‘JUST OPENS UP A WHOLE NEW POSSIBILITY OF CHANGE’

A Review of the Men Exploring New Directions (MEND) Online Program

MONASH GENDER AND FAMILY VIOLENCE PREVENTION CENTRE

2023

MONASH GENDER AND FAMILY VIOLENCE PREVENTION CENTRE

Acknowledgement of Country

We acknowledge the true custodians of the lands on which we meet and conduct our research and recognise that these lands have always been places of learning. The team involved in the MEND online program review work on unceded Boon Wurrung and Wurundjeri lands. We pay our respects to their Elders past and present.

Acknowledgements

The Monash Gender and Family Violence Prevention Centre review team would like to extend our gratitude to the affected family members who participated in this review and shared their stories with us. Your voices are critical to understanding efforts to improve perpetrator accountability and victim-survivor safety. We are extremely grateful for your contributions to this review.

We acknowledge the valuable contributions of program participants and key stakeholders who participated in this review. Thank you to program participants for sharing details about your experience attending the MEND online pilot program. Thank you to participating practitioners for sharing your professional expertise and insights with us.

The team gratefully acknowledges the financial and in-kind support received from No to Violence (NTV) and the Metamorphic Foundation towards this review. We further acknowledge the significant contributions of Men and Family Centre (MFC), who developed and delivered the online BCP for men in rural, regional and remote areas reviewed in this report, as well as Thorne Harbour Health (THH), who developed and delivered Clear Space, the online program for GBTQ+ men and non-binary people. The two programs were developed and delivered in parallel with significant cross-program support. Collectively, NTV, MFC, THH and ACON provided input into shaping the review design and support in relation to participant recruitment and data collection. We would also like to thank Elena Robertson and Ulla Inki-Gilabert for their support.

We would like to thank our Monash Gender and Family Violence Prevention Centre colleagues. Their valuable insights always enhance the quality of our work. Thank you also to Dr Amy Young and Professor Silke Meyer, who met with us early on in this project. We appreciate you sharing your expertise and your guidance in conducting this review.

Professor Kate Fitz-Gibbon contributed to this project in her capacity as Director of the Monash Gender and Family Violence Prevention Centre. This Review is wholly independent of Kate Fitz-Gibbon's role as Chair of Respect Victoria.

Suggested citation

Helps, N., McGowan, J., Fitz-Gibbon, K., Williamson, H., & Athwal-Yap, A. (2023). 'Just opens up a whole new possibility of change': A review of the Men Exploring New Directions online program. Monash Gender and Family Violence Prevention Centre, Faculty of Arts, Monash University. DOI: 10.26180/22126052

Support services

If you are concerned about someone using violence, call Men's Referral Service on 1300 766 491 or visit ntv.org.au/get-help/ for advice and support

1800RESPECT (1800 737 732) is a 24-hour national sexual assault, family and domestic violence counselling line for any Australian who has experienced, or is at risk of, family and domestic violence and/or sexual assault.

Men & Family Centre
Building safe respectful relationships

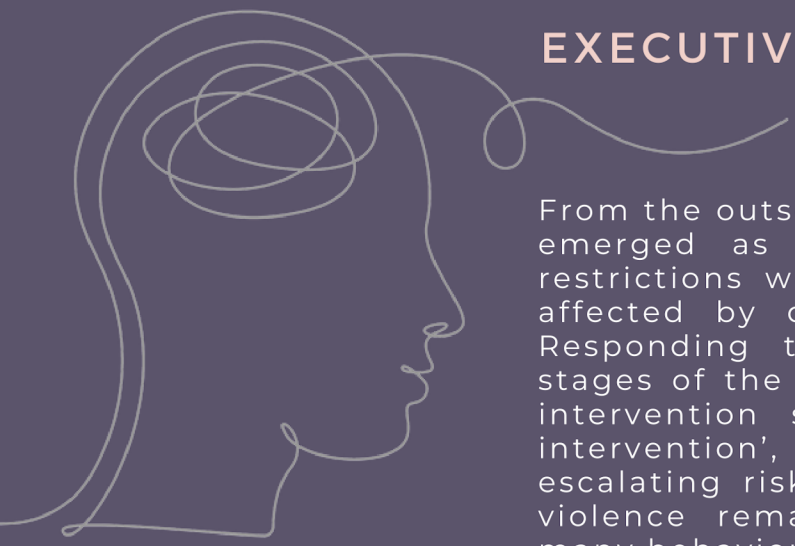
No to Violence
Leading the change to end male family violence in Australia

TABLE OF CONTENTS

TABLES & FIGURES

ACRONYMS

AA	Alcoholics Anonymous
ABI	Abusive Behaviour Inventory
AOD	Alcohol and Other Drugs
AVAW	Attitudes towards Violence Against Women
AVO	Apprehended Violence Order
BCP	Behaviour Change Program
DFV	Domestic and Family Violence
DVSAT	Domestic Violence Safety Assessment Tool
FSV	Family Safety Victoria
GBTQ+	Gay, Bisexual, Trans, Queer +
MFC	Men and Family Centre
MEND	Men Exploring New Directions
MRS	Men's Referral Service
MGFVPC	Monash Gender and Family Violence Prevention Centre
NCAS	National Community Attitudes Survey
NOSPI	National Outcome Standards for Perpetrator Interventions
NTV	No to Violence
THH	Thorne Harbour Health
WAI	Working Alliance Inventory



EXECUTIVE SUMMARY

From the outset of the COVID-19 pandemic, concerns emerged as to how the use of public health restrictions would impact the safety of individuals affected by domestic and family violence (DFV). Responding to such concerns, during the early stages of the pandemic, numerous DFV perpetrator intervention services entered a period of 'crisis intervention', working to identify and manage escalating risk and to ensure that people who use violence remained visible during a period when many behaviour change programs (BCPs) had paused in-person delivery. During this period of unprecedented change, rapid consideration was given to whether online BCPs could work as a safe alternative delivery format. In the Australian state of Victoria, where lockdowns were used heavily throughout the first two years of the pandemic, guidelines for perpetrator interventions during COVID-19 were developed by Family Safety Victoria in 2020, and several programs pivoted to online delivery. As we have now shifted to a phase of 'living with COVID', questions linger as to the effectiveness and need for online BCPs moving forward.

This Report presents the findings of a review conducted by members of the Monash Gender and Family Violence Prevention Centre in 2022-23 of the Men Exploring New Directions (MEND) online pilot program funded by No to Violence and developed by the Men and Family Centre. MEND is a 20-week online BCP for men in rural, regional and remote areas. The program's online format aims to ensure that BCPs are accessible to people who may not have access to in-person programs, which are typically located in metropolitan areas. While the provider (MFC) is based in NSW, participants can attend this online program from across Australia.

The MEND program was developed to cater to up to 10 program participants based in rural, regional or remote areas who would otherwise face barriers to accessing an in-person program. It is underpinned by a gender transformative approach that positions DFV perpetration within the broader social context of patriarchy, capitalism and colonialism. Topics include definitions of violence (exploring different forms of DFV); gender inequality; the man box (exploring societal norms and expectations of masculinity); victim-survivors' experiences of DFV; and impacts on parenting.

The review examined the delivery of the MEND online program. A mixed methods design was adopted, involving data collected across seven phases:

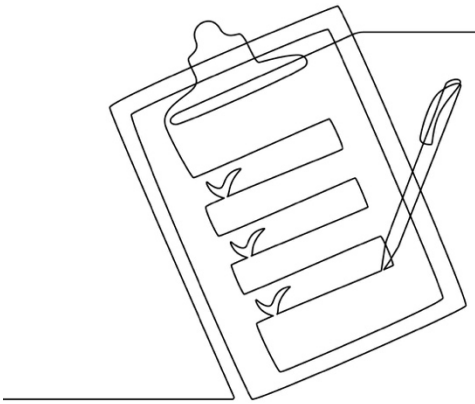
There is a dearth of research on the potential benefits of online BCPs in a range of contexts, including working with men in rural, regional or remote areas. This review thus represents an important opportunity to capture learnings about the development and delivery of a pilot online BCP.

While noting the limitations of this review, in particular the small number of participants and affected family members directly engaged, this report explores the potential for online programs to reach DFV perpetrators who otherwise might not attend a BCP due to geographical limitations, primary caring responsibilities or work commitments. The far-reaching accessibility of online programs, when considered with the lack of in-person interventions available to perpetrators in rural, regional and remote areas, stands to potentially benefit people who use violence and who face geographical barriers to engaging in timely interventions.

Drawing from the range of data collected, the review makes several findings that might enhance current program practice. Specifically, we explore the merits of co-facilitated intake assessments conducted by both facilitators, rather than one. While this process is resource intensive, it provides a valuable opportunity to build rapport between facilitators and program participants and enhances the safety of practitioners and participants. Recognising the need to explore all opportunities to better assess and manage risk of violence, the review also highlights the potential value of additional one-to-one work – pre-program, during the program and post-program.

In terms of the content and delivery of the pilot program, this review finds that there may be a need to limit the size of online BCPs. Practitioners engaged in delivering the program often had to cut conversations short to meet the set timeframes. Noting the challenges of ensuring engagement via online delivery, consideration should also be given to allowing greater flexibility in the length of sessions.

This review also highlights ongoing limitations around supports accessible to children and young people in the context of BCPs. There is increasing acknowledgement across Australia of the need to view children and young people as victim-survivors in their own right. This report draws further attention to the need to embed supports for children into the development and delivery of perpetrator interventions, including BCPs.



INTRODUCTION

From the outset of the COVID-19 pandemic concerns emerged as to how the use of public health restrictions, including periods of government-imposed 'lockdowns', would impact the safety of individuals affected by domestic and family violence (DFV).

While initial attention was understandably focused on the experiences and evolving safety needs of victim-survivors, a lingering concern emerged as to how perpetrators would be kept in view and held to account. Writing in the first year of the pandemic, Fitz-Gibbon, Burley and Meyer (2020) explained:

> … responses have been significantly hampered by the COVID-19 restrictions, which limit the ability of victims to seek help and highlight the need for others to step in and report suspected abuse. This raises the very real risk that new perpetrators will remain invisible for longer. Patterns of escalation among known perpetrators may also go "unchecked" unless they are monitored during this time of heightened risk.

Responding to such concerns, during the early stages of the pandemic numerous DFV perpetrator intervention services entered a period of 'crisis intervention', working to identify and manage escalating risk and to ensure perpetrators remained visible until group programs could resume (Vlais & Campbell 2020). Rapid consideration was given to whether online behaviour change programs (BCPs) could work as a safe alternative delivery format (Vlais & Campbell 2020), and guidelines for perpetrator interventions during COVID-19 were quickly developed in Victoria (see, for example, Family Safety Victoria [FSV] 2020).[1]

BCPs have been in operation for decades, yet until the pandemic, the shift to offer programs online had been slow and was often resisted. While some BCPs are offered online, particularly in the US, as Vlais and Campbell (2020) note, these are often self-paced educational programs with little supporting research. While other online programs were emerging prior to the COVID-19 pandemic (see, for example, Bellini & Westmarland 2021), lockdowns and social distancing measures accelerated the move online (No to Violence [NTV] 2022).

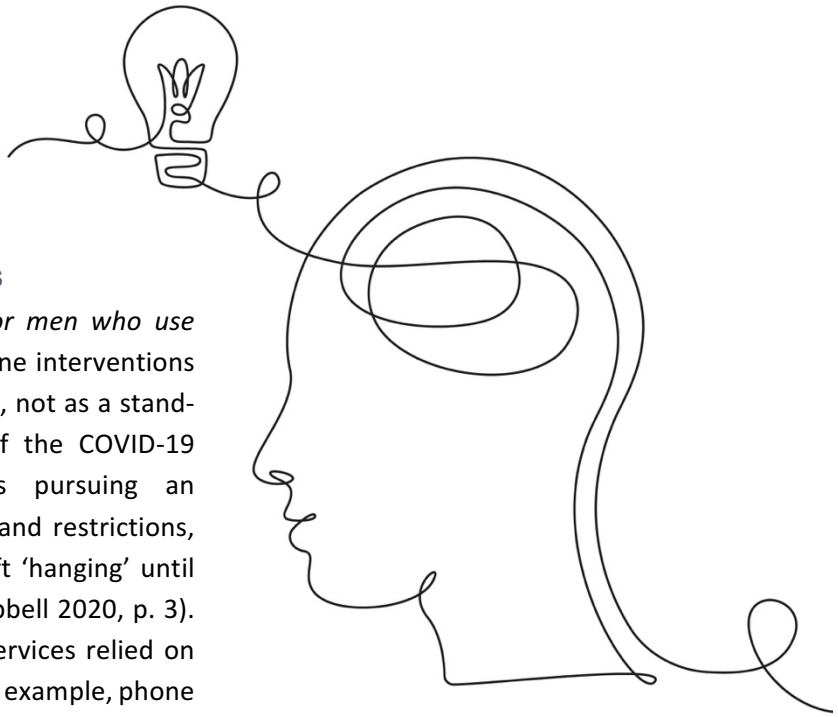
As pandemic-related restrictions began to ease, many service providers returned to in-person program delivery. However, questions remain about the place for online BCPs within the broader suite of perpetrator interventions. While there are some important studies in this space (see, for example, Bellini & Westmarland 2021), the potential benefits of online programs in various contexts, including for example, for working with men in rural, regional or remote areas remain under-researched.

In 2021 Men and Family Centre (MFC) was the successful respondent to an expression of interest put forward by No to Violence (NTV) to develop and deliver a 20-week online BCP for men in rural, regional and remote areas.[2] The Monash University research team was contracted by NTV to undertake the review of the MEND online program. Drawing on survey and interview data, this review highlights the potential value of online program offerings for reaching DFV perpetrators that otherwise may not attend a BCP due, for example, to geographical accessibility limitations.

[1] The dominant reference used within the sector is men's behaviour change programs (MBCP), however, this terminology does not capture the breadth of relationships in which family violence occurs, nor is it an accurate representation of the breadth of perpetrators who attend behaviour change programs. Here and in the Thorne Harbour Health (THH) Clear Space program review (see McGowan et al. 2023) we refer to behaviour change programs (BCPs).

[2] This program ran in parallel with a second online program for GBTQ+ men and non-binary people delivered by THH (see McGowan et al. 2023).

BACKGROUND



Online behaviour change programs

NTV's 2018 position paper *Online programs for men who use family violence,* recommended that current online interventions only be used as a supplement to in-person BCPs, not as a stand-alone intervention. During the early stages of the COVID-19 pandemic, particularly when Australia was pursuing an elimination strategy and relying on lockdowns and restrictions, concerns emerged about perpetrators being left 'hanging' until in-person programs could resume (Vlais & Campbell 2020, p. 3). While in-person programs were not possible, services relied on temporary one-to-one interventions through, for example, phone calls and videoconferencing (Vlais & Campbell 2020). As the lockdowns continued many service providers moved to online delivery. While online programs were being considered prior to the COVID-19 pandemic, the lockdowns accelerated this shift.

In their review of online programs – that included but was not limited to DFV perpetrator interventions – Spencer et al. (2021) found that the online programs were able to decrease participants' levels of emotional and physical intimate-partner violence perpetration. In their exploratory study of an online pilot program in Minnesota, US, Bellini and Westmarland (2021) found that men appeared to be more 'open' to sharing their thoughts and feelings than with in-person programs. They also found increased attendance compared to in-person programs that tend to be subject to weather conditions or health requirements (Bellini & Westmarland 2021).

Notwithstanding these benefits, facilitators in Bellini and Westmarland's study (2021) found it harder to gauge visual cues and/or engage men throughout online sessions, especially because they were not in physical proximity to each other and online program facilitators (Bellini & Westmarland 2021; see also, Vlais & Campbell 2020). Online video platforms also acted as a barrier for participants to speak to each other in a more organic manner at times, particularly when technical issues occurred (Bellini & Westmarland 2021; Vlais & Campbell 2020). Notably, facilitators expressed concern about not having control and/or the ability to identify men's behaviours that are normally disallowed during in-person sessions (Bellini & Westmarland 2021). Such behaviours that tend to divert attention away from online sessions often included the consumption of alcohol, cigarettes, or 'multi-tasking' by watching the television at the same time (Bellini & Westmarland 2021).

In these instances, the gap between reality and the 'performance' on video merely facilitates BCP completion, rather than an effective change in behaviour (Vlais & Campbell 2020). Additional and supplementary forms of intervention are, therefore, essential to gauge the impact of online interventions and the level of support that may be required to manage anger and the risk of violence in the future (Spencer et al. 2021). Moreover, not all perpetrators may have access to a foundational amount of software, bandwidth, or hardware necessary for the use of online interventions (Vlais & Campbell 2020). Further, there are concerns about privacy and the possibility of conversations within group being overheard or leaked to people outside online programs (Bellini & Westmarland 2021; Solove 2013; Vlais & Campbell 2020).

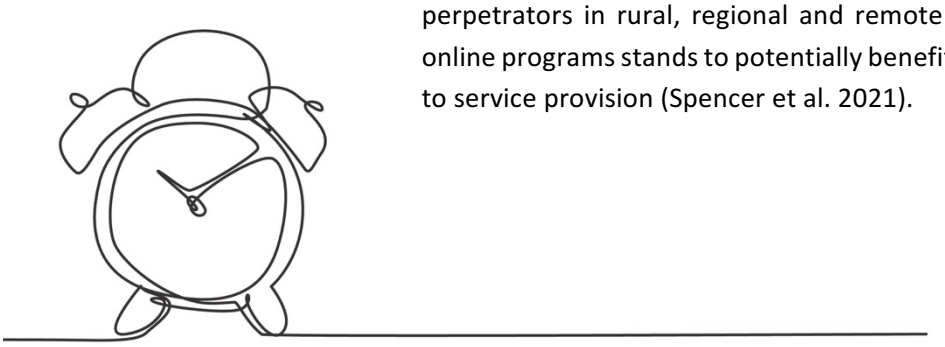
Notwithstanding these limitations, the impact of COVID-19 has significantly accelerated the shift to online services. This shift appears to act as a double-edged sword. On the one hand, the delivery of online interventions has helped to ease the caseload of service providers who have high proportions of higher-risk, higher-harm perpetrators – especially with many men being in precarious situations due to the loss of employment, income, and social connections as a result of the COVID-19 situation (Vlais & Campbell 2020). The ease of online interventions not only helped to manage the existing volume of caseload but, importantly, it also provided a much-needed response to the intensification of violence and its risk factors brought about by increased isolation (Vlais & Campbell 2020). On the other hand, online interventions have also been found to worsen existing home situations, especially when the distant mode of delivery and technical issues act as a hindrance, rather than as a form of intervention and support, as intended (Vlais & Campbell 2020).

While these studies support the potential value of online interventions, particularly for those who face barriers in accessing in-person programs, the shortcomings also indicate that more well-rounded services need to be integrated into BCP, including in-person interventions whenever required and/or available (Spencer et al. 2021).

Interventions for rural, regional and remote communities

Researchers underline that the perpetration of DFV in rural settings is unique. This is due to geographical and social isolation; an amplified sense of fear, stigma, and shame; and limited access to resources and support services, as compared to people experiencing violence in more populated areas (DeKeseredy 2015; Lanier & Maume 2009; Little 2017; Youngson et al. 2021). People living in rural communities are also at risk of significantly poorer psychological and physical health outcomes, as compared to the experiences of victim-survivors in urban settings (Edwards 2014). Victim-survivors living in rural areas are more likely to remain in abusive situations, especially because support services are lacking, while abusers can use coercive tactics in geographically vast regions, for example, lengthy law enforcement response time and fear of stigmatisation (Little 2017; Marr 2015). Critically, these circumstances do not only act as barriers to intervention and access to justice; they also often render rural victim-survivors vulnerable to more abuse, escalating forms of violence, economic control, and intimate partner homicide (Magnus & Donohue 2021).

The distinct nature of rurality, in which community members are geographically isolated from other parts of the country but share intimate social connections with each other, contributes to the normalisation of DFV acting as a barrier to the acknowledgment of violence and abuse and recovery following it (Dekeseredy, 2021; Walklate et al. 2019). In such close-knit communities there is often a reluctance to speak out and/or recognise violence, especially if reports of DFV are viewed as a 'petty' social issue for law enforcement, something that should instead be addressed between partners (Harris & Woodlock 2022; Magnus & Donohue 2021). Many victim-survivors are financially reliant on their abusers; they face poverty, higher levels of precarity, and/or homelessness should they leave their violent environment (Magnus & Donohue 2021).



In view of these circumstances, and the lack of in-person interventions available to perpetrators in rural, regional and remote areas, the far-reaching accessibility of online programs stands to potentially benefit individuals facing geographical barriers to service provision (Spencer et al. 2021).

The MEND online program

The MEND online program is a pilot program developed and delivered by MFC. NTV provided funding to MFC, and the pilot was initiated in 2022. The program's online format aims to ensure that BCPs are accessible to people in rural, regional and remote areas who may not have access to in-person programs, which are typically located in metropolitan areas. While the program provider (MFC) is based in NSW, as an online program, participants can attend from across the country.

The pilot program consisted of one 20-week program for up to 10 participants who were based in rural, regional or remote areas and would face barriers to accessing an in-person program. Prior to program commencement, participants were assessed for eligibility and readiness to engage in behaviour change work. Potential participants based in cities or other areas with access to in-person programs, or assessed as requiring additional individual work before being group-ready were deemed ineligible. Program participation involved attending four individual intake sessions, an orientation group session, 20-group sessions and an exit interview. There were additional optional individual sessions during the group, as well as an individual follow-up three months post-program. Topics explored during the 20-week program included definitions of violence (exploring different forms of DFV); gender inequality; the man box (exploring societal norms and expectations of masculinity); victim-survivors' (adult's and children's) experiences of DFV; and impacts on parenting (both self and co-parent).

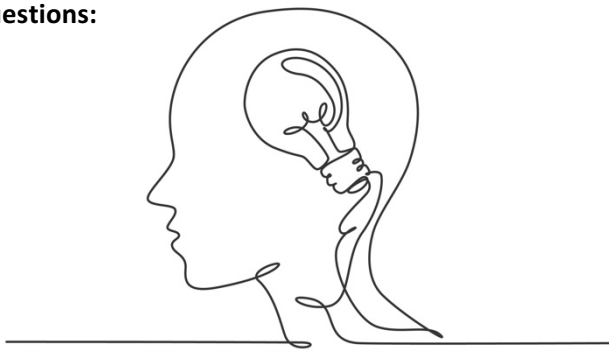
The program logic developed by MFC outlines that the program is underpinned by a gender transformative approach that positions DFV perpetration within the broader social context of patriarchy, capitalism and colonialism. It is this context of inequality and power inequity that gives rise to all forms of gender-based violence, including DFV (see further Our Watch, 2015). Informed by a gender transformative framework, alongside intersectional feminist principles, MFC work with people who use violence and with those affected by violence. In working with DFV perpetrators towards perpetrator accountability and the safety of women and children, the MEND online program is grounded in both the Duluth model and cognitive behavioural approaches to perpetrator intervention.

METHODOLOGY

Researchers from the Monash Gender and Family Violence Prevention Centre (MGFVPC) were contracted by NTV to undertake a review of the MEND Online pilot program, which ran from June to November 2022. The review examines the delivery of the MEND online program developed and delivered by MFC. To explore the delivery of an online intervention tailored to men in rural, regional and remote areas, we adopted a mixed-methods design. It included quantitative analysis of measures of client change collected from program participants and affected family members at the time of the men's program commencement, at its mid-point and at its conclusion; and qualitative analysis of interviews conducted with program participants and affected family members at program conclusion. Additional qualitative feedback was obtained via focus groups conducted with key stakeholders.

This program review is informed by the following four research questions:

1. What is the need for online BCPs?
2. What are some of the perceived benefits of online BCPs?
3. What are some of the challenges of delivering BCPs online?
4. How do online interventions impact family safety?



Data Collection

Several data sources were used as part of this review of the MEND online program. Specifically, there were seven phases of data collection as shown below in Figure 1.

Figure 1: Phases of data collection

1. Surveys with affected family members (undertaken at intake, mid-program and conclusion)
2. Surveys with program participants (undertaken at intake, mid-program and conclusion)
3. Interviews with affected family members (conducted at program conclusion)
4. Interviews with program participants (conducted at program conclusion)
5. Stakeholder small group interviews (conducted early in the program and at program conclusion)
6. Group observations (undertaken at four points throughout the program)
7. Community of practice observations (undertaken monthly)

Details of the approach taken to collect data during each of these phases are provided below.

Affected family member and program participant recruitment

Recruitment of affected family members was facilitated via the family safety contact (FSC) worker, who informed affected family members of the review early in the program. Contact details of those affected family members who were happy to be contacted by the Monash review team were provided to us by the FSC worker. Four affected family members consented to be contacted. We shared explanatory statements with information about the program review via email and we contacted each affected family member via telephone. Verbal consent to participate was also sought at this time.

MFC staff informed program participants of the program review during their intake assessment. All program participants were provided with an explanatory statement. MFC staff collected written informed consent from participants who agreed to be contacted by the Monash review team. At this stage, eight of the nine participants who enrolled in the program consented to complete the intake survey, and to be contacted for further data collection. The intake survey was facilitated by MFC staff.

Verbal consent processes were then completed at each further point of contact (program mid-point and conclusion) with both affected family members and program participants. At the conclusion of each contact, affected family members were asked if they would like a follow-up support call from the FSC worker, and program participants were asked if they would like a call from one of their case managers at MFC. Where this was requested, this information was passed to the relevant MFC staff member by the Monash review team.

