Let's talk about sex:

Exploring practitioners' views on discussing intimate partner sexual violence in domestic and family violence perpetrator intervention programs

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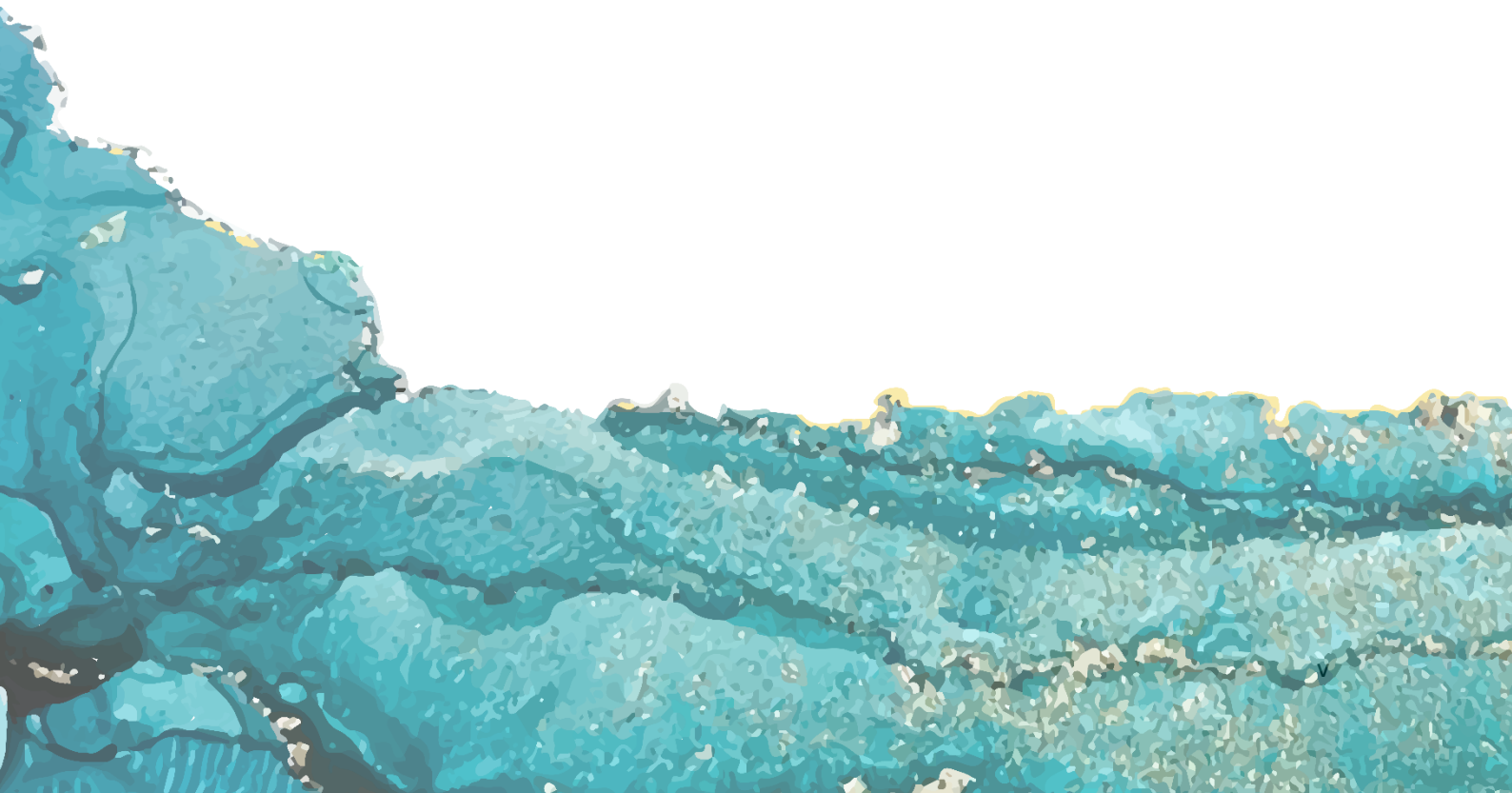
Acronyms

ABI	Abusive Behaviour Inventory
AFM	Affected Family Member
CRAF	Common Risk Assessment Framework
DFV	Domestic and Family Violence
DVSAT	Domestic Violence Safety Assessment Tool
IPSV	Intimate Partner Sexual Violence
IPV	Intimate Partner Violence
MBCP	Men's Behaviour Change Program
MGFVPC	Monash Gender and Family Violence Prevention Centre
MARAM	Multi-Agency Risk Assessment and Management Framework
NFS	Non-fatal Strangulation
NTV	No To Violence
RSSF	Risk, Safety and Support Framework
SARA	Spousal Assault Risk Assessment Tool



Executive summary

This report presents findings from a study examining how domestic and family violence (DFV) perpetrator intervention programs respond to intimate partner sexual violence (IPSV). The need for focused attention on sexual violence as part of reforms to address DFV is highlighted for example, in both the National Plan to End Violence Against Women and Children 2022-2032 (Department of Social Services [DSS] 2022, henceforth the National Plan) and the Victorian Royal Commission into Family Violence (RCFV 2016, henceforth the Commission). The need for increased attention on sexual violence reflects that it is an under-reported form of DFV and is a sign of escalating abuse and heightened risk including risk of lethality (RCFV 2016; Bagwell et al. 2015). Further, IPSV has unique impacts that are different to the harms of both non-sexual intimate partner violence, and sexual violence perpetrated by other assailant types.

DFV reform agendas in Australia increasingly assert the need to shift the burden of responsibility away from victim-survivors and ensure a sustained focus on DFV perpetrators. As the Commission (RCFV 2016, p. 10) states 'family violence policy must aim to stop violence at its source.' Perpetrator interventions are one mechanism that contributes to this objective. The most common perpetrator intervention programs in Australia are men's behaviour change programs (MBCPs), and while these play a key role in holding perpetrators to account, little is known about how they respond to IPSV.

This research sought to understand current practice and professional views related to how perpetrator intervention programs, including MBCPs and similar interventions targeting DFV perpetrators, engage with IPSV. The research examined three domains:

- Practitioners training experience,
- Screening and risk assessment practices used within the perpetrator intervention program context, and
- Perpetrator intervention program practice.

This report draws on survey responses from 97 practitioners who work across DFV perpetrator intervention programs. This includes practitioners working with DFV perpetrators, DFV victim-survivors (through for example family safety contact work), trainers involved in delivering training to practitioners working in DFV perpetrator intervention programs, and other professionals involved in the design and development of DFV perpetrator intervention programs.

The findings from this project highlight a key gap in training related to IPSV. One in four professionals surveyed reported that IPSV was not covered in any of their training at all. Further, where this was covered, this was often not rated highly by participants. The lack of IPSV focused training was particularly evident in relation to formal and institutional training. Our findings highlight a key opportunity for increased practical skills-based training around how to approach the topic of IPSV, have discussions related to IPSV with perpetrators and respond appropriately where this is disclosed. This research also found that practitioners are more comfortable responding to disclosures of DFV perpetration in one-to-one settings compared to group environments, demonstrating the importance of incorporating (and adequately funding) greater one-to-one work into group-based perpetrator intervention programs. Where training was discussed positively, this was often linked to past experience(s) working with victim-survivors and specific sexual assault training, delivered through for example Centres Against Sexual Assault (CASA). Such training had a positive influence on participants reported comfort and competency identifying, discussing, and responding to IPSV perpetration. This suggests that rather than needing to reinvent the wheel in creating training opportunities for practitioners working with DFV perpetrators, there may be opportunities to pivot existing training from victim-survivor services for sexual assault and domestic and family violence to the perpetrator context.

The data reveals limited screening and risk assessment of IPSV among survey participants, The results show that:

- One in five participants report that they rarely or never risk assess for IPSV perpetration,
- One in ten participants report that they rarely or never risk assess for IPSV victimisation,
- Two in five participants report that they risk assess for IPSV perpetration somewhat or much less often compared to other forms of DFV, and
- One in five participants report that they risk assess for IPSV victimisation much or somewhat less often than other forms of DFV.

Additionally, participants reported low confidence that IPSV perpetration and victimisation are identified where present. These findings identify a clear need to better support practitioners working with both DFV perpetrators and victim-survivors to enhance screening and assessment of IPSV. While there are a range of factors influencing screening and risk assessment practices, these findings illustrate limitations relating to existing DFV assessment tools. In particular, participants reflected on the use of language focused on ‘force’ and sexual assault, that is not supportive of creating a dialogue with clients. While practitioners rely on professional judgement and skills beyond assessment tools,

there is a need to develop conversational assessment tools to better support practitioners to identify and assess the risk of IPSV.

Our project findings also highlight variation in perpetrator intervention program practice related to IPSV, with one in four participants reporting that they rarely or never discuss IPSV in their work with DFV perpetrators. There was also variation in whether IPSV was incorporated into program content with some practitioners reporting IPSV was engaged with in programs and other practitioners reporting this was not covered in the programs they had delivered. The quality of engagement also varied with some practitioners describing this as only superficially explored. Practitioner and DFV perpetrator discomfort were discussed as key barriers to exploring IPSV within perpetrator intervention programs.

In accordance with these findings, the report makes the following six recommendations:

1. To develop and deliver IPSV-focused training for practitioners working within DFV perpetrator intervention programs.
2. To embed increased opportunities for one-to-one work alongside DFV perpetrator intervention group work.
3. To develop improved screening and risk assessment tools to better support practitioners to identify and assess the risk of IPSV.
4. To embed IPSV into DFV perpetrator intervention program content and practice across weeks not solely as a stand-alone topic.
5. To ensure available and resourced workplace supports for practitioners to undertake perpetrator intervention work related to IPSV.
6. To conduct further research on existing strategies that practitioners are using to identify, discuss and respond to IPSV perpetration to inform the development of improved training, resources and supports for practitioners.

Introduction

Over the last decade Australia has witnessed significantly more attention towards improving responses to DFV, as a result of, for example, the Victorian Royal Commission into Family Violence (RCFV 2016, henceforth the Commission), the Special Taskforce on Domestic and Family Violence in Queensland's (2015) *Not now, not ever report* and the development and delivery of the National Plan to End Violence against Women and Children 2022-2032 (Department of Social Services [DSS] 2022, henceforth the National Plan). Echoed throughout these examples and the broader DFV policy landscape in Australia is the need to shift the burden away from victim-survivors and to hold perpetrators accountable for their use of violence.[1] As the National Plan (2022, p. 73) states 'violence against women and children will not end without a clear and sustained focus on perpetration.'

Men's Behaviour Change Programs (MBCPs) are a common DFV perpetrator intervention utilised in Australia. These programs are group-based interventions intended to support men to explore and recognise their violent behaviours and attitudes, to learn non-violence and to address violence supporting beliefs. Programs promote the safety of women and children and focus on men's accountability for their use of violence. The focus on men's use of violence reflects the gendered nature of DFV and other forms of violence against women and the related over-representation of men as perpetrators (Our Watch 2021; Australian Bureau of Statistics [ABS] 2017). The effectiveness of MBCPs in supporting change continues to be the subject of debate, and while there is evidence that interventions reduce the use of violence among some participants, it is also evident that some perpetrators continue to choose to use violence despite this engagement (Babcock et al. 2004; Vlais et al. 2017). Inconsistencies in how effectiveness is measured also limit attempts to measure program effectiveness (Chung et al. 2020). There is an ongoing need to build the evidence base on the effectiveness of DFV perpetrator intervention programs (Mackay et al. 2015; DSS 2022; RCFV 2016).

One area in which there has been particularly limited attention is intimate partner sexual violence (IPSV). The National Plan (2022, p. 22) notes the increase in sexual violence across a range of settings, including online, and asserts the aim 'to bring addressing sexual violence [including IPSV] out of the

[1] In this report we use the term perpetrators to refer to people who have used violence against a current or former intimate partner or other family member, recognising that some people use other terms, such as person using violence (PUV). Following the terminology of the National Plan (DSS 2022) we use the term victim-survivors to refer to people who have experienced and/ or are currently experiencing DFV. As the National Plan asserts 'this term is understood to acknowledge the strength and resilience shown by people who have experienced or are currently living with violence' (p.134). While the impacts of DFV are enduring, victim-survivors are more than their experience of DFV and in this respect some people who have experienced DFV may use other terms.

shadows.' Further, a key action under the domain of recovery and healing outlined in the National Plan (2022, p. 121) is to 'ensure everyone impacted by sexual violence receives specialist recovery and healing services.' Similarly, the Commission (RCFV 2016) identified sexual assault as a common and under-reported form of DFV and an indicator for heightened DFV risk. While the specific focus on sexual violence both in relation to and beyond DFV is critical, this work remains focused predominantly on victim-survivors. There has not been a corresponding focus on understanding men's use of IPSV as part of broader patterns of DFV, or on the ways in which interventions like MBCPs impact or influence men's understanding and use of IPSV.

This study sought to build understandings of current practice in responding to IPSV perpetration within the DFV behaviour change space. While recognising that not all sexual violence that occurs in DFV contexts is perpetrated by an intimate partner (this can also be perpetrated for example by parents, siblings, carers, in-laws, and others), our focus on intimate partner relationships reflects that most sexual violence experienced by women is perpetrated by an intimate partner (ABS 2017).

While recent reviews and reform agendas within Australia including the Commission (RCFV 2016) and the National Plan (DSS 2022) highlight the need for focused attention on sexual violence, little is known about how sexual violence is engaged with within existing DFV perpetrator intervention programs. As Westmarland and Kelly (2017) note, there is more research on sex offender treatment programs than there is on sexual violence perpetrated by men in MBCPs. While some programs include content on sexual respect, generally limited attention has been paid to the intersection of DFV and sexual violence within DFV interventions (Heenan 2004; Yllö 1999). For this reason, there is a need to better understand IPSV perpetrated by men in DFV perpetrator intervention programs and to understand how interventions are responding to IPSV. To address this gap in current knowledge, this study sought to understand current practice and professional views related to the engagement of IPSV within:

- Practitioners experience of DFV and perpetrator intervention program training,
- Screening and risk assessment practices used within the DFV perpetrator intervention program space, and
- Perpetrator intervention program practice.

Background

Understanding IPSV

There is a lack of consensus in understandings of IPSV, with one review of terminology finding 14 different terms and 29 different definitions used in relation to IPSV (Bagwell-Gray et al. 2015).[2] The review draws attention to inconsistencies across definitions that are organised into four domains. First, the review found inconsistent use of the term 'force' with some definitions focused only on physical force. Relatedly, there was a preoccupation with physical violence in some definitions. This preoccupation persists despite not all IPSV resulting in physical injuries (Waterhouse et al. 2016), and often involving non-physical sexual coercion through verbal manipulation, withholding of money or other resources, and threats, such as threats of infidelity or to end the relationship (Logan et al. 2007). Second, some definitions stipulate that IPSV includes attempted acts, while others make no specific inclusion of attempted IPSV. Third, while a lack of consent was commonly included in definitions, inconsistent theorisations of consent remain. Fourth, definitions varied in their focus on penetrative sex acts or broader inclusion of non-penetrative sex acts (Bagwell-Gray et al. 2015). As these inconsistencies highlight, issues in defining IPSV are compounded by the lack of consensus in defining terms used to define IPSV such as force, consent, and coercion (Bagwell-Gray et al. 2015; Hamilton & Tidmarsh 2022).

The variation in definitions impact public understandings of IPSV and undermine our capacity to support victim-survivors and hold perpetrators accountable (Hamilton & Tidmarsh 2022; Logan et al. 2015). In attempting to reconcile these differences, Bagwell-Gray et al. (2015, p. 323) developed a taxonomy of IPSV that synthesises existing definitions. The taxonomy is based on two spectrums capturing: the type or level of force used by the perpetrator(s) (non-physical to physical) and the type of sexually abusive activities or level of invasiveness (penetrative to non-penetrative). This results in four categories: intimate partner sexual coercion, intimate partner sexual assault, intimate partner sexual abuse and physically forced sexual activity. The taxonomy captures coercive, controlling, and manipulative tactics, psychological abuse, abuses of power, unwanted sexual experiences, that includes actual and threatened physical sexual violence as well as non-physical sexual violence (Bagwell et al. 2015). Conceptualisations that seek to capture breadth such as Bagwell-Gray et al.'s (2015) taxonomy are important for recognising and naming all forms of IPSV. This is critical for validating victim-survivors experiences, acknowledging harm and aiding healing processes, as well as

[2] A shorter version of the background section to this report has been previously published as an online resource available at: https://www.monash.edu/arts/gender-and-family-violence

for ensuring perpetrator accountability that is not restricted to only particular forms of IPSV (Bagwell-Gray et al. 2015). Simultaneously, attempts to define IPSV must allow '[w]omen's own definitions and conceptualizations of IPSV [to] also inform the terms and definitions' utilised (Bagwell-Gray et al. 2015, p. 331).

IPSV includes a range of behaviours including but not limited to forced (physical or non-physical) or coerced sexual acts including acts submitted to, for example, in order to avoid the negative outcomes of refusal or out of perceived obligation or duty; sexual harassment and assault; threats or blackmail to obtain sexual acts; image-based abuse (for example, non-consensual filming of sex acts or forcing a partner to view pornography); and reproductive abuse, such as sabotaging contraception, refusing to use contraception and controlling reproductive decisions through for example, forced pregnancy or abortion (Bagwell et al. 2015; Campo 2015; Mortreux et al. 2019).

Much of the behaviours captured in definitions of IPSV also covers aspects of DFV more broadly, including coercion and control through physical and/or emotional abuse (Campo 2015). Like DFV and sexual violence perpetrated by other assailant types, IPSV is fundamentally shaped by gender inequalities that saturate institutional structures, cultural norms, and community practices (Our Watch 2021). These include factors such as a lack of comprehensive and accessible sex and relationships education, a prevalence of victim-blaming, and non-existing or inconsistent community level sanctions against gender-based violence (Funk & Bancroft 2017). IPSV is consistently viewed by the general community as less serious and more justifiable than sexual assault committed by strangers or acquaintances (Cox 2015), and community attitudes toward IPSV have been characterised as a compounding negative experience on top of victim-survivors' primary trauma related to the IPSV itself (Cox 2015). The likelihood of sexual violence being disregarded (for example police officers believing it is a lie or a victim-survivor believing it was a miscommunication) increases with greater familiarity between the victim-survivor and the perpetrator (Cox 2015).

In drawing attention to the unique contextual factors of IPSV, Tarzia (2021b) offers a nested ecological model. This model captures individual (such as sense of entitlement to sex and fragile masculinity), relationship (such as co-occurring psychological abuse and unequal power dynamics), community (such as taboos around sex and isolation and lack of support for women), and societal-level factors (such as misconceptions about 'real rape' and belief that women's duty is to give man sex) that perpetuate IPSV (Tarzia 2021b). In this model, there are overlaps with intimate-partner violence (IPV) and sexual violence allowing IPSV to be understood as connected to IPV and sexual violence. However,

the ecological model also reiterates that IPSV is not simply a form of IPV or sexual violence and that instead of relegating it to the periphery of either domain, focused attention on IPSV is needed.

