MONASH University

Evaluation of the TaskForce Early Intervention for Family Violence Program (U-Turn)

INTERIM REPORT

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GROUP OF EIGHT AUSTRALIA

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iii. Abbreviations and acronyms

K10	Levels of psychological distress (Kessler-10 scale)
AOD	Alcohol and Other Drugs
AFM	Affected Family Member
BIP	Batterer Intervention Programs
AUDIT	Alcohol Use Disorders Identification Test
DUDIT	Drug Use Disorders Identification Test
DV	Domestic Violence
DFV	Domestic and Family Violence
FV	Family Violence
FVIO	Family Violence Intervention Order
IPV	Intimate Partner Violence
MARAM	Family Violence Multi-Agency Risk Assessment and Management Framework
MBCP	Men's Behaviour Change Program
MGFVPC	Monash Gender and Family Violence Prevention Centre
RCFV	Royal Commission into Family Violence
U-Turn	Early Intervention for Family Violence program
Wave 1	Intake data
Wave 2	Exit data

iv. Evaluation Team

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v. Acknowledgements

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vi. Acknowledgement of Country

We acknowledge the Traditional Owners of the lands on which we meet and conduct our research, and recognise that these lands have always been places of learning. We pay respect to their Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander people continue to play in responding to domestic and family violence.

1. Background

TaskForce has designed and is currently delivering Victoria's first early intervention program (U-Turn) focused on the intersection of family violence (FV) and problematic alcohol and other drug (AOD) use for men who are potential perpetrators and who are respondents on Family Violence Intervention Orders (FVIO) in the civil space. TaskForce is running four twelve-week group-based programs throughout 2019 and 2020 for up to fourteen men per group who are recent respondents to FVIOs, who are assessed as 'group-ready', and who experience problematic AOD use issues. Participants will are being referred from Moorabbin Justice Centre, with completion of the early intervention program a condition on their FVIO.

Prior to program entry, participants are being assessed for risk and eligibility. Those who are ineligible for this intervention group are being referred into more suitable programs. Following assessment, participants join a three-week orientation group prior to commencing the 12-week group-based intervention program. Topics to be covered include harm reduction, the relationship between AOD and FV, the gendered nature of FV, the impacts of violence on women, children and the community, respectful communication (post-separation), emotional regulation and basic legal education (with regard to understanding and complying with FVIOs including any possible variations to the FVIO).

Informed by feminist theory and behaviour change and AOD harm minimisation principles, U-Turn ensures that men are visible and accountable for their actions, and that women and families are kept safe.

2. Evaluation Methodology

The Monash Gender and Family Violence Prevention Centre (MGFVPC) has been contracted by TaskForce to undertake the evaluation of four rounds of the U-Turn program between February 2019 and February 2021.

2.1 Evaluation approach and deliverables

This section outlines the evaluation questions, data collection process, and the participants. Wider demographics represent Round 1 and Round 2 participants of the 2019 Victorian pilot of the U-Turn program and include those participants at the beginning (Wave 1) and conclusion (Wave 2) of the program. Program rounds 3 and 4 are due to start in March and are discussed further in the 'Progress Update'.

The valuation examines the suitability and effectiveness of the U-Turn program, a combined AOD and FV intervention delivered by TaskForce aimed at preventing subsequent violence, including breaches of FVIOs. The broad approach to the evaluation is to gather information on the effectiveness of the program using surveys, interviews, and focus groups. Quantitative data is collected from program participants and affected family members (AFMs) at the time of men's program entry (Wave 1) and exit (Wave 2). In addition, a qualitative interview component is conducted with participants of the U-Turn program and AFMs at Wave 2. Further, qualitative feedback has been captured from key stakeholders in justice, mental health, FV and AOD services to examine the need for combined interventions in the FV and AOD space along with key benefits and challenges to consider when

combining such interventions. Evaluation data collection commenced in June 2019 and is ongoing until the conclusion of group 4.

2.2 Research questions

This evaluation draws on the following research questions:

a) What is the need for combined interventions?
b) What are some of the perceived benefits of combined interventions?
c) What are some of the challenges in delivering combined interventions?
d) Do combined interventions increase family safety?
e) Do combined interventions assist men to manage their AOD use and behaviour change in relation to FV?
f) Do combined interventions keep men who are subject to FVIOs out of the criminal justice system?

2.3 Data collection

Several data sources are being used throughout the life of the project. Data collection instruments fall under the following categories:

- Surveys,
- Group observations,
- Interviews,
- Focus groups.

2.3.1 Surveys

A range of measures were administered to group 1 and 2 participants of the U-Turn program at Wave 1 between 17th October 2019 and 19th February 2020. Data collection with groups 3 and 4 is yet to commence. Measures include scales on *levels of psychological distress (K10),* and *AOD intake assessments,* administered by TaskForce staff as part of the intake assessment. Where U-Turn participants provided written consent for their intake assessment data to be used for evaluation purposes, this data has been passed on to the MGFVPC team and has been incorporated in the data analysis. K10 measures are also administered at Wave 2 along with the follow up/exit interview conducted with group participants. All exit interviews are conducted at TaskForce with support services on hand to minimise any effects that may arise during the course of data collection. AFM surveys and interviews were conducted over the phone. Here, the researcher checked in with the participant and asked whether each research participant would like to receive a follow up support call from the family safety contact worker.