To acknowledge the contribution of affected family members in the review, a $25 voucher was provided following each survey, and a $50 voucher was provided following the final survey and exit interview. Program participants' involvement in the review was also acknowledged through a $50 voucher following the final survey and exit interview.

Survey instruments

Project Mirabal measures

Affected family member surveys consisted of six measures from Project Mirabal, including respectful communication; expanded space for action; safety and freedom from violence and abuse; awareness of self and others; shared parenting; and safer, healthier childhoods (Kelly & Westmarland 2015). Two additional measures were included in the survey instrument to give an overall rating of safety and quality of life. All items were asked on a scale from always (1) to never (5), except the safety and freedom from violence and abuse items, which asked for a binary yes or no.

Attitudes about violence towards women – National Community Attitudes Survey

The Attitudes towards Violence Against Women (AVAW) questions are from the 2017 National Community Attitudes Survey (NCAS) (Webster et al. 2018). The AVAW measure includes 35 items asked on a scale from strongly agree (1) to strongly disagree (5). These items were included to capture attitudes that excuse the perpetration of violence and perpetuate victim-blaming.

Program readiness

The program readiness scale was adapted from the Survey of Readiness for Alcoholics Anonymous (Kingree et al. 2006). This scale has not been validated for use with BCP participants. The measure consists of 15 items asked on a scale from strongly agree (1) to strongly disagree (5). These items were utilised in this review to capture participants' attitudes towards participating in the MEND online program.

Working Alliance Inventory

The Working Alliance Inventory (WAI) short form included 12 items asked on a scale from strongly agree (1) to strongly disagree (5). The WAI captures the relationship between program participants and the group facilitators, for example, agreement on behaviour change goals (Hatcher & Gillaspy 2006).

Interviews

Interviews with affected family members included questions about their relationship status and living arrangements; children; if/how the program had influenced their (ex) partner/other family members' behaviour; their quality of life; their experience with the FSC worker; views on what the program provider could have done differently; and hopes or concerns for the future, particularly related to their (ex) partner's/other family members' behaviour.

Interviews with program participants included questions about their relationship status and living arrangements; relationship with children; how they came across the MEND online program; experience of referral; motivation for attending the program; if/how their behaviour, including parenting, has changed over the course of the program; their understanding of family violence and its impact; program views; experience with the online delivery format; and access to supports.

Stakeholders were recruited by the Monash review team via email. Explanatory statements and consent forms were also sent via email. Stakeholders expressed their interest to participate in an interview via email, and a mutually agreed time was established. Written consent forms were returned via email. One stakeholder interview was conducted with three practitioners early in the program. This provided an opportunity to explore early challenges related to program design, set-up, recruitment and program delivery. At the program conclusion a further two interviews were conducted, each with two practitioners (including three who participated in the first stakeholder interview). These final interviews provided an opportunity to explore practitioners' experiences delivering the program online; their reflections on participant engagement; on disengagement and behaviour change; their experiences of managing safety and risk in the online space; of providing support to affected family members (FSC worker); and of community of practice.

All surveys and interviews with affected family members and program participants were conducted via telephone; stakeholder interviews and group observations were conducted via Zoom, and community of practice observations were conducted via Teams.

Observations

The Monash review team observed four group sessions over the course of the MEND online program. The observations were a valuable method for gaining insights into the program content and facilitation. Further, the observations informed the interviews, enabling the review team to ask specific questions around program content and experiences. Observations also provided an opportunity for program participants to meet the review team prior to being contacted by the researchers. This may have aided participant comfort and engagement with the program review.

The review team also observed the monthly community of practice sessions. These sessions were facilitated by NTV and attended by stakeholders from NTV, Thorne Harbour Health (THH), MFC, ACON and the Monash review team. They were an opportunity for stakeholders involved in the design, development and delivery

of the two concurrent programs, MEND online and Clear Space, to come together and discuss challenges and areas for improvement and practice learnings as the programs developed. Observations of the communities of practice sessions by the Monash review team allowed us to gain insights into practice challenges as they arose. This further informed the questions asked during the stakeholder interviews.

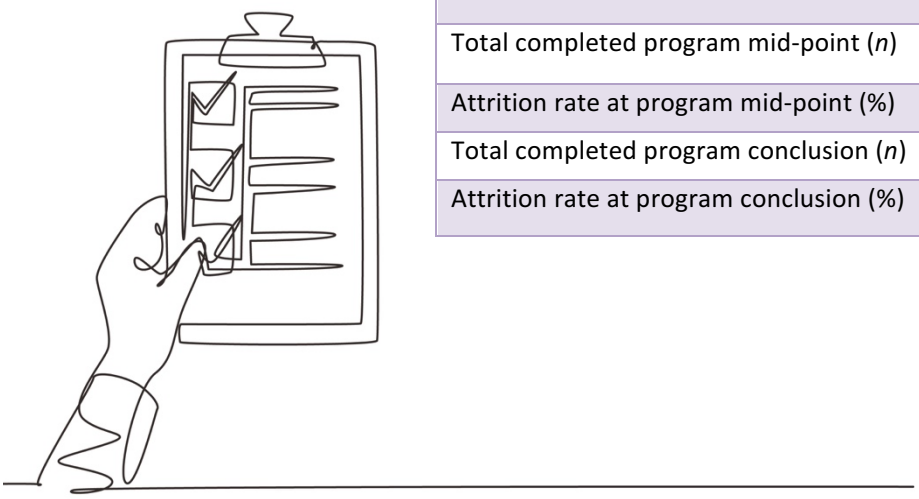
Response rate

Nine participants commenced the MEND online program, and eight consented to participate in this program review. As shown below in Table 1, eight program participants participated in the initial data collection and consented to be contacted by the Monash review team. Only six program participants completed the mid-point survey, but this was maintained, with all six participants completing the final survey and exit interview at program conclusion. This represents an attrition rate of 25 per cent between the intake and mid-point surveys. One participant who dropped out between the intake and mid-point surveys was early exited from the program at week 5 due to missing more than three sessions in a row. This participant was still contacted for the program review but declined to participate.

Twelve affected family members were contacted by the FSC worker; of these, seven responded initially to the FSC worker and four requested some form of ongoing contact. All four of these affected family members consented to be contacted by the Monash review team. As shown below in Table 1, four affected family members participated in the early program survey and completed the mid-point survey. Only one affected family member participated in the final program-conclusion survey. Over the course of the program, two affected family members also disengaged from the FSC. Two affected family members completed an exit interview, including one who completed this at mid-point when their (ex)partner/other family member was early exited.

Table 1: Response rates

	Program participants	Affected family members
Total completed intake/early program (*n*)	8	4
Total completed program mid-point (*n*)	6	4
Attrition rate at program mid-point (%)	25.0	0.0
Total completed program conclusion (*n*)	6	1
Attrition rate at program conclusion (%)	0.0	50.0[3]



[3] One affected family member completed the exit interview at the program mid-point, as their (ex)partner/other family member stopped attending the program. The attrition rate is calculated based on the two affected family members who stopped participating in the program review between mid-point and program conclusion.

Data analysis

Descriptive statistics for survey data are presented throughout this report. Due to data limitations, including the small sample size, analysis is limited to descriptive statistics of change between program intake and midpoint within each survey measure. Averages for affected family member data are presented throughout to further anonymise findings. Items were reverse coded where appropriate. Qualitative data was analysed thematically, with themes developed by the review team based on emerging themes within the interview datasets from affected family members, program participants and stakeholders. Each affected family member and program participant was assigned a pseudonym and each stakeholder was assigned a practitioner number. These identifiers are used throughout this report to ensure anonymity.

Participant samples

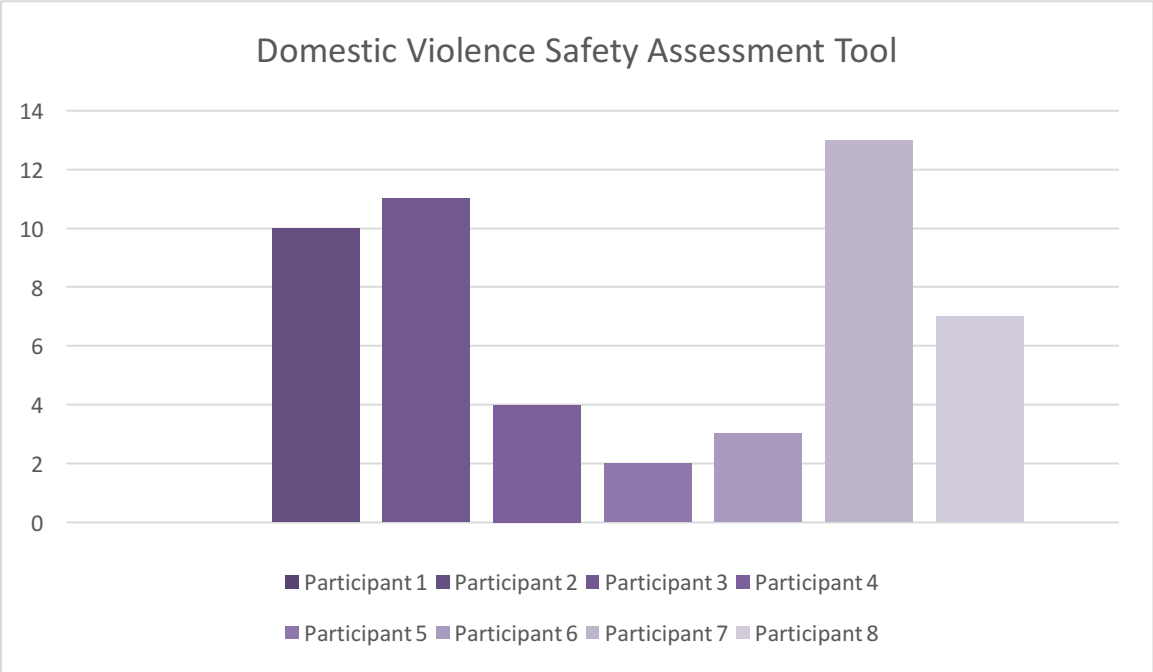
The majority of participants reported being born in Australia (*n*=6), with one participant stating they were from Chile and another participant stating they were born in the UK. One participant identified that they were both Aboriginal and Torres Strait Islander. The average age of participants was 41 years. All participants who responded to the survey question identified as being male and heterosexual. One participant advised that they had schizophrenia. No other participants identified having a disability. Seven participants reported having a partner (one of whom advised they were married), while one other participant stated they were single. Regarding participants' former relationships, three participants had no contact with them, while one participant stated they did have contact. All eight participants who completed the survey stated that they had children. Six participants reported having contact with their child(ren), while two stated that they have contact with some but not all children. Three participants identified that they had been issued an Apprehended Violence Order (AVO). Two of the three participants stated they had contact with the aggrieved party, while one reported that they have a 'no contact' order with their former partner. All three participants were required to attend court, and two of those had previously breached AVO orders.

Two participants reported that they had previously participated in a BCP, while the remainder of the sample had not (*n*=8). Participants were also asked about their alcohol and other drug (AOD) use. Four participants stated that they had been heavy drinkers but had stopped drinking. Three participants provided reasons for ceasing their alcohol use: one could not consume alcohol as a condition of their parole order, one was motivated to cease drinking by their children, and another was attending Alcoholics Anonymous (AA). One participant had a previous court request for AOD counselling. The remaining three participants who responded to the question related to alcohol consumption stated that they drank socially. Further, three participants identified past methamphetamine use and three participants identified marijuana use (two past, one present).

Program participants were also asked if they received any external support. While two participants stated that they were not receiving any support, two reported that they were involved in a parenting program, with one of these participants also attending an anger management program. One participant stated that they were speaking to a psychologist, while another participant reported that they were seeing a psychologist and attending an AA group. One participant outlined that while in jail, they had attended a counselling program for violent offenders, as well as a drug and alcohol program, and received peer support for trauma. They also mentioned that they accessed counselling when needed.

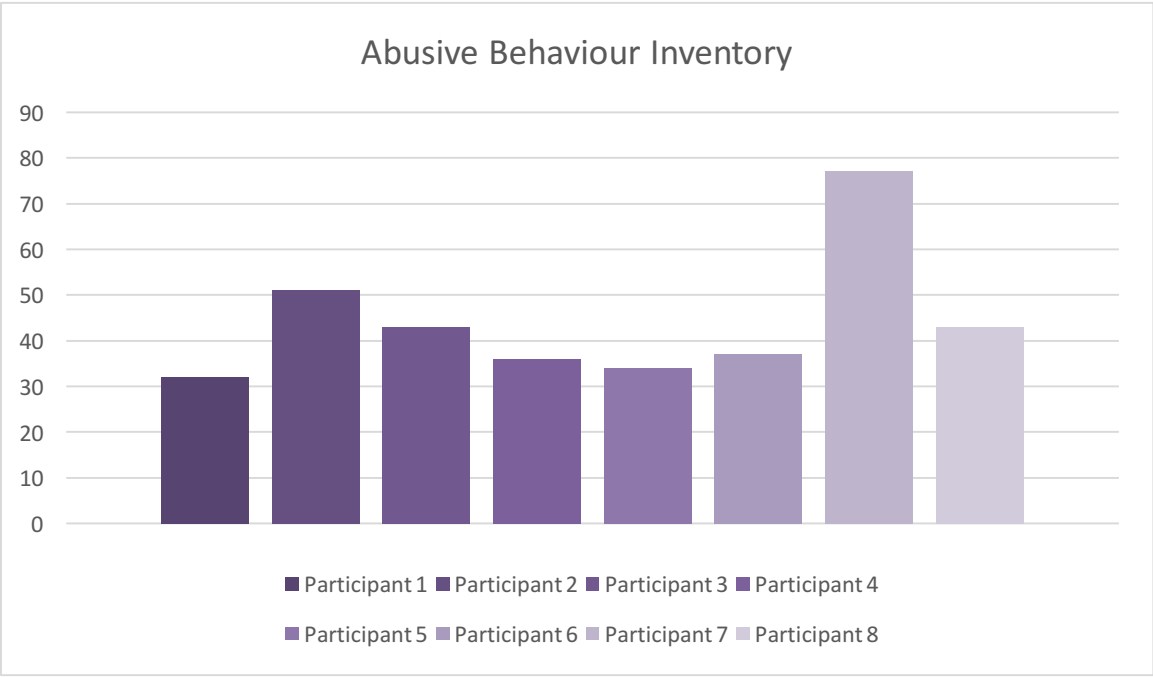
As part of the MFC intake and risk assessment processes the abusive behaviour inventory (ABI) and Domestic Violence Safety Assessment Tool (DVSAT) were conducted with each program participant. This data provides a risk profile of program participants at intake. The results are presented below in Figures 2 and 3.

Figure 2: Domestic Violence Safety Assessment Tool (DVSAT) results



Participants were asked to respond to 25 yes/no questions that sought to gauge the risk they posed for engaging in DV. Scores of 1 or more demonstrated that a participant was at-risk of committing an act of DV, and scores of 12 or more indicated that they were at serious risk of committing an act of DV (minimum = 0; maximum = 25). As shown in Figure 2, all participants demonstrated a level of risk (Mean = 6.25; SD = 4.71; Range = 2-13). Only one participant (Participant 7) received a score over 12, which suggests they present a serious risk of perpetrating further DFV.

Figure 3: Abusive Behaviour Inventory results



The ABI consists of thirty items that measure the frequency by which participants engaged in abusive behaviours. Higher scores were associated with greater frequency of self-reported abusive behaviours (minimum (never) = 30; maximum (very frequently) = 150). On average, participants reported low levels of abusive behaviour (Mean = 44.13; SD = 14.62; Range = 32-77; see Figure 3).

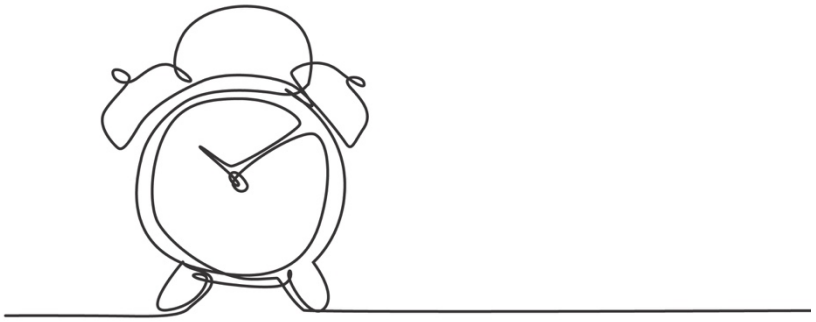
Due to the small number of affected family members (*n*=4) and the potential identifiability of affected family members to participants within the program, no affected family member sample details are provided in this report.

Limitations

This review is subject to several limitations. First, as is common in BCP research and FSC uptake more broadly (see, for example, Chung et al. 2020), very few affected family members participated in the program review (*n*=4). The Monash review team was only able to contact affected family members who had contact with the FSC worker, as the FSC worker facilitated this contact. While this practice ensures that affected family members are connected to supports via the service provider, and are not being cold-contacted by the review team, this also results in no review data related to affected family members who did not engage with the FSC.

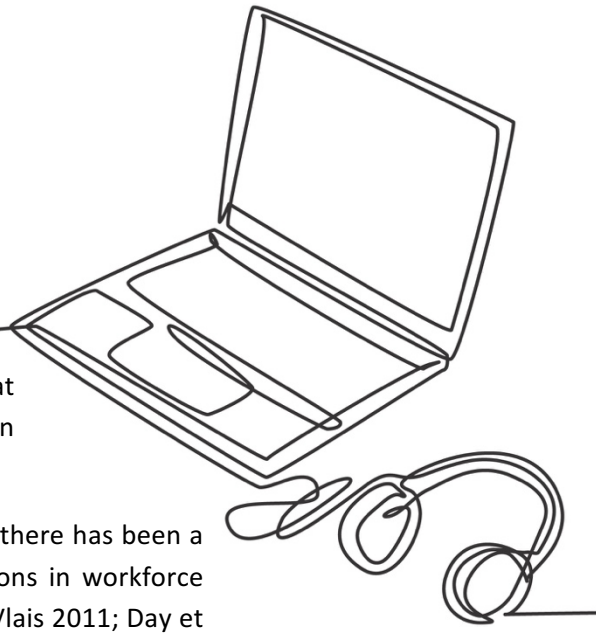
Further, only one affected family member participated in the final program exit survey. Due to this limitation, quantitative data is only presented for program intake and mid-point. The absence of program completion data is a significant limitation and any reported change between intake and midpoint suggested by survey measures should be interpreted with caution. The lack of program completion and post-program data also further limits the capacity to document reported behaviour change (or lack thereof) over the course of the program.

The review is also limited to a very small sample size of only six program participants and one affected family member who completed all stages of the data collection process. This limits the statistical analysis that could be conducted. Due to the small sample size, the findings presented in this report are not generalisable beyond the participant sample. Further, some of the scales utilised have not been tested for validity and reliability and should be interpreted with caution. It is also possible – across all survey items, but particularly regarding the attitudes about violence towards women scale – that answers reflect socially desirable responses. Explicit attitude items are subject to risk and biases and may be influenced by perceptions of socially acceptable responses (Webster et al. 2018). The emphasis within the findings is placed on learning from the qualitative data. While still limited to a small sample, the qualitative data provides deeper insights into the experience of delivering BCPs online.



FINDINGS

Referral, recruitment and intake challenges



There is increasing recognition in Australia and internationally that BCP work is highly specialised and skilled work, and that its effects can lead to staff burnout (Bahner & Berkel 2007).

In recent years, in many instances as a result of additional funding, there has been a significant increase in demand for the BCP workforce, yet limitations in workforce capacity have made recruitment of suitably qualified staff difficult (Vlais 2011; Day et al. 2018). One of the early challenges that arose during the MEND online program development was recruiting staff to facilitate the BCP, in particular, recruiting a qualified male facilitator. As one practitioner explained:

> *We did put advertisements out through different channels, including the NTV newsletter, national newsletters, and ethical jobs [...] we also put a call amongst our own workplace, [...] we weren't receiving applications from qualified men, and it was quite obvious that that is a gap, an incapacity within the sector, I suppose, that there's not that many available, qualified men to do this work. And I think that's something a lot of men's behaviour change program find [...] over the process of really starting to need a facilitator, I approached [someone already working as a facilitator internally …] otherwise I'm not sure where we would have gone with that, considering there was just not really adequate interest. (Practitioner 3, early program interview)*

Minimum standards in several Australian state and territory jurisdictions, including in NSW where the program provider is based, stipulate that there should be a one-male and one-female facilitator for each program session (see, for example, NSW Government 2017, p. 15; see also FSV, 2018).

Once the program staff were employed, there were additional recruitment challenges experienced in trying to recruit men into the program. This being a pilot online program, the service provider did not have well-established connections with potential referring services beyond the local area. This presented as a challenge during the initial participant recruitment phase. Two practitioners commented:

> *Without a pool of men, in a way, waiting to do the group, it's very difficult to establish that clientele base. [...] it's not easy – it's not only not easy to get facilitators, but it's not easy when you are not established with a clientele base, to build that up. That takes time. (Practitioner 1, early program interview)*

> *Being a group that didn't exist before as such. Obviously, it did in our own location, but we are a small regional service, so we aren't widely known [on a …] national scale. So, having to develop relationships with other services, and kind of establish that we are accredited, and that they will trust to refer to us [...] it's having that actual personal relationship with other services. (Practitioner 3, early program interview)*

Once these referral pathways were established, referrals were more forthcoming, and practitioners reported that some had to be turned away once the program had started, as the program was a closed group (i.e., no participants could join the group once the program had started, even if places became available through, for example, participants exiting). Five of the eight program participants who participated in the review were referred by the Men's Referral Service (MRS). The online pilot program was designed to engage men located in rural, regional or remote areas who would otherwise not have access to a program, as such there was a need to establish networks beyond the service's existing catchment area. While this challenge was ultimately overcome, the experience of struggling to recruit participants reflects the disconnect between referring agencies and service providers, and the reliance on established networks. Consequently, there are long wait lists for services in some areas even as other services are struggling to recruit for programs that are ready to commence. This disconnect has been raised in other research (Fitz-Gibbon et al. 2020; Meyer et al. 2023) and highlights the ongoing need for state-wide coordinated referral pathways that connect referring agencies and service providers.

When reflecting on the referral pathways they took into the program, participants often spoke about the point at which they decided to enter a program – when their own motivation or desire to address their behaviour reached a critical point. This was often associated with a moment of realisation that their behaviour was not acceptable. For example:

> *I hit the alcohol too hard, and I get to a point where I black out [...] the arguments got a bit more serious, police were involved [...] that was the point that actually got out of control to a point where I thought, "Well, that's it, I'm losing everything if I don't seek help." [...] I had a friend, and he went through a similar problem [...] he talked to me about men's behavioural program thing that he was doing [...] he was talking to me about how to change things and see things differently. […] and I thought, "You know, if this guy can change, maybe I've got a chance too." (Cary, exit interview)*

> *I just decided to take it upon myself to find something to help me change my behaviour. I just got online and rang around a bit. I certainly wasn't prompted by anybody else to do that. [...] I just realised that I had to do it. [...] A police officer actually contacted me the next day and she was sort of like support for me, yeah…. So maybe I did speak to her about some stuff and I said, "I really need to do something." I think she might have given me something [referral information]. It's a fair while back now but, yes, I did speak to a police officer who actually worried about me about how am I feeling and am I okay which was really good. I didn't expect that. So maybe I did get a little bit of support from the police in regards to that. (Daniel, exit interview)*

> *[I] was witnessing myself, it coming out on the kids, and that wasn't acceptable to me. I was like, I need to do something about this [...] I actually spoke with a couple of therapists and people about it [...] I said, look, I think I need to actually just look at where this anger and frustration is coming from. Surely, there's an anger management program, or whatever, that can help me. They were like, "I don't think you need that" [...] Maybe for me that was just normalising it, it was just like, well, everyone gets frustrated with their kids, and your ear turns like that. It was just like, no, that's not good enough for me. (Neale, exit interview)*

For Cary, there was a moment of feeling that if he did not do anything about his use of violence he would lose his family. Cary discussed the desire to reconcile and be with his family as a motivator throughout the interview (p. 16). There was also an important role for a friend who had attended a program previously in normalising the idea of attending a program. Participants in this review expressed embarrassment about attending the program and about the prospect of people knowing they were attending the program. One of the items asked in the program readiness scale is 'going to the group program can be embarrassing to me'; at intake 50.0% of participants (*n*=4) reported that they strongly or somewhat agree, at the program mid-point three participants (50%), and at program exit 33.3% (*n*=2) of program participants agreed that this was embarrassing.[4] However, the example from Cary also highlights how valuable disclosing attendance can be for encouraging others to attend programs. For both Daniel and Neale, services played a role in their pathway into the MEND online program. For Daniel, the police were supportive and encouraging of him attending a program. By contrast, Neale's interactions with support services, through therapists, presented as a barrier to identifying his behaviour as a problem and identifying the most appropriate intervention for his use of violence. (Initially Neale thought he might need an anger management program.) This highlights challenges in identifying DFV perpetration and providing appropriate referral pathways; numerous service settings outside the men's service and DFV space often fail to identify people who use violence (Meyer et al. 2023).