IPSV prevalence

Few studies measure IPSV specifically, with IPSV often combined with statistics on DFV and sexual violence more broadly (Bagwell-Gray et al. 2015). Where IPSV is measured, there is widespread variation in how this measurement is undertaken. In their review, Bagwell-Gray et al. (2015) found seven different measurement scales in use, with only one instrument capturing the four categories of IPSV outlined in their taxonomy (discussed above, p. 3). Measurement of IPSV is often limited to threatened or forced sex – typically without defining force – obscuring the use of sexual coercion (Logan et al. 2007; Logan & Cole 2011; Logan et al. 2015; Bagwell-Gray et al. 2015). Further issues in measuring IPSV reflect inconsistent definitions and understandings of IPSV (discussed above, p. 3). These inconsistencies manifest in persistent rape myths and misinformation, including the use of terms 'forcible rape' and 'legitimate rape' that perpetuate misunderstandings of IPSV and undermine attempts to measure the prevalence of IPSV. Further, some victim-survivors do not identify their experiences as IPSV, particularly in cases of sexual coercion (Cox 2015), complicating estimates of IPSV. In a study of college women (*n*=1060) who had experienced treatment within intimate relationships categorisable as sexual coercion, 49.5% did not consider themselves victim-survivors of IPSV and 45.4% considered the incident a 'serious miscommunication' (Cox 2015). In instances of sex obtained through physical force, only 30-47.9% of women identified the act as rape (Cox 2015).

Additionally, there are barriers to disclosure that result in under-reporting even where an act(s) is identified as IPSV (Bagwell et al. 2015; Wall 2012). IPSV is less likely to be reported than other forms of IPV, and sexual violence by other assailant types (Tarzia 2021b). In Australia, IPSV by a current partner has the lowest rate of reporting of all assaults (RCFV 2016). When asked about the most recent incident of sexual assault by a male (not specific to sexual assault perpetrated by an intimate partner), nine out of ten women reported they did not contact the police (*n*=553,900, 87%) (ABS 2017). Victim-survivors of IPSV are less likely to seek help and report the crime than those who experienced other forms of IPV (Cox 2015). ABS data shows that, of those who experienced sexual assault, 87% did not report if the perpetrator was an intimate-partner, and cases of sexual assault by any known assailant (including intimate-partner) was less likely to be reported within one week of the incident compared to sexual assault by strangers (ABS 2021).

These constraints notwithstanding, the ABS (2017) Personal Safety Survey estimates that 9.2% (*n*=864,000) of women and 1.2% (*n*=104,800) of men have experienced IPSV since the age of 15.[3] Further, among those who have experienced IPV, it is estimated that 29.55% of women and 9.68% of men have experienced sexual violence by a partner (ABS 2017).[4] Women and men are more likely to experience sexual assault by a known person than by a stranger, and the most common perpetrator of sexual assault against women is an intimate partner (ABS 2021). From police records over the period 2014-2019, out of 38,775 female victim-survivors who had experienced police-recorded DFV related sexual assault, 34% (*n*=13,075) of cases were perpetrated by an intimate partner (ABS 2021). These same police records show that DFV related sexual assault (inclusive of, but not specific to, IPSV) of female victim-survivors increased from 49.2 to 60.1 victim-survivors per 100,000; victimisation rate for males remained stable at around 10.0 victim-survivors per 100,000 (ABS 2021). In Fulu and colleagues' 2013 multi-country study that examined men's perpetration of violence against women in Asia and the Pacific, between 15% and 59% of men reported perpetrating IPSV, and rape of an intimate partner was more common than rape of a non-partner in all but one site.

Co-occurrence of IPSV with other forms of IPV

IPSV commonly occurs alongside other forms of IPV. For example, IPSV has been linked to ongoing controlling and psychologically abusive behaviour (Tarzia 2021b; Tarzia & Hegarty 2022; Sullivan et al. 2012). Victim-survivors in a study by Tarzia (2021b) described the co-occurrence of IPSV with generally controlling behaviours including monitoring the women's social media, demanding they dress certain ways as well as limiting and tracking the time they spent outside the home. An American study mapping the daily abuse patterns experienced by 49 women – who were at the time in abusive relationships – found that over a 90-day period, psychological abuse was the highest co-occurring factor of IPSV, occurring more frequently than IPSV alone and the co-occurrence of IPSV and physical abuse (Sullivan et al. 2012). Despite this co-occurrence, the intersection of IPSV and psychological abuse is poorly understood (Tarzia & Hegarty 2022).

[3] See Australian Institute of Health and Welfare (2022) Family, domestic and sexual violence data in Australia, https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-data/contents/how-is-family-domestic-and-sexual-violence-experienced/sexual-violence Noting that the definition of sexual violence used in this measure was limited to sexual assault and/ or sexual threat.

[4] These percentages are calculated based on ABS (2017) estimates that 1,625,000 women have experienced IPV since the age of 15 and 480,200 women have experienced sexual violence by a partner. Comparatively, the ABS (2017) estimates that 547,600 men have experienced IPV since the age of 15 and 53,000 men have experienced sexual violence by a partner. These estimates should be interpreted with caution. Noting that the definition of 'partner' used by the ABS in measuring experiences of partner violence only includes those who have cohabited.

Women experiencing IPSV also commonly experience physical violence enacted alongside and as part of IPSV (Cox 2015; Bagwell-Gray et al. 2015). Co-occurrence rates vary, with Cox (2015) reporting between 64-100% of women who indicated they had experienced IPSV also enduring physical violence in that same relationship. In 30% of intimate partner rape cases (*n*=124), women reported that they were physically assaulted in response to their physical refusal of forced sexual violence resulting in physical violence and IPSV perpetrated simultaneously in a single incident (Cox 2015). Bagwell-Gray et al. (2015) argue that physical violence targeted toward a sex organ or occurring during a sexual act should be captured as IPSV, particularly as it may have unique effects on victim-survivors compared to non-sexual physical IPV. IPSV is also perpetrated alongside, but separate to, incidents of physical abuse. Data taken from men arrested for physical assault of their partners found that 13.6% reported raping their partners (whether through coercion, threat, or physical force) immediately after committing physical assault (Cox 2015). While the study by Sullivan et al. (2012) found the co-occurrence of physical abuse and IPSV to be the least frequent co-occurrence and never co-occurred in the absence of psychological abuse, there is evidence that links IPSV with more severe forms of physical abuse. Women who are subjected to both non-sexual IPV and IPSV have been found to be at increased risk of being punched, kicked, and attacked with sharp objects (for example, knives) than women who experienced non-sexual IPV only (Cox 2015).[5] In a sample of 449 mothers staying in DV shelters who has experienced physical IPV, Spiller et al. (2012) found that mothers who had experienced IPSV were physically abused more than those who had only experienced non-sexual IPV only. Additionally, it has been argued that a relationship with ongoing IPV compromises victim-survivors' capacity to freely consent (RCFV 2016; Logan & Cole 2011).

IPSV is often understood as part of a broader pattern of DFV, is more often observed in relationships where other forms of abuse were already occurring and is identified as an abuse tactic that indicates higher risk of lethality in abusive relationships (Bagwell-Gray 2021; McOrmond-Plummer et al. 2013; Kropp 2018; Dobash et al. 2007; RCFV 2016). Higher incidences of non-fatal strangulation (NFS), threats to kill, stalking, and separation violence – all of which are lethality factors in their own right (Zilkens et al. 2016; Cox 2015; McOrmond-Plummer et al. 2013; Logan & Walker 2004) – occur alongside IPSV. Women who experience IPSV are more likely to endure NFS compared to both women who experience non-sexual IPV only and women who experience sexual assault by other assailant types (Zilkens et al. 2016; Messing et al. 2014). According to data collected from 1064 girls and women (age ≥ 13 years) referred to the Western Australian Sexual Assault Resource Centre (SARC) between

[5] The use of 'non-sexual IPV only' is used as a category to distinguish between victim-survivors who have experienced IPSV and those who have experienced IPV but not IPSV. This is not intended to delegitimise the harm of non-sexual IPV, indeed the harms of IPV are significant and well established.

January 2009 and March 2015 alleging recent sexual assault (inclusive of, but not specific to, IPSV), 79 (7.4%) alleged NFS during the sexual assault (Zilkens et al. 2016). From this data, 22.5% of women assaulted by an intimate partner cited a history of NFS compared to less than 6% of women assaulted by other assailant types; of all sexual assault with NFS presented, intimate partners were the assailant in 58.2% of cases (Zilkens et al. 2016). Other factors associated with NFS perpetrated during all sexual assault documented in the study included deprivation of liberty, verbal threats, being assaulted in the woman's home, and use of additional blunt force (Zilkens et al. 2016). Similarly, drawing on UK data, White et al. (2021), found the prevalence of NFS perpetration during sexual assault increased where the alleged perpetrator was a current or former partner. Further, over one in six (15.7%) of the women reported loss of consciousness from the NFS, suggesting near lethal assault (White et al. 2021). NFS has been identified as a high risk-factor for eventual lethality, with corroboratory findings spanning over a decade in both health and crime literature (Glass et al. 2008; Messing et al. 2014; Messing et al. 2020).

Higher incidences of threats to kill an intimate partner have also been observed in relationships where IPSV occurs compared to relationships where non-sexual IPV-only occurs. Analysis of intimate partner homicide following an identifiable history of IPV in Australia from July-2010 to June-2018, showed IPSV was identified as being perpetrated by 34 (16.0%) male primary abusers who killed a current or former female intimate-partner (Australian Domestic and Family Violence Death Review Network & ANROWS 2022). Similar findings have been established in data from the UK and US, which demonstrate sexual violence is associated more so in lethal versus non-lethal (attempted or completed homicide) IPV contexts (McOrmond-Plummer et al. 2013).

Women already subjected to IPSV are at risk of continued IPSV during the separation and post-separation period and in some cases experience IPSV in the first instance as retaliation to their attempt to leave (Cox 2015; McOrmond-Plummer et al. 2013). In a US study of 43 women who had separated from abusive partners, 74% were sexually assaulted when they expressed their desire to leave, 49% while they were trying to leave, and 33% after they had left (DeKeseredy & Schwartz 2008). It is also well established that the separation and post-separation period is a risk factor for lethality in IPV contexts generally (Logan & Walker 2004; Spearman et al. 2022). Research has also found an association between IPSV and stalking (Logan & Cole 2011). Logan and Cole (2011) found greater prevalence of sexual controlling tactics, verbal manipulation, strong pressure or insistence to have sex when they did not want to, substance-facilitated sexual activities, and implicit threats among women who had been stalked compared to those who had not been stalked. Further, Logan and Cole (2011)

found a relationship with stalking and separation with more women who were stalked and raped separated from their violent ex-partner. The co-occurrence of IPSV with NFS, threats to kill, separation violence and stalking, all of which are risk-factors for IPV lethality in their own right, as well as data that finds IPSV positively correlates with intimate partner homicide, highlights the significant and multifaceted lethality risks of IPSV.

Impacts of IPSV on victim-survivors

IPSV victimisation results in a range of harmful psychological, emotional, and physical conditions. Women who experience IPSV report higher levels of shame compared to women who experience non-sexual IPV only and compared to women who experience sexual assault by strangers, suggesting that IPSV results in more severe psychological harm than IPV or sexual assault separately (Cox 2015). IPSV also has 'invisible impacts' that are unique from the harms of both non-sexual IPV only and sexual violence perpetrated by other assailant types (Tarzia 2021a). In exploring women's lived experiences of IPSV, Tarzia (2021a) draws attention to four types of impacts: betrayal and exploitative violation of trust; the difference of IPSV harms from other forms of IPV; dehumanising; and long-term impacts on women's sexuality and relationships. Many women have described feeling deprived of agency and being objectified upon realising their partners do not care about their sexual autonomy or pleasure; difficulties trusting future partners and fear of experiencing IPSV in new relationships are also common (Tarzia 2021a). In comparison to women who experience non-sexual IPV only, those who endure IPSV are more likely to have clinically significant distress (Cox 2015). Victim-survivors of IPSV commonly report struggles with self-esteem, body-image, self-loathing, and overall lack of confidence following IPSV victimisation (Tarzia 2021a). In a study of trauma symptoms Broach and Petretic (2006) found similar trauma symptoms among those who had experienced sexual coercion and rape, suggesting that impacts may be similar. This reiterates the importance of recognising sexual coercion within understandings of IPSV.

Women subjected to IPSV are also more likely than those subjected only to non-sexual IPV to present with gynaecologic, central nervous system, and chronic stress disorders (McOrmond-Plummer et al. 2013). Other health conditions associated with IPSV include urinary tract conditions; gastrointestinal disorders; headaches; asthma; hypertension; and seizures (Cox 2015). IPSV increases the likelihood of cervical cancer, possibly due to increased transmission of the human papilloma virus (Cox 2015). Further impacts include unintended or unwanted pregnancies, increased likelihood of miscarriage, and sexually transmitted infections (Cox 2015). In a study of 432 women who had experienced police-

involved IPV, Messing et al. (2014) found that women who experienced intimate-partner perpetrated rape were 3.36 times more likely to experience a miscarriage compared to women who had not experienced IPSV. These harms are compounded by repeat victimisation; women who experience IPSV re-victimisation are 10 times more likely to experience anxiety disorders, 16 times more likely to experience PTSD, and 15 times more likely to attempt suicide (Cox 2015).

Despite the intersection of DFV and sexual violence, service responses for victim-survivors of IPSV are often siloed to either sexual assault or DFV services (Zilkens et al. 2017). Research shows that practitioners in DFV, as well as criminal justice services, often do not inquire about sexual violence in cases of women seeking assistance for DFV (RCFV 2016; Tarzia 2021b). Notably, practitioners in both sexual assault specialist services, and DFV-related services consider victim-survivors of IPSV, who have experienced a combined trauma related to these respective services, to be an especially difficult client group to assist (Cox 2015; RCFV 2016; Tarzia 2021b). There is some evidence that practitioners working within either the sexual assault or DFV services do not feel equipped to respond to IPSV and instead consider the issue as being more compatible with each other's service response (Cox 2015). Some service practitioners are concerned about how integrating sexual assault and DFV specific services may impact their respective funding, particularly where they may be misperceived to be duplicating services (Cox 2015; Fotheringham & Tomlinson 2009).

There has been some effort to address this lack of cohesive specialist support in recent years. For example, in Victoria, some Centres Against Sexual Assault (CASAs) sites – which provide free advocacy and counselling for victims of sexual assault – provide integrated DFV and sexual assault services (RCFV 2016). The literature demonstrates that there is a substantial demographic of women that experience the intersection of these two categories of abuse, many of whom subsequently face higher risk of lethality (Zilkens et al. 2017); yet, while some integration is occurring, common models of these services in Australia continue to distinguish between sexual assault services and DFV-related services, leaving IPSV largely invisible within service responses (Tarzia 2021b).

IPSV perpetrators

Like DFV more broadly, IPSV often reflects broader patterns of power and control (Easteal & McOrmond-Plummer 2017). IPSV is shaped by gender inequalities and is linked to misogynistic attitudes and behaviours towards women, adherence to restrictive gender norms (Our Watch 2021), sense of entitlement to sex, compensation for fragile masculinity and lack of respect for women (Tarzia

2021b). The sociocultural sentiment towards IPSV contributes to the lower likelihood that IPSV perpetrators will consider themselves as perpetrators, particularly in cases of having committed rape; they may have a genuine belief of entitlement to sex with partners that they would not presume to have over others, and so do not identify with common notions of 'rapist' (McOrmond-Plummer et al. 2013). These sentiments are largely underpinned by heteronormative and gender-restrictive relationship dynamics that embed traits of coercion and aggression and posit them as socially acceptable expressions of male sexuality (Cox 2015).

IPSV has also been linked to men's sexual jealousy and possessiveness, particularly when enacted during a woman's pregnancy (Kropp 2018). A large age-gap and difference in sexual (in)experience between perpetrators and victim-survivors has also been linked to IPSV (Tarzia 2021b). Tarzia (2021b) found that for over half of the 38 women interviewed, their sexually abusive (ex)partners were considerably older and more experienced in relationships. Nearly half of the participants viewed themselves as inexperienced when they entered the abusive relationships, which impacted their sense of appropriate sexual behaviour in relationships, leaving the abusive partner to set the standard.

Frequent and normalised consumption of pornography by perpetrators, as well as forcing victim-survivors to view pornography, particularly aggressive and degrading content, is also linked to increased IPSV perpetration (Tarzia & Tyler 2020). A study that examined correlations between frequency of pornography use and IPV (including IPSV) across four months, with a sample of 132 different-sex couples, found that higher frequency of pornography consumption among men predicted an increase in IPV perpetration, where women's use of pornography did not predict change in IPV perpetration or victimisation (Jongsma & Timmons 2021). In Tarzia and Tyler's (2020) qualitative study, many women interviewed discussed the role of their abusive (ex)partner's pornography habits in influencing their IPSV perpetration; importantly, pornography was not a topic prompted by the interviewers, yet it consistently came up in interviewee responses. In analysing the relationship between pornography and IPSV, the researchers established three themes of 'pornography as a sex manual', 'all about his pleasure', and 'dehumanising and devaluing' (Tarzia & Tyler 2020, p. 2698). These themes align with the attitudinal risk factors of negative attitudes towards women and sexual entitlement.

Research has found that prior perpetration of IPSV and/or IPV is a risk factor for future and ongoing IPSV (Cox 2015; Spark et al. 2020). Prior perpetration of IPV was identified as one of 53 key risk factors in a meta-analysis of 20 longitudinal studies that examined risk and protective factors for perpetration

of IPV adolescence, along with mental health issues, aggressive thoughts, and the use of aggressive media (Cox 2015). A Canadian study that utilised police reports to compare the risk/need profiles of 36 IPSV and 36 non-sexual IPV perpetrators found that perpetrators of IPSV had more severe risk/need profiles than those who committed non-sexual IPV only (Spark et al. 2020).

Siloed responses: sex offender programs and MBCPs

Responses to sexual violence and DFV are often siloed, with separate intervention pathways for DFV and sexual violence perpetrators (Mackay et al. 2015). A key response used in response to sexual violence, specifically sexual offending are sexual offender programs. These programs are predominantly used in custodial settings and employ a group-based cognitive behavioural therapy approach to intervention (Mackay et al. 2015). As most sexual offender programs operate in correctional settings and reporting and conviction rates for sexual violence (and in particular sexual violence perpetrated by an intimate partner) are low (RCFV 2016), these programs will not reach many sexual violence perpetrators, particularly those who do not come into contact with the criminal justice system. Despite increases in reporting, convictions for sexual offences remain low (Hamilton & Tidmarsh 2022). Further, these programs are often narrowly focused on offending behaviour, with limited attention to sexual violence beyond the convicted offence(s) or within the intimate-partner context. These programs are therefore unlikely to capture the breadth of sexual violence behaviours perpetrated. Additionally, there are a range of reasons why criminal justice pathways may not be utilised or may not be a response that victim-survivors want. For these reasons there is a need for a diversity of responses to sexual violence, including IPSV.

In response to DFV group-based MBCPs are often used. While there is variation in design and approach across programs and some programs include content on sexual respect as a core module, generally there is limited attention to the intersection of DFV and sexual violence (Heenan 2004; Yllö 1999). Existing research highlights several barriers to engaging in discussion of IPSV within MBCPs including limited identification of IPSV within referral processes, including from courts; perpetrators' reluctance to identify and discuss their own IPSV behaviours; and limited training and support available to practitioners, particularly in relation to technology-facilitated IPSV such as image-based abuse (Mortreux et al. 2019; Sundqvist 2012; Fall & Flasch 2019). Consideration of IPSV within both sexual offender treatment programs and MBCPs appears limited. Even where IPSV perpetrators come into either intervention pathway (due to identified DFV or sexual offending behaviours), their use of IPSV may not be identified and/ or there may not be specific attention paid to their use of IPSV alongside

and in conjunction with other DFV or sexual violence behaviours. It is this critical gap in current practice that this study seeks to better understand.

