‘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

2023

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Acknowledgement of Country

We acknowledge the true and ongoing custodians of the unceded lands on which we meet and conduct our research. The team involved in the review of the Clear Space program work across Boon Wurrung and Wurundjeri Country. We pay respect to Elders of these lands' past and present. These always were and always will be Aboriginal lands.

Acknowledgements

The Monash Gender and Family Violence Prevention Centre review team would like to extend our gratitude to the Clear Space program participants who participated in this research and shared their stories with us. We further acknowledge the valuable contributions of key stakeholders from Thorne Harbour Health who bring Clear Space to life and who shared their time and expertise with the review team. We also thank ACON for their input into this project. While no affected family members chose to participate in this Review, we would like to extend our gratitude to them as well as all affected family members who participate in research such as this. The voices of affected family members and victim-survivors are critical to ensuring that family violence reforms meet the goal of creating better security and safety for those experiencing family violence and improving perpetrator accountability.

The team gratefully acknowledges the financial and in-kind support it has received from No to Violence (NTV) and the Perpetual Impact Fund towards this review. We also recognise the significant work from NTV in managing the larger project, of which the review was one component. We further acknowledge the important role of Thorne Harbour Health who developed and delivered Clear Space, as well as Men and Family Centre who developed and delivered the online behaviour change program for men in rural, regional and remote areas. The two programs were developed and delivered in parallel with significant cross-program support.

We would also like to thank our Monash Gender and Family Violence Prevention Centre colleagues, in particular Jasmine Mead and Harshita Rupanagudi for their administrative support. Thank you also to Professor Silke Meyer whose valuable insights and contributions have undoubtedly enhanced the quality of this work.

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

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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.

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

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ACRONYMS

ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and Other Drugs
BCP	Behaviour Change Program
CoP	Community of Practice
DASS	Depression and Anxiety Stress Scale
DFV	Domestic and Family Violence
FSV	Family Safety Victoria
FVIO	Family Violence Intervention Order
FVRIM	Family Violence Reform Implementation Monitor
GBTQ+	Gay, Bisexual, Trans, Queer +
IPV	Intimate Partner Violence
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer +
MBCP	Men's Behaviour Change Program
MFC	Men and Family Centre
MGFVPC	Monash Gender and Family Violence Prevention Centre
NATE	Negative Attitudes Towards Effeminacy
NTV	No to Violence
THH	Thorne Harbour Health
WAI	Working Alliance Inventory

EXECUTIVE SUMMARY

There has been growing acknowledgement in Australian research and policy of the need to develop evidence-informed perpetrator interventions, including in response to intimate partner violence in LGBTQ+ communities. In 2016, the Victorian Royal Commission into Family Violence identified the need for the trial and evaluation of programs for people from diverse communities who use violence. Since the Royal Commission there has been a significant increase in focus on the development and delivery of a suite of perpetrator interventions in Victoria.

Within this broader reform context, and in response to the lack of behaviour change programs tailored to GBTQ+ men and non-binary people, in 2021, Thorne Harbour Health developed a 20-week group-based online program pilot – the Clear Space program. Delivered in 2022, the Clear Space online behaviour change program (BCP) was developed specifically for gay, bisexual, trans, queer plus men and non-binary people (GBTQ+) who use violence in their family and/or intimate relationships. The program is both feminist and queer informed. Like much of the BCP work underway in Australia, Clear Space has foundations in the Duluth model of perpetrator intervention and accountability. The Clear Space pilot aimed to increase awareness that violent behaviours are a choice; thus each person is responsible and accountable for their violent behaviour choices.

Prior to the COVID-19 pandemic, the dominant mode of delivery for BCPs had been in a 'co-located' in-person and on-site group format. The necessary 'pivot' to online delivery during the pandemic has advanced the possibility of extended modes of delivery moving forward. The development and delivery of the Clear Space pilot program can be seen in the context of the need for specialised and accessible DFV-informed behaviour change service provision for GBTQ+ populations.

This report presents the findings from a review of the Clear Space pilot program conducted by researchers from the Monash Gender and Family Violence Prevention Centre. The review used a mixed-methods design, incorporating both quantitative and qualitative analyses drawing from data collected from program participants and practitioners. The report examines the suitability and impacts of the Clear Space pilot program.

This review is limited in its ability to address the question of how online interventions impact family safety, as no affected family members participated in this review. While we do address this question in part by drawing on the views of the practitioners, we acknowledge that the voices of victim-survivors are critical to validating participants' own accounts of behaviour change and for ensuring that programs meet the goals of both enhancing safety for those experiencing family violence and improving perpetrator accountability. Without the voices of victim-survivors, this review is limited in its ability to assess behaviour change.

Drawing from the qualitative and quantitative data collected, the review examines practitioner views on working with GBTQ+ men and non-binary people, as well as learnings related to family safety contact work, recruitment, referrals and intake, the online mode of delivery, program facilitation, and the value of utilising communities of practice. The review findings also consider supports for co-occurring needs among program participants and offer reflections on behaviour change as a program outcome.

The findings from this review support the need for further consideration to be given to several key areas in the future delivery of online BCPs for GBTQ+ men and non-binary people. They also support the need for resourcing a larger scale and longer-term evaluation of the program.

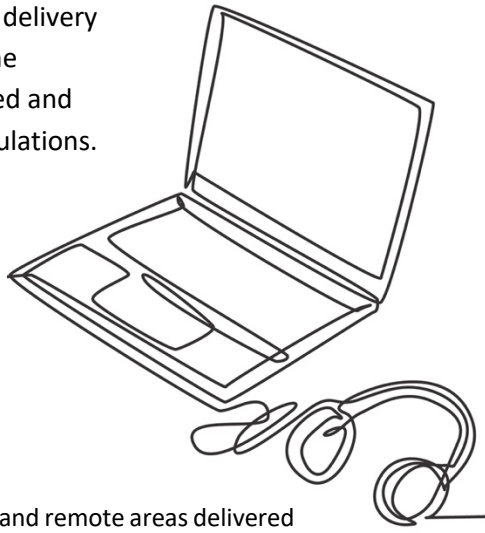
This review found that there is a need to consider the optimal program participant size; it may not be the same for online BCPs and those done face to face. Reflecting on the number of participants with co-occurring needs, such as those related to AOD, the review also highlights the necessity of better understanding the role and provision of additional supports for such BCP participants. Further practice-informed research is needed to identify best practice in identifying and addressing the co-occurring needs of BCP participants.

Although the finding is not specific to the online mode of delivery, this review also highlights the potential value of developing practice guidance to assist family safety contact workers at the first point of contact with an affected family member. There may be a lack of awareness in the broader community about family safety contact as a support service provided alongside BCPs, which may contribute to low engagement. Building on wider recognition of the difficulties of recruiting and retaining a skilled workforce, the findings from this review also demonstrate the need to ensure that practitioners with diverse skills and lived experience are supported to upskill to work in this field.

INTRODUCTION

In 2021, Thorne Harbour Health (THH), formally the Victorian AIDS Council, was funded by No to Violence (NTV) to develop and deliver one 20-week group-based program in 2022.[1] The resulting program, Clear Space, is a pilot online behaviour change program (BCP)[2] for gay, bisexual, trans, queer plus men and non-binary people (GBTQ+) who use violence in their family and/or intimate relationships. The pilot program was conceived as a response to the lack of behaviour change programs tailored to GBTQ+ men and non-binary people. While BCPs for men who use intimate and family violence have been around for decades, they have predominantly focused on heterosexual men's use of violence against women (Gray et al. 2020, p. 11). The need for the trial and evaluation of programs for people who use violence from diverse communities was identified in the recommendations and findings made by the Victorian Royal Commission into Family Violence (RCFV 2016, see specifically recommendation 87). Since the Royal Commission, there has been growing acknowledgement in Australian research and policy of the need for research and development of evidence-informed practice and DFV service delivery, including BCPs, specific to LGBTQ+ populations (Campo and Tayton 2020; Carmen et al. 2020; Gray et al. 2020).

The dominant mode of delivery for BCPs has been in a 'co-located' in-person and on-site group format (Bellini and Westmarland 2021, p. 500). However, as with other forms of health-related service delivery, including specialist DFV services for victim-survivors (Pfitzner et al. 2020), the COVID-19 pandemic has precipitated a shift from in-person to virtual delivery of BCPs (Bellini and Westmarland 2021; Vlais and Campbell 2020). While the pandemic restrictions that necessitated virtual service delivery are no longer government mandated, the capacity to deliver online BCPs has been firmly established. This development has the potential to improve the accessibility of BCPs for populations such as GBTQ+ men and non-binary people. Co-located group programs for diverse populations can be rare, as typically there may not be a sufficient number of participants in one location to justify a group program. Scholars have warned that for such groups inequities of access can be compounded (Bellini and Westmarland 2021, p. 501). However, this development has also given rise to questions about the challenges, opportunities and viability of remote delivery of BCPs (Bellini and Westmarland 2021). The development and delivery of the Clear Space pilot program can be seen in this context: the need for specialised and accessible DFV-informed behaviour change service provision for GBTQ+ populations.



[1] This program ran in parallel with a second online program for men in rural, regional and remote areas delivered by New South Wales-based organisation, Men and Family Centre (MFC) (see Helps et al. 2023c). The funding included provisions for the current review.

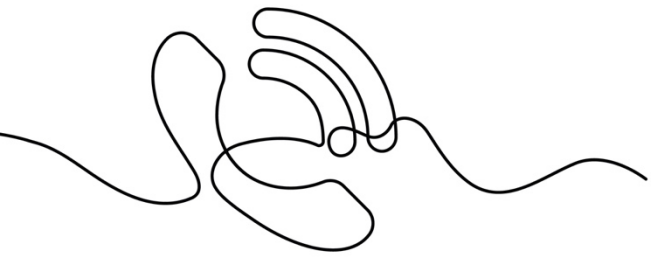
[2] Within the sector, the dominant term is men's behaviour change programs (MBCP), however, this terminology does not capture the breadth of relationships in which family violence occurs; nor is it an accurate representation of the variety of perpetrators who attend behaviour change programs.

The evidence for online BCPs

While some online BCPs were in operation prior to the COVID-19 pandemic (see, for example, Bellini & Westmarland 2021), they were few and far between. The shift to online BCPs was propelled by the pandemic and related lockdowns, but as restrictions have eased in many jurisdictions, many BCPs have returned to in-person delivery. However, the widespread use of online BCPs during the pandemic created space for broader consideration of the role of online BCPs as part of the offering of interventions available to DFV perpetrators.

In 2021, a meta-analysis of online interventions, including anger management and DFV perpetration interventions, was conducted. It aimed to improve participant wellbeing and reduce the risk of IPV, and it found that the programs decreased participants' 'anger, depression, emotional IPV perpetration, and physical IPV perpetration' (Spencer, Stith & King, 2021 p. 144). The review also found that 'online resources can help motivated individuals struggling with anger and/or at risk for IPV perpetration' (Spencer, Stith & King 2021, p. 138). Exploring 'alternative delivery formats' for perpetrator programs during the pandemic, Vlais and Campbell (2020) observed that online interventions were able to ease the caseload in services with a high number of high-risk perpetrators. They found that online interventions filled a need for responses to situations of increased risk due to employment precarity and COVID-specific isolation. However, Vlais and Campbell (2020) also found that the physical distance and the online interface impacted engagement both between participants and between facilitators and participants; and inequities related to computer equipment, software, internet access and private space existed among participants. Vlais and Campbell (2020) suggest that when these issues act as a barrier to participation, existing home situations can deteriorate rather than improve – further, that when participants are not effectively engaged, online intervention is doing little more than facilitating BCP completion.

Bellini and Westmarland made a number of similar findings in their exploratory study of an online domestic violence perpetrator programme (DVPP) in the United States (2021):

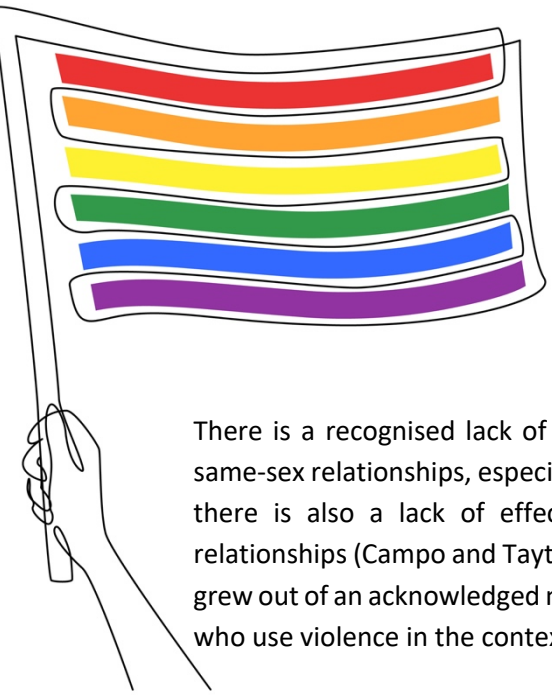


> Online, remote delivery of a … DVPP … was found to solve some of the problems associated with in-person delivery, however new problems arose in their place including access to technology, broadband, a private and safe space to participate, and learning new facilitation techniques (p. 499).

They concluded that while virtual DVPPs may fill a gap when in-person groups are not available, adjustments to both 'facilitation style and programme curricula' are required to address the challenges they identified (Bellini & Westmarland 2021, p. 499). Bellini and Westmarland (2021, p. 512) observe that when access to technology is inequitable, it can contribute to the creation of a 'deeper "digital divide" between perpetrators who possess digital hardware, broadband speeds and literacy skills and those who do not'. The authors note the importance of ensuring that digital inequities in online interventions do not put perpetrators with fewer resources at a disadvantage (2021, p. 512). Bellini and Westmarland also theorised that shifting BCPs into the home, and thereby removing the 'physical buffer' normally in place when perpetrators attend programs at an external

site, 'creates a novel risk' for affected family members (2021, p. 512). With this in mind, they contend that online DVPPs should always incorporate a family safety component in which service providers seek information from victim-survivors about risk and offer support (2021). While Bellini and Westmarland did find that facilitators were able to create a space conducive to open discussion and critical reflection about the men's use of violence, they ultimately warn against any temptation to see online BCP programs as a panacea to issues of accessibility in the provision of specialist family violence and men's services (2021, p. 512).

Evidence suggests that online BCPs have had a positive impact in the absence of in-person programs, yet experts caution against understanding remote delivery as a straightforward solution to waitlists and accessibility problems. Issues of concern – such as the authenticity of engagement in the online forum, the adaptability of content and facilitation styles, access to technology, the exacerbation of the digital divide, perpetrator visibility, and risk for affected family members – are yet to be properly understood and addressed.



Behaviour change programs for GBTQ+ men and non-binary people

The development and delivery of online BCPs has the potential to improve accessibility to BCPs for GBTQ+ men and non-binary people who may not have the option of a co-located group program.

There is a recognised lack of training for professionals supporting people experiencing violence in same-sex relationships, especially regarding the unique nature of same-sex intimate partner violence; there is also a lack of effective interventions for individuals perpetrating violence in LGBTQ+ relationships (Campo and Tayton 2020; Cannon & Buttell 2015; Gray et al. 2020). This pilot and review grew out of an acknowledged need to improve the accessibility of perpetrator interventions for people who use violence in the context of an LGBTQ+ relationship.

Research has highlighted both a reluctance in LGBTQ+ victim-survivors to disclose DFV and the multiple barriers to their doing so (Ovenden 2019, p. 11; Reeves & Scott 2022). Some barriers to disclosing and reporting, such as those based on gendered assumptions, have in turn been shown to act as a barrier to the recognition and identification of abuse. This is not just true for service providers and criminal justice responders; it can affect victim-survivors themselves. For example, the gendered and homophobic assumption that gay/queer men are less masculine than heterosexual men can work to stigmatise gay/queer men, inducing feelings of shame that make them reluctant to report – while simultaneously preventing them from seeing the person committing the violence as a perpetrator and themselves as a victim-survivor (Calton et al. 2015; Duke & Davidson 2009; O'Halloran 2015; Potoczniak et al. 2003; Ristock & Timbang 2005). These same cultural assumptions and biases can prevent service providers and criminal justice responders from recognising intimate partner abuse amongst GBTQ+ populations (see, among others, Reeves & Scott 2022).

Research has also found that these biases can have a pronounced negative impact on bisexual populations (Austin et al. 2002; Girshick 2002; Balsam & Szymanski 2005; Bornstein et al. 2006; Duke & Davidson 2009; Messinger 2011; Galletly et al. 2012). This is relevant to the current review, given that 40 per cent of Clear Space program participants (n=2) identified as bisexual. Further, some of the participants were referred to the group specifically in relation to violence used towards women. This is not to suggest that patriarchal norms and gendered power dynamics do not structure abuse in bisexual relationships in which partners have different gender identifications; but conceiving of these dynamics within a heteronormative framework may be reductive (Barrett and Pierre 2013).

These biases and assumptions are pervasive. They persist despite research showing that it is dynamics of power and control that are central to the perpetration of intimate partner violence in LGBTQ+ populations, not gender stereotypes (see, among others, Brown 2008; Little & Terrance 2010; Rollè et al. 2018; Santoniccolo, Trombetta & Rollè 2021). Evidence continues to suggest that family violence workers without LGBTQ+ specialist understanding may not be familiar with the distinct ways LGBTQ+ people experience intimate partner and family violence (Fileborn, 2012; Furman et al. 2017; Gray et al. 2020).

