ATTACHMENT "JO-1"

This is the attachment marked **"JO-1"** referred to in the witness statement of James R P Ogloff, dated 20 July 2015.

Centre for Forensic Behavioural Science

UNDERSTANDING AND RESPONDING TO COMPLEX CRIMINAL BEHAVIOUR RESULTING IN FAMILY VIOLENCE

SUBMISSION TO THE ROYAL COMMISSION ON FAMILY VIOLENCE
MAY 2015

SWINBURNE UNIVERSITY OF TECHNOLOGY

Forensicare

This document is a joint submission of the Centre for Forensic Behavioural Science, Swinburne University of Technology and the Victorian Institute of Forensic Mental Health (Forensicare).

Aknowledgements

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Executive Summary and Recommendations

This joint submission is made by Forensicare (Victorian Institute of Forensic Mental Health) and the Centre for Forensic Behavioural Science (CFBS), Swinburne University of Technology. The CFBS and Forensicare have unique expertise in the assessment, treatment, and understanding of a broad range of perpetrators, including those who engage in violence toward family members.

Family violence is pervasive in the community and this is reflected in the nature of the patients served by Forensicare. Depending upon the area of the service, between 30% to 50% of clients have an index offence that includes family violence. Forensicare and the CFBS is presently working with Victoria Police and a Medicare Local in a specialist family violence initiative. A clinical and forensic psychologist has been working on-site with the Victoria Police Family Violence Team to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. The program is being empirically evaluated by the CFBS and the preliminary findings are very promising.

Family violence is a broad phenomenon involving psychological, physical and sexual violence between partners, siblings, parents, children and more distant family members. Despite this, the family violence service sector in Victoria responds almost exclusively to adult female victims (and dependent children) and adult male perpetrators of intimate partner violence. This approach misses at least 30% of family violence situations.

Exposure to or perpetrating one form of family violence is associated with perpetrating other forms of family violence. This is not reflected in Victoria's model of service provision, which involves a range of agencies that respond to specific types of violence. A key deficiency of the current system is the lack of an integrated understanding and response to intimate partner violence, stalking, child to parent violence, severe sibling violence and child abuse and neglect. Failing to implement joint responses to these inter-related behaviours will not only leave victims and perpetrators without much needed assistance, it will mean missing important opportunities to intervene early and potentially prevent transmission of violence to future generations.

While family violence cases vary in complexity, a significant proportion of people who perpetrate family violence have multifaceted needs that are implicated in their violent behaviour. For these individuals, a brief family violence intervention focussing predominantly on gender-related attitudes and accountability – which is the type of service offered by men's change programs – is most unlikely on its own to produce longer term change in behaviour. Rather, intensive intervention programs which target the panoply of relevant risk factors are required to address cases of complex family violence. In addition, both gender-related attitudes and beliefs *and* broader criminogenic (factors relating to offending) needs must be dealt with when implementing prevention strategies. Such strategies should be tailored to the relevant risk factors in the specific case, including the dynamics within the relationship and individual needs. In the most complex cases, an increased level of service provision will be required, beyond the specific response to the family violence.

Victoria currently has no system allowing for assessment of the broad range of risk factors known to be related to family violence perpetration, or how they might interact in a specific case to increase or decrease risk. Opportunities exist to assess risk for family violence, and the related array of offence related factors (i.e., mental illness, substance misuse) at many junctures in the criminal justice system. Unfortunately, the opportunities are lost due to a failure to conduct such assessments. Agencies, such as Forensicare, which has a mandate for assessing and treating people who engage in offending and violence, are not funded to address the needs of family violence perpetrators. The only specialist family

violence intervention program, Men's Behaviour Change, has no formalised or standardised risk/needs assessment process. Requests for pre-sentence court reports to Forensicare are not routine in family violence cases. Corrections-based assessments do not routinely consider the unique context of family violence, and there is no formal referral process for more specialist, and comprehensive, forensic mental health assessment as is in place for other kinds of violent offending.

Existing programs for family violence perpetrators in Victoria do not reflect best practice in offender treatment or rehabilitation. They do not adhere to the tenets of the Risk Needs Responsivity model or other principles of evidence-based practice that have been shown to be effective in reducing recidivism. The focus of treatment and treatment intensity is not matched to the individual offender's assessed needs and a 'one size fits all' approach is provided rather than offering a range of treatment. In particular, complex offenders whose family violence is one of a range of problematic behaviours with multiple causes that include but are not limited to their attitudes towards women are not provided with sufficient treatment in the current model. Other types of offending such as general violence and sexual offending are dealt with in a far more comprehensive and evidence based way in Victoria, perhaps reflecting the fact that family violence has, tragically, long been considered to be less serious.

Despite the nature and range of family violence in the community, very few resources have been allocated to research in this area. There is a dearth of empirical evaluations of efforts made to assess and treat those involved as perpetrators or victims of family violence, and ultimately to prevent family violence. Assessment measures and intervention programs must be evaluated to determine the most effective way of responding to family violence in our community. The existing research literature is not sufficient to make this determination and investment in further rigorous evaluation is the only way to ensure that the programs implemented in Victoria are genuinely providing value for money. Ideally, such an evaluation program would identify and fund a small number of 'best-practice' assessment procedures and interventions that would be implemented in specific sites and compared on the same outcome variables (including formal records of reoffending as well as perpetrator and victim reports), with control sites that take a standard criminal justice approach. Such an evaluation would also take into account the need for more intensive treatment for higher risk perpetrators and evaluate whether increasing the intensity and adapting interventions for these offenders would effectively reduce further family violence.

Recommendations:

1. Broadening service provision for different types of family violence, and responding to the inter-related nature of family violence is essential. Specialised services are required that offer a response to the full range of family violence victimisation or perpetration, not just intimate partner violence focussing on male perpetrators and female victims. Service providers that focus on subgroups of family violence should establish formal links and referral pathways with external agencies that can provide assessment and intervention services for a comprehensive range of family violence as appropriate.

2. The identification of any form of family violence should routinely require assessment for the presence and nature of other types of family violence. This should be true regardless of the specialist nature of the service provider who might focus on responding to a particular type of family violence (e.g., Child Protection responses to abuse or neglect). Identification of multiple types of violence within a family should lead to increased service provision to the family, including appropriate intervention for anyone who perpetrates and/or is a victim of family violence.

3. The development of a recognition of a broader array of family violence situations will require training in understanding a range of family violence to a workforce that has traditionally focussed on intimate partner violence. Communication networks and services necessary to respond to different kinds of family violence will need to be developed. Additional specific funding will be required which is not available within the existing predominantly non-governmental service sector.

4. Initiatives, such as the collaboration of Victoria Police, Forensicare, and the CFBS in the provision of specialist forensic mental health services to family violence teams, should be explored and implemented as viable mechanisms for supporting and upskilling police in their work.

5. Victorian family violence policy documents need to be broadened to recognise the wide variety of contributing factors in cases of family violence so that decisions about appropriate funding for assessment and treatment services are made based on the scientific evidence-base in this area.

6. Agencies, such as Forensicare and Corrections Victoria, that already provide individual treatment aimed at ameliorating criminal behaviour, should be adequately resourced to provide services to family violence perpetrators with complex criminogenic needs both in prisons and the community.