Group 1 and 2 surveys with AFMs took place between 30th August and 13th December 2019. Wave 1 surveys were administered around week 2 of the U-Turn program and Wave 2 surveys occurred at, or near, the completion of the program. This survey included a series of questions about AFM's experiences of FV to examine improvement over the course of men's participation in U-Turn. The specific measures administered to AFMs included *respectful communication, experiences of violence,*

abuse and harassment, how often their child[ren] witnessed these incidents, shared parenting, and levels of psychological distress (K10). A second brief follow up interview will be conducted with AFMs who consented to Wave 3 data collection at the time of their Wave 2 involvement. The same points of data collection will apply to groups 3 and 4 of the currently funded U-Turn trial.

2.3.1.1 Levels of psychological distress (Kessler-10 scale)

The 10-item Kessler-10 (K10) scale is a global scale that was used to calculate levels of psychological distress in mothers and fathers. The purpose was to examine change in levels of psychological distress (K10 scores) in both mothers and fathers across the 12-week intervention.

2.3.1.2 Mothers' experiences of violence and abuse

Respectful Communication

Mothers' experiences of respectful communication in their relationship with fathers was measured using a 5-item questionnaire at the beginning and conclusion of the U-Turn program. Each item was rated on a 5-point Likert-type scale (1 = *never* to 5 = *always*).

Expanded Space for Action

Mothers' experiences of controlling and coercive behaviour by fathers was assessed using 12-item questionnaire. Each item was rated on a 5-point Likert-type scale (1 = *never* to 5 = *always*).

Safety and Freedom from Violence and Abuse

Mothers were asked questions around their experiences of harassment and other abusive acts (7 items), and physical and sexual violence (7 items). Each item was rated on a Likert-type scale (1 = *never* to 5 = *always*).

Shared Parenting

In situations where fathers maintained contact with their child[ren], mothers were asked questions around shared parenting using a 5-item questionnaire. Each item was rated on a 5-point Likert-type scale (1 = *never* to 5 = *always*).

2.3.2 Observations

The research team observed each program group at three points: beginning, middle and end. This method was used in order to gain insight into program content and how the U-Turn program was being facilitated. Observations assisted the research team in asking targeted questions around program content and experiences regarding its applicability during men's exit interviews. Observations of the first group of U-Turn were discussed with facilitators after attending individual sessions to provide feedback and inform further delivery of the program.

2.3.3 Interviews

This project utilised semi-structured interviews with participants of the U-Turn program, AFMs, and key stakeholders. All interviews were audio recorded and transcribed using Smartdocs, a transcription service within Australia.

Interviews with U-Turn participants of groups 1 and 2 were administered by the research team at Wave 2 between 10th October and 13th December 2019 and were conducted at TaskForce. Interviews with male participants were designed to canvass the experiences of participants who were asked a series of questions about FV, AOD use, individual wellbeing, and to provide any feedback relating to the program, including its content, facilitation and impact.

AFM interviews for groups 1 and 2 were conducted via telephone between 11th October and 13th December 2019 around the time of program completion and included questions about relationship status and living arrangements, the protection order, (ex)partner's AOD use, wellbeing, whether/ how things may have improved for themselves and their family (if relevant) since their (ex)partner or other family member's participation in the U-Turn program, feedback about the U-Turn program, and key hopes and expectations for the future.

Initially the aim was to administer only wave 2 surveys with AFMs to supplement men's survey responses around use of violence at program intake and exit. After ongoing consultation with U-Turn facilitators in the leadup to group 1 program commencement, the evaluation team and TaskForce agreed to rely on AFM's voices regarding men's abusive behaviours around the time of intake and exit instead. This decision was informed by two key criteria: 1) U-Turn facilitators felt that after conducting the comprehensive intake assessment and building an initial rapport with men around group uptake and engagement, administering a comprehensive suite of FV measures could adversely affect the rapport established between group participants and facilitators; 2) AFMs were seen as the more reliable source to provide an accurate reflection of the level of abusive behaviours present in relevant intimate (ex)partner and family relationships. As a result, men's evaluation data at intake was limited to AOD intake assessment data and AFMs data collection was extended to two waves of data collection, around the time of men's program commencement and program conclusion. AFMs were interviewed at program conclusion, regardless of whether men completed the U-Turn program, as long as AFMs were contactable and continued to agree to evaluation participation at the time of follow up contact.

To honour AFMs increased input into the evaluation, participating women received a $25 Coles/ Myer voucher at each wave of their participation in data collection.

Stakeholders were given the option of participating in individual telephone interviews if they were unable or unavailable for the focus group. Key stakeholder interviews took place in person or via telephone and asked participants a range of questions based around the research questions including: the need for combined AOD and FV interventions; the challenges and benefits associated with combined interventions; the key requirements in delivery; and challenges associated with referral pathways and information sharing. Interviews were conducted between the 6th February and 18th February 2020. Interviews were audio recorded and transcribed using Smartdocs transcription service.

2.3.4 Focus groups

One focus group was conducted with key stakeholders on the 6th of February 2020. Participants were asked the same questions as key stakeholders who took part in an interview (outlined above). Focus groups ran between 60 and 90 minutes and were audio recorded. These were then transcribed using Smartdocs transcription service.