The Clear Space program

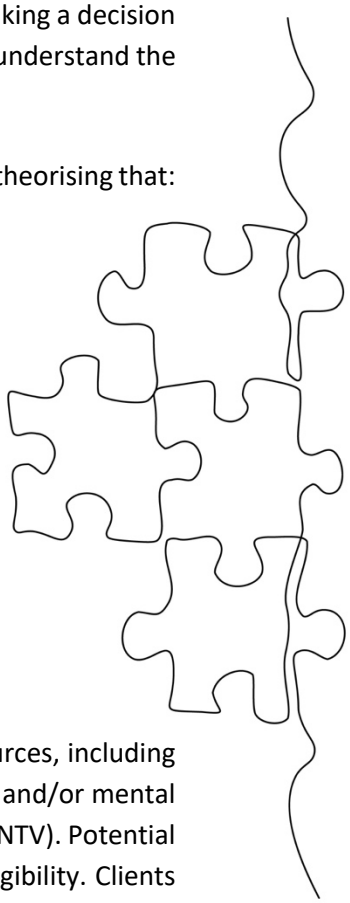
Clear Space, delivered by THH, is an online pilot program for GBTQ+ men and non-binary people who use violence in their family and/or intimate relationships. Clear Space is a 20-week program designed to cater to a maximum of 10 participants; it is both feminist and queer informed. Like much of the BCP work underway in Australia, Clear Space has foundations in the Duluth model of perpetrator intervention and accountability. The Duluth model, which originated in the United States, is based on a multi-agency collaborative approach which understands violence as a result of actions by the perpetrator to intentionally control and maintain power over their intimate partner (Praxis International 2010).

The Clear Space program logic integrates three key pillars of the Duluth model:

- The participant must be held fully accountable for [their] violence by a community which establishes and enforces consequences for continued acts of abuse.
- [They] must have an environment which is non-violent, non-judgmental, and respectful of women and children (amongst all other impacted people, regardless of gender identity), in which to start making those changes.
- [They] must be willing to work through a long process during which [they are] painfully honest with [themselves] and become…accountable to the women (children and other impacted people, regardless of gender identity) they have harmed (Thorne Harbour Health 2022, p. 5).

Beyond Duluth, the Clear Space pilot is also queer informed. Documents developed by THH outlining the program logic and framework for change emphasise the importance of understanding the complexity of violence within GBTQ+ communities, which results from multiple and varied intersections of power and marginalisation. Accordingly, the framework highlights the need for applying an anti-oppression lens, one acknowledging that participants come to the group with different life experiences and 'different levels of structural power' influencing behaviour. The Clear Space program logic provides a useful example of this: 'A cis-gendered, white gay man may have increased levels of structural power reduced levels of oppression/marginalisation when compared to a trans-masc person of colour' (Thorne Harbour Health 2022, p. 4).

The incorporation of the anti-oppression lens is intended to assist program participants in understanding that while they may experience structural oppression, they are also making a decision to use violence. It is hoped that through the use of this lens, participants will come to understand the impact of their violence and be accountable for it.



As outlined in the program logic, the need for Clear Space is premised on evidence and theorising that:

- Family violence, including partner violence within [GBTQ+] communities has been widely unaddressed.
- Mainstream … [BCPs] … may not be safe for [GBTQ+] participants due to lived experiences of homophobia, biphobia and transphobia.
- A program where the participants do not feel represented may be less effective.
- Drivers of violence for [GBTQ+] men may be unique to drivers of violence observed in mainstream groups.
- [M]ainstream group facilitators can lack the understanding to comprehensively analyse culturally specific nuanced forms of violence (Thorne Harbour Health 2022, p. 4).

Potential participants for the Clear Space program were referred from a variety of sources, including (but not limited to), the Orange Door; support services provided by THH, such as AOD and/or mental health services; courts; practitioners from MFC (the parallel online program funded by NTV). Potential participants were then assessed by Clear Space practitioners according to risk and eligibility. Clients deemed ineligible for Clear Space were supported by THH workers for their specific needs; this may have involved referral to another program or other services such as AOD or mental health services.

The Clear Space pilot aims to increase awareness that violent behaviours are a choice and that each person is responsible and accountable for their behaviour. Topics covered in the program included, among others, exploring the use of intimidation as a tactic of control, exploring emotional abuse as a tactic of control, non-threatening behaviour, and exploring respect.

REVIEW METHODOLOGY

Researchers from the Monash Gender and Family Violence Prevention Centre (MGFVPC) were contracted by NTV to undertake a review of the online Clear Space pilot program, which ran between July 2022 and November 2022. This review examines the suitability and impacts of the Clear Space program. The study used a mixed-methods design, incorporating both quantitative and qualitative data. Quantitative data was collected from program participants at three time points: program commencement, program mid-point and program completion. Qualitative data was collected through interviews with program participants at program completion, and stakeholders at program commencement and completion. No affected family members were able to be referred by the program provider to the study. This is discussed further in the limitations section (p. 13).

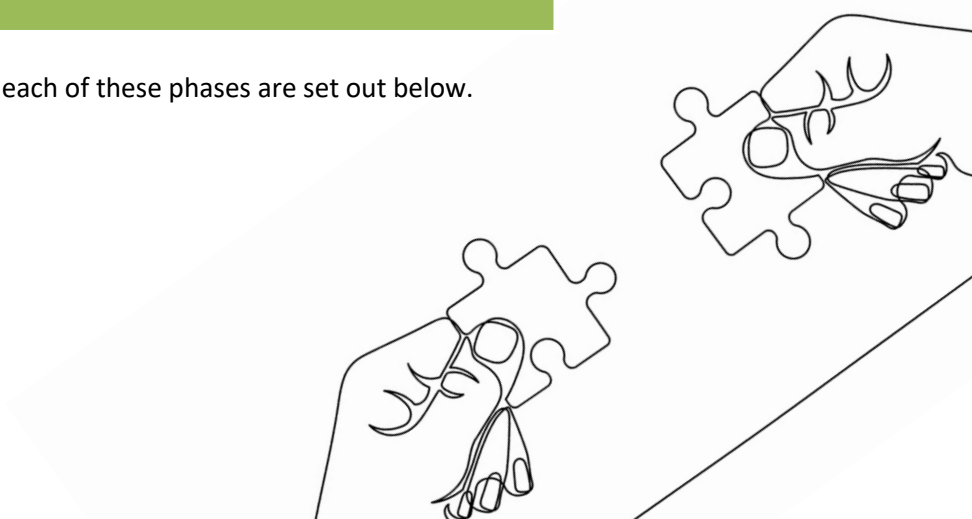
This program review is informed by the following five research questions:

1. What is the need for online interventions BCPs?
2. What is the need for interventions targeted at GBTQ+ men and non-binary people who use violence in their relationships?
3. What are some of the perceived benefits of online and targeted interventions?
4. What are some of the challenges of delivering BCPs online?
5. How do online interventions impact family safety?

To address these questions, several data sources were collected for this review. Specifically, there were five different phases of data collection:

- Surveys with program participants (completed at intake, mid-program and conclusion)
- Interviews with program participants (completed at program conclusion)
- Stakeholder small group interviews (completed early in the program and at program conclusion)
- Group observations (completed at three points throughout the program)
- Community of practice observations (completed monthly throughout the review)

Details of the data collected during each of these phases are set out below.



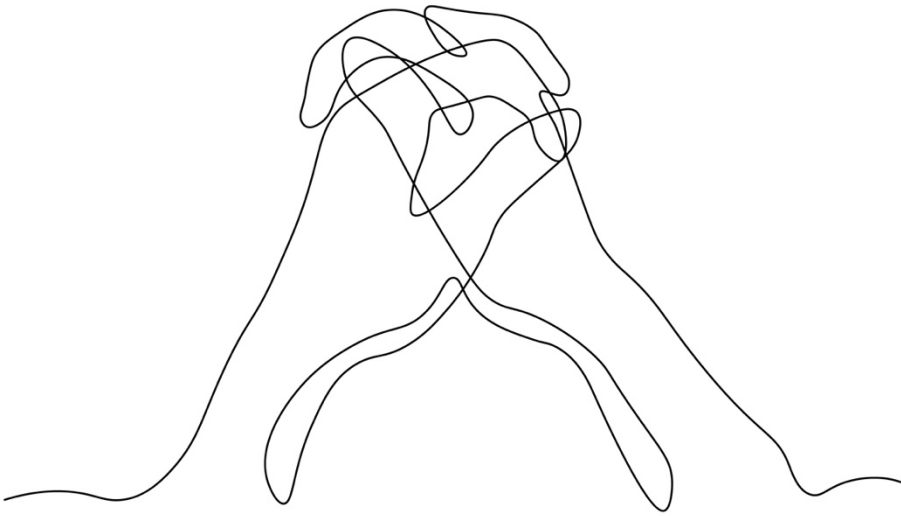
Affected family member and program participant recruitment

Eleven affected family members were contacted by THH and offered support through the family safety contact (FSC) worker. Only two accepted some form of contact with the worker. The FSC worker informed those affected family members who had accepted contact about the Clear Space review early in the program. No AFMs consented to being contacted by the Monash team to participate in this review. The low uptake of FSC by affected family members and low rates of participation in program reviews are common (Chung et al. 2020).

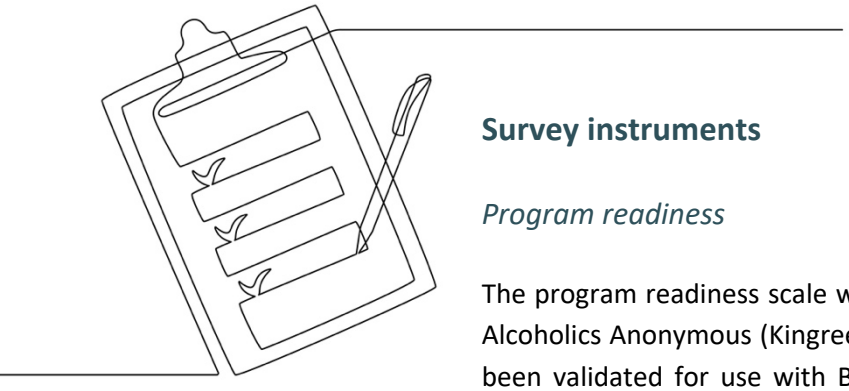
Eight individuals were referred to the pilot program for intake assessment and potential participation in the program. Three of these individuals were either assessed as unsuitable or declined to participate in the program. One participant was assessed as unsuitable for the program due to the facilitators' determination they had been 'misidentified' as the predominant aggressor.[3] In total, five participants commenced the Clear Space program. THH facilitators informed the participants of the review being undertaken by the Monash team and provided them with explanatory statements during the intake assessment. THH collected informed consent from participants to complete the intake survey and be contacted by the Monash researchers for the program mid-point and at the conclusion of data collection. The Clear Space practitioners administered the first program commencement survey to participants during the intake assessment.

For each subsequent data collection, the Monash review team contacted program participants directly. Verbal consent processes were completed at each point of contact by the Monash review team. At the conclusion of each data collection contact, program participants were asked if they would like a call from one of the THH facilitators. If so, this information was passed on to the THH team.

To acknowledge their contribution to the review, program participants were provided a $50 voucher following the final survey and exit interview as an acknowledgement of their participation in the review and the time required to do so. The decision to provide the voucher to program participants was made in consultation with NTV and the community of practice.



[3] The term 'misidentification' is used in this context to describe instances where the legal system has incorrectly identified a victim-survivor as the predominant aggressor, for further information on systems abuse see Reeves (2021) and Nancarrow et al. (2020).



Survey instruments

Program readiness

The program readiness scale was adapted from the Survey of Readiness for Alcoholics Anonymous (Kingree et al. 2006). We note that 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 used to capture program participants' attitudes towards participating in the Clear Space online program.

Negative attitudes towards effeminacy (NATE)

To measure the attitudes of the program participants, we drew on the negative attitudes towards effeminacy or 'NATE' scale (Taywaditep 2001). It contains 17 items asked on a scale from strongly agree (1) to strongly disagree (7). These items sought to understand participants' attitudes towards the effeminacy of other men (Taywaditep 2001). The NATE was developed to understand gay men's attitudes and has not been validated for use with GBTQ+ men and non-binary people specifically.

ACON Measures

For this review, the NATE was supplemented by nine additional items which were developed by ACON for the project 'Primary Prevention of Intimate Partner Sexual Violence'. These items sought to understand how the expression of gender may impact participants' attitudes towards others and impact relationship dynamics. The ACON scale has not been validated for use with BCP participants.

We ran a reliability analysis of all nine items and found that some items were not reliable. Our analysis found a potential for error; this means that a particular variable may not return the same answer from the same participant and is therefore not replicable. Based on this, we decided to present the ACON data as individual frequencies, otherwise it would not be accurate to present a mean of the scale.

Depression and anxiety scale (DASS)

The depression and anxiety scale or DASS-10 is a series of 10 items designed to measure the extent to which participants felt fear, worry or intolerance. The DASS-10 is an adapted version of the full DASS-42 and the briefer DASS-21 (Halford & Frost 2021; Lovibond & Lovibond 1995). The scales were designed for routine use in psychology and mental health contexts. This scale sought to measure participants' feelings of fear, worry or intolerance.

Working alliance inventory

The Working Alliance Inventory (WAI) included 12 items asked on a scale from strongly agree (1) to strongly disagree (5). The WAI captures the relationship between program participants and group facilitators and, for example, the extent to which there is agreement on behaviour change goals (Hatcher & Gillaspy 2006). For this review, the WAI was administered at program completion only.

Interviews

Following program completion, the Monash review team conducted an exit interview with each participant. The interviews, which were audio recorded and transcribed for qualitative analysis, were structured on open-ended questions. Subjects included relationship status and living arrangements, relationships with children (if relevant), reasons for participating in the program, information about referral/awareness of the program, motivation to participate, whether the program has led to self-perceptions of changes in their life and behaviour change, changes in relationships with children, awareness and understanding of what constitutes family violence, understanding of the victim-survivor's perspective, program feedback, additional supports accessed during the program and after it concluded, and plans for future behaviour change work.

Four small-group interviews were completed with THH stakeholders. These interviews were conducted at four points of the review:

- Interview 1 was an early program interview with facilitators in week three of the program (*n*=2).
- Interview 2 was with the AOD/Dual diagnoses worker and the program co-ordinator/facilitator in week 17 of the program (*n*=2).
- Interview 3 was a small-group interview with facilitators in week 20 of the program (at program completion; *n*=2).
- Interview 4 was with the FSC worker two weeks after program completion (*n*=1).

Small group interviews ran for 60 to 90 minutes. Stakeholders were recruited via email. Explanatory statements and consent forms were also sent via email. Verbal consent to take part and to be recorded was sought at the beginning of the interviews for those stakeholders who had not provided written consent prior to the interview commencing. Program facilitators were interviewed early in the program to explore the program set-up, recruitment and first few weeks of the program. A second interview was conducted with both facilitators at the end of the program to explore key learnings. One facilitator also participated in a third interview in relation to their role as program coordinator. This interview was focused on co-occurring needs, particularly in relation to AOD. In total, four stakeholders participated in the interviews. Interviews with stakeholders were audio recorded and transcribed for qualitative analysis. The interviews with facilitators included open-ended questions about program set-up and recruitment, online delivery, managing and responding to safety and risk, and the need for programs designed specifically for GBTQ+ men and non-binary people.

Interviews with the AOD/Dual diagnoses worker and FSC worker covered ground similar to facilitator interviews and included additional specific questions. The interview with the AOD/Dual diagnoses worker and program co-ordinator/facilitator included open-ended questions about their role in the program; the nature and extent of the support provided to program participants, including pre- and post-program where relevant; the unique challenges of working with comorbidities; and collaboration with the facilitators and FSC worker. The interview with the FSC worker included open-ended questions about the role of FSC in BCP work generally, and for GBTQ+ populations, specifically; affected family member responses to FSC in Clear Space; safety and risk for affected family members in online programs; and the role of the community of practice in this pilot.

Surveys and interviews with program participants were conducted over the telephone. Small-group interviews with stakeholders and program observations were conducted over Zoom. All interviews were professionally transcribed using SmartDocs and the resulting transcripts were thematically coded using NVivo.

Program observations

The Clear Space program sessions were observed three times during the pilot by members of the review team. The observations provided insights into program content, delivery and facilitation, and participants' engagement with content, facilitators and other members of the group. It also allowed the review team to develop and ask more targeted questions in both the program participant exit interviews and the interviews with stakeholders. Following observations, facilitators and observers engaged in informal feedback and discussion. The observations were also an opportunity for program participants to meet members of the review team, potentially fostering greater uptake in the review by program participants.

The Monash review team observed the monthly community of practice meetings on Microsoft Teams. The community of practice meetings were hosted by NTV and attended by stakeholders from THH, MFC and ACON. These observations provided information about the value of the collaborative practice between BCP services.

Response rate

As shown below in Table 1, all five program participants who began the program and consented to participate in the review completed the initial survey. Four program participants completed the mid-point survey, and two participants completed the completion survey and exit interview. This represents an attrition rate of 20 per cent at mid-point and 50 per cent at program completion. The participant who dropped off at the mid-point could no longer attend the program due to a scheduling conflict. This participant was still contacted for the review but declined to participate. Two further participants did not complete the final survey. One of these participants was formally exited from the program for missing too many sessions at the program mid-point, this participant completed the mid-point survey and early-exit interview. A second participant completed the program but declined to participate in the final stage of the review.

Table 1: Response rate

	Program participants	Affected family members
Total completed intake/early program (*n*)	5	0
Total completed program mid-point (*n*)	4	0
The attrition rate at program mid-point (%)	20.0	0
Total completed program conclusion (*n*)	2	0
The attrition rate at program conclusion (%)	33.3[4]	0

Data analysis

Throughout this report, we present descriptive statistics from the survey. Qualitative data was analysed thematically using NVivo, qualitative analysis software. Throughout the analysis, the review team identified key themes emerging from the interviews undertaken with program participants and stakeholders. To ensure anonymity in the presentation of the findings, each program participant has been assigned a pseudonym and each stakeholder has been assigned a practitioner number. These are used throughout this report. Given the small sample size of program participants involved in this review, we have presented descriptive statistics of change over time within each survey measure.