7. A consistent and comprehensive assessment procedure is required for identifying risk and treatment needs for family violence perpetrators who are subject to agencies including Victoria Police, court services, custody, community corrections, Forensicare and other services (human service agencies, victim support services, and Men's Behaviour Change). This approach is also critical for Forensicare's court liaison service, which provides assessment of people coming before the Magistrate's Courts who are suspected of having a mental illness. An effective assessment process should act as a pivot point:
    a. To identify the range and severity of needs in the individual case
    b. To identify the most appropriate treatment services for intervention (in the community as well as in custody)
    c. To provide a baseline that can be reviewed at completion of treatment to allow for comparison and evaluation

8. The tools used within this procedure should, wherever possible, be validated and consistent with approaches in other services that respond to family violence perpetrators (e.g., crisis services, substance abuse services, mental health services). Where these services do not actively use a risk assessment tool, being able to understand the results of family violence risk assessments used by specialist violence services would be desirable.

9. There are clear service gaps for complex family violence offenders whose behaviour is caused by a range of factors including their attitudes and beliefs. A system should be implemented to routinely identify such offenders as they enter correctional services or where they present to MBC programs. Where complex, high risk offenders are identified at these gateway points, they could be referred to more intensive programs offered by specialist services that can cater to the increased level of risk and need. Forensicare would be in a position to provide enhanced services, should resources be made available.

10. Any funding provided for implementation of perpetrator intervention programs should be predicated on the completion of an evaluation of the efficacy of the program within four years

from first receiving funding. These evaluations should report not only qualitative outcomes including interviews with affected family members and perpetrators, but also provide quantitative analysis of formal records of subsequent family violence wherever possible. It is likely that funding agreements would need to specify that an agreed of proportion of funds are being provided to support this evaluation process.

11. Specific funding should be made available, perhaps via public tender, for the implementation and evaluation of a specified range of assessment and intervention approaches under the auspices of relevant government Departments (Health & Human Services and Justice and Regulation). A condition of this evaluation funding should be that a range of interventions are implemented and evaluated, including traditional perpetrator programs as well as programs that include motivational elements, couples or individual therapy, and different dosages for clients assessed to present at different levels of risk. The results of this evaluation would guide future Victorian policy direction in the provision of family violence perpetrator interventions, ensuring that public money was invested in evidence-based practices.

CFBS and Forensicare Background and Terms of Reference Addressed

This joint submission is made by Forensicare (Victorian Institute of Forensic Mental Health) and the Centre for Forensic Behavioural Science (CFBS), Swinburne University of Technology. The CFBS and Forensicare have unique expertise in the assessment, treatment, and understanding of a broad range of perpetrators, including those who engage in violence toward family members.

The Centre for Forensic Behavioural Science (CFBS), Swinburne University of Technology

The CFBS is Australasia's leading centre in the areas of forensic mental health and forensic behavioural science research, teaching and practice development. The aims of the CFBS include: understanding, predicting, and ultimately reduce offending and violence by people with mental illness or problem behaviours; and improving the legal system through empirical research and policy analysis.

Forensic behavioural science concerns the study of factors that underlie offending and human behaviour in the legal system. Forensic behavioural scientists are interested in understanding how individual characteristics interact with the environment to produce criminal behaviour, and what might be done to prevent such behaviour. Our work informs practice in the field of forensic mental health including the disciplines of psychology, psychiatry, mental health nursing, health sciences, social work, and occupational therapy. These professionals are responsible for the assessment and treatment of those who are, or have the propensity to become, mentally disordered, and whose behaviour has led, or could lead, to offending. More broadly, forensic behavioural science concerns the way in which offenders are identified and managed by law enforcement, courts and criminal justice systems. It includes both clinical and experimental approaches to understanding the legal system.

The CFBS brings together academics, clinicians, researchers and students from a variety of disciplines. The specialist areas of psychology, psychiatry, social work, law, nursing, and occupational therapy are all represented. The CFBS was original established as centre in collaboration with Monash University and Forensicare in 2006. In 2014 the CFBS relocated to Swinburne University of Technology, while still being auspiced by Forensicare. Additional relationships exist through affiliations and contracts established with industry partners, such as Victoria Police, the Adult Parole Board of Victoria, Corrections Victoria, the Department of Justice and Regulation, the Department of Health and Human Services, and international agencies and organisations.

A key focus of the Centre is to transfer academic and clinical excellence into practice in the health, community services and criminal justice sectors.

Victorian Institute of Forensic Mental Health (Forensicare)

The Victorian Institute of Forensic Mental Health, known as Forensicare, is a statutory agency that is responsible for the provision of adult forensic mental health services in Victoria. Forensicare, which was established in 1997, is governed by a Board that is accountable to the Minister for Health. In addition to providing specialist clinical services through an inpatient and community program, Forensicare is mandated (under the *Mental Health Act* 2014) to provide research, training, and professional education.

Forensicare provides inpatient, prison-based services, and community services. The research program is carried out through partnership with the Centre for Forensic Behavioural Science, Swinburne University of Technology. The inpatient program includes the 116 bed secure facility, the Thomas Embling Hospital. Prison services are provided through a 16 bed Acute Assessment Unit at the Melbourne Assessment Prison, the 20 bed Marrmak Unit at the Dame Phyllis Frost Centre, and the Mobile Forensic Mental Health Service based at the Metropolitan Remand Centre that provides in-reach mental health services to the public prisons. Forensicare's prison services also include reception

screening by senior psychiatric nurses for all male prisoners entering the Victorian prison service and the provision of visiting psychiatric services throughout the public prison system. The community service includes a variety of programs including the Problem Behaviour Program that focusses on the assessment and treatment of offenders and potential offenders whose behaviours pose a high risk to the community. Services to the courts include pre-sentence court reports and the Mental Health Court Liaison Service provides court-based assessments in seven metropolitan Magistrates' Courts. Forensicare also has a contract with the Department of Health and Human Services to provide specialist assessments for Child Protection of people who have contact with children who may be at risk for sexual offending.

In addition, Forensicare and the CFBS are presently working with Victoria Police and a Medicare Local in a specialist family violence initiative. This innovative program involves having a clinical and forensic psychologist working on site with the Victoria Police Family Violence Team in Footscray to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. The program is being empirically evaluated by the CFBS and the preliminary findings are very promising.

Forensicare was established to achieve –

- improved quality of services in forensic mental health
- increased levels of community safety
- better community awareness and understanding of mentally disordered offenders
- increased specialist skills and knowledge
- policy advice, service planning and research that contributes to the improved delivery of mental health services across the system

Terms of Reference to be addressed in the Submission

This submission considers the terms of reference about which we have specialist knowledge and in which Forensicare has a role for the delivery of specialist forensic mental health services. In particular, the following terms of reference are addressed:

> 1(b) examine and evaluate strategies, frameworks, policies, programs and services across government and local government, media, business and community organisations and establish best practice for:
>
> b. early intervention to identify and protect those at risk of family violence and prevent the escalation of family violence
>
> 2. investigate the means of having systemic responses to family violence, particularly in the legal system and by police, corrections, child protection, legal and family violence support services, including reducing re-offending and changing violent and controlling behaviours;
>
> 3. investigate how government agencies and community organisations can better integrate and coordinate their efforts; and
>
> 4. provide recommendations on how best to evaluate and measure the success of strategies, frameworks, policies, programs and services put in place to stop family violence
>
> 7. the need to identify and focus on practical short, medium and long term systemic improvements to Victoria's current response to family violence and the need for this response to be sustainable into the future;
>
> 8. the need for coordination across jurisdictions to provide the most effective response to family violence;

9. the systems and mechanisms to identify and appropriately prevent and respond to family violence, including information sharing and data systems; and

10. the expertise of professionals and academics working in the field of family violence, including any relevant international and Australian family violence research, past inquiries, reports and evaluations that may inform your inquiry and avoid unnecessary duplication.