2.4 Participants

2.4.1 Eligibility

All men included in the evaluation had received an interim or final FVIO at the time of being referred to the U-Turn program. Respondents were referred by the Moorabbin Magistrates' Court of Victoria to a locally based AOD service provider (TaskForce) as part of their civil court proceedings. To be eligible for a program referral, men had to have problematic substance use identified as part of their FV perpetration. This could range from respondents disclosing a history of substance use in court, court records suggesting a history of substance use based on AOD related offending behaviour or simply having been intoxicated at the time of the most recent FV occurrence that led to a police and court response. As the pilot program under evaluation was designed as an early intervention for FV, respondents were screened for additional risk factors to ensure participants met the criteria for an early intervention from a criminal justice perspective.

2.4.2 U-Turn participants and women

A total of 21 men (*n* = 9, group 1, *n* = 12, group 2) who had received a referral to the U-Turn program gave initial consent to participate in the evaluation. Wave 1 (AOD intake) data is available for 19 U-Turn participants. Fourteen U-Turn participants also took part in the data collection for Wave 2 (*n* = 8 in group 1, *n* = 6 in group 2). Along with the Wave 1 and Wave 2 data sources outlined above, men in the first group also completed a Wave 1 and Wave 2 parenting survey as part of a Monash honours student research project.

Demographic information and AOD risk assessment data for U-Turn participants was obtained from intake data files produced by TaskForce. Demographic data relevant to women was obtained from survey questions administered at the beginning of the U-Turn program as part of the Wave 1 telephone survey.

Below Table 1 outlines demographic characteristics of male U-Turn participants and women involved in the study who provided Wave 1 data (*n* = 19 men, *n* = 8 women). Men for whom intake data is not available (*n* = 2) were not included in the analysis. Men were on average 49.77 years of age, with a median of 40.5 years and women were on average 45.1 years of age, with a median of 48.5 years. The average Alcohol Use Disorders Identification Test (AUDIT) score, for alcohol use, was 15.18 which indicates medium risk (close to high risk). The minimum AUDIT score obtainable for participants was 0 with a maximum of 40. Men's scores ranged from 4 to 37. Five men identified use of other drugs; four of these had comorbid AOD use. All five men with other drug use expressed mental health problems including depression and anxiety. Fourteen (out of nineteen) men indicated having a current

mental health issue[1] (although this number is not represented in the table as participants could identify having several mental health issues) and while five indicated having no mental health issues, most reported feeling frustrated and stressed.

Table 1 Descriptive statistics of demographic characteristics for U-Turn participants (men) and AFMs (women)

		Men (n)	*Women (n)*
Age	18-23 years	n=0	n=1
	24-29 years	n=1	n=0
	30-39 years	n=5	n=0
	40-49 years	n=7	n=3
	50-59 years	n=2	n=4
	60 years or older	n=1	n=0
	Total	n=16 *missing data (n=3)	n=8
Birthplace	Overseas	n=8	n=5
	Australia	n=8	n=3
	Total	n=16 *missing data (n=3)	
Employment status	Employed	n=13	n=2
	Unemployed	n=4	n=2
	Student	n=0	n=2
	Home duties	n=0	n=2
	Retired	n=1	n=0
	Total	n=18 *missing data (n=1)	n=8
Highest level of education achieved	Upper Secondary School (Years 9-12)	*N/A	n=4
	Technical or further education course		n=2
	Certificate III and/or Certificate IV		n=2
	Total	*N/A	n=8
Past engagement with support services	Yes	*N/A	n=5
	No		n=3
Types of support service(s) accessed	Housing	*N/A	n=2
	Family support		n=2
	FV		n=1
	Mental health		n=2

[1] Numbers presented in Table 1 may not add up to total number of participants identifying mental health issues as participants could nominate more than one mental health concern and categories were not mutually exclusive.

	AOFD		n=1
	Child Protection Services		n=2
	Other		n=2
HOMELESSNESS OR AT RISK OF HOMELESSNESS	Yes	n=5	*N/A
	No	n=11	
	Total	n=16 *missing (n=3)	*N/A
CURRENT MENTAL HEALTH ISSUES	Anxiety	n=6	*N/A
	Depressive disorder	n=10	
	Mood disorder	n=1	
	No diagnosis but symptoms reported	n=2	
	No mental health conditions	n=5	
COMORBID MENTAHL HEALTH ISSUES	Comorbid anxiety and depressive disorder	n=4	
	Comorbid other	n=1	
	Total	n=5	
PREVIOUS USE OF AOD SERVICES	Yes	n=5	*N/A
	No	n=7	
	Total	n=12 *missing (n=7)	*N/A
PRIMARY SUBSTANCE OF CONCERN	Alcohol	n=14	*N/A
	Other drugs	n=1	
	Alcohol and other drugs	n=4	
	Total	n=19	
*USE OF ALCOHOL (FREQUENCY)***	Never	n=1	
	Less than monthly	n=4	
	Monthly	n=3	
	Weekly 6	n=6	
	Daily or almost daily	n=4	
	Total	n=18 *missing (n=1)	
USE OF OTHER DRUGS (FREQUENCY)	Monthly	n=2	
	2-4 times a month	n=1	
	2-4 times a week	n=0	
	4 or more times a week	n=2	
	Total	n=5	

**N/A represents information not obtained during data collection therefore is not included in the sample description.*

*** How often participants have six or more drinks on one occasion.*

2.4.3 Affected family members

A total of eight AFMs participated in the evaluation (*n* = 5, group 1, *n* = 3, group 2). Of these, six took part in data collection at both Wave 1 and Wave 2 (*n* = 4, group 1, *n* = 2, group 2); two women did not complete Wave 2 as they were no longer contactable at the time of Wave 2 data collection.