Participant samples

The program participants involved in this review identified that they were born in Australia (*n*=5). The average age of participants was 36 years old. All participants identified as male and as cisgender. Of those program participants who responded to the survey, 60 per cent (n=3) reported being attracted to the same gender, while the remaining 40 per cent (n=2) stated they were attracted to individuals of varying gender. Participants also provided information regarding the affected family member

[4] One participant exited the program early. The attrition rate here is calculated based on the number of people who stopped participating in the review between mid-point and program completion. This number is one out of three. This doesn't include the participant who exited early.

relevant to their involvement in the program. Three participants (60%) reported that the involved affected family member was their ex-partner, while one stated that the affected family member was their mother, and one identified the affected family member as someone known to them but not a family member. Two participants (40%) reported being single, two participants (40%) stated that they had a partner, and one participant (20%) stated that they were in a casual relationship at the time of data collection. The majority of participants reported having no children (n=3; 60%), with the remaining sample stating that they had children in their lives; one participant indicated their partner had two children and another participant indicated they had two stepchildren (n=2; 40%).

Two participants identified that they had been issued with a Family Violence Intervention Order (FVIO), with one additional person stating they had an interim FVIO. Some participants also described facing charges in relation to current FVIO (breaches), and one was facing possible charges relating to sexual assault. One participant stated they had previously served a term of imprisonment.

Four participants responded to questions regarding their mental health. Two participants reported that they had disclosed their mental health concerns but received no formal diagnosis; one participant stated that they had disclosed their mental health concerns and received a formal diagnosis and had formal mental health supports; and one participant stated that they had not disclosed their mental health concerns.

Participants were also asked questions about their alcohol or other drug (AOD) use. Three participants responded, reporting that they had disclosed their AOD use/concerns and had formal AOD supports in place.

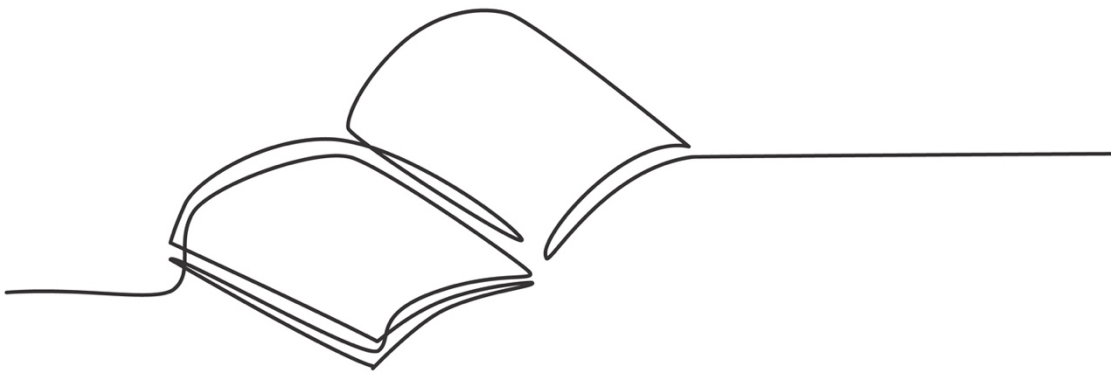
Most participants were employed (*n*=3; 60%), with two participants reporting they were unemployed (40%). Two participants were living in a rental property, two participants owned the home they lived in, and one participant did not specify their housing arrangement. Three participants (60%) reported living with their partner, one participant (20%) reported living alone, and one reported living with other family.

Review Limitations

This program review is subject to several limitations. First and foremost is the lack of victim-survivors/affected family members' participation. Research has shown that, in general, very few affected family members take up FSC or participate in program evaluations or reviews (Chung et al. 2020). In the current review, contact with affected family members was to be facilitated by FSC workers. This practice is deliberate, as it guarantees that affected family members are connected with support services both prior to and after participating in any research. No affected family members who accepted contact from the FSC worker consented to being contacted by the Monash team to participate in this review.

In line with practice standards, the Clear Space program logic established that victim-survivors must be at the centre of the application of evidence-based change theory. This means ensuring that victim-survivors' experiences are paramount in the promotion of behaviour change. This occurs by bringing the perspectives of victim-survivors into the work with program participants, but it is also about engaging with victim-survivors through the family safety contact work. The absence of victim-survivors from the program is a shortcoming of the review. As a consequence, this review is limited in its ability to address the final research question: How do online interventions impact family safety? We do address this question in part, but only by drawing on the views of the FSC workers and program facilitators. The voices of victim-survivors are critical to validating participants' own accounts of behaviour change, and they are critical to ensuring that programs meet the goal of enhancing safety for those experiencing family violence and improving perpetrator accountability. Without the voices of victim-survivors, this review is limited in its ability to assess behaviour change.

The review is also limited by the small sample size. The Clear Space pilot had five program participants with just two completing all stages of data collection for this review. Due to this 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 that survey answers reflect socially desirable responses. This is particularly the case in attitudinal measures, including the NATE scale and ACON measures. Research has shown that explicit attitude items are subject to risk and biases and may be influenced by perceptions of socially acceptable responses (Webster et al. 2018). For these reasons, our findings focus largely on the learnings extrapolated from the qualitative data. The qualitative data also draws from a small sample, but it can provide deeper insights into the experiences of delivering an online BCP for GBTQ+ men and non-binary people.



REVIEW FINDINGS

The review findings draw on the experiences of the Clear Space program participants and the professional views of practitioners involved in the program development and delivery, including those involved in ancillary work related to family safety contact work and AOD/mental health support.

The findings are organised into eight sections:

1. Practitioner views on working with GBTQ+ men and non-binary people
2. Family Safety Contact work
3. Recruitment, Referrals and Intake
4. Identifying and supporting co-occurring needs
5. Online delivery
6. Program facilitation
7. Practitioner and program participant reflections on behaviour change
8. Community of Practice.

Practitioner views on working with GBTQ+ men and non-binary people

Throughout the review, practitioners spoke about the complexity of working with GBTQ+ men and non-binary people in behaviour change and about the need to resist gendered assumptions. As one practitioner commented at the beginning of the program:

> *Regardless of the genders of the people they are currently in a relationship with, or where they've used violence, in what relationships in their life, none of these men … they're not straight men in rainbow clothes; nothing about their lives is heteronormative … it's just not the same […] we discover that every time we learn a little bit more about somebody's life or relationship […] the way that relationships and love are done and are navigated is deeply not heterosexual. (Practitioner 1, interview 1)*

Closer to the end of the program this practitioner reflected again about working against gendered assumptions, this time with a focus on the intricacies of unpacking power and control.

> *For our particular cohort … power is not always divided really clearly along gender lines. It means that we do have to think harder and we do have to look more closely […] To be really clear…[n]either of us are saying in any way that that means that there's a mutualisation of violence, but sometimes it's actually really unclear how power is working, and there's so much going on and there are so many different ways that power operates in these relationships that we … can't assume. […] It requires a really deep willingness to examine your beliefs, and also a really deep capacity to be wrong and to have an analysis of power that's expansive. (Practitioner 1, interview 2)*

To better understand some of the foundational differences between the focus of the pilot program and the heteronormative focus of most programs, we asked practitioners to reflect on how the program approach departed from the Duluth model. As noted previously, the Duluth model is foundational to much of the BCP work underway in Australia, and it was key to the development of the Clear Space frameworks for change. However, as the program logic details, the program design and development go beyond Duluth. Practitioners commented on the incorporation of the Duluth model into the pilot, while also raising the limitations of this framework:

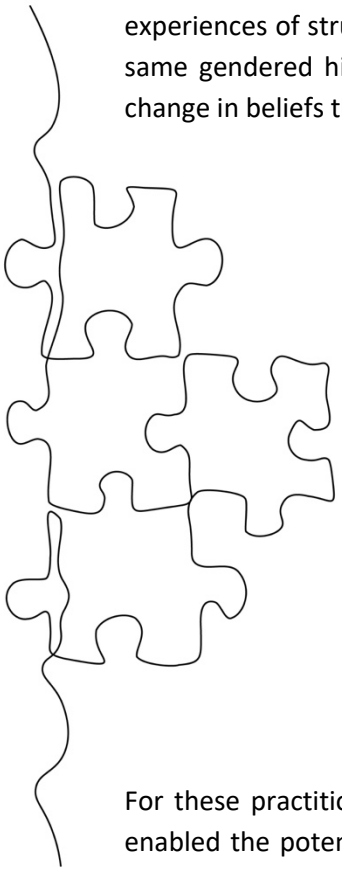
> *We have incorporated some of those tools and activities [from Duluth], but we have really been led by a real genuine curiosity in people's lives and what comes from that. And often we've been able to get to those places, but we've got there via a really different route. Rather than imposing, "This is what we're doing this week", we've been like, "We have some ideas about what we want to do." But then we follow a discussion and we'll get to talking about male dominance and entitlement, but we'll do that by talking about gay norms and coming out and whatever it is. […] We've done a lot of narrative therapy work in our group that's not really so present in Duluth at all. (Practitioner 2, interview 3)*

> *It's a carceral model … that's predicated on offending and accountability through the criminal justice system […] one way in which our framework departs from the Duluth model is that we have tried to be as far away from a carceral model as we possibly can, while also operating*

in the men's behaviour change system. And recognising that sometimes calling the police is the only option that a victim-survivor might have to support their safety. (Practitioner 1, interview 3)

Practitioners describe here two ways in which the program departed from Duluth while retaining a foundational adherence to the model. The first is the decision to address the core principles of behaviour change work – accountability, prioritising the safety of women and children, and recognition of the gendered drivers of violence – through a queer-specific framework. This was articulated by practitioners as key to creating a space in which transformative change can take place. As Practitioner 2 stated in the early program interview, "it absolutely can't be a straight MBCP [men's behaviour change program] dressed up in a rainbow flag."

Supporting program participants to reflect on their own experiences of gendered violence as queer men and non-binary people enabled them to identify impacts of gendered violence beyond their own experiences of structural victimisation, as well as the ways their behaviour was complicit with these same gendered hierarchies. This was noted by practitioners to be a more effective prompt for a change in beliefs than didactic approaches. As one practitioner explained:



What we did from week one was prioritise a queer affirmative space … where we're talking about sex and sexual culture in gay spaces. We've really prioritised this space that is deeply queer and gay, not just 'gay friendly', but that's the whole basis of what we're doing. We're all there. We have different experiences, but we have a peer understanding and a real love of gay life. So because we prioritise that kind of affirmation of queer lives as important, and special, and impacted by structural homophobia, where we got to was talking about men's violence against women, because [some] participants have been sexually violent towards women. And so instead of taking the approach of like, 'Okay, we know that you're gay but we need to talk about misogyny in week one' … what we actually did … is that we got to a space of being able to … have a really deep conversation about male dominance and sexual abuse as a tactic of control … And I think that the only way we were able to do that is by being like, 'Yeah, what is the impact of homophobia and transphobia on our lives?' and starting with that. (Practitioner 1, interview 2)

For these practitioners, the creation of a queer-affirmative, and therefore non-threatening, space enabled the potential for program participants to come to an understanding of gendered violence through their own experiences.

Another way practitioners distinguished the program from the Duluth model was through the rejection of the 'carceral model'. Practitioner comments point to the importance of such a model given the history of the criminalisation of queer communities and the suspicion with which many in those communities regard police and the court system (Reeves & Scott 2022). Compounding this is the risk of GBTQ+ victim-survivors being wrongly identified as perpetrators in criminal justice responses to FV and IPV (Reeves & Scott 2022).

Discussions of sexual violence in Clear Space

Australian research has found that open engagement on the use of sexual violence can be difficult in behaviour change work. It has found that practitioners often find participants reluctant to discuss sexual violence, that program facilitators often feel ill-equipped to discuss sexual violence, and hence are hesitant to do so in their practice (Helps et al. 2023a). Yet, sexual violence was frequently discussed in the Clear Space group, including in sessions observed by the research team. Researchers were informed that sexual violence was specifically prioritised in the Clear Space program design sessions. Practitioners told us that sexual violence was explored in 'at least six weeks' across the second half of the program and that this level of attention was not planned but came about because "participants wanted to talk about it" (Practitioner 2, interview 3).

Practitioners told us that they were aware notionally that sexual violence was a challenging topic in behaviour change but that this was not their experience in the pilot program. One practitioner commented:

> *We had, honestly, some very, very profound and transformational conversations, and challenging conversations, […] where participants were really, really engaged and reflecting on things, reflecting on their experiences, shifting their opinions, disagreeing with each other, unpacking beliefs. And also, really looking at beliefs that support sexual assault in their lives and in their communities, like gay and queer-specific contexts that were really profound. (Practitioner 2, interview 3)*

We asked practitioners whether they believed there was a 'shift' in participants' understandings of what sexual violence is during the program. One practitioner responded:

> *Unequivocally, yes, I would say for everyone. Because when I think about what had brought several participants to group, it had been their sexual violence towards people. However, at the start of group, neither of them named that as sexual assault, and neither of them, I don't think, really saw that as sexual violence. And it was only really through group, and by the end of the group, that they were able to be like, "Yeah, absolutely, I can really see that that was sexual violence" or "I sexually assaulted these people." And then for other participants, where that might not have been the reason they're in group, but they definitely had reflections like, "Oh, woah, holy fuck, how I acted at that club that time was sexually coercive", or, "And also what I've experienced in all of these contexts, that's sexual violence." And that was a real opening or broadening that I don't think people necessarily had prior to group. (Practitioner 2, interview 3)*

Practitioners were also asked to reflect on what they believed enabled this level of engagement on the topic of sexual violence. They raised the creation of a queer-affirmative space, a trusting online environment, authentic and caring engagement and the 'divest[ment] from carceral thinking' as key enablers. Two practitioners explained:

> *Mostly it comes back to the things that we've already mentioned, about building a space that is founded on trust and connection and relationality, having a genuine curiosity in people's*

lives; people being able to really feel that, that we actually genuinely care about them and that this is a space that's very open and non-judgmental … And also an abolitionist space … we've moved away from a carceral model as much as possible while also acknowledging we live in the world. But we created a space that actually allows conversations about sexual assault, because where else are you able to do that in this world? Where normally it's –" sexual assault's a crime," and so you're terrified of talking about it because then you get reported and locked up and all these sorts of things. And so, actually, if you have a space where you're like, 'That's not what we're here to do, we're here to have these conversations about identifying and shifting our beliefs and behaviours and working towards who we want to be in line with our values'... I really think that shifting away from the carcerality of … a Duluth model-type MBCP is really, really essential in terms of what it allowed around conversations around sexual violence. (Practitioner 2, interview 3)

For me, having worked in several straight men's behaviour change programs, the figure of the person who uses sexual violence or the rapist is this monster who's over there, who's not […] in our friendship group, isn't in our family, and it's definitely not us, and what that does is actually shut down conversation and shut down change. (Practitioner 1, interview 3)

For the practitioners, engaging GBTQ+ men and non-binary people in all aspects of behaviour change work, including content on sexual violence, was achieved through adopting a queer-specific and queer-affirming framework. Critically, such an approach is framed as antithetical to a carceral approach. This approach was posited as essential to the potential for transformational behaviour change.

Ensuring accountability for use of violence while acknowledging harms

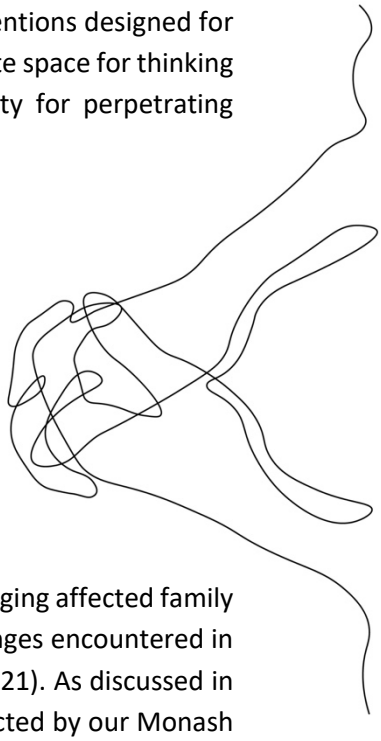
During the interviews, practitioners were asked how they acknowledge the impact of homophobia and transphobia while enabling a space for participants to talk about their own choice to use violence. Practitioners spoke about the strategies they employ to make space for both of these things. As two practitioners explained:

As an AOD worker working in LGBT+ organisations I need to consistently or always hold a[t] the forefront of my mind that all of the people that I'm working with are experiencing minority stress, but that doesn't necessarily excuse any behaviours and I really need to hold the potential for lateral violence, or nuance of the power dynamics at the forefront of my mind as well. So, it's this whole being able to hold the duality of the situation. Yes, there is this awful systemic oppression which is happening in our society, yes, we are also capable of really systematically oppressing each other within queer community too. (Practitioner 4, interview 2)

I actually think holding that is kind of the most important thing that you have to do, or that I feel that I have to do, and recognising that if I do that I do really hold the safety and the value of the life of victim-survivors as very important as well … I think there's this thin story … story that gets told where it's say for example like, 'That man's been violent but he's experienced so much homophobia so therefore his violence is excusable or less important or has less

impact', and I really don't think that's what we do. I think that what we do is [say] 'Wow, look at the impacts of structural violence. Wow, what world do we want to look towards? Wow, how do we be a part of that?' (Practitioner 1, interview 2)

As these practitioners articulate, accountability remains a foundational focus of behaviour change work in the Clear Space program. Gray et al. (2020) highlight that tailored interventions designed for LGBTQ+ people potentially enable better outcomes specifically because they create space for thinking about multilayered traumas without losing sight of the focus on accountability for perpetrating violence.