Methodology

This research project sought to better understand current practice and professional views related to how perpetrator intervention programs engage with IPSV across:

- Practitioner training,
- Screening and risk assessment practices used within the perpetrator intervention program context, and
- Perpetrator intervention program practice.

To do so, we developed an online survey that was distributed between March-July 2022 by the Monash Gender and Family Violence Prevention Centre (MGFVPC) and No to Violence (NTV) via social media networks and organisational e-newsletters. The research project received ethics approval from the Monash University Human Research Ethics Committee (project number 32345).

Survey instrument

The survey instrument was developed by the research team and consisted of five modules:

- Practitioner information,
- Views on training experience,
- Views on current screening and risk assessment practices used with perpetrators and victim-survivors,[6]
- Views on working with perpetrators, and
- Designing and developing DFV perpetrator intervention programs.[7]

While the focus of the survey was to understand the experiences and views of practitioners working with DFV perpetrators, we also sought the views of practitioners involved in ancillary work. Within each module separate questions were developed for four practitioner groups:

- Practitioners working directly with DFV perpetrators,
- Practitioners working with victim-survivors (through for example family safety contact work),

[6] In the survey and the subsequent findings presented in this report reference to victim-survivors refers specifically to victim-survivors of DFV whose (ex)partner or other family member is engaged in a DFV perpetrator intervention program. This reflects our research focus on DFV perpetrator intervention programs and victim-survivor supports offered in relation to these interventions through for example family safety contact. The survey did not explicitly examine DFV victim-survivor supports beyond the DFV perpetrator intervention context. We note however that many practitioners surveyed have experience working with victim-survivors within and beyond the DFV perpetrator intervention context and draw on this experience in their work.

[7] For an overview of the five survey modules see Appendix A (p. 79)

- Trainers who provide training and support for practitioners who work with DFV perpetrators, and
- Other professionals involved in the design and development of DFV perpetrator intervention programs.[8]

Response rate

There were 97 valid survey responses after data cleaning.[9] Responses were received from professionals in five Australian state and territory jurisdictions. Table 1 shows response rates for the five relevant state and territory jurisdictions.

Table 1: Response rate by jurisdiction (*n*=97)

	New South Wales	Queensland	Tasmania	Victoria	Western Australia
Response Rate *n* (%)	12 (12.4)	13 (13.4)	1 (1.0)	58 (59.8)	13 (13.4)

As shown in Table 1, most participants were from Victoria (*n*=58, 59.8%), followed by Western Australia (*n*=13, 13.4%), Queensland (*n*=13, 13.4%), New South Wales (*n*=12, 12.4%), and Tasmania (*n*=1, 1.0%). There were no responses received from participants based in from South Australia, Northern Territory, or the Australian Capital Territory. Participants were also asked about their current and previously held roles. Results are shown in Table 2.

[8] These categories are not exclusive, and many practitioners had experience working across these areas.
[9] There were 145 responses recorded in Qualtrics. Excluded responses were either incomplete or were not working specifically in DFV perpetrator intervention programs or similar roles.

Table 2: Practitioners role (*n*=97)		
Role	Current Role *n* (%)	Total[a] *n* (%)
Facilitator[b]	47 (48.5)	67 (69.1)
Family safety contact worker or similar role	9 (9.3)	30 (30.9)
Trainer	3 (3.1)	15 (15.5)
DFV specialist counsellor or social worker	20 (20.6)	35 (36.1)
Counsellor or social worker (other)	11 (11.3)	27 (27.8)
Case manager	18 (18.6)	36 (37.1)
Any other role related to the design, development, and/ or management of MBCPs	12 (12.4)	12 (12.4)
Another role	8 (8.2)	10 (10.3)

[a] Combined current and previous role. [b] Facilitator includes MBCP facilitators, Indigenous healing program facilitators, program readiness/ motivation for behaviour change program facilitators and other similar intervention programs. Note: Participants could select more than one current and previous role and most participants identified working across multiple roles. Totals are therefore greater than the total sample (*n*=97, 100.0%).

Most participants had worked across multiple roles demonstrating a range of experience. Most participants (*n*=67, 69.1%), had experience working as a program facilitator, including almost half of participants who were currently working as program facilitators (*n*=47, 48.5%). While only nine participants (9.3%) were currently working in a family safety contact worker or similar role, 30 participants (30.9%) had experience (current and previous) in this role and 23 participants (31.5%) had experience working as both a facilitator and a family safety contact worker or in a similar role. 15 participants (15.5%) had experience working as a trainer for program facilitators and/ or others working in DFV perpetrator intervention programs, and 12 participants (12.4%) had experience working in other roles related to the design, development, and/ or management of MBCPs. Most participants had experience working with DFV perpetrators (*n*=90, 92.8%), and many of these participants also had experience working with victim-survivors (*n*=61, 67.8%).

Participants were also asked how long they had been working in the DFV perpetrator intervention program space. Results are shown below in Table 3.

Table 3: Years' experience (*n*=96)[a]				
	< 1year	1year < 3years	3years < 5years	5years<
Response Rate *n* (%)	13 (13.5)	32 (33.3)	16 (16.7)	35 (36.5)

[a] One participant responded unsure to this item.

As shown in Table 3, most participants had been working in the DFV perpetrator intervention program space for five years or more (*n*=35, 36.5%), 16 participants (16.7%) between three years and less than five years, 32 participants (33.3%) between one year and less than three years, and 13 participants (13.5%) for less than one year. Participants were also asked about the type of training they had received, with results shown in Table 4.

Table 4: DFV specialist training (*n*=97)						
	Informal training	Internal professional development	Short course	Bachelor's degree	Graduate certificate or diploma	Postgraduate degree
Response Rate *n* (%)	25 (25.8)	16 (16.5)	83 (85.6)	49 (50.5)	43 (44.3)	24 (24.7)

Note: Participants could select multiple categories of training. Totals are therefore greater than the total sample (*n*=97, 100.0%).

The most common form of DFV specialist training was a short course (*n*=83, 85.6%), followed by a bachelor's degree (*n*=49, 50.5%), Graduate certificate or diploma (*n*=43, 44.3%), informal training (*n*=25, 25.8%), postgraduate degree (*n*=24, 24.7%) and internal professional development (*n*=16, 16.5%). Most participants (*n*=58, 59.8%) had received Multi-Agency Risk Assessment and Management Framework (MARAM) training,[10] 51 participants (52.6%) had received Safe & Together training,[11] 21 (21.7%) participants had completed the NTV foundational program,[12] and 47 participants

[10] The MARAM framework was developed and delivered in Victoria as part of the reforms implemented following the RCFV (2016). The MARAM seeks to improve victim-survivor safety through increased collaboration on identification, assessment, and management of DFV.

[11] The Safe & Together model was developed in the United States by David Mandel. The model employs a victim-survivor strength-based approach that centres child-wellbeing and views DFV perpetration as a pattern of violent behaviours and a parenting choice. The model seeks to support practitioners to intervene more effectively in DFV perpetration.

[12] The NTV foundational program is a four-day course that supports professionals to work with men using family violence. For more information see: https://ntv.org.au/training-and-professional-development/

(48.5%) had completed the NTV introduction to working with men training.[13] In terms of level of training, most participants (*n*=81, 83.5%) had received a bachelor's degree or higher.

Participants were also asked about their experiences of DFV perpetrator intervention program delivery. As shown below in Table 5, most participants reported experience delivering programs across regional areas (*n*=56, 58.3%), followed by metropolitan areas (*n*=45, 46.9%), rural areas (*n*=22, 22.9%), and remote areas (*n*=18, 18.8%).

Table 5: Metro, rural, regional, and remote program delivery (*n*=96)[a]

	Metro	Regional	Rural	Remote
Response Rate *n* (%)	45 (46.9)	56 (58.3)	22 (22.9)	18 (18.8)

[a] One participant responded unsure to this item. Note: Participants could select more than one category and most participants had work experience across multiple area types. Totals are therefore greater than the total sample (*n*=96, 100.0%).

Participants were also asked about their experience delivering one-to-one and group interventions, as well as delivering programs online or via telephone and in-person. Results are shown in Table 6.

Table 6: Delivery format (*n*=86)[a]

	Group		One-to-one	
	In-person	Online/ telephone	In-person	Online/ telephone
Response Rate *n* (%)	75 (87.2)	34 (39.5)	41 (47.7)	72 (83.7)

[a] Missing =11. Note: Participants could select more than one category and most participants had work experience across multiple delivery formats. Totals are therefore greater than the total sample (*n*=86, 100.0%).

Most participants had experience delivering group programs in-person (*n*=75, 87.2%), compared to only 34 participants (39.5%) who had experience delivering group programs online. This trend was reversed for one-to-one interventions, with 72 participants (83.7%) reporting experiencing delivering these online or via telephone, and 41 participants (47.7%) delivering one-to-one interventions in-person. Among participants who had delivered group programs (*n*=76), most had delivered programs in-person only (*n*=42, 55.3%), 33 participants (43.4%) had experience delivering group programs both

[13] The NTV introduction to working with men course is also a foundational course that develops practitioner skills to engage men in conversations about their use of violence. For more information see: https://ntv.org.au/training-and-professional-development/

in-person and online, and one participant (1.3%) had experience delivering group programs online only.

Data analysis

Quantitative data was analysed using SPSS Statistics software V.26. As detailed above, several five-point Likert scales were utilised in this survey. These items were used to measure for example, participants reported preparedness, comfort, confidence, and frequency. Participants responded to these items using a scale ranging from 1.00 to 5.00. Where for example, a 1.00=not at all prepared, and 5.00=very prepared. Where items were asked in ascending order (i.e. extremely comfortable (1.00) to extremely uncomfortable (5.00)), they were reverse coded prior to analysis so that a higher score consistently indicates are more positive response (for example, greater preparedness or greater comfort). Descriptive statistics were computed for responses to each of the survey items and are presented throughout, with the number of responses to each question (*n*) provided.

Throughout this report descriptive statistics are presented for the full sample where possible. For clarity and ease of interpretation, descriptive statistics are aggregated into three-point scales within tables and descriptions. The five-point scales have been maintained for analysis. Paired samples t-tests are utilised throughout to explore differences between two conditions on related samples, with means (*M*), standard deviation (*SD*) and mean difference (*MD*) reported throughout. Mann-Whitney U tests are also utilised to compare differences between groups where there is independence of observations, with medians (*Mdn*) reported throughout. Due to the small survey sample, particularly for comparisons between groups, findings should be interpreted with caution. Response numbers for paired samples (*n*) are reported throughout, and for some groups the sample size is very small ($n<15$).

Eighty-five participants also provided responses to open-text questions. Response rates to individual open questions ranged from 3-59 ($M=25.9$, $SD=15.7$). Qualitative survey data was coded manually using thematic analysis.

Limitations

There are several limitations to this study. While this study represents the most comprehensive Australian study on the specific issue of IPSV in perpetrator intervention programs, we recognise that the sample size is relatively small ($n=97$), limiting the generalisability of findings. Survey participants

are predominantly Victorian practitioners (*n*=58, 59.8%), with no participants from several jurisdictions including South Australia, Northern Territory, or the Australian Capital Territory. There is also a very small sample of trainers (*n*=15, 15.5%) and practitioners working in other roles related to the design, development, and/ or management of MBCPs (*n*=12, 12.4%). Data from these participants is provided as it provides further insights into training provided to MBCP practitioners and the design and development of program content related to IPSV. However, no further analysis of this data beyond descriptive statistics is possible due to sample limitations.

Additionally, there are some methodological issues with the way some survey items were constructed which limit the comparisons that can be drawn. These limitations are detailed where appropriate in the presentation of relevant findings. The survey relies on self-report data and is therefore influenced by self-report bias. There will be differences in how practitioners self-assess their own practice. This study focused on IPSV, and while this is by design, DFV intersects with other forms of sexual violence. Further research and consideration of how all forms of sexual violence are responded to within the DFV perpetrator intervention program context is required. Despite these limitations, the study findings offer new insights into the under-studied area of identifying and responding to IPSV within DFV perpetrator intervention programs.

Findings

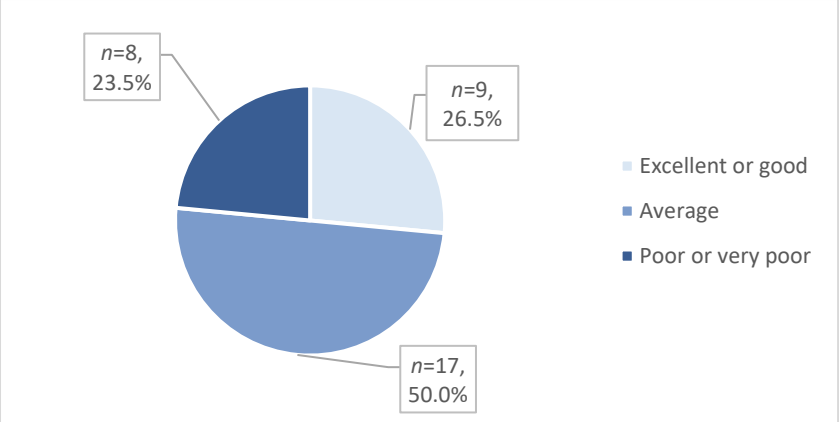
The survey captured both quantitative and qualitative data on engaging with IPSV in the DFV perpetrator intervention program space. The findings are presented here in three parts: training, screening and risk assessment tools and practices, and behaviour change intervention practices.

Training

Quality of training

While most participants (*n*=66, 75.0%) identified that IPSV was covered in their specialist DFV and/ or perpetrator intervention program training, one in four participants (*n*=22, 25.0%) said that IPSV was not covered in any of their training.[14] Of the 66 participants who identified that IPSV was covered in their training, 46 (69.7%) said this was covered in informal or on-the-job training, and 36 (54.6%) said this was covered in formal or institutional training.[15] Participants who said this was covered in their formal/ institutional training (*n*=36) were asked how they would rate the quality of that training. Results are shown below in Figure 1.

Figure 1: Quality of formal training (*n*=36)



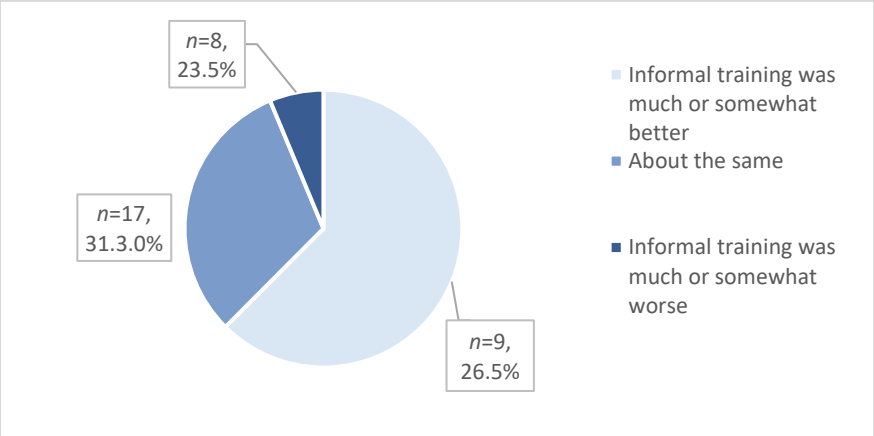
Most participants (*n*=17, 50.0%) reported that their formal training on IPSV was average, with an almost even number reporting their training was good or excellent (*n*=9, 26.5%) and poor or very poor

[14] Only participants who worked with DFV perpetrators or received training related to working with DFV perpetrators (*n*=95) were asked this item. Six participants were unsure if IPSV was covered in their training and one participant did not answer this item.

[15] These categories are not exclusive. Sixteen participants (24.2%) reported that engaging in discussions of IPSV with DFV perpetrators was covered in both informal and formal training they had received.

(*n*=8, 23.5%). Further, participants who identified that engaging in discussions of IPSV with DFV perpetrators was covered in both their formal or institutional training and their informal or on-the-job training (*n*=16, 24.2%) were asked how the formal training compared with informal training. Results are shown below in Figure 2.

Figure 2: Comparison of formal and informal training (*n*=16)



Most participants (*n*=10, 62.6%) reported that their informal training was much or somewhat better than their formal training, five participants (31.3%) reporting that it was about the same and one participant (6.3%) reported that their formal training was better than their informal training. While most participants had completed some form of formal DFV specialist training (see Table 4, p. 17), findings highlight that participants formal training opportunities related to IPSV have been limited, and participants are often reliant on informal or on-the-job training to fill this gap.

This finding was echoed in the open-text responses. Participants (*n*=18) spoke about the importance of learning on-the-job through experiential learning within MBCP groups, informal conversations around practice with colleagues and peer-support, especially related to managing disclosures, regular supervision, and reflective practice:

> We often discuss deeply uncomfortable topics (they can be uncomfortable for the men and practitioners alike) training never really focuses on how the practitioner will respond and what their beliefs are about sexual violence that exploration comes through in supervision not training.

> I was very unprepared to talk about sex with the participants when I first started, […] As time went on, I became more comfortable with talking about sex with the

> participants. Reflective practice, planning and debriefing with collogues [sic] and supervision all helped to develop the skills.

The above survey responses illustrate how experiences of on-the-job learning and particularly supervision was spoken about as positive for enabling discussions of IPSV. However, each of these elements were also discussed by some participants as barriers (for example, where there were limited opportunities for reflective practice or supervision), highlighting the varied nature of these supports.

Participants (*n*=25) reflected that there was often a lack of training (both formal and informal) in relation to IPSV. Where IPSV was explored in training, participants often described this as brief or superficial (*n*=21) or limited to introducing IPSV as a form of violence. Participants (*n*=15) said that IPSV received less attention compared to other aspects of IPV or DFV. In reflecting that their training was descriptive, it was common for participants (*n*=13) to express an interest in more practical training around *how* to discuss IPSV with DFV perpetrators (including how to approach the topic and how to respond):

> I've found that a lot of training tends to be heavily fact or statistics based; being educated around DFV is great, but I feel more training around how to have effective conversations and how to hold perpetrators accountable would be beneficial… I feel I'm lacking in knowledge of how to do this with the best impact/outcomes.

> The training struggled to include any analysis of family violence, sexual assault and consent […] There was no discussion about whether someone can 'freely consent' with the ever present threat of physical and sexual violence (power and control wheel). Also there was little confidence in delivering sexual consent content, particularly applying a gendered lens in practice.

> I don't have this conversation as much as I should, and I don't know how to bring it up with men. I feel like I have adequate understanding of what IPSV is, and that I'm comfortable in calling out sexual violence, but I need to be more aware to actively seek information and engage in these conversations with perpetrators.

Some participants (*n*=11) reflected on their past work experience with victim-survivors as having a positive influence on their comfort and competency identifying, discussing, and addressing IPSV perpetration. As discussed in the methodology (p. 16), most participants (*n*=61, 67.8%) had experience working with both victim-survivors and perpetrators, and it was clear in the open-text responses that

many participants drew on this experience in their work with perpetrators. In the open-text responses, participants spoke about training and work experience through organisations such as CASA (*n*=7) as informing the work they do with DFV perpetrators. The influence of prior sexual assault training on practice is explored later in this report (p. 59). These findings highlight that there are opportunities to enhance both the formal and informal training and supports available to practitioners.

