ANROWS

Practice Guide

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

Quality practice elements for men's behaviour change programs (MBCPs) in the Northern Territory

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Acknowledgement of Country

ANROWS acknowledges the Traditional Owners of the land across Australia on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present, and we value Aboriginal and Torres Strait Islander histories, cultures and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

Acknowledgement of lived experiences of violence

ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this resource. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS work.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include 1800RESPECT (1800 737 732), Lifeline (13 11 14), Men's Referral Service (1300 766 491), MensLine Australia (1300 78 99 78) and, for Aboriginal and Torres Strait Islander people, 13YARN (13 92 76).

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About this document

This document seeks to comprehensively outline elements of quality practice ("quality practice elements" or "QPEs") for men's behaviour change programs in the Northern Territory (NT). They were developed in response to the question: *"What might quality MBCP practice look like in the context of the Northern Territory?"*

Initially developed as part of a process evaluation of two government-funded men's behaviour change programs (MBCPs) in the NT, the elements were intended to form the basis against which an evaluative assessment of the two MBCPs' practice could be made.

Many or most of the practice elements are potentially applicable to MBCPs in other jurisdictions across Australia. As such, the elements are being made available to a broader audience outside the NT.

Background to the MBCP quality practice elements

In 2023, Australia's National Research Organisation for Women's Safety (ANROWS) was commissioned by the NT Department of Territory Families, Housing and Communities (TFHC) to undertake a process evaluation of the two MBCPs funded by the department in the NT. As part of this process, the evaluation sought to establish an understanding of what quality practice for MBCPs in the NT might look like. This process led to the development of these quality practice elements for MBCPs. The evaluation findings of both NT MBCPs are reported separately.

The MBCP quality practice elements have been developed alongside a number of reforms ongoing in the NT, including the development of the NT Minimum Standards and Application Process for Declared DFV Rehabilitation Programs (the NT Minimum Standards) to which these elements contributed.[1]

Context

Bringing together the evidence base and existing and emerging practice knowledge around quality practice for men's behaviour change programs is vitally important, so that we can better understand their role and effectiveness in improving safety outcomes for women, children and families. In Australia, there is renewed policy attention and focus on the role of programs that work with people who use domestic and family violence (DFV), with the release of the *National Plan to End Violence against Women and Children 2022–2032*, and in the Northern Territory, *Domestic, Family and Sexual Violence Action Plan 2: Taking Stock, Evaluating and Reviewing, and Building on What Works: 2022–2025*.[2]

In Australia and internationally, governments, researchers and practitioners have undertaken substantial work to document evolving understandings of what constitutes quality practice for MBCPs. Since early guidelines were developed in the mid 1980s, there has been a significant increase in the quality and evidence base for standards of practice in Australia – both at the national level and in certain jurisdictions.[3] Often conceptualised as practice principles or minimum practice standards, these types of documents seek to articulate consistent expectations of MBCP providers and sometimes present minimum requirements for programs to receive funding or accreditation.

Likely influenced by the NT's standing as a small jurisdiction in Australia and the small number of MBCPs funded in the Northern Territory, there has been limited but emerging evidence generated about MBCPs in the NT, largely centred on the Central Australian context. In the absence of jurisdiction-wide standards, in 2020, the Alice Springs-based Aboriginal Community-Controlled Organisation (ACCO), Tangentyere Council, developed the Central Australian Minimum Standards for Men's Behaviour Change Programs, a set of minimum practice standards for MBCPs in Central Australia.[4] At the time of the NT MBCPs evaluation, significant work was underway to develop a set of minimum standards for programs working with people who use DFV through the NT Minimum Standards. However, these standards focus on fairly minimal requirements for the running of safe programs and do not aim to capture a comprehensive picture of what quality practice looks like for MBCPs.

[1] Department of Territory Families, Housing and Communities. *NT Minimum Standards and Application Process for Declared DFV Rehabilitation Programs.* Northern Territory Government. 2024. https://tfhc.nt.gov.au/domestic-family-and-sexual-violence-reduction/mens-behaviour-change-programs

[2] Department of Social Services. *National Plan to End Violence against Women and Children 2022–2032*. Commonwealth of Australia. 2022. https://www.dss.gov.au/ending-violence; Northern Territory Government. *Domestic, Family and Sexual Violence Action Plan 2: Taking stock, evaluating and reviewing, and building on what works: 2022–2025*. Northern Territory Government and Territory Community Safety. 2022. https://tfhc.nt.gov.au/domestic-family-and-sexual-violence-reduction/domestic-and-family-violence-reduction-strategy

[3] Day A, Vlais R, Chung D, et al. *Evaluation readiness, program quality and outcomes in men's behaviour change programs*. Sydney: ANROWS. Research report number: 01/2019. https://www.anrows.org.au/publication/evaluation-readiness-program-quality-and-outcomes-in-mens-behaviour-change-programs/; Nicholas A, Ovenden G and Vlais R. *Developing a practical evaluation guide for behaviour change programs involving perpetrators of domestic and family violence*. Sydney: ANROWS. Research report number: 17/2020. https://www.anrows.org.au/publication/developing-a-practical-evaluation-guide-for-behaviour-change-programs-involving-perpetrators-of-domestic-and-family-violence/

[4] Brown C and Corbo M. *Central Australian Minimum Standards for Men's Behaviour Change Programs.* Tangentyere Council. 2020. https://genderinstitute.anu.edu.au/sites/default/files/docs/2020_docs/Central_Australian_Minimum_Standards_methodology_2020.pdf

About the quality practice elements

Purpose and intended use

The quality practice elements focus on how to lift the overall quality of an MBCP, with particular focus on programs based in the NT. They draw upon both contemporary minimum standards for the development, running and continuous improvement of safe MBCPs, as well as recent research and emerging practice-based knowledge about how to improve the effectiveness of these programs.

Alongside the quality practice elements, ANROWS has developed a quality practice assessment rubric (published separately). The rubric has been designed as a practical self-assessment tool to support the NT MBCP providers to assess their own programs against the quality practice elements and to support their continuous learning and improvement.

It is important to note the distinction between quality practice elements and minimum or professional standards. The quality practice elements do not intend to replace minimum or professional standards for MBCPs, nor act as a program manual. They do not outline specific operational requirements for programs to be safe and appropriate. For example, there are no references to operational considerations such as minimum frequency of particular service activities, processes such as obtaining criminal records checks for staff, or procedures for safely removing perpetrators from the program. These procedures and practices are very important but are too specific for the purpose of this document. These quality practice elements could, however, be used to inform the development of more operational practice guidelines.

Applying the QPEs outside of the NT

Despite being developed for the NT context, it is hoped the quality practice elements will prove useful for stakeholders outside of the NT in considering what quality practice might look like in other contexts and jurisdictions. They could also potentially help to inform future iterations of minimum standards across Australia.

For each quality practice element, factors that may affect quality practice due to the specific NT context or other place-based considerations are also highlighted. While many practice elements would apply equally across different contexts and jurisdictions, for some elements, the considerations or contextual factors that might affect quality practice are likely to differ from place to place. Some elements would also need to be adapted to fit the specific legislative requirements of the jurisdiction the MBCP is operating within.

How the QPEs were developed

The quality practice elements for MBCPs in the NT were developed through:

- an analysis of minimum standards and professional practice standards for MBCPs in relevant jurisdictions in Australia, and in comparable international contexts
- a rapid review of literature on quality practice in MBCPs, including for MBCPs located in First Nations contexts
- consultations with a selection of practitioners across Australia delivering MBCPs with First Nations communities
- consultations with the two NT government-funded MBCPs operating in the NT.

A full list of documentation reviewed is provided at Appendix A.

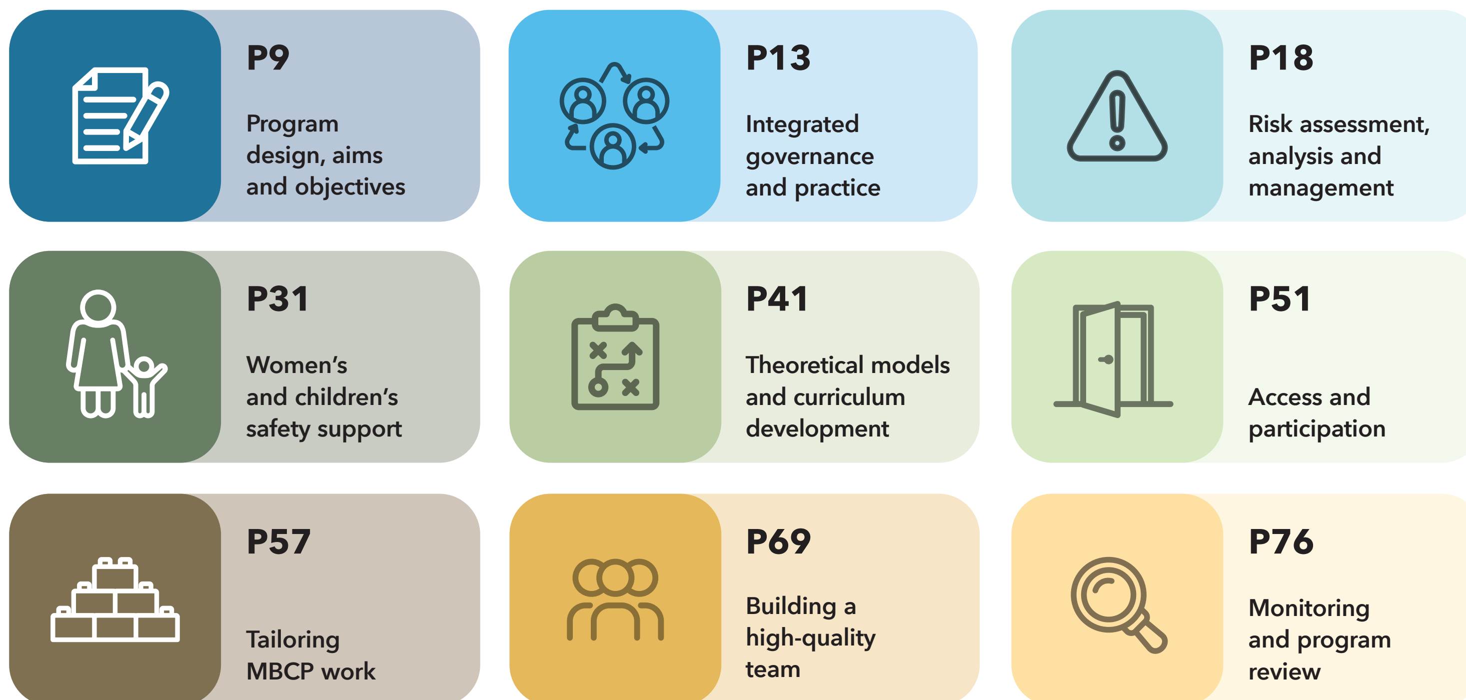
About the quality practice elements

How to read the QPEs

The quality practice elements are set out in the following pages according to:

- quality practice themes (9 themes)
- the quality practice elements relevant to each theme (60 elements)
- indicators describing what "good" looks like
- contextual factors or other factors that may be relevant or may affect quality practice for each element

The nine quality practice themes are:



About the quality practice elements

Critical and aspirational elements

Some of the quality practice elements are highlighted in orange and have been identified as **critical**, while a small number have been identified as ***[aspirational]***. Identifying some elements as aspirational recognises that there are some areas of quality practice that may not be feasible or expected for providers in the NT, but that could nevertheless be aspired to if conditions are conducive. The aspirational elements were identified through consultation with and advice from the NT MBCP providers. Given the particular context for these MBCPs, the elements that have been identified as aspirational for the NT may not be considered aspirational in other contexts.

First Nations elements

Some elements relate specifically to programs being delivered in Aboriginal and Torres Strait Islander community contexts. These are identified in the quality practice elements table by the label, “First Nations element”. The First Nations elements seek to capture some of the emerging evidence and understanding of practice in Australia relating to quality practice when working with First Nations communities in men’s behaviour change. Given the diversity of cultures, communities and contexts for First Nations people across Australia, it is critical that the First Nations elements are carefully considered, adapted and tested for each specific First Nations context to ensure that they are relevant and appropriate.

Key conditions for quality practice

Some important caveats apply to the full implementation of the quality practice elements. In the development of this document, program providers identified funding constraints as the most significant factor limiting their ability to implement quality practice. Programs should not be expected to demonstrate quality practice across all areas without adequate resources that allow the program to allocate funds to areas of quality practice outlined here.

Further, implementing the quality practice elements should not be the sole responsibility of MBCP providers. Governments, funders, partners and the service system all have critical roles to play to enable the successful implementation of these elements. The Epilogue: Enabling Quality MBCP Practice discusses the implications of the quality practice elements for stakeholders beyond MBCP providers.

Key notes on terminology

The quality practice elements refer to expectations for “the MBCP”. They also in some sections refer specifically to expectations of the provision of “women’s and children’s safety support” by workers who might either be situated within the MBCP team or provider, or be employed by a separate agency. In other sections, they refer to expectations of “men’s workers”. Broadly, a reference to the MBCP includes the program as a whole – that is, the component working with men (including men’s workers) as well as the component providing direct or indirect support for family members experiencing harm from the men’s use of violence. The term “women’s and children’s safety support” refers solely to the component providing direct or indirect support for family members experiencing harm from the men’s use of violence.

Women’s and children’s safety support: Terms such as “partner support”, “women’s safety support” or “women’s safety worker” may be used interchangeably in the context of MBCPs. In the Northern Territory, the term “partner contact worker” is commonly used in key policy documents. In other jurisdictions, this is referred to as “family safety contact/advocacy” or “women’s and children’s advocacy”. This document uses the term “women’s and children’s safety support” to ensure children are visible in this work, particularly in the context of talking about quality practice. The use of this term does not mean that the MBCP program is expected to work directly with children.

At the time of publishing, the two government-funded MBCPs in the NT provide women’s and children’s safety support primarily through external agencies, with two separate organisations funded to deliver the women’s and children’s safety support.

About the quality practice elements

However, this is not always the case in other jurisdictions where it may be more common for one service provider to deliver both parts of the program – the men's group component and the women's and children's safety support.

Person using violence: This document predominately uses the term "user of violence" to refer to the person who uses domestic, family and sexual violence, abuse or coercive control against a current or former intimate partner, or a member of their family or household. The terms "program participant" and "men" are used intermittently throughout to refer to the participants in the group-work component of the MBCP. The term "perpetrator" is avoided, noting the preference in policy and practice to move away from this terminology, while acknowledging that there is not necessarily sector consensus regarding the use of this term. We use gender-inclusive language while acknowledging that evidence reminds us that DFV is primarily perpetrated by men.

Victim and survivor: This document uses the term "victim and survivor" to describe a person against whom DFV has been perpetrated including a child or young person. The terms "adult and child victim-survivor", "current and/or former partner", "women and children" are used intermittently throughout to refer to adult and child victim-survivors of domestic, family and sexual violence. Victims and survivors may be accessing support provided by the women's and children's safety component.

First Nations: The term "First Nations" is predominately used in this document to refer to Aboriginal and Torres Strait Islander peoples. "Aboriginal" and "Aboriginal and Torres Strait Islander" may be used intermittently.

Domestic and family violence: The term "domestic and family violence" (DFV) is used throughout this document in line with current NT policy documentation related to MBCPs, including the abovementioned NT Minimum Standards.

For further information on other terminology used in the elements, please see the Glossary of Key Terms.

Acronyms

Acronym	Meaning
ACCO	Aboriginal Community-Controlled Organisation
ACT	Acceptance and commitment therapy
ANROWS	Australia's National Research Organisation for Women's Safety
AOD	Alcohol and other drugs
CALD	Culturally and linguistically diverse
CBT	Cognitive behavioural therapy
CRAT	Common Risk Assessment Tool
DBT	Dialectical behaviour therapy
DFV	Domestic and family violence
FSF	Family Safety Framework
FTE	Full-time equivalent
GBTQ	Gay, bisexual, trans and queer
IDS	Indigenous Data Sovereignty
IDG	Indigenous Data Governance
ISE	Information Sharing Entity
IPSV	Intimate partner sexual violence
LGBTIQ+	Lesbian, gay, bisexual, trans, intersex and queer/questioning, and other affiliated communities and identities
MACCST	Multi-Agency Community and Child Safety Team
MARAM	The Victorian Family Violence Multi-Agency Risk Assessment and Management Framework
MBCP	Men's Behaviour Change Program
MOU	Memorandum of understanding
NGO	Non-government organisation
NT	Northern Territory
QPE	Quality practice element
RAMF	Northern Territory Domestic and Family Violence Risk Assessment and Management Framework
RMAM	Risk Management Action Matrix
TFHC	Department of Territory Families, Housing and Communities (now Department of Children and Families)
TVIP	Trauma- and violence-informed practice
VET	Vocational education and training

Program design, aims and objectives

1 The MBCP has a clear statement expressing its fundamental aim and conceptualises and employs multiple strategies to work towards this aim. P10

2 [First Nations element] The MBCP has been developed with local and regional communities and has processes in place through which it is accountable to community. P11

3 [First Nations element] The MBCP has been intentionally designed to be culturally safe. P12

1 The MBCP has a clear statement expressing its **fundamental aim** and conceptualises and employs **multiple strategies** to work towards this aim.

Indicators: What does this look like in practice?

1.A The MBCP has a statement that articulates outcomes that matter both to adult and child victim-survivors and to the community in which the MBCP operates and is accountable to.

1.B The MBCP's statement includes reference to "enhanced safety" for adult and child victim-survivors but is not focused entirely on safety. This recognises that victims and survivors do not only strive for safety but also dignity, freedom from coercive control, space for action in their lives, and freedom to pursue individual human and collective rights in a non-oppressive environment.

1.C The MBCP demonstrates an understanding that there are multiple ways in which it can work towards its aim, that do not solely rely on the adult person who is using violence changing their behaviour. As such, the MBCP articulates their strategies in a way that balances pathways through which the MBCP:

1. in collaboration with other agencies, contributes towards an integrated response to "keep men in view" and to assess and manage dynamic risk
2. ensures women and children are directly supported; and
3. works towards behaviour change outcomes with the men.

STANDARD PRACTICE

1.D The MBCP has a program logic documenting the multiple pathways to work towards its fundamental aim. The program logic model focuses both on:

- program-level outcomes – intended outcomes for program participants and victims and survivors; and
- system-level outcomes – intended outcomes related to strengthening the capability of other agencies, and the system as a whole, to respond safely and effectively to DFV and to put and keep men and their patterns of violent and controlling behaviour "in view".

1.E The MBCP's program logic centres risk assessment and risk management at both program and systems levels.

1.F The MBCP proactively informs and educates partner agencies, and (where possible) the community, that its purpose is to promote safety and wellbeing for women, children and others who experience men's violence.

What contextual or other considerations are relevant to implementing this quality practice element?

MBCPs are not expected to take a "one-size-fits-all" approach to determining what successful outcomes might look like.

For MBCPs in First Nations contexts, defining successful outcomes requires consideration of colonisation, dispossession and ongoing structural racism, and the resultant impacts of intergenerational trauma, disconnection, loss and violence.

Collaboration can work at different levels – at the individual, service and systems level. At the individual level, working collaboratively on a case-by-case basis with other agencies promotes an integrated response to DFV. Working collaboratively with other agencies can also help to achieve systems-level outcomes by identifying opportunities to strengthen the integrated response in ways that will benefit multiple cases over time.

In some instances, the MBCP might have opportunities to indirectly (and sometimes directly) build the capability of other agencies to respond safely and appropriately to adult persons who use DFV. MBCPs can, through skillsharing, case conferencing, secondary consultations and (where feasible) co-located practice, contribute towards building this capability.

2 [First Nations element] The MBCP has been **developed with local and regional communities** and has processes in place through which it is **accountable to community.**

Indicators: What does this look like in practice?

2.A The MBCP has undertaken a process of engagement and trust-building with local and regional communities in the establishment of the program. This includes the incorporation of community inputs into the design or adaption of the program. Initial community engagement might cover:

- program aims and elements
- the particular needs, context and history of the community
- what it means to be culturally appropriate.

2.B The MBCP ensures its accountability to community through processes for ongoing engagement in the design and adaption of the program. This might mean engaging ACCOs, Elders (where appropriate) and other community representatives in aspects of the program.