2.4.4 Key stakeholders

Overall, ten key stakeholders participated in the evaluation. These included a range of different services and represented the following sectors: Magistrates' Court of Victoria, FV, AOD, and Men's Behaviour Change Programs (MBCP).

2.5 Limitations

This study has several methodological limitations. Recruiting AFMs for this evaluation proved challenging, particularly with regards to retention of participants. It is well documented that recruitment of vulnerable and hard to reach populations has its challenges (see for e.g. Liamputtong, 2007; Thummapol, Park, Jackson & Barton, 2019). Literature identifies that recruiting vulnerable populations can be both challenging and time-consuming (Liamputtong, 2008). It involves building a sense of trust with participants, communication, negotiating, and mutual respect (Roper & Shapira, 2000) and challenges can affect participation and retention. To overcome these challenges, it has been noted that there are a number of procedures that can employed, such as managing participant expectations, emphasising the benefits for participants involved, and outlining all confidentiality clearly at the outset (Thummapol et al. 2019). While the research team had procedures in place to make contact with women and worked closely with the family safety contact worker around AFM participation in the evaluation, only six women (out of the original eight) took part in both Wave 1 and Wave 2. As some women did not have regular contact with TaskForce, follow up contact was reliant on the research team for a small number of AFMs. Researchers attempted numerous phone calls with participants in an attempt to retain participants, yet these did not always prove successful. Conversely, when participants were connected and had regular contact with TaskForce, they were able to pass on preferred times to make contact, which was a more successful approach.

Along with this, there was a change in staff at TaskForce during the recruitment of AFMs. Initially, the person acting in the family safety contact worker role was employed in a part-time role specifically to do this work. This practitioner had greater flexibility in following up with women; both around family safety contact and women's involvement with the evaluation. For group 2 of U-Turn, the family safety contact worker role was allocated to a TaskForce AOD clinician who fulfilled this role in addition to her existing clinical caseload and during TaskForce opening hours, which likely impacted on capacity and flexibility around establishing and maintaining family safety contact.

3. Preliminary Findings Quantitative Data Analysis

Below are some of the preliminary findings relating to changes in psychological distress for U-Turn participants and AFMs as well as changes in violent and abusive behaviour, non-physical violence, respectful communication, and physical and sexual violence.

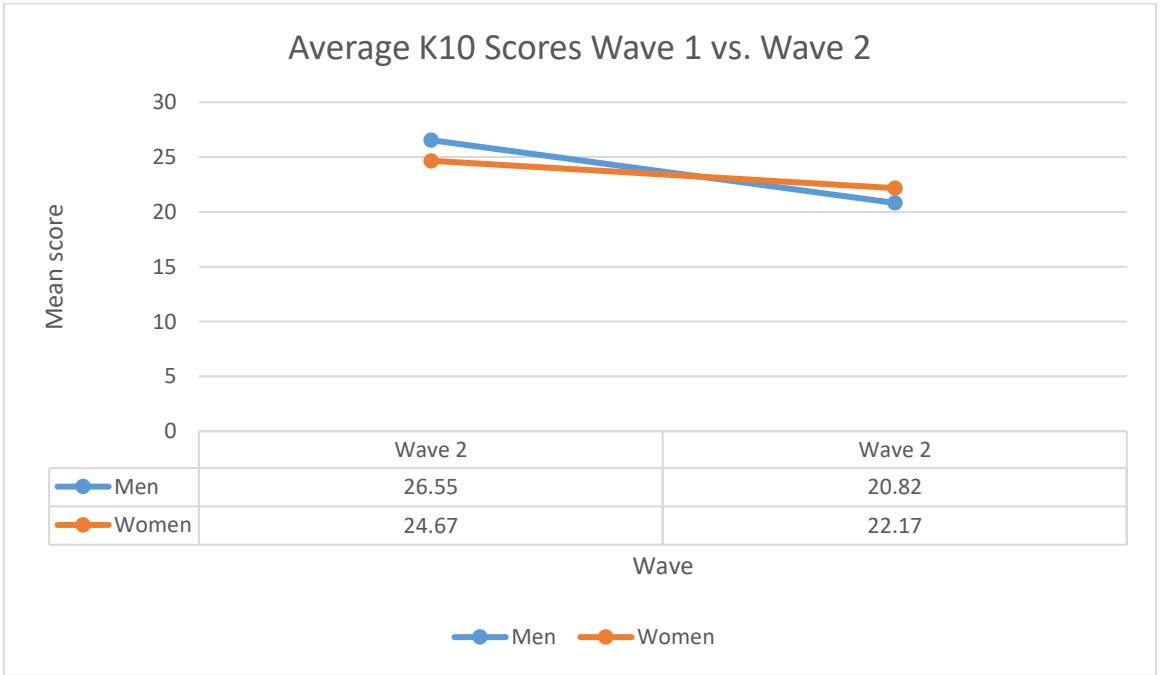
3.1 Psychological distress in U-Turn participants and AFMs

Psychological distress among parents in the current study were measured using the K10. The K10 categorises scores into low levels of distress (10-19 points), mild levels of distress (20-24 points), moderate levels of distress (25-29 points), and high levels of distress (30-50 points) (ABS 2001). The average K10 score was calculated for the wider sample description. Eleven men completed the K10 measure at both waves and the mean score for these men at Wave 1 was 26.55, indicating moderate levels of distress and at Wave 2 was 20.82, indicating a mild level of distress. Six AFMs completed the K10 measure at Wave 1 and 2 with an average score of 24.29, suggesting mild levels psychological distress which research shows is associated with depression or anxiety (ABS, 2003).