Trainers' views on training

Trainers involved in developing and/or delivering courses to MBCP facilitators and/or others involved in delivering perpetrator intervention programs (*n*=15) were asked about the training they had developed and/or delivered. While this sample is small (*n*=15), this data provides additional insights into the training available to MBCP practitioners. Trainers were asked about the topics covered in the training they delivered with results shown in Table 7.

Table 7: Topics covered in training courses delivered

	Response rate *n* (%)
Facilitating discussions on IPSV with DFV perpetrators	8 (53.3)
Facilitating discussions on sex, intimacy and respectful relationships with DFV perpetrators	7 (46.7)
Identifying and responding to disclosures of IPSV perpetration	2 (13.3)
Identifying and responding to disclosures of experiencing sexual violence (for example child sexual abuse)	3 (20.0)
Other areas related to IPSV	3 (20.0)

Approximately half of trainers reported that the training they delivered covered facilitating discussions on IPSV (*n*=8, 53.3%), and sex, intimacy, and respectful relationships (*n*=7, 46.7%) with DFV perpetrators. Fewer trainers' (*n*=2, 13.3%) reported that identifying and responding to disclosures of IPSV perpetration and disclosures of experiencing sexual violence (*n*=3, 20.0%) were covered. Three participants (20.0%) identified other areas related to IPSV including: risk assessment; DFV perpetrators' normalisation of violence within their relationship(s); how to be curious about sexual violence in the men's group space; and underlying drivers and sexist attitudes.

Trainers were also asked about the quality and depth of training delivered. Results are shown below in Table 8.

Table 8: Rating of quality and depth of training					
	Very or somewhat in-depth *n* (%)	Neutral *n* (%)	Somewhat or very superficial *n* (%)	*M*[a]	*SD*
Facilitating discussions on IPSV with DFV perpetrators (*n*=8)	4 (50.0)	1 (12.5)	3 (37.5)	3.25	1.12
Facilitating discussions on sex, intimacy, and respectful relationships with DFV perpetrators (*n*=7)	5 (71.4)	2 (28.6)	-	4.29	0.95
Identifying and responding to disclosures of IPSV perpetration (*n*=2)	-	1 (50.0)	1 (50.0)	2.50	0.71
Identifying and responding to disclosures of experiencing sexual violence (for example child sexual abuse (*n*=3)	2 (66.7)	-	1 (33.3)	3.33	1.16

[a] A higher mean indicates greater quality and depth of training, where 5.00 indicates very in-depth, 3.00 indicates neutral, and 1.00 indicates very superficial.

Most participants reflected that the training they delivered was very or somewhat in-depth across each item, except identifying and responding to disclosures of IPSV perpetration. This aligns with the open-text responses from practitioners' who reported a desire for more training related to IPSV broadly, but also raised a desire for more training specifically in how to respond to disclosures of IPSV perpetration. In the open-text responses, some trainers (*n*=3) reflected that the training was limited, particularly lacking content on sexual coercion or focused only on impact of sexual violence. However, in line with the quantitative findings, most participants reflected that this training was very in-depth. Trainers (*n*=3) also spoke about the role of practitioners' own values and beliefs, as well as history of sexual violence in their own life, which may present as barriers for some facilitators. One trainer also reflected that it can be challenging in the group training environment to explore how individual facilitators feel about exploring sexual violence in their own work. This finding reiterates the importance of individual supports such as supervision operating in tandem with institutionalised training opportunities.

Preparedness to discuss sex and intimacy and IPSV with DFV perpetrators

Participants who identified that IPSV was covered (*n*=66, 75.0%) were asked in relation to the training they had received, how prepared they felt to facilitate discussions related to sex, intimacy and respectful relationships and IPSV with DFV perpetrators. Results are shown below in Table 9.

Table 9: Preparedness to facilitate discussions related to sex, intimacy, and respectful relationships and IPSV with DFV perpetrators (*n*=66)					
	Very or somewhat prepared *n* (%)	Neither *n* (%)	Somewhat or very unprepared *n* (%)	*M*[a]	*SD*
Sex, intimacy, and respectful relationships	51 (77.3)	7 (10.6)	8 (12.1)	4.03	1.04
IPSV	49 (74.2)	6 (9.1)	11 (16.7)	3.89	1.08

[a] A higher mean indicates greater preparedness, where 5.00 indicates very prepared, 3.00 indicates neither, and 1.00 indicates very unprepared.

Reported preparedness is similar across both items, with 51 participants (77.3%) reporting they felt very or somewhat prepared to discuss sex, intimacy, and respectful relationships with DFV perpetrators, and 49 participants (74.2%) reporting they felt very or somewhat prepared to discuss IPSV with DFV perpetrators. A non-parametric t-test was conducted to explore differences between reported preparedness to discuss sex, intimacy, and respectful relationships and IPSV.[16] Within the paired sample (*n*=66), the mean was higher for preparedness to facilitate discussions of sex, intimacy, and respectful relationships (*M*=4.03, *SD*=1.04), compared to IPSV (*M*=3.89, *SD*=1.08, *MD*=0.14). The result is not statistically significant (*z*=1.576, *p*=.115).[17]

Preparedness to identify and respond to IPSV

Participants (*n*=66, 75.0%) were also asked in relation to the training they had received, how prepared they felt to identify and respond to disclosures of IPSV perpetration. In addition, participants who worked with and/ or had received training related to working with victim-survivors (*n*=91, 93.8%) were asked how prepared they felt to respond to disclosures of sexual violence victimisation. Results are shown below in Table 10.

[16] Wilcoxon Sign tests are used throughout this report where the difference of the paired sample was not normally distributed.

[17] Most participants (*n*=48, 72.7%) reported the same level of preparedness across both items, 12 participants (18.2%) reported greater preparedness to facilitate discussions of sex, intimacy, and respectful relationships, and six participants (9.1%) reported greater preparedness to facilitate discussions of IPSV.

Table 10: Preparedness to identify and respond to sexual violence

	Very or somewhat prepared *n* (%)	Neither *n* (%)	Somewhat or very unprepared *n* (%)	*M*[a]	*SD*
Preparedness to identify IPSV perpetration (*n*=66)	56 (84.9)	6 (9.1)	4 (6.0)	4.12	0.92
Preparedness to respond to disclosures of IPSV perpetration in one-to-one setting (*n*=52)[b]	44 (84.6)	5 (9.6)	3 (5.8)	4.31	0.94
Preparedness to respond to disclosures of IPSV perpetration in group setting (*n*=57)[c]	37 (64.9)	8 (14.0)	12 (21.1)	3.63	1.17
Preparedness to respond to disclosures of experiencing sexual violence (for example child sexual abuse) (*n*=65)[d]	54 (83.1)	7 (10.8)	4 (6.1)	4.12	0.94
Preparedness to respond to victim-survivors' disclosures of experiencing sexual violence (including but not limited to IPSV) (*n*=80)[e]	44 (55.1)	21 (26.3)	15 (18.8)	3.54	1.03

[a] A higher mean indicates greater preparedness, where 5.00 indicates very prepared, 3.00 indicates neither, and 1.00 indicates very unprepared. [b] Only participants who had worked in one-to-one interventions were asked this item. [c] Only participants who had worked in group interventions were asked this item. [d] missing=1. [e] missing=11.

Despite the reported limits of training on IPSV perpetration, most participants (*n*=56, 84.9%) reported that they felt very or somewhat prepared to identify IPSV perpetration. Most participants were also prepared to respond to disclosures of IPSV perpetration in both one-to-one (*n*=44, 84.6%) and group (*n*=37, 64.9%) settings, and to respond to disclosures of experiencing sexual violence (*n*=54, 83.1%). Most participants (*n*=44, 55.1%) also reported that they were very or somewhat prepared to respond to victim-survivors' disclosures of experiencing sexual violence, although this was lower than the proportion of participants (*n*=54, 83.1%) who reported they were prepared to respond to disclosures of experiencing sexual violence more broadly.[18] A non-parametric t-test was conducted to compare participants' reported preparedness to respond to disclosures of IPSV perpetration in one-to-one and group settings. Within the paired sample (*n*=47), participants reported greater preparedness to respond to disclosures of IPSV perpetration in one-to-one settings (*M*=4.30, *SD*=0.95) compared to group settings (*M*=3.66, *SD*=1.18, *MD*=0.64). This is a statistically significant difference (*z*=3.580, *p*<.001).[19] This finding highlights the importance of creating opportunities for one-to-one work

[18] The question on preparedness to respond to disclosures of experiencing sexual violence did not explicitly ask about disclosures from DFV perpetrators (all other items specified DFV perpetrators or victim-survivors). It is therefore possible that some participants answered this question thinking about disclosures more broadly.

[19] Of the 47 participants in the paired sample, 26 participants (55.3%) reported the same level of preparedness across both one-to-one and group settings, 20 participants (42.6%) reported greater preparedness in the one-to-one setting, and one participant (2.1%) reported greater preparedness in the group setting.

alongside group work, as this is the environment in which practitioners feel more prepared to respond to disclosures.

Screening and risk assessment

Assessment tools

Most participants who worked with DFV perpetrators (*n*=69, 76.7%) were involved in screening and risk assessment of DFV perpetrators who are either participating in and/or being screened for eligibility into a perpetrator intervention program. Of these participants, 59 (85.5%) said they use a specific tool(s) for risk assessment, primarily the MARAM (*n*=38, 64.4%) and/ or the Common Risk Assessment Framework (CRAF, *n*=17, 28.8%).[20] Many participants (*n*=25, 42.5%) identified other instruments including (but not limited to) internally developed organisational tools (*n*=10, 16.9%), the Risk, Safety and Support Framework (RSSF, *n*=4, 6.87%), the Safe & Together perpetrator mapping tool (*n*=2, 3.4%), the Domestic Violence Safety Assessment Tool (DVSAT) (*n*=2, 3.4%), the Abusive Behaviour Inventory (ABI *n*=2, 3.4%), and the Spousal Assault Risk Assessment Tool (SARA, *n*=2, 3.4%). Many participants (*n*=27, 45.8%) reported using a combination of more than one tool.

Similarly, most participants working with victim-survivors (*n*=42, 62.7%) were involved in screening and risk assessments of DFV victim-survivors, and 37 of these participants (88.1%) reported using a specific assessment tool(s).[21] Tools included (but are not limited to) the MARAM (*n*=19, 51.4%), DVSAT (*n*=6, 16.2), CRAF (*n*=5, 13.5%), Safe & Together (*n*=2, 5.4%), and internally developed organisational tools (*n*=2, 5.4%). There are evidently a range of assessment tools utilised by our survey participants and this reflects the breadth of tools in operation more broadly as well as the differences in current practices within and across jurisdictions in Australia.

Of those practitioners who reported using a specific assessment tool(s), 31 participants (83.8%) working with DFV victim-survivors reported that the assessment tool(s) they utilise explicitly capture IPSV victimisation. Comparatively, 34 participants (57.6%) working with DFV perpetrators reported that the tool(s) they utilise explicitly capture IPSV perpetration.

Participants were also asked how useful they found the assessment tool(s) they utilised for identifying and assessing risk of IPSV perpetration and victimisation. As shown below in Table 11, most

[20] The CRAF was a key component of the integrated family violence system in Victoria developed in 2007. The CRAF supports a shared understanding of risk of DFV and a standardised approach to assessing, managing and responding to risk of DFV (McCulloch et al. 2016).

[21] Screening and risk assessment of DFV perpetrators and victim-survivors are not mutually exclusive categories; 33 practitioners identified conducting risk assessments with both DFV perpetrators and victim-survivors.

participants found assessment tool(s) very or somewhat useful for identifying IPSV perpetration (*n*=36, 61.1%) and IPSV victimisation (*n*=28, 75.7%).

Table 11: Usefulness of assessment tool(s) for identifying and/ or assessing risk of IPSV perpetration and victimisation

	Very or somewhat useful *n* (%)	Neutral *n* (%)	Very or somewhat useless *n* (%)	*M*[a]	*SD*
Usefulness of assessment tool(s) for identifying and/ or assessing risk of IPSV perpetration (*n*=59)	36 (61.1)	18 (30.5)	5 (8.5)	3.68	0.84
Usefulness of assessment tool(s) for identifying and/ or assessing risk of IPSV victimisation (*n*=37)	28 (75.7)	1 (2.7)	8 (21.6)	3.76	1.04

[a] A higher mean indicates greater perceived usefulness of assessment tool(s), where 5.00 indicates very useful, 3.00 indicates neutral, and 1.00 indicates very useless.

While most participants found assessment tool(s) useful, approximately one in three participants (*n*=23, 39.0%) reported assessment tool(s) were either neutral, very, or somewhat useless for identifying and/ or assessing risk of IPSV perpetration. Further, while a greater proportion of participants working with victim-survivors found assessment tool(s) useful, almost one in four participants (*n*=9, 24.3%) reported that they found the tool(s) either neutral, very, or somewhat useless.

A small number of participants reported that the tool(s) utilised are useful for identifying IPSV victimisation (*n*=3, 8.1%) and perpetration (*n*=10, 17.0%) even where the tool utilised did not (or they were unsure if it did) explicitly capture IPSV victimisation or perpetration respectively. Assessment tool(s) are one component of processes to identify and assess risk of violent behaviours including but not limited to IPSV, while we are unable to ascertain the reasons why these participants find the assessment tool(s) useful, it may be that these participants find the tool(s) useful when used in tandem with other approaches. Indeed, in the qualitative data participants also reflected that the usefulness of assessment tools was dependent upon how practitioners use the tools in practice.

Participants spoke about the limitations of existing assessment tools and the importance of practitioner skill, comfort, and experience in shaping how assessment tools are utilised. Participants described the question prompts within assessment tools as 'blunt' and often focused specifically on sexual assault and/ or a language of 'force' (see also, Strauchler et al. 2004). Some participants described the tick-box approach of assessment tools did not support or enable a meaningful conversation and assessment of sexual violence:

> The Assessment Forms are one thing - in that there may be a question to ask and/or a box to complete - but unpacking the topic of sexual violence in a way that makes sense both to us as interviewers and to the client as a perpetrator is yet to be discovered.
>
> [IPSV is] often not discussed and there has not been an appropriate risk assessment tool to elicit these discussions.
>
> There is lack of clarity in our risk assessment tool […] There is consistent variation in what is considered sexual assault for the purposes of risk assessment.

Other participants reflected on the importance of not using the prompts verbatim but drawing on practitioner skill, experience, and confidence to identify IPSV:

> It depends on how it is used. Most people implementing do not apply it in a[n] exploratory discussion process, to open the discussion about the topic.
>
> Depending on the level of confidence from the assessor do they go into the sexual violence as in explicit acts or do they just mark the assessment with sexual violence?
>
> My experience was one question on the tool, there was often not an educational component to what it actually is, so this meant that reporting was I'm sure significantly underrepresented.

These findings highlight opportunities to improve the assessment tools currently in use; both to ensure availability of suitable tools and to provide more comprehensive definitions and language around sexual violence, and to provide greater guidance and training to enable practitioners to build confidence to apply tools in an exploratory and conversational way. This finding aligns with research on screening and risk assessment of DFV perpetration in Queensland which similarly found that while some practitioners felt assessment tools were limited, others found that they worked well when supplemented with information sharing systems and professional judgement informed by DFV-specific training and skills (Meyer et al. 2023).

Frequency of assessing risk of IPSV perpetration and victimisation

Participants were asked how often they risk assessed for IPSV perpetration and IPSV victimisation. As shown in Table 12, most participants said they assess risk of IPSV perpetration (*n*=43, 66.1%) and IPSV victimisation (*n*=32, 78.0%) always or most of the time.

Table 12: Frequency of assessing risk of IPSV perpetration and victimisation					
	Always or most of the time *n* (%)	About half the time *n* (%)	Rarely or never *n* (%)	*M*[a]	*SD*
Frequency of assessing risk of IPSV perpetration (*n*=65)	43 (66.1)	9 (13.8)	13 (20.0)	3.80	1.20
Frequency of assessing risk of IPSV victimisation (*n*=41)	32 (78.0)	4 (9.8)	5 (12.2)	4.00	1.12

[a] A higher mean indicates greater frequency of assessing risk of IPSV, where 5.00 indicates always, 3.00 indicates about half the time, and 1.00 indicates never.

Approximately one in five participants working with DFV perpetrators (*n*=13, 20.0%) and almost one in ten participants working with DFV victim-survivors (*n*=5, 12.2%) said they rarely or never assess risk of IPSV perpetration and victimisation respectively. A non-parametric t-test was conducted to determine if there were significant differences in frequency of assessing risk of IPSV perpetration and victimisation. Within the paired sample (*n*=32), the mean was higher for frequency of assessing risk of IPSV perpetration (*M*=4.03, *SD*=1.15) compared to victimisation (*M*=4.00, *SD*=1.08, *MD*=.03), although the result was not statistically significant (*z*=0.38, *p*=.707).[22]

In addition to asking participants about their frequency of assessing risk of IPSV perpetration and victimisation, we asked participants how frequently they assess risk of IPSV perpetration and victimisation *compared to other forms of DFV*. The results are shown below in Table 13.

Table 13: Frequency of assessing risk of IPSV perpetration and victimisation *compared to other forms of DFV*					
	Much or somewhat more often *n* (%)	About the same *n* (%)	Much or somewhat less often *n* (%)	*M*[a]	*SD*
Frequency of assessing risk of IPSV perpetration *compared to other forms of DFV* (n=65)	3 (4.6)	34 (52.3)	28 (43.1)	2.52	0.85
Frequency of assessing risk of IPSV victimisation *compared to other forms of DFV* (n=40)[b]	5 (12.5)	26 (65.0)	9 (22.5)	2.80	0.88

[a] A higher mean indicates greater frequency of assessing risk of IPSV compared to other forms of DFV, where 5.00 indicates much more often, 3.00 indicates about the same, and 1.00 indicates much less often. [b] missing =1.

[22] There were 16 ties (50.0%), with six participants (18.8%) reporting greater frequency of assessing risk of IPSV victimisation, and ten participants (31.3%) reporting greater frequency of assessing risk of IPSV perpetration.

Most participants reported assessing risk of IPSV perpetration (*n*=34, 52.3%) and IPSV victimisation (*n*=26, 65.0%) about the same amount as other forms of DFV. However, almost half (*n*=28, 43.1%) reported that they assess for IPSV perpetration much or somewhat less often than other forms of DFV, and approximately one in five (*n*=9, 22.5%) reported that they assess for IPSV victimisation much or somewhat less often than other forms of DFV. A non-parametric t-test was conducted to determine if there were significant differences between frequency of assessing risk of IPSV perpetration and victimisation compared to other forms of DFV. Within the paired sample (*n*=31), the mean was higher for frequency of assessing risk of victimisation (*M*=2.74, *SD*=0.86) than perpetration (*M*=2.58, *SD*=0.72, *MD*= 0.16), although the result was not statistically significant (*z*=-1.39, *p*=.166).[23] This finding aligns with existing literature which highlights that IPSV often receives less attention than other aspects of IPV or DFV (Cox 2015).

We also explored whether frequency of assessing risk of IPSV perpetration was influenced by whether assessment tools utilised captured IPSV perpetration, results are shown below in Table 14.[24]

Table 14: Assessment tool and frequency of assessing risk of IPSV perpetration (*n*=46)[a]

	IPSV captured in assessment tool(s)		Total	Mann-Whitney U Test		
	Yes	No	*Mdn*[b]	*U*	*z*	*p*
	Mdn (n)	*Mdn (n)*				
Frequency of assessing risk of IPSV perpetration	4.00 (32)	3.00 (14)	4.00	346.0	3.055	.002*
Frequency of assessing risk of IPSV perpetration *compared to other forms of DFV*	3.00 (32)	2.00 (14)	3.00	333.0	2.979	.003*

[a] missing=13. Nine participants were unsure if IPSV was captured in assessment tools and four participants did not answer this item. [b] A higher median indicates greater frequency of assessing risk of IPSV perpetration. * Statistically significant at p<.005.