Prior to the group work commencing, participants attended four intake sessions with the program's co-facilitators. For facilitators, as well as the service provider more broadly, this was their first time conducting four intake sessions with every participant. Practitioners reflected that this foundational work ensured participants were well-prepared for the group sessions:

> *The four assessment sessions I think were a really good number, because that enabled time for the participant's story, what was happening, what was coming up, to get to fill out that background, as well as complete what needed to be done. (Practitioner 1, early program interview)*

> *We were doing the work in the intakes, so everyone was really group ready [by the end of the four intake sessions], and really had brought in – yeah, it was a great beginning. (Practitioner 2, exit interview)*

In reflecting again at the end of the program, Practitioner 1 spoke about how additional intake sessions may be held when a need has been identified, but in other cases intake may only function as a tick-box assessment:

> *I've not experienced that [four intake sessions] before, unless there's been a lot of casework done [...] It was just an ideal situation, I felt that [co-facilitator] and I were able to do that, and bring, and respond individually with say a skill, or a feedback, or a calling on behaviours that weren't okay. Emotionally holding [...] being able to meet each participant where they're at in the assessment process, [...] And yes, resource-heavy, as compared to two sessions, where just really the lists [assessment forms] are [filled out]. (Practitioner 1, exit interview)*

These reflections highlight the value of one-to-one work pre-program, and the importance of creating space – and investing in the creation of space – that allows more in-depth work to be conducted. The nature and extent of pre-program one-to-one work varies between programs and across jurisdictions. For example, the

[4] Eight participants completed the intake survey, however, only six participants completed the mid-point and exit surveys.

Caledonian model, which originated in Scotland, positions pre-program one-to-one sessions as an essential component of behaviour change work, and the program incorporates a minimum of 14 pre-program sessions (Ormston et al. 2016).

In addition to conducting four intake sessions with all participants, the MEND online program also represented the first time the facilitators had experienced conducting intakes together. Practitioners similarly spoke about the co-facilitation model as an ideal situation:

> *The process of doing all the intakes together really helped build rapport between us [...] We pick up on different things, we're presenting as no-one has a particularly closer relationship with one of the practitioners [...] It's something that doesn't happen in the face-to-face work […] In the office it's myself doing the intakes, and then a female facilitator comes in, a group of men, sometimes hasn't met any of them before, and it just creates this imbalance. (Practitioner 2, early program interview)*

> *It was happening simultaneously that trust building, that working together, checking in with each other […] It's almost like you can't separate the engagement with the participants, and the building of the co-facilitation relationship, and the familiarity with the process. Each of those was building on one another as we went along. (Practitioner 1, early program interview)*

> *The dual practitioner, like dual facilitator intake model, I think that's worked really amazingly. Also, both for the fact of the facilitators developing a stronger relationship, which I think is just so crucial for safety in the group for both practitioners and clients, participants. But then also for the safety of when we have a man and woman model, which is often the case for men's behaviour change. A dual facilitator model also enhances the safety of the woman in the room and it not being seen – men who are in these groups are typically going to hold some misogynistic and sexist attitudes, and these guys tend to see the male facilitator as the leader of the group, and the dual-facilitator intake model can ameliorate this. (Practitioner 3, exit interview)*

As the program start date drew closer, some intake sessions were run individually rather than with both facilitators. This was done out of necessity, so that all the intakes could be completed prior to the start of the group sessions. While further research is required with larger sample sizes to explore the impact of additional pre-program intake sessions, and the effect of conducting intakes collaboratively, the experiences of practitioners in this program highlight the potential value of these approaches.

Motivation

Participants were asked by the program facilitators at intake what motivated them to attend the program. Motivations documented on intake forms include to be a better parent (*n*=3), partner (*n*=2) and person (*n*=3), wanting to learn coping strategies (*n*=2) and to positively change their behaviours (*n*=4). Participants also spoke about wanting to improve their relationships. The most common motivator listed was children (*n*=6), and other motivators included acknowledging problematic alcohol use, and as a condition of parole.

In the exit interviews, participants reported a range of motivating factors that brought them specifically to the MEND online program. This included, for example, wanting to return to the family home and reconciling with their partner and children:

> *I wanted to come home. I wanted to continue my life as a father of my children and not have everything just fall apart, because I was losing reality. I was – I don't know, I was somewhere else. (Cary, exit interview)*

In their systematic review, McGinn et al. (2020), found this motivation to be reported across previous studies. Further, one study in their review (Gray et al. 2014), found relationship breakdown to influence program dropout. Other participants spoke about wanting to change their behaviours:

> *I just didn't want to hurt my family anymore. When that happens you become isolated for a period of time until everything settles down and people forgive you. But I just didn't want that to happen anymore. (Daniel, exit interview)*

> *My behaviours were unacceptable, and that was it. Full stop. I need to, want to, change, it's a non-negotiable. (Neale, exit interview)*

For Neale, the length of the program was also described as a motivating factor. Neale spoke about signing up for a 20-week program as indicative of his level of commitment:

> *The one thing that I loved about the program was that it was a 20-week program. Because it was me saying, all right, it stops now and I'm going to do something more permanent, longer term, to commit to doing a change. It doesn't feel like something, I don't know, a free online, two-week course and then be solved. Do you know what I mean? And so it was much more so about going on a journey. (Neale, exit interview)*

Some participants reflected that at the beginning of the program they did not feel they needed to attend the group:

> *I did just more so – I didn't feel as though I needed it myself, but I more so done it so the courts they didn't have – use that against me so to speak. [...] It wasn't actually court ordered, but I went ahead and done it off my own back just to show the courts that I didn't have any issues with that sort of thing. (James, exit interview)*

> *First, I was like, "This is not the program for me." And then when I got to know the other people and the situation they were in, and I sort of thought, "Oh, this program might be handy for me, because it's about how you treat your kids, how you treat your partner." […] at the end of the day, I honest think I probably needed it, because of my attitude and my verbal situation towards them, towards my ex-partner was really poor. (David, exit interview)*

While David reflects that his position changed over the course of the program and he realised that he needed to be in the group, James continued to maintain the view that he did not need to be in the group. The breadth of motivations presented by participants reflects the evidence on motivation to attend groups more broadly. Other studies have highlighted similar motivations related to reconciliation, wanting to change, and wanting to fulfil conditions set by criminal justice bodies including courts (McGinn et al. 2020; Meyer et al. 2021).

Interestingly, while children were discussed as the key motivator documented in the intake documents, few participants (*n*=1) spoke about their children when discussing motivation to attend the program in the exit interviews. Children were discussed in other ways, as this report illustrates (for example, in discussing the impacts of their violence or wanting to improve their relationship with their children); however, for these participants children were not necessarily front of mind when reflecting on their own motivations to initially attend the program.

Participants were also asked whether their motivation shifted over the course of the program, and in particular, if there were any weeks when they felt they did not want to go to group, or would choose not to attend. Only one participant spoke about not wanting to attend some weeks:

> *There was a few times I felt like I didn't want to attend, because I felt like I didn't belong there. Yeah, I spoke to one of my [family member] and they said, "You need to do it. It's going to help you, and the way you connect with your family." (David, exit interview)*

As David states, the feelings of not belonging in group returned a few times. Further, as discussed above, David reported that at intake he felt "This is not the program for me" (p. 16). For David, the influence of family members encouraging him to attend was important for getting him to show up. Other program participants might not have these influences encouraging them to attend each week. These participant reflections highlight the value of ongoing motivational work – whether from a family member, as occurred for David, or from another source – to ensure participants stay engaged and continue to attend the program.

During the exit interviews, one affected family member also reflected on her (ex)partner/other family member's low motivation to attend, particularly when there was a requirement to speak to the group:

> *He didn't really like doing it, because he doesn't like – One time, they had to talk in front of – talk about their problems, and he doesn't like to do that. But he did it. He did it, but he used to say, "Oh, no. I've got to do that program again tonight," and he wasn't real thrilled about it. (Chloe, exit interview)*

Contributing to conversations and participating in activities, including activities that can be uncomfortable, is an important part of taking responsibility for using violence and being held accountable. Other studies have noted the importance of building rapport with facilitators and other group participants for men to be comfortable opening up to the group (O'Connor et al. 2022). The way that having to speak about problems in front of a group can influence disengagement highlights the importance of ongoing motivational and readiness work.

Only one participant (David, discussed above), spoke about motivation shifting throughout the program. However, David's experience was not unique. Practitioners also observed varying levels of engagement throughout the program:

> *Engagement, that was very stepped all the way along and grew. You could pick up when somebody was withdrawing, or yeh you could pick up just as you could in a [in-person] group, that energetically. I think there was a tolerance perhaps, like of the horizontals, we'd pick up on some things. And even one of them when he fell asleep towards one of the last sessions, and that was mentioned and he was really quite, didn't deny it, that was a really good start. And yeh, really engaged, he engaged more and more over the time of the group. (Practitioner 1, exit interview)*

> *Some people were quite horizontal, and they wouldn't be so reclined if they were face-to-face. [...] My sense is that it didn't negatively impact engagement. [...] I've had participants [in in-person programs] falling asleep in the room as well, so yeah. (Practitioner 2, exit interview)*

As these examples illustrate, while there were variations in levels of engagement, including participants at times falling asleep during the program, this was considered consistent with engagement in in-person groups and was not attributed to the program's online delivery. Further, as the above quotes illustrate, practitioners did not feel this indicated poor engagement. It was noted that the participants who fell asleep at various points of the group attended immediately following a full workday, and that had this been an in-person group with the requirement to be in the room five minutes before the start or miss out on the session, they would not have been able to attend the session at all. As Practitioner 1 (exit interview) went on to explain, in the context of the 'bigger picture' the online setting made the group more accessible to these men.

Online delivery

Benefits of online delivery

Online BCPs are considered 'second-best' to in-person programs (Vlais & Campbell 2020, p. 13) and are only recommended where in-person programs are not available, for example, in rural, regional and remote areas. However, during the COVID-19 pandemic, numerous programs had to pivot to online delivery, particularly in jurisdictions such as Victoria where there were long periods of lockdown throughout 2020 and 2021.

Aligning with the literature, a key benefit of the online format described by practitioners was the accessibility of online BCPs for participants based in areas where there were no in-person programs available. As two practitioners explained:

> *There is a need for online MBC work [...] Being able to offer this work for people who live remotely, or there isn't a BCP in the area, I think it's a really great thing. (Practitioner 2, early program interview)*

> *There is a really big need for online men's behaviour change programs [...] people living in all different places through NT and WA, especially men that are working FIFO for example, that they might be able to go to a capital city or a bigger town, but only once every three or four weeks. So, being able to do it online would be really great. (Practitioner 3, early program interview)*

Additionally, practitioners also expressed the view that BCPs could provide a range of accessibility-related benefits. These perceived accessibility benefits are captured in the comments made by three practitioners:

> *For me it was the bigger picture of this was available, this was accessible. Not like face-to-face where there can be cut off time, if there's no advance notice and they aren't in the room for start of the group, they miss that session. (Practitioner 1, exit interview)*

> *I would see it as an opportunity to access far more participants. So, I wouldn't keep it specifically for geographical distancing [...] the online forum provides access. People who are in range of face-to-face, a lot of them can't follow through because*

> *of, they still have to organise childcare, they still have to organise. So, to do a group online at night, while someone, a neighbour or a friend comes in and is with the children, if say a partner is working or they're a single parent, that just opens up a whole new possibility of change. (Practitioner 2, early program interview)*

> *It's amazing that this is available now for people, and if that works for them and it's available, I don't think it should be limited to people who don't have access to face-to-face. Some people, you know, being in the comfort of your home, it's easier to be vulnerable than in this space with bright lights. So, I think there's a lot of things that interplay. (Practitioner 2, exit interview)*

Interestingly, while the MEND online program was developed to engage men living in rural and regional areas via the accessible online offering, the above practitioner reflections demonstrate a professional willingness to open up the eligibility for online programs. Practitioners recognised a range of other reasons why men may benefit from access to an online program, including where they are juggling primary care responsibilities or work commitments.

When asked about the accessibility of the online group, some participants said they could have gone to an in-person program, but that it would have been a lot of effort to get to (for example, an hour's drive each way) and it would have made completing the program more difficult. As two participants reflected:

> *[Online] was just, yeah, much easily more accessible. [...] It [in-person] would have been a barrier for me. [...] I would have gone but with the, you can only miss three or four, it would have been, okay, I think I would have been booted out. But not from not wanting to go, you know what I mean? But from just a logistical perspective. (Neale, exit interview)*

> *I think that being online it was good. [...] It was good because I did it at home and I didn't have to drive anywhere. Drive an hour down somewhere in the city and have the meeting and then come back. I found it reassuring that it was at home [...] I think I would have gone [to an in-person program] but I think it certainly would have been more demanding. (Daniel, exit interview)*

In earlier research, Jamieson and Wendt (2008) similarly highlight challenges associated with in-person attendance for men in rural areas, including lack of public transport and the need to travel long distances. For those required to attend an in-person program, these factors were associated with non-attendance and program drop-out (Jamieson & Wendt 2008). In addition to logistical challenges, one participant spoke about living in a small town and the appeal of the anonymity in an online group:

> *I prefer the fact of talking to someone anonymous. You're not feeling judged, you're not feeling known. Whereas here, where I live here, it's a small little town [...] You know the person that lives 20km away here in [town], because the kids go to the same school, the buses are the same, the shopping centre's one – you meet people. [...] everyone knows everyone. Do you know what I mean? So, yeah, and even if you're travelling to [town], which is an hour away, it's very close. It's a small area. Yeah. So, there would be that in the back of my mind. You know, am I going to run into someone that goes to my school where the kids are, and you sort of – that plays in the back of your mind, definitely. (Cary, exit interview)*

Cary said that even if there was an in-person program in his town, he would not attend for fear of being seen by someone he knew. Concerns about anonymity related to the delivery of programs in small communities have also been raised in previous research (Jamieson & Wendt 2008). Cary's attendance in a BCP appeared conditional on its being delivered online. Online BCPs can open intervention opportunities to people who would otherwise be reluctant to attend an intervention program.

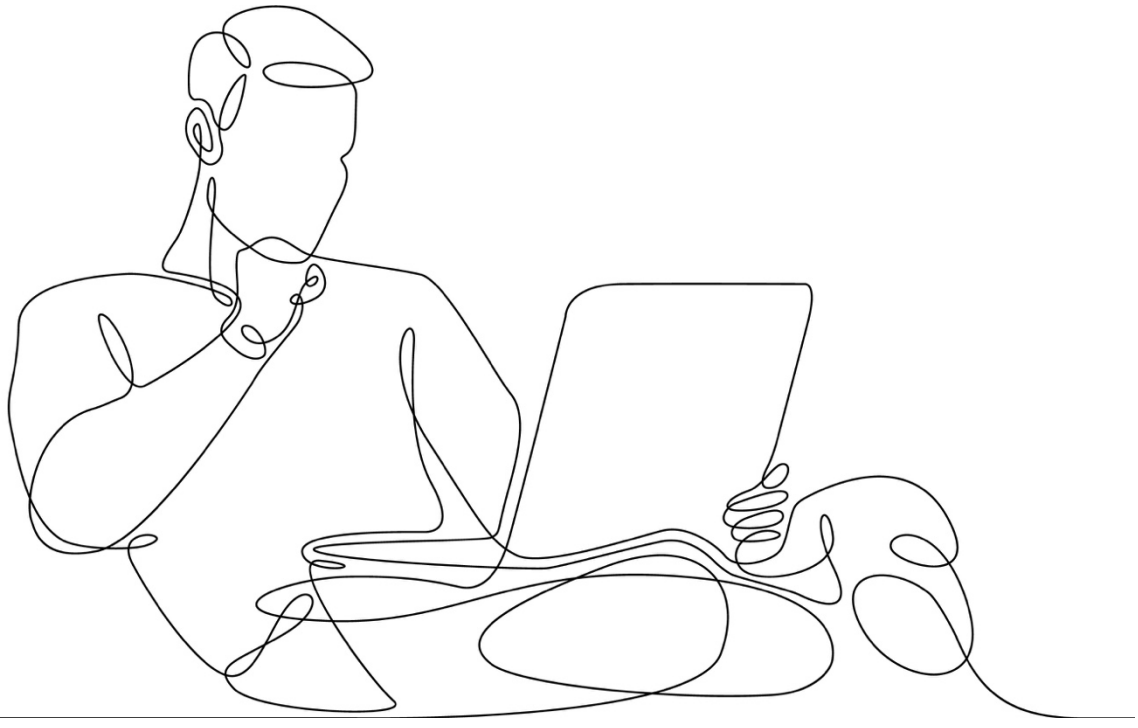
Beyond accessibility, practitioners also identified other benefits of the online program environment. This included, for example, having additional insights into participants' behaviours in their homes. As one practitioner described:

> *I'm thinking of some of the individual sessions where a child came into the room, you witness how that participant is speaking with the child. And then right at the exit interview, witness them speaking to that exact same child, and it was different. You would not get that in a [in-person] group, you'd only get their story, their perspective. (Practitioner 1, exit interview)*

Similar observations of getting a 'window' into program participants' interactions with family members were described by practitioners of the Clear Space program (see McGowan et al. 2023). Further, the online format also provided benefits for practitioners working remotely:

> *I could facilitate from [a different city ...] that's a real plus. [...] [Co-facilitator] and I facilitated 21 sessions without either of us being unavailable – yeh, we both got sick at different times, but that was a real plus. (Practitioner 1, exit interview)*

Being online meant practitioners were able to continue facilitating groups while travelling interstate or when sick. The capacity to deliver programs without needing to take time off was a notable difference to the in-person context; however, it does also raise concerns around staff burnout and the supply of facilities by the organisational provider to ensure that program staff are able to separate their home and work lives. Victorian-based research undertaken during the height of COVID-19 public health restrictions observed significant challenges among specialist family violence practitioners who were required to deliver work from their own homes, including experiences of burnout, feeling that trauma had entered into their home spaces, and an inability to 'switch off' from work (Pfitzner, Fitz-Gibbon, McGowan & True, 2020).



Challenges of online delivery

Practitioners reflected on the challenges of online program delivery, including concerns related to potential risk to affected family members' safety. The practitioners spoke about the need to be mindful of risk and to build trust with participants. During the exit interviews, two practitioners reflected:

> *Really mindful of escalation and impact on family members and safety, that's what's coming to my mind. [...] I don't think I approached the work any differently in how I would bring up – how I would challenge, or how I would bring up topics or something, I don't think. But I definitely was very aware, especially initially before really the trust had built, and our trust of participants, around if people escalate, how's that going to look. So, being mindful of maybe initially not challenging as much as I might in a face-to-face, because of being aware of yeah, if they were to escalate, how that would impact others. (Practitioner 2, exit interview)*

> *Privacy is really key here, so some people were actually attending from, like, for example, their workplace because they knew that would be the most private spot for them. [...] So then there's the safety planning and discussing around what might you do in the drive home to be decompressing from group. So that by the time you get home, you're able to be accountable and safe once you reconnect with the family. Or there were people that did it in a room, in the house, and their family were there, and that was something that was also disclosed previously and discussed, and therefore there was the importance of having the video camera on. And we didn't have breaks where or turned our screens off and whatnot. If someone did need to go to the bathroom, that was, [about communicating] "I've got to go the bathroom." They're being communicative about these things because, yeah, there is a different level of risk when they're doing a group like this from within the house. Or even if it's down the road from where their partner lives or whatever. In a way, similarly to an in-person group is that someone could leave that group and drive home five minutes down the road and be there in a[n] almost similar amount of time. You know what I mean. So it's not wildly different, but it is different. (Practitioner 3, exit interview)*

The importance of allowing time to build trust with participants, and of having a better understanding of them before exploring particular attitudes, behaviours or topics (as described by practitioner 2), highlights the potential value of additional intake sessions and/or additional work – whether group work or one-to-one – early in the program. Further, while there were some differences – for example, "maybe initially not challenging as much as I might in a face-to-face" (Practitioner 2, exit interview), or the "different level of risk when they're doing a group like this from within the house" (Practitioner 3, exit interview) – practitioners generally reflected that the online mode of delivery was not actually experienced that differently to in-person programs.

When asked how they found the online format, participants similarly reflected that, while there may have been some differences in interactions compared to in-person meetings, overall, it was not that different. Two program participants described this:

> *It was hard sometimes because of the connections and that, to tell you the truth. But it was different. It's different to doing a normal program really, like face-to-face, because you can actually see people's body languages, and sort of connect –*

> *you sort of like can connect. But even that we were far away, when someone told you a story, you can sort of feel them. So, I think it's still the same, but it's just – yeah, it's a bit different. (David, exit interview)*

> *I felt it was good we were all online. It probably could have been – if it was face-to-face, better interactions between people. But online, I felt that the interactions were quite good. (Simon, exit interview)*

Both David and Simon suggest that some communication and interaction is potentially lost in the online context; however, the quality of the interactions was not necessarily experienced or reported as 'less' by these participants. Similar observations were made by practitioners:

> *You're less able to pick up on the non-verbal cues, I think. You're just seeing the shoulders up. So, connection is lost, I think. But not beyond – you're still able to do the work, still be able to create a safe space from a distance. (Practitioner 2, early program interview)*

> *The difference with the face-to-face, is that there is not as much potential to be able to pick up a lot of those nuances, that if you're scribing at the board and you're sort of turning around in between. You're observing, you are doing that as well online, if you're going between tiles, you're missing somebody up there if you're looking down here. (Practitioner 1, early program interview)*

There was one participant in the group who spoke about finding the online environment easier to attend because he did not have to be in the same room as 'real' perpetrators:

> *I found that was a lot easier for me [to attend online]. If I was doing it face-to-face, I think I would have had more of a hard time dealing with being around those sort of people. Yes, because I've grown up very old school where you don't hit women or kids. So being in a room with people like that it would have definitely – I would have had a different behaviour towards it. (James, exit interview)*

Online delivery formats make BCPs accessible to a range of people who otherwise would not attend a BCP at all (whether due to location-related access or other factors), or who may struggle to meet the attendance requirements and complete the program. Yet, the example from James highlights that in a sense there may be less accountability for some participants in the online space. As the above quote here demonstrates, James used being online to further distance himself from the 'other', 'real' perpetrators. These attitudes and behaviours – distancing from the 'real' perpetrators and presenting as the 'exception' to the other men in group – also occur in in-person groups (Renehan 2020; Meyer et al. 2021), yet for James this appears to have been further reinforced by the additional 'distance' of the online format.

Practitioners also spoke about some differences in the nature of the activities they were able to do in the online format. For example, the use of the digital whiteboard and breakout rooms for small group work was viewed as important, as it mimicked interactions that occur in person:

> *Some creative activities, like cards online, you know the signposts or the picture cards, to explore more ways of – like whiteboard we ditched in the end, because it just was chaotic really. They weren't seeing anything, and we weren't seeing necessarily what the other person [was writing]. But you hear of stick-it notes, and you hear of – which is what you would do in the room, you'd have people writing*

> *all over a sheet on the floor. I think to bring some of that in would be really helpful. (Practitioner 1, exit interview)*

> *They could talk more [in the breakout rooms]. Yes, I think it required them to step into the space more, reflect more, when in the larger group it's easier to sit back. So, I think that's – and it connected the participants as well more, I feel. After the breakout rooms, there was a levelling up of connection between participants. (Practitioner 2, exit interview)*

In Bellini and Westmarland's (2021) study, facilitators similarly spoke about the challenge of converting in-person elements of the program to the online context. One facilitator spoke, for example, about using a physical whiteboard and holding this up to the web-cam, but later switching to a 'digital whiteboard' (in this example a word document was used as a 'whiteboard') (Bellini & Westmarland 2021). In the MEND online pilot, this was a process of trial and error with different methods; as Practitioner 1 describes they ultimately stopped using the digital whiteboard. As online BCPs develop further, there may be value in developing practice guidelines specifically around adapting activities for the online space and/or the development of software specifically for online BCPs. It should be remembered that delivering programs online is a unique skill that draws on the level of familiarity and literacy practitioners have with particular virtual programs (such as Zoom or Teams) and the features being utilised (such as the digital whiteboard or sticky notes). While practitioners reported facilitating the BCP online with minimal technical issues, the example provided by Practitioner 1 identifies opportunities to provide additional training related to online software.

While practitioners spoke about small group work in breakout rooms as valuable, there were limits to the use of these functions:

> *We had some feedback from one of the participants who was suggesting pairs, and the efficiency of that of getting through the time taken, as opposed to eight in the room. Part of the criteria of this group is that we are able to see you the whole time. So, I can't envisage that it could be anything but two breakout rooms, one facilitator each. Yeh, I would think as part of the safety of the online group. (Practitioner 1, exit interview)*

> *Which is interesting, because in face-to-face, we do breakout into pairs, and you can't have an ear in every conversation. So, there is collusion happening in that space. But I suppose you still [...] kind of see. Yeah, you can hear if there was escalation or something like that. So, yeah, I think that's a barrier of the online is, you can't have more than two groups if there's only two facilitators. (Practitioner 2, exit interview)*

As these quotes highlight, practitioners felt they could not safely conduct pair work in breakout rooms, due to the invisibility of participants and the risk of collusion. As a result, while pair work may form part of in-person program offerings, practitioners in the MEND online program felt unable to safely replicate this in the online environment.

Challenges related to technology

Practitioners identified several barriers associated with technology. One had to do with participants attending a device with a small screen such as a smartphone. As one practitioner described it:

> *There was some hurdles, but no-one was unable to be – some people are attending group on their phone, so the share screen is small, so that is a bit of a challenge. But still able to participate in group, and they're engaging. (Practitioner 2, early program interview)*

NTV strongly recommends that all online program participants have screens that are at least 18 inches (NTV 2022). One of the noted reasons for this is that on a small screen, in particular a smartphone, participants will have difficulty seeing a shared screen and facilitators and other participants at the same time. While practitioner 2 above reported that this did not prevent participation or engagement in a group session, consideration should be given to providing further resourcing to ensure participants can access technology adhering to the requirements and that allows them fully to engage with practitioners, other participants and content that may be shared on screen. If the delivery of online programs proliferates, further consideration should be given to setting up technology packages which can be allocated by service providers to facilitate an individual's involvement in an online program.