3.2 Change in psychological distress among women and men

Figure 1 shows Wave 1 and 2 data measuring psychological distress (K10) scores among men (*n* = 11) and women (*n* = 6) across Group 1 and Group 2. K10 data is missing for two participants in Wave 1 and one participant in Wave 2 and is therefore limited to 11 participants.

Figure 1 Psychological Distress (K10) Scores among women and men Wave 1 vs. Wave 2



Overall there was a 5.73% decrease (improvement) for men and a 2.5% decrease (improvement) for women. Both male participants and women showed either moderate or mild levels of psychological

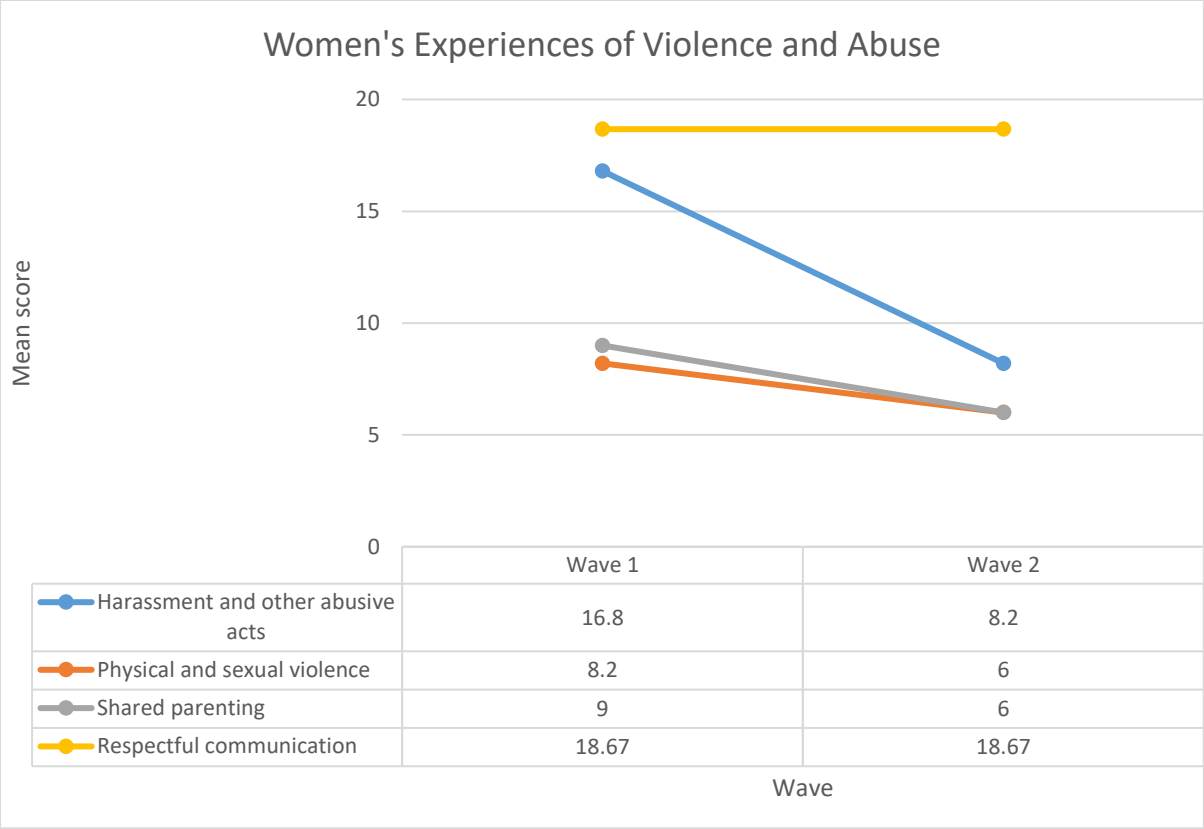
distress over the course of the program. For men, this moved from moderate to mild at the completion of the program, while for women, the K10 scores remained at mild levels of distress throughout the program.

While non-significant for both women and men, results suggest levels of psychological distress improved in both groups. In Wave 1, men (M=26.55, SD = 11.175) presented moderate levels of distress, while women presented mild levels of psychological distress (M=24.67, SD = 9.480). Following the intervention, both had reduced levels of psychological distress with men's scores showing mild levels of distress (M=20.82, SD = 9.400) and women showing a lower level of mild distress (M=22.17, SD = 7.808). On average, women's scores were 2.50 points lower than their pre-intervention scores while there were greater improvement's to men's distress with men's scores averaging 5.73 less in Wave 2 than their Wave 1 score. While the findings presented here may be non-significant, the observed change for men suggests a substantial improvement in levels of distress.

3.3 Change in women's experiences of violence and abuse

Women's experiences of abuse were measured in the form of physical and sexual violence, non-physical violence (such as harassment and financial abuse), and controlling behaviour (in shared parenting). One woman had no contact and so was not included in the analysis and some women did not provide answers for all measures (as the questions was either not relevant or they had limited contact) and these were not included in the analysis.

Figure 2 Women's Experiences of Violence and Abuse Wave 1 vs. Wave 2



The three measures in Figure 2 reflect women's experiences of violence and abuse across Wave 1 and Wave 2. A two-tailed, paired samples *t* test with an alpha level of .05 was used to compare pre-intervention and post-intervention scores related to respectful communication, expanded space for action, experiences of physical and sexual violence, experiences of harassment and other acts of abuse, and shared parenting.