Where relevant, recommendations are made to address the identified gaps in service delivery.

Family Violence Royal Commission Submission

The focus of this submission is on emphasising the need to recognise that family violence is broad and diverse, that many family violence perpetrators are influenced by a range of crimiongenic risk factors that extent beyond patriarchal attitudes that include power and violence, and that current assessment and service delivery systems are inadequate for those with a more complex presentation. There is a need for specialist services, such as Forensicare, to provide comprehensive assessments and treatment of complex individuals who engage in family violence, particular those who have mental illnesses. This report addresses the following areas relating to family violence: incidence, causes, assessment processes, and effective interventions.

High rates of family violence perpetration among Forensicare clients

Forensicare is in a unique position to observe and respond to the full range of family violence across our different services. As shown in the table below, 30% to 50% of clients attending a Forensicare service engaged in family violence during the index offence (excluding those seen via the specialist police family violence team). Violence against current or former partners accounts for a significant proportion of these cases: 18% of all clients across all the non-specialist family violence services and 46.5% of the victims of those who have committed an offence against a family member. Moreover, 70% of incidents within the Victoria Police Family Violence Team involve violence against current or former partners.

These figures emphasise the importance of developing comprehensive responses to violence between current and former intimate partners, but also highlight that other types of family violence account for a quarter to half of cases and also require specialist response. The potentially serious consequences of violence in non-intimate familial relationships should not be underestimated. Ninety percent of child to parent violence cases amongst forensic patients[1] resulted in the death of one or both parents. In many cases the homicide was not the first violence committed against the victim(s).

Prevalence of family violence among clients across Forensicare services, and prevalence of different relationships amongst family violence cases.

Client group	Any family violence N (%)	IPV/stalking N (%)	Child to parent violence N (%)	Parent to child violence N (%)	Other family violence N (%)
Current Forensic patients Custodial Treatment Orders	40 (44.9)	13 (32.5)	19 (38.8)	2 (5.0)	6 (15.0)
Current Forensic Patients on Non-custodial Supervision Orders	25 (35.2)	12 (40.0)	8 (32.0)	1 (4.0)	6 (25.0)
Problem Behaviour Program*	36 (36.0)	22 (61.0)	3 (8.3)	4 (11.1)	7 (19.4)
Police family violence team	323 (100)	226 (70.0)	44 (13.6)	14 (4.3)	38 (11.8)

* Random sample of 100 Problem Behaviour Program clients assessed in 2014/15

[1] Forensic patients are those persons found not guilty by reason of mental impairment under the *Crimes (Mental Impairment and Unfitness to be Tried) Act*, 1997.

Forensicare and the CFBS are presently working with Victoria Police and a Medicare Local in a specialist family violence initiative. This innovative program involves having a clinical and forensic psychologist working on site with the Victoria Police Family Violence Team in Footscray to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. The program is being empirically evaluated by the CFBS and the preliminary findings are very promising. While currently funded by Medicare Local, there is no ongoing source of funding for this innovative initiative.

The diverse and inter-connected nature of family violence

Family violence is a broad phenomenon involving psychological, physical and sexual violence between partners, siblings, parents, children and more distant family members (*Family Violence Protection Act 2008* (Vic)). Despite this, the family violence service sector in Victoria responds almost exclusively to adult female victims (and dependent children) and adult male perpetrators of intimate partner violence. Victims and perpetrators who do not fit within these categories find it difficult to access much needed assistance. The current model of service provision does not reflect the heterogeneity and the interconnected nature of different forms of family violence that has been observed in research and in our own practice at Forensicare.

Relationships between different types of family violence

Different types of family violence and abuse frequently co-occur. For example, large epidemiological studies of US men have shown that those who frequently witnessed serious male to female IPV as children were 7 times more likely to have been physically abused or neglected by a caregiver as a child and 9 times more likely to have experienced psychological abuse (Roberts et al., 2010). The frequency with which child abuse and neglect (CAN) and IPV co-occur is also strongly supported by data collected by the CFBS from Australian Coroner's Courts. In 130 cases between 2000 and 2011 in which a child was killed by their parent, IPV was definitely present in 52% (and possibly present in up to 85%). Together, these very different sources of data indicate that IPV and CAN frequently co-occur within the home, suggesting that the presence of IPV should be routinely investigated where CAN is detected, and vice versa.

Not only do IPV and CAN frequently co-occur, but experience of CAN within the family has been shown to *predict* future perpetration of IPV. This can only been examined prospectively, by following children who have been abused or neglected to determine whether proportionally more go on to commit IPV. While no such research exists in Australia, Millet and colleagues (2013) followed more than 5000 US children from childhood to their 20s, comparing adult IPV in those with formal records of CAN to those without. This study showed that for women, CAN predicted poor mental health outcomes and general violence, but not later IPV perpetration. Amongst men, experience of CAN directly predicted perpetration of adult IPV, poor mental health outcomes, substance misuse and juvenile violence. The results of this and other similar studies, indicate that effective primary prevention of child maltreatment (including neglect), may reduce a range of negative societal outcomes, including later IPV perpetration.

The relationships between other forms of family violence are less well studied and understood, however the available data does suggest that they are inter-related. In the specific area of IPV and post-relationship stalking, recent research with stalkers assessed at Forensicare and followed up via Victoria Police files showed that approximately one third of ex-intimate stalkers have had contact with police for family violence during their prior relationship with the victim.

Looking beyond violence between intimates, US figures suggest that sibling violence is actually the most common form of family violence and, like CAN, it has been linked to violence in later intimate relationships (Noland, 2004). Child to parent violence (CPV) is poorly understood, but recent and as yet unpublished research at the CFBS found that 1 in 5 university students sampled had physically abused a parent. There was a clear relationship between physical CPV and later physical IPV, with 30% of physical CPV perpetrators also physically abusing a partner, compared to only 10% of those without physical CPV.

Key points

Family violence is pervasive in the community and this is reflected in the nature of the patients served by Forensicare. Depending upon the area of the service, between 30% to 50% of clients have an index offence that includes family violence. Forensicare and the CFBS is presently working with Victoria Police and a Medicare Local in a specialist family violence initiative. A clinical and forensic psychologist has been working on-site with the Victoria Police Family Violence Team to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. The program is being empirically evaluated by the CFBS and the preliminary findings are very promising.

Exposure to or perpetrating one form of family violence is associated with perpetrating other forms of family violence. This is not reflected in Victoria's model of service provision, which involves a range of agencies that respond to specific types of violence. A key deficiency of the current system is the lack of an integrated understanding and response to IPV, stalking, CPV, severe sibling violence and child abuse and neglect. Failing to implement joint responses to these inter-related behaviours will not only leave victims and perpetrators without much needed assistance, it will mean missing important opportunities to intervene early and potentially prevent transmission of violence to future generations.