There are also concerns around online programs and issues with technology, such as Wi-Fi dropping out or connection speed not being sufficient to allow consistent contribution throughout the session (NTV 2022). Vlais and Campbell (2020) note that due to bandwidth limitations, there may be instances where participants need to turn off their video in order to maintain a connection. The online format creates accessibility by addressing logistical challenges associated with travelling long distances to an in-person program – yet some of these challenges may be replaced by limitations associated with internet access, particularly in rural and remote areas where internet connection is often less reliable (Bellini & Westmarland 2021). During the intake sessions needed to be rescheduled due to connection issues; during the group sessions, however, this did not present as a significant issue. Participants and practitioners did drop out or freeze occasionally, but this only ever lasted for a moment. Some participants did note that they had poor internet connection at home, but they were generally able to travel somewhere else to attend. As one participant described:

> *The NBN here where I am is really, really bad, really poor. So, if I drive 15 minutes in either direction, chances of getting reception is maybe. (Cary, exit interview)*

A few participants reported that they would attend the program from work. As such, while there were some technical issues, they did not present as a significant problem within the pilot program. During the exit interview, practitioners spoke about additional set-up requirements that would have been useful. One practitioner elaborated:

> *There's something about [technology set-up] that in our assessment process that I would like to see tightened up. And it's asking that they have a light. You talk about these things, [but actually] making sure that they are able to. And people said they would have access to a computer – some didn't all the way through, and one got a new phone towards the end, and the difference was enormous in terms of being able to see that person there. So, I think a phone can be okay, but not an old phone, or a phone where there's no lighting of the face, that's what I think for the online. Being much more tight around that and say, "Look, we'll give it a go." And in our assessment sessions, if I think of a few people that were very dark in those, and you were engaging, I think that would be one of the things – right back to the*

orientation or the Week Zero, yeh really tightening up that. (Practitioner 1, exit interview)

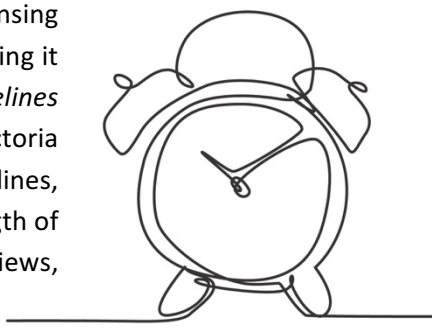
Relatedly, some participants said they would have liked to have a brief zoom course to help them become familiar with the online environment prior to the group starting:

> *I'm not much with computers, I never really have, and even for our – it wasn't hard at all. Once you pick it up, you know, there's your split screens, and obviously your addresses that you've got to log onto. It's just – yeah, I can see that older people with less computer knowledge than me might find it harder, but it's not really difficult. It's just one thing that you've got to get used to. Maybe a Zoom short course at the start, and then you can sort of interact. Because I remember the first times it was more, "Can you hear me? Can you hear me? Can you see me?" (Cary, exit interview)*

Additional sessions prior to the commencement of group sessions could be a valuable addition to the online program offering. Bellini and Westmarland (2021) similarly highlight the importance of not assuming a particular level of digital literacy among participants prior to or during an online program. Running an additional introductory session focused on technology would provide an opportunity to address any technical issues, to navigate through participants' and practitioners' set-ups, and to provide participants with a brief introduction to Zoom. If programs such as MEND retain their online delivery mode, then it is recommended that such sessions are built in as a standard part of the offering.

Length of sessions

Like other online BCPs (Bellini & Westmarland 2021), the MEND online program ran for 90 minutes. In-person sessions typically run for two hours. During some of the community of practice sessions, practitioners spoke about the challenge of condensing program content into the 90-minute format (July 2022), and the practice of stripping it back a bit to focus on one main activity (September 2022). Victoria's *Service guidelines for perpetrator interventions during coronavirus (COVID-19)* (Family Safety Victoria 2020) stipulate a maximum 90-minute format for online BCPs, while the NSW guidelines, which were adapted by NTV from the Victorian standards, stipulate a sessions length of 90 to 120 minutes with the possibility of a short break. During the exit interviews, practitioners spoke about the 90-minute format as restrictive:



> *There is a difference online and staring at a screen, to being in a room with other people. So, you're not wanting to really drag it on. But I think we could have gone up to two hours. I think we could have managed engagement, and I think we would have been able to not have to rush through so much of the content if we had the two hours. So, for our facilitation I think it would have been easier to cover. We covered everything, but we did have to rush through some things. (Practitioner 2, exit interview)*

> *Two hours would mean that you'd be able to, I don't know about covering more, but I think one of the reasons for not having people talking lots and lots, was the sense that there was this to get through today. (Practitioner 1, exit interview)*

Interestingly, several program participants also said they felt the sessions were short:

> *Maybe the sessions could be a bit longer to fit a bit more in. Because some nights I felt that we covered the content, but going around, talking to everyone at the end to discuss about it, was sometimes cut a bit short because there were too many of us to go through the debrief bit at the end. We could've done a bit more brainstorming parts and that through it. (Simon, exit interview)*

> *To tell you the truth, I think it was too short, but I suppose people have, because you're stuck in different times [zones] everywhere, so you have to – some people are busy at that time, and some people don't have people to look after kids at that time. It's pretty hard. (David, exit interview)*

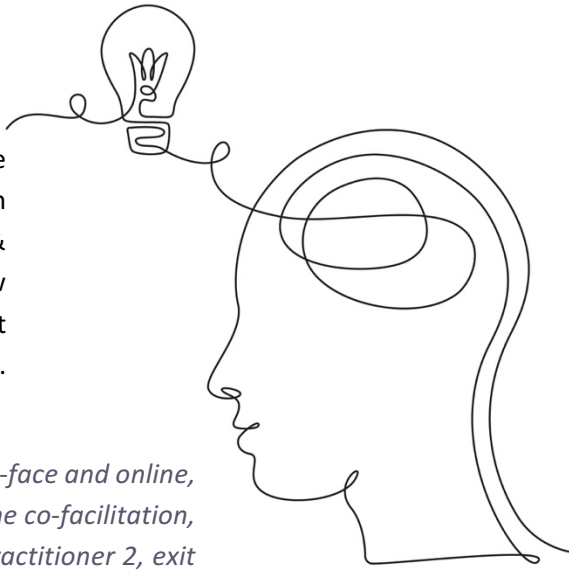
> *There was a lot of that – of the content, but it wasn't individual. So, sometimes, you wanted to express something, but time was – there wasn't enough time. [...] Sometimes you wanted to just talk about a little bit of an upset you had during the week, and – you know, you're emotional, and how that made you feel. But then you thought, well, the other people need to talk too, and it's their turn. (Cary, exit interview)*

Following a debrief after one of the program observations, facilitators reflected on the challenges of managing content and participant contributions in the 90-minute format. At commencement, there were nine program participants, which dropped to eight. On some nights, only six or seven participants would attend. Both facilitators reflected that in the online format "nine and eight [participants] is a lot and that really six is the ideal number." This was also discussed in the community of practice sessions. Practitioners said that some conversations get cut short when there are eight participants, and that more time would allow them to go deeper into some of the content (September 2022). This practice experience suggests that smaller groups may work better online. Trialling smaller groups (with a maximum of six participants), should be considered.

There are additional implications related to risk in a long-session online delivery format containing a break, particularly when participants are attending from the home with their (ex)partner/other family members in another room. Practitioners highlighted that even in the 90-minute format, participants would still take brief breaks to go to the bathroom or grab a drink. As one practitioner explained:

> *They are going to go to the bathroom anyway, you know, grab a drink. Some of those that got in from work were eating. That wouldn't be on in a group face-to-face. So, there were allowances if you like, or tolerances that you might not otherwise have. We talked about that where there were a few of them eating one week, and we're thinking, "We need to address this," and then it didn't happen again. (Practitioner 1, exit interview)*

As these examples demonstrate, both practitioners and participants felt there would be a benefit to greater flexibility around the 90-minute timeframe. In particular, this would allow greater space for participants to speak and to unpack content in relation to their specific use of violence.



The challenges of delivering BCPs online are not insurmountable

There are a number of practice challenges associated with online delivery of BCPs, as outlined above, and concerns have been raised in existing literature (NTV 2018, 2022; Vlais & Campbell 2020; Bellini & Westmarland 2021). However, practitioners involved in this review were of the professional opinion that these challenges were not insurmountable and that BCPs could be successfully delivered online. Two practitioners explained this:

> *Thinking about the groups and the difference of face-to-face and online, for me, the things that make the group a success are the co-facilitation, the content, less about if it's face-to-face or online. (Practitioner 2, exit interview)*

> *The disadvantages are basically the same ones that appear [in] in-person men's behaviour change groups [...] I haven't seen any dramatic divergences through this online version than I do in the face-to-face version. In fact, because of the way that we got to have that really great co-facilitator intake model, I actually think there's probably more cohesiveness and connectedness in this group [...] I think because of online being – we don't know what's going to happen, is this really risky. There was just so much focus on structuring that safety, to begin with. And I think because of that, yeah, some of the risks maybe that there could have been were minimised. There's also such a big focus on the group agreement, which of course, there is in person. But I think when it's online, there's just even more, we've got to make sure this is really incorporated in. So, yeah, I think that you can absolutely do this online (Practitioner 3, exit interview)*

These viewpoints are important as they point out that many of the potentially perceived shortcomings in the MEND pilot, as well as the Clear Space pilot (see McGowan et al. 2023), are not unique to the mode of online delivery; they could have easily arisen in a face-to-face program. As Australian states and territories (and their international counterparts) move through the pandemic there is a general openness to persevering with the online delivery of some services that had always been envisaged as occurring face to face. The comments from practitioners and participants involved in this pilot BCP demonstrate why further consideration should be given to expanding the number of available remote programs; doing so may increase accessibility for participants in rural and remote communities as well as those balancing work and primary care responsibilities.

Managing ongoing risk and safety concerns in the online space

Among the concerns associated with delivering BCPs online are the additional challenges of detecting behaviour such as drinking alcohol, or affected family member(s) being present during group sessions (Bellini & Westmarland 2021; No to Violence 2022). There are also concerns related to the lack of a physical 'buffer' between the man and their affected family member(s), particularly that the perpetrator may become aggravated during a session in response to one of the topics (Bellini & Westmarland 2021; Valis & Campbell 2022; No to Violence 2022). At the commencement of the programs, practitioners were similarly cautious about these potential risks. As one practitioner reflected:

> *Initially, we were kind of like really aware of this person is in their home, potentially with the family member that they've caused harm to. So, being really, how is that going to go, is there a space where you're away; how are you going to self-soothe? So, before we got to really know the participants, that was definitely more on our radar than if they're in [an in-person] group, in the building with us, away from the – so, there was a concern about escalation, and then how that's going to look and impact the family. That was definitely a consideration. (Practitioner 2, exit interview)*

The need to get to know participants and develop a deeper understanding of potential risks both prior to and early in the program was considered particularly important in the online context:

> *A lot of that connection and the trust buildings happened in the [intake] assessments, and in those first session, second session, that's sort of there now. But keeping that going and maintaining and catching things that are happening for individuals. (Practitioner 1, early program interview)*

Having four pre-program intake sessions (discussed above, p. 14) provided additional opportunities to build these connections with program participants and understand them. Practitioners also found that the co-facilitation model utilised during the intake sessions provided additional perspectives and more comprehensive assessment than a single facilitator model (discussed above, p. 15). Despite concerns, practitioners reported that the pilot generally ran with few worries of risk escalating. A significant limitation is the absence of affected family member perspectives to validate or challenge this account.

In reflecting on the ongoing management of risk throughout the program, and how this is done in an online environment, practitioners spoke about the importance of men being visible and audible and communicating when there are issues. One practitioner commented:

> *The criteria of the men knowing that we have to be visible and audible the whole time, and that part of being in this group is agreeing, or is one of the requirements of the group is that if we lose contact with you and not letting us know fairly quickly and we can't contact you, then a wellbeing check will be organised immediately. That's a pretty strong boundary I think, and in the online group essential. [... I] would feel confident that's in the back of each person's mind, because they were very good with sending through a message or, "Having internet trouble." (Practitioner 1, exit interview)*

While there were no examples of risk escalation requiring further intervention during the pilot, there were instances of perpetrators weaponizing their participation in the program against their affected family member(s). This is not explored in detail here due to concerns about identifiability. However, the ways that

participation was weaponized were, as practitioners noted, no different to how they occur in in-person programs. One practitioner explained:

> *That's not something new to this pilot or program app, that it's just that same disappointing thing over and over when you're like, sometimes these programs actually can have negative impacts. Sometimes, or actually, it's very common that men who use violence and abuse, put what they learn in these programs through their lens of making everything her fault and making themselves – like absolving themselves from responsibility. And therefore recognise what they learn and make actually life harder for her, in whatever way. That happens in any men's behaviour change group ever. And so I guess just knowing – keeping that at the forefront, and I think for practitioners working with users of violence, for them to be keeping that at the forefront and thinking about that when they're considering any progress – quote unquote, 'progress' – that's being made on his behalf. And of course, I'm not saying that these guys don't make progress, because of course they do in understanding and engagement, things like that. But that doesn't always translate to actual behaviour change. And I think, yeah, that's the disappointing truth. (Practitioner 3, exit interview)*

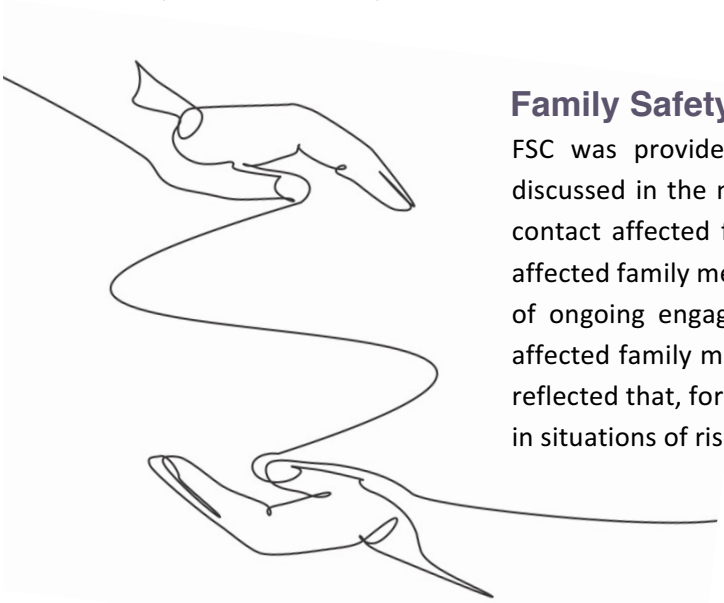
Existing research highlights the issue of perpetrators using participation in a BCP to extend their coercive control tactics (see, for example, Vlais & Campbell 2020). While this is an issue that needs to be addressed, it is not unique to the online environment; it manifests across BCP delivery formats. There remains limited evidence on whether risks are heightened through online delivery formats compared to in-person formats (Vlais & Campbell 2020). While practitioners reflect that safety issues were no different to the in-person programs they have been involved in, the pilot program is limited to a small sample of participants. Further research in this area is required.

Practitioners had the capacity, for example, to organise a welfare check should they have concerns about risk, but they also spoke of their reliance on participants' honesty throughout the program. One practitioner explained:

> *We do put all these different safety procedures in place, but at the end of the day, a lot of it is relying on honesty from the participant and if we had concern that that wasn't happening, yes, there are avenues like getting a welfare check from police or whatever, but without contact with that affected family member and them saying, "He's telling you that we don't live together, but we actually do live together." Without that intel, we don't necessarily know. How to remedy that, I don't quite know without it becoming really quite invasive, that everyone has to have a welfare check before the program begins, or something like that, which would be quite [a] triggering or punitive kind of approach to doing something like this. (Practitioner 3, exit interview)*

Building connections and trust and establishing honest communication between practitioners and facilitators – these are critical, given the well-established problems with relying on men's self-reports (Langenderfer 2013; McLaren et al. 2020; Westwood et al. 2020). As the practitioners' quotes above illustrate, they do not rely solely or uncritically on men's accounts, but there are limits to the 'intel' available to them. Practitioners rely heavily on their own professional views and observations of men both within and outside of group sessions. When affected family members choose not to engage with FSC, there may be a greater reliance on

practitioners' perspectives, information-sharing practices (for example, from external agencies such as the police), and perpetrators' self-reports. Opportunities for further ongoing assessment, through, for example, ongoing one-to-one work alongside group work, could be considered. The value of one-to-one work is explored further on p. 57).



Family Safety Contact

FSC was provided by one worker throughout the MEND program, as discussed in the methodology. Attempts were made by the FSC worker to contact affected family members at the beginning of the program. Seven affected family members responded initially, with four opting for some form of ongoing engagement. Over the course of the program, two of these affected family members stopped engaging with the FSC. Practitioners also reflected that, for this cohort, particular affected family members who were in situations of risk were not engaged with the FSC.

Low uptake of FSC by affected family members is common; it reflects the challenges of engaging with affected family members through FSC work and in research more broadly (Chung et al. 2020). There was nothing to suggest that the low uptake result from, or was influenced by, the program's online delivery.

Discussing the low uptake and ongoing engagement of FSC, practitioners spoke about the challenges of identifying and contacting affected family members. As practitioners explained, this process relies on practitioners working with perpetrators to identify the relevant affected family members and provide those details to the FSC worker. The barriers to achieving affected family member contact are well captured in the following quotes from two practitioners:

> *[Identifying and contacting affected family members] does rely on what they [perpetrators] tell us. (Practitioner 4, exit interview)*

> *That identification of AFMs [affected family members], it does primarily start with the practitioners working with the user of violence, and we rely on that referral getting passed across as who they are, who they are identifying. So, I don't – I mean, I am thinking in hindsight that knowing that one of the men had used violence towards, or that had actually been the primary victim was a child, I do think that we should have probably been more conscious of that. (Practitioner 3, exit interview)*

In this program cohort, 12 affected family members were identified through intake and assessment processes; this includes three secondary affected family members. As raised in the above quote from Practitioner 3, a further affected family member was identified during the course of the program. This is explored further below in the discussion on engaging children (p. 34). The identification of affected family members may be limited by the exploration of relationships during initial contact(s) with perpetrators – and the specific (ex)partners/other family members that are discussed as a result. Practitioners also spoke about

further challenges in contacting affected family members once they were referred to the FSC worker. As one practitioner explained:

> *There are a few [program] participants who gave us details for their ex-partners [...] It proved quite difficult to contact those women, given that there was a bit of concern about just ringing them up out of the blue. I didn't have any success going through the lawyers, I contacted two, attempted to contact two of them through the lawyers, but there was no response. (Practitioner 4, exit interview)*

This practitioner had concerns about contacting affected family members who did not want contact and/or had no contact orders in place with their (ex)partner/other family members. They went on to comment:

> *It's an ongoing concern in all this work to the extent where I don't know that it's not breaching privacy laws. I don't know that. (Practitioner 4, exit interview)*

This concern highlights the critical need for greater guidance for practitioners undertaking this work, regardless of whether the program is delivered in person or online. Practitioner 4 also described a situation in which contacting the affected family member caused distress:

> *She was completely freaked out by the call, and it really distressed her, and she was crying. She was able to talk to me about it and tell me why and everything like that. But she may well have been better off without that call. […] I don't know that there's a solution to it, but it certainly is a concern there. I don't know what the workaround is [...] She's tried to move on, and then there's a call about him again. (Practitioner 4, exit interview)*

Providing FSC is essential, however, there remain a number of challenges in navigating the delivery of FSC in practice. One practitioner described the need to balance ensuring support is available to affected family members who want it with respecting affected family members' choice not to engage:

> *There are some services that hound people, and they'll go through all sorts of avenues to get in touch with someone that's clearly not answering their calls [...] to us that feels like quite a breach of their self determination to not consent to having a conversation with someone if they don't want to. [...] Some people want support, and some people don't, we can't force that on someone and yes there's concerns about risk when we're working with a man and we don't have any contact with the family members. But at the end of the day, if those people choose not to – and yes, there's also the risk of that he's using power and control to prevent her from accessing support – But there's absolutely also people that are just like, no thank you. (Practitioner 3, exit interview)*

In principle, this is how FSC should operate: it should be available and accessible to affected family members who want this support, but it should not be imposed or forced on people. However, navigating this in practice can be complex. As this practitioner describes, there are numerous potential reasons why affected family members chose not to engage, including situations in which the perpetrator is preventing the affected family member from accessing support. As practitioner 3 continued:

> *There's women that have not responded to texts and calls when I've initially called them, and this is generally in the service, not this particular project. And then, a year later, I get a call from her saying, "I've actually left a relationship now, I saved*

> *your number back then, but there was no way that I could have called you or responded to you at that time." So we do know it happens, but we often don't know at the time because all we're getting is just radio silence [...] there wasn't as much uptake [from] some of these people. It could very well be because their phones are being monitored and even though he agrees in the intake, knowing that partner contact is a part of this program. He can say whatever in the intake to appear like he's fine with that, and then it could absolutely be – I think that happens quite a lot, actually – that they're [women] coerced and that there'll be consequences if they take up that offer of support. (Practitioner 3, exit interview)*

An additional barrier to engaging in FSC raised in this pilot program was the fear of child protection involvement. As Practitioner 4 explained, this influenced one affected family member's decision not to take up the FSC:

> *There was one [program participant] who, and I'm not sure if he continued with the program in the end. But during the intake, an incident was described which the men's workers felt needed to be reported to child protection. And I had lots of conversations with the mother about this and the possibility of that report, and that led to her going, "I am not having anything to do with this." (Practitioner 4, exit interview)*

Women often report interactions with child protection agencies to be intimidating, stressful and associated with a fear that children will be taken away (Buckley et al. 2011). The fear of child removal can also hinder affected family members' help-seeking decisions (Meyer 2011). As this example illustrates, fear of child protection involvement may also influence affected family members' decisions to engage in FSC.

FSC provides an opportunity to assess and manage safety concerns of affected family members (Day et al. 2019). Where affected family members are not engaged, the capacity to provide support is restricted. Importantly, the above example from Practitioner 3 (in which a client reached out at a later date) emphasises the need to make an offer of support and to ensure that the offer is communicated in such a way that it can be taken up at a later date. This also highlights a knowledge gap in identifying and addressing barriers to engagement, such as technology-facilitated abuse (as described above).

Affected family members' voices are critical to understanding perpetrators' use of violence and for validating reports of behaviour change (Westwood et al. 2020; McGinn et al. 2016). Where their accounts are not visible, the capacity to cross-check any suggested behaviour change will be restricted. While affected family members' voices are the strongest tool for validating accounts of behaviour change, there is a critical need to consider alternatives to making these assessments in cases where affected family members choose not to engage. The reliance on affected family members in these assessments can undermine attempts to shift responsibility away from them and onto perpetrators.

Benefits of family safety contact

Only two affected family members who engaged with the FSC worker participated in the exit interviews as part of the MEND online program review. Both of these affected family members spoke positively about their experiences. These women explained that while they did not have much contact with the FSC worker, they had the level of contact they needed:

> *[Name] would ring me and see how we were going. [...] I mean, not a huge [amount of contact] – probably because I didn't feel that I needed it [...] every time she'd check in with me, which was lovely, I'd said, "Look, all's going good." [Name's] very positive about the program. I can see some changes. He's got some strategies in place." [...] I'm sure she could've been a great support to me if I needed it, but I didn't feel like I needed it. (Jan, exit interview)*

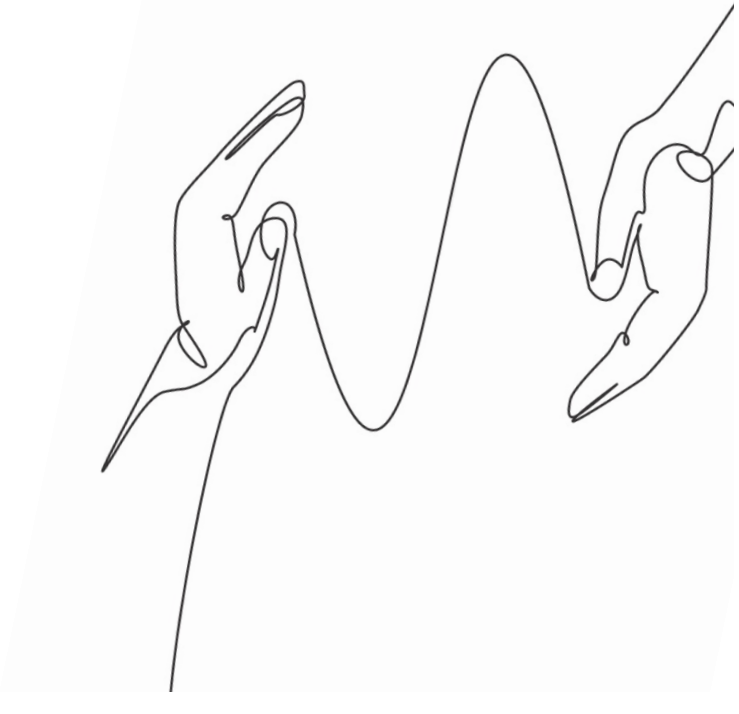
> *She rang me a few times, yeah. Maybe three or four times, she rang me. [...] It was good, actually. Yeah, talking to her was good. [...] she was there if I needed to talk about anything, [...] She was just someone to talk to, I suppose. (Chloe, exit interview)*

These accounts highlight the value of having someone to talk to and the importance of continuing to offer FSC to all affected family members. Importantly, while both Jan and Chloe spoke about low-level contact, they also felt more support was available if needed.