2.C The MBCP has processes and systems in place to keep it accountable to Aboriginal women.

What contextual or other considerations are relevant to implementing this quality practice element?

Who constitutes "community", and who represents community, will differ from place to place. What remains fundamental, however, is whether and how community is involved in various aspects of the development of the program.

Ideally, the development of the MBCP should not be siloed from broader community engagement and violence prevention strategies run by and with the community.

In different contexts, program participants and their families might be from a diverse range of communities or Nations. It is still important, however, to work collaboratively with local or regional ACCOs.

Program providers, in consultation with community, need to manage complexities that arise in cases where program participants have family or other community links with other participants.

3 **[First Nations element]** The MBCP has been intentionally **designed to be culturally safe.**

Indicators: What does this look like in practice?

3.A	The MBCP has established meaningful, accountable and equitable long-term relationships with communities, built on an understanding of their cultures, worldviews, unique needs and strengths.	STANDARD PRACTICE
3.B	The MBCP demonstrates a commitment to developing a skilled Aboriginal and culturally safe non-Aboriginal workforce. This includes non-Aboriginal staff being supported to engage in an ongoing process of critical reflection and being trained and supported to enact culturally safe practice.	
3.C	The MBCP's approach supports Aboriginal women and men to walk in "two worlds" (both their community and "mainstream" worlds), reconnecting with culture, and with the respect for women and anti-violence stance inherent in Aboriginal ways of being.	
3.D	The MBCP has policies and procedures in place for the safe use of interpreters with men and women, that support risk identification (to victims and survivors, to the man and to the interpreter) and mitigation strategies for using an interpreter in each situation.	

What contextual or other considerations are relevant to implementing this quality practice element?

While an MBCP run by a mainstream service can strive towards providing a culturally safe response, it cannot replace the need for specialist, community-controlled MBCPs to be accessible to First Nations men, women and families.

Ideally, First Nations men and their families should be offered a choice as to whether to participate in a community-controlled MBCP, or one run by a mainstream organisation.

It is not automatic that a culturally safe program should involve Aboriginal practitioners from local or regional communities. This decision about how to balance the complex array of considerations involved is best made by the communities themselves.

Integrated governance and practice

4	The MBCP's governance draws on collaborative interagency networks.	P14
5	The MBCP builds and strengthens collaborative relationships to support an integrated response to DFV.	P15
6	[First Nations element] The MBCP is guided by Aboriginal and Torres Strait Islander self-determination.	P16
7	The MBCP is open to observers to promote transparency, accountability and continuous improvement.	P17

4 The MBCP's **governance draws on collaborative interagency networks.**

Indicators: What does this look like in practice?

4.A	The MBCP has a *multi-agency advisory group*, or similar function in place, to provide advice and support for ongoing program implementation and improvement in the context of an integrated response to DFV and for adapting the program to changing circumstances. This group might consist of stakeholders such as: specialist victim and survivor facing organisations, statutory child protection, non-government organisation (NGO) family support service providers, corrective services, police, legal services, local court representatives, health services (alcohol and other drugs [AOD], mental health) and community cohort representative agencies.	
4.B	The MBCP receives advice and support from advisory group members both during and between advisory group meetings, on an ongoing basis.	
4.C	The MBCP advisory group has terms of reference in place that outline the role of the group, which includes providing guidance and support for the MBCP to strengthen its collaborative practice.	
4.D	The MBCP educates advisory group members about MBCP service delivery, including the uncertain and incremental nature of behaviour change and the importance of having realistic expectations of the outcomes of MBCP work. The MBCP performs secretariat and administrative functions for the advisory group and supports its ability to function.	
4.E	The MBCP participates in local or regional DFV integrated service system forums or partnership activities, additional to any advisory group that it runs for its MBCP.	STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

Community cohort representative agencies can include those working specifically with migrant, refugee and other culturally and linguistically diverse (CALD) communities, and those working with LGBTIQ+ communities.

DFV service systems vary substantially in terms of the degree of integration, or even coordination, among constituent agencies. In some jurisdictions, formalised local or regional partnerships or consortia do not exist beyond agencies coming together in the context of multi-agency high-risk meeting processes. Others have formal or informal arrangements where partner agencies meet to identify opportunities to strengthen service coordination and integration at a systems level.

5 The MBCP builds and strengthens **collaborative relationships to support an integrated response to DFV.**

Indicators: What does this look like in practice?

	Indicator	
5.A	The MBCP has established strong relationships with *specialist DFV organisations,* including those working with victims and survivors.	STANDARD PRACTICE
5.B	The MBCP has made efforts to strengthen relationships with *organisations with partial, limited or no specialisation in DFV.* This includes organisations it receives referrals from, makes referrals to, seeks secondary consultations from, provides secondary consultations to, and/or shares information with, for the purposes of assessing and managing DFV risk.	
5.C	Collaborative relationships are demonstrated through both formal procedures (for example, participation in Family Safety Framework (FSF) meetings, information exchange consistent with information sharing laws) and informal procedures.	
5.D	The MBCP has formalised relationships through memorandums of understanding (MOUs) with key partners including the women's and children's safety support service and statutory and non-statutory agencies who are major referrers into the program.	
5.E	MOUs with key referring partners include a focus on realistic expectations for what a man's participation in the MBCP might achieve and outlines the responsibilities of the referrer to collaborate in assessing and managing risk while the man participates in the program.	
5.F	***[aspirational]*** The MBCP has formalised relationships through MOUs with other agencies that the program works closely with. The MBCP takes active, concerted and sustained efforts to support collaboration between agencies to both share information as well as responsibility for assessing, managing and monitoring risk to keep the adult person using violence and their patterns of behaviours in view.	
5.G	The MBCP is transparent in its practice to other agencies participating in the integrated response to DFV.	
5.H	***[aspirational]*** Drawing upon its specialist expertise, the MBCP identifies and enacts opportunities to support sectors, services and workforces within its catchment area to build their knowledge and skills in responding to DFV.	

What contextual or other considerations are relevant to implementing this quality practice element?

Integrated practice operates on a continuum from networking, to cooperation, to coordination of some activities, to collaboration and through to systems integration. A truly integrated system, among other things, involves the establishment of (often region-based) multi-agency partnership structures with some degree of decision-making authority to direct resources towards consensually determined processes and priorities.

The MBCP should be located as part of a collaborative response in which all agencies share the responsibility of holding DFV behaviour in view, enabling change in adult persons who use violence and enhancing the safety and freedom (space for action) of adult and child victim-survivors.

Referral to the MBCP should not be used by statutory agencies as a reason to close cases; these agencies have specific responsibilities to hold and monitor risk that they can share with the MBCP and other agencies.

6 [First Nations element] The MBCP is guided by Aboriginal and Torres Strait Islander self-determination.

Indicators: What does this look like in practice?

6.A	The MBCP demonstrates sensitive collaborative practice with ACCOs, Elders (in some contexts) and key community representatives, both as part of the multi-agency advisory group but also outside this group.	STANDARD PRACTICE
6.B	The MBCP understands the history of local community struggles for self-determination and the efforts made by community to resist colonisation and to strive towards collective healing.	
6.C	The MBCP recognises that First Nations organisations, services and practitioners operate within two service systems: the formal DFV service system (as conceived by governments and non-Indigenous organisations) and Indigenous systems of ACCOs, community and extended family responders. The MBCP supports both systems to function and finds ways for the two systems to work together on a case-by-case basis and through integrated policy development in decolonising ways.	
6.D	The MBCP works with community to establish and support a cultural advisory group, or groups of First Nations women and men, to: • be a conduit from the community to the program and for the community to determine whether it can trust the program • support community input into the development, running and continuous improvement of the program • link the program with the community's existing and emerging efforts to respond to, and prevent, DFV within the community • advise on matters of cultural safety • support community engagement and primary prevention activities, if appropriate.	

What contextual or other considerations are relevant to implementing this quality practice element?

For MBCPs operating in a First Nations context, measures to promote cultural authority of the MBCP need to suit that local context. What might produce cultural authority in one context might be culturally unsafe in another. A nuanced approach may be required to navigate the complexities faced by already overburdened First Nations workers, consultants and community representatives. MBCP providers need to learn what it will take to be genuinely invited into a community and how not to place unfair or unrealistic expectations on Aboriginal and/or Torres Strait Islander leaders and advisors.

A cultural advisory framework for the MBCP can include separate women's and men's safety groups represented by community members, that provide cultural authority for the program and respect for women's leadership.

Mainstream MBCP providers need to identify and work towards ways in which they can decolonise their practice to provide support for Aboriginal self-determination.

MBCPs that rely on one or two Aboriginal representatives through an advisory group to provide cultural authority for the program are less likely to be able to fully enable Aboriginal self-determination.

7 The MBCP is **open to observers** to promote transparency, accountability and continuous improvement.

Indicators: What does this look like in practice?

7.A	Each MBCP group includes observers for at least some of the sessions, unless this would jeopardise the safety of participants or of victims and survivors.
7.B	The MBCP assesses the potential impact on the men's participation in the program of having an observer from an external agency and on risk to victims and survivors before the observer is confirmed. Where required, risk mitigation strategies are developed and enacted before the observer attends.
7.C	The MBCP prepares observers for the group, including expectations and parameters of how they will participate as observers.
7.D	Observers are given opportunities to provide verbal and written feedback to facilitators after the group-work session to encourage reflections that might assist with the continuous improvement of the program.

What contextual or other considerations are relevant to implementing this quality practice element?

Observers can be workers from within the team (e.g. emerging facilitators, women's and children's safety workers), DFV specialists from other services, workers from referring and collaborating agencies, or other key stakeholders.

It is important to consider when it is appropriate to invite certain observers, particularly those who represent services that may have recently had or currently have contact with a man in the group. For example, it may not be appropriate for an observer from NT Child Protection to sit in on a group where one or more of the men, at that point in time, have particularly hostile attitudes towards child protection authorities. Alternatively, it might be possible to prepare men beforehand for the presence of the observer as a risk mitigation strategy.

Risk assessment, analysis and management

8	The MBCP provides timely and flexible responses to risk.	P19
9	The MBCP has a thorough understanding of, and practices aligned with, the NT Domestic and Family Violence Risk Assessment and Management Framework (RAMF).	P20
10	The MBCP incorporates evidence- and community-informed risk factors specific to DFV in First Nations and other community cohort contexts when assessing risk.	P21
11	The MBCP conducts comprehensive and ongoing risk, harm and needs assessments and analyses.	P22
12	The MBCP, where possible, engages in direct safety planning with the adult person using violence through individual contact.	P23
13	The MBCP has developed interlocking and robust indirect risk and harm management processes.	P24
14	The MBCP provider uses its powers as an Information Sharing Entity (ISE) to assess, manage and monitor risk and to keep the behavioural patterns of adult persons using violence in view.	P25
15	The MBCP prioritises risk and harm management responses to serious-risk adult persons using violence.	P26
16	The MBCP has processes in place to identify program- and systems-instigated risks of causing inadvertent negative harm, on a case-by-case basis.	P27
17	[First Nations element] The MBCP is cognisant of the complexities in relation to common risk assessment and management frameworks and approaches when working with First Nations communities.	P28
18	The MBCP has a sound approach to monitoring how the adult person using violence responds to the program.	P29
19	The MBCP has a sound approach to progress reporting and post-program completion reporting.	P30

8 The MBCP **provides timely and flexible responses** to risk.

Indicators: What does this look like in practice?

8.A	The MBCP pays attention to the particularities of each referral and considers the best response for each case, based on initial and ongoing risk assessment and analysis. The response to any particular case might shift over time.	STANDARD PRACTICE
8.B	The MBCP works in a coordinated manner with other agencies in responding to the risk posed, and the harm caused, by the adult person using violence.	STANDARD PRACTICE
8.C	The MBCP can, when required, respond to risk and harm and engage with men in a timely and flexible manner through ways other than, or in addition to, group work.	STANDARD PRACTICE
8.D	***[aspirational]*** The MBCP safely uses proactive forms of brief, high-frequency engagement (e.g. frequent short phone calls, brief messaging) with serious risk users of violence to scaffold safety during periods of acute risk.	
8.E	The timing of responses to risk are guided by a Risk Management Action Matrix (RMAM;[5] see also element 13), risk review meetings and, where applicable, FSF meetings and processes.	
8.F	The MBCP has robust procedures and tools to support identification, assessment and response to participant suicide risk.	STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

A flexible response to risk requires the program provider, within limits, to have capacity and capability to engage with men through a diverse range of service activities including, but not limited to, group work. While a central part of most MBCPs, group work is only one means through which an MBCP can work towards reducing risk and harm through direct engagement with the user of violence.

Guidance provided by the women's and children's support can be essential in determining the safety and appropriateness of alternative direct engagement options with the user of violence to respond to risk.

Recent UK evidence suggests that the risk of completed suicide is over 20 times higher among serious-risk users of DFV than among the general population of men.[6]

[5] An RMAM specifies key information sharing and risk management responses to different examples and types of acute or escalating risk situations (for example, MBCP participant breach of court order conditions, significant participant escalation during a group-work session, evidence of a participant weaponising his participation in the program, separation by a participant's partner). An RMAM can be organised under broad categories of risk situations, for example: danger situation/immanent risk, elevated and escalating risk, change in dynamic risk factors, current or predicted acute spike in risk. Each category of risk – or row – has adjoining columns specifying key or common information sharing and risk management actions required to respond to the risk, whose responsibility with the program team and provider organisation it is to enact these actions and the timeframes in which these actions should be taken. While an RMAM cannot specify all or even most of applicable information sharing and risk management actions for every possible risk situation, it provides guidance to help to ensure that key actions are not forgotten.

[6] Knipe D, Vallis E, Kendall L, et al. Suicide rates in high-risk high-harm perpetrators of domestic abuse in England and Wales: A cohort study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention.* 2024; 45(3): 242-245. https://doi.org/10.1027/0227-5910/a000925 (See also the workshop recording here: https://www.youtube.com/watch?v=-NCOs3gYMS0&list=PLRmYyMTndST6hXFK3FcK6IpX3pKvditfZ&index=10)

9 The MBCP has a thorough **understanding of, and practices aligned with, the NT Domestic and Family Violence Risk Assessment and Management Framework (RAMF)**.

Indicators: What does this look like in practice?

9.A	The women's and children's safety support service associated with the MBCP uses the Common Risk Assessment Tool (CRAT) with victims and survivors.
9.B	The MBCP uses direct engagement opportunities with men to make ongoing observations related to evidence-based risk factors, complex needs, violence-supporting narratives, belief systems, situational changes and meaning-making that are indicative of serious risk.
9.C	In addition to risk assessment information obtained from the women's and children's safety support component, the referrer and other agencies through information sharing requests, the MBCP contributes additional risk assessment information obtained directly or indirectly through engagement with the adult user of DFV towards a combined assessment of risk.
9.D	***[aspirational]*** The MBCP safely uses proactive forms of brief, high-frequency engagement (e.g. frequent short phone calls, brief messaging) with serious risk users of violence to scaffold safety during periods of acute risk.
9.E	***[aspirational]*** The MBCP service provider (organisation as a whole), across all relevant program and services areas including those without DFV specialisation, is RAMF-aligned.

STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

The NT Government is considering the development of perpetrator-focused tools to include within the RAMF. A suite of perpetrator-focused tools and associated practice guidance have been produced by the Victorian Government as part of the Multi-Agency Risk Assessment and Management (MARAM) Framework, some of which can be adapted for the NT context.

Two other jurisdictions are also in the early developmental stages of perpetrator-focused tool development to incorporate within their common risk assessment and management frameworks.

RAMF alignment across the whole agency provides a supportive organisational environment for the MBCP to operate. It also facilitates DFV-informed information sharing and internal referrals between the MBCP and other program areas and services provided by the agency.

10 The MBCP incorporates **evidence- and community-informed risk factors specific to DFV in First Nations and other community cohort contexts** when assessing risk.

Indicators: What does this look like in practice?

10.A	The MBCP identifies risk factors and considerations that often are indicative of increased risk and harm in the context of DFV in local or regional First Nations communities, that are not reflected in the RAMF.	STANDARD PRACTICE
10.B	The MBCP identifies risk factors and considerations that often are indicative of increased risk and harm in the context of DFV in migrant and refugee communities.	
10.C	The MBCP identifies risk factors and considerations that often are indicative of increased risk and harm in the context of DFV in LGBTIQ+ communities.	

What contextual or other considerations are relevant to implementing this quality practice element?

The RAMF focuses on a set of factors linked to higher risk of serious DFV harm or lethality. These evidence-based risk factors are relevant across community and cohort contexts. Additional risk factors and considerations, however, apply in First Nations contexts, as they do in other cohort and community contexts.

11 The MBCP conducts **comprehensive and ongoing risk, harm and needs assessments and analyses**.

Indicators: What does this look like in practice?

STANDARD PRACTICE

11.A The MBCP assesses each participant's patterns of violent and controlling behaviours and the current, ongoing and cumulative harms caused by these behaviours on an ongoing basis.

11.B The MBCP, on an ongoing basis, assesses the risk of the adult user of violence continuing, resuming, escalating or adopting new patterns of violent and controlling behaviours.

11.C Through obtaining information from multiple sources, the MBCP analyses risk information on an ongoing basis concerning:

- evidence-based risk factors
- patterns of coercive control
- power advantages in relation to, or social marginalisation of, the victim and survivor
- systems abuse tactics
- how the adult person using violence responds to the MBCP and to other interventions
- new or changing circumstances and the meaning the man makes of these
- the man's beliefs, thinking and narratives
- characteristics suggestive of serious risk; and
- complex needs.

11.D The MBCP draws together this information, where available and obtained over time, to consider possible spikes in risk (acute risk). In the case of serious risk, this includes identifying scenarios in which the adult person using violence might be at increased risk of using lethal, near lethal or otherwise severe violence.

11.E The MBCP continually assesses the impact of the MBCP's direct engagement with the adult person using violence, and the impact of other systems interventions, on particular risk factors. The MBCP remains vigilant to the possibility of unintended negative consequences arising from the program or other interventions.

11.F The MBCP assesses any complex needs of the adult person using violence and the implications for developing a case plan, addressing them as barriers to service participation and as contributing factors to risk.

11.G Risk, harm and needs assessments contribute towards decisions regarding service coordination, case management and service mix, including the timing of particular intervention components.

11.H ***[aspirational]*** The MBCP draws upon perpetrator pattern-mapping tools to assist with its analysis of the harm caused by the adult person using violence to family functioning.

11.I ***[aspirational]*** The MBCP draws upon tools and practice guidance, and collaborations with child- and family-focused services and agencies, to assess the harm caused by the adult person using violence separately to each affected child. These assessments focus on the impacts on each child's development, stability and wellbeing, as well as their safety.

What contextual or other considerations are relevant to implementing this quality practice element?

Risk assessment is an ongoing, dynamic process of analysis that continually informs both safety planning and risk management.

Risk assessment considers both the seriousness of risk and the degree of imminence.

Risk should be understood both in terms of high risk of lethality or severe injury and/or in terms of degree of social entrapment and impacts on victim and survivor human rights and freedom, and on child development and wellbeing.

Initial risk, harm and needs assessments can have significant implications for the types and sequencing of services and intervention components offered to the adult person using violence. The results of these assessments will often need to be shared with mandated and statutory referrers so that agreement on the case plan can be reached.

12 The MBCP, where possible, engages in **direct safety planning** with the adult person using violence through individual contact.[7]

Indicators: What does this look like in practice?

12.A	The MBCP does not rely on group work alone to work towards direct safety planning goals with each program participant. At least a minimum degree of individual contact is used to focus on direct safety planning goals.	STANDARD PRACTICE
12.B	Safety planning is an ongoing process that builds throughout the participant's and current/former partner's engagement with the program.	STANDARD PRACTICE
12.C	Additional individual check-in time – with a strong focus on safety planning – takes place when current or future periods of heightened risk are identified.	STANDARD PRACTICE
12.D	The MBCP determines whether the adult person using violence requires legal support to assist with his compliance with the conditions of any police or court order he is subject to. Access to legal advice, or legal education, is actively supported in these situations.	
12.E	Individual check-ins, that include a focus on safety planning, occur regularly throughout the man's participation in the program.	
12.F	Safety planning evolves, where possible, into safety and accountability planning, where the program participant is supported to consider commitments he can make to repair or minimise the accumulative harm he has caused through his use of violent and controlling behaviour.	