Recommendations:

1. Broadening service provision for different types of family violence, and responding to the inter-related nature of family violence is essential. Specialised services are required that offer a response to the full range of family violence victimisation or perpetration, not just intimate partner violence focussing on male perpetrators and female victims. Service providers that focus on subgroups of family violence should establish formal links and referral pathways with external agencies that can provide assessment and intervention services for a comprehensive range of family violence as appropriate.

2. Identification of any form of family violence should routinely require assessment for the presence and nature of other types of family violence. This should be true regardless of the specialist nature of the service provider who might focus on responding to a particular type of family violence (e.g., Child Protection responses to abuse or neglect). Identification of multiple types of violence within a family should lead to increased service provision to the family, including appropriate intervention for anyone who perpetrates and/or is a victim of family violence.

3. The development of a recognition of a broader array of family violence situations will require training in understanding a range of family violence to a workforce that has traditionally focussed on intimate partner violence. Communication networks and services necessary to respond to different kinds of family violence will need to be

developed. Additional specific funding will be required which is not available within the existing predominantly non-governmental service sector.

4. Initiatives, such as the collaboration of Victoria Police, Forensicare, and the CFBS in the provision of specialist forensic mental health services to family violence teams, should be explored and implemented as viable mechanisms for supporting and upskilling police in their work.

Family violence has a variety of complex causes

Social norms about gender, violence and relationships support the perpetration of violence against women at a societal level, and primary prevention efforts should be directed towards changing these social and cultural factors. These factors are clearly relevant but alone are insufficient to explain why one person engages in family violence while another in the same society, and even the same background or household, does not. It is individual and relationship-specific factors that can help to explain these differences. Linking family violence to individual and contextual risk factors is somewhat contentious due to understandable fears that such a focus might undermine attention paid to the role of misogynistic attitudes in violence against women. Such concerns must be heeded, but they should not outweigh scientific evidence that supports a link between family violence and factors such as relationship dynamics, perpetrator personality, mental illness and substance misuse.

The interpersonal dynamics within a relationship or family, in conjunction with individual factors such as anger experience and expression, and attitudes about violence, gender and relationships, are thought to be key causes of individual acts of family violence (Eckhardt & Dye, 2000; O'Leary et al., 2007). Mental illness and substance abuse also play a contributory role in some cases, just as they do in other forms of interpersonal violence (Capaldi et al., 2012). Indeed, as noted at the outset, a high percentage of Forensicare's forensic patients, who, by definition have a serious mental illness that caused their offending, engage in family violence. Contextual factors, such as age, minority status, unemployment, the pressures of parenting, homelessness and the availability (or lack) of support services also influence when and how family violence might occur (Capaldi et al., 2012). Effective, evidence-based assessment and treatment of perpetrators of family violence requires attention to all of these factors and acknowledgment of the multiply-determined nature of this behaviour.

Risk factors for perpetrating family violence

Perhaps one of the strongest risk factors for perpetrating family violence is being a victim of family violence. This is true regardless of the gender of the victim/perpetrator. Strong evidence for this relationship comes from a New Zealand epidemiological study, in which all babies born in Dunedin between 1972 and 1973 were followed for 20 years. Almost 1,000 (N=941) reported information about their intimate relationships at age 21 years, including information about IPV perpetration and victimisation. Amongst both men and women, those who reported severe IPV victimisation were 10 (women) and 19 (men) times more likely to report perpetrating severe IPV. Rates of joint perpetration and victimisation were high, accounting for 80% of men who perpetrated violence and 41% of women. The results of this rigorous study indicate that IPV perpetration and victimisation should not be assumed to be mutually exclusive and many individuals will require assistance with family violence victimisation *and* perpetration to reduce its impacts.

In the same study, those who perpetrated severe IPV reported poorer mental health and more substance misuse problems than those who did not. This relationship was stronger among men, whereby men who perpetrated severe IPV experienced higher rates of unemployment, had fewer social supports, and higher rates of polydrug use (72%) than those who did not perpetrate severe IPV (15%). They also reported more symptoms of depression and antisocial personality disorder than other participants, and were more frequently violent outside of their intimate relationships (51% vs 21%).

Many of these findings were also true for female perpetrators of severe IPV, although the between group differences were not as large.

These New Zealand data are supported by Australian research at the CFBS into family violence amongst those with severe mental illnesses (Short, Thomas, Mullen & Ogloff, 2013). Police family violence incident data from 5693 Victorians diagnosed with a psychotic illness was age and gender matched to data from 4830 Victorians randomly selected by the Australian Electoral Commission. Analyses showed that, although the majority of people with a severe mental illness did not engage in family violence (91%), people in this group were 2.5 times more likely to be a respondent in a family violence incident than those without a severe mental illness. The relationship between severe mental illness and family violence incidents was present for both women (2.2 times more likely) and men (2.4 times more likely).

Data from Forensicare's clinical files provide further evidence of the complex presentations of clients who engage in family violence. In a random sample of 100 Problem Behaviour Program (PBP) clients, one third were referred for some form of family violence. More than three quarters (78%) of these clients had a criminal history, in 68% of cases this involved a previous violent offence. Three quarters (75%) presented with problems associated with substance abuse; 58% were diagnosed with a major mental illness (psychotic disorder or major mood disorder), and 19% were diagnosed with a personality disorder. These figures strongly indicate that family violence is frequently accompanied by other forms of violence and by a range of complex risk factors and needs that require a nuanced and integrated response.

Key point

While family violence cases vary in complexity, a significant proportion of people who perpetrate family violence have multifaceted needs that are implicated in their violent behaviour. For these individuals, a brief family violence intervention focussing predominantly on gender-related attitudes and accountability – which is the type of service offered by men's change programs – is most unlikely on its own to produce longer term change in behaviour. Rather, intensive intervention programs which target the panoply of relevant risk factors are required to address cases of complex family violence. In addition, both gender-related attitudes and beliefs *and* broader criminogenic[2] needs must be dealt with when implementing prevention strategies. Such strategies should be tailored to the relevant risk factors in the specific case, including the dynamics within the relationship and individual needs. In the most complex cases, an increased level of service provision will be required, beyond the specific response to the family violence.

Recommendations:

5. Victorian family violence policy documents need to be broadened to recognise the wide variety of contributing factors in cases of family violence so that decisions about appropriate funding for assessment and treatment services are made based on the scientific evidence-base in this area.

6. Agencies, such as Forensicare and Corrections Victoria, that already provide individual treatment aimed at ameliorating criminal behaviour, should be adequately resourced to provide services to family violence perpetrators with complex criminogenic needs both in prisons and the community.

[2] Criminongenic needs are dynamic (changeable) risk factors that contribute to an individual's propensity for engaging in crime (e.g., substance misuse, violent attitudes, patriarchal attitudes).

Assessment – the key to a system that is flexible to different needs

Current Assessment Practices in Victoria

The Department of Health and Human Services (DHHS) has developed and disseminated a protocol for health and social service professionals to assess risk in family violence cases, referred to as the Common Risk Assessment Framework (CRAF; DHS, 2012). The CRAF was designed specifically to identify the presence of risk factors for future family violence and guide service provision for women who have experienced family violence *victimisation* and are presenting to health or social services. Unfortunately, the CRAF has not been empirically validated.