A Mann-Whitney U test was run to determine if there were differences in frequency of assessing risk of IPSV perpetration between participants who utilised assessment tools that explicitly captured IPSV perpetration and those who utilised tools that did not explicitly capture IPSV perpetration. Frequency of assessment scores were higher where tools captured IPSV (*Mdn*=4.00), compared to where tools did not capture IPSV (*Mdn*=3.00). The result was statistically significant (*p*=.002). As shown in Table 4, frequency of reported assessment *compared to other forms of DFV* scores were also higher where tools captured IPSV (*Mdn*=3.00), compared to where tools did not capture IPSV (*Mdn*=2.00). The result

[23] There were 21 ties (67.7%), with eight participants (25.8%) reporting greater frequency of assessing risk of IPSV victimisation, and one participant (3.2%) reporting greater frequency of assessing risk of IPSV perpetration.
[24] These tests were not run on victimisation items as the sample size within the sample who said IPSV was not captured in assessment tool(s) was too small (*n*=4).

was statistically significant (p=.003). While practitioners draw on experience, confidence, and skill, beyond assessment tool(s) to create a dialogue and facilitate disclosures (discussed above, p. 30-31), this finding reiterates the importance of assessment tool(s) in the screening and risk assessment of IPSV. Further, 25 participants (42.4%) reported that the tool(s) they use *do not* capture IPSV perpetration highlighting the critical need to further develop assessment tool(s) to ensure IPSV is explicitly captured.

Identification of IPSV

Participants working with perpetrators (n=63) estimated on average that IPSV perpetration was present and identified in 39.92% (*M, SD*=31.02) of cases. Participants working with victim-survivors (n=39) comparatively estimated on average that IPSV victimisation was present and identified in 52.00% (*M, SD*=26.15) of cases.[25] A paired t-tests was conducted to compare participants' perceptions of the proportion of cases where IPSV perpetration was present and identified compared to the proportion of cases where IPSV victimisation was present and identified. Within the paired sample (n=29), participants reported that IPSV victimisation was present and identified in a greater proportion of cases (M=54.66, SD=26.32, t(28)=2.226, p=.034) compared to IPSV perpetration (M=42.59, SD=31.19). This is a statistically significant difference of 12.07 (95% CI [0.96, 23.17]), although the effect size is small (d=0.41).

Further, participants (n=69) were asked how confident they are they are that a history of perpetrating IPSV is identified where the behaviour is present. Almost half of participants (n=31, 48.4%) were somewhat unconfident or not at all confident that IPSV perpetration was identified where the behaviour was present, ten participants (15.6%) felt neutral, and 23 participants (36.0%) were very or somewhat confident. The low proportion of cases where participants feel IPSV perpetration is present and identified (M=39.92%, SD=31.02) coupled with the low confidence that IPSV perpetration is identified where present (48.4% somewhat unconfident or not at all confident) suggests that IPSV perpetration is being missed in current risk assessment practices.

Participants (n=40) also reported low confidence that IPSV victimisation is always identified where the behaviour is present, with 22 participants (55.0%) reported they were somewhat unconfident or not

[25] In these items we specifically asked participants about cases where IPSV was present and identified. The remaining cases could include both cases where IPSV is not present or identified, and cases where IPSV is present but not identified.

at all confident that IPSV victimisation was identified where the behaviour was present, seven participants (17.5%) felt neutral, and 11 participants (27.5%) were very or somewhat confident.[26]

Barriers and enablers to screening and assessing risk of IPSV

Participants were also asked open-ended questions about the barriers and enablers to screening and risk assessment. Barriers identified by participants include a lack of service coordination and limitations related to referral information, non-disclosures from both perpetrators and victim-survivors and concerns of escalating abuse. Participants also identified enablers including effective service coordination, centring victim-survivors' point of view, building rapport and one-to-one sessions, through for example case management and individual counselling.

Service coordination and referral information

Numerous participants (*n*=13) spoke about a lack of service coordination and limitations related to details contained within referral information (as well as other sources) as barriers to identifying IPSV perpetration:

> Unless specifically identified from available information e.g. AFM [affected family member] disclosure, Police referral/identification, assessing intimate partner sexual violence in an initial risk assessment can be difficult.

> As I think about it, no referral agency we deal with (The Orange Door, Corrections, Child Protection, The Magistrates Court) ever identifies sexual violence in IPDFV [Intimate Partner Domestic and Family Violence] unless there is a specific charge for a sexual-crime (and if there is, it isn't a charge connected with the IPDFV). Perhaps this is a barrier in our MBCP Assessments, in that, because this form of violence is unaddressed, we don't raise it either. We work (perhaps unconsciously)

[26] There is a difference in the way the two confidence items (confidence that IPSV perpetration and victimisation are identified) were asked, where the perpetration question is framed in relation to past behaviour (*a history of perpetrating IPSV*) not current or ongoing behaviour, and the victimisation question is framed in relation to behaviour that is *always identified*. Unfortunately, this error means we can't compare these items. It is possible that the higher proportion of participants working with victim-survivors reported low levels of confidence because of the higher benchmark set in the framing of the question (*always identified*). This limitation notwithstanding, there is a lack of confidence among survey participants that IPSV victimisation and perpetration are being identified.

> with the notion that if the above agencies have done their screening and referrals and sexual violence isn't mention[ed] then it must not have happened.

As the above quotes demonstrate, participants described a reliance on other agencies involved in screening and referral to be identifying IPSV and an assumption that this screening has taken place prior to service contact with the MBCP. While this is not to suggest that this is always the case, where this does occur there is an increased likelihood that experiences of IPSV perpetration are being missed. In addition to assumptions around prior screening, there are limitations to assessments associated with service roles. This is linked to funding, as one participant, a counsellor, noted they are 'funded for treatment not assessment and need to justify how time in sessions is spent.'

Participants reflections on assessment and referral information raise important questions about whose responsibility it is to screen for IPSV (and this extends to other behaviours as well). Some participants observed that practitioners may not feel this is their responsibility:

> Not all clinicians/practitioners screen for it and this can cause a division between services as not everyone may be on the same page.

> Clinicians in my team are mostly women and generally they are hesitant to talk about sexual violence. They feel this is better left to other specialists, particularly those in the sexual assault services.

This aligns with existing literature that highlights that some DFV practitioners feel that sexual violence is more appropriately responded to by specialist sexual assault services (Cox 2015). Perceptions of responsibility, as well as funding decisions that shape responsibility to screen and assess risk of IPSV are barriers for some practitioners working with DFV perpetrators. This reflects broader issues around service co-ordination and questions of whose responsibility it is to assess for IPSV perpetration. Importantly, as discussed below (p. 42) disclosures of both IPSV perpetration and victimisation take time and depend upon rapport being built with clients. Consequently, disclosures are unlikely to come from a single interaction and therefore there is a need to conceptualise screening and risk assessment of IPSV (as well as other behaviours) as an ongoing process not a process restricted to intake assessments or something that will have occurred in assessment prior to referral and contact with subsequent services.

In contrast participants who spoke about service coordination as an enabler to identifying and assessing risk of IPSV (*n*=18), reflected on the regularity of discussions between facilitators and family safety contact workers, and the process of collaboration to collectively determine how to best

approach the issue. While some practitioners did reflect on inter-agency coordination, this was predominantly discussed in relation to internal collaboration between facilitators and family safety contact workers.

Non-disclosure

Participants spoke about non-disclosures from both perpetrators and victim-survivors as a barrier to identifying IPSV. Participants associated these non-disclosures with feelings of shame (*n*=21), understandings of consent (*n*=5) and perpetrators' fear of legal consequences (*n*=6). Concerns of shame and judgement were frequently raised within the open-text responses, for example:

> Men will often disclose the 'less severe' side of FV and IVP [sic], such as yelling or hitting walls. Men are less likely to disclose behaviours that they feel shame around or that they think they will be judged for disclosing. Similarly, the AFM may feel shame around admitting sexual violence.

> Shame is a huge barrier to self-disclosure regarding perpetrators. Often, I find this is information that they are unwilling or unable to disclose early in the intervention however over time with work pertaining to shame and creating a non-judgemental space allows participants to be more open.

While shame was predominantly spoken about in relation to perpetrators' and victim-survivors' feelings, participants also highlighted the issue of shame and judgement in the reactions of some facilitators:

> A lot of MBC[P] practitioners are too reactive and too focused on shaming and using socio-political understanding of the drivers of violence, instead of understanding the underlying causes and inner world and motivators of DFV and Sexual Violence. The current training is limiting, tends to perpetrate the parallel abuse of students as that of the perpetrators they intend to work with.

These findings are consistent with previous research, which highlights that IPSV is a high shame topic for both perpetrators and victim-survivors (Wright 2022; Cox 2015), and this was the predominant barrier to disclosure raised by participants in the open-text responses. Understandings of consent (*n*=14) was also presented as a barrier to IPSV disclosures from both perpetrators and victim-survivors:

> Boundaries of consent are often unclear, and sexual violence may not be identified by the people perpetrating and experiencing it. In my experience, both parties often minimise sexual violence to a further extent than other forms of violence.

> People say they consent to sex whenever their partner wants it, so they don't fight or get angry not understanding this consent is coerced and therefore not consent.

Participants (*n*=11) also highlighted the difficulty of delineating consensual sex from IPSV, given the abusive relationship context. Participants acknowledged the effects of both IPSV and non-sexual IPV in eroding victim-survivors' sense of safety in the relationship:

> I think there are challenges in delineating what intimate partner sexual violence is - especially when sex is happening in the context of DFV, and coercion is omnipresent in that.

Non-disclosures associated with understandings of consent and IPSV were often also connected to normalisation of IPSV (*n*=6):

> The victim-survivors acceptance of what is 'normal' and therefore non-disclosure from her. We are working within the gendered societal parameters of what is acceptable and 'normal' and 'ok' and having to break through this in order to work with her as well.

> There is a barrier where there is a[n] intimate relationship as it's harder for the AFM to identify sexual violence as they are often coerced or told it falls under "being in the relationship." …Often it's up to the practitioner to ask the right questions and then provide psychoeducation on sexual violence so the AFM can identify and name it.

Understandings of consent and IPSV reflect gender inequalities, attitudes, and cultural norms, for example the belief of entitlement to sex, that this is just part of 'being in the relationship' (Our Watch 2021). Additionally, the need to 'ask the right questions' described by one practitioner above reiterates that the identification of IPSV relies on broader discussion beyond the tick-box use of items within assessment tools. These insights further evidence why having the time and space to engage in dialogue about IPSV is critical.

While issues of consent were often spoken about in terms of a 'lack of understanding' there was also some resistance among practitioners to such representations. Some participants framed issues

around consent and sexual violence not as a lack of understanding, but in terms of the language. For example, in reflecting upon the limitations of existing screening and risk assessment tools and their discomfort in asking victim-survivors about 'forced' sex one participant explained 'women may not recognise their experience in this language.' Any misalignment between the language used by practitioners and victim-survivors' own understandings of their experience will impact disclosures:

> In the context of partner contact often the women are still in relationship so how they're making sense of something and how they communicate that with us is informed by that context.

> Sex can be a time when an AFM felt more loved, accepted and/or valued so they may have chosen to participate in sexual activities they were uncomfortable with not only to avoid physical violence but in the cycle of violence wanting to seek positive experiences with the AFM and feeling responsible.

Relatedly, participants spoke about the erasure of women's voice[s], autonomy and agency not only through their experiences DFV, but through the responses to that violence. The need to navigate victim-survivors autonomy and agency to define and make sense of their own experiences, while also recognising the ways in which the abusive relationships context can undermine capacity to freely consent was something many practitioners grappled with:

> What are the ethics of me saying she can't freely and actively consent when he hospitalised her last week. I want to uphold not subordinate her voice, choice, agency to define her own reality. At the same time - I may want him to think about that context of coercion.

> It is always helpful to explore power and control and how the perpetrator may have created an environment where a woman feels unable to be able to say no or have no control over any aspect of her life.

Participants identified the importance of prioritising victim-survivors' perspectives and the broader context of power and control within the relationship. These findings highlight the importance of shared language of consent and sexual violence to facilitate communication around behaviours of concern, including but not limited to IPSV, whilst also prioritising victim-survivors own framing(s) of their experiences. This aligns with Bagwell-Gray et al.'s (2015) work on conceptualising IPSV in which they emphasise the importance of using – at the very least initially – the language of victim-survivors. Differences in language used by practitioners, clients (both victim-survivors and perpetrators) and researchers will only limit the identification of IPSV. Consistency of both language and meaning is

therefore critical (Bagwell-Gray et al. 2015). Hegarty et al. (2022) similarly found that trouble understanding terms used by practitioners was a barrier to help-seeking for 71.9% of victim-survivors of IPV and sexual violence surveyed. Language should offer victim-survivors a way to make sense of their experiences, to validate the harms experienced and aid healing, but it should not operate to dictate or impose particular understandings of experience(s). The process of working towards a shared language therefore needs to be collaborative (Bagwell-Gray et al. 2015). The importance of shared language was predominantly raised in the context of victim-survivors, however there are also important implications for engaging with perpetrators, as perpetrators own understandings of family violence, including sexual violence, and the language used to discuss these forms of violence may similarly impact disclosures.

Another barrier to DFV perpetrators disclosures of IPSV raised by participants was fear of legal consequences (*n*=6). This was particularly discussed in relation to sexual offending behaviour and court-mandated participants, for example:

> Programs for mandated DV perpetrators tend to concentrate on a conviction, not a pattern of offending. Clients tend to concentrate on their specific DV offences, and shy away from sexual violence for fear of being charged for other offending which carries severe penalties.

Where program participants only focus on identified behaviours – whether related to criminal charges or initial behaviours identified at referral or intake – the broader pattern of offending behaviours, which may or may not include IPSV may be missed.

Concerns of abuse escalation

Several participants (*n*=10) also raised concerns of escalating risk for victim-survivors as a barrier to both assessing perpetrator risk of IPSV and responding where this behaviour is identified:

> As a DFV Specialist, I need to remain aware of the issue being raised by a client/PUV [person using violence] themselves, I can support them but challenging their behavior if they are not acknowledging their use of violence can be a risk to the victim.

> [A barrier is] Working with a perpetrator and ensuring management rather than escalation of risk.

> Risks to a client if the PUV is 'challenged' and not identifying the DFV concerns. Clients fears of retribution if I spoke to the PUV. (Risk of further DFV escalating due to outside people being aware of this issue).

As these quotes demonstrate, some practitioners are hesitant to raise IPSV because of a concern for victim-survivor safety; specifically, practitioners are concerned that asking about use of IPSV may result in more serious violence by the perpetrator, creating an immediate risk for the victim-survivor(s). While victim-survivor safety should be of paramount concern, this caution and concern for victim-survivor safety also presents as a barrier to exploring and addressing perpetrators' use of IPSV, resulting in IPSV behaviours not being identified and explored in some cases. There are implications of this for behaviours that are in turn engaged with in the context of the perpetrator interventions and for meaningful behaviour change related to IPSV behaviours.

Centring victim-survivors' point of view in perpetrators accounts

While participants raised several concerns around identifying and assessing risk of IPSV perpetration, importantly they, also identified enablers to this work. As discussed earlier in this report some participants found assessment tools useful for supporting IPSV screening and risk assessment (see Table 11, p. 30), particularly when combined with practitioner confidence, skill, and experience in exploratory discussions around IPSV. Some participants also reflected on the usefulness of coordination and collaboration between family safety contact workers and program facilitators (p. 36-37). Additionally, participants (*n*=7) spoke about the importance of centring victim-survivors' point of view in perpetrators accounts as an enabler to identifying IPSV:

> When asked to frame sexual abuse from the victim/survivors' perspective men are more likely to disclose - for example - she tells me I'm pushy is more likely than the man directly admitting to being pushy, because he can externalise the problem to her.

> It is always helpful to explore power and control and how the perpetrator may have created an environment where a woman feels unable to be able to say no or have no control over any aspect of her life.

Bringing in the victim-survivors' point of view has parallels with the earlier discussion of using a shared language around consent and IPSV (p. 39-40), while DFV perpetrators may not recognise their behaviours as IPSV, they may recognise external elements. For example, perpetrators may be able to explore their current or former intimate partner's experiences if asked to reflect on the relationship

as a whole or the environment in which known forms of abuse occurred. Existing research supports the influence of 'labelling' on disclosures, for example, that men may admit to rape when it is not called rape, and that perpetrators are more likely to admit to sexual violence when behavioural descriptions of sexual coercion, such as 'being pushy' (in the above survey participant example) are used (Edwards et al. 2014).

Building rapport to support client disclosure and discussion

Numerous participants (*n*=14) spoke about the need to establish rapport, trust, and safety with clients. This was seen as pivotal to reducing resistance and encouraging disclosures from perpetrators:

> Sexual violence may not come up in initial screening as […] Sexual violence is something I have noticed is more likely to come up once a relationship has been established with the client.

> Time spent developing therapeutic relationship/rapport with man (where possible) would reduce resistance and encourage accountability/disclosure.

While participants spoke predominantly about the need to build rapport between facilitators and perpetrators, participants also discussed the importance of building rapport between participants within the MBCP group. Participants recognised that this work takes time, and many spoke about the limited time available to work with both perpetrators and victim-survivors (*n*=8) as a barrier to both disclosures and assessing risk of IPSV.

One-to-one settings

Participants (*n*=8) also reflected on the importance of one-to-one settings (for example case management or individual counselling) for supporting disclosures and discussion of IPSV as well as managing risk and referrals:

> In a one-to-one situation, it is more easily discussed, and referrals and concerns can be managed […] It is more difficult to manage this in a group setting.

> Men will admit to the more "normalised" acts of sexual violence strangling (sex play) wolf whistling etc but will never admit to rape unless in a more private setting.

The finding that participants feel one-to-one settings are more conducive to disclosures compared to group settings echoes the quantitative finding that participants are more prepared to respond to IPSV disclosures in one-to-one settings (see, Table 10, p. 27). This highlights the importance of offering one-to-one sessions, through for example case management and individual counselling, alongside group sessions. Further, where disclosures are made in group, one-to-one work also provides an important opportunity for further debriefing and support to be provided to participants who had heard the disclosure(s).

Collaboration where IPSV is identified

Participants who work with victim-survivors (*n*=41) were asked about their experiences collaborating with MBCP practitioners and/ or case managers to address identified IPSV. While most participants (*n*=26, 66.7%), said their experience was excellent or good, six participants (15.4%) said their experience was average and seven participants (18.0%) said their experience was poor or terrible.

In reflecting on their experiences of collaborating with MBCP facilitators (*n*=16), some participants spoke positively about the openness and readiness of facilitators to collaborate and address IPSV. Other participants reported that while facilitators were receptive, there was a 'trickiness' to responding and felt that 'little that could be instigated to prevent further perpetration'. This reflected concerns around escalating risk of abuse discussed above (p. 40-41). One participant said it was easier to address the issue if the disclosure came from formal information sharing pathways such as police because they felt in those circumstances, they could directly address the behaviour. Experiences varied between practitioners, and some practitioners felt that in some instances facilitators 'do not want to know about it.' Participants also raised concerns of collusion, and one participant spoke specifically about challenges working alongside male facilitators with a history of violence perpetration:

> It is difficult to discuss some victim-survivor experiences as they [facilitators] aren't wanting to hear this information and "pollute" the way they work with the men. In my experience, many male MBCP facilitators are collusive and unaware of how they demonstrate male privilege and power imbalances within the MBCP space.