What contextual or other considerations are relevant to implementing this quality practice element?

All efforts to engage the adult person using violence are considered forms of direct risk and harm management. Safety planning with the person is one example, as are group-work interventions, case management sessions, individual violence-focused work, and forms of proactive contact such as telephone calls.

Safety planning in this context concerns engaging the adult person using violence directly in upstream, midstream and downstream strategies that, in the immediate and short-term, intend to make it less likely that he will (continue to) use particular violent and controlling behaviours.

Direct safety planning with the adult person using violence is only one component of an overall risk and harm management approach.

[7] For more information on "direct safety planning", please see: https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence/responsibility-4#48-safety-planning-with-a-person-using-violence

13 The MBCP has developed **interlocking and robust indirect risk and harm management processes.**

Indicators: What does this look like in practice?

STANDARD PRACTICE

13.A The MBCP conducts internal risk review meetings on a regular basis. While some cases might be allocated more time, during these meetings men's workers, women's and children's safety support workers and a team leader review each case in terms of ongoing risk analysis and program goals. Risk review meetings track actions on how best to manage risk and increase the safety of adult and child victim-survivors.

13.B For each adult person using violence who poses a serious risk to the safety of victims and survivors, and/or who is causing serious levels of harm, a risk and harm management plan is developed. The plan might include strategies developed in collaboration with other agencies.

13.C The MBCP works collaboratively with relevant agencies to assess, manage and monitor risk. This includes:

- exchanging information with agencies to support and inform risk assessment, risk management and monitoring of risk
- working to improve accountability and visibility of the behavioural patterns of adult persons who use violence across all systems and services
- participating in case conferencing with relevant agencies; and
- coordinating service responses to adult and child victim-survivors and the man perpetrating violence.

13.D Risk and harm management processes, plans and actions are informed by ongoing risk and harm assessment and analysis.

13.E Risk and harm management processes, plans and actions are informed by victim and survivor needs and wishes, where possible. Victims and survivors have a say in key risk management decisions, where they so desire.

13.F The MBCP has a RMAM which provides guidance to workers when responding to different types of risk escalation situations. This includes guidance on internal reporting and decision-making based on appropriate levels of seniority and on notifications to, and information sharing with, other agencies.

STANDARD PRACTICE

13.G The MBCP has a process for documenting the implementation, outcomes and review of risk management plans and actions. This requires men's and women's and children's safety support workers to document in sufficient detail:

- internal communications (for example, with a manager or supervisor)
- information shared with external agencies
- decisions, actions and outcomes of actions taken in relation to assessing and managing risk.

What contextual or other considerations are relevant to implementing this quality practice element?

Indirect risk and harm management processes and strategies are those that do not centre on, or even involve, direct engagement with the adult person using violence. They include discussions and actions taken by MBCP team members, information shared with other agencies, and decisions made in both these contexts, that the adult person using violence is often not aware of. For more information, see the Glossary of Key Terms.

14

The MBCP provider uses its powers as an **Information Sharing Entity (ISE)** to assess, manage and monitor risk and to keep the behavioural patterns of adult persons using violence in view.

Indicators: What does this look like in practice?

STANDARD PRACTICE

14.A The MBCP prioritises women's and children's wellbeing and right to safety above men's right to confidentiality.

14.B The MBCP responds appropriately and in a timely manner to information sharing requests made by other agencies.

14.C The MBCP makes information sharing requests of other agencies to assist with ongoing risk assessment and risk analysis.

14.D The MBCP demonstrates an understanding of when they can share information without the knowledge or consent of the adult person using violence.

14.E The MBCP identifies and offers information that would be useful for other agencies who perform a role in managing the risk posed by the adult person using violence, even where those agencies do not request (and might not be aware of) such information.

14.F The MBCP and women's and children's safety support proactively share information to assist other agencies to understand the behavioural patterns of the adult person using violence and to more effectively partner with the victim and survivor by making sense of her decisions and actions in light of her experience of these patterns. The MBCP might do this through:

- providing information during warm referral processes for either the victim and survivor or user of violence
- providing information to law enforcement, justice system or child protection authorities so that they can better understand the victim's and survivor's situation
- providing behavioural maps using a perpetrator pattern-based mapping tool
- case consultations
- case conferencing; and
- convening and/or participating in multi-agency case management.

14.G The MBCP has clear policies, written procedures and practice guidance on information sharing and documentation.

14.H *[aspirational]* The MBCP provider (the organisation as a whole), across all relevant program and services areas including those without DFV specialisation, is compliant with its responsibilities as an ISE.

What contextual or other considerations are relevant to implementing this quality practice element?

The full use of an MBCP provider's information sharing responsibilities and opportunities as an ISE depends on the degree of trust that exists between DFV service system agencies.

Information sharing practices can take some time to change; some services will remain wary of what will happen to client sensitive information that they provide and what impact this might have on their clients, and these services will impose their own boundaries and constraints around the information they are willing to share and/or to seek.

Some services work with the victim and survivor but do not have full DFV specialisation. Assisting these services to understand the perpetrator's patterns of violent and controlling behaviours, the impacts on child and family functioning, and what the adult survivor does to resist the violence and these impacts, can help them to adopt a more sensitive and less victim-blaming approach.

Information sharing involving statutory authorities can cause considerable anxiety for First Nations families and communities, given these authorities' actions in causing dispossession and intergenerational trauma, as well as the ongoing over-representation of First Nations people in child removal, policing and incarceration. Safety for First Nations families and communities is multi-layered, including safety from institutionalised responses.

While it can be highly beneficial for mainstream organisations to take a whole-of-organisation approach towards ISE compliance, for ACCOs, compliance might need to be more restricted (for example, to particular program areas such as its MBCP). Expecting the whole of an ACCO to be ISE compliant may compromise its ability to balance, on a case-by-case basis, its work towards enhancing the safety and welfare of children and adult victims and survivors with its work to protect children, families and communities from child removal.

15 The MBCP prioritises risk and harm management responses to **serious-risk adult persons using violence**.

Indicators: What does this look like in practice?

STANDARD PRACTICE

15.A An individualised and tailored risk management plan is developed for each program participant who poses a serious risk to the safety of adult and/or child victims and survivors. Risk management plans are developed jointly by men's workers and women's and children's safety and support workers.

15.B The MBCP has a flexible approach to engaging serious-risk adult users of violence. This might include, for example, keeping a serious-risk adult in the program to keep him within view despite him showing little or no motivation towards changing his behaviour or engaging the serious-risk adult predominately through individual sessions.

15.C The MBCP is aware of all instances when a program participant is involved in an FSF matter.

15.D The MBCP makes referrals to FSF meetings in situations where program participants are assessed as posing a serious risk.

15.E The MBCP participates in FSF meetings and Multi-Agency Community and Child Safety Team (MACCST) meeting discussions when a program participant is the focus during a meeting.

15.F The MBCP does not rely solely on FSF and MACCST meetings for interagency risk management collaboration; the risk management plan identifies other avenues for collaboration.

15.G ***[aspirational]*** The MBCP contributes to FSF meetings regularly, even where no program participants are discussed, to contribute their specialist expertise across cases.

15.H ***[aspirational]*** In cases where the adult user of violence poses a serious risk to the safety and wellbeing of children, the MBCP delineates the specific adverse outcomes that the adult is at risk of causing for the child. Risk mitigation strategies are, where possible, put into place for potentially serious or severe outcomes that have at least a low to moderate likelihood of occurrence.[8]

What contextual or other considerations are relevant to implementing this quality practice element?

Multi-agency high-risk teams across Australia differ in their capacity and capability to identify and support perpetrator-focused, and perpetrator-facing, actions that keep the adult person using violence and his behaviour in view. The MBCP has a potential role in supporting particular agencies in this work. However, this requires the MBCP to understand the constraints and paramount concerns of each agency.

[8] For further guidance, refer to this recording: https://www.youtube.com/watch?v=dZOqw4cUUyQ&list=PLRmYyMTndST6hXFK3FcK6lpX3pKvditfZ&index=7&t=2126s (from 29:55 mins)

16 The MBCP has processes in place to identify program- and systems-instigated **risks of causing inadvertent negative harm**, on a case-by-case basis.

Indicators: What does this look like in practice?

16.A	The MBCP and women's and children's safety support both monitor and identify, on a case-by-case basis, any inadvertent harm caused by a man's participation in the program, or by the actions and responses of other agencies, to the safety and wellbeing of adults and children experiencing the man's use of DFV.	STANDARD PRACTICE
16.B	Where program- or systems-instigated harm to the safety and wellbeing of a victim(s) and survivor(s) has been identified, the MBCP and the women's and children's safety support service develop a strategy to respond to and minimise the harm and consider the implications for ongoing or escalations in risk.	STANDARD PRACTICE
16.C	The MBCP proactively identifies the most likely occurrences of program- and systems-instigated harms and risks and proactively develops strategies, across the program as a whole, to prevent or mitigate these harms and risks. This includes a specific focus on program- and systems-instigated risks and harms to children.	
16.D	Where an adult person using violence is involved in family law matters regarding access to children, the MBCP considers carefully whether the potential benefits of the man participating in the program might be outweighed by any potential for harm to be caused through the man weaponising his participation in the program.	
16.E	The MBCP has clear, transparent criteria and sound procedures to discontinue a man's participation from the program, including to manage any new or escalated risks arising due to the program's decision to exit the man. Decisions about discontinuing men and strategies to mitigate associated risks are made jointly by men's and women's and children's safety support workers.	STANDARD PRACTICE
16.F	The MBCP does not provide program participants with completion certificates.	

What contextual or other considerations are relevant to implementing this quality practice element?

Inadvertent negative harm might occur due to the adult person using violence and:

- distorting program content due to the way he misinterprets it (for example, through a victim stance lens)
- deliberately misrepresenting (weaponising) program content, worker comments or actions, or program policies or procedures, to control or harm the victim and survivor; and/or
- using his participation in the program to gain favourable responses by other agencies or systems towards him and to disadvantage the victim and survivor.

In some instances, women's and children's safety support service contact with victims and survivors can create potential risks to their safety and wellbeing; these need to be identified and mitigated.

Program completion certificates can be misused by adult users of violence to manipulate other services and responders to believe that more behaviour change has occurred than has actually been the case. The broader service system might also assume that program completion automatically means that a man is now safe to be around his family members.

17 **[First Nations element]** The MBCP is cognisant of **the complexities in relation to common risk assessment and management frameworks and approaches when working with First Nations communities**.

Indicators: What does this look like in practice?

17.A	The MBCP nuances its risk assessment and management processes and framework to First Nations men, women and families, noting there are different risk assessment and risk management considerations than when working with non-Indigenous participants.	STANDARD PRACTICE
17.B	The MBCP's approach to collaborative risk management and information sharing with state-based authorities (e.g. NT Police Force, Child Protection) considers the history and ongoing role these agencies have as agents of child removal, colonisation, occupation of lands and attempted genocide for First Nations people.	STANDARD PRACTICE
17.C	The MBCP demonstrates an understanding that, in some cases, family members not disclosing information about a man's behaviour may be an active safety-making strategy (e.g. due to child protection system considerations or reprisals from the man's family), in the context of assessing the multiple factors impacting victim and survivor decisions about disclosure.	
17.D	The MBCP, where possible, attempts to identify and assess how family (including the victim's and survivor's family and the family of the adult person using violence) and community responses might impact upon risk, control and entrapment, and the harm experienced by the victim(s) and survivor(s).	
17.E	The MBCP demonstrates an understanding through their risk assessment and management processes of the multiple meanings of safety for First Nations communities, which might include safety from state-based interventions and from state-based micro-management of community life (given the context of the NT Intervention).	

What contextual or other considerations are relevant to implementing this quality practice element?

When considering the complexities of risk assessment and management, the MBCP might seek to understand the following:

- How is safety defined by local communities?
- What additional risk factors or considerations have been present in domestic homicides committed by local/regional First Nations men?
- What might be the roles of extended families in accentuating and/or mitigating against threat and risk?
- What do we need to know about the specific history of colonisation, dispossession and community dynamics in this context to help understand and inform risk and to help understand family and community responses?

Non-disclosure by any victim and survivor can be a strategy to prevent escalation in risk and to attempt to manage the harms caused by the user of violence. For the victim and survivor, disclosure can place at risk things they are battling to preserve for themselves and their children, such as dignity, some semblance of normality, and some space away from experiencing humiliation. For First Nations people who struggle to preserve dignity and self-determination in the context of colonisation, the risks of disclosure can be even higher.

18 The MBCP has a sound approach to **monitoring how the adult person using violence responds to the program**.

Indicators: What does this look like in practice?

18.A Where possible, the MBCP does not rely solely on program attendance, participation data, or observations about the quality of the man's participation in the program to monitor how he is responding to the program and the extent to which he is stepping into the required elements of a behaviour change journey.

18.B Where available, the MBCP uses victim and survivor reports to assist in monitoring any changes – positive and/or negative – in attitudes, beliefs or behaviours made by the adult person using violence throughout his participation in the program. STANDARD PRACTICE

18.C To augment victim and survivor reports, or when these reports are not available, the MBCP discerns proximal indicators,[9] based on observations of the adult person using violence in group-work and individual sessions, of whether he is genuinely stepping into the required elements of a behaviour change process.

18.D The MBCP does not automatically assume that a man's demonstration of proximal indicators means that he has become a safer man for current and future family members.

18.E The MBCP uses observations of the man's responses to, and participation in, the program to assist with ongoing risk assessment. STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

MBCP workers need to exert caution in using proximal indicators to gauge the extent to which – if at all – a program participant is stepping into the required elements of a behaviour change journey.

[9] See: Vlais R, Campbell E and Green D. *Signposts for assessing and reporting family and domestic violence perpetrator behaviour change.* RMIT University and Stopping Family Violence. 2022. https://cij.org.au/news-and-views/signposts-to-perpetrator-change/

19 The MBCP has a sound approach to **progress reporting and post-program completion reporting**.

Indicators: What does this look like in practice?

19.A Where an adult user of violence, at an advanced point in the program, is still not demonstrating proximal indicators that he is stepping into the required elements of a behaviour change journey and/or is still displaying strong commitment to violence-supporting attitudes and beliefs (for example, victim blaming, minimisation of his harmful behaviour), the MBCP proactively shares this information with the referrer and/or other services involved in managing the risk posed by the adult. In sharing this information, the MBCP outlines implications for the current and/or future safety and wellbeing of adult and child victim-survivors.

19.B The contents of post-program reports are determined collaboratively by men's workers and the women's and children's safety support service. These reports:

- focus predominantly on conclusions regarding the risk that the man poses to victims and survivors at the point of his completion or exit from the program and outcomes concerning any changes in the harm that his behaviour is causing
- consider how risk might change given any significant changes in circumstance (e.g. when the person is no longer in view of the service system); and
- focus on what further work might be required to address outstanding issues of risk and harm.

STANDARD PRACTICE

19.C The MBCP has a template to ensure that post-program report writing is consistent in format, length and tone. The template prioritises reporting on violent and controlling behaviour used since the point of referral, significant concerns and changes in risk, and caveats on the conclusions that can be drawn from this information.

19.D MBCP workers are provided with training, and/or coaching, to write reports in ways that are professional, evidenced and defendable, including in how they represent concerns about risk. This coaching includes how to draw upon ongoing assessments and analyses of risk.

19.E Post-program reports clearly state that conclusions cannot be drawn about future behaviour change outcomes based solely on the fact that a man has positively participated in the program.

STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

Historically, MBCPs have been hesitant to provide anything other than attendance dates when reporting a man's progress through the program to referrers, or when providing post-program completion reports. Despite MBCPs attempting to make clear that meeting the attendance requirements of the program is not in and of itself indicative of behaviour change and of reduced risk to victims and survivors, the absence of any other information leaves a vacuum for the referrer to assume that program attendance is the key outcome. MBCPs can, in some circumstances, provide additional information to help referrers develop more informed conclusions about behaviour and risk as a result of the man's participation in the program.

Women's and children's safety support in the context of MBCPs

20	There is close collaboration and trust between the women's and children's safety support workers and men's workers, and between MBCPs and specialist women's DFV service providers.	P32
21	Women's and children's safety support workers have a clear and deliberate understanding of the scope of their role.	P33
22	The women's and children's safety support service operates as an independent service in its own right.	P34
23	Women's and children's safety support is offered as early as possible.	P35
24	Women's and children's safety support is offered to all potentially eligible participants.	P36
25	The women's and children's safety support component is prioritised and sufficiently resourced.	P37
26	The MBCP, in collaboration with specialist women's, children's and family-focused services, attempts to assess the impact of the man's behaviour on child and family functioning and to support child victim and survivor needs.	P38
27	[First Nations element] Holistic and culturally safe and appropriate support is provided to First Nations women and children experiencing DFV.	P40

20 There is **close collaboration and trust** between the women's and children's safety support workers and men's workers, and between MBCPs and specialist women's DFV service providers.

Indicators: What does this look like in practice?

STANDARD PRACTICE

20.A Men's workers and women's and children's safety support workers share information and collaborate regularly, through scheduled meetings and impromptu verbal and written communications. This includes making joint decisions in assessing and managing risk and regarding what information to share with other agencies.

20.B Sufficiently detailed and clear written records are maintained of risk assessment analyses, decisions, and risk management and other follow-up actions discussed during meetings between women's and children's safety support and men's workers, including review of previous action commitments.

20.C The MBCP and women's and children's safety support build a high-functioning team environment that enables men's workers, without defensiveness, to centralise the perspectives and insights of women's and children's safety support workers.

20.D Where women's and children's safety support is provided by an external agency, the MBCP provider collaborates very closely with the external agency to assist them to understand the additional nuance, considerations and requirements of this work in the specific context of perpetrator interventions.

20.E When women's and children's safety support is provided by an external agency, a formal agreement is in place outlining roles and responsibilities for each agency and worker, information sharing, scope and parameters of service provision, and strategies for monitoring and reviewing the arrangement and outcomes.

What contextual or other considerations are relevant to implementing this quality practice element?

Women's and children's safety support can be offered in different ways: the MBCP may employ its own women's and children's safety support workers, collaborate with external specialist victim and survivor agencies that provide this support, or may partner with a specialist victim and survivor agency that introduces a team to work with men who cause DFV harm.

Women's and children's safety support and men's workers can still collaborate on cases where the (ex)partner of the man declines the women's and children's safety support service. Women's and children's safety support workers can offer important insights and contribute to risk assessment and management decisions in these situations.

21 Women's and children's safety support workers have a **clear and deliberate understanding of the scope of their role**.

Indicators: What does this look like in practice?

21.A	Women's and children's safety support workers, and their managers, understand how this role is *different* to standard specialist victim and survivor advocacy and support that is not associated with the provision of MBCP work.	STANDARD PRACTICE
21.B	Women's and children's safety support workers, their managers and the MBCP providing agency are clear and intentional on what the women's and children's safety support does and does not entail. A considered process to map out the women's and children's safety support role should inform a written statement detailing the service model of the women's and children's safety support and the types of support that are and are not offered to victims and survivors through the service.	
21.C	Women's and children's safety support workers tailor the frequency, intensity and forms of support to each victim and survivor depending on the levels and nature of risk and the victim's and survivor's needs.	STANDARD PRACTICE
21.D	The scope and parameters of the women's and children's safety support service is communicated to other relevant DFV service system agencies, such as to specialist DFSV women's services.	
21.E	Women's and children's safety support workers have a firm understanding of how the MBCP works and what it covers, so that they can talk about the program in detail with victims and survivors and answer their questions in an informed way.	STANDARD PRACTICE
21.F	*[aspirational]* The scope of the women's and children's safety support service takes into account the availability, scope and workloads of other specialist DFV victim and survivor services in the catchment area. The women's and children's safety support worker role encompasses more goals and service activities when victims and survivors have few other available options for support.	

What contextual or other considerations are relevant to implementing this quality practice element?

Women's and children's safety support services need to offer tailored assistance to victims and survivors, continually assess risk, and address any additional harm to them that might arise from the man's participation in the MBCP.