In addition to concerns about the lack of empirical evaluation of the CRAF, importantly, there is no equivalent common framework for identifying risk factors or service needs for men, or others, who have *perpetrated* family violence and are presenting to health, social, or criminal justice service providers. Victorian services for male perpetrators of family violence are operated, funded, and developed separately from one another, and there is no framework or shared protocol for the integration of service provision, risk assessment, or risk management. Instead, each service (e.g., mental health, drug and alcohol, community corrections, and offence-specific treatment services) has its own established protocols and focus, and there is no systematised assessment process to identify or provide a full range of individual service needs.

The Need for Comprehensive Assessment of Family Violence Perpetrators

In most other areas of offender rehabilitation, psychological theories of offending, offender typologies, risk assessment protocols, and best-practice intervention pathways are well-established in the international literature and integrated into the Victorian criminal justice system, although there is room for further improvement. Commonly, a 'triage' or screening assessment is conducted using an actuarial (mathematical) summation of known risk factors; those deemed 'low risk' are deferred to low-intensity or no intervention, and moderate- and high-risk offenders proceed to a second-tier, comprehensive assessment of risk, criminogenic need, and responsivity, then streamed into appropriate treatment pathways accordingly. This system is established on international best practice guidelines based on scientific evidence of "what works" in offender rehabilitation (Andrews & Bonta, 2006; Day et al., 2003; Ogloff & Davis, 2004).

By contrast, there is almost no reference to the principles of evidence-based practice in offender assessment and rehabilitation in the international literature or practice settings for family violence (for recent exceptions, see Corvo et al., 2008; McMaster, 2012). This is in large part due to the predominance in both academic and social service settings of explanatory theories that singularly attribute male perpetration of family violence against women and children to a gendered sense of entitlement, power and control (see, for example the 'No To Violence' website www.ntv.org.au).

Whilst this predominance has been instrumental in the international recognition of family violence as a serious social problem, and the establishment and funding of much needed services for victims and addressing perpetrators (Day et al., 2009), nevertheless, sociological feminist models have been criticised for their singular focus, failing to account for the role of individual psychosocial factors (such as mental health, substance use, personality, neurobiology, emotion, stress, and dysfunctional relationships that underpin family violence) (Corvo et al., 2008; Day et al., 2009). Moreover, social-constructionist models fail to adequately explain unique variance in offence pathways, the existence of violence committed by females, against males, or in GLBTI relationships, or the overlap between family violence and more general criminality. Moreover, the predominance of this social systems-level theory in the family violence field is at odds with the predominant explanatory theories of criminal behaviour in general, which utilise an individual-level psychological explanation (e.g., Andrews &

Bonta, 2006). Given the clear link between mental health, personality, and substance use (among other personal factors) and risk of family violence, there is a clear need for a more comprehensive understanding of how family violence develops in each case, in accordance with our understanding of violence risk in general.

Developing a better assessment system

At each stage of criminal justice processing, there are multiple opportunities for appropriate assessment of family violence perpetrators to occur, and be communicated to relevant service providers.

- Once family violence is brought to the attention of police, cases are triaged for prioritisation by specialist Family Violence Teams; however, protocols for triage and case intervention are developed locally rather than state-wide, and police capacity for intervention is often limited to law enforcement. While mental health, personality and substance use needs are often identified by police, there is no common practice for referral for more specialist assessment of these areas (except in cases of acute risk of harm under Section 351 of the *Mental Health Act, 2014)*.

- Police routinely refer male offenders to Men's Behaviour Change (MBC), the community-based Duluth-style psycho-education program for family violence perpetrators sponsored by No To Violence (NTV) and implemented locally by various non-government organisations (NGOs). There is no protocol for communication between MBC programs and other relevant community or criminal justice services, or for case-by-case referral to additional specialist services (NTV, 2015). MBC has no explicit protocol for triage of referrals or assessment of risk or treatment need (NTV, 2006; 2015), whether to determine program eligibility, risk of recidivism, or need for additional referrals such as mental health. In practice, whatever local procedures are in place are likely to vary considerably between program sites, run by different NGOs. Indeed, the MBC program philosophy explicitly states that individual, psychological-level factors such as mental health, personality disorder, or substance use *cannot* be causal of family violence (NTV, 2006; 2015), and any attempt to pursue an understanding of these factors in treatment is akin to finding excuses for violent behaviour (NTV, 2006). This simplistic view is in contrast to the scientific literature on the relationship between mental illness and violence in general (for a review and commentary, see Hodgins et al., 2001), and the importance of victim vulnerability factors in assessing risk for targeted violence in particular (e.g., Belfrage & Strand, 2008). Failing to assess these factors may have the unfortunate consequence of having an offender's criminogenic needs, and their true violence risk, being unaddressed.

- Forensicare is funded to provide mental health clinicians in seven of the metropolitan Magistrates' Courts. These clinicians provide 'front-end' assessment and triage for people who are suspected of having a mental illness. These services, if expanded and funded, would be ideal for reviewing people charged with offending in the family context who may have a mental illness.

- When individuals appear at court for family violence-related offences, Magistrates and Judges also have access to Forensicare for specialist forensic mental health assessment to assist in sentencing. Requests to Forensicare for psychiatric and psychological Court Reports where there has been a finding of guilt occur routinely for a variety of offending behaviours and psychiatric needs. However, Forensicare data suggest that this service is under-utilised for family violence matters. Moreover, this service remains unfunded for assessments where the

individual is on bail as opposed to remanded in custody, but the community is likely to be the setting of most family violence offenders prior to sentencing.

- For offenders who are remanded or bailed prior to a determination of guilt, there are few alternative options for risk assessment and offence-specific treatment due to the risks of disclosure prior to Court matters being finalised. For those on bail and still in contact with victims (and therefore at risk for further offending), this delay to service provision is concerning. Protocols need to be developed to ensure timely assessment and service provision in the highest risk period after the matter has attracted police attention but before the court is able to take any action. Intervention services that take place in this window either need formal protection for the therapeutic relationship so that treatment can be provided without being used against the perpetrator in court, or by providing risk management interventions without requiring offence disclosure. This is particularly crucial for those presenting with current serious or poorly controlled mental health, substance use, emotional regulation and substance use problems.

- Once sentenced, all offenders are now assessed by Corrections Victoria for risk of *general* offending and areas of criminogenic need, and those with violent crimes are assessed for risk of *any violence* (i.e., against anyone) and allocated to appropriate interventions accordingly. While sex offenders and stalkers are routinely diverted to specialist services to address offence-specific risk and needs, family violence offenders are not. This failure to consider the unique circumstances of family violence is problematic, because generic risk assessment measures do not consider the familial or relationship context of the offending and cannot provide a specific assessment of risk to an identified victim (i.e., risk of targeted violence). They also do not account for non-physical forms of violence that commonly co-occur with family violence (e.g., stalking, controlling behaviours, emotional abuse). For those who are on a community corrections order, those with stalking offences (but not other forms of family violence) are frequently referred to Forensicare's Problem Behaviour Program for expert assessment and treatment of stalking-related risks, but there are no similar provisions for specialist services in for custodial offenders.

- Finally, critical transition points such as completion of treatment programs, custodial release, and sentence expiry provide opportunities for updated assessments of risk, therapeutic progress, and identification of outstanding treatment needs. This occurs routinely for correctional clients; however, there is no formalised process for updated assessment or measure of therapeutic change for clients of MBC.