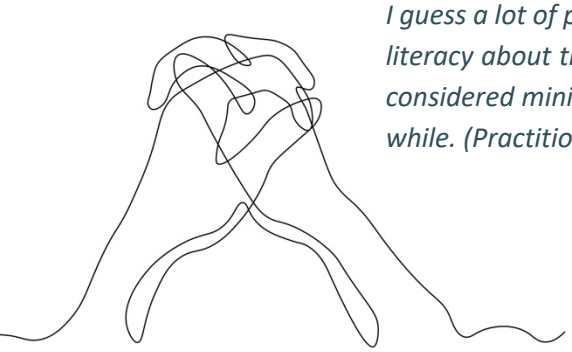
Family Safety Contact

There's still so much we don't know about what family safety contact looks like, or what it should look like, or what is ideal in this space. Yeah, I think it's very much a learning process that needs to be further developed. (Practitioner 3, interview 4)

Evaluations and reviews of BCPs more broadly have noted the importance of engaging affected family members in program evaluations; this occurs alongside recognition of the challenges encountered in doing so (see, for example, O'Connor, Morris, Panayiotidis, Cooke & Skouteris 2021). As discussed in the methodology section, no affected family members consented to being contacted by our Monash review team. The FSC worker noted that she had 'three or four clients' that requested a weekly check-in. The weekly 'check-in' would consist of the FSC worker providing some information on what was covered in the group program that week and an offer to 'have a discussion' about anything, if the affected family member wished to. The three or four clients either did not respond to the check-in text messages or ceased engaging in further dialogue with the FSC worker; however, as they had requested a weekly update, the FSC worker continued to send weekly updates to these clients for the duration of the pilot program.

The absence of affected family member data prohibits this review from making any outcome findings related to program participant behaviour change. Perpetrators' self-reported behaviour change data is known to be limited, and this reiterates the importance of affected family member voices in validating and cross-checking program participant accounts. Despite these limitations, some learnings about FSC emerged from the practitioner data.

Specifically, a key insight from the FSC worker was the general lack of awareness of FSC as a minimum standard of support and service in Victorian BCPs. As one practitioner commented:



I guess a lot of people have heard of men's behaviour change, but that sort of greater literacy about there being an aspect of partner safety work to that, and then it's like considered minimum standards. Like I wasn't familiar with it, being in the space for a while. (Practitioner 3, interview 4)

This lack of awareness may have contributed to adverse reactions from some affected family members. For example, the FSC worker reported that some affected family members reacted with suspicion, panic, fear and stress when contacted as part of the safety and support component of the program. The FSC worker reported needing to explain to clients the role of FSC, what it was for, and its place within the program. This practitioner reflected:

> *I had a few people who were quite a bit panicky at the start, being on board, "What is this? I don't understand." Yeah. Once I'd had a few of those conversations, then things really settled down. (Practitioner 3, interview 4)*

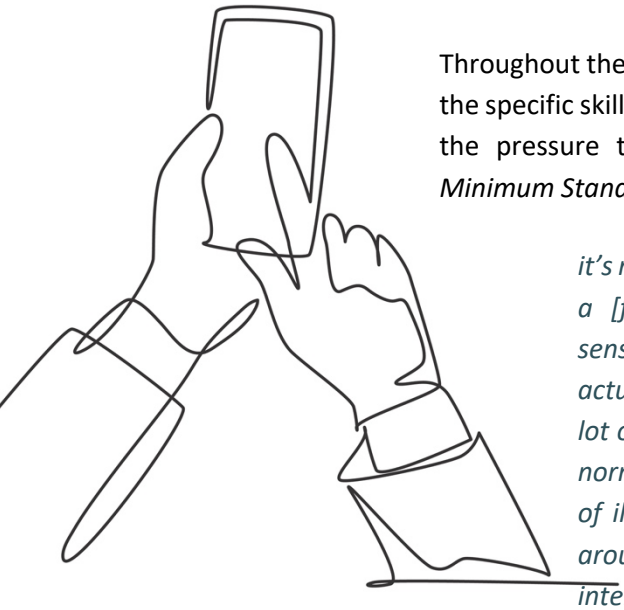
While the provision of this type of information is typical in the initial stages of FSC, in these examples the worker was required to explain their role over the phone or via text in a context heightened by fear and suspicion. The FSC worker told us that affected family members expressed concern about FSC as a tactic of the perpetrator, as is captured in the following:

> *I did have a few really concerned clients contacting me back, kind of concerned that … this was a tool of the perpetrators to try and get access to the client, that it was part of the perpetrator's power [and] control … [they were] concerned that it was a way of the perpetrator breaching the IVO without actually breaching the IVO … I had one client in particular, who … wanted to know a little bit more. This particular comment was, "Isn't this a breach of his order? As far as I know he can't even contact me through a lawyer." This particular client said she found this really frightening and really stressful. So the actual process for her felt – I think was quite traumatising. (Practitioner 3, interview 4)*

In response to these adverse reactions, the FSC worker advised that she 'tweaked' the initial contact message. When asked if it would be useful to have greater practice guidance around the role of FSC work and the processes involved in making initial contact, this practitioner responded positively, noting that she believed practice guidance, especially in relation to "ameliorat[ing] the issue of cold calling people" would be beneficial. Reflecting on the lack of affected family member participation in the review process, the FSC worker pointed again to the lack of 'general knowledge' about FSC. Indeed, evaluation and research participation are often facilitated and achieved via FSC workers: it relies on FSC worker engagement with affected family members.

Recruitment, Referrals and Intake

In their ANROWS report, *Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence*, Gray et al. (2020, p. 13) note that the way practitioners understand family, domestic and sexual violence for LGBTQ+ populations 'has implications for how potential clients are identified, directed to and treated within DFV/ IPV programs'. In this section, we discuss the recruitment of practitioners for the pilot program, as well as the referral of GBTQ+ men and non-binary people as program participants. Practitioner contributions on intake processes are also included, and we begin to outline practitioner views on the importance of specialised knowledge when working with GBTQ+ populations in violence intervention, from referral through to program delivery and post-program support.



Recruitment

Throughout the review, practitioners emphasised that recruiting facilitators with the specific skill set for engaging this cohort is challenging. They also spoke about the pressure to ensure the program meets the *Men's Behaviour Change Minimum Standards* (2018). As one practitioner summarised:

> *it's really challenging to … meet all of [the] requirements but also have a [facilitator] who has the right frameworks, has the cultural sensitivity and competency to know what the lives of queer men are actually like. To understand the criminalisation that queer men face a lot of the time, to understand the context around, for example … the normalisation of massive age difference in sexual relationships or use of illicit drugs in a sexual context or some of the real complexities around like consent and STIs and HIV, for example. (Practitioner 1, interview 1)*

The recognised difficulties of recruiting and retaining a skilled workforce are – in part – reflective of a wider workforce shortage in Victoria (RCFV 2016), and this was explicitly acknowledged by Clear Space practitioners. However, these challenges are amplified in the context of the pilot program and programs tailored to GBTQ+ men and non-binary people. In such programs, a significant level of specialisation is required, not only in relation to working with perpetrators of family violence but specifically with GBTQ+ men and non-binary people who have perpetrated violence. While industry planning and workforce development strategies have been developed and implemented by the Victorian Government, the viewpoints of these practitioners demonstrate the continued need to ensure that practitioners with diverse skills and lived experience are supported to upskill to work in this field.

The recruitment process for the co-facilitator was protracted. The successful candidate was recruited through a pre-existing professional network. Gray et al. (2020, p. 13) note that members of the LGBTQ community believed 'it would be better to be treated by a fellow community member than risk poor service from an uninformed professional'. This suggests that in addition to resourcing for specialised training in the LGBTQ+ DFV and perpetrator intervention space, attention could be given to expanding the diversity of practitioners within DFV and perpetrator services more broadly.

Referrals

In the recently released Family Violence Reform Implementation Monitor (FVRIM) report, *Service Responses for Perpetrators and People using Violence within the Family*, the Monitor found that while early evaluation data indicates that innovative pilot programs are showing promise, many 'had unfilled spots due to the lack of coordination of referrals and visibility of program availability' (2023, p. 8; on this FVRIM report, see Helps et al. 2023b). As outlined below, the difficulty with referral pathways and the low number of program participants that took part in the pilot program highlight the relevance to this pilot of the Monitor's finding.

During the interviews, practitioners spoke directly about the challenges of program referrals due to lack of established pathways. As one practitioner explained:

> *one … thing I just wanted to put on the record … is … around referrals and the challenge we had [with] referrals into the program and the lack of existing referral relationships and … how much work we had to do there to actually build those referral relationships and pathways. (Practitioner 2, interview 1)*

As noted in the methodology section, the Clear Space pilot program was run in parallel with a second online pilot program for men in rural, regional and remote areas delivered by the Men and Family Centre (MFC). The MFC program was the source of one successful referral into the program (for further details on this program, see Helps et al. 2023c). As one program participant reflected:

> *I was initially in conversation with the Men and Family Centre […] I did the intake and was just about to start their program, and before it started one of the facilitators said, "Actually I think you might be better suited to do Clear Space, which is particularly for queer men." (Joel, exit interview)*

As this example highlights, the concurrent program model contributed positively to the enhanced coordination of referrals between the programs. When these reviews' findings are considered in the context of broader recognition of the long waiting lists and inconsistent referral pathways for people who use family violence across Victoria, the need to enhance referral pathways into existing programs becomes evident (see, among others, Fitz-Gibbon et al. 2020; NTV 2020).

Intake

Moving beyond the referral point, practitioners spoke at length throughout the review about the importance of their relationships with program participants. Practitioners understood such relationships to be central to the process of behaviour change and emphasised that relationship building is key from the very beginning of practitioner/client engagement. Practitioners told us that they found existing intake forms to be inadequate, and that they worked to re-develop them to better achieve their aims:

> *Even just like the lack of appropriate forms as well, we ended up entirely making a new intake form that actually served our purposes, because the existing intake forms were just for a very different context but didn't work for us … [the] existing form … was not at all conducive to a conversation and to relationship building. It was very much a sort of tick box interrogation style intake, which for both of us just doesn't fly, given … what we said about our values around … relationality … [as] ... key in … change work … I feel it's really important to see the intake as an opportunity to begin building your relationship. (Practitioner 2, interview 1)*

For Practitioner 2, the existing intake forms were interrogative and may have given the impression that the intake process was a 'tick box' exercise rather than an opportunity for authentic engagement. Previous research conducted with young victim-survivors of family violence in Victoria has similarly noted the perception that practitioners who were 'going through the motions' in risk assessment or

intake processes left them feeling invalidated (Fitz-Gibbon, McGowan & Stewart 2023, on the limits of a tick-box approach to family violence risk assessment see also McCulloch et al. 2016).

Practitioners also highlighted the inability of standardised intake questions to accurately capture the lived experience of GBTQ+ community members' lives. In particular, practitioners noted that the forms were not able to capture diversity in relationship and familial structures. Two practitioners explained:

> *for our community … the way you ask questions, the types of questions you ask … it's not the same … around family, around relationships, around kids, around pets, around safety, around risk … having a form that is able to capture the complexity of someone's living circumstances and their relationships … we were just hoping we could make a form that actually reflected that a bit more, with a bit more integrity. (Practitioner 2, interview 1)*

> *The way that questions around children and families were asked on the existing intake forms didn't allow for real, accurate or invitational conversations that would allow a worker to assess risk. […] Also, we found that they weren't adequate for the way that our community actually has family. (Practitioner 1, interview 1)*

The question of program eligibility also came up in interview discussions related to intake. Practitioners were asked if exclusion criteria were utilised and whether any clients were assessed as ineligible for the program. Practitioners confirmed that some clients were deemed ineligible and indicated that these decisions were made with risk, safety and participant comfortability in mind. As one practitioner explained:

> *importantly, it's not that we were trying to control the makeup of the group ... It was more … like, 'Actually, what is this going to be like for the participants?' We want this to be a positive transformational experience, people will be able to show up and to feel like they can do this work. It's not so much that we were like, 'We're trying to get the perfect group', but more, 'Actually, what's best for participants. … I know that in terms of mainstream MBCPs based on the Duluth model, there's very, very broad eligibility, and the underpinning principle is screen in … don't have many conditions of screen out … And I do think that this work is really different … when you're working in this space … It's more just about, actually, risk, safety, power, and those sorts of things. (Practitioner 2, interview 3)*

Practitioners explained why some clients were deemed ineligible. Examples included a case of wrongful identification of the predominant aggressor, in which they determined that the participant was experiencing family violence and systems abuse from a partner who had been identified by police as an affected family member (on misidentification, see further FVRIM, 2021), and another in which a person seeking healthy relationships support had been incorrectly referred to Clear Space. In the case of the latter, the practitioner determined that the participant had complex needs and was likely referred to Clear Space due to the lack of GBTQ+ programs. This practitioner explained:

> *My professional view after doing a risk assessment was like, 'Actually, I don't think this is appropriate … You've experienced significant abuse in your life, you're wanting help with that, healthy relationships and stuff like that, but you don't need a behaviour change course.*

You have survived a lot of violence in your life, and you're queer, therefore, because you're seeking some sort of support around relationships, they've all been pushed into a behaviour change space because that's all there is.' (Practitioner 2, interview 3)

Existing research has found that an understanding (gained from experience) of the forms DFV takes in LGBTQ+ relationships is critical to the successful identification, referral and treatment of clients from these communities (Gray et al. 2020). Practitioner views gathered from early program and completion interviews support this finding, with both practitioners underlining the crucial importance of a skill set that combines mainstream perpetrator intervention and behaviour change knowledge alongside GBTQ+ cultural competency. The issues and key learnings highlighted here have a broad application beyond the GBTQ+ context. Specifically, when considering the limits of assessment forms that are not 'fit for purpose', the need for conversational tools becomes apparent, as does the importance of professional judgement and GBTQ+ cultural competency.

Identifying and supporting co-occurring needs

In this section we examine the co-occurring needs of program participants. To do so, we present findings related to alcohol and other drugs (AOD) and mental health. This section also includes discussion of individual case management work and post-program supports. In this review, individual supports were predominantly discussed in relation to co-occurring needs.

Intersecting AOD needs were identified for most individuals participating in the pilot program. This high prevalence was commented upon by one practitioner:

Including the people that we had to early exit and a few people who we assessed and who weren't able to attend even though they were eligible, all apart from one have identified AOD issues, four have been either referred to AOD services within Thorne Harbour or were referred [into Clear Space] from an AOD service within Thorne Harbour … we know that (AOD] doesn't cause family violence but we also know that our communities use a lot of drugs and alcohol. (Practitioner 1, interview 2)

THH offers state-wide alcohol and other drug service for LGBTIQ+ and people living with HIV (Thorne Harbour Health 2023). In the context of this pilot, this meant that internal referrals for support were made for participants when needed. As one practitioner explained:

We … successfully engineered a really fast referral pathway with our AOD service for people who needed some AOD support in terms of being able to participate … [we] worked really closely with in-house Thorne Harbour AOD workers who were doing outreach or case management or drug and alcohol counselling. (Practitioner 1, interview 3)

In addition to the facilitation of more efficient referral pathways, another benefit of the internal referral system is that the facilitators and the AOD/dual diagnosis worker were able to work collaboratively to support program participants. In particular, practitioners reflected on the benefits of internal collaboration for managing risk:

> *I collaborate a lot with other AOD workers and having … a fundamental ethic of collaboration it means that it's not all on [practitioner 4] to hold all of the family violence risk, and it's also not all on me to hold, you know, like the risk of overdose or something. (Practitioner 1, interview 2)*

> *I like what you mentioned there … about not having the capacity to be everything. It's really, really hard I think in an AOD space to hold really high-risk family violence at the same time, speaking as someone who's done it a lot. With changes in MARAM and stuff like it's been a big shift in terms of an AOD sector which has felt really huge across the AOD sector, and a lot of clinicians are still learning and grappling with that. (Practitioner 4, interview 2)*

We note that some research on the delivery of online programs has been circumspect about the ability of online interventions to deliver safe and adequate AOD support (Vlais and Campbell 2020 p. 6; p. 23). While we cannot make a finding related to AOD and program participant outcomes, as the quotes presented here capture, practitioners who took part in this review spoke positively about their collaborative work supporting participants with intersecting FV and AOD needs.