Women's and children's safety support services must assess and assist with addressing the needs of victims and survivors arising from the man's use of violent and controlling behaviour. They must provide information to the victim and survivor about the MBCP and its approach to working with the man, the man's attendance or non-attendance at the program, and straightforward information about the likelihood of behaviour change and the limitations of the program.

Victims and survivors need a clear understanding of the MBCP so that they can make an informed judgement about what the man communicates about the program and how he is progressing through the program in terms of taking responsibility for his behaviour and steps towards change. Clear information about the MBCP from the women's and children's safety support service enables the victim and survivor to gauge the truthfulness of what he might say about the program and to identify any signs that he is weaponising his participation in the program or (deliberately or unintentionally) misinterpreting any of the content.

The scope of women's and children's safety support varies significantly. Some services have a very broad remit and focus on a wide range of goals; others have a narrower focus and frequently refer out to other services for issues that it cannot respond to.

22 The women's and children's safety support service operates as an **independent service in its own right**.

Indicators: What does this look like in practice?

22.A Women's and children's safety support continues to be offered to a victim and survivor – for a period of at least a few months – after their (ex)partner either completes the program, discontinues with the program before he is due to complete it or is exited from the program.

22.B In circumstances where the man does not complete the program, the frequency and/or intensity of support offered to the victim(s) and survivor(s) should, in most situations, increase.

22.C Women are provided with exit interviews when they are transitioned out of the women's and children's safety support service. However, they are made welcome to recontact the women's and children's safety support service at any point.

STANDARD PRACTICE

22.D *[aspirational]* Women's and children's safety support continues to be offered for periods of several months or more after the victim's and survivor's (ex)partner completes the program, discontinues with the program or is exited from the program.

22.E Women's and children's safety support does not focus solely on themes directly related to the man's participation in the program.

22.F *[aspirational]* Women's and children's safety support is offered to (ex)partners of men who commence intake and initial assessment but who do not go on to complete the assessment process. Support is also offered to (ex)partners of men who complete assessment but who choose not to continue with the program.

22.G Women's and children's safety support is provided to the victim and survivor by a worker who is not also working with her (male) (ex)partner. Where a worker has a dual role working with both male program participants and partners through the women's and children's safety support service, they only support victims and survivors where they are not working with their male (ex)partners.

STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

Women's and children's safety support should be highly integrated with MBCP components that are focused on engaging adults who are using violence. However, a man's continued participation in the MBCP should not determine whether victims and survivors continue to receive this support. Nor should the focus of this support revolve predominantly around conversations about the man.

If a man discontinues with the MBCP before completion, discontinues with the initial assessment process after making a start or decides not to continue with the program after initial assessment, this can be an indicator of increased risk to victims and survivors. Women's and children's safety support should be prioritised in these situations.

The ability of a women's and children's safety support service to operate as an independent service in its own right is heavily impacted by program funding and by the relative allocations of funding for work with victims and survivors related to work with men through MBCPs. Women's and children's safety support is generally underfunded across most Australian jurisdictions.

23 Women's and children's safety support is **offered as early as possible**.

Indicators: What does this look like in practice?

23.A	Women's and children's safety support is offered as soon as possible after the adult person using violence has participated in his first assessment session.	STANDARD PRACTICE
23.B	***[aspirational]*** Women's and children's safety support is offered within a week after the (ex)partner's contact details have been obtained either from the user of violence or from the referring or other agency.	

What contextual or other considerations are relevant to implementing this quality practice element?

Initial contact with the victim(s) and survivor(s) should contribute to initial comprehensive assessment of the man. Where possible, this should begin before he commences the group-work component. This enables a collaborative assessment of the man entering into the MBCP, drawing on information from multiple sources including victims and survivors. It also enables risk assessment and management responses to victims and survivors when a man does not complete the assessment process or decides not to commence the group-work component of the program. This is especially important due to the higher risk posed for victims and survivors in these situations.

Participation in the women's and children's safety support is of course voluntary; women's and children's safety support workers require sensitive and skilled approaches to outline the goals and benefits of participating in the service, suited to the victim's and survivor's context.

24 Women's and children's safety support is offered to all potentially **eligible participants**.

Indicators: What does this look like in practice?

24.A The MBCP and women's and children's safety support service prioritise identifying all adults and children who are at risk from the man's use of DFV, through seeking this information from the man, his current or former partner, referral sources and other agencies. *STANDARD PRACTICE*

24.B Women's and children's safety support is offered to:

- any person with whom the man is currently having, or has recently had, a romantic or sexual relationship, regardless of whether they live(d) together
- any new intimate partner that the man has commenced developing a relationship with after he started the program
- the mother(s) of any children aged under 18 whom the man fathered (either as a birth or step-parent) and still has contact with, regardless of the time elapsed since he and the mother separated
- any other adult victim and survivor whom the program provider reasonably expects might be affected by the man's use of violence (e.g. his mother, if he has recently returned home to his family of origin).

STANDARD PRACTICE

24.C The women's and children's safety support worker attempts to "try again" to offer support to a victim and survivor who initially declined the offer of support in situations where her (ex)partner discontinues with, or is exited from, the program.

24.D The women's and children's safety support worker recontacts victims and survivors who initially declined support when a significant risk issue has occurred.

24.E Partner safety support is available for victims and survivors who are male, non-binary, agender or intersex.

24.F The women's and children's safety support service and MBCP considers affected children to be participants in the women's and children's safety support process even though direct contact with children will generally not occur. This can include:

- considering the meaning that the children might be making out of the father attending a program.
- referring children to, and working collaboratively with, other services that can address their needs arising from the father's use of DFV.

What contextual or other considerations are relevant to implementing this quality practice element?

The MBCP requires the adult person using violence to disclose names and contact details of all former or current partners eligible to receive women's and children's safety support and all children who he is a parent or co-parent to. The MBCP uses its powers as an ISE to seek this information from other sources where there appears to be adult and/or child victims and survivors and the man is unwilling or unable to disclose them.

Men should be informed about the women's and children's safety support service, but not told whether their (ex) partner has elected to participate in the service.

Women's and children's safety support workers generally do not have direct contact with children. However, the harm experienced by, and risk of further harm to, children is assessed by women's and children's safety support workers to the best extent possible through contact with their parent victim and survivor and through collaboration with men's workers attempting to gain insights on this by engaging the man.

In some First Nations contexts, women play the role of caregivers to extended family members' children. These relational and kinship structures are important support networks and social capital; however, they can also add complexity to the dynamics of DFV and should be considered in relation to partner eligibility.

25 The women’s and children’s safety support component is **prioritised and sufficiently resourced**.

Indicators: What does this look like in practice?

25.A	Women’s and children’s safety support workers operate a manageable case load.	STANDARD PRACTICE
25.B	The full-time equivalent (FTE) allocation for the women’s and children’s safety support worker(s) is in proportion to the allocation for men’s workers.	
25.C	Women’s and children’s safety support is not provided by male-identifying workers, nor by non-binary workers socialised male at birth, unless requested by the victim and survivor.	
25.D	Women’s and children’s safety support is undertaken by workers who have specific knowledge, training and experience in providing support and advocacy for people impacted by DFV. This includes advanced skills in comprehensive DFV case management, risk assessment, safety planning and risk management, collaborative practice and in response-based practice.	STANDARD PRACTICE
25.E	Women’s and children’s safety support workers observe a sample of MBCP sessions (not involving men of ex/partners they are supporting) and learn about the program and its approach to behaviour change from men’s workers so that they can provide accurate information to victims and survivors.	
25.F	Professional development opportunities are available to women's and children's safety support workers.	STANDARD PRACTICE
25.G	Decisions about MBCP capacity to intake men into the program, at any point in time, are influenced by the capacity of the women's and children's safety support service to support their (ex)partners.	
25.H	Women’s and children’s safety support workers have the capacity to provide (limited) in-person support on a selective basis to a small proportion of their case loads.	
25.I	*[aspirational]* Women’s and children’s safety support workers have capacity to offer each woman in-person support (in the women's and children's safety support provider’s office or through outreach) for at least one or two of their contacts, rather than relying entirely on telephone-based contact.	

What contextual or other considerations are relevant to implementing this quality practice element?

There are multiple ways in which the women's and children's safety support can be provided in relation to MBCP components working with the men. These include:

- the women's and children's safety support being provided by dedicated workers employed by the MBCP provider, situated either within and as a part of the MBCP team, or part of a different specialist DFV program area within the agency; or
- the women's and children's safety support being provided by a specialist women’s DFV agency separate to the MBCP provider.

The MBCP provider should be aware of the strengths and limitations, including challenges, of their particular arrangement and have strategies in place to meet these challenges.

Women's and children's safety support is highly challenging and nuanced work. Women's and children's safety support workers are guided by practice frameworks underpinning their women’s and children’s advocacy work. Professional development opportunities are required to support women's and children's safety support workers to enhance the application of preferred practice frameworks and to learn from new ones.

Equality in resourcing, working conditions and status between programs or program components working with men and those working with victims and survivors is crucial. Men’s workers and managers need to identify power dynamics and imbalances where they exist and work towards equality.

Women's and children's safety support provision in remote contexts is likely to require greater resourcing to enable outreach in response to difficulties, for example, in reaching (ex)partners by phone, requiring outreach.

26 The MBCP, in collaboration with specialist women's, children's and family-focused services, attempts to **assess the impact of the man's behaviour on child and family functioning** and to support child victim and survivor needs.

Indicators: What does this look like in practice?

26.A	Both the women's and children's safety support workers and men's workers take a deliberate approach towards assessing the impact of the man's patterns of behaviour on child and family functioning.	STANDARD PRACTICE
26.B	Both women's and children's safety support workers and men's workers, where possible, identify options to address the needs arising from these impacts, in relation to each child experiencing the man's violent and controlling behaviour.	
26.C	The MBCP considers risk of serious impacts on child safety, such as the risk of child homicide, or of a significant traumatic event such as child kidnap or physical injury.	STANDARD PRACTICE
26.D	The MBCP and women's and children's safety support service work to strengthen the relationship between the mother and her children, if this has been impacted by the man's use of DFV.	
26.E	The MBCP and women's and children's safety support service have close working relationships with intensive family support services and other family-focused services. In situations where these working relationships break down, the MBCP takes steps to address this.	
26.F	The MBCP and the women's and children's safety support, on a case-by-case basis, work collaboratively with other professionals involved with the family.	STANDARD PRACTICE
26.G	The women's and children's safety support and MBCP support children's access to culturally secure services that address their needs arising from the man's use of DFV.	

What contextual or other considerations are relevant to implementing this quality practice element?

Children affected by the man's use of DFV can include those living with him (biological or otherwise), those living with an ex-partner, and/or those living in extended family households.

The Safe & Together™ Model and associated processes and tools are a useful guide for how DFV services can ally with adult and child victim-survivors.[10]

Mapping perpetrator patterns of harmful behaviours, the impacts of these behaviours, and victim and survivor strengths and resistance to the violence, can inform the development of case plans for each MBCP participant.

Assessing the impact of the man's patterns of violent and controlling behaviour on child and family functioning includes considering how his behaviour harms:

- the bond and relationships between adult and child victim-survivors
- the parenting capacity of the adult victim and survivor
- the family's connections with health, educational and community services; and/or
- the family's connections with extended family, cultural, community and other informal supports.

Many fathers who use DFV, in addition to the impacts of their violent and controlling behaviours, utilise harmful parenting practices that are often centred on their own needs and preferences rather than the needs of the child.

While most or all MBCPs focus on the impacts of DFV on children, and to some extent on the victim's and survivor's parenting capacity and other aspects of family functioning, relatively few address the father's harmful parenting practices that are not fully explained by his patterns of coercive control.

Some, but not most, adolescents and young people who have experienced DFV, or other forms of complex trauma, go on to engage in adolescent to parent violence. Responding to this has some similarities, but a number of notable differences, to responding to adult use of DFV.

[10] The Safe & Together™ Model is an internationally respected approach for working with families impacted by the patterns of behaviour of users of DFV. Developed by David Mandel in the United States, it seeks to help child welfare systems to become better partners to adult and child victim-survivors and to intervene more effectively with users of violence. See: https://safeandtogetherinstitute.com/the-sti-model/model-overview/

26 The MBCP, in collaboration with specialist women's, children's and family-focused services, attempts to **assess the impact of the man's behaviour on child and family functioning** and to support child victim and survivor needs.

Indicators: What does this look like in practice?

26.H	***[aspirational]*** The MBCP and the women's and children's safety support adopt perpetrator pattern-mapping processes and tools to help assess and respond to impacts on child and family functioning.
26.I	***[aspirational]*** The MBCP and the women's and children's safety support consider and assess men's use of problematic and harmful parenting practices.
26.J	***[aspirational]*** The MBCP and the women's and children's safety support have expertise in identifying and assessing adolescent to parent violence.
26.K	***[aspirational]*** Safe and appropriate ways are identified for children and young people to be informed (by either or both parents) about their father's participation in the MBCP.
26.L	***[aspirational]*** There is a children's safety worker who works in partnership with the women's safety support worker to support, represent and advocate for children impacted by violence.

27 [First Nations element] Holistic and culturally safe and appropriate support is provided to First Nations women and children experiencing DFV.

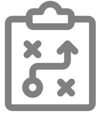
Indicators: What does this look like in practice?

27.A	The women's and children's safety support service takes a holistic approach to individual, family and community healing, within a culturally strong framework that considers the cultural, spiritual, physical, and social and emotional wellbeing needs of women and children.
27.B	Women's and children's safety support in First Nations contexts is, where possible, driven by ACCOs within a holistic child and family framework.
27.C	The women's and children's safety support service determines how it takes into account women's and children's healing needs and journeys in relation to the specific contexts of local and regional communities.
27.D	The women's and children's safety support service works within its limits concerning how it can, and cannot, contribute to women's and children's healing journeys.
27.E	***[aspirational]*** Where the women's and children's safety support service is not equipped to integrate healing work into, or alongside, support work and advocacy, the service explores other options to support the victim's and survivor's healing journey.

What contextual or other considerations are relevant to implementing this quality practice element?

The provision of women's and children's safety support should not be siloed from community efforts and initiatives to address the harms caused to families through DFV.

Considerations of healing, and healing journeys, are as important for First Nations adult and child victim-survivors as they are for First Nations men. This includes considerations of the trauma histories, loss and lateral violence experienced by women and children that might not directly stem from the violence used by the MBCP participant.



Theoretical models and curriculum development

28	The MBCP puts into practice its theoretical foundations – in terms of the processes and elements of change the program is purported to be based on – with integrity.	P42
29	The MBCP uses dialogical processes that cater to a range of learning styles, not just psychoeducation.	P43
30	The MBCP uses trauma- and violence-informed practice (TVIP) in the context of MBCP work.	P44
31	[First Nations element] The MBCP is considered and deliberate in how and why it does, or does not, integrate healing work into its program when working with First Nations communities.	P45
32	[First Nations element] First Nations participants can locate cultural strengths, cultural pride and resistance to colonisation and its impacts in the MBCP curriculum and approach to behaviour change.	P46
33	The MBCP has sufficient capability, capacity and processes in place to assess and address intimate partner sexual violence (IPSV).	P47
34	The MBCP curriculum includes a focus on jealousy and provides men with strategies to make safe and respectful choices when experiencing jealousy.	P48
35	The MBCP explores the specific impacts of violence on children, and the safety and wellbeing of children is kept in view at all times.	P49
36	The MBCP works towards secondary and tertiary desistance goals.	P50

28 The MBCP puts into practice its **theoretical foundations** – in terms of the processes and elements of change the program is purported to be based on – **with integrity**.

Indicators: What does this look like in practice?

28.A	The MBCP's model of work addresses the underlying drivers of men's choices to use DFV and supports men's motivation to stop violent and controlling behaviour and to build safety for their relationships, family and community.	STANDARD PRACTICE
28.B	The MBCP's model of work supports the development of men's accountabilities to the experiences and needs of those who his behaviour has harmed, to his own values and strivings consistent with nonviolence and, in a First Nations context, to family and community healing.	
28.C	The MBCP's intended processes and elements of DFV behaviour change, based on its theoretical foundations, are clearly articulated in a program manual.	
28.D	The MBCP's approach to men's behaviour change – as operationalised through its group-work curriculum and individual contact with each adult person using violence – is consistent with these theoretical foundations.	
28.E	Facilitators and other MBCP workers are sufficiently trained and skilled in the program's theoretical foundations and approach and critically reflect on the approach's strengths and weaknesses.	
28.F	The MBCP's supervision system considers the program's theoretical foundations and approach.	
28.G	The MBCP provider's management supports the program's theoretical foundations and approach and the implications of this approach for the agency's response to DFV across the organisation.	
28.H	The MBCP has a sufficiently detailed program guide for workers that fosters a consistent approach while maintaining flexibility and responsiveness.	
28.I	Reflective practice processes, including observation and live supervision of practice, is used to check on program integrity.	STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

Many MBCPs are a hybrid of multiple theoretical approaches to the work. The most common approaches include narrative, cognitive behavioural therapy (CBT; including "third wave" such as dialectical behaviour therapy [DBT] and acceptance and commitment therapy [ACT]), the Duluth Model,[11] trauma-informed and strengths-based approaches.

When drawing upon multiple approaches, the MBCP should not adopt "a little bit of this and a little bit of that" in an ad hoc way. Quality MBCP work is intentional in terms of the approaches it adopts and scaffolds for the behaviour change journey of the men.

Having a clear understanding and conceptualisation of the MBCP's theoretical approach is crucial, as are processes to monitor whether workers are putting into practice the approach as intended, in flexible and responsive ways. Program drift away from its intended approach to behaviour change, and to assessing, monitoring and managing risk, can occur for a variety of reasons.

[11] For more information on the Duluth Model, see: https://www.theduluthmodel.org/

29 The MBCP **uses dialogical processes that cater to a range of learning styles**, not just psychoeducation.

Indicators: What does this look like in practice?

29.A The MBCP curriculum, and the approach towards engaging the men, is based at least in part on dialogical processes. This might include invitational narrative or Duluth-structured enquiry, or other means through which participants become active agents in the learning.

29.B The MBCP adopts a mix of engagement styles, including visual concepts and prompts, movement, and opportunities for practice.

29.C Group-work processes and activities are responsive to participants' learning preferences, neurodiversity, cognitive capacities, and mental and physical health considerations.

29.D While minimising collusion with men's violence-supporting narratives, the MBCP provides space for men to talk about their lives, be listened to, and to feel that their lives and aspirations matter.

What contextual or other considerations are relevant to implementing this quality practice element?

Men generally do not change their beliefs and attitudes regarding family, relationships and violence through providing them with information or through telling them that their beliefs are wrong. Indeed, this can breed levels of resistance that can block their engagement. Space and time are required for men to discover their own motivations, beliefs, impacts and intentions.

The curriculum therefore should be designed to hold participants in a space where they collectively engage in the struggle to identify and reflect upon their beliefs, attitudes and intents that they draw upon to use violence, while simultaneously providing care for the process and for the men.

30 The MBCP uses **trauma- and violence-informed practice (TVIP)** in the context of MBCP work.

Indicators: What does this look like in practice?

30.A	MBCP workers do not await disclosure before applying the principles of TVIP,[12] especially when working with men from communities or cohorts who experience significant rates of trauma.	STANDARD PRACTICE
30.B	The MBCP has processes in place to identify when an adult person using violence might be continuing to experience ongoing traumatic experiences.	
30.C	The MBCP ensures that assessing men's shame tolerance, shame anxiety and the presence of chronic shame is a routine part of the assessment process with serious-risk adult users of DFV.	
30.D	The MBCP makes a thorough safety assessment in relation to men who have experienced complex trauma, not just of the man's propensity to use violent and controlling behaviour, but also his own living conditions.	
30.E	The MBCP actively works to avoid unintentionally triggering clients' traumatic experiences (for example, through ensuring they have choice and autonomy, providing privacy and confidentiality in physical spaces, providing predictability and consistency in how policies and procedures are applied).	
30.F	The MBCP aims to help adult persons using violence with complex trauma to identify trauma symptoms when they occur and to assist him to manage and reduce these symptoms "in the moment".	