These findings highlight inconsistencies of practice across the MBCP space and the challenges of collaboratively addressing IPSV, particularly where this is raised by victim-survivors, through for example, family safety contact work.

Intervention practice

Program content

Participants (*n*=90) were asked if the perpetrator intervention programs they have been involved in have a session(s) dedicated to discussing or addressing IPSV. The majority of participants (*n*=38, 59.4%) said yes, and 26 participants (40.6%) said no.[27] Additionally, participants working in roles related to the design, development and/ or management of MBCPs or other similar interventions (*n*=12, 12.4%) were asked about the design and development of MBCP sessions. Nine participants (75.0%) responded to these questions. While this sample is small, these findings are included as they provide unique insights into the professional views of those engaged in developing MBCP curriculum. There is presently limited research in Australia and elsewhere exploring the design and development of MBCP program content related to IPSV. These participants were asked how frequently content related to sex and intimacy, and IPSV is designed into program content. Responses are shown below in Table 15.

Table 15: Frequency of designing sex and intimacy and IPSV content into perpetrator programs

	Always or most of the time *n* (%)	About half the time *n* (%)	Sometimes or never *n* (%)	*M*[a]	*SD*
Sex and intimacy (*n*=9)	4 (44.4)	-	5 (55.6)	3.00	1.50
IPSV (*n*=9)	3 (33.3)	-	6 (66.7)	2.78	1.48

[a] A higher mean indicates greater frequency of designing sex and intimacy or IPSV into program content, where 5.00 indicates always, 3.00 indicates about half the time, and 1.00 indicates never.

While some participants involved in program design and development reported incorporating sex and intimacy (*n*=4, 44.4%), and IPSV (*n*=3, 33.3%) content into program sessions always or most of the time, five participants (55.6%) said they either sometimes or never incorporate sex and intimacy content, and six participants (66.7%) said they either sometimes or never incorporate IPSV content. Among the participants in this survey, there is evidently mixed practice regarding the incorporation of content related to sex and intimacy and IPSV. Participants (*n*=9) were also asked about their confidence in designing and developing content related to both sex and intimacy and IPSV. Results are shown in Table 16.

[27] Missing =26.

Table 16: Confidence developing content related to sex and intimacy and IPSV					
	Very or somewhat confident *n* (%)	Neither *n* (%)	Somewhat or very unconfident *n* (%)	*M*[a]	*SD*
Sex and intimacy (*n*=9)	5 (55.6)	1 (11.1)	3 (33.3)	3.44	1.51
IPSV (*n*=9)	4 (44.4)	2 (22.2)	3 (33.3)	3.22	1.39

[a] A higher mean indicates greater confidence developing content related to sex and intimacy or IPSV, where 5.00 indicates very confident, 3.00 indicates neither, and 1.00 indicates very unconfident.

Most participants reported they were very or somewhat confident incorporating sex and intimacy (*n*=5, 55.6%), and IPSV (*n*=4, 44.4%) content into program sessions, with three participants (33.3%) reporting they were somewhat or very unconfident in incorporating both sex and intimacy and IPSV content into programs. Further reflections on program content related to sex and intimacy and IPSV was provided through open-text questions. Of the nine participants involved in the design, development and/ or management of MBCPs or other similar interventions, four participants, including two participants who said they were somewhat confident in developing content on the topic, described the sex and intimacy content as limited or superficial and a fifth participant said it was 'often easier to not touch on the topic.' Similarly, five participants described the IPSV content as limited. This finding suggests that confidence does not necessarily correlate with increased practice regarding the incorporation of sex and intimacy and IPSV content into DFV perpetrator intervention programs among survey participants.

Further insights into program engagement with the topics of sex and intimacy and IPSV are provided through survey participants open-text responses. Numerous practitioners (*n*=13) referenced the Duluth model[28]:

> As part of the Duluth training, facilitators engage in critical dialogue techniques to explore men's beliefs about sexual violence entitlement and using male privilege and impacts on partners and children.

> A large part of the training was based on the Duluth Model of sexual respect and using tools of actions, intent, belief and impact. This was not particularly specific to intimate partner sexual violence and more general in nature.

[28] Developed in the 1980s the Duluth model is a feminist, psycho-education approach to DFV perpetrator interventions. A key focus of the Duluth model is the power and control wheel (Pence & Paymar, 1993)

For these participants sexual violence and/ or sexual respect is being explored in program content, however the data provides limited insights into the way in which this is operationalised. Some participants simply reflected that the Duluth model and the power and control wheel is 'a helpful tool when explaining different types of abuse.' Given the variance between responses provided, it was often not possible to ascertain the nature and extent to which IPSV is being explored in group from the data received. The study does however highlight inconsistencies in practice. Further research focused on how IPSV content is engaged with in programs is required.

Some participants had experience working on programs that did not have a session dedicated to exploring IPSV:

> My colleague and I use the Duluth Wheel of Power and Control to illustrate the various forms of violence and abuse. As we explore each segment we acknowledge that physical and sexual violence forms the rim of the Wheel, but we never spend a session on just those topics.

> One program I worked for didn't have a session on intimate partner sexual violence. The program I'm currently in does. However, it's later in the program. We do explore different types of violence in session one.

This supports the quantitative data where 40.6% of participants (*n*=26) said they did not have a session dedicated to IPSV. Within our participant sample, there is clear variation in practice regarding the embedding of IPSV within program content. Some participants also expressed a desire for a more targeted approach to thinking about sexual violence:

> It could be helpful to have a more structured approach to thinking about sexual violence that explores more specifically all the forms of sexual violence (e.g forcing someone else to watch porn etc) and what sexual violence might look like in specific communities e.g queer, kink, poly spaces.

Four participants spoke in the survey about the need for focused attention on pornography and for greater training to support practitioners to discuss pornography with clients. The need to develop a more structured and comprehensive approach to thinking about harmful sexual behaviours, and in particular to address the role of pornography is highlighted in the National Plan consultation report (Fitz-Gibbon et al. 2022), as well as the National Plan (2022, p. 52, 106). Other areas raised by participants as requiring a more targeted focus include reproductive violence (*n*=2) and technology-facilitated abuse (*n*=4), as well as what sexual violence might look like in specific communities. Among

participants who worked in a program that did explore IPSV, some discussed this as a separate session while others highlight the way in which IPSV (and other forms of sexual violence) is explored across various topics (for example, in relation to coercive control, or emotional abuse):

> One challenge is that sexual violence overlaps with so many other forms of violence - e.g. we talk about degrading/derogatory comments such as "slut" as sexual violence - as it is an attack on someone's sexuality, but it's also emotional/psychological abuse. So, I guess a challenge that sexual violence is imbricated in each of the other types of violence - as the example of technology-facilitated intimate partner sexual violence. I'm thinking we should in group be more intentional about exploring all the different types of sexual violence - e.g. recording without consent, sharing images etc.

> We could weave sexual violence in a more embedded way through all of our topics - there's a risk it becomes a siloed conversation on the week we focus on it.

These responses demonstrate the need to ensure IPSV is explored in relation to other forms of violence rather than solely as an isolated topic (or not at all). A common barrier raised by survey participants (*n*=8) to discussing IPSV is that DFV perpetrators assert 'I'm not a rapist' and close-off when topics of sexual violence are introduced in isolation of other behaviours. It is essential to understand that IPSV is entangled in the broader context of DFV. While having a separate and dedicated discussion of this form of violence may be useful, particularly for exploring the different types of sexual violence and for shifting understandings that suggest IPSV is synonymous with rape, separating this topic (without also enmeshing it across other topics) risks reinforcing participants distancing from this form of violence. There is a need to (at least initially) explore IPSV in ways that is connected, meaningful and related to the use of violence participants recognise.

Practitioners (dis)comfort discussing sex and intimacy and IPSV

Participants were asked how comfortable they are discussing sex and intimacy and IPSV with DFV perpetrators. Results are shown in Table 17.[29]

[29] These findings need to be interpreted with caution due to an inconsistency in the survey construction. Most survey questions, including the sex and intimacy question, were asked in descending order (i.e. extremely comfortable (5.00) – extremely uncomfortable (1.00)), while the IPSV question was asked in ascending order (i.e. extremely comfortable (1.00) to extremely uncomfortable (5.00)). It is possible that some participants may have inaccurately responded to the IPSV question due to the inconsistent order of responses between this question and all other survey questions. Items asked in ascending order were reverse coded for analysis, so that a higher score consistently indicates a more positive response.

Table 17: Practitioners (dis)comfort discussing sex and intimacy and IPSV					
	Extremely or somewhat comfortable *n* (%)	Neither *n* (%)	Somewhat or extremely uncomfortable *n* (%)	*M*[a]	*SD*
Comfort discussing sex and intimacy with DFV perpetrators (*n*=66)	51 (77.2)	7 (10.6)	8 (12.1)	4.08	1.01
Comfort discussing IPSV with DFV perpetrators (*n*=65)	31 (47.7)	7 (10.8)	27 (41.6)	2.82	1.48

[a] A higher mean indicates greater comfort, where 5.00 indicates extremely comfortable, 3.00 indicates neither, and 1.00 indicates extremely uncomfortable.

Most participants (*n*=51, 77.2%) reported they were extremely or somewhat comfortable discussing sex and intimacy with DFV perpetrators, compared to only 31 participants (47.7%) who reported they were extremely or somewhat comfortable discussing IPSV with DFV perpetrators. A sign test with continuity correction was conducted to determine differences in comfort discussing sex and intimacy and IPSV with DFV perpetrators.[30] Within the paired sample (*n*=65) participants reported greater comfort discussing sex and intimacy (*M*=4.08, *SD*=1.01), than IPSV (*M*=2.82, *SD*=1.48, *MD*=1.26), a statistically significant difference (*z*=4.17, *p*<.001).[31] While this finding should be interpreted with caution due to the inconsistency in survey construction, this does align with broader findings of a distinction between comfort, receptiveness and challenges to discussing sex and intimacy compared to IPSV. For example, participants similarly reported greater receptiveness of program participants to discussing sex and intimacy compared to IPSV (discussed below, Table 18, p. 50). In the open text responses, survey participants (*n*=13) also reflected on practitioner discomfort discussing sexual content:

> There is lots of shame and reluctance on behalf of many facilitators and this transfers into reluctance from participants. Staff need to be confident and well supported to have this discussion [about IPSV] without transference of shame and discomfort occurring.

> I feel uncomfortable discussing sex and intimacy with clients. I'm not sure how to open this conversation in a way that feels appropriate. I am somewhat confident to discuss it if there has been a systems history or disclosure of sexual violence, but otherwise I'm not sure where to start.

[30] A sign rank test was used because the data violates assumptions of normality and symmetry.
[31] Of the 65 participants, 31 participants (47.7%) reported greater comfort discussing sex and intimacy compared to IPSV, 29 participants (44.6%) reported the same level of comfort across both items, and five participants (7.7%) reported less comfort discussing sex and intimacy compared to IPSV.

> A barrier is the working relationship with the perpetrator and how comfortable I feel discussing it [IPSV] with him. Being a female asking a male these questions can feel a bit difficult at times

This discomfort was linked by participants to practitioners' own experiences of IPSV, gender identity (explored further on p. 55-58), 'fear of offending or over stepping', and being unsure about how to have these conversations in practice. Practitioners also spoke about the relational nature of this discomfort, whereby practitioner discomfort is felt by participants and vice-versa potentially reinforcing and further entrenching discomfort. Such discomfort presented for practitioners as a barrier to discussing IPSV as well as to identifying IPSV. These findings highlight the importance of providing appropriate supports for facilitators to engage in this work and the need to create the space required to support meaningful discussions about sex and intimacy as well as IPSV in order to build confidence and comfort among both practitioners and program participants.

Discussing sex and intimacy and IPSV with DFV perpetrators

Participants (*n*=67) were also asked how often sex and intimacy is discussed with DFV perpetrators during interventions. While most participants (*n*=37, 55.3%) said that discussions about sex and intimacy occur in all or most cases, nine participants (13.4%) said about half of cases and 21 participants (31.4%) said only in some cases or never. Participants (*n*=65) were also asked how often IPSV comes up in discussions with DFV perpetrators. 24 participants (36.9%) said frequently or often, 24 participants (36.9%) said sometimes, and 17 participants (26.1%) said rarely or never.

There is a difference in the way these two frequency questions were framed. The sex and intimacy question was asked in relation to the proportion of cases, and the IPSV question was framed in terms of frequency. Unfortunately, this error limits the comparability of these items. Nonetheless, results show that both sex and intimacy and IPSV are not always discussed with DFV perpetrators, with 30 participants (44.8%) reporting that sex and intimacy is discussed with DFV perpetrators in half of cases or less, and 41 participants (63.0%) reporting that IPSV is discussed only sometimes, rarely, or never. Given the evidenced prevalence of IPSV in abusive intimate partner relationships (ABS 2017), the lack of discussion about IPSV in the experience of over 60% of responding practitioners is highly concerning.

Additionally, practitioners who facilitate group MBCPs were asked how receptive they felt program participants were to the topics of sex and intimacy and IPSV. Results are presented below in Table 18.

Table 18: MBCP participants receptiveness to discussing sex and intimacy and IPSV					
	Very or somewhat receptive *n* (%)	Neither *n* (%)	Somewhat or very unreceptive *n* (%)	*M*[a]	*SD*
Receptiveness to discussing sex and intimacy (*n*=53)	31 (58.5)	9 (17.0)	13 (24.5)	3.42	1.01
Receptiveness to discussing IPSV (*n*=52)	20 (38.5)	11 (21.2)	21 (40.4)	2.98	1.08

[a] A higher mean indicates greater receptiveness, where 5.00 indicates very receptive, 3.00 indicates neither, and 1.00 indicates very unreceptive.

The majority of practitioners (*n*=31, 58.5%) reported that group program participants are very or somewhat receptive to discussing sex and intimacy, however almost one in four practitioners (*n*=13, 24.5%) reported that in their experience program participants were somewhat or very unreceptive. Comparatively, 20 practitioners (38.5%) reported that program participants are very or somewhat receptive to discussing IPSV and 21 participants (40.4%) reported that program participants were somewhat or very unreceptive to discussing IPSV. A non-parametric t-test was conducted to determine if there were significant differences in reported receptiveness of program participants to discussing sex and intimacy compared to IPSV. Within the paired sample (*n*=51) practitioners reported greater receptiveness among MBCP participants to discussing sex and intimacy (*M*=3.41, *SD*=1.02), compared to IPSV (*M*=3.00, *SD*=1.07, *MD*= 0.41), a statistically significant difference (*z*= 2.88, *p*=.004).[32]

Program participants discomfort discussing sexual content: group size and group composition

Practitioners also discussed the receptiveness of program participants, particularly reluctance and discomfort discussing sexual content in the open-text responses. (Dis)comfort discussing sex and intimacy as well as sexual violence was raised in relation to all population groups: victim-survivors, program participants and practitioners. Here we focus on practitioners' perceptions of the way in which group dynamics – group size and composition – influence program participants discomfort. Program participant discomfort was frequently raised by survey participants (*n*=9):

[32] Most participants (*n*=28, 54.9%) reported no difference in the receptiveness of DFV perpetrators to discussing IPSV compared to sex and intimacy, 20 participants (39.2%) reported greater receptiveness to discussing sex and intimacy compared to IPSV and three participants (5.9%) reported greater receptiveness to discussing IPSV compared to sex and intimacy.

> In my experience, some men are reluctant to discuss this and can resort to 'banter' to hide their uncomfortableness with the discussion.

> It can make clients uncomfortable to talk about it.

> [Barriers include] client not feeling safe or generally not comfortable to talk about anything relating to sex

Discussions about sex and intimacy as well as IPSV is not commonly practiced, and this abnormality of divulging personal experiences related to sex and sexual violence was a barrier to discussion not only for men discussing sexual content, but also for practitioners. As captures in the following reflections:

> I think the barrier lies in having the conversation […] we don't talk sex.

> Many people men and women have been brought up to believe that sex should not be discussed that it is private

The discomfort described here by practitioners about discussing sexual content aligns with evidence that IPSV is less likely to be disclosed than other forms of IPV or DFV (McOrmond-Plummer et al. 2013) and reflects broader social norms around not discussing sexual content. Discomfort was also linked by practitioners to program participants, victim-survivors past experiences of child sexual abuse. This supports calls in prior research for greater consideration of childhood trauma into perpetrator intervention program work (Voith et al. 2020).

In asking practitioners about group program participants' receptiveness to sex and intimacy and IPSV content, practitioners were prompted to factors such as group size that may influence clients' willingness to engage in discussions. Most participants (*n*=11) deemed small group size, or a one-to-one environment, to be more beneficial than larger groups:

> The smaller the groups are better as there is nowhere to hide… hard to challenge everyone in large groups.

> Discussing this in a group context may be problematic as many people do not feel comfortable discussing sex and particularly not in a group situation

The benefit of smaller groups was largely described as being more conducive to fostering in-depth discussions and accountability. The role of one-to-one work was predominantly discussed in the context of screening for IPSV (discussed above, p. 42-43), but a minority of participants also felt this content was not appropriate for the group environment and should only be addressed in one-to-one

settings. While smaller sized groups were favoured by most participants for discussing both IPSV and sex and intimacy, some participants (*n*=5) felt larger groups were preferable:

> A larger group (9-12) is more conducive than a smaller group where men might feel more exposed. Even though we don't allow men to 'hide' in group, the fact that there are more voices and experiences in the room provides a level of comfort for them.

> Groups of ten appear to work because there is room to take a back seat in group discussions and the level of perceived anonymity is heightened.

There was some dissent in responses to these questions, with two participants stating larger groups were not helpful for disclosure nor discussion of either IPSV or sex and intimacy. Generally, there was an indication among participants that, while smaller groups were preferable for in-depth discussion due to lack of anonymity and heightened accountability, larger groups were preferable for easing clients into these discussions and for encouraging initial disclosures. As one participant explained:

> Easier in big group because they can hide… [but] small groups have better in-depth discussions

Beyond recognising group size as an influencing factor in DFV perpetrators' willingness to engage, practitioners (*n*=11) identified the composition and dynamic of group members to being equally as impactful. Components like 'trust', 'personalities', and 'group cohesion' were common in responses describing the importance of program participants' peer relations and its influence on receptiveness to discussing sex and intimacy as well as IPSV. It was noted that support among group peers, certain members 'taking the lead', could encourage disclosure and discussion of IPSV and sex and intimacy:

> If there is trust in a group, they will discuss most things.

> Once one man opens up the others seem to feel more open to talking about the subject.

Opposingly, if there is a sense of judgement among peers, or certain members express misogynistic and violence-supportive attitudes, these factors can discourage disclosure and discussion:

> Most men recognise that other men see intimate partner sexual violence as being totally unacceptable and therefore do not disclose and discuss their own behaviour for fear of being judged.

> If there are a number of men who are overtly resistant to discussing or have misogynistic attitudes they may disrupt or prevent other men from participating.
>
> Collusion - as soon as one group participant turns against the facilitator, most (if not all) participants start to push back and deny any wrong-doing.