One area identified for improvement was the sharing of information related to program content. When asked if she had received sufficient information about her (ex)partner/other family member's participation in the program, Jan explained:

> *No, I didn't get it – I mean, I didn't have any information. Like I didn't have a little summary about what they were learning each week. He would tell me the summary about what he was learning each week […] I didn't have a lot of information specifically about the content of the program, no. Only through him. (Jan, exit interview)*

The need to provide information about program content to affected family members has been raised in previous studies (McGinn et al. 2019; Opitz 2014; Meyer et al. 2021). Ensuring that affected family members are informed about the content of the program and when different topics will be delivered can provide them with valuable reassurances. Further, equipping affected family members with program knowledge may work as a protective factor in situations where perpetrators try to use knowledge gained from programs in their abuse or to project learnings onto their (ex)partners/other family members (McGinn et al. 2016).



Engaging children

All eight men who started the MEND online pilot program and participated in the review had children. Six had contact with their children at the time of their involvement in the program, while two had contact with some of their children but no contact with others. When asked during the intake assessments about their motivation to attend the program, five participants spoke about their children. For two of the men, the behaviours that brought them into the group were specifically related to violence used against children.

Generally, an FSC worker will discuss children with the identified affected family member where appropriate (for example, the child's mother), and children can be included in safety assessments. However, among the cohort in the pilot program, there was little engagement with FSC from affected family members and little support requested in relation to children and young people. As Practitioner 4 explained:

> *An unusual feature of this program was how little support the AFMs [affected family members] were asking for, particularly in relation to the children because they were – mostly they were saying that the children are fine. There was no need for safety planning in relation to the children or including the children in a safety plan. (Practitioner 4, exit interview)*

While affected family members' engagement with FSC and the program review in the present study was limited, when asked if they would have liked any additional supports, one affected family member identified supports for children as necessary. She explained:

> *Maybe additional information. [...] I think I knew what [child's name] needed to do. [...] I knew once we had all those things in place that [child's name] would feel better [...] maybe some information [for child …] It's been pretty challenging. (Jan, exit interview)*

There is consideration and assessment of children via the identified affected family member (for example, the child's mother). But, as discussed above in relation to identifying family members affected by their use of violence (p. 30), it is possible that some affected family members, including children, may be missed in this process. There is a particular practice gap in understanding how to engage with children and young people as part of the FSC work process. This gap was noted by practitioners in this review:

> *We have no clear procedures about how to engage with children who are victims of domestic violence. (Practitioner 4, exit interview)*

> *There was a training or a webinar [...] where they were talking about impacts on children and a variety of other things and I asked the question then of, as a person working with affected family members, is it considered best practice that we also work with children regardless of age. And there was – they actually said, "We don't know yet" [...] I thought they'll have kind of a hard and fast answer, and there wasn't one. (Practitioner 3, exit interview)*

Concerns about how to engage children in FSC work are not unique to the MEND online pilot program. The limited inclusion of – and need for greater support for – children's needs and voices within BCPs has been raised in previous research (see, for example, Lamb et al. 2018; Kelly & Westmarland 2015). The importance of this focus is reflected in the shift from referring to 'partner contact' work to 'family safety contact' terminology (Chung et al. 2020). However, while the terminology shift has gained traction, the findings from this review, among others, suggest that a change in training and practice to embed the objective of this name

shift are yet to follow. Recognition of the importance of engaging children is increasing. For example, NSW practice guidelines (NSW Government 2017) include preparing children for the participation of their family member in the BCP and ensuring information is available to them (standard 1.4), as well as ensuring children have access to appropriate supports (standard 1.2). However, further guidance and support for practitioners to undertake this work are needed (Fitz-Gibbon et al. 2019). Notably, internationally, there are jurisdictions with more comprehensive approaches to engaging children; for example, the Caledonian system in Scotland incorporates a dedicated children's service into MCBP delivery (Ormston et al. 2016).

The lack of engagement with children presents a missed opportunity to provide support and connect children and young people who may have experienced DFV with services (Chung et al. 2020). There is increasing acknowledgement across Australia of the need to view children and young people as affected family members in their own right (see, among others, DSS 2022; Fitz-Gibbon, McGowan & Stewart 2023; Meyer & Fitz-Gibbon 2022). BCPs should be part of the wider shift needed across the response system to better identify and respond to the needs of young affected family members, including children (Department of Social Services, 2022; Fitz-Gibbon, et al. 2023; Meyer & Fitz-Gibbon 2022). The present lack of dedicated support services and interventions for children reinforces the problematic positioning of children and young people as 'witnesses to violence' rather than affected family members in their own right (Callaghan, Alexander, Sixsmith & Fellin, 2018). This approach risks further invisibilising the impacts and harms of DFV on children and young people, and it fails to take up meaningful opportunities to engage young people and offer supports (Fitz-Gibbon et al. 2023).

Reports of behaviour change

In considering potential behaviour change this review draws on accounts from affected family members, practitioners and men's self-reports of change. It is well-established that men's reports of behaviour change can be unreliable (see, for example, Langenderfer 2013; McLaren et al. 2020; Westwood et al. 2020). Where possible, they should be validated by other data sources, including affected family members' accounts. Due to the limited affected family member data available for this review, however, this is not possible. Again, the men's self-reports should be interpreted with caution.

Project Mirabal

Affected family members were asked a range of questions replicated from Project Mirabal, a project conducted in the United Kingdom (UK) which sought to understand the efficacy of behaviour change programs for perpetrators of domestic violence (Kelly & Westmarland 2015). Due to the limited sample participating in the final survey at program exit (*n*=1), results are only presented for intake and program mid-point. The limitations of the available dataset are discussed in the methodology above (p. 11).

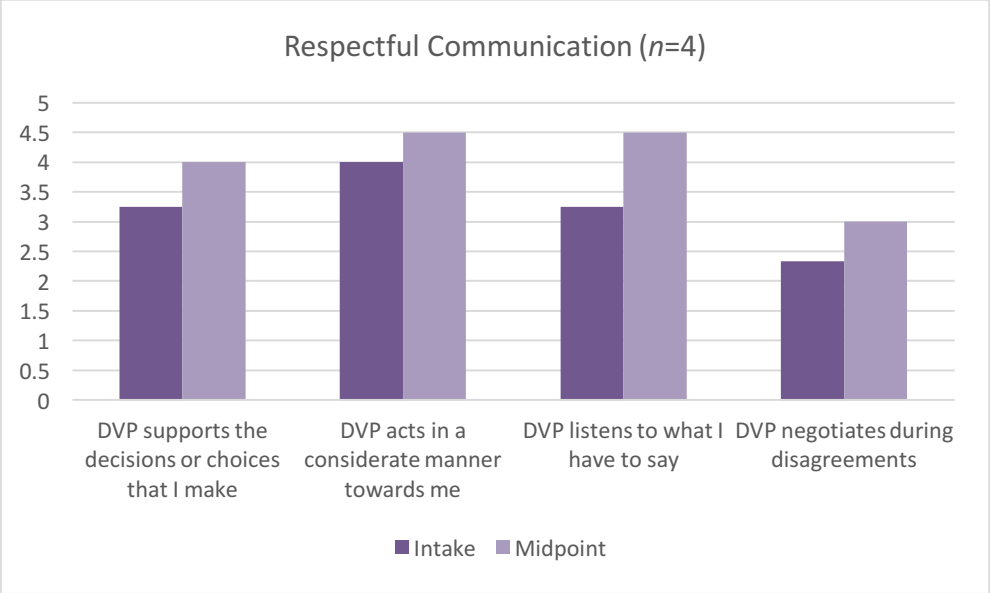
Respectful communication

Affected family members were asked five questions that measured the extent to which they felt their (ex)partner/other family member treated them with respect and consideration and acknowledged and respected their boundaries regarding issues such as levels of contact and decisions they made.[5] Questions were asked on a scale of always (1) to never (5) and scores were reverse coded for analysis, so higher scores

[5] No affected family members responded to the first question as it was not applicable ('[If separated] DVP [domestic violence perpetrator]).

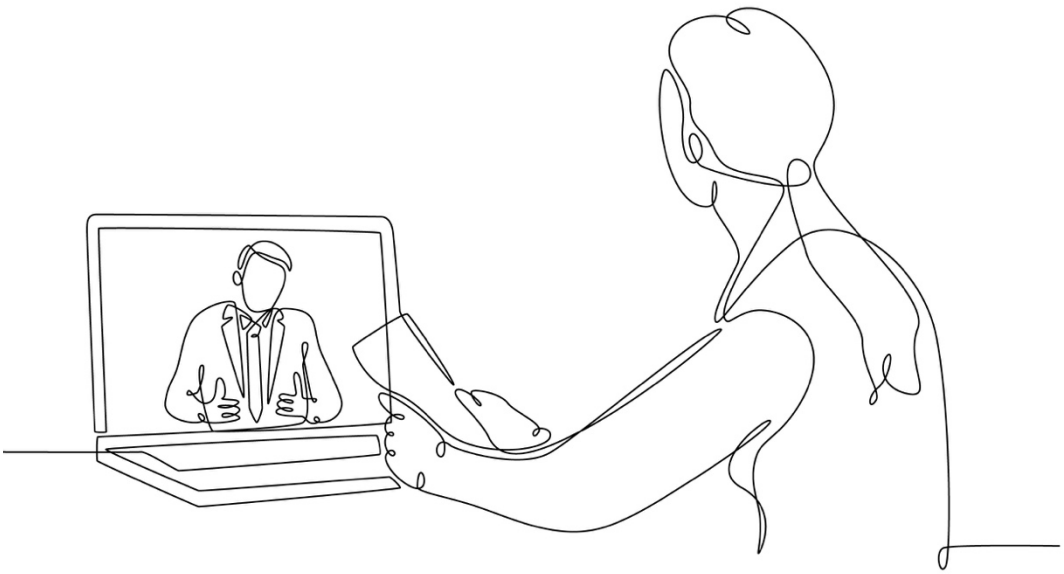
indicate that the affected family member felt their (ex)partner/other family member engaged in more frequent respectful communication. Results are shown in Figure 4.

Figure 4: Respectful Communication



Note: For the final item, 'DVP negotiates during disagreements' (*n*=3), DVP=Domestic Violence Perpetrator.

On average, affected family members reported slightly more respectful communication at program midpoint compared to intake (see Figure 4).



Expanded 'space for action'

Affected family members were asked 12 questions that gauged the extent to which they felt as though their (ex)partner/other family member controlled what they did and whom they spoke to. Questions were asked on a scale of always (1) to never (5). A higher score indicates that the affected family member felt they had greater space for action. Results are shown below in Table 2.

Table 2: Expanded 'space for action'

	Intake		Midpoint	
	M	SD	M	SD
[If separated] I feel afraid of how DVP would react if I got a new partner (*n*=0)	-	-	-	-
I feel like I have to be very careful around DVP if they are in a bad mood (*n*=4)	3.00	2.31	3.50	1.91
[DVP] Makes the final decision about whether people can visit/stay in the house (*n*=4)	5.00	0.00	5.00	0.00
[DVP] Tries to restrict where I go (*n*=4)	5.00	0.00	5.00	0.00
[DVP] Tells me to change the way I dress or my appearance (*n*=4)	4.00	2.00	4.50	1.00
[DVP] Prescribes or criticises the way housework is done (*n*=4)	3.50	1.91	4.00	2.00
[DVP] Tries to look at my messages and contacts (*n*=4)	4.50	1.00	4.50	1.00
[DVP] Tries to use money/finances to control me (*n*=3)	4.33	1.15	4.33	1.15
[DVP] Tries to prevent me participating in activities or groups outside the home (*n*=3)	4.33	1.15	4.33	1.15
[DVP] Is suspicious that I have been with another man/someone else (*n*=3)	4.33	1.15	5.00	0.00
[DVP] Insists on knowing where I am or what I am doing (*n*=4)	2.75	2.06	4.25	0.96
[DVP] Tries to prevent me seeing or contacting my friends/family (*n*=4)	4.00	2.00	5.00	0.00

On average, affected family members reported feeling as though they sometimes had more expanded space for action at the midpoint survey, compared to intake (see Table 2).

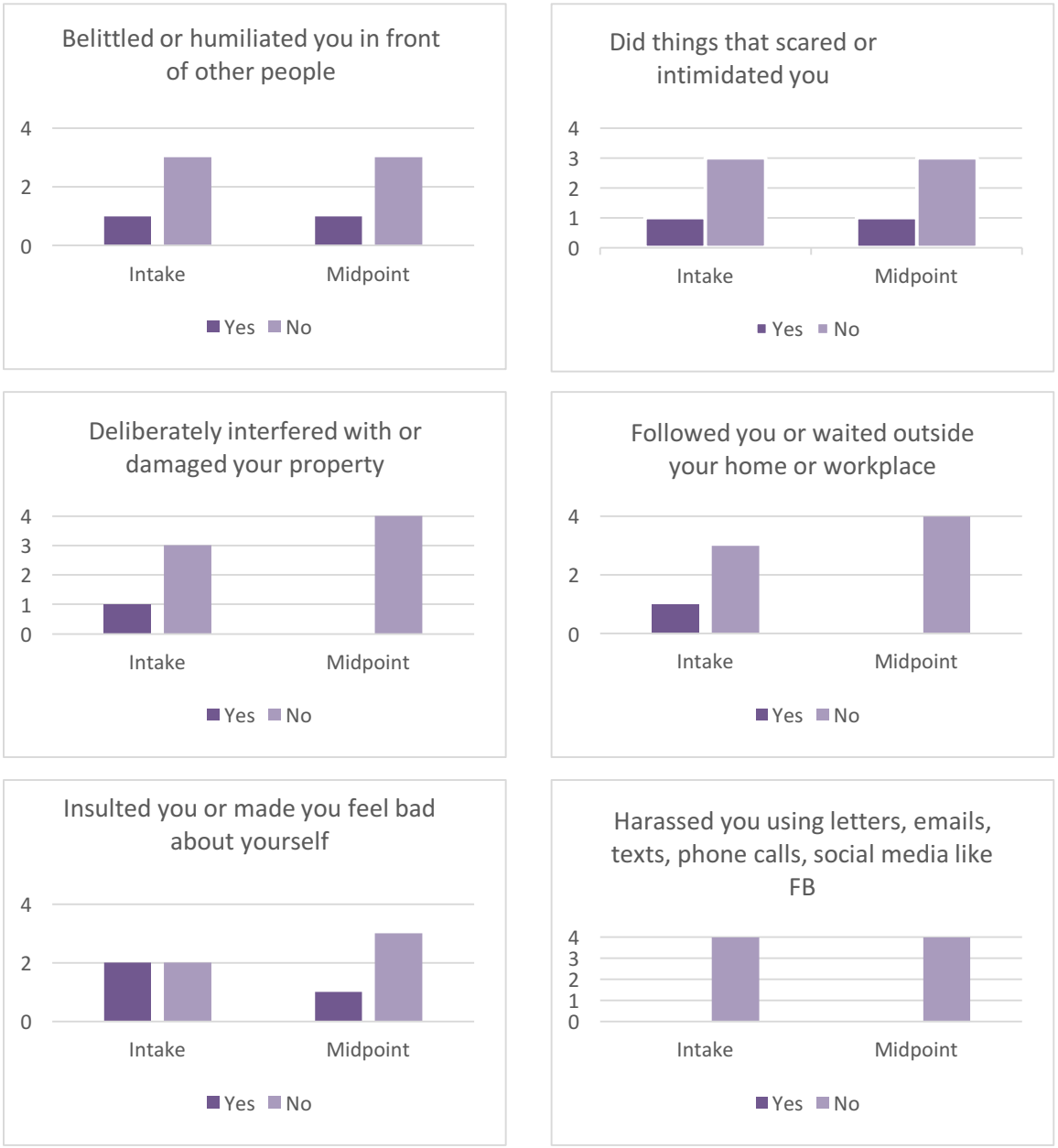
Physical and sexual violence

Affected family members were asked seven questions that sought to understand whether they had been subject to physical or sexual violence by their (ex)partner/other family member. The three affected family members who responded to these items answered 'no' to all seven questions across the intake and midpoint waves of the survey.

Harassment and other abusive acts

Affected family members were asked six questions to gauge whether they had been subjected to harassment and other abusive acts. These items were asked as a binary 'yes' or 'no'. Results are shown below in Figure 5.

Figure 5: Harassment and other abusive acts (*n*=4)



As shown in Figure 5, at the intake and midpoint surveys, one affected family member stated that their (ex)partner/other family member had done things that scared or intimidated them and that their (ex)partner/other family member had belittled or humiliated them in front of other people. Two affected family members stated that their (ex)partner/other family member had insulted them or made them feel bad about themselves at intake, but only one affected family member stated that this had also happened at the midpoint survey. One affected family member also stated that their (ex)partner/other family member had followed them or waited outside their home or workplace and had deliberately interfered with or damaged their property at the intake wave of the survey, but no affected family members reported this

behaviour at the midpoint survey. Finally, none of the affected family members who participated in the study reported experiencing harassment from their (ex)partner/other family member through the use of letters, emails, texts, phone calls or social media like Facebook.

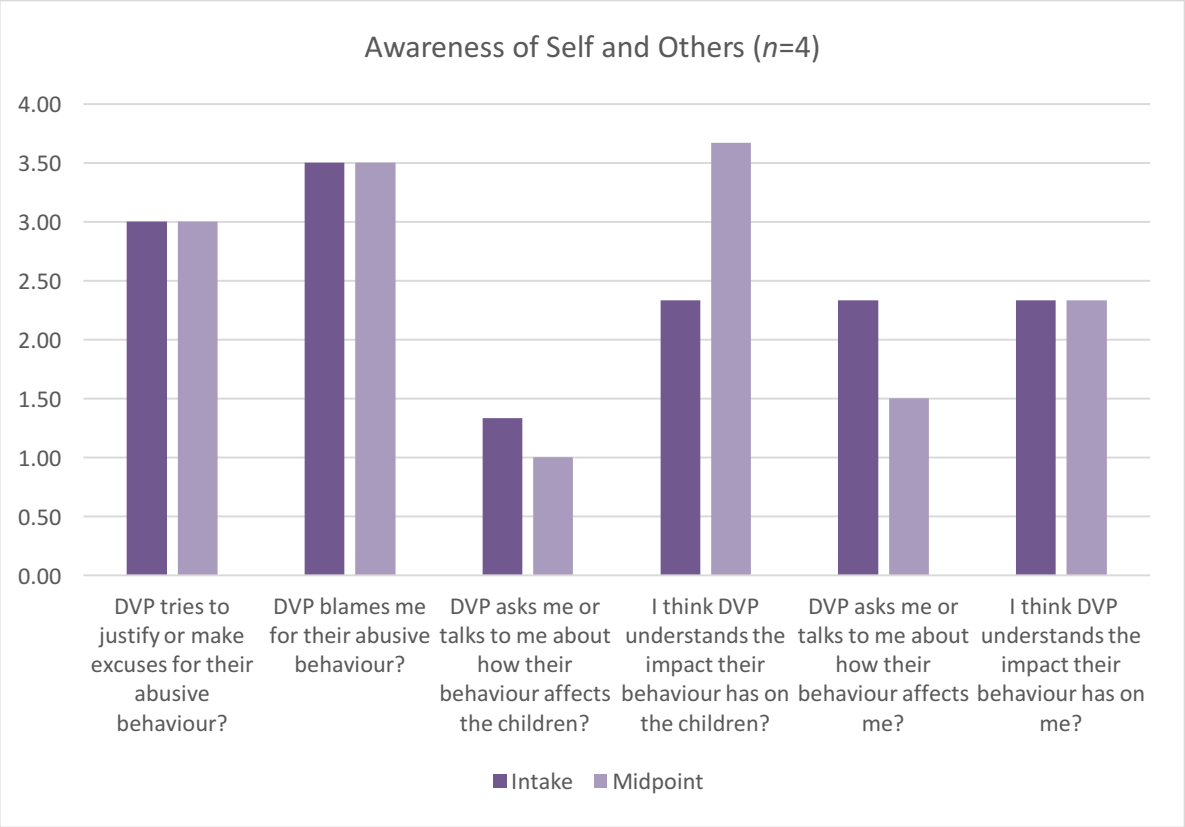
Overall safety

Affected family members were asked overall how safe they felt at each timepoint of the survey. Higher scores represented greater feelings of safety (1=not at all safe; 5=very safe). All affected family members reported feeling somewhat or very safe at both the intake and midpoint survey timepoints. The mean overall safety score was 4.75 at intake and was unchanged at program midpoint.

Awareness of self and others

Affected family members were asked six questions to determine the extent to which they felt self-aware and aware of others' behaviours. Questions were asked on a scale ranging from always (1) to never (5). Scores were reverse coded where appropriate, so a higher score consistently indicates greater awareness of self and others. The mean response to these items is presented below across the intake and midpoint surveys.

Figure 6: Awareness of self and others



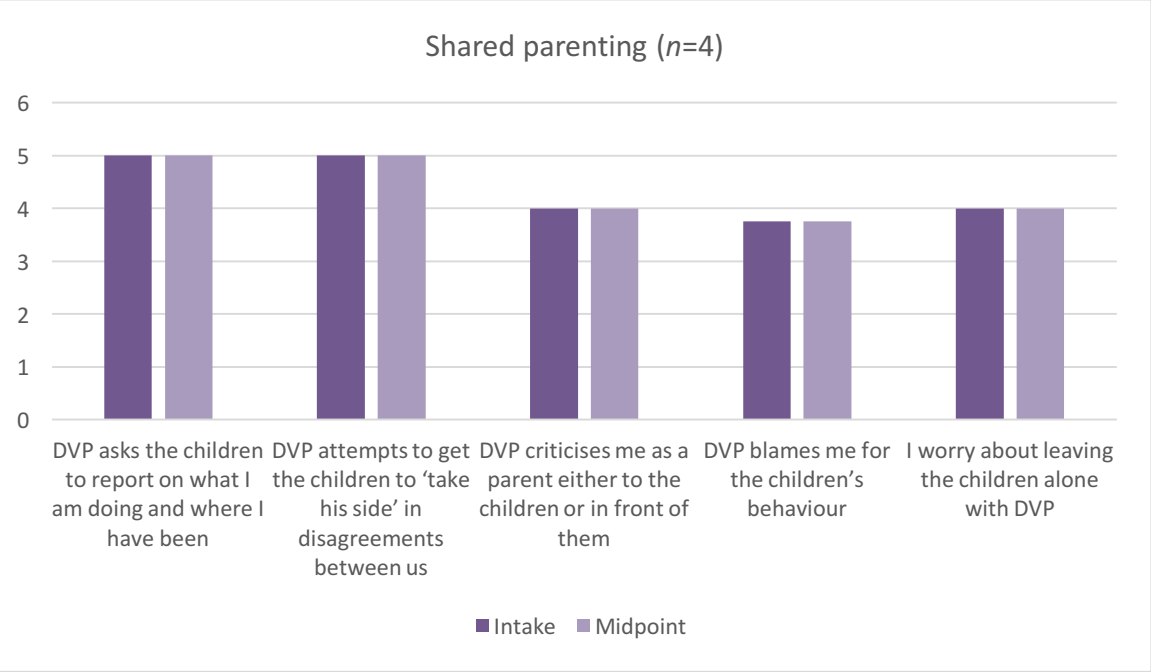
Note: For items 3-6 (*n*=3).

As shown in Figure 6, there were no changes in affected family members' attitudes across three items (items 1, 2 and 6). However, there were some differences in the remaining items. For example, the sentiment that the DVP understands the impact their behaviour has on their children some of the time (item 4) increased at midpoint (*M*=3.67, *SD*=2.31) compared to intake (*M*=2.33 *SD*=2.31). The remaining two items (items 3 and 5) decreased at midpoint compared to intake.

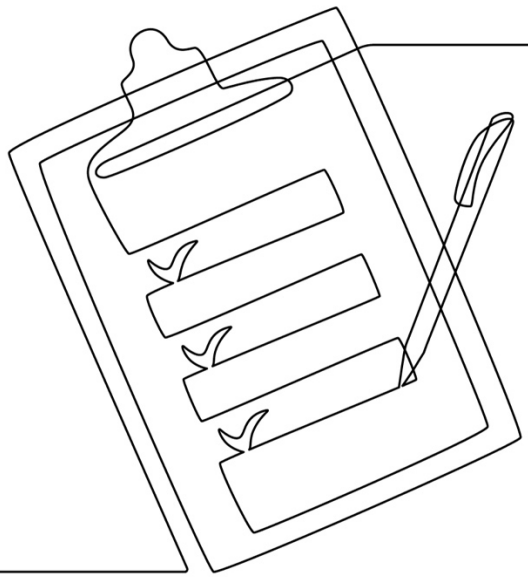
Shared Parenting

Affected family members who reported having children were asked five questions that measure safe, positive and shared parenting. Higher scores indicate greater shared parenting. Results are shown below in Figure 7.