Key point

Victoria currently has no system allowing for assessment of the broad range of risk factors known to be related to family violence perpetration, or how they might interact in a specific case to increase or decrease risk. Opportunities exist to assess risk for family violence, and the related array of offence related factors (i.e., mental illness, substance misuse) at many junctures in the criminal justice system. Unfortunately, the opportunities are lost due to a failure to conduct such assessments. Agencies, such as Forensicare, which has a mandate for assessing and treating people who engage in offending and violence, are not funded to address the needs of family violence perpetrators. The only specialist family violence intervention program, Men's Behaviour Change, has no formalised or standardised risk/needs assessment process. Requests for pre-sentence court reports to Forensicare are not routine in family violence cases. Corrections-based assessments do not routinely consider the unique context of family violence, and there is no formal referral process for more specialist, and comprehensive, forensic mental health assessment as is in place for other kinds of violent offending.

Recommendations:

7. A consistent and comprehensive assessment procedure is required for identifying risk and treatment needs for family violence perpetrators who are subject to agencies including Victoria Police, court services, custody, community corrections, and non-correctional settings (such as those coming to the attention of human service agencies, victim support services, and MBC). This approach is also critical for Forensicare's court liaison service, which provides assessment of people coming before the Magistrate's Courts who are suspected of having a mental illness. An effective assessment process should act as a pivot point:
    - To identify the range and severity of needs in the individual case
    - To identify the most appropriate treatment services for intervention (in the community as well as in custody)
    - To provide a baseline that can be reviewed at completion of treatment to allow for comparison and evaluation
8. The tools used within this procedure should, wherever possible, be validated and consistent with approaches in other services that respond to family violence perpetrators (e.g., crisis services, substance abuse services, mental health services). Where these services do not actively use a risk assessment tool, being able to understand the results of family violence risk assessments used by specialist violence services would be desirable.

Interventions to reduce family violence – one size does not fit all

"What Works" in Offender Rehabilitation

There are now a considerable number of systematic reviews, meta-analyses and research syntheses to identify 'what works' in reducing offending in general, and violent offending in particular (e.g., Andrews et al., 1990; Dowden & Andrews, 2000; Lipsey, 1992). The results of these have led to the development of a number of principles of "evidence based practice" (EBP) that are associated with increased program effectiveness (Andrews & Bonta, 2006; Day et al., 2003; McGuire, 2001). There is also now a large empirical evidence base to support these principles, which are known as the Risk Needs Responsivity principles, and widespread agreement among researchers and commentators in the fields of criminal justice and forensic psychology that programs that adhere to these principles are more effective than those that do not (e.g., McGuire & Priestly, 1995; Ogloff & Davis, 2004).

Briefly, the Risk principle requires the intensity and offender treatment must be commensurate with the individual's level of risk, as measured by valid, reliable risk assessment tools. Higher-risk cases require more intensive and extensive services in order to effectively reduce risk, while for low-risk offenders, minimal or even no intervention is appropriate. This principle is based on considerable evidence that short-term interventions have no impact on reducing recidivism for high-risk offenders (while more intensive interventions can impact recidivism rates), while "over-treating" low-risk offenders has no effect (Andrews & Bonta, 2006).

The Need principle requires that offender rehabilitation resources must focus on those stable and acute dynamic risk factors (so-called criminogenic needs) that directly relate to risk of re-offending. By addressing these risk factors, the level of risk can be reduced. Focusing on personal needs that have no relationship to recidivism will not have any impact on reducing re-offending.

Finally, the Responsivity principle refers to the delivery of treatment programs in a style and mode that is consistent with the ability and learning style of the offender. In general, this emphasises that the

most effective treatments to bring about behaviour change are cognitive-behavioural in nature. More specifically, is the need to match treatment style, delivery and focus to the idiosyncratic characteristics of the individual (such as personality, culture, gender, age, cognition/learning style, motivation, and readiness) that may impact one's ability to respond to treatment interventions.

In practice, these principles state that the most effective programs combine the following characteristics:

- Cognitive and behavioural skills-based in orientation
- Multi-modal, focusing on a range of risk factors and skills-development
- High intensity and dosage, aimed at higher risk offenders
- Consistent in delivery, with ongoing monitoring and evaluation of program integrity and effectiveness
- Facilitated by appropriately skilled clinicians using a collaborative, respectful, non-confrontational therapeutic style to enhance treatment engagement
- Involving ongoing efforts to enhance offender readiness and motivation for behaviour change
- Manualised, but with flexibility for adaptation to the specific offender
- Adhere to the principles of risk, need and responsivity (RNR).

Family violence fits very well into the RNR principles. In particular, patriarchal attitudes of entitlement and power are seen as criminogenic needs and cultural factors that underpin some degree of acceptability of these attitudes fall into the responsivity principles. The risk principle would indicate that the level of risk and the degree of intervention required to ameliorate the risk would depend on the number and severity of risk factors present that contribute to the family violence, including, but not limited to entitlement and power.

To some extent, the philosophy underpinning the MBC programs recognises the need to address the RNR principles:

> "A case management approach to this work assumes that while men's gender-based power to entrap and coercively control an (ex)partner based on male entitlement and privilege is at the heart of their choice to use violence, other factors can contribute to making these choices 'easier', and to the severity of the tactics they choose. These factors – AOD abuse, mental health issues, problem gambling or homelessness for example – do not cause domestic and family violence, but if they are part of a perpetrator's context, they make his task of choosing non-violence more difficult. A focus on these contributing factors – or criminogenic needs in corrections terminology – is by no means sufficient to address the man's use of violence and coercive control, but can help make the pathway easier for the man to choose non-violence" Vlais (2014, p16).

Current Service Delivery in Victoria

The heterogeneity of family violence acts, causes, and contexts highlights the need for differing intensities and types of offender interventions according to the RNR model and other EBP principles. Current family violence perpetrator interventions in Victoria do not meet this need. For violent offenders in the correctional system (in custody or subject to community supervision), more intensive programs are offered by more skilled clinicians in line with RNR (greater dosage for higher risk), however these do not consider the unique relationship context of family violence, and are available only to those with lengthy sentences (at least 12 months). The community-based MBC programs provide only basic psycho-education, attitude challenging, and limited skills development, and has low minimum standards for facilitator qualifications and skill (NTV, 2006). There is no formal manual for this program, and variation in content, delivery and staff expertise across different NGOs is likely to

result in variable program integrity, reducing efficacy in preventing reoffending. Moreover, MBC programs offered in Victoria are considerably shorter than equivalent programs in many other jurisdictions, potentially under-treating some offenders (NTV, 2015). While increased program intensity is necessary for some offenders, the recent observation that MBC programs should be at least six months long for all attendees (NTV, 2015) is arbitrary and does not reflect the need to tailor offender treatment intensity to their level of risk and need. Research with generally violent offenders has shown that delivering high intensity offender treatment to low risk offenders is not only inefficient, but it can increase recidivism (Andrews & Bonta, 2013).

Both correctional and NGO programs are ill equipped to treat those very high-risk, high-need offenders with serious mental health and personality problems, and participants are typically excluded from existing groups on these grounds (e.g., in the 2011 No To Violence Men's Behaviour Change sector snapshot publication, substance abuse was cited as a common reason for finding someone unsuitable to engage in the program). Such offenders typically have difficulty engaging in treatment and require considerable pre-group efforts at building internal motivation and treatment readiness, yet both correctional and MBC programs do not have the required resources to deal adequately with complex responsivity issues. For those who do receive a variety of segregated services to meet multiple needs (i.e., offending, substance abuse, and mental health), there is no formal process for collaboration in risk management planning between the standard offender programs and specialist services.