As these quotes illustrate, the level and type of rapport among group peers shapes how participants respond to not only program content but program facilitators as well. While rapport between practitioners and program participants is necessary to foster their willingness to disclose and discuss sexual content, particularly IPSV, it is also important to manage the level and type of rapport formed among participants within the group. Where group dynamics may hinder productive conversations, there is perhaps a greater need for this work to be supported through one-to-one or smaller group work, where the influence of collective group hostility or resistance can be removed. More broadly, practitioners' experiences of group size and dynamics influencing discussions of sexual content should prompt greater consideration around the role of one-to-one, small, and large group work in the DFV perpetrator intervention program space.

Indigenous and culturally-specific client needs

Practitioners (*n*=20) identified language and culture as a barrier to discussing IPSV, in particular practitioners reported challenges in working with Indigenous and culturally diverse participants. This was raised by practitioners working with DFV perpetrators and victim-survivors, as well as in the context of delivering training:

> [A barrier to discussing IPSV is working with] clients from CALD background where this topic is not something discussed openly.
>
> As a female facilitator, when it comes to men's business, some cultures are not comfortable to speak about this with people of the opposite sex.
>
> Working in the cultural context of the Northern Territory is more difficult to deliver not only training about sexual respect or respectful relationships but also having the conversation with community. Men's and women's business define the content allowed to deliver and must gain community input prior to the conversations being held.

As these participants highlight such barriers require collaboration with communities to explore how to have these conversations. Failure to account for diverse cultures and communities in program

design (including program content and governance, such as guidelines and minimum standards) undermines the workability of programs, particularly for Indigenous and culturally diverse participants. As noted by participants, gender and cultural background of practitioners can influence program participants willingness to engage. A lack of both culturally informed content and representation among practitioners – specific to the communities or cultural contexts that the program is operating within – inhibits discussions of IPSV. This speaks to the need for greater availability of programs that are representative of the diversity amongst DFV perpetrators (Expert Advisory Committee on Perpetrator Interventions 2018; Kelly & Westmarland 2015; RCFV 2016), the need to build a representative workforce, and the need to develop the cultural humility of existing programs and workers.

Delivery format

Participants were asked open-text questions about the different formats (in-person, video-call, telephone) that their programs and related intervention work (for example, case management and one-to-one counselling) are delivered through and how this impacts engagement with sexual content. All participants who had experience delivering across two or more platforms (and responded to the open-text question, *n*=10) favoured an in-person format. It was identified across responses that neither video-call or telephone formats offer the level of body language observation and environmental risk management that are needed for productive interactions with clients:

> I don't think MBC groups in general, and this topic in particular, are useful in an online setting. There is little to no way of managing risk online, or being aware of who else might be present.

> During COVID I was doing one on one telehealth sessions. It was extremely difficult to discuss this topic in this format; this was true for discussing all types of violence. Even using video it is difficult to gauge the response of the man to the topics discussed and therefore difficult to facilitate the discussion.

> It would be easier to discuss intimate partner sexual violence in-person as opposed to online or over the phone as you can observe body language and are better able to identify mood shifts.

Additionally, some participants raised concerns related to practitioner safety in the online context:

> As a female it can be difficult discussing intimate partner sexual violence as you cannot view the client and ensure they are behaving appropriately throughout the discussion.

Concerns related to practitioner safety, particularly when discussing IPSV are not unique to the online environment (explored further in the below discussion on gender), yet they manifest differently in this delivery format due to the reduced visibility of program participants. This example highlights that in discussions of delivery format, there is a need to consider potential impacts on practitioner safety, including but not limited to potential exposure to sexual harassment or abuse. Concerns related to delivery format are not exclusive to IPSV, but also extend to broader concerns around delivery of DFV interventions more broadly. In the context of the Covid-19 pandemic and restrictions to movement, there was a significant move to online program delivery (Vlais & Campbell 2020; NTV 2022). Despite the significant shifts to online and telephone work in recent years, among our survey participants concerns about delivering programs and services online or over telephone persist.

Gender

Minimum standards in MBCPs often stipulate one-female and one-male co-facilitator as the preferred model in MBCPs (see for example, Family Safety Victoria 2017, p. 10, standard 3.5; NSW Government 2017, p. 15, standard 4.2; Department for Child Protection and Family Support (WA) 2015, p. 16, standard 3.2). Existing literature also highlights differences in the experiences of men and women in facilitating MBCPs (Apps and Gregory 2011; Blacklock 2003), which is also supported in the qualitative data from this study where participants identified gender as a barrier to discussing IPSV. For these reasons, we explored differences in views and experiences between men and women across screening, risk assessment and intervention practice items.[33] Results are shown in Table 19.

[33] Due to limitations within our data gender is explored as a binary comparison of men and women's experiences.

Table 19: Screening, risk assessment and intervention practice items by gender

	Gender		Total	Mann-Whitney U Test		
	Men	Women	*Mdn*[a]	*U*	*z*	*p*
	Mdn (n)	*Mdn (n)*				
Frequency of assessing risk of IPSV perpetration (*n*=65)	4.00 (14)	4.00 (51)	4.00	372.5	0.258	.796
Frequency of assessing risk of IPSV perpetration *compared to other forms of DFV* (*n*=65)	2.50 (14)	3.00 (51)	3.00	361.0	0.070	.944
Confidence IPSV perpetration is identified where present (*n*=64)	3.00 (14)	2.00 (50)	3.00	320.0	-0.509	.611
Proportion of cases where IPSV perpetration is present and identified (*n*=63)[b]	20.00 (13)	31.00 (50)	30.00	392.5	1.147	.251
Comfort discussing sex and intimacy with DFV perpetrators (*n*=66)	5.00 (14)	4.00 (52)	4.00	237.5	-2.117	.034*
Comfort discussing IPSV with DFV perpetrators (*n*=65)	1.00 (14)	3.00 (51)	3.00	505.5	2.434	.015*
Proportion of DFV perpetrator cases sex and intimacy is discussed (*n*=67)	4.00 (14)	4.00 (53)	4.00	302.0	-1.100	.271
Frequency IPSV comes up in discussions with DFV perpetrators (*n*=65)	3.00 (14)	3.00 (51)	3.00	372.5	0.258	.797
Perception of DFV perpetrators receptiveness to discussing sex and intimacy (*n*=53)	4.00 (12)	4.00 (41)	4.00	202.0	-1.005	.315
Perception of DFV perpetrators receptiveness to discussing IPSV (*n*=52)	4.00 (11)	3.00 (41)	3.00	179.5	-1.078	.218

[a] A higher median indicates greater frequency, confidence, proportion, or comfort as appropriate for the item listed. [b] This item was asked on a continuous scale 0-100. *Statistically significant at p<0.05.

As can be seen in Table 19, results by gender are quite varied. Women reported greater frequency of assessing risk of IPSV perpetration compared to other forms of DFV (*Mdn*=3.00, *n*=51), than men (*Mdn*=2.50, *n*=14, *U*=361.0, *z*=0.070, *p*=.944); and a higher proportion of cases where IPSV is present and identified (*Mdn*=31.00, *n*=50) compared to men (*Mdn*=20.00, *n*=13, *U*=392.5, *z*=1.147, *p*=.251), although these differences were not statistically significant. Women also reported greater comfort discussing IPSV with DFV perpetrators (*Mdn*=3.00, *n*=51) compared to men (*Mdn*=1.00, *n*=14, *U*=505.5, *z*=2.434, p=.015). While this result was statistically significant it should be interpreted with caution due to an error in the way this item was asked in the survey (see p. 47, fn. 29). Comparatively, men reported greater confidence that IPSV perpetration is identified where present (*Mdn*=3.00, *n*=14) compared to women (*Mdn*=2.00, *n*=50, *U*=320.0, *z*=-0.509, *p*=.611); and greater receptiveness of DFV perpetrators to discussing IPSV (*Mdn*=4.00, *n*=11) compared to women (*Mdn*=3.00, *n*=41, *U*=179.5, *z*=-1.078, *p*=.218), although these results were not statistically significant. Men also reported greater comfort discussing sex and intimacy with DFV perpetrators (*Mdn*=5.00, *n*=14) compared to women

(*Mdn*=4.00, *n*=52, *U*=237.5, *z*=-2.117, *p*=.034), a statistically significant difference. As can be seen in Table 19, there was no difference in medians between men and women for any other items.

In the qualitative data facilitators (*n*=14) noted how gender identity could influence male DFV perpetrators' disclosure(s) and discussion of both IPSV and sex and intimacy. Practitioners reported that some male clients are more likely to exhibit discomfort, reluctance, and hostility if the practitioner is a woman:

> When men are being held to account, often they feel vilified and become agitated/aggressive, particularly when this messaging is coming from women/female practitioners.
>
> Embarrassment and reluctance to talk about sex, particularly with a female practitioner (depends on the client).

In addition to clients' discomfort, this was also discussed in terms of facilitators own discomfort, particularly for women:

> …there is the additional layer that comes with being a young female facilitator in this space, I am more likely to be sexualised by the men which could act as a barrier to having these conversations with them.
>
> A difficult topic for all female facilitators of MBCP, requiring lots of support usually as the participants have some very confronting perspectives that they will often feel comfortable expressing.

These findings align with evidence from the European Network for the Work with Perpetrators of Domestic Violence (Iwi & Eisenstadt 2020) which found that 79% of women working with perpetrators reported feeling threatened by their clients, compared to 21% of men. Women were also more likely to report avoiding sexual contact in their own lives because of interactions with sex offenders (p. 2). These responses highlight the need to consider the implications of having women facilitate discussions of sex and intimacy and IPSV with men who have perpetrated violence against women, and to consider supports in place for staff. This is particularly important as practitioners highlight the risk of sexual violence against facilitators.

While practitioner discomfort discussing both sex and intimacy and IPSV was a common issue raised by survey participants in both quantitative and qualitative findings, these challenges appear to be

amplified in the context of women working with male DFV perpetrators. Additionally, some participants spoke about the gender roles within the one-male, one-female co-facilitation model:

> The men would often then ask me to speak for all women's experience. Which they were receptive to - but I'm not getting paid more than my male co-facilitator to be a proxy to speak about what it's like to live in a world that objectifies women. It has been much more helpful to situate the conversation in how they are sexually abusive to their ex/partners.

Apps and Gregory (2011, p. 30) note that the rationale behind the one-male, one-female co-facilitation model is for the male facilitator to model 'non-violent ways of relating, as well as showing that men can stand up against violence and the abuse of women and children' and the role of the female facilitator 'for male perpetrators to be offered the experience of relating respectfully to a woman.' The experience described by the participants above illustrates that this role extends beyond practicing respectful dialogue, to being positioned for example, 'to speak for all women's experience[s]' and 'to be a proxy to speak about what it's like to live in a world that objectifies women.' While it is critical for women's experiences to be brought into behaviour change work, in this participant's experience the way this is practiced places unequal responsibility and labour on women working in the behaviour change space. The qualitative findings regarding gender, suggest that for some practitioners, gender is a key issue that sits at the forefront of barriers to discussing sex and intimacy as well as IPSV.

Understandings of IPSV, sex and intimacy, and healthy relationships

Practitioners also spoke about DFV perpetrators' limited understandings of – and relatability to – concepts of IPSV, sex and intimacy and healthy relationships as a challenge to behaviour change work:

> Perpetrators not having any healthy relationship to relate to, … so it seems unrealistic to them…

> Men are often resistant to entering these conversations, and while I'm educated on these topics, I don't know how to discuss these in a way that increases men's understanding.

> I suppose the type of violence impacts service because a lot of sexual violence appears "subjective"- image base sexual violence might not be recognised as sexual violence, and 'active consent' is not something that everyone agrees with.

These challenges were often linked to the sociocultural normalisation of IPSV as obscuring any recognition of IPSV. Participants (*n*=11) explained that the normalisation of coercive and forceful sexual interaction (within a heteronormative frame) leads to IPSV being minimised and rationalised by perpetrators, victim-survivors, and the public:

> Societal expectations of gender stereotypes in the area of sexual behaviour and their wide expectations. "Boys will be boys."

> Some AFMs believe men have a right to sex if married or within a relationships, women's sexual needs and boundaries are not prioritised by society.

> Society [is a barrier] - society continues to reinforce that women should protect themselves against rapists, rather than men being held to account. When men are being held to account, often they feel vilified and become agitated/aggressive, particularly when this messaging is coming from women/female practitioners.

Understandings of IPSV, sex and intimacy, healthy relationships, and consent impact upon disclosures of IPSV perpetration and victimisation. As explored here, they also present as a barrier to engaging in discussions of these concepts as part of the behaviour change intervention work. These challenges are connected to broader sociocultural attitudes around sexual violence. While this is not new, it reiterates the enormity of the task of responding to IPSV through MBCPs and related interventions.

Influence of sexual assault training on screening, risk assessment and intervention practice

As discussed previously (p. 23-24), some participants spoke about their past work experience, in particular working with victim-survivors of sexualised violence, through organisations such as CASA, as influencing their comfort and competency in identifying, discussing, and addressing IPSV perpetration. This finding within the qualitative data prompted us to explore differences between participants who had received sexual assault training and those who had not received sexual assault training across screening, risk assessment and intervention practice questions. The results are shown below in Table 20.

Table 20: Screening, risk assessment and intervention practice items by sexual assault training

	Sexual assault training		Total	Mann-Whitney U Test		
	Yes	No	*Mdn*[a]	*U*	*z*	*p*
	Mdn (n)	*Mdn (n)*				
Frequency of assessing risk of IPSV perpetration (*n*=59)	4.00 (14)	3.00 (45)	3.00	214.5	-2.193	.028*
Frequency of assessing risk of IPSV perpetration *compared to other forms of DFV* (*n*=60)	3.00 (15)	2.00 (45)	3.00	220.0	-2.187	.029*
Confidence IPSV perpetration is identified where present (*n*=59)	4.00 (15)	2.00 (44)	2.00	161.5	-3.056	.002**
Proportion of cases where IPSV perpetration is present and identified (*n*=58)[b]	70.00 (15)	30.00 (43)	31.00	186.0	-2.426	.015*
Comfort discussing sex and intimacy with DFV perpetrators (*n*=60)	5.00 (15)	4.00 (45)	4.00	213.0	-2.264	.024*
Comfort discussing IPSV with DFV perpetrators (*n*=59)[c]	3.00 (14)	3.00 (45)	3.00	264.5	-0.923	.356
Proportion of DFV perpetrator cases sex and intimacy is discussed (*n*=61)	4.00 (15)	3.50 (46)	4.00	275.0	-1.212	.226
Frequency IPSV comes up in discussions with DFV perpetrators (*n*=59)	4.00 (14)	3.00 (45)	3.00	226.0	-1.657	.097
Perception of DFV perpetrators receptiveness to discussing sex and intimacy (*n*=47)	4.00 (11)	4.00 (36)	4.00	200.0	0.054	.957
Perception of DFV perpetrators receptiveness to discussing IPSV (*n*=46)	3.00 (11)	3.00 (35)	3.00	180.0	-0.336	.737

[a] A higher median indicates greater frequency, confidence, proportion, or comfort as appropriate for the item listed. [b] This item was asked on a continuous scale 0-100. [c] Due to an error in survey construction this item should be interpreted with caution (see explanatory comment on p. 47, fn. 29). *Statistically significant at p<0.05. ** statistically significant at p<0.005

As can be seen in Table 20, there were significant differences between participants with sexual assault training and participants without sexual assault training across multiple items. Participants with sexual assault training reported greater frequency of assessing risk of IPSV perpetration (*Mdn*=4.00, *n*=14) compared to participants without sexual assault training (*Mdn*=3.00, *n*=45, *U*=214.5, *z*=-2.193, *p*=.028); greater frequency of assessing risk of IPSV perpetration *compared to other forms of DFV* (*Mdn*=3.00, *n*=15) than participants without sexual assault training (*Mdn*=2.00, *n*=45, *U*=220.0, *z*=-2.187, *p*=.029); greater confidence that IPSV perpetration is identified where present (*Mdn*=4.00, *n*=15) compared to participants without sexual assault training (*Mdn*=2.00, *n*=44, *U*=161.5, *z*=-3.056, *p*=.002); estimated a higher proportion of cases where IPSV is present and identified (*Mdn*=70.00, *n*=15) compared to participants without sexual assault training (*Mdn*=30.00, *n*=43, *U*=186.0, *z*=-2.426, *p*=.015); and greater comfort discussing sex and intimacy with DFV perpetrators (*Mdn*=5.00, *n*=15) compared to participants without sexual assault training (*Mdn*=4.00, *n*=45, *U*=213.0, *z*=-2.264,

p=.024). As shown in Table 20, each of these differences were statistically significant. Participants with sexual assault training also reported a higher proportion of cases where sex and intimacy is discussed with DFV perpetrators (*Mdn*=4.00, *n*=15) compared to participants without sexual assault training (*Mdn*=3.50, *n*=46, *U*=275.0, *z*=-1.212, *p*=.226); and greater frequency that IPSV comes up in discussions with DFV perpetrators (*Mdn*=4.00, *n*=14) compared to participants without sexual assault training (*Mdn*=3.00, *n*=45, *U*=226.0, *z*=-1.657, *p*=.097), although these differences were not statistically significant. As can be seen in Table 20, there was no difference in medians between participants with sexual assault training and participants without sexual assault training for any other items. While the sample size for these tests is small, these findings suggest that sexual assault training does influence the way in which practitioners' work with DFV perpetrators when it comes to both IPSV and sex and intimacy.

Strategies for engaging with IPSV in DFV intervention practice

As this report has highlighted, participants spoke about many barriers to engaging in this work. Additionally, some participants spoke about the ways in which they are already having conversations around sex, intimacy and healthy or respectful relationships and IPSV with DFV perpetrators and victim-survivors. These participants demonstrate some of the strategies and considerations for having these discussions.

Participants spoke, for example, about the need to create conditions for open conversations and the importance of finding entry points into these conversations. While some participants felt they did not know where to start (p. 48-49), others reported specific entry points (such as sexual health, or an acknowledgement of discomfort) that they found useful:

> I frequently have contact with victim survivors who disclosed sexual violence and when contacting the other service systems, sexual violence has not been screened. There is no shame in asking and even a discussion around UTIs etc is a segway [sic] to exploring sexual violence.
>
> This is on the facilitators to make a safe environment with clear boundaries for discussion. If done well men in the group will often come along for the journey with minimal resistance. Often discussing the taboo nature of sex and peoples reluctance to discuss is a good way of setting the tone for the sessions. I also find a gentler session for intro of topic is best and a heavier more targeted discussion

> the following week. (My organisation does topics in fortnightly blocks as per Duluth).
>
> Looking at society's views of sex is a valuable tool to open up conversation without it starting as personal.

Other considerations already raised in the presentation of findings including centring the victim-survivors experience in the conversation (p. 41-42). Participants also reflected on the nuances of the work and the ways in which information could be 'woven into the individual or group work.' Participants emphasised the relevance of IPSV across topics, and cautioned against siloing discussions of sexual violence and sexual respect to separate weeks:

> There are risks in discussing "respectful and healthy relationships" as a stand-alone or through a knowledge/skill framework as it is easily implemented within their patterns of violence. We centre our work on beliefs and attitudes and the ways of knowing, being and doing that arise from that. In this sense, respectful and healthy relationships including sexuality is ubiquitous in the work we do.
>
> When we are exploring sexual assault, intimidation, entitlement, ownership, disrespect, superiority etc we are also always exploring their opposites - i.e. when men are exploring and challenging their own entitlement they are finding possibilities of respect for another, choice, voice, agency etc.