Significant findings indicate that the biggest shift was seen in women's experiences of harassment and other non-physical abusive acts (*n* = 5), which decreased across Wave 1 and Wave 2 by 8.6%. On average, scores in Wave 2 were 8.60 points lower than in Wave 1. Four women reported the minimum possible score in Wave 2, indicating no harassment or other non-physical abusive acts had occurred in the final four weeks of the intervention. Non-significant findings indicate women's experiences of physical violence and sexual violence (*n* = 5) decreased across Wave 1 and Wave 2 by 2.2%. Four out of the five women who had experienced physical and sexual violence in Wave 1 reported the minimum possible score in Wave 2, indicating no sexual violence was committed by the perpetrator in the final four weeks of the intervention. Non-significant findings indicate that women (*n* = 3) were subject to less controlling behaviours by men in the study across Wave 1 and Wave 2 with scores on average 3% lower at Wave 2. Unlike harassment and other non-physical abusive acts, physical and sexual abuse, and shared parenting scores, a higher respectful communication score is positive. Only three women completed the respectful communication questions and this stayed relatively stable. Only one woman's experience improved over time in this category.

3.4 Overview

While the results are predominantly non-significant and the numbers are low, the overall trend indicates that mental health in both men and women improved, and the majority of women no longer experienced forms of physical or sexual abuse. Further, women's experiences of non-physical abuse, while still prevalent, had decreased substantially by Wave 2.

4. Preliminary Findings Qualitative Data Analysis

4.1 U-Turn Participants and AFMs

Interviews with male U-Turn participants and AFMs reveal a number of preliminary findings.

Definitional issues of 'early intervention'

- This definition may be more applicable for DFV-related court/ police contact as men with chronic alcohol and/ or other drug dependency, underlying trauma, or substantial criminal histories may not be suited for an 'early intervention' program. Instead it seems more applicable for DFV-related court/ police contact.

Past history for U-Turn participants

- The majority of men had substantial history of chronic binge drinking, some alcohol dependence, some other drug use and a substantial number of participants shared childhood trauma experiences.

Abusive behaviour

- There was a reduction in abusive behaviours for U-Turn participants.
- There was a low level of physical victimisation reported by AFMs at Wave 1 and emotional and verbal abuse and property damage were more common.
- While perpetrators underscore abusive behaviours at the beginning of the program (Wave 1), women confirm a reduction in abuse by Wave 2.
- There was almost no physical and/ or sexual abuse at Wave 2, less emotional and verbal abuse, and less property damage.

AOD use and violence/ abuse

- The use of DFV was closely tied to the use of AOD, by male participants and AFMs.
- The majority of participants used alcohol as the primary drug of concern.
- Women described (ex)partners as calmer, better in interaction, and less angry when they were not drinking.
- Men, equally tied their anger and aggression to intoxication and described themselves as better partners, co-parents, and fathers when applicable.
- However, it is important to note that because most men ceased or reduced their alcohol intake prior to commencing the U-Turn program and because several men had court orders restricting their drinking habits, it is difficult to determine the role, if any, of U-Turn in decreased intoxication and decreased related abusive behaviours. Six months follow up interviews with consenting men and women will be used to explore whether a reduction in AOD use and use of FV was sustainable for families.

Illicit drug use and complex needs

- The only participant with illicit drugs as the primary substance use issue did not complete U-Turn, had substantial complex needs (including childhood trauma, homelessness, and mental health issues) and both the AFM Wave 1 and Wave 2 interview suggested little improvement.
- As this participant only attended a few U-Turn sessions, it is difficult to determine whether U-Turn in generally may not sufficiently cater for men with significant illicit substance use.
- Overall, it is unlikely that U-Turn, being an early intervention, offers sufficient wraparound support for men with this level of complex needs.
- As well as this, men with highly complex needs may not fit the target population or eligibility criteria of the U-Turn program due to their multi-layered risk factors and an absence of key protective factors associated with group readiness and ongoing engagement.

4.2 Focus group findings

For the purpose of this evaluation, the research team conducted interviews with key stakeholders identified by the funding body and developers of the U-Turn program. Ten stakeholders representing DHHS/ Family Safety Victoria, TaskForce, Moorabbin Justice Centre, the men's behaviour change, mental health and AOD service sector participated across one focus group and four interviews.

Interviewees were asked to comment on a range of open-ended questions, addressing the following themes:

- The need for a combined approach to comorbid use of FV and problematic alcohol and/ or other drug (AOD) use
- The timing of funding and trialling combined group-based interventions
- Key considerations (or ingredients) when combing interventions
- The role of partner/ family safety contact
- Situating combined interventions in different service sectors
- Offering combined interventions in residential AOD treatment
- Voluntary versus mandatory program referral and participation

The identified themes are discussed in detail below.

4.2.1 The need for a combined approach to comorbid use of family violence and problematic alcohol and/ or other drug use

We asked participants to describe their views around the need for taking a combined approach to FV and problematic AOD use in group based interventions. All participants felt that due to the persistent intersection of FV and AOD use observed in research and practice evidence, taking a combined intervention approach is an important step towards more holistic service responses to FV. Participants highlighted that the two service sectors (along with other service areas, such as mental health) have historically operated in siloes, which can isolate clients and leave relevant support needs unaddressed. Here, interviewees emphasised that interventions addressing FV need to take a holistic approach to individual and family needs rather than dissecting individuals and human behaviour into different characteristics and behaviours that need to be addressed separately by different service providers. Instead, interviewees felt that taking a combined approach acknowledges that individuals often have more complex needs than solely needing to address the use of abusive behaviours in their relationships and by bringing FV and AOD focused interventions together, this offers a more holistic approach to clients' behaviours and support needs.

