Role and Funding Allocation

To ensure adequate support to AFMs associated with male U-Turn participants, it is recommended that future U-Turn programs continue to operate with a dedicated FSC worker role. It is recommended that this dedicated role has dedicated funding attached to it when refunding the program. It is further recommended that this role has a level of flexibility that allows the FSC worker to operate outside of standard TaskForce hours in order to meet the needs of and maximise engagement with AFMs who require outside-of-office-hours support due to fulltime work and/or carer commitments.

Recommendation 3 – Consideration of a Father-specific Group Format

Given the positive aspects noted by U-Turn participants and AFMs with individual or mutual dependent children, it is recommended that U-Turn is trialled in an additional format, specifically targeting fathers with dependent children and incorporating a greater focus on the engagement of AFMs in their roles as mothers, carers or guardians. It is recommended that such a model involves a collaborative approach with child protection to better support families where FV occurrences have led to initial or ongoing child protection involvement.

Recommendation 4 – Exit Assessment to Identify Further Referral Needs

It is recommended that a brief exit assessment is conducted with all program participants to identify potential ongoing MBCP needs and facilitate relevant referral pathways. Exit assessment and referral decisions may be further informed by facilitators' professional judgement based on observations of persistent attitudes and beliefs around victim-blaming and denial of accountability during group facilitation.

Recommendation 5 – Extended Partnership Approach with Additional Service Sectors for Participants with Complex Needs

While the current format of U-Turn is delivered as an 'early intervention model', some referrals considered for program intake presented with an accumulation of complex needs. Referrals with an accumulation of complex needs seemed to be more likely to disengage from the program and/or the evaluation. It is therefore recommended that U-Turn extends its partnership beyond the court – TaskForce partnership to include at a minimum child protection, probation and parole, and housing support service to better support men who may require a more holistic wrap-around support to facilitate their ongoing engagement in U-Turn and related behaviour change.

8. References

Boxall, H., Morgan, A., & Brown, R. (2020). The prevalence of domestic violence among women during the COVID-19 pandemic. *Australasian Policing*, *12*(3), 38-46.

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

Day, A., Vlais, R., Chung, D., & Green, D.J. (2019). Evaluation readiness, program quality and outcomes in men's behaviour change programs. ANROWS research report, Issue 01, April.

Douglas, H. (2018). Legal systems abuse and coercive control. *Criminology & Criminal Justice*, *18*(1), 84–99. https://doi.org/10.1177/1748895817728380

Easteal, P., Young, L., & Carline, A. (2018). Domestic violence, property and family law in Australia. *International Journal of Law, Policy and The Family*, *32*(2), 204-229.

Freeman, A. J., Schumacher, J. A., & Coffey, S. F. (2015). Social desirability and partner agreement of men's reporting of intimate partner violence in substance abuse treatment settings. *Journal of Interpersonal Violence*, 30(4), 565–579.

Kelly, L., & Westmarland, N. (2015). Domestic Violence Perpetrator Programmes: Steps Towards Change. Project Mirabal Final Report. London and Durham: London Metropolitan University and Durham University.

Kraanen, F. L., Scholing, A., & Emmelkamp, P. M. G. (2010). Substance use disorders in perpetrators of intimate partner violence in a forensic setting. *International Journal of Offender Therapy and Comparative Criminology*, 54(3), 430–440.

Liamputtong, P. (2007). Researching the vulnerable: A guide to sensitive research methods. London, England: Sage.

Liamputtong, P. (2008). Doing cross-cultural research: Ethical and methodological perspectives. Dordrecht, the Netherlands: Springer.

Lipsky, S., Krupski, A., Roy-Byrne, P., Lucenko, B., Mancuso, D., & Huber, A. (2010). Effect of co-occurring disorders and intimate partner violence on substance abuse treatment outcomes. *Journal of Substance Abuse Treatment*, 38(3), 231-244.

Maher, J. M., Spivakovsky, C., McCulloch, J., McGowan, J., Beavis, K., Lea, M., Cadwallader, J., & Sands, T. (2018). Women, disability and violence: Barriers to accessing justice: Final report (ANROWS Horizons, 02/2018). Sydney: ANROWS.

McGowan, J., & Elliott, K. (2019). Targeted violence perpetrated against women with disability by neighbours and community members. Women's Studies International Forum 76 (September-October).

Meyer, S., Hine, L., & McDermott. L. (2019a). Caring Dads Program (Queensland Trial) Evaluation – Final Report. Prepared for the Queensland Department of Child Safety, Youth and Women.

Meyer, S., Hine, L., McDermott, L., & Eggins. E. (2019b). Walking with dads trial evaluation – final report. Summary Report. ISBN: 978-0-9953934-7-9. Prepared for the Queensland Department of Child Safety, Youth and Women.

Meyer, S., & Stambe, R.M. (2020). Mothering in the context of violence: Indigenous and non-Indigenous mothers' experiences in regional settings in Australia. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260520975818

McCulloch, J., Maher, JM., Walklate, S., McGowan, J., & Fitz-Gibbon, K. (2020). Justice perspectives of women with disability: An Australian story. *International Review of victimology*, 27(2), 196-210.

Pfitzner, N., Fitz-Gibbon, K., Meyer, S., & True, J. (2020). Responding to Queensland's 'shadow pandemic' during the period of COVID-19 restrictions: practitioner views on the nature of and responses to violence against women. Monash Gender and Family Violence Prevention Centre, Monash University, Victoria, Australia.

Radcliffe, P., & Gilchrist, G. (2016). "You can never work with addictions in isolation": Addressing intimate partner violence perpetration by men in substance misuse treatment. *International Journal of Drug Policy*, 36, 130–140.

Roper, J. M., & Shapira, J. (2000). *Ethnography in nursing research*. Thousand Oaks, CA: Sage.

Smith, J., Humphreys, C., & Laming, C. (2013). The central place of women's support and partner contact in men's behaviour change programs. Ending Men's Violence Against Women and Children: The No To Violence Journal.

State of Victoria 2016, Royal Commission into Family Violence: Report and recommendations, Vol III, Parl Paper No 132 (2014–16).

Stuart, G. L., O'Farrell, T. J., & Temple, J. R. (2009). Review of the association between treatment for substance misuse and reductions in intimate partner violence. *Substance Use and Misuse*, 44, 1298–1317.

Thummapol, O., Park, T., Jackson, M., & Barton, S. (2019). Methodological challenges faced in doing research with vulnerable women: Reflections from fieldwork experiences. International *Journal of Qualitative Methods*, 18, 1-18.

VicHealth. (2020). Coronavirus Victorian wellbeing impact study, report for survey #1. Victorian Health Promotion Foundation, Melbourne. https://doi.org/10.37309/2020.PO909

Westwood, T., Wendt, S., & Seymour, K. (2020). Women's perceptions of safety after domestic violence: Exploring experiences of a safety contact program. *Affilia*, *35*(2), 260-273. https://doi.org/10.1177/0886109919873904