As discussed in relation to program content, separating out discussions of sexual violence, without also considering it in relation to other forms of DFV, risks reinforcing that this topic is taboo and unapproachable. One strategy raised by participants is to practice talking about sexual violence by exploring its connection to other content. As the above quotes illustrate, some practitioners working in this space report that they are already having these conversations in ways that are meaningful. These experiences suggest that there is already knowledge within the sector than can be drawn on to enhance this work.

Discussion

In Australia, we have witnessed increased attention on the need to address all forms of domestic, family, and sexual violence, yet limited attention has been paid to IPSV. The National Plan (DSS 2022) notes an increase in the prevalence of sexual violence across all settings and makes a commitment to respond. The National Plan further details that while myths about sexual violence remain, change is happening: our attitudes are shifting, our awareness and understandings of sexual violence, including IPSV are expanding, and there is a 'readiness to talk about sexual violence' (p. 22).

At the same time in Australia, domestic, family, and sexual violence reform agendas assert a commitment to focusing on perpetrators. Yet, this study demonstrates that IPSV remains on the periphery of DFV perpetrator intervention programs.

Training

Survey findings illustrate that IPSV was not sufficiently covered in participants training experiences, with one in four participants reporting that IPSV was not covered in any of their training. Further, where this was covered, this was predominantly covered in informal or on-the-job training, highlighting a specific gap in formal or institutional training related to IPSV. In addition to the lack of IPSV specific training, where participants had received formal training, this was predominantly rated as at best average, with almost one in four participants (*n*=8, 23.5%) rating their formal or institutional training as poor or very poor and a further one in two participants (*n*=17, 50.0%) rating their training average. Participants placed particular emphasis on a practical skills deficit, with reflections that training often focused on descriptive and conceptual matters rather than practical elements. Most participants spoke more positively about their informal or on-the-job training suggesting that for many participants this may be filling a gap left by their formal or institutional training. Quality supervision, reflective practice, and informal opportunities to discuss IPSV with colleagues were particularly noted as valuable learning and support opportunities by survey participants. Perhaps not surprisingly, participants expressed a desire for future training opportunities, both formal and informal. In particular, survey participants want more practical training around, how to approach the topic of IPSV, how to discuss IPSV, and how to respond where this is disclosed.

Despite the reported limitations of existing training, most participants felt prepared to identify and respond to IPSV perpetration and victimisation. Importantly, participants reported in relation to the

training that they had received, that they felt more prepared to respond to disclosures of perpetrating IPSV in one-to-one compared to group formats. This was reiterated in the qualitative data, where participants spoke about one-to-one environments as an enabler to disclosures of IPSV perpetration. There are two important implications of this finding. First, there is a need to embed opportunities for one-to-one conversations alongside and in conjunction with group work, through for example case management and/ or individual counselling, as this is the environment where practitioners are more prepared to respond. Creating greater opportunities for one-to-one work may therefore enhance the identification of, and response to IPSV perpetration. Second, there is also a need to provide supports and training for practitioners with a focus on increasing preparedness to respond to IPSV in group environments.

The limitations of existing training experiences reported by participants highlight the need to review how IPSV is currently incorporated into DFV perpetrator intervention program training; to develop and deliver training specific to IPSV with a particular focus on practical training; and, to ensure access to regular training and professional development opportunities to upskill. Addressing current limitations of existing training is critical for improving DFV perpetrator intervention program practice related to IPSV. Survey findings also demonstrate that past experience(s) working with victim-survivors, through for example organisations such as CASA, and having specific sexual assault training has a positive influence on participants' reported comfort and competency identifying, discussing and responding to IPSV perpetration. Importantly, the value of practitioners pre-existing sexual assault training suggests that there may be opportunities to use training focused on victim-survivors as a starting point and pivoting elements of this work to focus on working with DFV perpetrators.

Screening and risk assessment

Survey findings show that there are gaps in assessment tools used to identify DFV victimisation and perpetration related to identifying IPSV. While 83.3% of participants (*n*=31) working with DFV victim-survivors reported that the assessment tool(s) they utilise explicitly capture IPSV victimisation, among those working with perpetrators, only 57.6% (*n*=34) reported IPSV was explicitly captured by assessment tools. This impacted risk assessment practices, with greater frequency of assessing risk of IPSV reported by participants who said they used assessment tools that explicitly captured IPSV. Further, in the qualitative data participants reflected on the 'blunt' nature of assessment questions, which often focused on 'force' and were not conducive to exploratory conversations and disclosures. These criticisms echo those found in existing literature which suggest that risk assessment and

prevalence measurement tools are often preoccupied with sexual assault and 'force', further compounding the invisibility of the breadth of IPSV behaviours, and in particular sexual coercion (Strauchler et al. 2004; Logan et al. 2007). Additionally, while noting the recent rollout of the MARAM assessment tools and practice guides for working with adults using family violence in Victoria, and research supporting that the MARAM has increased practitioners' confidence in screening and assessing risk of DFV victimisation and perpetration (Meyer et al. 2023), some participants in the present study reflected that they rely on tools designed to be used with victim-survivors in assessments of perpetrators, illustrating a specific gap in access to assessment tools for use with perpetrators. Notably, the MARAM was the most commonly reported assessment tool used by survey participants working with both victim-survivors and perpetrators, and many participants who reflected on assessment tool limitations for identifying IPSV reporting using the MARAM. Further, qualitative survey data highlighted the importance of practitioner skill, comfort, and experience in engaging in exploratory discussions that supports the identification and risk assessment of IPSV perpetration. This aligns with broader research on screening for DFV perpetration, which similarly affirms that DFV expertise and professional judgement are critical for identifying DFV through for example, recognising warning signs and knowing when and how to prompt further (Meyer et al. 2023). Survey findings illustrate that assessment tools could be improved to better support the identification and risk assessment of IPSV specifically, with further findings suggesting that this should occur alongside practitioner upskilling to build confidence and support practitioners to apply tools in an exploratory and conversational way.

Survey findings also show that some participants are not assessing for risk of IPSV perpetration and victimisation in their work with DFV perpetrators and victim-survivors. Findings show that one in five (*n*=13, 20.0%) participants reported that they rarely or never risk assess for IPSV perpetration. Comparatively, approximately one in ten (*n*=5, 12.2%) participants reported that they rarely or never risk assess for IPSV victimisation. In addition, two in five participants (*n*=28, 43.1%) reported that they risk assess for IPSV perpetration somewhat or much less often compared to other forms of DFV, and one in five (n=9, 22.5%) reported that they risk assess for IPSV victimisation much or somewhat less often than other forms of DFV. Further to these issues of assessing risk, survey findings also capture limitations associated with the identification of IPSV. Participants estimated that IPSV victimisation was present and identified in a greater proportion of cases compared to IPSV perpetration. On average, participants working with perpetrators (*n*=63), estimated that IPSV perpetration was present and identified in 39.92% of cases, while participants working with victim-survivors (*n*=39), estimated IPSV victimisation was present and identified in 52.00% of cases. Further, almost one in two

participants (*n*=31, 48.4%) were somewhat unconfident or not at all confident that IPSV perpetration was identified where present, and one in two participants (*n*=22, 55.0%) were somewhat unconfident or not at all confident that IPSV victimisation was identified where the behaviour was present. This lack of confidence compounds the above findings that some practitioners are not frequently assessing for IPSV victimisation and perpetration; the low proportion of cases where participants feel IPSV perpetration and victimisation are present and identified alongside the low confidence that IPSV perpetration and victimisation are identified where present suggests that IPSV perpetration and victimisation are inconsistently identified through existing risk assessment practices and that IPSV may be missed. These findings reiterate existing research that suggests IPSV often receives less attention than other forms of DFV (Cox 2015). The survey findings illustrate a clear need to support practitioners to increase screening and risk assessment related to IPSV, to bring IPSV 'out of the shadows' and ensure IPSV is not positioned outside the scope of work with DFV perpetrators.

There are several barriers to this work, highlighted in the qualitative survey data. These include issues related to service coordination and information received in referrals, non-disclosures from both perpetrators and victim-survivors, and concerns of escalating abuse. An important question raised in the qualitative data was whose responsibility it is to screen for IPSV (as well as other behaviours), as it was clear that sometimes assumptions were made that screening and identification of relevant behaviours had occurred prior to perpetrator intervention service contact (such as MBCP contact). This was at times compounded by limitations around time spent with clients as well as pressures, including funding pressures, around how the time is spent (for example, 'for treatment not assessment'). Despite increasing emphasis within DFV policy around shared and coordinated approaches to risk assessment and management (Our Watch 2016; DSS 2022; RCFV 2016), in practice there are still barriers to the way in which responsibility to identify and manage risk of DFV (including, but not limited to IPSV) is held and shared. This reflects issues of service co-ordination, as well as pressures on services that limit, for example, time spent with clients, and by extension limit the capacity to do this work well.

Additionally, participants spoke about several enablers to screening and risk assessment including the importance of a shared language of consent and sexual violence, and the need to centre victim-survivors' points of view. A shared language was considered necessary for facilitating communication related to behaviours of concerns, whilst prioritising victim-survivors' own understandings of, and way of thinking or talking about their own experiences. Bringing in the victim-survivors point of view, both in work with victim-survivors and work with perpetrators was discussed as an enabler to identifying

IPSV. Participants highlighted that while perpetrators may not recognise their behaviours as IPSV, and may not connect with language of IPSV, they may recognise other elements, such as victim-survivors discomfort that can be drawn on to open conversation. The discussion of enablers illustrates that some practitioners are finding ways to identifying IPSV and are already having conversations about IPSV with victim-survivors and perpetrators. There may be opportunities to draw on existing knowledge and practice experience to strengthen the broader engagement with IPSV across the DFV perpetrator intervention space.

Practice

Survey findings show that there is inconsistency in practice related to embedding IPSV within MBCPs. While some practitioners said IPSV was incorporated into programs they had delivered, it was clear that both sex and intimacy and IPSV are not consistently included in MBCP content. Further, where IPSV and sex and intimacy are included, participants often described this as superficial engagement. The qualitative findings illustrate that pornography, reproductive violence, technology-facilitated abuse, and consideration of what sexual violence looks like in specific communities all require greater attention. Participants also highlighted the importance of embedding IPSV 'through all of our topics', rather than as an isolated topic. Taking an embedded approach is important for supporting perpetrators to recognise the connection between IPSV and other forms of violence; for challenging the dissociation of IPSV from other forms of DFV and the view that IPSV is not relevant to their choice to use violence.

Discomfort on the part of practitioners as well as victim-survivors and perpetrators were raised as a key barrier to discussing IPSV. Many practitioners (*n*=27, 41.6%) reported that they were somewhat or extremely uncomfortable discussing IPSV with DFV perpetrators, compared to only eight participants (12.1%) who reported the same discomfort discussing sex and intimacy. This discomfort likely influences how IPSV is brought into the work with DFV perpetrators: approximately one in four participants (*n*=17, 26.1%) reported that they rarely or never discuss IPSV in their work with DFV perpetrators. While discomfort was raised by many participants across genders, in the qualitative data, participants also discussed the influence of gender identity in raising IPSV, particularly for women practitioners raising IPSV with male clients, noting that they are sexualised by male clients. Survey participants also reported that they often found program participants to be unreceptive to discussing IPSV, with 21 practitioners (40.4%) reporting program participants to be somewhat or very unreceptive. In the qualitative data, survey participants reported challenges in working with

Indigenous and culturally diverse participants: the lack of culturally-informed content and representation among practitioners were both raised as barriers, highlighting a need for greater availability of culturally relevant programs that reflect the diversity of DFV perpetrators (Expert Advisory Committee on Perpetrator Interventions 2018; Kelly & Westmarland 2015; RCFV 2016), greater diversity within the workforce, as well as the need to develop the cultural humility of existing programs and workers. Issues of discomfort discussing sex and intimacy as well as IPSV are not unique to the DFV perpetrator intervention program context. This is reflective of broader societal trends where sex is still considered a taboo subject and rarely discussed (Tarzia 2021b). The inconsistent ways in which the DFV perpetrator intervention sector engages with IPSV, and the inconsistent ways in which IPSV is raised with perpetrators is a significant concern given the relevance of this behaviour to broader patterns of DFV and the unique impacts of IPSV (Cox 2015; Tarzia 2021a).

Participants were prompted to consider the influence of group size on IPSV discussions. There was variation in survey participants' views regarding the role of group work as a barrier or enabler to discussing IPSV. Some survey participants spoke about the value of small-group and one-to-one work for facilitating in-depth discussions, while other participants felt larger groups were more helpful. Group size and perhaps more importantly group dynamics influence how IPSV is discussed. Survey findings support that embedding variation and ensuring opportunities for one-to-one, small, and large group work may be valuable for enhancing opportunities to meaningfully discuss IPSV. Beyond opportunities for varying group formats, participants spoke about finding entry points into conversations about sex and intimacy, healthy relationships and IPSV. This included, for example, starting by owning and acknowledging the discomfort people experience discussing sex, or beginning with a broader discussion around societal views. Another key entry point was health: sexual health was discussed as an entry point to discussions with both victim-survivors and perpetrators and aligns with existing research around the role of healthcare settings and conversations around healthy relationships for identifying IPSV (Kimberg 2008).

Existing literature from work with victim-survivors is clear on the unique context of IPSV and the significant harm of this form of violence. Despite this understanding, survey findings suggest that there remain significant gaps in identification, assessment, and response to IPSV in current work with DFV perpetrators. These research findings demonstrate a clear need for focused attention on IPSV as part of the sector's work to hold perpetrators accountable for all forms of violence.

Recommendations

Our project findings support the following six recommendations:

1. ### To develop and deliver IPSV-focused training for practitioners working within DFV perpetrator intervention programs.

   Many participants expressed a desire for additional training focused on IPSV. There is a need for training focused on practice skills including how to approach the topic of IPSV, how to discuss IPSV and how to respond safely where this is disclosed. The findings also highlight opportunities to draw on existing training developed for working with victim-survivors, particularly training related to sexual assault, and to pivot this training to support practitioners working with DFV perpetrators.

2. ### To embed increased opportunities for one-to-one work alongside DFV perpetrator intervention group work.

   Findings support the value of additional one-to-one work alongside larger group work. These additional settings would create further opportunities to discuss IPSV and to support the work happening in group.

3. ### To develop improved screening and risk assessment tools to better support practitioners to identify and assess the risk of IPSV.

   Limitations of existing assessment tools, particularly a focus on 'force' and/ or sexual assault in identifying and/ or assessing risk of IPSV are not conducive to capturing the breadth of IPSV behaviours, and in particular sexual coercion. While identification and assessment are largely dependent upon how practitioners operationalise available tools, improved tools could support practitioners to better identify IPSV. Identified improvements include providing comprehensive definitions, language, and guidance around IPSV to better support practitioners to engage in meaningful conversations and work to open an exploratory dialogue more conducive to disclosure.

4. To embed IPSV into DFV perpetrator intervention program content and practice across weeks not solely as a stand-alone topic.

   There is a need for specific, intentional practice related to exploring IPSV in perpetrator intervention programs such as MBCPs. IPSV should be embedded into intervention content across weeks, not solely as a stand-alone topic. Survey findings suggest that practitioners and program participants alike are uncomfortable talking about sex and intimacy and IPSV. This highlights the importance of building in multiple opportunities to 'practice' talking about sex and intimacy, and sexual violence, to introduce the topic where relevant to discussions of other behaviours, including for example discussions of coercive control and emotional abuse. Creating an environment where practitioners and perpetrators have multiple opportunities and avenues to discuss IPSV and sex and intimacy increases opportunities to identify IPSV and for perpetrators to recognise the impacts of IPSV. Further, findings support the need for considered attention to pornography, reproductive violence, technology-facilitated abuse, and of how sexual violence manifests in specific communities.

5. To ensure available and resourced workplace supports for practitioners to undertake perpetrator intervention work related to IPSV.

   This study highlights the importance of providing appropriate workplace supports to practitioners undertaking this work. While this is critical for all staff, there is a particular need to consider the impacts of this work on women who work with male perpetrators of IPSV, who may be more likely to experience workplace sexual harassment from clients. There is also a need to be conscious that practitioners may have lived experience of IPSV and to ensure suitable supports are in place for these practitioners.

6. To conduct further research on existing strategies that practitioners are using to identify, discuss and respond to IPSV perpetration to inform the development of improved training, resources and supports for practitioners.

The present study sought to identify how DFV perpetrator intervention programs identify, address, and engage with IPSV. Findings demonstrate that engagement is currently limited, and is stymied by a lack of training, guidelines, strategies and supports for practitioners to undertake this work. Further research on overcoming these challenges is required. Examining and documenting the existing strategies that practitioners are using to identify, discuss and respond to IPSV perpetration, and drawing lessons from where this is being practiced well is a critical next step to inform the development of training, resources and supports for practitioners.

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Appendix A: Overview of survey modules

Practitioner Information

Participants were asked a series of questions related to their work, including for example current and past role(s), jurisdiction, years' experience, training, and education. Participants were also asked one demographic question about gender. This item was included because of the standard one female, one male co-facilitator model preferred in behaviour change program minimum standards (see for example, Family Safety Victoria 2017, p. 10, standard 3.5; NSW Government 2017, p. 15, standard 4.2; Department for Child Protection and Family Support (WA) 2015, p. 16, standard 3.2) and perceptions of differences in the experiences of male and female co-facilitators in behaviour change programs (Apps and Gregory 2011; Blacklock 2003).[34]

Views on training experience

Participants were asked a series of questions about the training they have received related to IPSV. Participants who have worked as trainers were also asked questions about the training they have developed and/ or delivered. This included a series of five-point Likert scale questions about how participants formal and informal training had prepared them to identify and respond to IPSV. Possible responses ranged from not at all prepared (1.00) to very prepared (5.00).

Views on screening and risk assessment practices

Participants were asked about their screening and risk assessment practices in relation to DFV perpetration and victimisation. This included questions about assessment tool(s) used; frequency of assessing risk of IPSV perpetration and perpetration, and confidence that IPSV is identified where present. These questions were asked using a five-point Likert scale (1.00-5.00). Participants were also asked to estimate the proportion of cases where IPSV victimisation or perpetration was present and identified. These were asked as slider questions, where participants could indicate any value between 0 and 100. Participants working with victim-survivors were asked additional questions about their experience collaborating with MBCP practitioners to address identified IPSV behaviours.

Views on working with perpetrators

Participants were asked a series of five-point Likert scale questions about the nature and extent of their discussions related to sex and intimacy and IPSV with DFV perpetrators. For example, participants

[34] While this standard allows for variations in 'exceptional circumstances', it does not reflect the diverse genders of facilitators involved in behaviour change work.

were asked how comfortable they are discussing sex and intimacy and IPSV with DFV perpetrators in both one-to-one settings and group formats, as well as their perceptions of perpetrators receptiveness to the topics of sex and intimacy and IPSV.

Designing and developing perpetrator intervention programs

Participants who identified that they were involved in the design and development of perpetrator intervention programs were asked additional questions about program content. For example, participants were asked how often content related to sex and intimacy and IPSV was designed into DFV perpetrator programs (Always: 5.00 to Never: 1.00), and how confident they are developing content related to sex and intimacy and IPSV (Very confident: 5.00 to Very unconfident: 1.00).

Open-ended questions

Participants were also asked open-ended questions that enabled them to provide additional qualitative feedback about their experiences of training, risk assessment and screening practices and intervention practices as it related to sex and intimacy and IPSV.