What contextual or other considerations are relevant to implementing this quality practice element?

MBCP workers need to apply an intersectional lens when considering a man's exposure and response to trauma.

When working with First Nations participants, MBCPs need to be cognisant of the ongoing impacts of colonisation, trauma, intergenerational trauma and racism on women, men, their families and their communities.

Concepts such as shame can also manifest and may be understood differently for First Nations communities and talked about in indirect ways. Shame can be chronic, deep and reflected in people's considerable anxiety. Workers should be careful not to embarrass (in other words, cause deep shame for) First Nations men by not respecting culture or by ignoring factors such as primary language.

[12] For more information, see: Scott KL and Jenney A. Safe not soft: Trauma- and violence-informed practice with perpetrators as a means of increasing safety. *Journal of Aggression, Maltreatment & Trauma*. 2022; 32(7–8): 1088–1107. https://doi.org/10.1080/10926771.2022.2052389

31 **[First Nations element]** The MBCP is considered and deliberate in *how* and *why* it does, or does not, **integrate healing work** into its program when working with First Nations communities.

Indicators: What does this look like in practice?

31.A	The MBCP understands that behaviour change work with First Nations men occurs in the context of long-term journeys of healing, and that the former cannot be disconnected from the latter.	STANDARD PRACTICE
31.B	The MBCP understands that First Nations men's healing journeys are not separate from the healing journeys of their families nor of their communities as a whole.	
31.C	The MBCP determines how it takes into account First Nations participants' healing needs and journeys in relation to the specific contexts of local and regional communities.	
31.D	The MBCP works within its limits concerning how it can, and cannot, contribute to men's healing journeys.	
31.E	***[aspirational]*** The MBCP considers each First Nations man's specific healing needs and journeys as part of its case-planning processes. Where the MBCP is not equipped to integrate healing work into, or alongside, behaviour change work, other options to support the man "where he is at" in his healing journey are, where possible, identified.	
31.F	When an MBCP is equipped to facilitate healing work and contribute to healing journeys for the men, it considers the most appropriate means of integrating healing work with behaviour change work.	

What contextual or other considerations are relevant to implementing this quality practice element?

In First Nations contexts, the multigenerational impacts of colonisation and continued structural and systemic racialised impacts of settler colonialism intersect with cross-cultural issues of gendered power and control as fundamental drivers of DFV. As such, Aboriginal healing work can integrate with DFV-focused behaviour change work to address the root causes of men's choices to use harmful behaviour.

There is no single approach to Aboriginal healing work. This work can take many forms, depending on local histories of colonisation, dispossession and disconnection; the needs and preferences of each community and individuals who access the program; and where and how the program is situated.

The various forms of, and approaches to, healing work with First Nations men have in common the intention to address loss of identity, meaning, purpose and connection for First Nations men, in a context of multiple intersecting layers of trauma. While they might incorporate Westernised trauma-informed practice, they occur in the context of community-based healing networks and role models and incorporate community healing processes and strategies arising from local First Nations knowledge and self-determination.

It is not possible to completely separate out healing work from behaviour change work in First Nations contexts. MBCPs have indirect elements of DFV-informed First Nations healing work, for example, through the provision of social support and a program's connection to community and Country. Culturally informed healing programs, however, are distinct from MBCPs.

Who might be best positioned to support First Nations men in their healing journeys, and to address their own, their family's and their community's healing needs, will depend on the local and regional context.

Integrating healing work with behaviour change work in First Nations contexts can include, depending on what works best for the local and regional context:

- using healing work as an entry point into men's DFV behaviour change work
- having "soft, flexible edges" around the program to do healing work (e.g. through making healing-related activities available after a group-work session)
- integrating healing work more substantively into the program (e.g. facilitating group work on Country); and/or
- addressing trauma through sensitive and intensive individual healing work parallel to or after behaviour change components.

32 [First Nations element] First Nations participants can **locate cultural strengths, cultural pride and resistance to colonisation and its impacts in the MBCP curriculum** and approach to behaviour change.

Indicators: What does this look like in practice?

32.A	The MBCP curriculum and approach demonstrates consideration of how it can enable First Nations men to explore the impacts of colonisation, including intergenerational trauma and loss, and how these impacts are a driver of violence against Aboriginal women.	
32.B	The MBCP incorporates into its curriculum local and regional historical and current examples of colonisation and oppression, that the men in the program can relate to in a sensitive and informed manner.	
32.C	The MBCP curriculum and approach enables First Nations men to grapple with the problem of lateral violence and its impacts on themselves, their partners, children and the community.	
32.D	Women's experiences are centralised and placed at the forefront of the behaviour change work with First Nations men, even when exploring the impacts of colonisation, identity loss and disconnection on the men.	STANDARD PRACTICE
32.E	The MBCP curriculum and approach includes a focus on collective accountability in the contexts of men's community responsibilities and opportunities to contribute towards family and community healing.	
32.F	The MBCP uses strengths-based approaches that draw upon the cultural knowledge and ways of local and regional communities.	STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

A focus on colonisation and lateral violence does not preclude an accompanying focus on gender-based drivers of DFV. Gender-based drivers operate across all communities in similar and different ways.

When the local/regional First Nations communities prefer MBCP work to be conducted by non-Aboriginal workers, considerable thought and sensitivity is required regarding how to acknowledge and explore these issues. This exploration will need to take a different approach than in contexts where practitioners are Aboriginal.

Loss and disconnection are a recurring, painful and traumatic experience for First Nations families and communities, including for men. Disconnection from culture, Country, spirit and community does not, however, look the same for each community. MBCPs need to be guided by local and regional contexts and community experiences.

33 The MBCP has sufficient capability, capacity and processes in place to assess and address **intimate partner sexual violence (IPSV)**.

Indicators: What does this look like in practice?

33.A	The MBCP has the capacity and processes to assess IPSV, particularly through women's and children's safety support, but also through direct engagement with the adult person using violence.	STANDARD PRACTICE
33.B	MBCP workers (male and female) are supported through training, professional development and debriefing to work with issues of IPSV comfortably and skilfully.	
33.C	The MBCP curriculum seeds and builds its focus on IPSV across the program, rather than confining this focus solely to one or two dedicated sessions. Addressing IPSV is a major and continuous part of the curriculum.	STANDARD PRACTICE
33.D	***[aspirational]*** The MBCP complements the focus on IPSV via group work with individual sessions with each man that focus in part on IPSV.	
33.E	Where appropriate, the MBCP ensures issues of IPSV are included in safety planning with adult persons using violence at multiple points through the program.	

What contextual or other considerations are relevant to implementing this quality practice element?

Goals when addressing IPSV in MBCP work include assisting men to:

- explore what sexual respect entails and why it is important and to focus on the caring and connecting behaviours that help to build sexual respect
- understand and commit to their intimate partners' sexual autonomy; and
- understand the conditions required for someone to freely provide consent.

In doing so, the MBCP workers need to avoid providing serious-risk adults using DFV with new tactics that they can use to coerce their intimate partners and others into sexual activity.

Explorations of intimacy, respect, safety and consent in sex need to be explored throughout the MBCP curriculum, as it can take time for men to drop their defensiveness to the issues.

A lack of both culturally informed content and approach specific to the communities or cultural contexts that the program is operating within can inhibit further discussions of IPSV.

34 The MBCP curriculum includes a focus on **jealousy** and provides men with strategies to make safe and respectful choices when experiencing jealousy.

Indicators: What does this look like in practice?

34.A	Jealousy is recognised as a significant risk factor in ongoing risk assessments.	STANDARD PRACTICE
34.B	The MBCP focuses on jealousy and its destructive effects on relationships at multiple points across the program.	
34.C	The MBCP engages adult users of violence on strategies to make safe and respectful choices when experiencing jealousy.	
34.D	Men are supported through the program to grapple with destructive and gendered attitudes and beliefs about jealousy.	

What contextual or other considerations are relevant to implementing this quality practice element?

Jealousy is a common emotion experienced by men who choose to use DFV. It is a particularly pertinent issue in some First Nations contexts.

Jealousy can be a particularly difficult emotion to focus on during group work, as the emotional dynamic of jealousy is often one of "angry, agitated worry" that can be associated with significant rumination.

Many MBCP participants choose social violence and other DFV tactics when experiencing jealousy. However, not all use of social violence is linked to jealousy.

In some First Nations contexts, the act of "jealousing" refers to highly controlling behaviours engaged in public to punish someone for perceived infidelity.

35 The MBCP explores the **specific impacts of violence on children**, and the **safety and wellbeing of children is kept in view** at all times.

Indicators: What does this look like in practice?

35.A	The MBCP brings children's needs and experiences into view, when safe to do so, throughout group-work and individual sessions.	STANDARD PRACTICE
35.B	The MBCP does not automatically assume that each adult person using violence who is a parent or parent figure to children will be motivated to change his behaviour by appealing to the impacts on children.	
35.C	The MBCP is conscious of how some adult users of violence weaponise their role and identity as a father to control, punish or otherwise harm their (ex)partner.	STANDARD PRACTICE
35.D	The MBCP assists men to explore what their growing understanding of the impacts of DFV on children mean for commitments they can make to change their behaviour.	
35.E	The MBCP assists men to explore the vital importance of children's bond with their mother for their development and wellbeing and of supporting, rather than harming, mother-child relationships and her role as a parent.	STANDARD PRACTICE
35.F	The MBCP assists men to explore the vital importance of children's relationships with extended family and kin, with other cultural and community supports, and with services that focus on children's health and social and emotional wellbeing.	
35.G	***[aspirational]*** The MBCP provides additional program time – in the form of additional group-work sessions and/or individual sessions – for program participants who are fathers or father figures. This additional time is used to explore: • the abovementioned themes in more depth • what being a "good father" means to him • becoming more child focused rather than self-focused in his parenting • what the impacts of his violence on the children he cares for means for how he might need to parent or care for them differently • what he might be able to do to repair some of the harm he has caused to his children's emotional wellbeing, social relationships, stability and development; and • what he might be able to do to help restore a safe and nurturing environment for his children.	

What contextual or other considerations are relevant to implementing this quality practice element?

As First Nations men can be parent figures and carers for children beyond their biological children or stepchildren, engaging First Nations men as fathers can mean more than just appealing to their strivings to be the "best father they can be" to their own children. Rather, it may mean tapping into the man's broader responsibilities to act as role model for family and community healing and wellbeing.

Due to the impacts of colonisation, intergenerational trauma and loss, First Nations men's disconnection from their responsibilities as role models to children and young people can be severe. The extent, nature and patterns of disconnection in local and regional community contexts influences how men can be engaged by the MBCP in terms of their responsibilities to children.

36 The MBCP **works towards secondary and tertiary desistance goals.**

Indicators: What does this look like in practice?

36.A	The MBCP recognises that behaviour change takes time and that gains are often incremental. The MBCP provider as a whole, and the MBCP team, do not make claims about the potential effectiveness of the program that are unwarranted in relation to the particular length of the program and its power to change ingrained attitudes, beliefs and behaviours.	STANDARD PRACTICE
36.B	The MBCP has deliberate, culturally appropriate processes to work towards secondary and tertiary desistance goals and is not solely focused on primary desistance. This includes a focus on men's evolving identity in ways that might drive current and future choices to use nonviolence, build safety and engage in respectful ways of relating. It also includes a focus on how men might develop or restore connections with others who value these aspects of the man's evolving identity.	

What contextual or other considerations are relevant to implementing this quality practice element?

MBCP programs need to be of sufficient length to support behaviour change and internal accountability processes for the men. While it can be beneficial to increase program intensity (frequency of engagement contacts) for men who pose serious risk and/or who have complex needs, program length needs to be sufficient to enable men to adopt and assimilate new practices and ways of being.

Internal accountability for First Nations men can mean working with the men in the program towards their own accountability to acting nonviolently, as well as their collective accountability to their values and roles as Aboriginal men in their community as potential leaders and influencers.

For First Nations men, taking responsibility for social and emotional wellbeing is not an individualised pursuit; it can include building social and emotional health of family and kin, community, culture, Country and spirit.

Access and participation

37	The MBCP has appropriate eligibility and suitability criteria and processes.	P52
38	The willingness and motivation of each adult person using violence to participate in the program is assessed on an ongoing basis beginning with initial assessment.	P53
39	The MBCP manages waitlists carefully.	P54
40	[First Nations element] The MBCP has strategies in place to increase the likelihood of participation from First Nations men.	P55
41	The MBCP considers current evidence and quality practice regarding the use of technology in MBCP work prior to introducing this into their program.	P56

37 The MBCP has appropriate **eligibility and suitability** criteria and processes.

Indicators: What does this look like in practice?

37.A The MBCP communicates its eligibility criteria clearly to referrers.

37.B The MBCP listens to the community and is flexible about suitability criteria and referral pathways with the safety of women and children at the core of all decision-making.

37.C The MBCP does not automatically exclude a referral in situations where the man poses a particularly serious risk to victims and survivors and/or demonstrates little or no motivation to work on his behaviour. Instead, the MBCP considers multiple factors when determining whether to accept referrals in these situations, particularly focusing on what would produce most benefit for victims and survivors and how accepting the referral would fit into other agency efforts to manage the risk posed by the man.

37.D The MBCP has guidelines or processes in place so that when a man is assessed as ineligible or unsuitable for the group, they are referred to other appropriate services and their ex/partners are referred to women's services.

STANDARD PRACTICE

37.E The MBCP does not automatically deem a referral unsuitable when the adult person using violence is struggling with AOD use, poor mental health or other complex needs. Instead, the MBCP conducts a risk and needs assessment to determine if the complex needs can be addressed in parallel with the commencement of MBCP work, or if the complex needs should be stabilised first.

37.F Where an adult person using violence is deemed temporarily unsuitable for the group due to the intensity of AOD use, mental health or other complex needs, and the MBCP provider does not have the capacity to address or case manage these needs, the MBCP liaises with the referrer about what would be required for the adult to be suitable for the MBCP.

STANDARD PRACTICE

37.G ***[aspirational]*** The MBCP develops and enacts strategies to improve the program's responsiveness to cohorts that are eligible for the program, but not suited to a strictly mainstream approach. This might include GBTQ men, refugee or migrant men with limited English skills, men with significant cognitive impairment or men without neurotypical privilege.

What contextual or other considerations are relevant to implementing this quality practice element?

While the majority of men who attend MBCPs are referred by the courts and correctional services, MBCPs should accept men through a range of different pathways including accepting referrals from community members as well as self-referrals.

To facilitate self-referrals, the MBCP should create presence and awareness in the community, while maintaining safety and confidentiality for men and workers.

First Nations workers working in the DFV and related fields are often called upon 24/7 to respond to matters in their community, and as such, may have opportunities to generate referrals to the MBCP through community channels.

38 **The willingness and motivation** of each adult person using violence to participate in the program is **assessed on an ongoing basis** beginning with initial assessment.

Indicators: What does this look like in practice?

38.A	The MBCP anticipates that most men will commence the program with limited internal motivation to participate genuinely in the program. However, it does not consider men with limited internal motivation unsuitable for the program.
38.B	Motivational interviewing and enhancement strategies are incorporated within initial assessment sessions, and in the group-work curriculum, to strengthen the man's willingness and commitment to work towards change.
38.C	The MBCP monitors changes in the nature and levels of each man's motivation across his participation in the program. This monitoring influences each man's evolving case plan and is considered in ongoing risk assessment. STANDARD PRACTICE
38.D	***[aspirational]*** Additional individual sessions are available for adult persons using violence who demonstrate markedly low levels of willingness and motivation during initial assessment.

What contextual or other considerations are relevant to implementing this quality practice element?

The journey of building motivation of adults using violence, and in shifting from external to internal motivations to genuinely participate in the program and change behaviour, is a gradual, multifaceted and complex one over time. Motivation can wax and wane and factors that support enhanced motivation can co-exist with others that reduce the man's motivation to participate genuinely and to work hard to change his behaviour.

The application of overall "stages-of-change" analyses of men's readiness to change should be used cautiously. Often, men are at different stages of change with respect to different aspects of their violent and controlling behaviour; attempting to generalise across this varied readiness to assign an overall "stage" might not be meaningful or helpful.

39 The MBCP manages **waitlists** carefully.

Indicators: What does this look like in practice?

39.A	The MBCP adopts strategies to attempt to avoid the need for, or that limits the size of, waitlists. This might include modular or open entry group structures and extending the number of initial assessment sessions.
39.B	The MBCP makes periodic contact with men on waitlists, in an attempt to keep them engaged and to monitor risk. (STANDARD PRACTICE)
39.C	Women's and children's safety support is offered to (ex)partners of men on waitlists, especially in cases where men are assessed as serious risk. (STANDARD PRACTICE)
39.D	***[aspirational]*** Women's and children's safety support is offered to all eligible (ex)partners of men on waitlists.
39.E	The MBCP notifies government, the funding body and key referrers when waitlists build towards unsustainable levels, or when major changes occur in program capacity in other ways.

What contextual or other considerations are relevant to implementing this quality practice element?

Waitlists can occur at two points: a waitlist for men referred to the MBCP to be offered an initial comprehensive assessment and/or a waitlist for men who have been assessed as eligible and suitable for the MBCP to commence the group work or other main intervention component of the program.

40 **[First Nations element]** The MBCP has strategies in place to increase the **likelihood of participation from First Nations men**.

Indicators: What does this look like in practice?

40.A	MBCP workers spend time developing trusting relationships with First Nations men referred into the program.	
40.B	The MBCP develops or sources culturally safe resources to support men's understanding of program content. Metaphors and concepts are adapted for local context, culture and levels of literacy. Images and other strategies that are used to help build empathy are culturally appropriate and grounded in context.	STANDARD PRACTICE
40.C	The MBCP understands the cultural obligations of Aboriginal men and attendance will be negotiated during these times.	
40.D	The MBCP learns from local and regional communities about cultural protocols that need to be respected for men to feel safe to participate in the program and for the program to be aligned to community norms and expectations.	STANDARD PRACTICE
40.E	***[aspirational]*** The MBCP uses proactive outreach to assist men who have transport or other barriers to attend group-work and individual sessions.	

What contextual or other considerations are relevant to implementing this quality practice element?

Aboriginal men, women and families should have the option to access an MBCP run by an ACCO as well as the option of a mainstream MBCP in their context.

First Nations communities and contexts can differ significantly. What men and the broader community might need for an MBCP to be culturally safe in one context might differ significantly from another context.

Outreach to support men's participation in an MBCP, such as agency-provided transport for the men, can be highly important in regional and remote settings. Outreach through community visits can serve multiple purposes, including to maintain the visibility of the program in the community and to enable informal (but still safety-focused) conversations with participants in the program between groupwork sessions and with men who have completed or discontinued the program.

41 The MBCP considers current evidence and quality practice regarding the **use of technology in MBCP work** prior to introducing this into their program.

Indicators: What does this look like in practice?

41.A The MBCP reviews published and informal evaluations of, and guidelines for, running MBCP group-work sessions online, to inform whether and, if so, how to introduce this modality into their program.

41.B ***[aspirational]*** The MBCP considers new developments in the use of apps and other new technologies designed to assist adult users of DFV to make safe behavioural choices around family members.

What contextual or other considerations are relevant to implementing this quality practice element?

The COVID-19 pandemic significantly increased the use of online MBCPs. While most providers returned to in-person program delivery, online groups are still run in some situations where barriers for participants to attend in person are significant.

Running MBCPs online using videoconferencing software is not a "less expensive alternative" to running programs in person. The amount of planning and careful attention to a range of considerations required to run online programs safely means that they are relatively more resource intensive to run.