Figure 7: Shared parenting



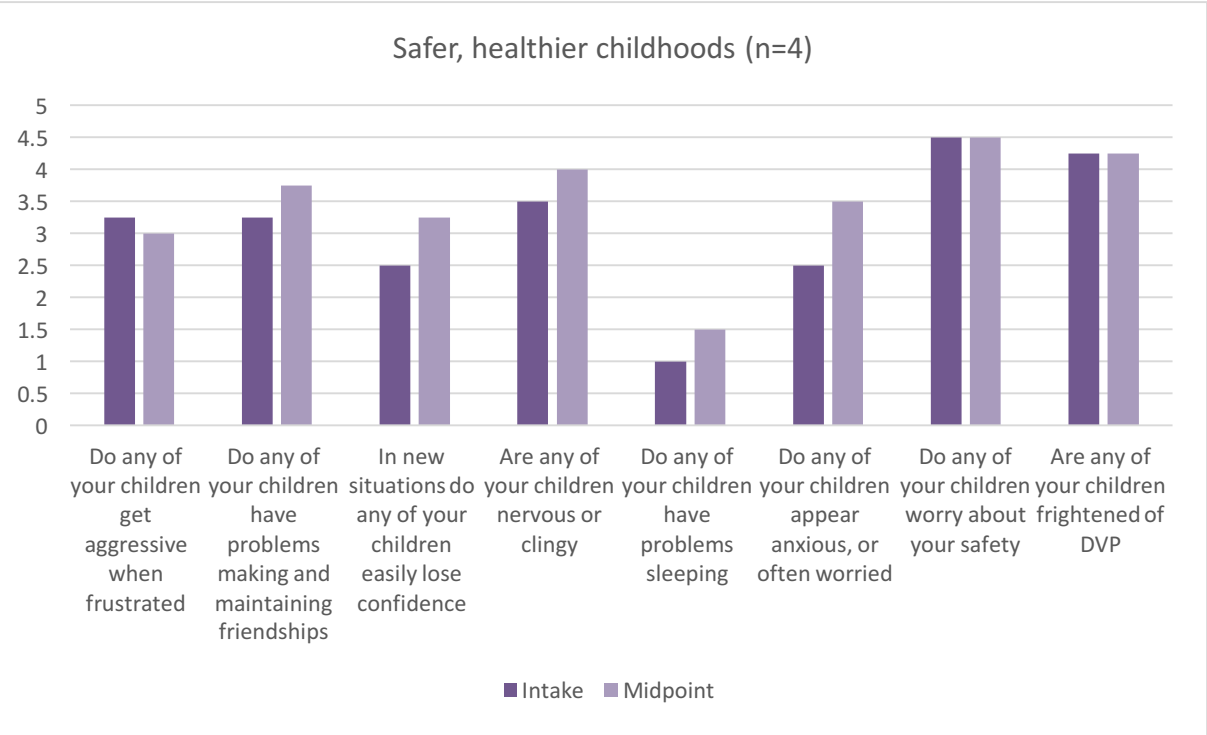
The mean scores across all items remained the same at intake and midpoint (see Figure 7).



Safer, Healthier Childhoods

Affected family members who had children were asked a series of eight questions about their children's emotional and mental health states. Affected family members were asked to answer each question on a scale ranging from never (1) to always (5). Scores were reverse coded where appropriate, so higher scores consistently indicate safer, healthier childhoods. Results are shown below in Figure 8.

Figure 8: Safer, healthier childhoods



As shown in Figure 8, there were some changes in affected family members' perceptions towards their children's health, wellbeing and safety. Item 1 shows a slight decrease from intake to midpoint. Items 2–6 show a slight increase from intake to midpoint, and across the final two items (7–8) there is no reported change.

Quality of life

Affected family members were asked an additional question regarding how they would rate their overall quality of life. Higher scores represented greater feelings of quality of life (1=very poor; 5=very good). At intake, mean overall quality of life scores were 3.5; at midpoint, this improved slightly to 4.0.

Affected family members' reflections on change

The affected family members who participated in exit interviews as part of this review described overall improvements in their (ex)partner/other family member's temperament and ability to manage stressors. For example, two affected family members described the following:

> *Our relationship has become stronger. I don't feel like the children's behaviour will – you know, the children's behaviour will make him go off. Because I'm confident now he knows – he's got some strategies in place to help him manage their antics, if I want to put it that way, because you know what teenagers are like. So he knows now just to walk away or take a couple of deep breaths or take the dog for a walk or sort of take himself out of the situation when they're doing what they do sort of thing. So he's a lot more tolerant of them, I would say. And that puts me at ease. I feel more comfortable in the home because I know that he's not going to blow up at them like he used to. (Jan, exit interview)*

> *He has changed a lot. He's more calmer than he ever has been. He's more helpful, too – which has been good – since he's been doing that [program] and when he did that – started doing that program. (Chloe, exit interview)*

These accounts highlight the value of the MEND online program for providing men with strategies to identify what is happening in their body emotionally and behaviourally prior to their use of violence and to manage and stop the potential escalation of that violence. These kinds of improvements related to self-regulation are commonly reported outcomes of BCPs (McGinn et al. 2016; Meyer et al. 2021). In this review, affected family members also spoke about men's efforts to improve their relationships with their children:

> *[He is] starting to build the relationship, a stronger relationship with his children. But that's going to take time. I mean, that can't happen in six months or however long he's been doing the program. So it's going to take time. So I noticed that he's reaching out to them more and then trying to find out more about them and – he's always helped them, but certainly – I guess it's going to take time before he builds the trust from them, builds their trust. (Jan, exit interview)*

> *He [program participant] keeps going [saying], he has to do this "because it's my daughter". And he's really starting to step up a bit, which is really, really good. (Chloe, exit interview)*

As noted elsewhere in this report (see p. 16), children were discussed as a strong motivator for men's initial decisions to participate in the program, as well as an influential factor in their ongoing participation. While affected family members reported overall improvements in their behaviour, they did also express both concerns and hope that the men will continue the behaviour change work in the future:

> *Just hope that he keeps on track, I guess, and doesn't lose it again. Because the kids will continue to push the boundaries. (Jan, exit interview)*

> *I think if he had someone like – that would work with him, I think he'd be okay. But it's finding someone, and someone to help him and teach him [...] I'm hoping that he goes to link in somewhere and try. (Chloe, exit interview)*

While it is encouraging to see the hopeful attitudes of these affected family members, we note that there is limited ongoing support offered to participants at the conclusion of the MEND online program. At exit, there

is no requirement for participants to link in with other supports or programs, and while participants may be encouraged to do so through the post-program exit and three-month follow-up interviews, there is a significant risk that the system will lose visibility of the man at the point of program completion. Further research is needed to understand the factors that influence program participants to continue to engage with services post program completion, and the ways that practitioners can facilitate further referrals and ongoing system contact most effectively.

Practitioners' reflections on change

In this review, practitioners were also invited to reflect on the changes participants had made over the duration of the program. During the exit interviews, several practitioners reflected on the small or incremental changes that were made:

> *All participants make shifts and changes, all starting from different spots. So, some participants now still would benefit from more programs, and there's still things that could be done differently. [...] I think people were more, through the program, were aware of impact, empathy building, what that was like for their family members to experience those behaviours. I think they had a better understanding of, maybe can't speak for every participant, but pretty much of gender inequality, of how different people in society have different amounts of power. So, I think there was an awareness building, there was awareness building of the subtle and not so subtle, but the pressures of expectations of what it is to be a man, and trying to get out of that man box. Yeah, and an awareness of their behaviour, and how that impacted [their families]. (Practitioner 2, exit interview)*

> *Participants' responses further down the track to situations that were arising at home, we were hearing – and particularly in this exit interview, because you've had three weeks [pass since groupwork ended], and of course they've not been the regular weekly supports. And it's almost like the universe sent each of them something to deal with that was pretty big. And hearing their response as a more thoughtful, a more measured, using the skills. (Practitioner 1, exit interview)*

Additionally, practitioners reflected that even among participants who continued to separate out their behaviour towards (ex)partners/other family members from that toward their children, or who continued to deny their use of violence, there were moments of recognising the impact of their behaviour. In particular, practitioners observed noticeable learnings related to the 'being in their shoes' exercise:

> *For [participant name] it was extremely difficult to do that [put themselves in (ex)partner/other family members shoes] and I think all the way along, [participant name] has been able to park that [impact on (ex)partner/other family member] somewhat. Even though he heard about partners and the cycle of violence, he's been able to park that, because the focus was on the child [...] it almost brought it back the other way, because there's a lot of stuff with the partner, there's a history of, and a blindness to particularly the patriarchal and the authoritarian parenting, [and] partnering. And so, that was sort of a full circle, and it's almost like a whole new body of work that [participant name] could start on now. (Practitioner 1, exit interview)*

> *Afterwards [the participant] was like, "Whoa, I would have been really hard to live with." And yes, even though he still has this narrative of false allegations, he was able to see how he really impacted and caused harm to his children and to his [(ex)partner/other family member]. (Practitioner 2, exit interview)*

These accounts reiterate the incremental nature of the changes observed through BCP participant interviews, and they highlight the significant amount of work that remains to be done at the end of the program. In considering the barriers to behaviour change, practitioners reflected on how their work operates within the broader social and cultural patriarchal backdrop:

> *It was challenging – we live in a patriarchy. I feel like [participants, working in male-dominated industries] a perfect example. But also, the participants engaging in the court system, that's so patriarchal. It's trying to dig up dirt on the person that you're at the Family Court with, instead of trying to empathise and be in their shoes. [...] this work is constantly in the context of patriarchy. I think [participant name] it was very tricky, and he's still allowing himself to be patriarchal, to use power over in the workplace. And so, his learning was, "I need to not take my work home," and put two different hats on. But yeah, we had conversations about, "Could you not use power over in work as well?" So, yeah, it was a challenge. His terminology of, "I'm in a man box, in a man box" I think is very powerful. But this work is always coming up against – we're trying to address and unlearn patriarchal ways of doing things. (Practitioner 2, exit interview)*

One participant reflected in the exit interview on their friendship group reinforcing the normalisation of violence, and that for him, part of the process of change has been leaving those friendships:

> *If I played up one day, you know, I'd think to myself and talk to friends that had the same sort of intelligence, that, "Oh, you know, you pay the bills, sometimes things happen." [...] It's not good enough. And that's what I was taught through the program. It's not – yeah, it's not a free ticket. [...] the friends that I used to do that with are also going through their own issues that are pretty similar at the moment, so it's not – it's a toxic environment to – I decided I should move away from it. [...] I've left all my friends [...] I think, now, I need to – I need to just talk to like-minded people and feel like I do have support. (Cary, exit interview)*

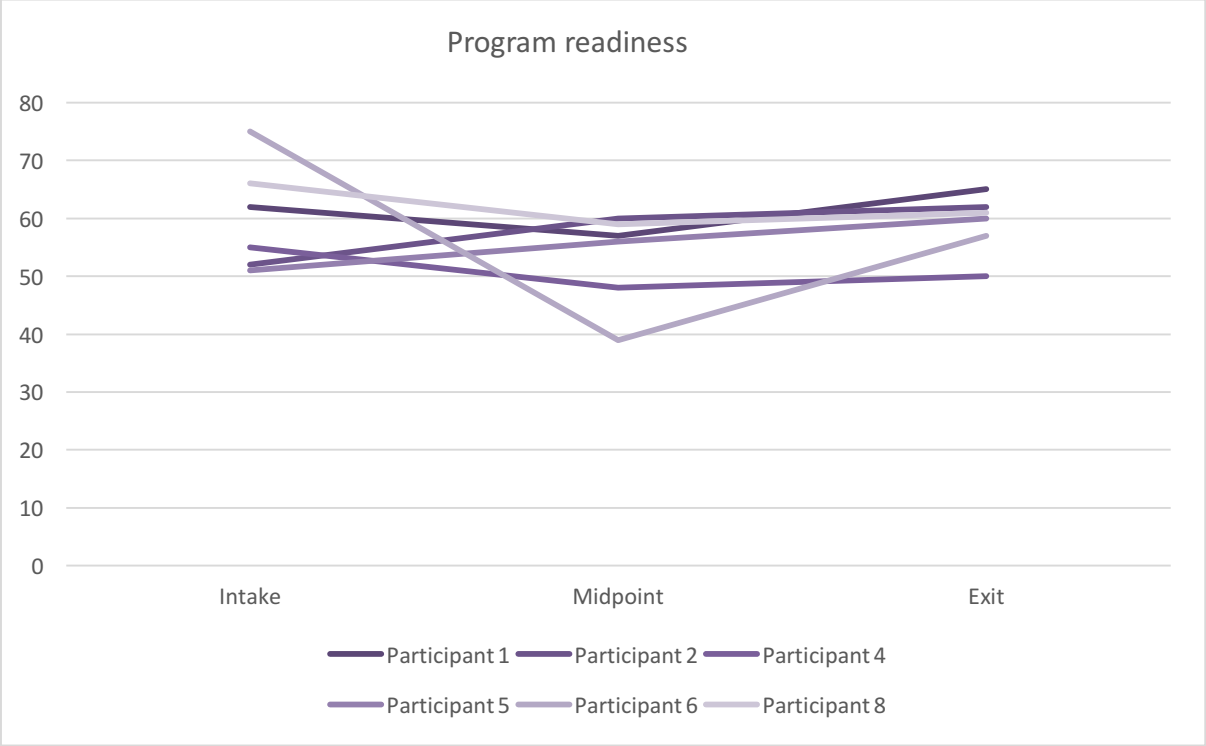
This reiterates the challenges of working towards change when external environments including social network groups can work against the learnings from group. Further, there can be a significant cost associated with ending friendship groups, as social supports are important. Disassociating from friends considered a problem may not always be an option for people who use violence, and it is also not necessarily a long-term solution, as these problematic attitudes and norms are entrenched in society.

Men's self-reports

The Program readiness scale seeks to determine how participants feel about attending the group program, whether or not they acknowledged the seriousness and impact of their behaviour, and if they believed going to the group program would contribute to a change in their attitudes and behaviours. The scale included 15 statements, and participants were asked to state their level of agreement with each statement. Scores were reverse coded where appropriate, so higher scores are associated with greater self-reported program

readiness (minimum (strongly disagree) = 15; maximum (strongly agree) = 75). The results from the scale are presented in Figure 9 (below).

Figure 9: Program readiness



As shown in figure 9, participants 1, 4, 6 and 8 self-reported lower readiness at midpoint compared to intake. For these four participants, readiness self-reported at exit increased from what was reported at midpoint. Participants 2 and 5 both reported improved readiness from intake to midpoint and again from midpoint to exit.

Questions from the National Community Attitudes Survey (NCAS) were also utilised during this review. The NCAS was first developed in 1987 and represents the longest-running survey of community attitudes towards violence against women globally (see, for example, Webster et al., 2018). Program participants were asked a series of 35 questions taken from the NCAS that measured the extent to which they normalised or trivialised violence against women. Higher scores represented stronger attitudes towards the normalisation and trivialisation of violence against women (minimum (strongly disagree) = 15; maximum (strongly agree) = 175).

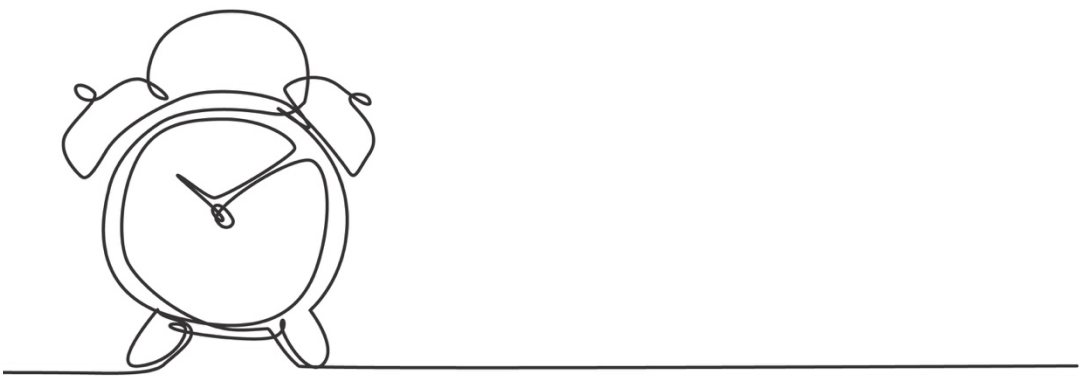
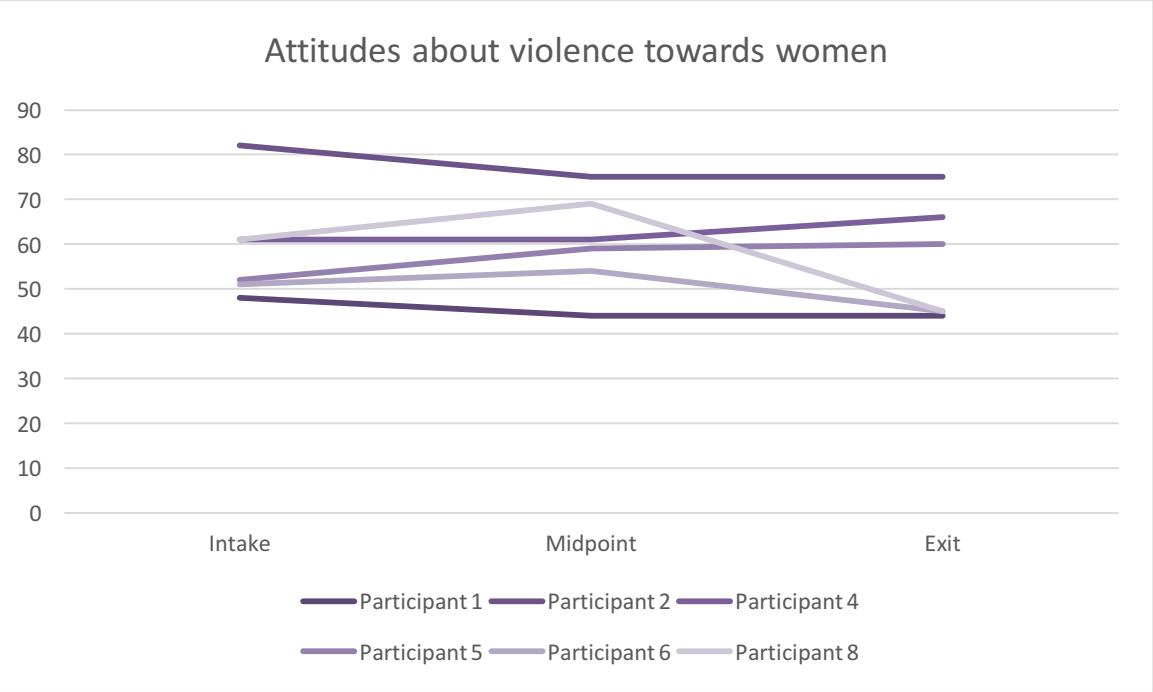


Figure 10: Attitudes about violence towards women



As shown above in Figure 10, on average, participants did not agree with the statements during the intake survey. These attitudes slightly fluctuated at the midpoint, and for all but Participant 4 continued on a downward trend at the exit survey, potentially suggesting less acceptance of violence-supporting attitudes.

In the qualitative data men reported shifts in their understanding of DFV, the impact of their behaviours on their (ex)partners/other family members, as well as changes in their ability for emotional and behavioural self-regulation. This data should be interpreted with caution due to the limitations of men's self-report data, and in particular evidence of the unreliability of this data (Langenderfer 2013; McLaren et al. 2020; Westwood et al. 2020). A key limitation of this review is the lack of alternate data sources available to validate men's self-reports. Nonetheless, when interpreted with caution, men's data does still provide insights into their own self-reported behaviour change as well as insights into ongoing denial, limitations around acceptance, and acknowledgement of personal responsibility.

Men's reported understanding of domestic and family violence

All participants reflected on how their understanding of what constitutes DFV had shifted as a result of the MEND online program. For example, two participants described:

> *There was a whole aspect of family violence that may not have included actual physical violence. The whole control, denying rights and things, saying things I guess that's violent as well. I don't know about eye opener, but I guess it reinforced some of those things [...] I've probably taken on a lot more than what I probably would have thought about before, yes. (Daniel, exit interview)*

> *There was just things that I just wasn't exposed to that, yeah, things like the financial control and all the forms of abuse and violence. When we did that, I was just like, wow, okay. Yeah. There is such a thing, didn't realise. So, it broadened my awareness around it all (Neale, exit interview)*

As the above examples highlight, participants reflected broadly on how their understanding of DFV had shifted, often in terms of learning about different forms of abuse. Further, most participants applied their broader understanding of DFV to their own use of violence, reflecting specifically that what they were doing was violence. This is captured in the reflections of two participants:

> *I knew what I was doing was affecting the family and I needed to change. I thought it was just anger issues that I had, but after doing the course I found out there was a lot more going on inside me than just anger. [...] I knew a little bit on family violence, but doing the course and watching the videos and going right in-depth into a lot of things, it opened my eyes up to a lot of other things that I was doing that I thought was just normal, which turns out to be taught behaviours for domestic violence and that. (Simon, exit interview)*

> *It was definitely a broader understanding of different – how do I say it – different types of family violence. There was occasions where it could be said that I did use family violence [...] I'd return home from the pub and an argument would ensue because I'd been at the pub. And me, I'd walk out and slam the door and stuff like that. So that group made me understand that that still is the form of family violence or a form of an emotional violence of slamming doors and raising your voice and walking out. (James, exit interview)*

As illustrated here, during the exit interviews participants reported learning that their behaviours were DFV. Yet there often remained conditions or limits on this, for example, deferring responsibility as a 'taught behaviour', or that their behaviour 'could be said' to be DFV but that there are other interpretations of that behaviour as well. The limits of men's acceptance of responsibility are explored further below (p. 49).

Some participants also expressed an improved understanding of the impact of their use of violence on their (ex)partner/other family members. Such reflections were notable across a number of the interviews conducted at exit:

> *I don't want to pass to my kids [...] I don't want to pass on sexism to them, you know, in that sense where the woman is in the kitchen and the man is at work, and that kind of antiquated crap. [... My daughter] needs to find someone respectful, not to see me being disrespectful to her mother and then thinking that's okay. [...] When it came to the children, I was stupidly showing them the machismo and the sexism, you know, just by – my boy, if he played up, and he was sent to his room, and he'd start to cry – I'd send him up saying, "Stop being a little girl," you know? Or "a baby", you know? "Don't cry." Whereas these things are fine, they're only children… And for my daughter, too, hearing that – what's wrong with crying? Girls can cry. Don't be weak, don't be – you know? All that sort of business, and, yeah. An awareness of that, and bringing up nice boys. (Cary, exit interview)*

> *The anxiety, the fear, walking on eggshells sort of thing, I guess. I guess the trepidation that they had that when's he going to explode again. When's that volcano going to come out. Yeah, I guess those kids were fearful. Even though it wasn't very often but I guess they just didn't know if I'd snap. (Daniel, exit interview)*

> *I don't know how I thought about it before, but it [the program] really gave me a greater level of clarity around how I made her feel scared and threatened and*

frightened and worried and concerned, and all those negative emotions around it. (Neale, exit interview)

These reflections highlight the importance of program content focused on impact, including, for example, the 'being in their shoes' and the 'what would your children say about you in a eulogy' exercises. As discussed elsewhere in this report both participants and practitioners (p. 53), reflected on these elements of the program as particularly valuable. Additionally, as discussed above (p. 42), the affected family members who did participate in the program review also spoke about men's efforts to improve their relationships with their children and to rebuild trust. This may indicate some understanding of the impact and harm caused. Any observations of behaviour changes are, however, limited by the lack of paired participant and affected family member data, which prevents the validation of men's accounts.

Men's reports of improved emotional and behavioural self-regulation

Program participants also reported improvements in their emotional and behavioural self-regulation. These reports suggest an increased awareness of abusive behaviours, predominantly related to identifying bodily signs of the moments of pre-violence, and improved techniques and communication skills to de-escalate. Here are three participants' descriptions:

I'm working on it. I had a bit of a blow up the other day. I didn't blow up but I felt a trigger that I could have escalated. [...] I could feel that rise in anger in me and normally I would have gone at her, gone and got her. Anyway, I sort of started to do that and then I realised what I was doing. [... I] walked down the stairs and kept going outside, just kept walking. [...] I can feel the things that are triggering me and I'm reacting to those now and changing my behaviour. (Daniel, exit interview)

I still get a bit angry every now and again, but I pick that up and we talk about it. But I feel I'm a lot more open and verbal with her now, and we talk and we're trying to build a better relationship [...] We've been taught ways to help recognise things, how to try to stop them, how to calm down, methods, breathing and all that. And we've been given the tools. (Simon, exit interview)

Going in the program and that, it's sort of showed me, you need to listen, and you need to breathe, and you need to just concentrate on, yeah. So, it's taught me some skills to try and work with the kids. (David, exit interview)

These outcomes are also linked to framings of violence as 'losing control' or 'boiling over'. During the exit interviews, two participants commented:

I didn't want it [violence towards children] happening anymore because it wasn't frequent, very rarely really, but I did lose some control when I did it. (Daniel, exit interview)

There was an awareness of, wait a minute, now it's that boiling frog analogy. You just don't realise how things creep up on you. Then it's suddenly, wait a minute, I catch myself in the moment going, wow, this is not right. (Neale, exit interview)

These examples suggest a focus on anger management and a misrepresentation of using violence as beyond their control rather than as a choice. As discussed above in relation to affected family members' accounts of

change (p. 42), reports of improvements related to emotional and behavioural self-regulation and communication skills are common in BCPs. However, changes in belief systems, which are more commonly associated with reductions in violence, are less commonly observed (McGinn et al. 2016). Additionally, there are limits to men's reported improvements in their behaviour (Langenderfer 2013; McLaren et al. 2020; Westwood et al. 2020).