This collaborative approach also supported the delivery of post-program supports. For example, during the program review there was one participant who became a shared client of Clear Space practitioners and the AOD/dual diagnosis counsellor. The practitioner advised that this was primarily in relation to mental health support. At the time of the interview, the participant was being supported with weekly sessions. The dual diagnosis practitioner outlined the type of support this participant could engage in after the program had concluded:

> *He can do a step-down model of care, so he can engage with drug and alcohol counselling onsite, if he wants to engage with the … Care and Recovery Coordination, to get into detox or rehab or other psychosocial supports, then absolutely get a referral from me to do that. If he wanted to get into detox and rehab I could support him to do that, and also – yeah, absolutely it would be ongoing support if ever he wanted it. (Practitioner 4, interview 2)*

The level of support provided by this practitioner was made possible by their role within the Primary Health Network. As they explained:

> *What that means is that this particular role that I've got is funded for two years … I've got the potential … to actually work with this person for another year, if that's the case. And that might look like step-up, step-down care, it might look like continuing outreach dual diagnosis counselling support, I could advocate for that. Because of the flexibility in this program, I can do that, whereas if I was engaging with this person with a drug and alcohol counselling support with the standard 6 or 12 sessions, it would be so limited. (Practitioner 4, interview 2)*

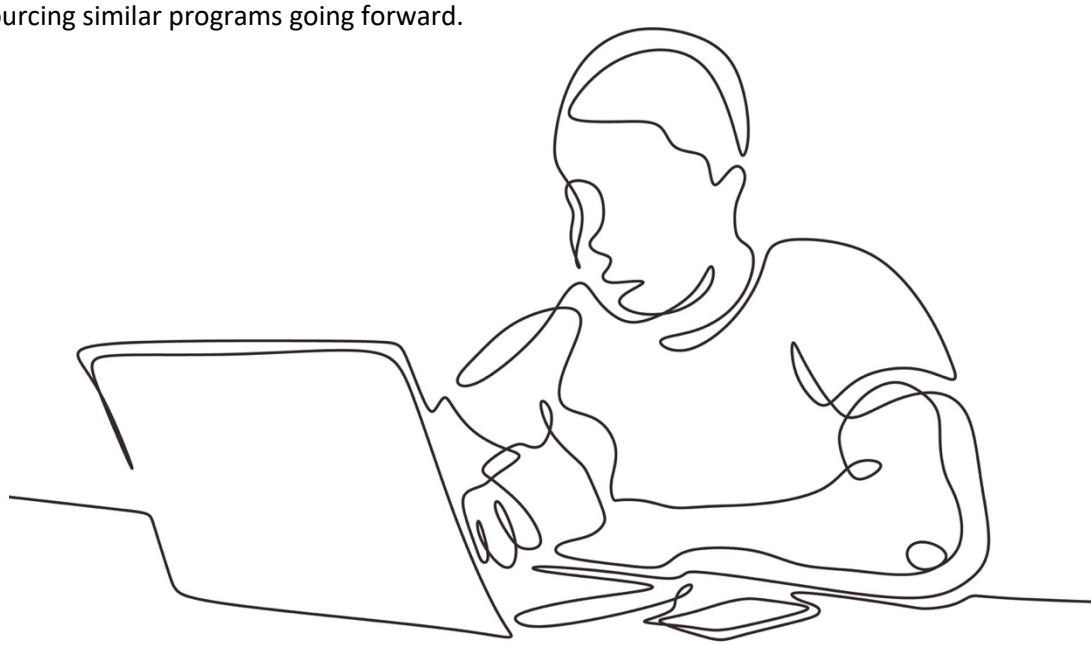
Further research into the benefits of providing additional supports, such as AOD and mental health support discussed here would help to guide the resourcing and delivery of programs moving forward.

Case management was a key component of the work undertaken by facilitators. This work was critical, both to support the co-occurring needs of program participants and to support the behaviour change and accountability work being done in group. Facilitators conducted one-on-one support and, in some cases, more extensive case management for participants over the course of the program. As the practitioners outline below, this support was provided primarily to enable group participation; in other cases, the presence of co-occurring needs was also noted. Practitioners were clear that the group space was where accountability work was done, so this support was critical to ensure attendance and participation in the group sessions.

> *We did a lot of case management … It also included one-on-one check-ins as well, sometimes earlier in the week, sometimes after group if people were really distressed or dysregulated. And that also coincided with AOD use or just other shit going on in their lives … For someone, we actually worked very, very closely with a lawyer – actually, several lawyers … including a person who was exited from group but then is still someone who [we] ... might provide extensive case management and one-on-one support to. And also including just groceries, material aid. (Practitioner 2, interview 3)*

> *All of that case management and individual check-ins is so important to support people emotionally, materially, and socially, and medically, and all these things. To support them to be in a space where they're able to participate in group. And it's scaffolding, and also just around risk and safety for other people in their lives and for them. But that's not the substitute for where you're doing accountability work. (Practitioner 2, interview 3)*

Program practitioners spoke about the capacity they had to identify and provide support for co-occurring needs, including sometimes complex comorbidities. Though we are not able to make any outcome findings, based on practitioner observations it appears that a significant level of support was provided. This level of support may have been enabled by the low numbers of program participants and the unique resourcing of the Primary Health Network Dual Diagnoses worker. As noted above, were the pilot to continue in its current form, the collection of evidence by future reviews could provide guidance for resourcing similar programs going forward.



Online delivery

The need for online programs

During the interviews, practitioners were invited to share their views on the need for online BCPs, considering that prior to the COVID-19 pandemic there was a hesitance among some men's services to deliver BCPs remotely (Vlais and Campbell 2020).

Practitioners voiced concerns about the potential for elevated risk and the impact on victim-survivor safety, particularly prior to undertaking the pilot program. However, there was also an acknowledgement among practitioners of the importance of weighing the need for closer risk management against the pressing need for BCPs for the GBTQ+ community. As two practitioners reflected:

> *Before starting this group I was unsure around whether online would be an appropriate format or not … of course, there are still really live questions around … risk and safety, and you're always managing that. And I wouldn't say this applies across the board for MBCPs, heteronormative MBPCs, but specifically for what we're doing and for our community, because we're seen as a minority … and I don't say that in terms that we are intrinsically but rather … structurally in terms of discourse, in terms of government funding, that's how LGBT communities are positioned. We're an addition or an add-on or a separate thing … and therefore it doesn't work, actually, to just have one localised, in-person MBCP. (Practitioner 2, interview 3)*

> *I was a bit of a late convert. [Reflecting on previous experience co-facilitating online] I think part of that was that … there was lots of things I felt didn't work and I was like 'This isn't for me. I think I'd prefer to wait until we go back to in-person groups.' But I guess obviously COVID is not going anywhere and there are lots of reasons why online groups are really … important. (Practitioner 1, interview 1)*

Captured here is the significance of the COVID-19 pandemic to the framing of the need for online BCP programs. There were no COVID-related restrictions in place in Australia when the pilot commenced, however, as these practitioners highlight, there are other reasons why online offerings are valuable. As one practitioner commented:

> *There are a couple of gay, bi, trans or queer men in our group in Clear Space who live in regional areas and who have – like where there's literally no other possible service to them to go to that's culturally safe. And so yeah … I've done a total 180 on my … thoughts on online spaces, and I actually think it feels like a big access need. (Practitioner 1, interview 1)*

Reflecting broader concerns about the use of online programs (Vlais and Campbell 2020), practitioners were asked whether they thought online programs should only be offered to those clients who cannot attend a face-to-face program. In their responses, practitioners again focused on accessibility and the

benefits of responding to a diversity of community needs, rather than prioritising in-person programs by default. As two practitioners remarked:

> *I don't know if people should … only be offered face-to-face in the first instance. … Before Clear Space, [another program] was the only queer-specific men's behaviour change program in Victoria. For a long time the Thorne Harbour office was in St Kilda yet it's a state-wide program. […] So I think that maybe it's again another case of like, 'Okay, maybe for our community we need to actually be like making additional concessions for people or … removing barriers rather than kind of like being, 'Okay, you have to try this first and then if that doesn't work, go to the online one.' (Practitioner 1, interview 1)*

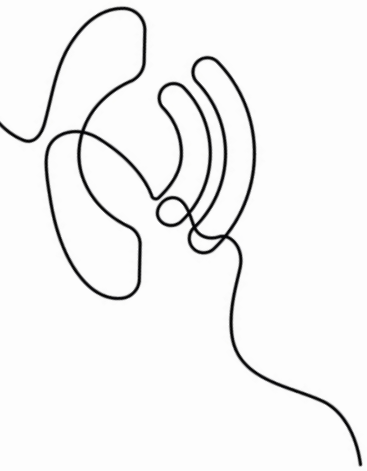
> *Also, people who really struggle around the anxiety and fear of being in a group space or whatever, I think that's been like another aspect. (Practitioner 2, interview 1)*

In their considerations of the value of online program delivery, practitioners also pointed to the ongoing problem of waiting lists. In 2020, drawing on the findings of a survey of member organisations primarily based in Victoria and New South Wales, NTV (2020) found that, on average, people who use family violence were waiting two and a half months to enter a program. The Royal Commission into Family Violence (RCFV 2016) also documented problems with demand, noting the number of people in Victoria on waiting lists.

At the conclusion of the Clear Space program, practitioners were united in their view that online BCPs should be continued for GBTQ+ cohorts. Further, practitioners also expressed views that suggest the focus on comparing in-person and online programs has the potential to be reductive. In the remainder of this section, we present practitioner views on how this comparison sets up a false dichotomy between online and face-to-face delivery, in which the latter is understood by default to be the preferred mode. Practitioner reflections instead suggest that online and in-person delivery are equivalent insofar as both formats have benefits and unique challenges. Lessons from both have the potential to mitigate emergent issues. What emerges from the practitioner data is that the successful delivery of a BCP is not necessarily determined by the format but rather whether the group 'space' and dynamic is conducive to behaviour change.

Technical challenges

Program participants and practitioners both identified some technical challenges experienced during the pilot program. Internet connections could sometimes be 'choppy'. One participant spoke about attending a group session on his phone and not being able to view the interactive whiteboard. He noted that the facilitators talked him "through what was happening" (Joel, exit interview). A facilitator recounted that one participant could not install Zoom on his computer for the first two weeks, so he dialled in as a temporary solution. This facilitator also spoke about some difficulties they encountered assisting someone in a regional location to set up a laptop (Practitioner 2, early program interview). While technical difficulties sometimes disrupted the flow of a group session, these challenges were described by practitioners as surmountable and not qualitatively different to the impact of similar issues they might encounter when working in a face-to-face program. As two practitioners explained:



It was a challenge, but it wasn't insurmountable. It's also like when you're facilitating a group in-person and the sink is dripping, tech goes wrong, the PowerPoint thing doesn't work. Stuff also happens in-person, too. That didn't actually feel like a huge thing. My internet sometimes was a bit choppy. It didn't feel so debilitating that it shifted things that drastically, I would say. (Practitioner 2, interview 3)

if I thought back to 20 weeks of Clear Space … none of that really – it didn't make a difference, it didn't impact it. (Practitioner 1, interview 3)

Practitioners were of the view that the success of a BCP relies not on the format but on whether the group 'space' and dynamic is conducive to behaviour change. This idea came through clearly when practitioners were asked what they thought were the key requirements of online BCP delivery. As one practitioner commented:

> *I feel like any key requirements for doing this work online can't be separated from key requirements for doing this work with our community, like with the queer community or the gay community. And what's required for that is just a fundamental curiosity about people's lives and a rejection of rigid adherence to hetero-gendered stereotypes … if you … prioritise connection, you prioritise a queer-affirmative space … That actually creates change and it mitigates risk. (Practitioner 1, interview 3)*

Practitioner comments here suggest there is more of an equivalency between online and in-person programs than anticipated. Practitioners recognised that both formats pose challenges, but that the challenges here did not significantly impact or disrupt the program.

Benefits and challenges of online delivery

Participants reported several benefits of online delivery specifically related to enhancing accessibility. One participant noted that had the program been delivered "in person [he] would have had to go down to Melbourne" and that it was much easier to attend via Zoom (Adam, exit interview). Another participant explained that he sometimes attended the program from the office, which enabled him to "switch on [and] concentrate", and that he also attended from an interstate location when he was travelling for work (Joel, exit interview). The ease of balancing work commitments and program attendance could not be achieved so easily if the program required in-person attendance.

Reflecting on the benefits of online delivery, practitioners also noted the benefits of being able to communicate privately with each other using the chat function. Practitioners believed that this improved facilitation and flow of group sessions. As one practitioner explained:

> *One person might lead an activity and the other person would be in a real space of listening and witnessing, which was made possible by the online environment … We would pick up on themes and say, "Okay, let's come back to that," or "Let's bring in that." And that became particularly useful during conversations when we wanted to be like, "Okay, let's bring affected family members or affected people into the space, let's bring it back to those people." And so that was one of the really helpful functions of Zoom […] I know that I often*

will think of a question, but I'm so interested in what the participants are saying that I'll forget my question after two minutes. It can be really helpful to have this scrolling little parchment scroll where we keep our questions and can circle back to them or make suggestions of each other. Or check in, "Do you have a question?", "Do you want to talk?" (Practitioner 1, interview 3)

Of course, the use of Zoom requires access to a computer, and as discussed above, reliable internet connection. Some program participants required provisions of a laptop to enable their participation in the program. The importance of ensuring each participant had access to their own computer is well-captured in the comments provided by one practitioner:

One point that is really important for being able to do this work online is having access to brokerage and having the ability to support people materially … I'm thinking about – access to laptops and actually being able to support people with that is something that was really important for several participants, including around risk, so that they weren't – in one instance, they weren't relying on the AFM's laptop, and so they actually were able to have independence and reduce reliance and therefore risk in relation to her. (Practitioner 2, interview 3)

To mitigate risk such as that outlined above, as well as to ensure all participants were able to participate on an equal standing from a technical point of view (noting that internet connection difficulties could not be ameliorated), practitioners were able to utilise 'perpetrator brokerage packages' to provide laptops where needed.

Managing safety and risk in the online space

To manage any emerging safety concerns, the FSC worker reported that weekly meetings were held with both Clear Space practitioners before the group sessions in which risk issues were discussed. One practitioner explained:

We had a lot of email communication, back and forth, and we email with any AOD practitioners as well. Nothing really ever came up, so we never had to put in any specific kind of risk management strategies or anything like that. (Practitioner 3, interview 4)

As previously outlined in the background, ensuring safety is a key issue in relation to the delivery of online behaviour change work (Vlais and Campbell 2020; Bellini and Westmarland 2021). The following two practitioner observations highlight the ways in which the online environment, which often provides a viewpoint into the home lives of the participant, may offer some benefits for risk assessment:

another example … during … a one-on-one that I was having with a participant prior to group who was like living with his mum … [practitioner describes interaction] and I was just like, 'Oh whoa. Okay. Yep.' And I think online is actually – it comes with risks and also comes with real benefits or insights … in that you do get a window into people's worlds, I think it's quite useful in terms of assessing risk … it does give you a real insight into people's lives, what their

relationships look like, how they're managing risk, how they're using their spaces, how they're interacting with people, like actually that's really valuable information when working with risk and safety as well. (Practitioner 2, interview 1)

… one person who seems to frequently have a family member around when they are participating or on the phone to me …is somebody who … has like been misidentified by … police and unfortunately still has current ongoing criminal matters in relation to that … what's going on is this participant is experiencing like family violence … And so while the question of safety in terms of family members being around is really integral to this work, actually the way that it's showing up specifically for us is in this kind of like a little bit bizarre hall of mirrors way where I'm like, "Oh actually I'm really worried about your safety." I'm not worried about the safety of the person who is – who might be coming in and out of the room. I really want to know – like I'm like, "I want you to have headphones in for your safety." (Practitioner 1, interview 1)

While practitioners acknowledged that online delivery comes with risks, both also reflected on instances where the mode of delivery provided them with information they would not normally be privy to. Incidental activity in the background revealed further details about the program participants' interactions with family and intimate partners in the home environment. In the case of the misidentified party, witnessing these behaviours in the background indicated the possibility of risk connected to surveillance and prompted the practitioner to suggest an additional safety measure.

In the context of discussing safety concerns, risk and possible collusion, practitioners were asked whether there were any issues with participant 'visibility' during the online sessions. It is typical in the delivery of BCPs for there to be small group work separate from large group work. In the virtual space this requires the use of breakout rooms. In sessions where the number of breakout rooms exceeded two, the facilitation team reported no issues with visibility and noted that creating space beyond facilitator visibility had become a part of the program structure. As one practitioner explained:

I acknowledge that we had a very small group, so at most there were only ever two. In the beginning there were three breakout rooms. But also we have a real practice of supporting participant autonomy and not wanting to align with a culture of surveillance, and so the whole purpose of breakout rooms for us was to be like, "This is a space for you." … Even in our final group yesterday … it was a very, very small group, only two participants, had really good rapport, but we were like, "Actually do want to give you at least five minutes in a breakout room to have a chat without us because if we were in-person you would be able to just chat on the way out of the room or something like that, and we acknowledge that you can have really different conversations together than you can with us in the room." So we weren't at all concerned about not being able to have eyes on people when they're in breakout rooms because for us that was the whole point of it. (Practitioner 1, interview 3)

This reflects the broader non-carceral approach which practitioners emphasised (see above, p. 22). The way that safety and risk were discussed by practitioners in this pilot was a notable contrast to some of the concerns raised in literature related to online delivery of BCPs (Vlais & Campbell 2020).