There are risks, disadvantages and limitations, and some advantages, to running MBCP groups online. Knowledge is starting to build regarding quality practice in running online groups safely, with some practice guidance and evaluation learnings emerging.[13]

[13] For further guidance see: Robertson E. *Discussion paper: Online perpetrator interventions.* No to Violence. 2022. Available at: https://ntv.org.au/wp-content/uploads/2022/10/NTV-Discussion-Paper_Online-Perpetrator-Interventions-2022-1-1-1.pdf

Tailoring MBCP work

42	The MBCP works towards providing a safe response to men and their families from a range of community and cultural contexts.	P58
43	The MBCP tailors approaches to participants with cognitive disability or impairment.	P59
44	[First Nations element] The MBCP tailors the program for First Nations users of violence and their families.	P60
45	The MBCP tailors responses to each program participant based on the needs of adults and children who experience his violence.	P61
46	The MBCP tailors its response to men with complex needs and who present a serious risk.	P62
47	The MBCP demonstrates some attempts to address AOD use in the context of its work.	P63
48	The approach to all adult persons using violence engaging in the MBCP is influenced by case-planning processes.	P64
49	The MBCP has capacity to provide case management sessions for those adult users of DFV who need it.	P66
50	The MBCP has some capacity to offer individual sessions and other forms of individual contact to at least some program participants, beyond those provided during initial assessment and at program exit.	P67
51	The MBCP has an approach that considers transitions after the adult person using violence has completed the program towards other forms of support that might assist him to stay committed to a path towards nonviolence.	P68

42 The MBCP works towards providing a **safe response** to men and their families **from a range of community and cultural contexts**.

Indicators: What does this look like in practice?

42.A The MBCP has a multifaceted strategy in place to improve its responsiveness to *lesbian, gay, bisexual, trans, queer and non-binary people* who use or experience DFV. This includes staff professional development and links with specialist LGBTIQ+ services to enable secondary consultations.

42.B The MBCP puts into practice strategies to improve its responsiveness to men who use DFV from *CALD, refugee or newly arrived backgrounds*. These strategies focus on developing cultural proficiency and humility at the organisational and worker levels and respectful collaboration with migrant and refugee centres, settlement services providers and ethnocultural organisations and associations.

42.C The MBCP adopts a respectful approach towards assessing how the adult person using violence might draw upon and appropriate culture and religion to support his victim-stance thinking and violence-supporting attitudes and beliefs.

42.D The MBCP demonstrates sensitivity to the oppression, trauma, collective shame and discrimination experienced by minoritised communities, and what this means for taking an intersectional approach towards working with adult users of violence from these communities. STANDARD PRACTICE

42.E ***[aspirational]*** The MBCP identifies program participants who do not have *neurotypical privilege* and, where possible, adapts aspects of program delivery to these participants.

What contextual or other considerations are relevant to implementing this quality practice element?

An understanding of intersectionality, and intersectional feminism, underpins safe responses to men and their families. Intersectionality is relevant for understanding and responding to:

- how clients and communities respond to the oppression they experience
- trauma and oppression as contributing factors to DFV
- stereotypes, biases and ethnocentric assumptions made by workers
- structural, systemic and institutional barriers towards safe access of services.

In addition to LGBTIQ+ focused services in the MBCP's jurisdiction, the MBCP can link with specialist LGBTIQ+ DFV service providers in any jurisdiction.

Cultural proficiency and cultural humility goes beyond cultural competence. It involves organisations and workers enacting an ongoing critical consciousness regarding their own cultural worldviews, lens and biases, and to reflect on what this means for becoming more open to understanding others. It also requires organisations and workers to identify privilege that comes from aspects of their own identity and location in sociopolitical dimensions of power.

Research is only emerging regarding the common and unique challenges of engaging neurodiverse adults who use DFV.

43 The MBCP tailors approaches to **participants with cognitive disability or impairment**.

Indicators: What does this look like in practice?

43.A The MBCP screens for cognitive disability or impairment in circumstances where this is suspected.[14]

43.B The MBCP adapts aspects of program delivery for participants with cognitive disability or impairment.

43.C ***[aspirational]*** The MBCP runs separate group-work sessions or processes for men with cognitive disability or impairment and/or for men who for other reasons might struggle to participate effectively in a standard group context. This might include smaller groups and other adjustments.

What contextual or other considerations are relevant to implementing this quality practice element?

There are screening tools available to assist MBCP workers to identify cognitive disability and impairment.

Innovations have recently arisen in adapting group-work and individual behaviour change approaches for this cohort.

Rates of cognitive impairment can be high among some cohorts of adult users of DFV.

The presence of cognitive disability and impairment in the adult user of violence, and/or in his (ex)partner, can raise particular considerations in the provision of women's and children's safety support.

[14] For some examples of screening tools, see: Family Safety Victoria. *MARAM Practice Guides: Guidance for professionals working with adults using family violence, Responsibility 3 Appendix 5: Screening questions for cognitive disability and acquired brain injury*. State of Victoria. 2021. https://www.vic.gov.au/maram-practice-guides-professionals-working-adults-using-family-violence/responsibility-3; and Alcohol and Drug Cognitive Enhancement (ACE) program screening and assessment tools, available at: https://aci.health.nsw.gov.au/projects/ace-program#:~:text=The%20ACE%20program%20is%20a,identify%20clients%20with%20cognitive%20impairment

44 [First Nations element] The MBCP tailors the program for First Nations users of violence and their families.

Indicators: What does this look like in practice?

44.A The MBCP takes steps to tailor the program for First Nations men and families. This may involve:

- deep listening to each man, including his journey, what matters to him and his family
- a focus on social and emotional wellbeing
- support to access the program (addressing barriers)
- to the extent possible depending on existing practitioner skillset, offering different modalities of behaviour change work such as art, role play, yarning and outside grounding work
- responsivity to men with cognitive disability or other cohorts such as the First Nations queer community
- the use of additional individual sessions to build rapport and prepare the man for the program and/or to address complex needs (for example, employment, housing, education, substance abuse); and
- developing safety plans that the men will remember, that suit their ways of learning and being in their community.

44.B The MBCP works with community correctional services and other organisations to support throughcare for Aboriginal men recently released from prison.

44.C *[aspirational]* The MBCP engages men in prison, through individual sessions, on motivational enhancement and behaviour change work that is continued post release.

What contextual or other considerations are relevant to implementing this quality practice element?

Where MBCPs delivered by mainstream providers have a focus on First Nations men and families or have a large proportion of First Nations men participants, the provider's capability to run culturally safe, sensitive and responsive programs for Aboriginal communities within its catchment area requires careful consideration.

45 The MBCP tailors responses to each program participant based on the **needs of adults and children who experience his violence.**

Indicators: What does this look like in practice?

45.A	The MBCP ensures ongoing risk and harm assessment shapes intervention goals and case plans with the man.	
45.B	Women's and children's needs and preferences are actively sought through the women's and children's safety support service, and when safe to do so, influence intervention goals and case plans with the man.	STANDARD PRACTICE
45.C	***[aspirational]*** Perpetrator pattern-mapping tools and processes are used to help identify specifically what family members need the man to stop doing, start doing, or do less or more of.	

What contextual or other considerations are relevant to implementing this quality practice element?

Each MBCP team member should be trained and supported through supervision and other capability-building processes in the Safe & Together™ Model, including in the use of perpetrator pattern-mapping processes and tools.

46 The MBCP tailors its response to **men with complex needs and who present a serious risk.**

Indicators: What does this look like in practice?

46.A The MBCP has sound risk assessment and analysis processes to identify adult users of DFV who present a serious risk to the safety and wellbeing of victim(s) and survivor(s).

46.B The MBCP conducts a risk and needs assessment through initial individual sessions with the man, initial contact with their (ex)partner through women's and children's safety support, and through information sharing with other agencies. This assessment determines the nature, significance and intensity of any complex needs that contribute towards risk and that limit the man's capacity to participate in DFV behaviour change processes.

STANDARD PRACTICE

46.C The MBCP identifies those adult users of violence who – due to posing serious risk and/or having complex needs – require a lengthier and/or more intense program response involving additional intervention components. To the extent possible, the MBCP provides these participants with a lengthier and/or more intense program than other participants.

46.C In situations of mandated referrals, when a risk, harm and needs analysis identifies that a man requires a relatively lengthy and/or intense program response and/or complex arrangements for service sequencing and coordination, the MBCP communicates this to the referrer to confer about the implications.

46.E The MBCP ensures that interventions involving direct engagement with serious-risk men are integrated with multi-agency responses that work on strategies to disrupt opportunities for violence and reduce risk. The MBCP performs an active role in contributing to the development of these multi-agency strategies through both the FSF meetings as well as through multi-agency collaboration before and after the case is considered by the FSF.

STANDARD PRACTICE

46.F ***[aspirational]*** The MBCP provides an extended and enhanced approach to participants who have a significant history of using violence in a range of situations and settings, including outside of a family context. This approach considers the interplay of both gendered and generalised violence beliefs.

46.G The MBCP addresses AOD use, mental health and other complex needs through case management approaches. Case management approaches focus on reducing the influence of these factors in limiting capacity to engage in behaviour change work and in contributing towards escalated risk.

What contextual or other considerations are relevant to implementing this quality practice element?

The proportion of program participants who could be considered to pose a serious risk to the safety of victims and survivors varies between MBCPs. In some contexts, most men in an MBCP pose this degree of risk, with several posing a very serious to severe risk. As such, managing high risk is a part of the everyday work of these programs. In other contexts, only a minority pose a serious risk.

Program participants who pose a serious risk and those who have complex needs overlap but are not identical cohorts. Some serious-risk adult users of violence do not have complex needs; similarly, not all adult users of violence with complex needs present a serious level of risk.

Tailoring program length and intensity for serious-risk adult users of violence raises complexities for referrers, funders, participants and family members in terms of MBCP providers not being able to guarantee a particular program length at the outset. These complexities need to be weighed with providing programs with insufficient longevity and power to effect change.

Dedicated, evidence-based programs focusing specifically on serious-risk adult users of violence are emerging in some Australian and overseas jurisdictions. These include The Drive Project in the United Kingdom,15 the Changing Ways program in Victoria and the Bankstown high-risk perpetrator response initiative (2021–2023) in NSW. They utilise a generalised clinical case management approach in the context of a multi-agency integrated response.

In First Nations contexts, responding to complex needs such as mental health might mean working to restore the individual's social and emotional wellbeing (that is, building the social and emotional health of the individual in the context of his connections with family and kin, community, culture, Country and spirit).

47 The MBCP demonstrates some attempts to **address AOD use** in the context of its work.

Indicators: What does this look like in practice?

47.A The MBCP addresses AOD use, when applicable, as a priority contributing factor. This could be through case managing the involvement of specialist AOD services for those participants where AOD use is an issue.

47.B The MBCP assesses the behaviours associated with the individual's substance use – not only the substance use itself – in terms of the dynamics associated with risk and harm. This includes the individual's thinking, motivation for use and behaviours associated with cravings; acquiring the substance; planning its use; withdrawal; and maintaining connections related to use.

47.C ***[aspirational]*** The MBCP co-locates some service provision with AOD services to enhance a closely collaborative response.

47.D ***[aspirational]*** The MBCP includes a module or multiple sessions within the group-work curriculum focusing on AOD use or, alternatively, this is weaved into the curriculum at multiple points.

47.E The MBCP draws upon the support of specialist AOD services, through secondary consultations and other means, to expand their capability to assess AOD use during the initial risk, harm and needs assessment.

47.F ***[aspirational]*** Secondary consultations allow MBCP workers to provide treatment of AOD issues within realistic parameters.

What contextual or other considerations are relevant to implementing this quality practice element?

The mechanisms through which substance use increases risk and harm can be varied and complex. Multiple aspects of the individual's lifestyle can be associated with patterns of coercive control.

Risk can be heightened when the victim(s) and survivor(s) is also using substances. Adult persons who use violence choose relatively more severe forms of physical violence when a victim and survivor uses substances.

For adult users of violence who also have long-term substance use, it is important to understand the function(s) that substance use has served at different stages of their life and how this might relate to experiences of complex trauma and/or the use of generalised violence.

Working collaboratively with an AOD service from the start of the man's participation in the MBCP can be crucial in some cases.

48 The approach to all adult persons using violence engaging in the MBCP is influenced by **case-planning** processes.

Indicators: What does this look like in practice?

STANDARD PRACTICE

48.A The MBCP has a sufficient intake and initial assessment phase, consisting of a sufficient number of individual sessions with the adult person using violence prior to commencing group work. These individual sessions:

- contribute towards an initial assessment of risk, harm and complex needs
- determine suitability for the adult to participate in the program
- identify how the program might need to be responsive to the adult's identity, health issues, cognitive capacity and processing, and to other considerations
- establish a working relationship with the man
- support his motivation to participate
- introduce him to the program including his responsibilities as a participant; and
- enable preliminary development of a case plan or at least some degree of tailored focus.

48.B The case plan is informed by information obtained through the women's and children's safety support service and through information sharing with other services. It reflects the ongoing risk, harm and needs analysis conducted by the MBCP, and the needs and preferences of victims and survivors who experience the impacts of the man's behaviour.

48.C The MBCP adopts two streams of the case-planning process:

1. A worker-facing stream where case plans are developed collaboratively between MBCP team members, involving, where relevant, the women's and children's safety support service. Case plans, and associated documentation, is not shown to the adult person using violence. The case plan is influenced by information provided by the victim and survivor and other sources, including worker observations and professional judgement that have not been communicated to the man. The case plan serves as a guide for workers.
2. A client-facing stream that involves collaboration with the participant through, for example, case planning with him to establish and further develop goals concerning his participation in the program. This stream of case planning is documented or represented in a way that is shared with the adult person using violence and is used directly with the client as an active intervention tool.

48.D The MBCP considers carefully which components of a worker-facing case plan are safe to share with the adult person using violence and how these case-plan goals are worded.

48.E In situations of mandated referrals, the MBCP considers whether the referrer should be provided with case plans to assist their role in engaging the man and in contributing to risk management.

What contextual or other considerations are relevant to implementing this quality practice element?

Case-planning processes can be resource intensive. However, they are central to tailoring the program to each program participant.

In situations of local court referrals, the provision of case plans to the court can assist with any processes or actions that the court can take to exercise judicial oversight over the man's change journey. All parties must be conscious, however, of the circumstances in which adult persons using violence can obtain access to court documents, including worker-facing case plans and other documentation not intended for the man to access. Such access can sometimes result in increased risk to victims and survivors.

48 The approach to all adult persons using violence engaging in the MBCP is influenced by **case-planning** processes.

Indicators: What does this look like in practice?

48.F	The MBCP gives some attention to updating or modifying both the worker-facing and client-facing streams of the plan as new information and observations come to hand.
48.G	The worker-facing and client-facing case plans are documented in sufficient ways. The client-facing plan is accessible to the man's preferred styles of learning and attuned to his language and literacy needs and preferences.
48.H	The client-facing case planning is informed by ongoing safety planning throughout the man's participation in the MBCP.
48.I	The participant's progress in relation to case-planning goals has a bearing on the program provided to him. That is: • if he is not making sufficient progress towards meeting the behavioural and attitudinal goals in the case plan, the MBCP reviews and revisits how the intervention can be adapted to make this more likely • where adaptions are not possible, or might not make a difference, the MBCP considers how to communicate to the man, victims and survivors and to key system agencies involved in managing the risk he poses, that he is not making sufficient progress in working towards the goals in his case plan.

49 The MBCP has **capacity to provide case management** sessions for those adult users of DFV who need it.

Indicators: What does this look like in practice?

49.A The MBCP adopts principles and practices of *safe and effective DFV-focused case management* with adult users of DFV.

49.B The MBCP considers how success in meeting the complex needs of an adult person using violence might increase the person's capacity to cause harm to victims and survivors.

49.C Case management goals are reviewed and modified on an ongoing basis. The MBCP anticipates how successfully addressing particular complex needs might result in new stresses and challenges for the adult person using violence that will need to be incorporated into the case plan.

49.D The MBCP develops and strengthens relationships with AOD, mental health, other health, housing and community services to enable and streamline referral options for program participants. STANDARD PRACTICE

49.E The MBCP adopts a flexible and proactive outreach approach through frequent liaison with service providers, the use of active referrals and other means to support men's attendance and participation in services that address complex needs.

What contextual or other considerations are relevant to implementing this quality practice element?

For some serious-risk adults, case plans will be mostly limited to maintaining or enhancing visibility for purposes of ongoing risk assessment and to attempting to work towards some degree of preliminary safety planning.

Service coordination can be required for men who potentially have multiple services attempting to engage him in various forms of case management.

In a First Nations context, case management can mean more than addressing particular factors that inhibit service participation and that contribute to risk. For some First Nations men, case management can be part of broader healing journeys towards taking responsibility across multiple life domains, including, depending on the local context, fulfilling cultural responsibilities and obligations. These broader journeys of reconnecting to identity, role and purpose can be supported both by individual case management elements (assisting the man to address multiple neglected areas of his life) and collective healing processes. In a First Nations context, case management can assist the man to tap into individual and collective motivation to be on a path away from using violence, through assisting him to build dignity and self-respect, and to work towards becoming a more positive influence on (if not a role model for) boys and young men in his community.

50 The MBCP has some **capacity to offer individual sessions and other forms of individual contact** to at least some program participants, beyond those provided during initial assessment and at program exit.

Indicators: What does this look like in practice?

50.A The MBCP's capacity to provide individual sessions is used strategically and prioritised for adult persons using violence who:
- pose a serious risk to victims and survivors; and/or
- have complex needs; and/or
- who are at risk of deciding to discontinue with the program.

STANDARD PRACTICE

50.B Adult users of violence who demonstrate a pattern of participating in group-work sessions in disruptive or passive ways are offered individual sessions to attempt to motivate them to participate more constructively, actively and genuinely.

50.C At least one individual session is offered to each adult person using violence approximately halfway through his participation in the program.

50.D The MBCP attempts some forms of individual contact to assess and enhance the man's motivation to genuinely participate in the program at periodical points through the program. This can include phone contacts in between group-work sessions, discussions after group-work sessions or outreach visits.

50.E Phone contacts in between group-work sessions are used selectively and where resources allow to follow-up particular issues with participants in a targeted and strategic way.

STANDARD PRACTICE

50.F *[aspirational]* Participants are offered more than two initial assessment sessions before they commence the group-work component of the program, to assist with motivating their readiness to participate in the program and to begin the process of inviting them to move away from victim stance thinking.

50.G *[aspirational]* Participants are offered individual sessions to strengthen their engagement with challenging program content, such as to focus on sexual respect and sexual violence and impacts of DFV on children. These individual sessions would be offered in close proximity to the group-work sessions focusing on these themes.

50.H The MBCP takes a deliberate and planned approach when engaging adult users of DFV in individual sessions as a replacement for group-work sessions.

STANDARD PRACTICE

50.I The MBCP applies safeguards for workers providing individual sessions so as not to fall into collusive practice. This might include audio-recording some sessions for review in supervision.

50.J Women's and children's safety support, and all other essential elements for safe and appropriate program delivery, take place when individual sessions are used as a replacement for group-work sessions for any adult person using violence.

STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

Individual sessions should only be a replacement for group work in exceptional circumstances. However, there is growing recognition that for many adult persons using violence, the provision of both group-work and individual sessions offers the greatest likelihood of achieving behaviour change outcomes.

Some First Nations men, however, might not respond to individual sessions in the same way, preferring the familiarity of the group yarn. They might prefer to commence group work at an earlier point than other men, where they have the support of group participants who have already journeyed through the program for some months. Some might also not respond as well to supplementary individual sessions run in parallel with group work.

One contact (group-work session) per week might not be sufficient intensity to affect change for some adult persons using violence. At the same time, a range of barriers can make accessing even one service activity per week difficult for some men.

51 The MBCP has an approach that considers **transitions after the adult person using violence has completed the program** towards other forms of support that might assist him to stay committed to a path towards nonviolence.

Indicators: What does this look like in practice?

51.A The MBCP enacts a deliberate strategy of stepped down support, or a "tapering off" of engagement, in the latter part of the man's participation in the program.

51.B The MBCP's stepped down support includes one or more individual exit review sessions with the adult person using violence. These sessions, in part, help to consolidate the participant's behaviour change commitments and safety-building actions, based on his journey throughout the program. STANDARD PRACTICE

51.C *[aspirational]* When a man is referred to the MBCP by a court, the man presents and explains his safety and accountability plan to the magistrate or judge as part of the court's judicial oversight of the man's participation in the MBCP.

51.D The MBCP requires mandated men, and encourages men who self-refer or participate voluntarily, to continue formally engaging with the program for at least an additional 2 to 3 months beyond the cessation of the main group-work component of the program. This participation might occur through individual sessions, phone contact, outreach to men's homes, and/or participation in a "maintenance" or ongoing support group.