Limits to men's acceptance of personal responsibility

The findings presented in this report from affected family members, practitioners and men's self-reports suggest some improvements in men's use of violence. However, concerningly, men's self-reports also indicate ongoing denial of behaviours among some participants. For example, at the conclusion of the program, two of the participants commented:

> *I had a lot of false allegations put against me and that was family violence and domestic violence, and they were absolutely just false allegations. (James, exit interview)*

> *I've never done any programs about domestic violence, or any other, because I've never been – my ex, ex-partner tried to charge me a long time ago with me hitting her, but that got thrown out of court, because it wasn't true. (David, exit interview)*

These participants distanced themselves from the 'real' perpetrators of violence within the group. They went on to state:

> *The only problem I had with the course was being around and involved with people that actually perpetrated the things that I was accused of. [...] That was a bit hard. So some nights it would take me a little bit to wind down from courses, just being around people and hearing them openly talk about it, and I was accused of it. (James, exit. interview)*

> *I couldn't relate to anyone, to their – there was only two people that I really connected with, that sort of had a similar problem to me. It was pretty hard, actually. (David, exit interview)*

Rather than seeing similarities between their own use of violence and those of others within the group, for these participants the group context potentially reinforced their perception of themselves as *not* perpetrators of DFV. This was reinforced at various points in the interview with David, where he maintained that his use of violence was general violence rather than DFV: "I was a violent person before [...] I was violent not towards her, but towards other people." (David, exit interview).

As discussed above, there were moments in which these participants expressed some admission of their use of violence. For example, in the context of slamming doors, raising his voice and walking out, James said "it could be said" that he used DFV (p. 47). Similarly, in reflecting on what he learnt from the program, David said:

> *It's sort of showed me that some of the signs I was doing, what I was doing was sort of like family violence, which was family violence. Not towards my kids, but towards her, just verbally. (David, exit interview)*

Like James, David's admission is similarly limited to being "sort of like family violence" and limited to his (ex)partner, not his children. David's lack of recognition of how his violence impacts his children is discussed elsewhere (p. 53).

These examples also illustrate the inconsistencies in some men's accounts of their own behaviours throughout the interviews. James and David had moments of denying their use of violence towards (ex)partners/other family members, while also having moments in which they – conditionally – admit to using violence. This aligns with practitioners' reports of the incremental changes made by program participants (p. 43) and points further to the limits to men's acceptance of responsibility for their use of violence. These findings also demonstrate the value of interviews and conversational assessments of behavioural change that can capture these nuances from multiple viewpoints.

Other participants focused predominantly on their use of violence towards their children (as discussed by practitioners elsewhere, p. 43). At times the focus on children was accompanied by a minimisation or denial of their use of violence towards (ex)partners/other family members. For example, two participants commented:

> *We're certainly very loving to each other, never had violent altercations with my [(ex)partner/other family members] at all, ever. [...] I guess probably my problem really being was I used to discipline the children. I would be physical and smack them and I probably did that to them and used unnecessary force I'd say. (Daniel, exit interview)*

> *There was at least one other participant who was on there who had the same kind of thing [as me], where the frustration was coming out on kids, rather than [(ex)partner/other family members]. (Neale, exit interview)*

As explored elsewhere in this report (p. 51) both of these participants also had moments of recognising the impact of their violence on their (ex)partners/other family members, but there were limits to the ways in which men understood the interplay between their use of violence towards a particular person – whether children or an (ex)partner/other family member – and others within the home. Further, in one example, Neale separates his use of violence towards the children from his parenting:

> *I was pretty connected and involved and all that kind of stuff [as a parent]. It was just the frustration and the anger kind of spurting out. (Neale, exit interview)*

Neale makes a disconnect between anger and parenting. That is, he isolates 'anger' and its eruption, choosing not to see those behaviours as a part of parenting. This suggests a focus on anger management rather than a challenge to systemic attitudes about power and control. In the context of current national policy shifts to better recognise children as victim-survivors of DFV in their own right (DSS, 2022; see also Meyer & Fitz-Gibbon, 2022), the data from this review highlights the critical importance of further interrogating parenting practices and understandings of the impact of DFV on children.

Additionally, at the point of exit, some participants expressed a deferral of responsibility for their use of violence, particularly through persistent narratives of mutual responsibility and a preoccupation with their (ex)partners/other family members' behaviours. This is captured in the comments of three participants:

> *My ability and our ability, including my wife's as well, because I think the programs really impacted her about how she shows up with the children as well is, yeah, so much better. [...] I think what's happened is that by talking about it and making it*

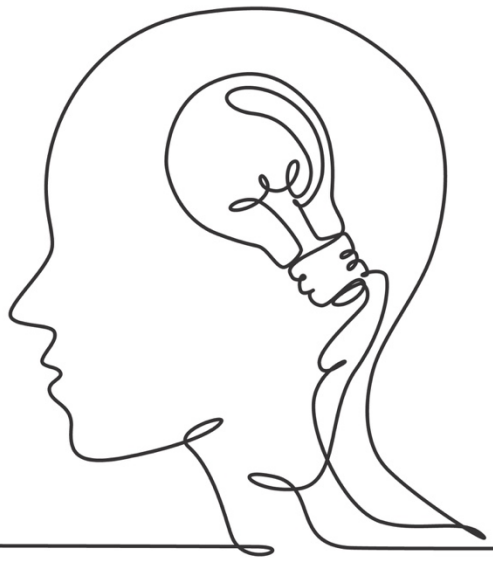
really real, that it's made her stop and actually assess what are the contributing factors to the frustrations, and those kind of trigger points. Actually, realising maybe her contribution in some ways to the tenseness around things, and realising we need to back off way before we even get there. Also, some of the tools and stuff that we've gone through, I've gone through them with her, and we use them very much so. (Neale, exit interview)

I've learnt how to read the signs of when she's thing, I can give her some space when she's not feeling thing, like her mind, mentally she's not – when my kids are running amuck and she needs some space, I sort of read that and take the kids away. And she clicks onto it now, and she's appreciated that much, because I never used to do that. [...] all the little things, when she gets frustrated and she swears and that, I just tell her to breathe. (David, exit interview)

She's been doing her own soul searching and research and stuff into her own issues over this time as well, and we've come together as a better family, as a whole. She's spending more time with the kids, taking them to the park instead of being standoffish. (Simon, exit interview)

As the above quotes illustrate, these participants implicate their (ex)partner's/other family members' behaviour, and in particular their parenting, as part of the 'problem'. These examples demonstrate a persistent denial of personal responsibility and an inability of these participants to see how their perpetration of violence may impact how their (ex)partners/other family members are with their children.

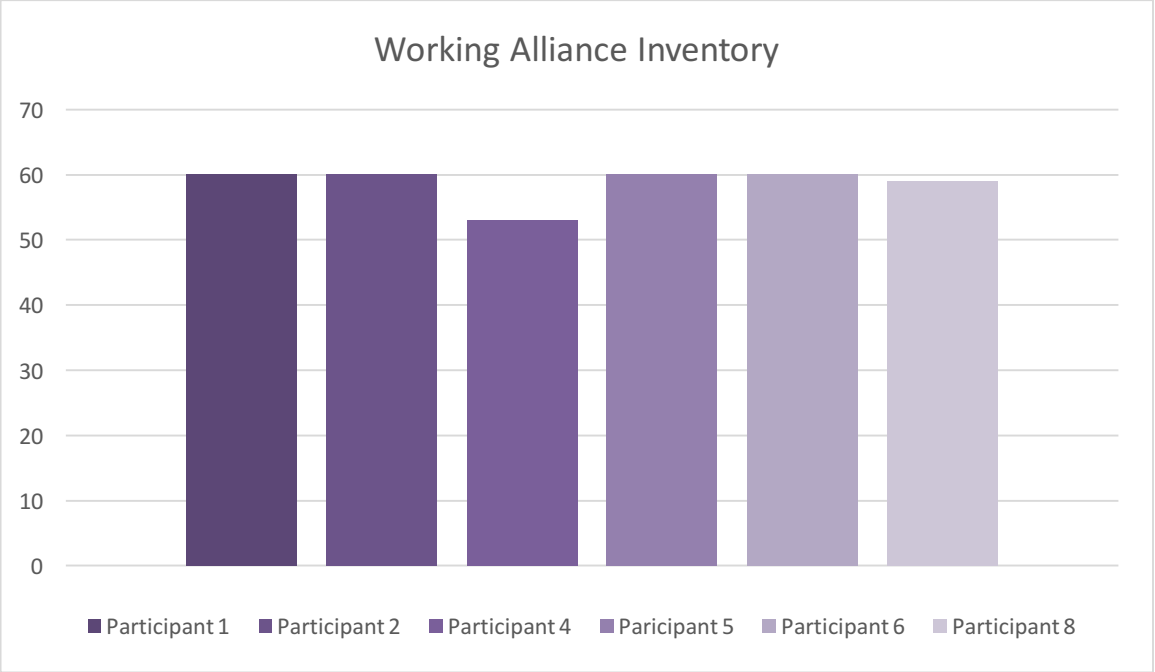
Further, Neale and David also present examples of projecting the lessons from group – going through the tools with (ex)partners/other family members and using the tools together, or telling (ex)partners/other family members to breathe – onto their (ex)partners/other family members. While these participants speak to the impact of their use of violence on their (ex)partners/other family members, including children, at various points, they also repeatedly demonstrate limits to their own understanding of their use of violence and their acceptance of personal responsibility for that violence.



MEND online Program feedback

As noted in the methodology, the WAI captures the relationship between program participants and the group facilitators. In this review it was incorporated into the exit survey to gauge how much participants felt that they could make positive changes upon completing the program. Specifically, participants were asked 12 questions regarding their working alliance. Higher scores represented stronger feelings of working alliance (minimum (strongly disagree) = 15; maximum (strongly agree) = 60).

Figure 11: Working Alliance Inventory



As shown in Figure 11 (above), six participants completed the exit survey, and results showed that four participants strongly agreed with all items, suggesting a strong self-reported working alliance. Participant 4 provided mixed responses to some questions, agreeing with questions that asked them about the clarity they had with regards to changing, and how much the facilitators care about and agree upon how to make such changes. They also neither agreed nor disagreed that group facilitators care about them even when they do things that the facilitator does not approve of. These findings suggest that while the other participants felt quite assured and supported in their abilities to make positive changes in their lives, Participant 4 still required some additional guidance (see above Figure 11).

Participants spoke positively about the value of the program for expanding their understanding of their perpetration of violence. Here are four participants' comments:

> *I'm just really appreciative of the program, to be honest. Yeah. I'm really appreciative of the program, and it has made a massive difference. (Neale, exit interview)*
>
> *I found it a tremendous help – it was a huge help for me. (Cary, exit interview)*
>
> *Doing the course and watching the videos and going right in-depth into a lot of things, it opened my eyes up to a lot of other things that I was doing that I thought was just normal [...] Definitely. It [the program] opened my eyes up. (Simon, exit interview)*

> *I think it's really helpful. It's been really helpful. I hope that it continues for other people because it's important. I didn't find it overbearing. In fact, I was quite happy to hop on on a Wednesday night and do it. (Daniel, exit interview)*

Participants were asked if there were any topics or exercises that they found particularly valuable. Participants spoke about two exercises where they were positioned to think about the impact of their behaviours on their (ex)partner/other family members, and in particular children:

> *We did 'In Their Shoes' piece where we were our partner and getting asked questions by the facilitators, and just pretending to be on the other side and going over what happened over the years, it opened my eyes up to actually what I had done [...] There were one or two nights where we'd cover, 'What would your kids say at their 18th of you', and that was an eye-opening night for a lot of us in the thing. (Simon, exit interview)*

> *Looking through their eyes. Yeah. At the tension. Looking through the kids' eyes, when they're showed videos of the stress. For instance, a man came home from work, and bad temper, bad day at work, and then criticising the wife hadn't done [enough around] the house, and blah, blah, blah. And then the look on the children, you know? All the shutting down, going quiet. Yeah. All that behaviour stuff that's behind the scenes that you don't really pick up on when you're in the heat of it, but it's always been there. (Cary, exit interview)*

Participants also spoke positively about the group format:

> *I just enjoyed listening to most of it, and really just hearing everyone's stories, because you learn by listening. (David, exit interview)*

> *I really liked the group and, I don't know, there was just an unsaid respect from everyone around, how we were all showing up. In a lot of ways, I feel it is sad that it's the end, [...] I really feel connected to those guys and they're not going to be in my life anymore. (Neale, exit interview)*

These are important reflections, as they highlight the perceived value of group work in an online setting, combatting any myths that connections can only be formed in person and via in-person program delivery. Participants were also asked if there were any topics or content that they did not find useful. In response participants reflected on particular manifestations of violence that they felt were not relevant to them. For example, three participants commented:

> *It would probably only be about the kids, the violence towards kids [that I didn't relate to]. Because I've never hit a kid in my life. (David, exit interview)*

> *Some of the more severe – I can't really remember, to be honest, but it was things around sexual violence. Stuff around sexual violence. So, if there was all stuff around sexual violence, and money and restriction and that stuff; I've just never done any of that, do you know what I mean? I don't think I would. But then, I didn't think I'd do what I did. That's why it was good to see the spectrum, but it wasn't directly relevant for me. (Neale, exit interview)*

> *There was definitely some [topics] that I didn't – I couldn't relate with, like there was definitely a lot in there that I couldn't relate with, but there were some key things that I did take from the group. [...] It would be more along the lines like the physical and sexual violence side of things that I couldn't relate with, or I couldn't take anything from because I'm so dead against that side of things. (James, exit interview)*

These examples illustrate some of the work that remains for these participants in recognising their use of violence and its impacts. For example, David continues to separate his use of violence against his (ex)partner/other family members from his behaviour towards his children. In asserting that he does not use violence towards his children, David's recognition of how his violence impacts his children and how they are also affected by his use of violence appears limited. This was reinforced at various points throughout this interview, including when David reflected on how the program showed him that "what I was doing was sort of like family violence, which was family violence. Not towards my kids, but towards her" (discussed above, p. 49). This demonstrates a limited understanding of the impact of DFV on children more broadly. Further, in asserting that he is not violent towards his children, David focuses on physical violence ("I've never hit a kid in my life") and fails to recognise the range of other abusive behaviours and tactics that may have been employed. Similarly, James reflects that there was a lot of content he could not relate to, and as discussed previously in the men's self-report of behaviour change section, James continues to deny his use of violence (see, p. 49).

In discussing topics that were not perceived to be as relevant or useful, participants often mentioned sexual violence. In the final practitioner interview, we asked practitioners how sexual content came up throughout the program. Practitioners reflected that sexual coercion was relevant to many of the group participants, through behaviours such as sulking, but that this was a particularly 'tricky' subject to explore with this cohort. As two practitioners reflected:

> *One participant really early on identified sexualised violence in some of his abusive behaviours. I'm trying to think, yeah apart from that [dedicated] topic that week [on sexual consent], it doesn't come to mind addressed in other spaces. (Practitioner 2, exit interview)*

> *I think it was a more tricky subject to bring into this particular group, in as much as the man box is so strong in this particular group and I felt that after the [weeks on] boundaries, self-boundaries, other boundaries and consent, sexual consent, there were lots of references back to it, to that. And I think that was, and I think your question [co-facilitator's name] about the [...] Sulking, yeh. There was such agreement in the room by nods and voices, that it then in a way, gave opening to continue the references back towards it, or to speak about that. (Practitioner 1, exit interview)*

Barriers to discussing sexual content within the DFV perpetrator intervention space have been raised in recent Australian research (Helps et al. 2023). Practitioners in Helps et al.'s (2023) study highlight a range of barriers to discussing sexual violence with BCP participants, including for example, practitioner discomfort and program participant reluctance. While some practitioners felt these challenges were amplified in the online context, they were not unique to online BCP work.

Participants were asked if they felt the program had met their needs and/or if there was anything they would have liked to explore further. Participants generally spoke about a more specific focus on their circumstances,

for example, the use of violence towards children or the intersection of problematic alcohol use and the use of violence:

> *If it was solely a group of men about children in their custody or whatever then, yeah, I think that would have been more relevant. Yeah, it would have been even better, maybe. But yeah, who knows, the diversity of what we went through was really valuable anyway. (Neale, exit interview)*

> *In my case, yes [talking about alcohol]. Yeah. But then, that's sort of like – more individual treatment, not like a group thing. (Cary, exit interview)*

Participants suggested that there probably would not have been space for these issues to be addressed within the group. Cary spoke in the interview of trying to link in with Alcoholics Anonymous, but that the options were limited in the rural area where they live. As this is the target cohort of the online pilot program, there is scope for greater consideration of additional support for participants with co-occurring needs such as problematic alcohol use. This is further reason to consider the role of additional one-to-one work with relevant specialists, such as an alcohol and/or other drug counsellor who can work with participants to address these issues alongside group work. There is also scope to consider whether other, more targeted programs – such as the Caring Dads program, which is focused on the intersection of the use of DFV and parenting (Meyer et al. 2019), or the U-Turn program, which is focused on co-occurring problematic alcohol and/or other drug use (Meyer et al. 2021) – may also be effectively delivered in the online format.

Jurisdictional issues

The nine program participants were located across five Australian states and territories (New South Wales, Victoria, Northern Territory, Western Australia and Tasmania). One concern at the referral and recruitment stage was whether the cross-jurisdictional program would meet the practice standards of each jurisdiction. As one practitioner explained:

> *When [referring services] would ring and want more information, we'd talk about [jurisdictional issues …] whether the program would be recognised in courts in other states [...], I would discuss that with them regarding our practice standards and things like that. (Practitioner 3, early interview)*

Practice standards for BCPs vary between state and territory jurisdictions. This creates an additional complexity, particularly where participants may be court mandated to attend. Practitioners may not know whether a program meets the standards across all jurisdictions, or if it has been accredited by more than one state body. In the context of the pilot program cohort, only one participant was on parole condition, and one participant had ongoing Family Court matters. No participants were specifically mandated to attend, and therefore jurisdictional requirements did not present as an issue within this pilot. However, if the program were to expand (and future programs are delivered to participants across jurisdictions) this may present as a challenge. In the first instance, and as the above example highlights, consideration of referring services across jurisdictions is required. The implications of running programs across jurisdictions require further research, and consideration should be given to the development of national minimum practice standards that are consistent across state and territory jurisdictions to ensure consistency of practice (see also NTV 2023). Such standards would need to be developed at a more specific, and practice-focused, level than the National Outcome Standards for Perpetrator Interventions (NOSPI).

Perhaps unsurprisingly, given that it has been a key concern in the delivery of services and risk assessment for affected family members, jurisdictional issues were also raised in the context of ongoing risk management and information sharing. As one practitioner explained:

> *We are closely involved with a multi-agency response here in New South Wales and we have regular fortnightly meetings [...] We're familiar with the process. So, had there been an example where we, here, if we thought that somebody was a serious threat, we would have made a referral to those meetings [...] But I'm not sure how that happens in other places. (Practitioner 4, exit interview)*

> *The provisions that govern that information sharing are state legislation. And I just make the assumption that they're the same as they are in New South Wales. But I didn't have – there wasn't an occasion in this program where I had to test that. (Practitioner 4, exit interview)*

Victoria and Queensland have undertaken significant reform to develop and implement common risk assessment and management frameworks, to enhance multi-agency responses, and to increase information sharing, including via legislative requirements (see further, Department of Communities, Child Safety and Disability Services 2017; Department of Justice and Attorney-General 2022; McCulloch et al. 2020).

Other states and territories are at varied points in their agendas to improve risk assessment and management practices, and to develop information-sharing schemes. One of the implications of this variation in practice is that, where risk is identified, responses may vary depending on where the program participant lives.

Jurisdictional issues also presented as a challenge for the FSC worker providing support to affected family members. As one practitioner commented:

> *I have familiarity with what's available here and can make those referrals almost instinctively. But with somebody in Western Australia, for example, anywhere else that's not here, I have to look it up. And I mean, even here, I'll ring up and make a warm referral with another service, and it's the same sort of [process] in other geographical places. But even just to find out what they do, I've had to ring up. I don't have that familiarity with their process. [...] It is a bit more work because you do have to – you're not familiar with the processes in other jurisdictions. You're not familiar with if they've been in contact with the criminal justice system [if they need support with an AVO for example]. Those processes are not necessarily the same. And sometimes, an understanding of them enhances the engagement. [...] It's not prohibitively an additional amount of work, but there's certainly more research to be done. (Practitioner 4, exit interview)*

One of the benefits of online programs is increased accessibility – being able to reach people in locations that otherwise may not have contact with the service. However, as Practitioner 4 explains, for onward referrals this also presents as a challenge. Because practitioners may be making referrals anywhere across the country, they need to build a knowledge of the services that are available. Critically, this is not only about looking up a service but being able to develop a relationship with that service to better facilitate warm referrals. As Practitioner 4 highlights, having knowledge of services and being able to share that with affected family members can enhance engagement and provide affected family members with a more positive experience. Evidently, this work can be more resource intensive for programs delivered online.

One-to-one work

As discussed above (p. 14) the intake processes involved additional individual work (program participants meeting with both facilitators) prior to the group sessions commencing. One-to-one sessions were also available to program participants over the course of the program. Two optional sessions were available and encouraged, once in the first 10 weeks of the program and once in the second 10 weeks. Additional check-ins were available and provided on an as-needs basis to participants, for example, following challenging topics. Where there were any concerns, practitioners would also conduct additional check-ins. Program participants spoke about the individual conversations as useful for focusing specifically on their own situation:

> *I spoke to them three times separately, one-on-one, which was good. I'd waited till the end of one of the meetings and had a chat, so then they arranged a meeting the next week to have a one-on-one, face-to-face talk. [...] It was good. One of the times I had an issue and I had [facilitator] call me that same day, and we had a 40-minute chat on the phone straight away, which I found really good. They're really supportive. [...] one-on-one, I'd talk directly about my current issues that were happening at home and with myself, and then we'd talk about that, which was good. [...] they'd give me things to do, different ways to think about – a different perspective, which made me start thinking differently about it straightaway [...] It was good because I could talk exactly about what I was thinking, how I was feeling, and then they'd have their different views and ideas, and made me think differently or start thinking differently about the issue that was going on. (Simon, exit interview)*

Practitioners similarly spoke about the value of one-to-one support alongside group work:

> *It really adds to that individual, we can see how people are going, what's going on in their personal life. So, that more kind of focussed support, and then the group is more broader. So, I think they go really well together. (Practitioner 2, exit interview)*

> *It helps to really bring the participant into what is happening in your life now. So, those two check-ins brought [co-facilitator] and myself up to speed with the changes in the individuals, which there's limited time for in the group. [...] It more than value-adds to the group. I think it's an integral component in facilitating and supporting that growth along the way. (Practitioner 1, exit interview)*

> *We've always, at our service, done it where they can access one-to-ones and people who need to do [take-up the one-to-one sessions] and we obviously check in with people [...] I think that particularly given it was online and the geographical distance and all that stuff, I think it actually would have been really helpful to be like, you have the 20 weeks of group, but you also – there's say, like four or five, whatever number, of one-to-ones and this is when they happen at these different check-in points and that's when if there's been any risks identified from either the affected family members or from just what you hear in group, but you might not be able to bring it up directly in the group environment. So then you've got these one-to-one check-ins along the way and after. I think that that would be something I'd actually build into the program. Whereas like instead we did do it spontaneously, but it*

> *meant that there was, I think there was a couple of people that didn't take it up because it wasn't like an absolute must for them to complete the program and stuff. (Practitioner 3, exit interview)*

As the practitioner quotes highlight, there are limited opportunities within the group environment to comprehensively assess individual risk and circumstances. As practitioner 3 explains, having one-to-one sessions as a requirement rather than an optional add-on would provide additional opportunities to assess and manage risk. Further, while participants are required to notify practitioners of changes to circumstances, the additional check-ins would provide another opportunity for practitioners to explicitly check in on changes to relationship status or living arrangements, for example. This would also provide an opportunity to facilitate further referrals to supports such as alcohol and other drug or parenting supports, and/or to see if previously provided referrals had been taken up.

As the one-to-one sessions were optional and uptake was participant-led, not all participants chose to take up the one-to-one sessions:

> *No, I didn't [take up the one-to-one support] because to tell you the truth, I wouldn't know what to say to [the facilitators], because of, like I said, I honestly got – [into trouble] for normal violence. (David, exit interview)*

David's reflections on not taking up these sessions because he "wouldn't know what to say" highlights the potential value of embedding this practice. As explored elsewhere (p. 62), there remained limits to David's acceptance of responsibility at the end of the program, and these one-to-one supports would have provided further opportunities to support learnings from the group. Embedding this as standard practice may overcome any potential awkwardness or uncertainty participants may feel around requesting this support.