4.2.1.1 Perceived benefits of combining interventions

Overall, interview participants believed that taking a combined approach would have clear benefits for family safety because addressing problematic AOD use in the context of FV offers an opportunity to generate behaviour change through more than one lens, which in return was seen as beneficial to family members affected by men's use of FV.

Some interviewees further discussed that police and court statistics clearly indicate the involvement of primarily alcohol and to some extent other drugs in FV occurrences that come to the attention of law enforcement. Further, AOD sector representatives stated that FV is certainly overrepresented in client populations accessing AOD services, including female clients who primarily disclose a history of victimisation and male clients who have frequently been identified as a perpetrator of FV and at times other forms of violence. While interviewees clearly stated that the presence of AOD use should never be seen as a cause of FV, it needs to be acknowledged as a contributing factor, especially with regards to the escalation of violence in frequency and severity. Interviewees therefore welcomed the

consideration of combined interventions while also flagging some challenges and potential pitfalls to consider.

4.2.1.2 Perceived challenges associated with combining interventions

A number of potential challenges were raised across interviews, including the challenge associated with FV and AOD service providers working from different ideological standpoints at times, the need to ensure expertise of both sectors in the room when combining interventions and the stigma that may potentially be associated with one or the other service sector. The latter will be discussed in greater detail under considerations around where combined interventions may be best situated sector wise.

One of the identified key challenges to address when combining interventions was the approach to client work in FV/ MBCP and clinical AOD interventions. Interviewees from both sectors highlighted that there are traditionally differences in client work. While both sectors have an awareness of the intersection of FV and AOD use, each takes a different approach to client work. FV interventions/MBCPs traditionally focus on men's behaviour and related risk in the wider context of family and community life and create accountability work in this wider context. Further, FV focused MBCPs tend to focus on social structural factors (including gender inequality, male privilege and patriarchy) as key drivers for abusive behaviours. AOD focused interventions on the other hand tend to operate from a client-centred, therapeutic approach that examines AOD use and related behaviours as the result of individual factors and experiences rather than the wider family or social structural context. As a result, MBCPs tend to conduct risk assessments that examine the perpetrator's social and family context to estimate the risk he may pose to others. Family members are therefore assessed around their risk of harm rather than the support they may be offering to the perpetrator engaging in behaviour change. AOD interventions on the other hand tend to prioritise client needs and assess for individual risk and protective factors while taking a therapeutic approach to assessing support needs. As a result, the traditional ideological standpoints of these two sectors may clash. However, in the context of this evaluation, interviewees strongly felt that the AOD sector has become more FV informed, and that the FV sector is becoming more open to approaches addressing intersectionality around perpetrator risk factors and support needs. While an ongoing need for upskilling the AOD sector in FV informed practice and upskilling the FV sector around the core intersecting issues, such as AOD use and mental health issues, especially in individual client work was voiced by a number of interviewees, participants were optimistic that combined group-based interventions are ready to overcome these challenges by bringing together expertise from both areas in the development and delivery of combined interventions.

4.2.2 The timing of funding and trialling combined group-based interventions

We asked interviewees why a shift towards trialling combined interventions is only just emerging at this particular point although the research and practice evidence regarding the overlap of FV and problematic AOD use has been present for over a decade. In response, some interviewees were very clear that they had been having conversations around the need for combined interventions for at least a decade. Overall, interviewees reiterated that both service sectors have been operating in siloes,

partly due to ideological differences but mostly due to siloed approaches to funding service delivery. The majority of interviewees felt that the timing had been right and the right champions had come together when the conceptualisation of U-Turn was developed and funded. This role of champions driving service and sector reforms around responses to FV overall was strongly emphasised by those involved in the initial development of the U-Turn program.

4.2.3 Key considerations (or ingredients) when combing interventions

Interviewees addressed a number of areas as key ingredients or key considerations when developing and implementing combined group-based interventions. Some have been addressed above, such as the need to combine expertise in the development and delivery of combined interventions rather than letting one or the other sector 'just run with it'. Interviewees strongly felt that program developers must either have expertise, skills and qualifications in both MBCP design and/ or delivery as well as clinical AOD work or program developers must come together from both sectors to take a joint approach to development and delivery. Interviewees who were familiar with the U-Turn program described the service provider currently offering the program as 'fortunate enough' to have relevant staff members with expertise, skills and qualifications relevant to both sectors but acknowledged that this is unique. As a result, all interviewees acknowledged that this cannot be expected as the status quo and that partnership approaches are therefore required during the development as well as delivery phase of combined interventions.

Other 'key ingredients' discussed by interview participants include the role of theoretical underpinnings informing combined approaches, DFV-informed risk assessment, ensuring a closed feedback loop, program content and facilitator skills and qualifications.