51.E The MBCP supports men to engage in other options after they have completed the program, that will assist them to continue a focus on their behaviour change journey and to address issues that will support this journey.

51.F The MBCP shares information with other options/services that men are referred to after they have completed the program, so as to support those services to keep the man's behaviour in view and to reinforce behaviour change themes.

51.G *[aspirational]* The MBCP maintains periodical contact with services the man is referred to after he has formally completed engagement with the program, to enable these services to encourage the man to maintain some engagement with the program (for example, through occasional individual maintenance sessions).

51.H *[aspirational]* The MBCP conducts one or more follow-up contacts with the man several months after he has formally completed his engagement with the program.

What contextual or other considerations are relevant to implementing this quality practice element?

Many men who participate in an MBCP have little (or sometimes no) contact with family members who have been experiencing his violence during the entire period in which he is participating in the program. This is commonly due to court orders designed to protect victims and survivors by limiting contact. In many situations, these orders lapse some months after the man has completed the program. If he reunites with his family, it is only at this point where the genuine test occurs as to whether he is able to apply what he has learnt and grappled with through the program. Yet this is often at a time: months after he has completed the MBCP, where there are no service system touchpoints keeping him and his behaviour in view, and there is no engagement with him to support the application of what he learnt through the program.

Particularly in First Nations contexts, or for MBCPs in regional centres, many of the men who complete the MBCP will return to remote communities, where there are few services and limited support. The MBCP should aim to assist men with transitioning to their specific context of community life by making referrals, and where possible, support the development of community groups and services.

Safety and accountability planning is an extension of safety planning conducted with the adult person using violence throughout the program, beginning with preliminary safety planning during the initial assessment phase. Safety and accountability plans are a way to consolidate and represent the commitments that the man has made at different points in the program into a forward-facing plan.

Follow-up contacts with men can be difficult as many will not want such contact. However, it is important to attempt these as risk-related circumstances might change after they complete the program (e.g. a protection order might have expired).

Building a high-quality team

52	MBCP workers have adequate qualifications and foundational training.	P70
53	The MBCP has in place professional development plans for each worker.	P71
54	The MBCP is aware of and addresses the gender-dynamics of its team.	P72
55	The MBCP has a sufficiently developed supervision system in place.	P73
56	[First Nations element] The MBCP has an appropriate team for working with First Nations men, women and families.	P74
57	The MBCP is supported by its organisation.	P75

52 MBCP workers have adequate **qualifications and foundational training**.

Indicators: What does this look like in practice?

	Indicator	
52.A	The facilitator team consists of at least one senior facilitator with several years' experience in the provision of MBCP group work.	STANDARD PRACTICE
52.B	Emerging facilitators observe and critically reflect on at least the majority of a group-work program before they commence co-facilitation as part of a facilitator team.	STANDARD PRACTICE
52.C	Only senior facilitators, or those with an intermediate level of experience, conduct individual sessions with adult persons using violence.	STANDARD PRACTICE
52.D	Emerging facilitators without social work, psychology, behavioural sciences or equivalent undergraduate qualifications are supported by the MBCP provider agency to obtain a relevant vocational education and training (VET) or tertiary qualification.	
52.E	Workers have relevant and ongoing training and/or qualifications in intersectional feminist theory and frameworks for understanding DFV, response-based practice, application of the Safe & Together™ Model, specialist DFV training, violence- and trauma-informed practice, cultural safety, and specialist DFV risk assessment and risk management.	
52.F	The MBCP provider conducts a capability gap analysis for each worker recruited into the team. The provider identifies gaps in knowledge and skill competencies required for the role and supports the worker to eliminate these competency gaps through training, professional development, coaching and supervision.	STANDARD PRACTICE
52.G	***[aspirational]*** The MBCP workers are supported by the program provider, and by government, to obtain competency-based or subject-based qualifications specific to interventions with adult users of DFV.	
52.H	***[aspirational]*** New and emerging male MBCP workers experience MBCP work as a program participant during their initial period of learning the work.	

What contextual or other considerations are relevant to implementing this quality practice element?

It can be difficult in the case of new programs to always be able to pair an emerging facilitator with a senior one. The MBCP can consider other avenues to coach, mentor and support new staff in these situations, and to monitor and address any shortfalls in safe practice.

Implementation of the NT DFSV Workforce and Sector Development Plan is needed to build the capacity and sustainability of the workforce.

DFV workforce development needs to balance professionalisation with growing a movement that people from a variety of backgrounds can step into. Rigid rules regarding minimum qualifications can close doors to emerging workers in some communities.

Women's and children's safety support workers need to become familiar – through brief training or professional development – with the theoretical approach and model employed by the MBCP to attempt to change men's behaviour, so that they can have informed conversations with (ex)partners.

53 The MBCP has in place **professional development plans** for each worker.

Indicators: What does this look like in practice?

53.A Each MBCP worker – both men's and women's and children's safety support workers – have their own, individualised professional development plan. These plans are updated on a regular basis.

53.B Professional development plans include an analysis of the worker's capability building needs with respect to culturally safe work with people from:

- First Nations communities
- LGBTIQ+ communities
- culturally and linguistically diverse communities.

53.C Professional development for team members includes issues related to the intersection of the practitioner's gender identity and their work.

53.D Professional development is offered to women's and children's safety workers in ways that reflect the highly specialised and nuanced nature of this work.

STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

A much greater range of professional development opportunities are now available online than prior to the COVID-19 pandemic. Management should support MBCP team members to identify appropriate professional development opportunities that meet capability building goals.

54 The MBCP is aware of and addresses the **gender-dynamics of its team**.

Indicators: What does this look like in practice?

STANDARD PRACTICE

54.A MBCP group-work sessions include at least one female-identifying worker. Where this is not possible, the MBCP puts measures in place to reduce the impact of the lack of a woman in the room.

54.B Female workers in the MBCP team are supported to reach out and find solidarity with female workers from other programs and jurisdictions, to share experiences about what it means to be "the only woman in the room".

54.C Male workers in the MBCP team are encouraged to identify and reflect on their own use of male privilege and entitlement, including in their relationships with female colleagues and to contribute proactively towards gender equitable processes, structures and systems in the workplace and elsewhere.

54.D Male staff are expected and supported to be accountable to the experience of their female colleagues, particularly in terms of how male staff enact and understand gender.

54.E MBCP team leaders and managers identify work practices that create gender inequality within the team and more broadly across the organisation. Gender equitable strategies are adopted, applied sensitively and guided by the experience and wishes of staff members without male hetero-cis privilege.

What contextual or other considerations are relevant to implementing this quality practice element?

In many circumstances, it is safe and appropriate for MBCP group-work sessions to be co-facilitated by two females, if mixed-gender co-facilitation is not possible. It is generally less safe for group sessions to be run by two males: men's exclusive spaces should be avoided in this work.

Safe and potentially effective male MBCP workers should embark on their own "parallel journey" of behaviour change, identifying how to counteract their own male privilege and entitlement to understand women's and children's experiences and to become an ally to their struggles for autonomy, equality and dignity. Not doing so creates the risk that male workers will fail to model gender equality and respect to MBCP participants.

55 The MBCP has a sufficiently developed **supervision system** in place.

Indicators: What does this look like in practice?

54.A	The MBCP provider adopts a multifaceted supervision system for its MBCP workers.	STANDARD PRACTICE
54.B	The MBCP provider understands that supervision is different to management of individual workers and conducts management separately and additionally to supervision activities. External supervisors – who are highly experienced and qualified in MBCP work – might be used for this purpose.	STANDARD PRACTICE
55.C	MBCP supervision activities include: • individual clinical supervision at minimum frequency of monthly or fortnightly for less experienced workers • some opportunities for team-based, group or peer supervision • debriefing that is responsive to critical incidents or situations where staff wellbeing has been impacted.	
54.D	Supervision is offered to women's and children's safety workers and men's workers equitably.	STANDARD PRACTICE
55.E	Supervision activities incorporate, and are sensitive to, gendered issues in MBCP practice, including the unique and different challenges facing female and male workers.	STANDARD PRACTICE
55.F	Supervisors have sufficient experience and expertise both in DFV service delivery and in the provision of supervision.	STANDARD PRACTICE
55.G	Supervisors look out for signs of vicarious trauma among MBCP team members and respond in an appropriate and timely manner.	
55.H	***[aspirational]*** Observations of live practice are made of each worker by a sufficiently qualified and experienced MBCP supervisor; alternatively, group-work sessions can be recorded on a periodical basis and reviewed by the supervisor.	

What contextual or other considerations are relevant to implementing this quality practice element?

High-quality supervision is essential to promote safe and sustainable practice and for the continuous improvement of the MBCP.

Live observation of practice, or review of video-recorded practice, is highly important to engage workers in reflective practice concerning how they are implementing the intended approach to the work and the quality of their practice.

Recording of practice needs to be done carefully and in a culturally sensitive way. Many First Nations MBCP participants have been subject to video recorded scrutiny through, for example, police body cameras or prison cameras.

Many DFV workers have their own lived experience of violence. These workers should be viewed and engaged with as experts who can teach and guide those without lived experience about appropriate responses to DFV.

All First Nations MBCP workers, no matter how experienced, are understood to be on a healing journey of dignity restoration and cultural repair, in the face of the ongoing effects of colonisation and occupation of Indigenous lands and spaces.

56 [First Nations element] The MBCP has an appropriate team for working with First Nations men, women and families.

Indicators: What does this look like in practice?

56.A	The MBCP is deliberate and responsive to community preferences in their decision as to whether to use Aboriginal or non-Aboriginal workers.	STANDARD PRACTICE
56.B	Where the MBCP uses non-Aboriginal workers, it provides adequate professional development, supervision and support to enable them to work safely with First Nations people and communities.	STANDARD PRACTICE
56.C	***[aspirational]*** The MBCP draws upon Aboriginal cultural advisors or peer support workers to support non-Aboriginal workers in their work with First Nations people and communities.	
56.D	Where the MBCP uses First Nations workers, they have a process to consider whether they have good community standing.	STANDARD PRACTICE
56.E	The MBCP provider, where it is not an ACCO, demonstrates consideration of its own barriers to providing culturally safe services (e.g. by examining its own white culture and white lens) and embeds cultural safety in workplace practice, including policies and procedures.	STANDARD PRACTICE
56.F	MBCP workers demonstrate significant knowledge and understanding of the ongoing impacts of colonisation for Aboriginal and Torres Strait Islander people and the impacts of trauma. This needs to include the local history of the area they are working in, including significant local events that marked accelerated or new forms of dispossession of First Nations communities from land and culture, massacres, mission camps and Aboriginal resistance.	STANDARD PRACTICE
56.G	The MBCP engages local community advisory group/s or engages with community through other means to support staff awareness of the context of the work.	STANDARD PRACTICE
56.H	The MBCP's induction includes a component on the history of the local environment and cultural history of the area, including the additional barriers and obstacles communities may face in the context.	STANDARD PRACTICE

What contextual or other considerations are relevant to implementing this quality practice element?

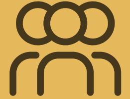
In some contexts, having MBCP facilitators who are First Nations, or from community, will not be appropriate. In other contexts, having facilitators that are First Nations might be considered essential.

DFV is both men's and women's business. Women need to have a seat at the table in program delivery.

The MBCP must be able to contextualise its practice to the particular community context in which the program operates.

MBCP workers must understand how significant local and regional events marking colonisation, dispossession and disconnection from Country, spirit, community and identity/role create ongoing trauma for Aboriginal communities and families.

57 The MBCP is **supported by its organisation.**



Indicators: What does this look like in practice?

57.A	The MBCP provider has policies and procedures in place to manage the program safely and effectively.	STANDARD PRACTICE
57.B	The MBCP provider organisation, as a whole, is DFV-informed in how it runs its range of services.	
57.C	The MBCP provider has the resources to run the program safely. This includes both men's and women's and children's safety support workers having the time and resources to conduct their work with integrity.	STANDARD PRACTICE
57.D	The MBCP provider monitors case loads and puts strategies into place to prevent long-term patterns of unsustainable work practices.	STANDARD PRACTICE
57.E	Management supports MBCP workers to engage in practices of mutual and self-care, through a social justice and ethics driven approach towards burnout prevention and sustainable practice.	
57.F	Management listens to the expertise and perspectives of its MBCP team and does not make decisions about service expansion, new funding contracts or new services without genuinely seeking their input.	
57.G	Management uses the status of senior positions to assist the MBCP team, when required, in communications with partner agencies, for example, when agencies are unresponsive to the team's request for information sharing or risk management collaboration.	STANDARD PRACTICE
57.H	Management understands the limits of its organisation in conducting work with and for Aboriginal communities. Management does not collude with the expectations of others that the organisation can start collaborating with Aboriginal communities that they have not (yet) been invited into.	

What contextual or other considerations are relevant to implementing this quality practice element?

There are many instances in Australia where small MBCP teams do not feel that they have the support of their management and are subject to decisions that limit their ability to do quality MBCP work.

There are also instances where staff struggle to find sufficient time for key elements of their roles such as to prepare for and debrief after group-work sessions, participate in regular reviews of risk and the men's progress through the program, communicate effectively with other professionals to manage risk within a multi-agency context, and participate in training and supervision activities.

Management oversight and support of staff capability and capacity to fulfill the roles required to run an MBCP safely is essential.

Monitoring and program review

58	The MBCP undertakes review activities to monitor program integrity and assist with continuous improvement of program quality.	P77
59	The MBCP undertakes or participates in program impact evaluation processes that measure medium-term outcomes.	P78
60	[First Nations element] The MBCP considers issues of Indigenous Data Sovereignty (IDS) when planning and undertaking evaluation activity.	P79

58 The MBCP undertakes **review activities** to monitor program integrity and assist with continuous improvement of program quality.

Indicators: What does this look like in practice?

58.A	The MBCP conducts regular brief reviews of the program. This review process includes information and learnings from worker perspectives on various aspects of service delivery, feedback from adult persons using violence, from victims and survivors, and from stakeholders.	STANDARD PRACTICE
58.B	The MBCP applies structured and consistent processes to obtain feedback from men and from victims and survivors participating in women's and children's safety support.	
58.C	The MBCP conducts *formal operational reviews* periodically. These have a similar focus to brief reviews, but also entail analysis of a minimum dataset (and additional data if required), disaggregated for various population cohorts to determine specific access and participant trends.	
58.D	All reviews attempt to identify opportunities to improve the program towards promoting victim and survivor safety, including through improvements in assessing, managing and monitoring risk.	STANDARD PRACTICE
58.E	The MBCP and its workers are grounded in the evidence base and constantly engage with emerging evidence. Reviews are informed by emerging evidence, identifying opportunities for continuous improvement.	
58.F	The group-work curriculum, and model of men's behaviour change practice, is reviewed regularly.	
58.G	Critical incidents that occur in program delivery trigger a review of relevant processes and procedures.	STANDARD PRACTICE
58.H	Implications arising from reviews are provided to the MBCP provider's senior management, and to the MBCP's multi-agency advisory group, for consideration.	
58.I	Learnings to improve the quality of the program are, where feasible, put into practice. Issues identified that compromise the safety of practice are responded to with priority.	STANDARD PRACTICE
58.J	***[aspirational]*** The MBCP enacts an ongoing practice management strategy through activities such as: • auditing of random samples of case files to determine if MBCP policies and procedures related to quality practice have been implemented • case study presentations to enable reflection and discussion by the whole team • review of recorded group-work and individual sessions; and/or • peer and group supervision sessions focusing on particular areas of program implementation.	

What contextual or other considerations are relevant to implementing this quality practice element?

Brief reviews are based predominantly on qualitative data and worker team perceptions, though they might include a degree of quantitative data analysis.

These should focus on trends and issues related to service access and participation for both adults using violence and for victims and survivors; collaboration between men's and women's and children's safety support practitioners; delivery and participation of specific program components; referral trends, program discontinuation and completion; complex needs; collaborative practice with other agencies; considerations related to communication with referrers and partner agencies; information sharing and risk management actions; and team functioning. Notes should be taken of patterns, trends and issues discussed, and of actions taken to adjust elements of delivery.

Brief and formal operational reviews focus mostly on process evaluation questions, to determine whether the program is being implemented as planned, and whether there are particular implementation challenges with respect to aspects of the program or with respect to referral cohorts or communities. They might also focus on immediate outcomes relating to indicators that point towards the potential for improved safety, wellbeing and space for action for victims and survivors.

Practice management strategies determine whether practice has drifted from quality or best practice and help to generate ideas for continuous improvement. Practice management strategies also facilitate peer learning across workers in the team in a supportive reflective practice environment.

59 The MBCP undertakes or participates in **program impact evaluation** processes that measure medium-term outcomes.

Indicators: What does this look like in practice?

59.A The MBCP builds upon program review processes to conduct its own internal evaluations every few years, focusing on intermediate outcomes in its program logic model.

59.B The MBCP ensures that when piloting a new or innovative approach or program, funds are set aside for an independent evaluation.

59.C The MBCP seeks to become evaluation ready before attempting an impact evaluation.

59.D ***[aspirational]*** The MBCP seeks collaborations with DFV researchers and research centres to build collaborative capacity for evaluation and research.

59.E ***[aspirational]*** The MBCP allocates resources for independent evaluation of the MBCP to examine intermediate outcomes.

What contextual or other considerations are relevant to implementing this quality practice element?

Data sovereignty and governance considerations may be relevant for MBCPs working with First Nations communities.

The Evaluation Guide: A Guide for Evaluating Behaviour Change Programs for Men Who Use Domestic and Family Violence is a key resource to assist MBCP providers when planning and conducting program evaluations.[16]

[16] Nicholas A, Ovenden G and Vlais R. *The Evaluation Guide: A guide for evaluating behaviour change programs for men who use domestic and family violence*. Sydney: ANROWS. ANROWS Insights number: 02/2020. https://www.anrows.org.au/publication/the-evaluation-guide-a-guide-for-evaluating-behaviour-change-programs-for-men-who-use-domestic-and-family-violence/

60 **[First Nations element]** The MBCP considers issues of **Indigenous Data Sovereignty (IDS)** when planning and undertaking evaluation activity.

Indicators: What does this look like in practice?

STANDARD PRACTICE

60.A	The MBCP has awareness of the legacy and ongoing harms to First Nations people of coloniser appropriation and misuse of First Nations knowledge, data and cultural heritage.
60.B	The MBCP considers how the collection, analysis, reporting and dissemination of data about First Nations people and communities might impinge upon the community's rights to exercise control over their data.
60.C	Processes of Indigenous Data Governance (IDG) are well defined so that decisions about governance of First Nations data are self-determined by First Nations communities.

What contextual or other considerations are relevant to implementing this quality practice element?

Mainstream MBCP providers have a responsibility to learn about and understand the concepts and practices of IDS and IDG. There are a growing number of First Nations research collectives and IDS and IDG consultants who can provide guidance.

Epilogue: Enabling quality MBCP practice

Implementing the quality practice elements outlined in this document cannot be the sole responsibility of program providers. Their ability to do so is inevitably influenced, enabled or hindered by a range of factors beyond the control of an individual MBCP provider.

Local conditions and contexts also influence how and to what extent the elements can realistically be put into practice. In the NT for example, some of these limiting conditions include:

- the historically late development of MBCPs in comparison to other jurisdictions. MBCPs initially commenced in South Australia and Victoria in the 1980s, and then into all other states and territories except the NT and Tasmania the following decade.[17] Outside of the Cross Border Program for remote communities in the APY Lands, the first specialist program for working with adult users of DFV was introduced into the NT in 2015 (Tangentyere Council)
- high workforce turnover and transience across the health, human and justice service sectors in the NT
- extreme remoteness of many communities in the NT
- substantial structural and systemic racism experienced by Aboriginal people and communities.

Beyond factors such as these, the ability of program providers to implement the quality practice elements is influenced by the decisions, actions and policies of funders and other key stakeholders. This includes considerations related to:

- funding
- contractual arrangements
- quality assurance supports and systems
- integrated service-system development.

Funding quality practice

Adequate funding and resources are a fundamental requirement for program providers to implement these quality practice elements.