There is some scope for individual treatment for offenders with complex mental health needs at Forensicare's community-based Problem Behaviour Program; however, this is a limited resource, and referral typically only occurs once offenders have already been deemed unsuitable for other programs. A standardised, shared and comprehensive assessment process may reduce this delay.

Contemporary Family Violence Intervention

It appears that the developments in our knowledge of "what works" in offender rehabilitation over the past 30 years have had little impact in the family violence field (Day et al., 2009). Universally, specialist domestic violence perpetrator programs do not tailor interventions according to individual level of risk, criminogenic needs, or responsivity issues. Further, little consideration is given to the therapeutic alliance, therapist skill, and treatment readiness. Instead, blanket one-size-fits-all programs of short duration (typically 12-26 weeks) provide gender-based psycho-education (rather than therapy), confrontational challenging of attitudes, and only limited scope for simple skills building. Indeed, more client-centred, empathic approaches to treatment are viewed as colluding or excusing violence (Day et al., 2009). There is growing acknowledgement by those in the family violence field that these approaches are ineffective, and even recent acknowledgement that this may be directly due to their failure to tailor interventions according to the principles of risk, need and responsivity (McMaster, 2012; Vlais 2014). Despite these recent acknowledgements, the programs in practice have not evolved.

The Need for a Systematised, Integrated, and Tiered Approach

To increase the efficacy of family violence perpetrator interventions, a review and overhaul of the current system is required. Intervention programs need to be responsive to the complex needs of the wide variety of family violence offenders. In particular, we must improve provision of specialist interventions to those with complex and serious mental, personality, and substance use disorders. There is a clear need for better integration and communication between mental health services, drug and alcohol services, and offence-specific program providers. Reflecting the principles of evidence-based offender treatment, program referral should be based on a comprehensive, integrated and systematised assessment process, with consistent program delivery and integrity across sites, and

pathways for perpetrators not catered for in existing programs (e.g., youth, female perpetrators, GLBTI perpetrators).

Programs must also be delivered in accordance with the principles of risk, need, and responsivity, and other principles of evidence-based offender treatment. Low risk offenders with fewer criminogenic needs may be suitable for brief psycho-education interventions such as that currently offered by MBC, particularly those who do demonstrate patriarchal attitudes of power and control and where this is assessed and identified to be a primary driving factor in their violence. Moderate and high-risk offenders should be streamed into more intensive and lengthy rehabilitative programs provided by staff with increased training and underpinned by a comprehensive understanding of the causes of violence, including gender-related causes. Such programs are able to address a broader range of criminogenic needs and deal with the types of responsivity issues that such offenders inevitably have (e.g., poor literacy, substance use, active symptoms of mental illness). Participation in such treatment would depending on the identified needs of the individual (thus, higher risk offenders would receive the highest dosage).

Pre-group interventions aimed to promote treatment readiness and motivation are also required. While treatment modules and approaches are expected to be similar to those generalist violence intervention programs offered by corrections currently, family violence interventions must consider the unique context of targeted family violence, and the full range of control and intimidation behaviours being employed, and ongoing issues of victim safety. It may also be appropriate in some cases to engage other family members in individual or couple-based treatment as an adjunct to a group perpetrator program, something that is not possible within existing programs.

In addition to tailoring programs according to individual risk and need, interventions must be responsive to a heterogeneous group of offenders. While it is clear that the majority of family violence perpetrators are male, and the majority of victims are their female partners, programs that *only* address this common offender type fail to meet the needs of female offenders, the GLBTI community, or those who target other family members. Specially tailored programs need to be available to meet the unique needs of these offenders, and to be sensitive to other responsivity issues such as cultural and linguistic diversity, Indigenous culture, age, cognitive and mental impairment, and gender and sexual identity. An understanding of the impact of these issues on the offending itself (for example, cultural attitudes of patriarchy, or delusions of pathological jealousy) should also inform the treatment approach.

These different levels of intervention according to complexity of risk, need, and responsivity should be offered by organisations with differing levels of expertise in the relevant areas, with those with the most serious mental health and personality disorders receiving specialist treatment from expert forensic mental health services. Availability of such services to prisoners and those with short sentences is currently limited, and consideration of sentencing alternatives may assist to broaden the accessibility of interventions to a wider range of offenders.

Key point:

Existing programs for family violence perpetrators in Victoria do not reflect best practice in offender treatment or rehabilitation. They do not adhere to the tenets of the Risk Needs Responsivity model or other principles of evidence-based practice that have been shown to be effective in reducing recidivism. The focus of treatment and treatment intensity is not matched to the individual offender's assessed needs and a 'one size fits all' approach is provided rather than offering a range of treatment. In particular, complex offenders whose family violence is one of a range of problematic behaviours with multiple causes that include but are not limited to their attitudes towards women are not provided with sufficient treatment in the current model. Other types of offending such as

general violence and sexual offending are dealt with in a far more comprehensive and evidence based way in Victoria, perhaps reflecting the fact that family violence has long been considered to be less serious.

Recommendation:

9. There are clear service gaps for complex family violence offenders whose behaviour is caused by a range of factors including their attitudes and beliefs. A system should be implemented to routinely identifying such offenders as they enter correctional services or where they present to MBC programs. Where complex, high risk offenders are identified at these gateway points, they could be referred to more intensive programs offered by specialist services that can cater to the increased level of risk and need.

Creating an evidence-base for Victorian responses to family violence

A key element of preventing family violence must be to provide effective, evidence-based interventions for perpetrators. Australia has not seen the kind of governmentally sponsored perpetrator intervention that is dominant in the United States and which has seen feminist-informed treatment approaches being mandated by law in many US states. Rather, Australian perpetrator services have largely been developed in a piecemeal way by community sector and non-governmental agencies (Monash review) over the past 25 years.

In the past five years governments have provided increased funding support to Men's Behaviour Change (MBC) programs in Victoria, leading to a proliferation of these programs under the auspices of a variety of different service providers. During this time, Forensicare has observed courts increasingly requiring male offenders to attend these programs where there are offences against family members. Partly as a consequence of increased court ordered perpetrator treatment, Forensicare is aware that there are now long waiting lists for many existing MBC Programs. The growth in funding for MBC Programs has seen a concomitant increase in training in perpetrator treatment, which is frequently provided by the organisation 'No to Violence'. This organisation emphasises a feminist explanatory model for family violence, situating violence as problem of male behaviour used to exert power and control, while victimisation is an issue exclusively faced by women and children (see No to Violence website). It should be emphasised that MBC Programs are focussing heavily on intimate partner violence and, as suggested by the name, only available to adult male perpetrators.

Evidence-base for IPV interventions

Men's Behaviour Change Programs reflect the traditional batterer intervention program approach developed in the United States in the 1970s and 80s. Such programs are grounded in feminist models of IPV, which explain violence as a consequence of the normal socialisation of males in patriarchal societies, and consequent need to exert power and control over women. Given this theoretical grounding, these programs therefore emphasise the need for education to raise awareness of patriarchal or misogynistic attitudes and behaviours, encourage personal responsibility for violent behaviour, and promote gender egalitarian attitudes and behaviours. In many cases these programs also use the principles and techniques of cognitive behavioural therapy (CBT), to try to effect change in beliefs or attitudes and address factors such as anger management, problem solving and relationship skills deficits.