In addition to the individual work at intake, and over the course of the program, two post-program check-ins were conducted – one at exit, and one as a three-month follow-up. While exit interviews are a standard component of the program, the additional post-program sessions provided another opportunity to assess and manage risk:

> *We decided that we would offer a one-to-one session for all of the men post the end of the 20-week program. We already do an exit interview, but we wanted to offer more of a check-in immediately after, as well as an offer of another one a couple of months later so that we could keep eyes on the participants. […] we could be checking in, have you been working with these services, do you need us to facilitate another referral, whatever it might be that we can keep an eye on that. And [the] concern was that [some of the men would] be like, yeah, yeah, great, I'll take those referrals but then wouldn't actually go once [the program had ended]. So I guess by creating this plan that the practitioners would meet with [each participant] two more times after group is finished, allows, I guess, in the hope for there to be a bit more accountability […], there's actually a checking in and more encouragement to actually make contact with those services [post-group]. (Practitioner 3, exit interview)*

While uptake of the during-program sessions was optional and participant-led, the post-program (exit) check-in was discussed and scheduled during the final group session. Comparatively, all participants booked an exit session. Further, all participants expressed to practitioners that they would like a check-in at the three-month follow-up point post-program. Enhancing the visibility of perpetrators through pre-, during- and post-program individual work provides a more thorough intervention than would be otherwise achieved. Further research into the role of one-to-one work alongside and in conjunction with group work is required. In particular, there is a need to understand how one-to-one work may impact factors such as ongoing

motivation to attend or participate in group; engagement and active participation in group sessions; assessment of risk; program outcomes, including changes in behaviours and attitudes; and uptake of referrals and participation in ongoing behaviour change work beyond the end of the group sessions. Notably, program participants spoke about a range of other supports, including parenting programs, support groups for mental health and/or alcohol or other drug support and individual support through psychologists. While we are unable to speak to the impact of these supports, further research on the role of additional supports that occur pre-, during or post-group would be valuable.

Community of practice

As discussed in the methodology section, NTV ran monthly community of practice sessions over the course of the pilot program. These sessions brought together practitioners and other stakeholders involved in the design, development, delivery and review of the MEND online program, as well as the Clear Space program delivered by Thorne Harbour Health (THH). Practitioners spoke positively about these sessions and the opportunity to hear from practitioners in a program that was running in parallel:

> *Typically [it is] such binary work, and so I'm really getting a lot of value out of hearing the stuff that Thorne Harbour is bringing. And also really enjoyed the facilitators bouncing off each other and checking in with each other. (Practitioner 2, early program interview)*

> *With the coordination side of things, having [name of program coordinator] and myself to be able to go, "Oh, well we're also at this point, and we're also struggling with getting referrals, and we're also struggling with XYZ." And then at the same time, both being like, "Oh, we're going to start groups soon," and there being that kind of similar trajectory. And I think if you were doing it alone as a pilot, and we were "running late," there'd be more of a feeling of, for me anyway like, "I'm failing." And it's been really good to have other people that are experiencing similar challenges, because it's like, "Okay, it's actually not a personal thing, it's just the context of doing something like this." So, that's been really helpful for me. (Practitioner 3, early program interview)*

As Practitioner 3 highlights, there was a particular benefit, given the pilot context, to experiencing alongside each other the challenges of each stage, from design and development, recruitment, and foundational weeks, through to the completion of the programs. Practitioners spoke about the value of the community of practice sessions for creating dialogue between practitioners and the opportunity to learn from each other, but the presence of stakeholders not directly involved in program delivery sometimes impeded this benefit:

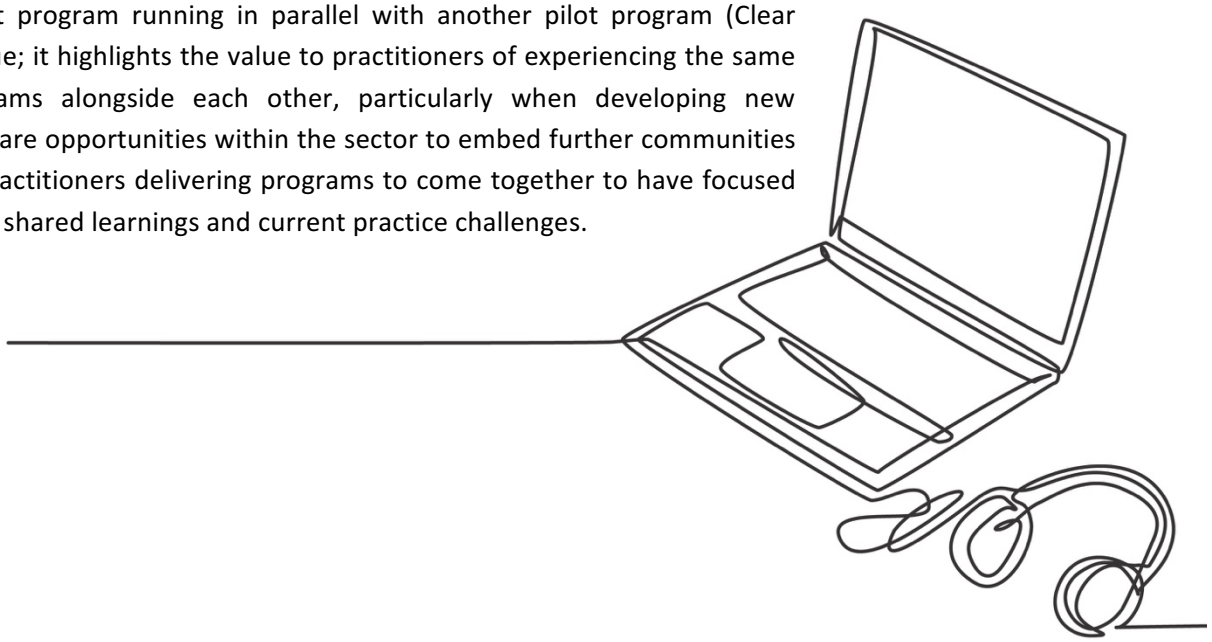
> *My understanding of communities of practice is very much that everyone at the community of practice is kind of – practising. Whereas [in this community of*

> *practice …] it was almost just like questions getting directed at them from this, I don't know, panel [...] what's really useful* ***is like [THH practitioners] and the practitioners from [MFC] being able*** *to actually talk about practice. [...] In the future, I'd probably try and make it a little bit more of a safer space for the practitioners to talk about practice. (Practitioner 3, exit interview)*

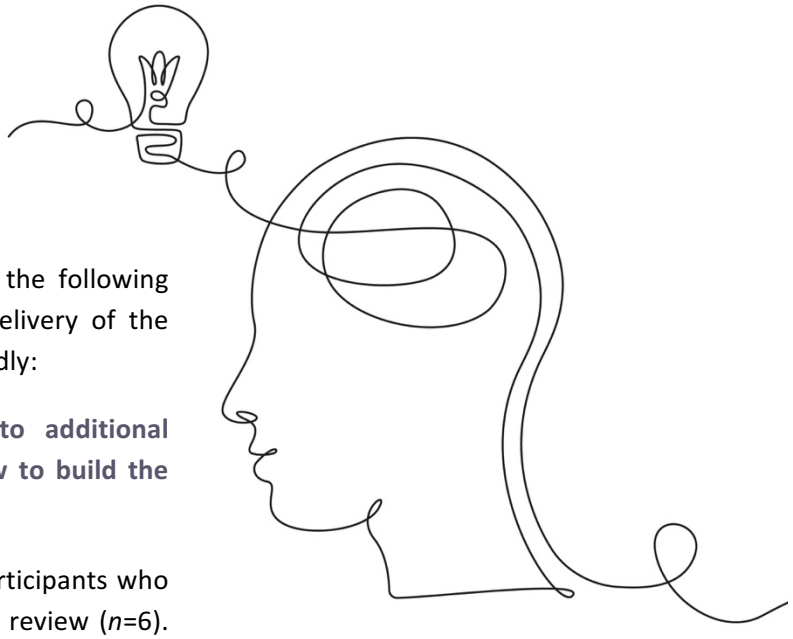
In reflecting upon sector-wide community of practice opportunities, practitioners similarly highlighted that while these could be valuable, they did not necessarily create a space for practice-focused discussion:

> *I haven't been [to the sector-wide communities of practice] for a while. It feels less kind of talking about practice, a little bit. Yeah, I suppose this project, because we're coming at it together, "Oh we're at Week 3," it feels more connected, supportive. Because [at] those [sector-wide] communities of practices there's people from ECAV [Education Centre Against Violence], it's people who aren't running group, it's not all [facilitators], yeah [...] The parallel process has been, yeah – Which is different in the other, in the broader communities of practice, because people are at different spots. So yeah, coming at it from the same spot has been useful. (Practitioner 2, early program interview)*

The current pilot program running in parallel with another pilot program (Clear Space) was unique; it highlights the value to practitioners of experiencing the same stages of programs alongside each other, particularly when developing new programs. There are opportunities within the sector to embed further communities of practice for practitioners delivering programs to come together to have focused conversations on shared learnings and current practice challenges.



CONSIDERATIONS



Based on the findings of this review we propose the following points to be taken into consideration in future delivery of the MEND program, as well as in online BCPs more broadly:

1. **Consider extending the pilot program to additional cohorts, with further oversight and review to build the evidence base related to online BCPs.**

This review was limited to a small cohort of participants who completed the program and participated in the review (*n*=6). Only one affected family member participated in all three stages of data collection for the review.

The findings of this review are limited in scope and are not generalisable beyond the study cohort and pilot context. While there are some positive findings for the potential of online BCPs, further evidence on the role of online BCPs as part of the broader sector offering is required.

2. **Consider providing online programs to cohorts beyond men in rural, regional and remote areas.**

Findings presented in this review suggest that there may be value in making online BCPs available to additional cohorts. For example, the online format may provide access to programs for people juggling primary care responsibilities or work commitments who may not be able to attend an in-person group.

3. **Further trial the co-facilitation model to intake assessments.**

A key learning of this program identified by practitioners was the process of co-facilitating intake assessments. While this process was resource intensive compared to conducting intakes individually, practitioners reflected that this provided an opportunity to build rapport between facilitators and program participants and enhanced the safety of practitioners and participants. Further research into the impact of co-facilitation models on intake assessment processes would also be valuable.

4. **Strengthen BCP engagement with children.**

This review highlighted some of the ongoing limitations around supports accessible to children and young people in the context of BCPs. This issue is not unique to online BCPs and remains an issue across the BCP space. Further consideration and guidance around how to engage children through BCP work would better support practitioners and ensure children are not missed in the provision of support.

5. **Consider embedding additional one-to-one work.**

A consistent theme across the project findings is the potential value of additional one-to-one work. This includes additional pre-program work, through intake assessments (co-facilitated by two practitioners), additional one-to-one supports during the program and additional post-program support. This would create more opportunities to assess and manage risk and facilitate warm referrals to additional supports.

6. **Consider limiting the size of online BCPs to six participants.**

Practitioners and participants reflected on the difficulties of running a group with eight participants, including the experience of having to cut off conversations due to time limitations. While practitioners said they were able to cover all the content they needed to, it would be valuable to have greater time for participants to contribute to discussions. Practitioners experienced running groups with various numbers of participants in attendance and felt that for the online environment six participants would be ideal.

7. **Consider a more flexible approach to session length for the delivery of online BCPs.**

Practitioners spoke about the challenge of delivering the program session in the tight 90-minute timeframe. While there are challenges to maintaining people's attention for long sessions, particularly when online, practitioners felt that greater flexibility in the session length would be valuable. Trialling a longer session, whether of two hours or an open 90 minutes to two hours, may be useful for ensuring all content is explored in sufficient depth.

8. **Embed a brief introduction to Zoom sessions, prior to the first group session, into the program structure for online BCPs.**

Some program participants spoke about the awkwardness of navigating the Zoom online space, in the first few weeks of the online group, including the video and audio set-ups of everyone in the group. While some participants may have experience using Zoom in other contexts, providing a separate pre-program session to navigate these challenges would better enable the group sessions to run smoothly from the beginning.

9. **Provide additional opportunities for community of practice for BCP providers.**

Practitioners spoke about the value of the community of practice sessions, particularly for solidarity among service providers facing the challenges of establishing a new pilot program. However, they also reflected on the way conversations about practice got lost in the space. Importantly, practitioners spoke about this experience not only within the community of practice set-up as part of the pilot program but in their experiences of community of practice sessions within the sector more broadly. There is potential value in providing community of practice sessions that are spaces specifically for practitioners to discuss current practice challenges.

REFERENCES

Bahner, A.D., & Berkel, L.A. (2007). Exploring burnout in batterer intervention programs. *Journal of Interpersonal Violence*, 22(8), 994–1008.

Bellini, R., & Westmarland, N. (2021). A problem solved is a problem created: The opportunities and challenges associated with an online domestic violence perpetrator programme. *Journal of Gender-Based Violence*, 5(3), 499–515.

Buckley, H., Carr, N., & Whelan, S. (2011). 'Like walking on eggshells': Service user views and expectations of the child protection system. *Child and Family Social Work*, 16, 101–110. https://doi.org/10.1111/j.1365-2206.2010.00718.

Callaghan, J., Alexander, J. H., Sixsmith, J., & Fellin, L. C. (2018). Beyond "witnessing": Children's experiences of coercive control in domestic violence and abuse. *Journal of Interpersonal Violence*, 33(10), 1551–1581. https://doi. org/10.1177/0886260515618946

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

Day, A., Vlais, R., Chung, D., & Green, D. (2018). Standards of practice in domestic and family violence behaviour change programs in Australia and New Zealand. *Australian and New Zealand Journal of Family Therapy*, 39(4), 501–513. https://doi.org/10.1002/anzf.1332

DeKeseredy, W.S. (2015). New directions in feminist understandings of rural crime. *Journal of Rural Studies*, 39, 180–187.

DeKeseredy, W. (2021) *Woman abuse in rural places*. Routledge.

Department of Communities, Child Safety and Disability Services. (2017) *Domestic and family violence information sharing guidelines*. Queensland Government. Accessed via: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/06796d15-6f8a-4556-b0ba-ea7a16cdbf1e/info-sharing-guidelines.pdf?ETag=f1f3173ae89e1fe1e9737316e4da732d

Department of Justice and Attorney General. (2022) *Domestic and family violence: Common risk and safety framework*. Queensland Government. Accessed via: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/c927ea9b-6973-4912-966e-dc11d1d46a67/common-risk-safety-framework-2022.pdf?ETag=70793b6943532f9f1f2c9f038704f600

Department of Social Services. (2022) *National plan to end violence against women and children 2022–2032*. Commonwealth of Australia. Accessed via: https://www.dss.gov.au/sites/default/files/documents/10_2022/national_plan_accessible_version_for_website.pdf

Edwards, K. M. (2014). Intimate partner violence and the rural-urban-suburban divide: Myth or reality? A critical review of the literature. *Trauma, Violence & Abuse*, 16, 359–373.

Family Safety Victoria. (2018) Men's behaviour change minimum standards. Accessed via: https://ntv.org.au/wp-content/uploads/2020/06/FINAL-BCP-Minimum-Standards-1-1.pdf

Family Safety Victoria. (2020). Service guidelines for perpetrator interventions during the Coronavirus (COVID-19) Pandemic. Melbourne, Australia: Family Safety Victoria (DHHS).

Fitz-Gibbon, K., Burley, J., & Meyer, S. (2020) How do we keep family violence perpetrators 'in view' during the COVID-19 lockdown? *The Conversation*, 28 April. Accessed via: https://theconversation.com/how-do-we-keep-family-violence-perpetrators-in-view-during-the-covid-19-lockdown-135942

Fitz-Gibbon, K., Maher, J., McCulloch, J., & Segrave, M. (2019). Understanding and responding to family violence risks to children: Evidence-based risk assessment for children and the importance of gender. *Australian & New Zealand Journal of Criminology*, 52(1), 23–40. https://doi.org/10.1177/0004865818760378

Fitz-Gibbon, K., Maher, J., Thomas, K., McGowan, J., McCulloch, J., Burley, J., & Pfitzner, N. (2020). *The views of Australian judicial officers on domestic and family violence perpetrator interventions* (Research report, 13/2020). ANROWS.

Fitz-Gibbon, K., McGowan, J. & Stewart, R. (2023) I believe you: Children and young people's experiences of seeking help, securing help and navigating the family violence system. Monash Gender and Family Violence Prevention Centre, Monash University, doi: 10.26180/21709562

Gray, R., Broady, T., Gaffney, I., Lewis, P., Mokany, T., & O'Neill, B. (2014). 'I'm working towards getting back together': Client accounts of motivation related to relationship status in men's behaviour change programmes in New South Wales, Australia. *Child Abuse Review*, 25, 171–182.

Harris, B., & Woodlock, D. (2022). Spaceless violence: Women's experiences of technology-facilitated domestic violence in regional, rural and remote areas. *Trends and Issues in Crime and Criminal Justice*, 1–14.

Hatcher, R. L., & Gillaspy, J. A. (2006) Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, 16(1), 12–25. https://doi. org/10.1080/10503300500352500

Helps, N., Conner, M.D., Montgomery, I., & Petocz, H. (2023) Let's talk about sex: Exploring practitioners' views on discussing intimate partner sexual violence in domestic and family violence perpetrator intervention programs. Monash Gender and Family Violence Prevention Centre, Monash University. https://doi.org/10.26180/21902865

Jamieson, S., & Wendt, S. (2008) Exploring men's perpetrator programs in small rural communities, *Rural Sociology*, 18(1): 39–50. https://doi.org/10.5172/rsj.351.18.1.39

Kelly, L., & Westmarland, N. (2015). *Domestic violence perpetrator programmes: Steps towards change: Project Mirabal final report*. London Metropolitan University and Durham University. https://www.respect.uk.net/resources/27-domestic-violence-perpetrator-programmes-steps-towards-change-project-mirabal-final-report

Kingree, J. B., Thompson, M., McCrady, B., Tonigan, J. S., & Lautenschlager, G. (2006). The development and initial evaluation of the survey of readiness for Alcoholics Anonymous participation. *Psychology of Addictive Behaviors*, 20(4), 453.

Lamb, K., Humphreys, C., & Hegarty, K. (2018). "Your behaviour has consequences": Children and young people's perspectives on reparation with their fathers after domestic violence. *Children and Youth Services*, 88, 164–169. https://doi.org/10.1016/j.childyouth.2018.03.013

Langenderfer, L. (2013). Alcohol use among partner violent adults: Reviewing recent literature to inform intervention. *Aggression and Violent Behaviour*, 18, 152–158

Lanier, C. & Maume, M. (2009). Intimate partner violence and social isolation across the rural/urban divide. *Violence Against Women*, 15(11): 1311–1330.

Little, J. (2017). Understanding domestic violence in rural spaces: A research agenda. *Progress in Human Geography*, 41(4), 472–488.

Magnus, A. M., & Donohue, F. A. (2022). Reimagining access to justice through the eyes of rural domestic violence survivors. *Theoretical Criminology*, 26(3), 434–455. https://doi.org/10.1177/13624806211035103

Marr, E. (2015). Assessing transportation disadvantage in rural Ontario, Canada: A case study of Huron County. *Journal of Rural and Community Development*, 10(2): 100–120.

McCulloch J., Maher, J., Fitz-Gibbon, K., Segrave, M., Benier, K., Burns, K., McGowan, J. , & Pfitzner, N. (2020). Review of the Family Violence Information Sharing Scheme final report. Monash Gender and Family Violence Prevention Centre, Monash University. Accessed via: https://content.vic.gov.au/sites/default/files/2020-08/FVISS%20Review%20Final%20Report.pdf

McGinn, T., McColgan, M., Daly, M., & Taylor, T. (2019). Participants' views about the survivor contact element of IPV perpetrator programs: A preliminary study. *Violence and Victims,* 34(5), 889–909.

McGinn, T., McColgan, M., & Taylor, B. (2020). Male IPV perpetrator's perspectives on intervention and change: A systematic synthesis of qualitative studies. *Trauma, Violence, and Abuse*, 21(1), 97–112. https://doi.org/10.1177/1524838017742167

McGinn, T., Taylor, B., McColgan, M., & Lagdon, S. (2016). Survivor perspectives on IPV perpetrator interventions: A systematic narrative review. *Trauma, Violence & Abuse*, 17(3), 239–255.

McGowan, J., Helps, N., Fitz-Gibbon, K., Athwal-Yap, A., & Williamson, H. (2023) "You can't just … add a bit of rainbow dust": A review of the Clear Space online behaviour change program for GBTQ+ men and non-binary people. Monash Gender and Family Violence Prevention Centre, Monash University, doi: 10.26180/22153310.

McLaren, H., Fischer, J., & Zannettino, L. (2020). *Defining quality of life indicators for measuring perpetrator intervention effectiveness*. (Research report, 05/2020). ANROWS

Meyer, S. (2011). 'Acting in the children's best interest?': Examining victims' responses to intimate partner violence. *Journal of Child and Family Studies,* 20, 436–443. https://doi.org/10.1007/s10826-010-9410-7

Meyer, S. & Fitz-Gibbon, K. (2022) To end gender-based violence in one generation, we must fix how the system responds to children and young people. The Conversation, 20 October. Accessed via: https://theconversation.com/to-end-gender-based-violence-in-one-generation-we-must-fix-how-the-system-responds-to-children-and-young-people-192839

Meyer, S., Helps, N., & Fitz-Gibbon, K. (2023). Domestic and family violence perpetrator screening and risk assessment: Current practice and future opportunities. Monash University. Report. https://doi.org/10.26180/21905868.v1

Meyer, S., Hine, L., & McDermott. L. (2019). *Caring Dads Program (Queensland trial) evaluation – Final report*. Prepared for the Queensland Department of Child Safety, Youth and Women.

Meyer, S., McGowan, J., Helps, N., & Williamson, H. (2021) *Evaluation of the TaskForce Early Intervention for Family Violence Program (U-Turn) final report.* Monash Gender and Family Violence Prevention Centre, Monash University. https://doi.org/10.26180/16800877.

NSW Government (2017). *Practice standards for men's domestic violence behaviour change programs*. Justice Strategy and Policy, Department of Communities and Justice. Accessed via: https://www.dcj.nsw.gov.au/

No to Violence [NTV] (2023). 2023–2024 Commonwealth pre-budget submission funding perpetrator accountability. Accessed via: https://ntv.org.au/wp-content/uploads/2023/01/250123_NTV-Cwth-Budget-Sub-23-24.pdf

NTV (2022). *Discussion paper: Online perpetrator interventions*. Accessed via: https://ntv.org.au/wp-content/uploads/2022/09/NTV-Discussion-Paper_Online-Perpetrator-Interventions-2022-1.pdf

NTV (2018). *Position statement: Online programs for men who use family violence*. Accessed via email communication following request to NTV.

O'Connor, A., Panayiotidis, A., Bickerdike, A., Opoku, S. & Skouteris, H. (2022). Men's behaviour change program: Participants and facilitators' perceptions. *Australian and New Zealand Journal of Family Therapy*, 43, 412–422

Opitz, C. (2014). Considerations for partner contact during men's behaviour change programs: Systemic responses and engagement. *Ending Men's Violence against Women and Children: The No to Violence Journal,* Autumn, 114V142.

Ormston, R., Mullholland, C. & Setterfield, L. (2016). *Caledonian System evaluation: Analysis of a programme for tackling domestic abuse in Scotland*. Accessed via: https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2016/11/caledonian-system-evaluation-analysis-programme-tackling-domestic-abuse-scotland/documents/00507596-pdf/00507596-pdf/govscot%3Adocument/00507596.pdf

Our Watch. (2015). Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia. Accessed via: https://www.ourwatch.org.au/change-the-story/

Pfitzner, N., Fitz-Gibbon, K., McGowan, J., & True, J. (2020). *When home becomes the workplace: Family violence, practitioner wellbeing and remote service delivery during COVID-19 restrictions*. Monash Gender and Family Violence Prevention Centre, Monash University.

Renehan, N. (2020). *Building better relationships? Interrogating the 'Black Box' of a statutory domestic violence perpetrator programme*. PhD Thesis. University of Manchester.

Solove, D.J. (2013). Privacy self-management and the consent dilemma. *Harvard Law Review,* 126(7), 1880–1903.

Spencer, C. M., Stith, S. M., & King, E. L. (2021). Preventing maltreatment at home: A meta-analysis examining outcomes from online programs. *Research on Social Work Practice*, 31(2), 138–146. https://doi.org/10.1177/1049731520969978.

Vlais, R. (2011). A work in progress: A snapshot of men's behaviour change programs in Victoria. DVRCV Quarterly, 3, 1–5. https://search.informit.org/doi/10.3316/informit.158761157324874

Vlais, R., & Campbell, E. (2020). *Alternative delivery formats for domestic and family violence perpetrator programs in the COVID-19 situation: Draft report for consultation and feedback*. 8 May. Accessed via: https://www.doj.state.or.us/wp-content/uploads/2020/10/Alternative_delivery_formats-DV_perpetrator_programs-in_COVID-19.pdf

Walklate S., McCulloch J., Fitz-Gibbon K., et al. (2019). Criminology, gender and security in the Australian context: Making women's lives matter. *Theoretical Criminology*, 23(1): 60–77.

Webster, K., Diemer, K., Honey, N., Mannix, S., Mickle, J., Morgan, J., Parkes, A., Politoff, V., Powell, A., Stubbs, J., & Ward, A. (2018). *Australians' attitudes to violence against women and gender equality. Findings from the 2017 National Community Attitudes towards Violence against Women Survey (NCAS)* (Research report, 03/2018). ANROWS.

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

Youngson, N., Saxton, M., Jaffe, P.G., Chiodo, D., Dawson, M., & Straatman, A. (2021). Challenges in risk assessment with rural domestic violence victims: Implications for practice. *Journal of Family Violence*, 36, 537–550. https://doi.org/10.1007/s10896-021-00248-7

MONASH GENDER AND FAMILY VIOLENCE PREVENTION CENTRE

2023