Since their inception in the 1980s, funding for MBCPs across Australia has been largely insufficient for providers to implement many of the quality practice elements outlined in this document. In part, this is due to some of these elements emerging only over the past 10 to 15 years.[18] Other quality practice elements, however, were either firmly established or at least introduced in preliminary forms in the 1990s.[19]

Indeed, a 2017 report into the state of the MBCP field in Australia found:

> *Historically, men's behaviour change programs in Australia have operated without sufficient government funding relative to the cost of running these programs (Vlais, 2011a). This has reflected the relatively ad hoc and opportunistic development of these programs, often ahead of state government policy and commitment (Laing, 2002; Monsour, 2014).*
>
> *For many years (and continuing to a reasonable extent to this day), most program providers have needed to substantially cross-subsidise MBCP work with funding derived from other sources (Vlais, 2011a; State of Victoria, 2016). Funding for community-based, NGO-provided MBCPs has either commenced only in the last few years or is still almost non-existent in five of Australia's eight states and territories.*
>
> *This has created significant pressure for program providers to deliver programs that are safe, high quality and which meet existing minimum standards or professional practice guidelines (Day et al., 2009). The flow-on effects have included a predominantly part-time and casual workforce with low pay relative to the complexity*

[17] Mackay E, Gibson A, Lam H, et al. *Perpetrator interventions in Australia: Part one – Literature review. State of knowledge paper*. Sydney: ANROWS. ANROWS Landscapes number: PP01/2015. https://www.anrows.org.au/publication/perpetrator-interventions-in-australia/ Note: NGO-provided MBCPs did not commence in the ACT until the 2010s; however, a Corrections-run MBCP that included partner contact provided by a specialist women's DFV NGO commenced in the late 1990s. The first specialist program for DFV offenders was introduced in Tasmania in the mid 2000s.

[18] New knowledge development concerning how to improve the effectiveness of MBCPs gathered pace in the early to mid 2010s. See, for example, Minns K. *To investigate men's domestic violence behaviour change programs, particularly effective practice and integration with the criminal justice and human service systems.* Winston Churchill Memorial Trust of Australia. 2013; Vlais R. Ten challenges and opportunities for domestic violence perpetrator program work. *Ending Men's Violence Against Women and Children: The No To Violence Journal.* 2014: 86–136. https://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=4592

[19] Minimum standards for running MBCPs were first introduced, for example, in Victoria in 1995, Queensland in 1997 and Western Australia in 2000.

Epilogue: Enabling quality MBCP practice

and difficulty of the work (Vlais, 2010), creating a somewhat less than ideal environment for program delivery.

These funding constraints have significantly limited the opportunities that program providers have had to innovate and heed the calls of some stakeholders and industry experts to evolve in particular ways. Indeed, even before and independent of these external calls, MBCP coordinators and practitioners have felt a tension between what they can do given the funding environment, and what in their professional judgment they believe that they should, or at least could, be doing to make their programs as effective as possible (Vlais, 2014b).[20]

A financial cost analysis of MBCPs in Victoria in the early 2010s found that the unit cost funded by the Victorian Government to provide these programs was approximately two thirds of what was required to provide a large, urban program with elements of quality.[21] For relatively smaller programs run in rural locations, funding levels at that time met only approximately half the costs.[22] Unit cost funding has been increased by the Victorian government, and by some other Australian governments, since that time. However, it is debatable whether current funding levels in any jurisdiction would enable program providers to implement all or even most of the quality practice elements in this document, based on what we currently know is required to give these programs a strong chance of succeeding.

Unfortunately, governments often face pressure to justify committing funds to adequately fund MBCP work. This is despite recent Australian social return on investment (SROI) analyses clearly showing that,[23] due to the significant costs of DFV borne by both the community and the state, an MBCP needs only to produce positive outcomes for a small proportion of its participants to result in an overall positive return on investment.[24]

Program providers should not be held accountable for failing to implement quality practice elements if they do not have adequate funding and resources to do so. While the protests of insufficient funding can be used by providers as a reason to absolve themselves of their responsibility to attempt to find creative options to implement particular quality practice elements – or at least to meet them in spirit – they should not be expected to heavily cross-subsidise these programs to run them safely and with quality.

Contracting and service agreements that enable quality practice

As with any service, contracting in the MBCP field can have a critical impact on the ability of the service to maximise its resources and inputs towards implementing quality practice and producing desired outcomes. What is and isn't included in a service agreement shapes not only the initial service model, but also how the service is monitored by government over time. A program provider's ability to implement the quality practice elements outlined in this document can be significantly curtailed if a service agreement directly precludes certain activities required to implement an element – or if meeting particular requirements in the agreement draws away from the resources and time needed to put these elements into practice.

[20] Vlais R, Ridley S, Green D, et al. *Family and domestic violence perpetrator programs: Issues paper of current and emerging trends, developments and expectations.* Stopping Family Violence. 2017: 22. https://sfv.org.au/wp-content/uploads/2017/05/FDV-perpetrator-programs-issues-paper.pdf

[21] Based on elements of quality outlined by No to Violence at the time: see Vlais et al. (2017), ibid.

[22] Kneale J. *Running a men's behaviour change program in Australia: A financial cost analysis.* No to Violence. 2014. This analysis found that the unit cost funding for MBCP providers needed to range from – in 2014 dollars – approximately $2,800 (per program participant) for large programs in densely populated urban areas to $3,600 for relatively small rural programs. This costing analysis included some limited provision for expanded service provision (for example, to enable programs to provide additional individual sessions and some degree of case management for some participants) beyond the minimum standards as outlined by No to Violence at the time. These unit cost requirements would be a significant underestimate of what would be needed today to meet the quality practice elements outlined in this document.

[23] See Chapter 9 of Chung D, Upton-Davis K, Cordier R, et al. *Improved accountability: The role of perpetrator intervention systems*. Sydney: ANROWS. Research report number: 20/2020. https://www.anrows.org.au/publication/improved-accountability-the-role-of-perpetrator-intervention-systems/

[24] Table 9.4 of this report summarises the SROI analysis, reporting that an MBCP funded at a unit cost of $4,375 per participant (2019 dollars) would provide a positive return on investment to both the community and to the state's budget, even if the program resulted in successful outcomes in only a minority of cases.

Epilogue: Enabling quality MBCP practice

Contracting in the MBCP field faces several challenges. Contracts are often based on service targets associated with particular service activities – for example, numbers of men participating or completing an MBCP within a given period. Rigid specification of service targets can lock the provider away from innovation and developing flexible, responsive approaches towards meeting core service delivery goals.

Service agreements specify what activities are and are not to be funded under the terms of the agreement. An agreement might directly specify that particular activities do not come under the scope of the agreement and/or infer that certain activities are out of scope by virtue of omission from the contract.

If a service agreement makes it difficult for an MBCP provider to do anything other than run group-work sessions (and a limited number of individual sessions at points of intake and exit), the provider might become locked into using its highly specialised DFV resources in only this single form – that is, a single type of intervention (group-work program) that might not be fit-for-purpose for responding to particular aspects of community need. This can result in a "marriage of convenience", where a narrowly specified contract "colludes" with a program provider's hesitancy to deploy its specialised resources in more flexible and responsive ways, resulting in significant areas of community need remaining unmet.

This is particularly crucial given the need for program providers – as emphasised in the quality practice elements – to respond to dynamic DFV risk in flexible ways, centred on the needs and experiences of victims and survivors. Standard group-work approaches are a central and highly important component for most MBCPs. However, putting an adult user of DFV through a group-work program – or relying on a standard program as the sole response – might not in some circumstances be the most responsive approach to address current victim and survivor needs.

Working creatively and adaptively with partner agencies to respond to risk in tailored ways, however, takes time and resources. It also requires providers to deploy their specialised perpetrator-focused expertise and resources in a flexible manner. The time and flexibility required is not always recognised within the constraints of service agreements.

System supports for quality assurance

MBCP providers should be providing safe and potentially effective practice regardless of whether there is a formal accreditation system in place. However, an external, supportive quality assurance system can provide services with feedback and guidance to lift quality practice in their programs.

While there are examples of MBCP accreditation systems of various scale and scope internationally, there are currently no such accreditation systems in any jurisdiction in Australia for monitoring MBCP compliance with relevant minimum standards.

A review of overseas minimum standards compliance systems in the United Kingdom, United States, Canada and Aotearoa (New Zealand) found that the most robust schemes incorporated systems and processes of support for program providers to meet minimum standards.[25] Quality compliance monitoring processes were found to:

- be clear and transparent in the expectations placed on program providers
- support providers over a period of time to become accreditation ready, rather than merely expect them to be so
- be based on consistent and documented processes
- scaffold these processes through accreditation-related tools, templates and resources
- not be duplicative or overly complex and be sensitive to the time and resource requirements for providers to pass accreditation or otherwise prove compliance
- be mindful of how the accreditation system might intersect with any other auditing processes that MBCP providers are required to undergo, for example, more general human (or justice) services auditing processes based on very broad cross-sectorial service standards
- utilise accreditors or compliance monitors with experience and expertise in the delivery of MBCPs

[25] Day et al. (2019), ibid.

Epilogue: Enabling quality MBCP practice

- have a review and appeal process for program providers who do not agree with the outcomes of an accreditation-related decision or who believe that an anomaly in the process has occurred
- provide program providers with the space to demonstrate adherence to minimum standards in ways that make sense given local and cultural implementation contexts and the barriers and complexities that these contexts might raise for program provision
- enable opportunities for program providers who do not meet particular minimum standards to improve their practice and then demonstrate that they do so
- include taking a step back to focus on an organisation's capacity to sustainably provide MBCPs and other DFV perpetrator interventions, rather than only focus on the particular program
- have a defined accreditation period, after which accreditation needs to be renewed
- be based on a positive rather than punitive approach, framed as providing opportunities to support reflective practice and continuous improvement in program quality towards the safety, wellbeing and dignity of people and communities affected by men's perpetration of DFV.

At the same time, accreditation systems need to be implemented well in order to support programs in quality practice. Indeed, the review critiqued "thin" registration processes found in many US jurisdictions and (at the time of publication) in NSW, in that they:

- are implemented by government employees with little or no experience in MBCP service delivery or perpetrator intervention systems development at either a managerial or practitioner level
- provide minimal checks regarding program provider adherence and capacity to adhere to the standards
- cannot monitor program quality
- are vulnerable to discrepancies between what program providers claim to be doing through the documentation they provide and what actually happens in practice
- cannot determine how programs operate systemically and their relationships with partner agencies.

These registration processes require one-off or periodical provision of varying degrees of depth of program documentation and are characterised by the registration committee or government department having quite a "hands off" relationship with program providers. No auditing of case files or clinical practice is made; the registration/government committee only considers the program provider's written operational policies and procedures.

The review also concluded that funded service agreements as part of contractual arrangements with the respective state government serves as a poor mechanism for monitoring adherence to standards – unless the contractual body has sustainable and specific expertise in MBCP provision in the form of contract managers who can devote significant amounts of time to program provider liaison. For example, an attempt made in Victoria in 2010 to 2011 to train and equip generic government human services contract managers to monitor program provider adherence to MBCP minimum standards failed – the training and tools to enable this focus were rarely used.[26]

Program providers cannot implement quality practice elements in isolation. While providers should not be expected to rely on external monitoring and support to provide safe and potentially effective practice, an external supportive quality assurance system can provide them with feedback to lift practice in important ways.

The role of the service system in enabling quality practice

The ability of a program provider to implement the MBCP quality practice elements is significantly affected by, and reliant on, the service system that works around them.

[26] The review did, however, find successful instances of contract managers (in Alberta and Aotearoa/NZ) monitoring program provider compliance with MBCP minimum standards when drawing upon the expertise of industry experts with prior experience delivering services in the field.

Epilogue: Enabling quality MBCP practice

Perpetrator response systems need to be based on realistic expectations for what any single MBCP or other specialist perpetrator response can achieve.[27] Facilitating meaningful shifts in harmful patterns of behaviour, including patterns of coercive control that impact significantly on adult and child victim-survivor safety and wellbeing, and on family functioning as a whole, can take considerable time. For some adult users of violence, in some situations, facilitating meaningful shifts in these patterns is too much to expect from participation in any single MBCP alone. Indeed, the evidence base for the power of MBCPs as standalone, singular interventions to shift behaviour is not strong.[28]

The reputation of MBCPs is not helped by the often unrealistic expectations placed upon them. The behaviour of men who perpetrate DFV is often reinforced by peers, structural sexism and the benefits they gain from the use of gender-based power. For some, complex trauma, chronic shame and ongoing oppressive experiences of being part of a minoritised community contribute significantly to their choices to cause harm. Others exploit multiple forms of advantage and "privilege levers" over the victim and survivor to degrade, exploit, humiliate, regulate and dominate them (and their children). Realistic expectations of program success mean recognising that in many instances MBCPs facilitate incremental change.

Asking the blanket question *"Do these programs work?"* across varied cultural, cohort, service system and implementation contexts might therefore not be very helpful. Rather, it can be more appropriate to ask, *"How do these programs contribute to men's longer-term journeys towards becoming safe and accountable men?"*

In this context, program provider implementation of quality practice elements is affected by the service system around them. The ability of these programs to ally with victim and survivor efforts and struggles for safety, dignity and freedom from fear and control in their lives depends significantly on how referring agencies and other partner agencies collaborate with the MBCP. Unrealistic expectations of referrers to these programs to "fix men" can lead to a "refer and forget" approach, where referrers and other systems agencies absolve their responsibility upon the point of referral. Instead, these agencies should be collaborating with the MBCP provider towards joint responsibility in monitoring and responding to risk and towards scaffolding processes of accountability for the person causing harm.[29]

It is difficult for any program provider to work towards quality practice, and in turn, positive change if the service system around it is not DFV competent or proficient.[30] Key partner agencies – police, court personnel, corrections, child protection, family support services, health services (particularly AOD and mental health) and community-controlled advocacy organisations – need to be supported by government reforms to build capabilities in responding to people who cause DFV harm in ways that are appropriate to their role.[31] While responsibilities and opportunities to directly and indirectly engage people who cause DFV harm vary significantly across different roles (with some degree of overlap), MBCPs should not be expected to operate as isolated islands, nor to swim against the tide of DFV-destructive or -neglectful practice.

[27] Day et al. (2019), ibid; Vlais et al. (2017), ibid.

[28] Arce R, Arias E, Novo M, et al. Are interventions with batterers effective? A meta-analytical review. *Psychosocial Intervention.* 2020; 29(3): 153–164. https://doi.org/10.5093/pi2020a11; Cheng S-Y, Davis M, Jonson-Reid M, et al. Compared to what? A meta-analysis of batterer intervention studies using nontreated controls or comparisons. *Trauma, Violence, & Abuse*. 2021; 22(3): 496–511. https://doi.org/10.1177/1524838019865927; Day et al. (2019), ibid.; Travers Á, McDonagh T, Cunningham T, et al. The effectiveness of interventions to prevent recidivism in perpetrators of intimate partner violence: A systematic review and meta-analysis. *Clinical Psychology Review*. 2021; 84: Article 101974. https://doi.org/10.1016/j.cpr.2021.101974; Wilson DB, Feder L, and Olaghere A. Court-mandated interventions for individuals convicted of domestic violence: An updated Campbell systematic review. *Campbell Systematic Reviews.* 2021; 17(1): e1151. https://doi.org/10.1002/cl2.1151

[29] Centre for Innovative Justice. *Beyond "getting him to a program": Towards best practice for perpetrator accountability in the specialist family violence court context.* RMIT University. 2018. https://cij.org.au/cms/wp-content/uploads/2018/08/cor-literature-review.pdf

[30] See the following for a definition of these terms: https://safeandtogetherinstitute.com/wp-content/uploads/2020/07/JUL19-DV-Informed-Continuum-of-Practice.pdf

[31] See the Phase Two and three reports at: https://cij.org.au/research-projects/bringing-pathways-towards-accountability-together/

Glossary of Key Terms

Direct and indirect risk management:

Direct risk management concerns actions taken directly with the user of DFV that contribute towards an overall risk management approach. These types of risk management actions can include:

- motivational interviewing and enhancement work to expand his readiness to participate in a specialist behaviour change intervention and to acknowledge and work on changing his behaviour
- direct safety planning (perpetrator-focused, perpetrator-facing safety planning) to encourage him to use existing skills and supports and to help equip him with new skills and supports that he can draw upon to interrupt his usual patterns and choices to use violent and controlling behaviours
- working with him (or referring him to services) to address complex needs and contributing factors which escalate risk and which reduce his capacity to participate in behaviour change work
- specialist behaviour change work – and in the context of First Nations men, DFV-informed Aboriginal healing programs – that addresses the core drivers of the adult's use of DFV.

Indirect risk management with respect to an adult person using DFV concerns "behind-the-scenes" actions taken to contribute towards an overall risk management approach. These actions might not be safe for the adult person using violence to be aware of and do not require his consent. These risk management actions can include:

- documentation of risk concerns
- information sharing with the women's and children's safety support supporting those who are experiencing his violence and external agencies that are contributing to a collaborative risk management response
- risk review discussions involving key practitioners and services involved in managing risk
- development of a risk management plan (perpetrator-focused, professional-facing document) that pulls together intended risk management actions and strategy
- risk management actions taken by multi-agency, high-risk teams
- covert monitoring of high-risk perpetrators by police.

Eligibility and suitability:

Eligibility refers to definitive inclusion and exclusion criteria for who can be referred to a program. For example, most MBCPs will not accept referrals of men under the age of 18 years. *Suitability* refers to whether men who are eligible for the program are suitable to participate. Suitability criteria provide a second set of filters based on the initial intake and assessment process and concerns factors that might influence the likelihood of the man making change and/or his (ex)partner and children becoming safer. Someone who is eligible for the program might be assessed as unsuitable for reasons such as his complete unwillingness to participate in the program or tenuous willingness to participate with the additional presence of relevant indicators suggesting he is very unlikely to engage. It is possible for a user of violence to be unsuitable for the program at one point in time and suitable at another.

Glossary of Key Terms

Primary, secondary and tertiary desistance:

In the context of an adult person using DFV, *primary desistance* refers to the short to medium term cessation of his violent behaviour. *Secondary desistance* is about adopting a non-offending identity. That is, an individual makes fundamental changes over time to their self-identity, general ways of being in the world, his social environments and sometimes other factors in his life (for example, his area of employment or male peer cultures he participates in) to become a person fundamentally incompatible with violent offending. *Tertiary desistance* refers to where a person's new personal identity of nonviolence is valued and reflected in new and/or existing social groups and networks to which he belongs. That is, his newly evolving identity is recognised and situated among others in a "social home". Secondary and tertiary desistance goals are particularly important for serious-risk adults using DFV, including those with long histories of using violence, to achieve sustainable, long-term behaviour change. Secondary and tertiary desistance work supports the person using violence to be:

- responsive to advice, as the wellbeing of women, children and (in some circumstances, community) becomes more valued
- able to experience rewards (benefits) from the wellbeing of women, children and the community to which he belongs
- confident in his ability to make changes as goals – centred in his own prosocial internal values and ethical strivings – related to wellbeing and nonviolence are set, achieved and reviewed
- able to access support from others who view him as striving for change towards mutually valued goals
- able to view his use of violence as a previous aspect of his identity that he is striving to move away from and to take responsibility for his violence and incorporate the lessons he has learned into his new, developing identity – for example, as a partner or father
- more committed to internalised motivation to be accountable to women, children and community, rather than being "held accountable" by external forces.

Neurodiversity:

Neurodiversity is an umbrella term used to describe people who experience the world differently than others. This may be because they live with a condition such as Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Dyslexia or Tourette syndrome. Neurodiversity acknowledges the diversity in the way that people process things. The term "neurotypical" is an informal term often used in the same context to describe a person whose brain functions are considered usual or expected by society.

Appendix A: Documents reviewed

Minimum standards and professional practice standards for MBCPs reviewed

Brown C and Corbo M. *Central Australian Minimum Standards for Men's Behaviour Change Programs*. Tangentyere Council. 2020. https://genderinstitute.anu.edu.au/sites/default/files/docs/2020_docs/Central_Australian_Minimum_Standards_methodology_2020.pdf [Accessed 20th June 2024].

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Appendix A: Documents reviewed

Broader literature on quality practice in MBCPs reviewed

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Appendix A: Documents reviewed

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