The efficacy of traditional perpetrator interventions is hotly contested and has been subject to a number of wide-ranging empirical reviews over the past 20 years. In each case the reviewers have concluded that the research literature in this area is highly problematic (Gondolf, 2004; Eckhardt et al., 2013), limiting the conclusions that can be drawn. Most studies do not meet best-practice treatment evaluation standards and use non-experimental or quasi-experimental designs, meaning that it is difficult determine whether the programs actually produce any effect. Moreover, definitions of

programs vary widely between studies, making it difficult to compare results (Gondolf, 2004). In many cases active components of the program have not been sufficiently standardised or monitored, and there are limitations in the breadth of the outcomes used to assess program efficacy (Eckhardt et al 2013). Empirical evaluations have generally found small to moderate effects for traditional programs, although in most cases the authors suggest caution in interpretation due to underlying problems with the data. Eckhardt and colleagues' recent review of 30 experimental studies of IPV treatment efficacy concluded that traditional feminist-CBT programs produce a positive effect as often as they produce no effect. In practice, this means that the probability that men assigned to traditional intervention programs will engage in further IPV is no different to the probability of further IPV amongst men not assigned to such a program. They did note that traditional programs that included a motivation-enhancing element prior to the commencement of the intervention itself appear to have somewhat more positive outcomes, although there are only a few published studies using this method.

Studies using single sample quasi-experimental designs do suggest that a substantial proportion of men who attend programs such as MBC do not engage in further intimate partner violence. A recent evaluation of such programs in Western Australia concluded that those who completed a BCP reoffended less often (12.4%) than those who did not (26.8%) or those who dropped out (24.6%) (WA Attorney General's Dept, 2014). Although this is a promising initial result, there are significant caveats that must be considered when interpreting these findings. One third of those who completed treatment were lost to follow-up, compared to only one quarter of the other two groups, potentially inflating recidivism rates in the latter groups. Moreover, comparing treatment completion to drop out is problematic as drop out from offender treatment is associated with having more risk factors for reoffending (e.g. substance misuse, mental illness). Additionally, 36% of men assessed for a BPC in this study were found to be unsuitable. The reasons for this were unclear and may well have been associated with having a more complex presentation or being at higher risk. Perhaps the most significant problem with this study, however, is that family violence reoffending was combined with any violent reoffending when examining outcomes. It is possible that men who were accepted into BPC had lower overall rates of general violence, making them less likely to recidivate than other groups.

Other quasi-experimental investigations of traditional IPV intervention programs are subject to similar criticisms, in addition to having problems with sample size. A recent widely publicised study from the UK, which has been lauded as providing in "strong evidence" of the efficacy of traditional intervention programs (http://respect.uk.net/highlights-mirabal-research-findings-respect-accredited-domestic-violence-perpetrator-programmes-work/), evaluated outcomes for fewer than 100 women and only 64 men (Kelly & Westmarland, 2015 – project mirabal). Reported outcomes for these participants were impressive, with both men and women reporting reductions in physical violence and increases in positive relationship skills. However, given the absence of a comparison sample, it is difficult to determine whether these outcomes would differ for men and women who were not engaged with support and treatment services. Moreover, the final report did not include any qualitative analytic methods or quantitative statistical analyses to determine whether baseline and follow-up observations actually differed.

Perhaps the most methodologically rigorous quasi-experimental study of traditional interventions is a multi-site US study by Gondolf and colleagues (Gondolf, 2004). The authors tentatively concluded that "at least some programs are effective in stopping assault and abuse and that batterer intervention in general shows some promise" (p. 616). They also suggested that traditional intervention approaches "may be appropriate for the majority of men", but highlighted that more intensive programming is required for high risk men. Again, given the absence of a comparison sample it is difficult to determine whether reductions in reoffending in this study were greater than that observed amongst men who did not attend a program.

Some have argued that gold-standard scientific evaluation of perpetrator treatment programs are inherently biased and should not be applied to family violence interventions (see Gondolf, 2004 for discussion). While there is clearly value in research that does not take a scientific realist approach and favours qualitative methodologies, such approaches cannot produce outcomes that can be easily translated into policy outcomes or justify broad funding decisions. Funding for equivalent interventions in the areas of health and corrective services is predicated on a sufficient evidence-base to show that there is good reason to spend public money on a specific intervention. The same standards must apply to family violence interventions or the sector runs the risk of being in the unsustainable position of expending public money without any mechanism of accountability.

Interventions for other forms of family violence

Outside of IPV, there are relatively few validated intervention approaches for family violence. No validated programs for stalkers exist, although a program has been piloted at Forensicare's Problem Behaviour Program over the past three years. There are no published standardised treatments for CPV, and in Victoria children who engage in violence towards their parents can only access specific violence intervention programs if they are subject to a youth justice order. Treatment for those who sexually offend against children is available via Corrections Victoria, however this treatment program is not suitable for other forms of family violence. Violence intervention programs are offered within prisons in Victoria, however they are not tailored towards family violence specifically and is not available to all male or female offenders who may benefit from them as attendance is predicated on sentence length and prison placement.

A way forward for family violence intervention in Victoria

Part of any effective systemic response to family violence must be the provision of appropriate intervention services for perpetrators. At present the Victorian system is heavily weighted towards a single type of treatment (traditional intervention programs) for a single type of family violence (male IPV towards female victims). While commonly used around the world, there is not currently strong evidence supporting this type of program over any other type of intervention.

If Victoria intends to provide effective intervention programs for known perpetrators of family violence, the key will be to identify specific programs and evaluate them thoroughly so we can determine the most effective way of responding to family violence in our community. The existing research literature is not sufficient to make this determination and investment in further rigorous evaluation is the only way to ensure that the programs implemented in Victoria are genuinely providing value for money. Ideally, such an evaluation program would identify and fund a small number of 'best-practice' assessment procedures and interventions that would be implemented in specific sites and compared on the same outcome variables (including formal records of reoffending as well as perpetrator and victim reports), with control sites that take a standard criminal justice approach. Such an evaluation would also take into account the need for more intensive treatment for higher risk perpetrators and evaluate whether increasing the intensity and adapting interventions for these offenders would effectively reduce further family violence.

Such an evaluation would be methodologically rigorous and would require participation and cooperation between different service sectors and research groups. The CFBS has undertaken a variety of treatment program evaluations in the past, including cost benefit analyses of rehabilitation change programs.

Recommendations:

10. Any funding provided for implementation of perpetrator intervention programs should be predicated on the completion of an evaluation of the efficacy of the program within four years from first receiving funding. These evaluations should report not only qualitative outcomes including interviews with affected family members and perpetrators, but also provide quantitative analysis of formal records of subsequent family violence wherever possible. It is likely that funding agreements would need to specify that an agreed of proportion of funds are being provided to support this evaluation process.

11. Specific funding should be made available, perhaps via public tender, for the implementation and evaluation of a specified range of assessment and intervention approaches under the auspices of relevant government Departments (Health & Human Services and Justice and Regulation). A condition of this evaluation funding should be that a range of interventions are implemented and evaluated, including traditional perpetrator programs as well as programs that include motivational elements, couples or individual therapy, and different dosages for clients assessed to present at different levels of risk. The results of this evaluation would guide future Victorian policy direction in the provision of family violence perpetrator interventions, ensuring that public money was invested in evidence-based practices.

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