Group size

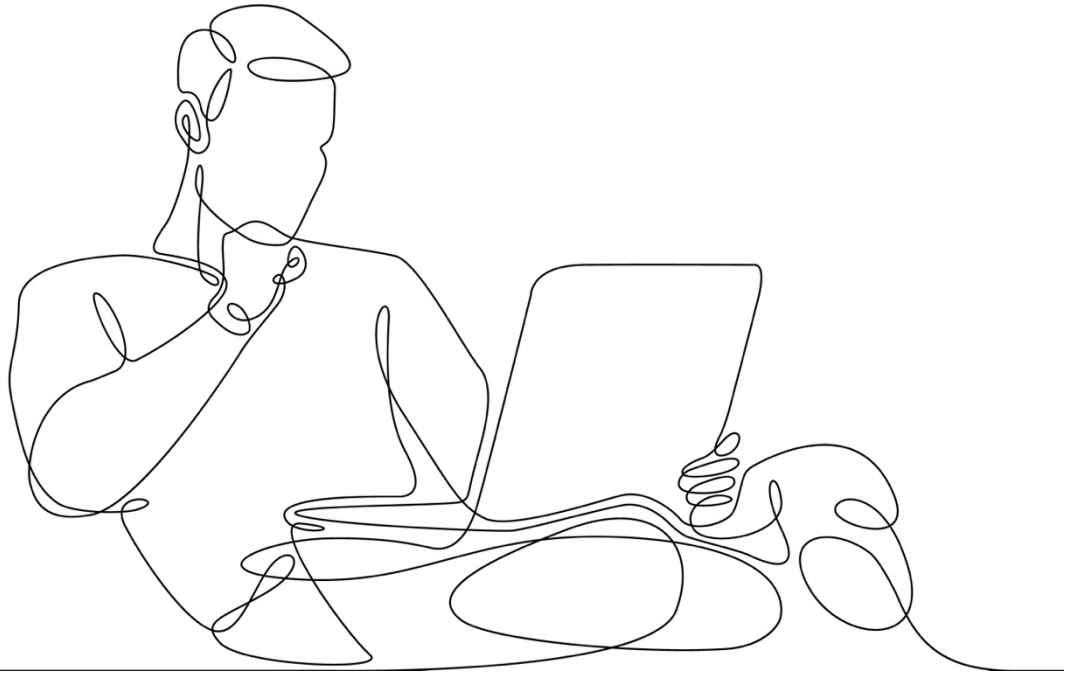
The Clear Space group was small from the outset. Practitioners commenced the program with five participants and were down to two people by the program's conclusion (noting that the program was originally conceptualised to cater for 10 participants). Facilitators reflected that the sessions with two participants were worthwhile and allowed for conversation and reflection that would not be possible in one-on-one sessions. Facilitators commented that due to the limited space on a Zoom screen, more than eight people would be difficult to manage. As one practitioner explained:

> *I just think practically in terms of … the faces on the screen. Any more than that would just be impossible. And then also because we're shortening the group time and you just don't have time otherwise. I would say ideal, honestly, is probably more like four to six and maximum eight, if I had to put a number to it. (Practitioner 2, interview 3)*

For the participants, the small number of people enrolled in the group was recognised as a limitation of group work, whereby the 'group dynamic' becomes hard to achieve with a very small group. As one participant described:

> *I quite liked the group dynamic. I connected with a few of the other people doing it … I think it was a bit tricky because only two of us ended up finishing, going to the end [...] and so it's hard to maintain a group dynamic when it's two people. (Joel, exit interview)*

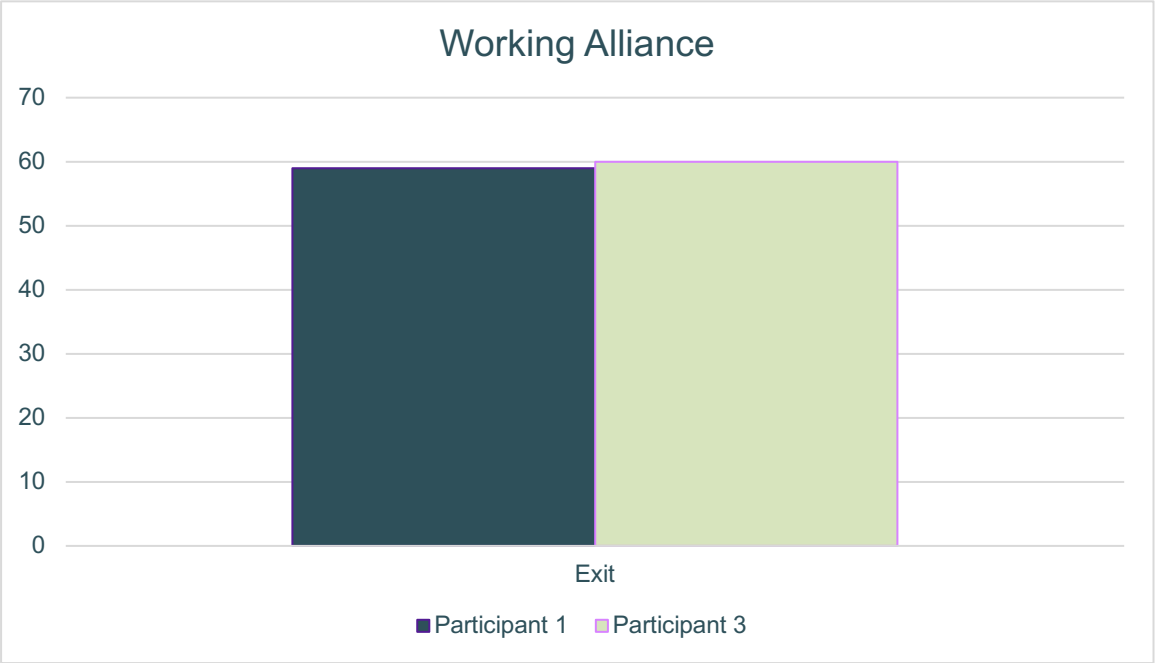
The findings from this review suggest that smaller group size in the online environment may be beneficial for ensuring the group is manageable. Presently, the minimum standards prescribe that in-person program groups should not exceed 14 participants (FSV 2018), however, this number was considered unworkable in an online setting by practitioners involved in this review.



Program facilitation

In the exit survey, participants were asked 12 questions that measured their working alliance. These questions spoke to the extent to which program participants felt they could make positive changes as a result of the program and felt supported to do so by group facilitators. Higher scores represented stronger feelings of working alliance (minimum (strongly disagree) = 12; maximum (strongly agree) = 60). Two participants completed the exit survey, with results showing that Participant 3 strongly agreed with all items, suggesting strong self-reported working alliance. Participant 1 strongly agreed with all items except for the first question, which asked them whether they are clearer as to how they might be able to change as a result of the sessions. This latter finding suggests that this participant has a strong sense of working alliance but may require additional support to visualise how to make the changes they have identified as important to improving their attitudinal and behaviour outcomes (see Figure 1 below).

Figure 1: Working Alliance Results



These positive scores were supported by the positive comments made by program participants in the exit interviews. Participants were asked whether the program met their needs, whether they felt it was the right program for them, what aspects of the program were most useful and what they thought of the online format.

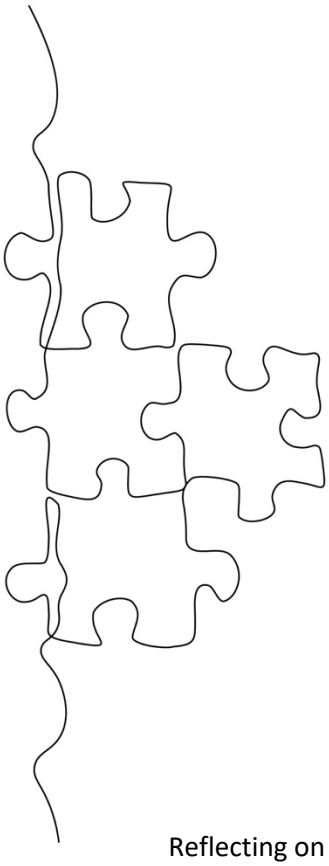
Specifically, program participants were unanimously positive about the program and the facilitation. This is captured in the reflections of three participants:

I think that the facilitators were really great, were very experienced and had great skills to facilitate and to hear people, and I always felt my contributions were always really valued and my attendance was really appreciated. (Joel, exit interview)

They were too helpful and then I guess that's it, they were very helpful, very understanding and yeah, good support … I've got so much praise for them, they did a really good job. A very good job. (Adam, exit interview)

Everyone was really, you know – I was a bit nervous at first, obviously, but, yeah, it was very inclusive and safe, and, yeah, everyone was very respectful, yeah. (Kyle, exit interview)

Reflecting on what they found the most useful component of the program, one participant singled out the emphasis placed on confronting and talking about the use of violence that had brought them to group. For several participants, the space to reflect on their individual motivations and to appreciate the range of reasons that participants may attend the program was viewed as valuable:



I think that the most useful thing for me was the importance that was placed in talking about the reason why – what brought us all there, talking about the violence … Not just the opportunity [to be open], but the encouragement [...] and the sort of – there was importance placed on it to be like "this is important, talking about it is just really important", and that was something I – that was something I hadn't been thinking about [...] and so, to be in that space – because it took time, it took a few weeks to communicate how important that was, and then create a space where people could share that. (Joel, exit interview)

I just realised our own individual problems, and that none of us were the same, and we were all there for a reason, to change our behaviours … there was the support of other people and yeah, knowing that, yeah, I was not alone. (Adam, exit interview)

It was a very robust kind of – everyone had very different situations, and answers and feedback, so there was a very mixed kind of view of things, I think. So it created good conversation, I suppose, and some good insight … I'm just thankful to be a part of it. Yeah. It was a good experience, and, yeah, I would recommend it for other people, or I would recommend that it be done again for whoever needs the help or whatever. (Kyle, exit interview)

Reflecting on the 'space' that was created and the group dynamic, one participant commented:

having a space which felt so flexible and adaptable and open to go where the energy was, or where the interest was, was really useful. It wasn't too tightly facilitated, it wasn't too – it wasn't restrictive. It didn't shut down conversations, it allowed conversations to open up and flow. I found that was really useful because it was always really interesting. And I think that doing it with other people, and hearing about their journeys and their journeys alongside mine, was really useful. If it was just a one-on-one thing, I think it would have been much harder to – it would have lost out on that great element. (Joel, exit interview)

Overall, participants felt a strong sense of working alliance and felt supported by the facilitators to make positive changes. Survey responses from one participant suggested that additional support about how to realise these changes may be needed. Reflecting on the most useful aspects of the program, participants highlighted the focus on confronting and talking about the use of violence that brought them to the program, the value of hearing about experiences different to their own, and robust dialogue. One participant commented that he would have liked more information on consent. One participant expressed his appreciation for the openness and flexibility of the online space and the way the facilitators fostered a group dynamic that allowed free-flowing conversation. The participants were unanimous in their opinions that the facilitators were skilled and created a safe and inclusive environment.

Practitioner and participant reflections on behaviour change

The NATE scale was used in this review to understand participants' attitudes towards the effeminacy of other men. Participants were asked 17 questions to understand to what extent they held negative attitudes towards effeminacy (NATE). Items were summed to create an overall NATE scale, with higher scores representing more negative attitudes (minimum (strongly disagree) = 17; maximum (strongly agree) = 119). When participants first completed the survey, their attitudes towards effeminacy were not overly negative. For participants who completed all three waves of the survey, these attitudes did not really change. For those two participants who completed the entry and midpoint survey, these attitudes decreased notably, suggesting a slight improvement in attitudes overall (see Figure 2).

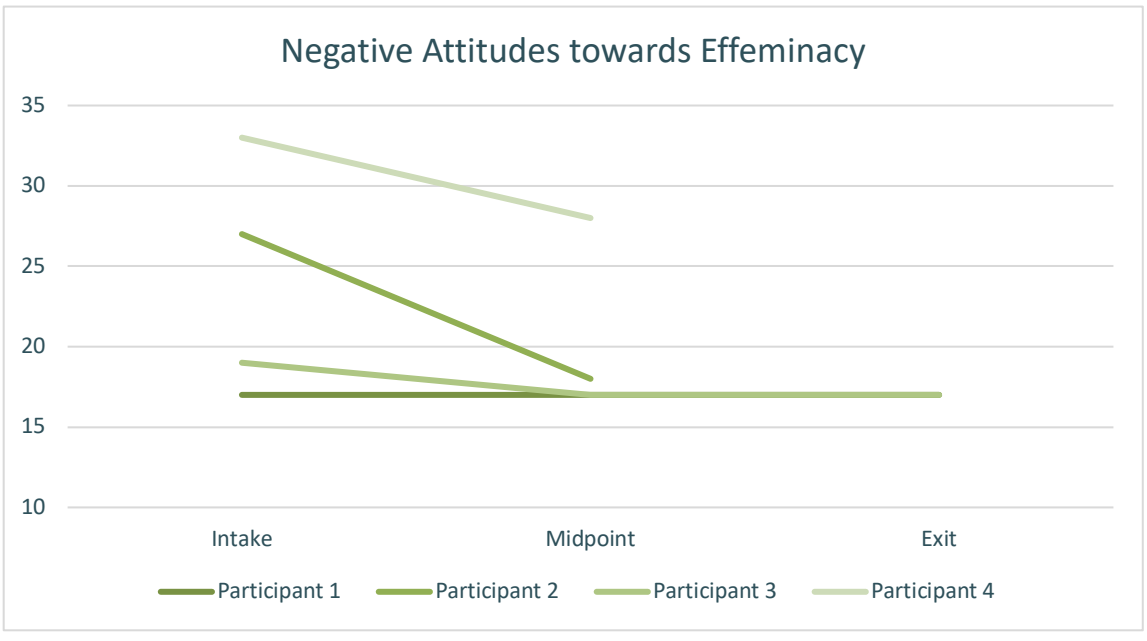


Figure 2: Negative Attitudes towards Effeminacy Results

Using the ACON measures, participants were also asked a series of questions to gauge how the expression of gender might impact attitudes towards others and relationship dynamics. Questions were asked on a scale ranging from strongly disagree (1) to strongly agree (7): higher scores indicated stronger agreement with each statement, suggesting more negative attitudes. Two participants responded to all nine questions across the three time points. Across every question, participant 3 strongly disagreed with each statement, however, participant 1 showed some variation in their perceptions throughout each wave of the survey. For example, participant 1 disagreed that "anyone that wants to be referred to as 'they' is just being precious or trying to be cool" but agreed with the statement at the midpoint survey and disagreed with it again at the exit survey. This pattern was also observable in their response to "Bisexuals are just straight people experimenting" and "In a relationship, there is one person who takes charge and has more of the power, that's just the way it is". In addition, participant 1 ascribed more value to their expectations around how their partner should dress, agreeing across all waves of the survey with the statement "I expect my partner to dress well and be regularly groomed (haircuts, make-up, skin treatments, botox, white teeth, etc.)". They were also in agreement that "I can't imagine being attracted to a transgender person", while participant 3 strongly disagreed with both statements across each wave (see Figures 3-11).

Figure 3: ACON measure 1

Figure 4: ACON measure 2

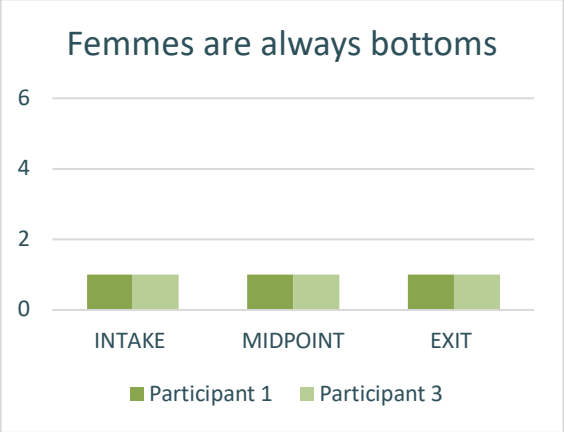


Figure 5: ACON measure 3

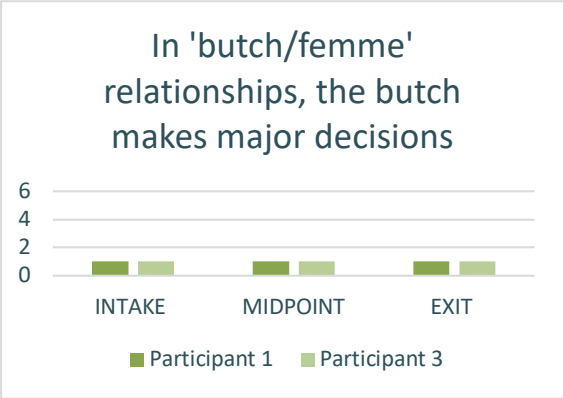


Figure 6: ACON measure 4

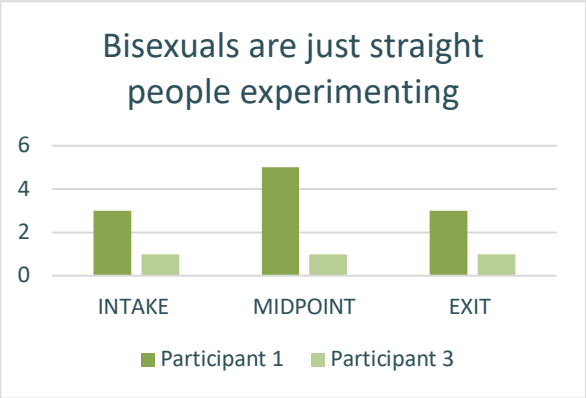


Figure 7: ACON measure 5

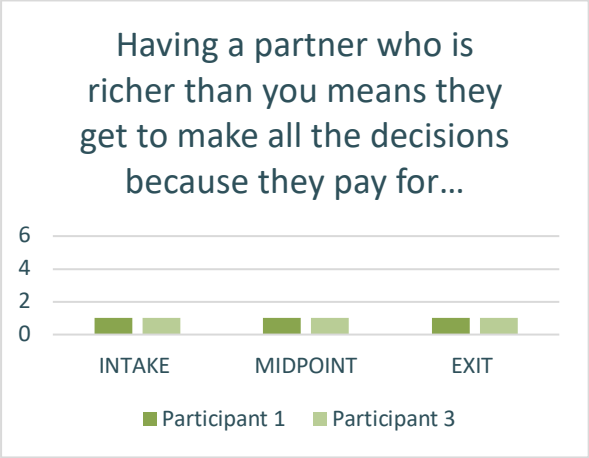


Figure 8: ACON measure 6

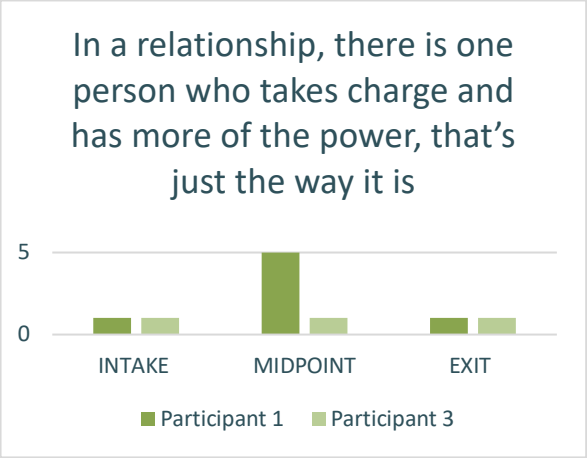


Figure 9: ACON measure 7

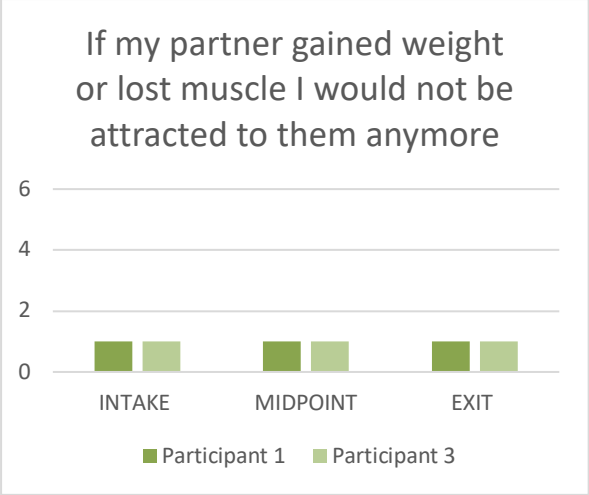


Figure 10: ACON measure 8

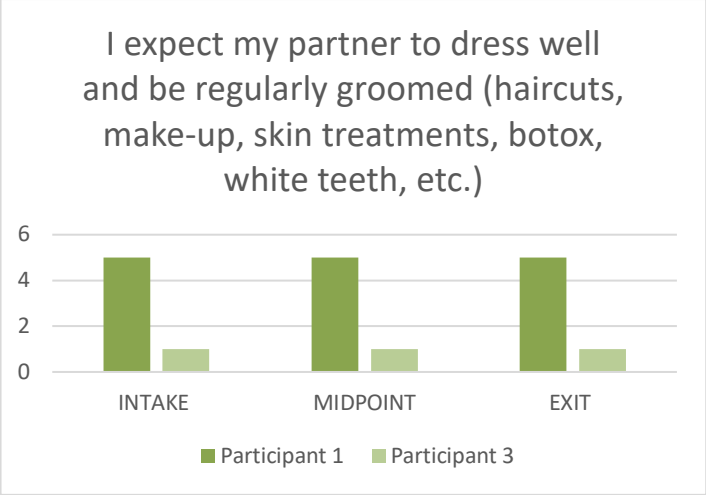
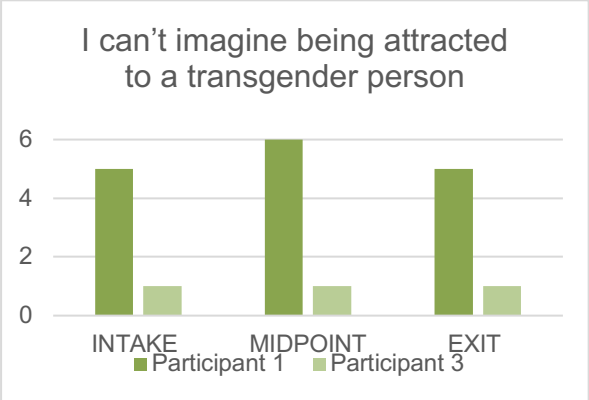
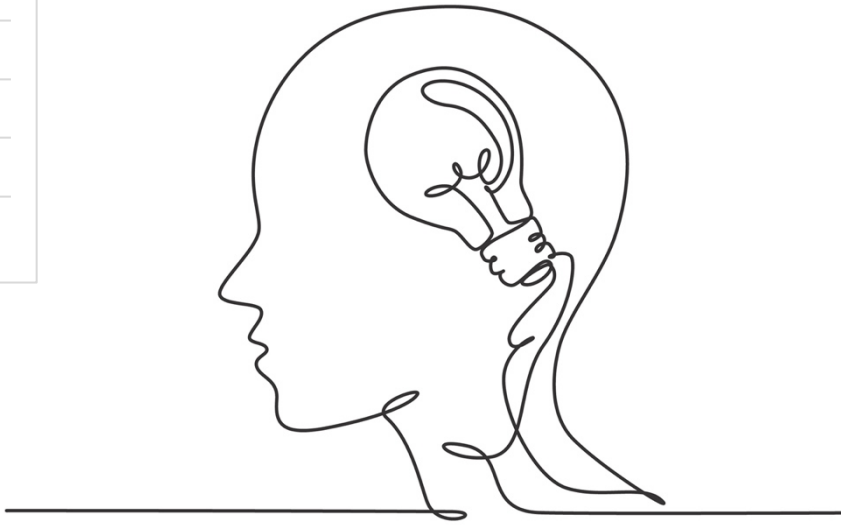
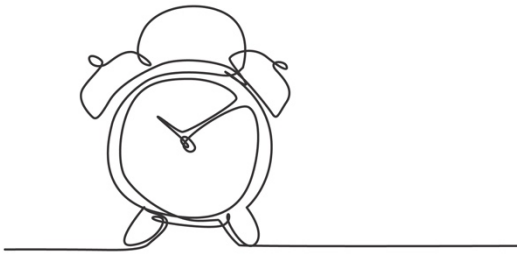


Figure 11: ACON measure 9



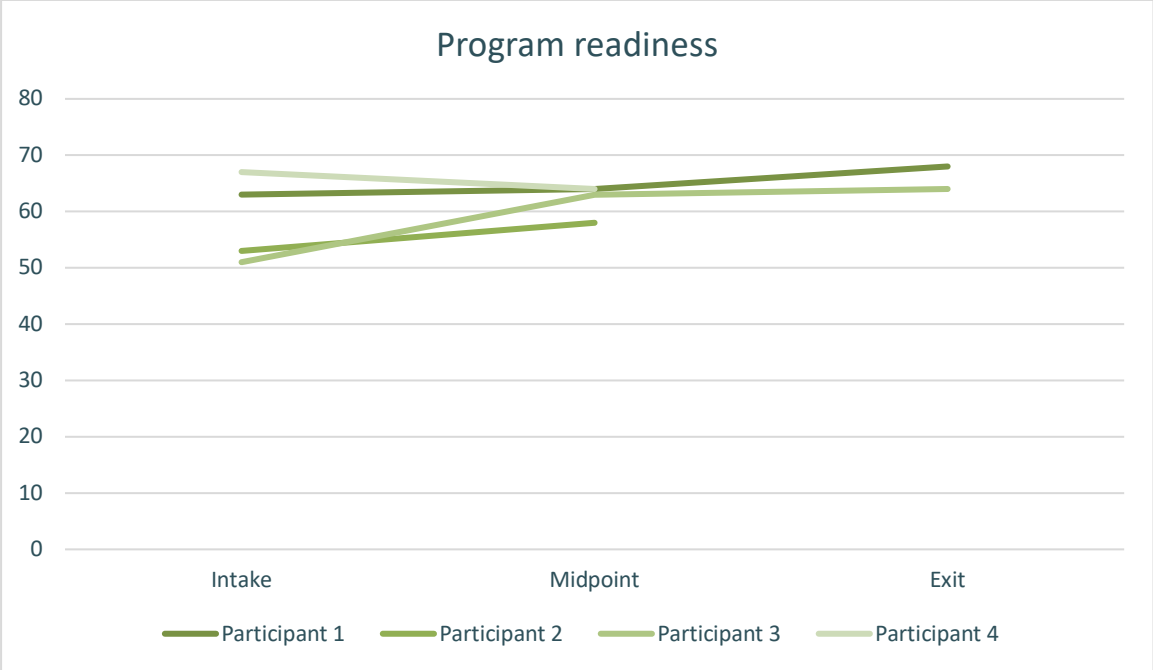




Program readiness

Program readiness gauged the extent to which participants felt they were ready to complete the program. As with the other survey instruments (with the exception of the working alliance inventory) this scale was used at the three program time points. The program readiness scale is a temporal measure. Questions asked in this section sought to understand how participants felt about attending the group program, whether 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 comprised 15 statements, and participants were asked to state how much they agreed or disagreed with each statement. Higher scores were associated with greater self-reported program readiness (minimum (strongly disagree) = 15; maximum (strongly agree) = 75).

Figure 12: Program Readiness Results

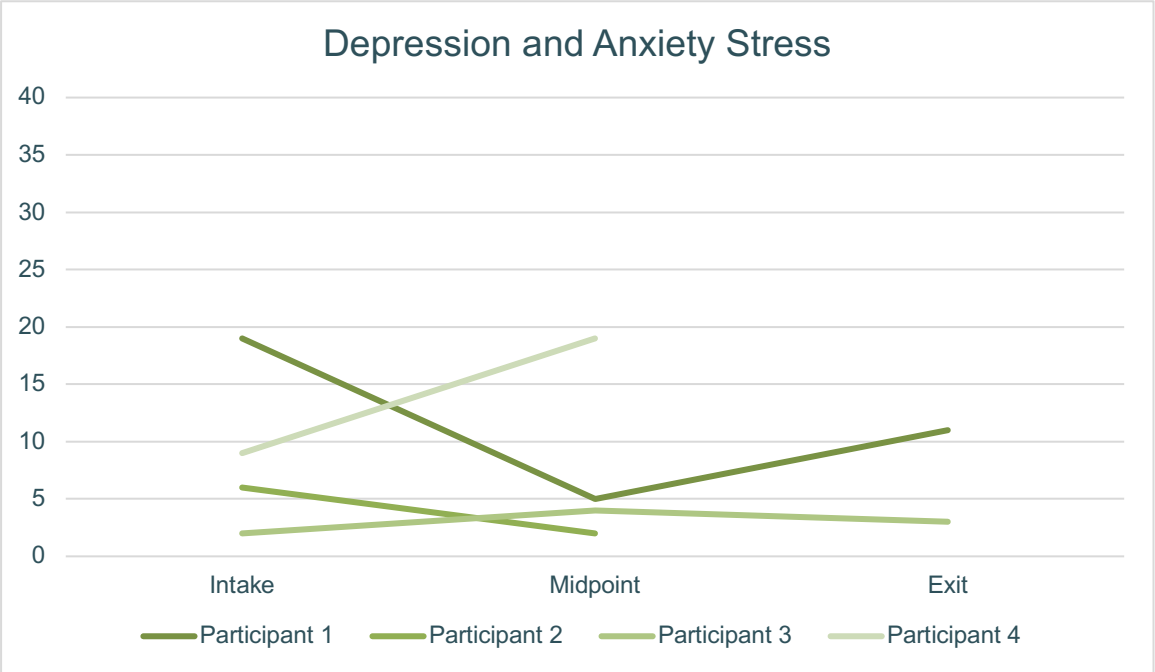


As figure 12 shows, Participant 1, Participant 2 and Participant 3 reported greater program readiness at midpoint compared to intake, while Participant 4 reported feeling slightly less prepared at midpoint compared to intake. Both participants who completed the exit survey (Participants 1 and 3) reported slightly improved program readiness from midpoint to exit.

Participants were asked a series of questions from the DASS-10 to determine their levels of depression and anxiety. Specifically, 10 questions were included in the survey to measure the extent to which participants felt emotions such as fear, worry, and intolerance. Other questions were included to understand whether participants had difficulty finding the energy and motivation to do things. Participants were asked to choose whether such feelings occurred never (0), sometimes (1), often (3) or always (4), with higher scores representing stronger feelings of depression and anxiety (minimum (never) = 0; maximum (almost always) = 40). Results in Figure 13 below show that participants' self-

reported feelings of depression and anxiety decreased from intake to the midpoint survey, increasing slightly for one participant who completed the exit survey (Participant 1), while continuing to decrease for another participant who completed the exit survey (Participant 3) (see Figure 13).

Figure 13: Depression and Anxiety Stress Results



Practitioner reflections on behaviour change

This section presents practitioner reflections on participant behaviour change and motivation for program participation. It is important to note that this section does not present findings or outcomes. We do not have outcome measures related to behaviour or attitude change, as no affected family members participated in this review, prohibiting any reliable measure of change. Measuring behaviour change in this space requires validation of participants' reports against those of affected family members.

All practitioners who worked with participants felt they had witnessed some form of change over the duration of the program. During the interviews, practitioners provided individual case examples of transformation. In this first example, the AOD/Dual diagnosis practitioner reflected on the progress she witnessed in a participant's awareness and potential for change. She described:

> *I really feel like it was hands down [other practitioner's] excellent capacity to engage with this client and get really good rapport that really opened up his tiny little bit of hope to even engage with mental health and AOD. Because he was massively, severely lacking in hope when he first started talking to me, and now there's questions around maybe changing [AOD use] ... for him, which might not have occurred otherwise. So he's moved from being quite pre-contemplative and lacking in hope to contemplative and possibly envisioning a different future. (Practitioner 4, interview 2)*

Other practitioners also noted the positive shifts they had witnessed in participant attitudes over the course of the program. Expressing cautious optimism, two practitioners described:

> *There's all the caveats of 'Who knows?' Because obviously doing a 20-week group is no guarantee of anything … I'm just like, actually, I feel like we have witnessed some pretty profound transformations in people. Of course, it's up to them in terms of where they go from here and what they do with that, but particularly around … participants' ability to own, acknowledge, name their use of violence; talk about the people that they've harmed, put themselves in their shoes, consider impacts for them and for other people in their life; to think about what repair looks like for that person. (Practitioner 2, interview 3)*

> *some of the reflections that people had in our final group. There were a few people who said, like, "When I did the intake I didn't think that this stuff really related to me, and then as time went on I really realised that it did" or, "When I did the intake I hadn't really spoken with anybody else about my use of violence, and now I speak with this person every week, and I'm going to go and speak with this person next week." And so those are some changes that people have shared with us and that we've witnessed as well. (Practitioner 1, interview 3)*

A key concern for practitioners centred on 'what comes next' for participants following program completion. As noted in the program description above, additional funding from the Victorian Government has been allocated for post-program support following the pilot's conclusion. However, loss of regular contact with participants was identified as a key concern. As one practitioner noted:

> *There's this specific bit of funding from Family Safety Victoria … around post-group support … So that will continue and I think can continue into the new year [2023] or until people are able to be referred to other group programs if social connection's really important to them. So there's scope within funding structures for that to continue, but I am a bit worried about what's going to happen when this isn't a weekly thing in the calendar with people that you know and trust. I'm not going to pretend that it's not worrying to me. (Practitioner 1, interview 2)*

There is limited research to date on the effectiveness and resourcing of long-term behaviour change programs, where engagement occurs for numerous years. Further research is required to examine both the long-term outcomes of BCPs and the impact of longer-term interventions (such as the post-program individual supports described here) to support ongoing behaviour change work beyond the BCP.

Participant reflections on behaviour change

Participants were asked what their main motivation to participate in the program was. As captured in the following comments, participants emphasised personal responsibility and a need to understand the impact of their actions on others:

I guess to get a better understanding of my behaviour and the actions that I had caused, and trying to understand that, yeah, I was out of control and, yeah, I needed help. (Adam, exit interview)

Yeah, so being asked to do it was a part of it, in regards to my responsibility to be accountable and to learn from my actions. That was a big part of it. I think as well as it got on, I realised that it was not just responsibility because I was asked, but also to myself and to those around me because actions don't sit in isolation. So I wanted to learn more about it, and learn more about that, and reflect more deeply about the ways that I could have hurt others, or the ways I could potentially hurt people in the future if I'm not thinking about it and I'm not being proactive in addressing it. (Joel, exit interview)

All program participants who completed an exit interview (n=3) acknowledged their prior use of FV and/or sexually violent behaviours. As two participants reflected:

Now I've got a better understanding of what I did and why I did it … I've said to my ex-partner that I'm changing my ways to get better understanding of myself and to acknowledge my problems and to be more accountable for the things I do. (Adam, exit interview)

I guess I never really considered myself to be a violent person, I suppose. But I realised that a lot of [...] that words can be violence as well. (Kyle, exit interview)

During the exit interviews, each of the participants was asked if they had noticed changes in relation to their behaviour or relationship. Each of the participants described changes they believed had occurred in their understandings of their own behaviour:

I've tried to implement a lot more understanding, a lot more patience, a lot more – yeah, trying to put myself in their shoes and see how they feel and things like that. So empathy, I suppose you'd say. Yeah. (Kyle, exit interview)

I think that I have really gone on a big journey in regards to self-awareness and honesty and integrity. I think more deeply about those things, and I believe that I had made changes in the ways that I communicate or make decisions or consider things. (Joel, exit interview)

While it is not possible to validate this, for the range of reasons previously elaborated, it is worth noting that none of the participants denied that they used abusive behaviours within their relationship. Nonetheless, participant self-reports are often unreliable (REF), and measuring change without the viewpoint of the affected family member is problematic. Affected family member accounts are critical for validating and/or challenging program participant self-reports. Program participant self-report data did illustrate some limitations in reflections of behaviour change and individual responsibility for use of violence. This has been explored elsewhere. A previous evaluation of a pilot BCP in Victoria suggested that 'the persistence of attitudes that deflect personal responsibility … [can] ... highlight the need for more work to be done in generating men's insights into personal responsibility to support meaningful and lasting behaviour change' (Meyer et al. 2021, p. 12). Further research with diverse communities into the influence and impact of insights into personal

responsibility in the behaviour change space is critical to understanding subtle shifts in behaviours and attitudes.

Community of practice

Over the course of the pilot, monthly community of practice sessions were held with key stakeholders from NTV, THH, ACON, and MFC. The Monash review team attended these sessions as observers. The sessions provided an opportunity for practitioners to share experiences and discuss practice strategies and concerns.

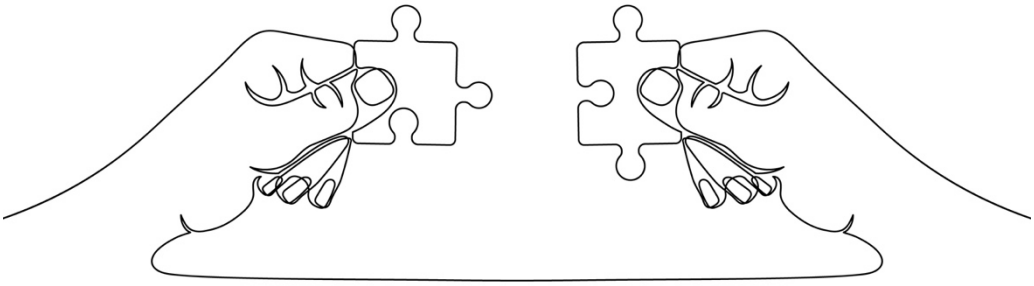
The Clear Space practitioners interviewed were largely very positive about the community of practice meetings. Reservations, where they came up, related to the number of non-practitioners present at these meetings. While practitioners appreciated how useful they would be to those working within policy, they commented that the onus was largely on practitioners to contribute to the sessions. Overwhelmingly, the benefit of the community of practice was the connection with the Men and Family Centre (MFC) and the opportunity to discuss practice and share learnings in a collaborative setting. One practitioner suggested that going forward the community of practice could be more informal, noting that "some of the most generative conversations happened really informally" (Practitioner 1, completion interview). Another practitioner commented:

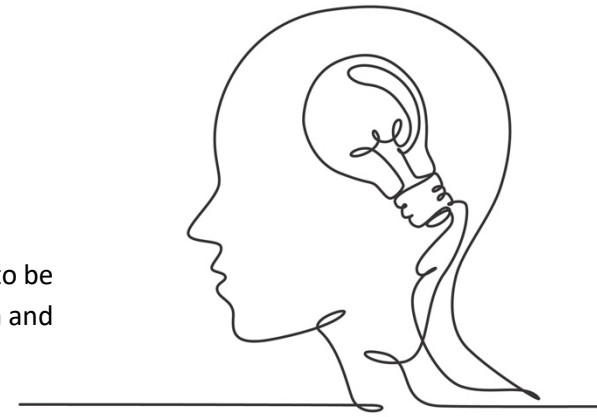
> *It worked when it was focused on practice. Because it often felt like policy people trying to learn about practice and interviewing us about practice, which I get it's important, but it's not as fulfilling for us. But when it was useful for us is when it can actually build connection between practitioners and use this space to share and deepen. (Practitioner 2, interview 3)*

A FSC worker reflected that they found great value in the community of practice at the point when they were encountering distress from AFMs they were working with. This practitioner explained:

> *Especially at the beginning, where – and I actually found the community of practice at the beginning, where it was – like I had that client who was really frightened by the messages, being able to speak about that, and find that it was not an uncommon response, was really good. (Practitioner 3, interview 4)*

These reflections highlight the value of collaborative models of professional practice, including communities of practice, which facilitate opportunities for sharing learnings and practice-based discussions among practitioners working in the field. This may be particularly beneficial for workers during the first year of their employment, for practitioners developing a new program or intervention model, and for practitioners during the first year of delivering a new program.





CONSIDERATIONS

The findings from this review support the need for further consideration to be given to six key areas in the future delivery of online BCPs for GBTQ+ men and non-binary people.

1. Extending the Clear Space pilot program with further resourcing for evaluation

The current review was limited by the small number of program participants and the lack of affected family members. The absence of data from affected family members means there are no findings from this review related to outcomes for behaviour change. Further, the review findings are not generalisable beyond the sample participants. Though the review made some positive findings for the potential of online BCPs for GBTQ+ men and non-binary people, further evidence is required. Consideration should be given to resourcing a larger and longer-term evaluation as part of any program extension.

2. Exploring further the role of additional supports related to co-occurring needs, such as AOD and mental health needs, for BCP participants

Findings presented in this review illustrate the value of additional supports – for example, through AOD and mental health counselling – to support and motivate participants to attend the group program. Further practice-informed research is needed to identify best practice in identifying and addressing the co-occurring needs of BCP participants.

3. Developing a workforce strategy to ensure representation and diversity within the BCP workforce. Practitioners with diverse skills and lived experience should be supported to upskill to work in behaviour change interventions with GBTQ+ men and non-binary people

The difficulties of recruiting and retaining a skilled workforce, which emerged during this review, present unique challenges for diverse programs. While industry planning and workforce development strategies have been developed and implemented by the Victorian Government, the findings from this review demonstrate the need to ensure that practitioners with diverse skills and lived experience are supported to upskill to work in this field.

4. Developing family safety contact practice guidelines

This review found that there may be a lack of awareness in the broader community about FSC as a support service provided alongside BCPs. Additional guidance to assist FSC workers in the first contact stages of this work may be beneficial and may contribute to achieving higher engagement with affected family members.

5. Standardising the size of online BCPs to six participants or fewer

Drawing from reflections provided by practitioners and program participants, this review documented the need to consider standardising the use of lower program participant numbers for online programs. This recommendation reflects limited space on screens and the time required to ensure participant contribution to group discussions. A maximum of six participants alongside two practitioners may be ideal for the online environment.

REFERENCES

Austin, S. B., Freed, L. H., Freedner, N., & Yang, Y. W. (2002). Dating violence among gay, lesbian, and bisexual adolescents: Results from a community survey. *Journal of Adolescent Health*, 31, 469–474. doi:10.1016/S1054-139X(02)00407-X.

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *The Psychology of Women Qarterly*, 29, 258–269. doi: 10.1111/j.1471-6402.2005.00220.x

Barrett, B., & Pierre, M. (2013). Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: An exploration of within-group variations. *Journal of Gay & Lesbian Social Services*, 25(1), 1–23, doi: 10.1080/10538720.2013.751887

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.

Bourne, A., Amos, N., Donovan, C., Carman, M., Parsons, M., Lusby, S., Lyons, A., & Hill, A. O. (2022). Naming and recognition of intimate partner violence and family of origin violence among LGBTQ communities in Australia. *Journal of Interpersonal Violence*, 0(0). doi: 10.1177/08862605221119722.

Bornstein, D. R., Fawcett, J., Senturia, K. D., Shiu-Thornton, S., & Sullivan, M. (2006). Understanding the experiences of lesbian, bisexual and trans survivors of domestic violence: A qualitative study. *Journal of Homosexuality*, 51, 159–181. doi: 10.1300/J082v51n01_08.

Brown, C. (2008). Gender-role implications on same-sex intimate partner abuse. *Journal of Family Violence*, 23, 457–462. doi: 10.1007/s10896-008-9172-9.

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2015). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma, Violence, & Abuse*, 17(5), 585–600. doi:10.1177/1524838015585318.

Campo, M., and Tayton, S. (2020). Intimate partner violence in lesbian, gay, bisexual, trans, intersex and queer communities: Key issues. Practitioner Resource. Australian Institute of Family Studies.

Cannon, C., & Buttell, F. (2015). Illusion of inclusion: The failure of the gender paradigm to account for intimate partner violence in LGBT relationships. *Partner Abuse*, 6(1), 65–77. doi: 10.1891/1946-6560.6.1.65.

Carman, M., Fairchild, J., Parsons, M., Farrugia, C., Power, J., & Bourne, A. (2020). Pride in prevention: A guide to primary prevention of family violence experienced by LGBTIQ communities. Rainbow Health Victoria.

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.

Duke, A., & Davidson, M. M. (2009). Same-sex intimate partner violence: Lesbian, gay, and bisexual affirmative outreach and advocacy. *Journal of Aggression, Maltreatment & Trauma*, 18(8), 795–816. doi:10.1080/10926770903291787.

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

Family Violence Reform Implementation Monitor. (2021). Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor. December. Available from:

https://www.fvrim.vic.gov.au/monitoring-victorias-family-violence-reforms-accurate-identification-predominant-aggressor

Fileborn, B. (2012). Sexual violence and gay, lesbian, bisexual, trans, intersex, and queer communities. Australian Government: Australian Institute of Family Studies. https://aifs.gov.au/resources/practice-guides/sexual-violence-and-gay-lesbian-bisexual-trans-intersex-and-queer.

Fitz-Gibbon, K., Maher, J., Thomas, K., McGowan, J., McCulloch, J., Burley, J. & Pfitzner, J. (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

Furman, E., Barata, P., Wilson, C., & Fante-Coleman, T. (2017). "It's a gap in awareness": Exploring service provision for LGBTQ2S survivors of intimate partner violence in Ontario, Canada. *Journal of Gay & Lesbian Social Services*, 29(4), 362–377. doi:10.1080/10538720.2017.1365672.

Galletly, C., Herrmann, M. M., Hollander, G., & Turell, S. C. (2012). Lesbian, gay, bisexual and transgender communities' readiness for intimate partner violence prevention. *Journal of Gay and Lesbian Social Services*, 24, 289–310. doi: 10.1080/10538720.2012.697797.

Girshick, L. B. (2002). No sugar, no spice: Reflections on research on woman-to-woman sexual violence. *Violence Against Women*, 8, 1500–1520. doi: 10.1177/107780102237967.

Gray, R., Walker, T., Hamer, J., Broady, T., Kean, J., & Ling, J. Bear, B. (2020). *Developing LGBTQ programs for perpetrators and victims/survivors of domestic and family violence* (Research report, 10/2020). ANROWS.

Halford, W. K., & Frost, A. D. J. (2021). Depression Anxiety Stress Scale-10: A brief measure for routine psychotherapy outcome and progress assessment behaviour change. *Journal of the Australian Behaviour Modification Association*, 1–14. doi:10.1017/bec.2021.12

Helps, N., Burley, J., McGowan, J. & Fitz-Gibbon, K. (2023) Why the work to hold family violence perpetrators accountable is only just beginning. Monash Lens, 8 February. Available from: https://lens.monash.edu/@politics-society/2023/02/08/1385453/why-the-work-to-hold-family-violence-perpetrators-accountable-is-only-just-beginning

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. doi:10.26180/21902865

Helps, N., Burley, J., McGowan, G., & Fitz-Gibbon, K. (2023b). Why the work to hold perpetrators of family violence accountable is only just beginning. Monash Lens. 8 February. https://lens.monash.edu/2023/02/08/1385453/why-the-work-to-hold-family-violence-perpetrators-accountable-is-only-just-beginning

Helps, N., McGowan, J., Fitz-Gibbon, K., Williamson, H., & Athwal-Yap, A. (2023c). *'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, Monash University. doi: 10.26180/22126052

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.

Little, B., & Terrance, C. (2010). Perceptions of domestic violence in lesbian relationships: Stereotypes and gender role expectations. *Journal of Homosexuality*, 57, 429–459. doi: 10.1080/00918360903543170.

Lovibond S.H. & Lovibond P.F. (1995). *Manual for the Depression, Anxiety, Stress Scale*. Psychology Foundation, University of New South Wales.

McCulloch, J., Maher, J.M.M., Fitz-Gibbon, K., Segrave, M., and Roffee, J. (2016) *Review of the Common Risk Assessment and Management Framework (CRAF): Final report*. Department of Health and Human Services, Victoria.

Messinger, A. M. (2011). Invisible victims: Same-sex IPV in the national violence against women survey. *Journal of Interpersonal Violence*, 26, 2228–2243. doi: 10.1177/0886260510383023

Nancarrow, H., Thomas, K., Ringland, V., & Modini, T. (2020). *Accurately identifying the "person most in need of protection" in domestic and family violence law* (Research report, 23/2020). ANROWS.

No to Violence. (2020) Long waitlists for Men's behaviour change programs, survey shows. Immediate Release, 6 July. Available via: https://ntv.org.au/wp-content/uploads/2020/07/Final-No-to-Violence-commence-monitoring-waitlist-times-for-MBCP-060720.pdf

No to Violence (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

O'Connor, A., Morris, H., Panayiotidis, A., Cooke, V., & Skouteris, H. (2021). Rapid review of men's behavior change programs. *Trauma, Violence, & Abuse*, 22(5), 1068–1085. doi:10.1177/1524838020906527

O'Halloran, K. (2015). Family violence in an LGBTIQ context. https://sayitoutloud.org.au/wp-content/uploads/2015/01/Family-violence-in-an-LGBTIQ-context-Kate-OHalloran.pdf.

Ovenden, G., Salter, M., Ullman, J., Denson, N., Robinson, K., Noonan, K., Bansel, P., … Huppatz, K. (2019). *Sorting it out: Gay, bisexual, transgender, intersex and queer men's attitudes and experiences of intimate partner violence and sexual assault*. Sexualities and Genders Research, Western Sydney University and ACON.

Pfitzner, N., Fitz-Gibbon, K., McGowan, J., and 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. doi: 10.26180/13108352

Potoczniak, M. J., Mourot, J. E., Crosbie-Burnett, M., & Potoczniak, D. J. (2003). Legal and psychological perspectives on same-sex domestic violence: A multisystemic approach. *Journal of Family Psychology*, 17(2), 252–259. doi:10.1037/0893-3200.17.2.252.

Praxis International. (2010). Foundations of effective intervention in The Duluth Blueprint for Safety. https://www.theduluthmodel.org/wp-content/uploads/2017/03/2-Duluth-Foundations-Chapter-1.pdf

Reeves, E. (2021). 'I'm not at all protected and I think other women should know that, that they're not protected either': Victim-survivors' experiences of 'misidentification' in Victoria's family violence system. International Journal for Crime, Justice and Social Democracy, 10(2), 39-51. doi: 10.1080/10345329.2021.2021721.

Reeves, E., & Scott, B. (2022). *'Can't you girls work this out?': LGBTQ+ victim-survivors' experiences of Victoria's family violence intervention order system.* Monash Gender and Family Violence Prevention Centre, Monash University. DOI: 10.26180/21530898

Ristock, J. L., & Timbang, N. (2005). Relationship violence in lesbian/gay/bisexual/transgender/queer (LGBTQ) communities. Available at: https://pdfs.semanticscholar.org/23b6/1c0642d6b09fe881fc4c3e465e59905dccc6.pdf.

Rollè, L., Giardina, G., Caldarera, A.M., Gerino, E., Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology*. 21(9), 1506. Doi: 10.3389/fpsyg.2018.01506. Erratum in: *Frontiers in Psychology*, 19(10), 1706. PMID: 30186202; PMCID: PMC6113571.

Royal Commission into Family Violence. (2016) *Report and recommendations*. State of Victoria. Accessed via: http://rcfv.archive.royalcommission.vic.gov.au/Report-Recommendations.html

Santoniccolo, F., Trombetta, T., & Rollè, L. (2021). The help-seeking process in same-sex intimate partner violence: A systematic review. *Sexuality Research & Social Policy: A Journal of the NSRC*. doi:10.1007/s13178-021-00629-z

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. doi:10.1177/1049731520969978.

State Government of Victoria, Department of Premier and Cabinet. (2023). Monitoring Victoria's family violence reforms – Service response for perpetrators and people using violence within the family. Family Violence Reform Implementation Monitor. Retrieved from https://www.fvrim.vic.gov.au/monitoring-victorias-family-violence-reforms-service-response-perpetrators-and-people-using

Thorne Harbour Health. (2023). Alcohol and other drug (AOD) services. https://thorneharbour.org/services/alcohol-and-other-drug-services-aod/

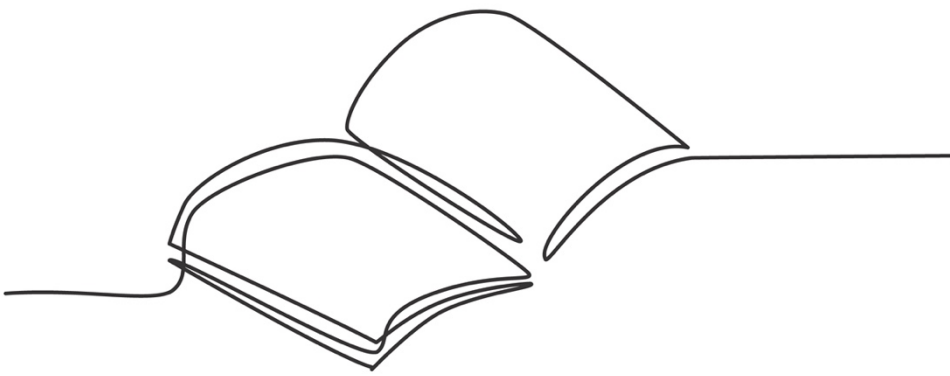
Thorne Harbour Health. (2022). Clear Space Program logic and family safety contact procedures. Not publicly available.

Townsend M. H. & Bailey R. K. (2021). Same-sex partner violence: A look at domestic violence in the LGBTQ community. In Bailey R. K. (Ed.), *Intimate partner violence* (pp. 47–56). Springer. doi:10.1007/978-3-030-55864-2_8/.

Taywaditep, K.J. (2001). *Marginalization Among the marginalized: Gay men's negative attitudes towards effeminacy*. Doctoral Dissertation, University of Illinois at Chicago. https://www.worldcat.org/title/marginalization-among-the-marginalized-gay-mens-negative-attitudes-toward-effeminacy/oclc/793530767

Taywaditep, K.J. (2002). Marginalization among the marginalized. *Journal of Homosexuality*, 42(1), 1–28, doi: 10.1300/J082v42n01_01

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



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