4.2.3.1 Theoretical framework/ underpinnings

Despite the support for a more holistic approach to generating behaviour change at the intersection of FV and AOD use, interviewees all emphasised the need to have a feminist framework underpinning any form of MBC work, including combined interventions. A gendered understanding of FV, including control, manipulation and coercion was seen as crucial when working with men who use FV, regardless of other co-occurring risk factors. Further, some interviewees highlighted the need for a harm minimisation framework, which the majority of interviewees supported both in relation to problematic AOD use and FV. All interviewees agreed that family safety needs to be a key criteria when combining interventions and that a harm minimisation approach towards changing the impact of FV as well as men's AOD use on (ex)partners, children and other family members would therefore form a useful contribution to a gendered analysis.

Further, interview findings suggest that a therapeutic, or trauma-informed - approach to understanding men's use of violence needs to form part of the framework for combined interventions. Due to levels of childhood trauma observed in FV perpetrator and AOD client populations, several interviewees discussed the need for a trauma informed understanding of the impact of childhood trauma on men's behaviour (including the use of violence as well as problematic AOD use). This has further been highlighted under some of the key considerations around program content discussed further below.

4.2.3.2 FV-informed risk assessment

In line with the emphasis on FV-informed practice in combining interventions, interviewees highlighted the need for FV-informed intake and risk assessment processes. Findings support that risk needs to be assessed in relation to men referred for intake into combined interventions as well as their immediate environment, including former or current partners and other family members affected by their use of FV. Further, risk needs to be understood as dynamic and something that requires regular reassessment during program participation. While emerged as less of a concern where a combined intervention program may be offered by an established MBCP provider, interviewees emphasised that where combined interventions are delivered by an AOD or other service provider, providers need to ensure initial and subsequent risk assessments are FV focused and informed, and guided by an understanding of the complexities of FV, including its various forms, impact and the use of manipulation and image management among many perpetrators of FV. In the Victorian context, the roll out of the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) will play a crucial role here although it is acknowledged that not all states and territories have transitioned to the use of standardised FV screening and risk assessment tools across all services sectors, including AOD services.

4.2.3.3 Feedback loop

In the context of information exchange between key stakeholders relevant to combined intervention approaches, some interviewees highlighted that similar to any MBCP following good practice and minimum standards, combined intervention programs must ensure a closed feedback loop. In the context of U-Turn, this was described as the information sharing between the referral agency (local magistrates court) and the service provider conducting intake assessment and delivering the program. It was emphasised that information sharing around referral pathways, referral uptake, risk assessment, program drop out and subsequent court responses needs to go both ways to ensure the program provider is aware of all referrals to expect, the court remains aware of all program uptake (including referrals that were assessed as ineligible, referrals that declined program uptake and referrals that dropped out after initial commencement of the program) and the program provider remains updated on any subsequent court responses to men remaining in and dropping out of the program. Especially the referring court and program providers described this element as crucial in keeping perpetrators of FV in view of key stakeholders and holding them accountable for their behaviour while equally holding referral agencies and service providers accountable for information sharing around program availability, uptake, drop out or completion and related court contact.

4.2.3.4 Program content

In relation to program content, the majority of interviewees agreed that a combination of different content areas is required when taking a combined intervention approach. Beyond ensuring a gendered analysis of abusive behaviours and addressing such behaviours as a personal, relationship and – where applicable – parenting choice, interviewees equally agreed that substantial content around AOD use is crucial. Here, interviewees discussed the need to incorporate content on the

underlying drivers for AOD use as well as how AOD use interacts with men's use of violence. Findings suggest that it is therefore equally important to cover triggers of AOD use to generate an understanding among program participants why and when they individually engage in AOD use for example and to include content on how AOD use may affect the use and choice of violent behaviours, including how different stages of problematic AOD use (e.g. stages of intoxication, stages of withdrawal) may contribute to the use and escalation of violence.

As discussed under the theoretical framework underpinning combined interventions, interviewees further discussed the level of childhood trauma often present in men with comorbid FV and AOD use. Some interviewees therefore raised the need to incorporate sessions on the family of origin for participants to make the relevant connection between potential trauma experienced over the life course, subsequent coping responses (including problematic AOD use) and their use of abusive behaviours in their own family relationships. Similar to addressing the intersection of FV and AOD use, interviewees emphasised that childhood trauma needs to be understood and addressed as a contributing factor to generate behaviour change but never be seen as an excuse for the use of violence in adulthood.

4.2.3.5 Facilitators

As covered under findings discussed around the need for combined sector expertise in the development and delivery of combined interventions, interviewees strongly felt that facilitators need to bring expertise in FV, MBCP facilitation and clinical AOD work to a combined intervention delivery. As highlighted earlier on in the findings, the U-Turn program provider was unique in that one of the program developers and facilitators held qualifications, expertise and experience in MBCP and clinical AOD service delivery. As it cannot be expected that this is the case across service providers which may consider the development and delivery of a combined group based intervention, it is important to have a combination of facilitators that bring together expertise in FV, MBCP delivery and clinical AOD work. This combination is crucial to ensure combined interventions offer content relevant to the use of FV along with problematic AOD use and its interconnectedness. Further, combined facilitation skills and expertise are important to ensure the voices of women and children are always present and the program and its facilitation to maintain focus on the overarching goal of increasing victim and family safety.

4.2.4 The role of partner/ family safety contact in combined interventions

Further in relation to including the voices of victims and children in the room when facilitating combined intervention programs, interviewees discussed the importance of partner-, or so-called family safety contact. Interviewees agreed that family safety contact should form a crucial component of all perpetrator-focused intervention programs to ensure family safety, provide support and referral pathways to AFMs and hold program participants accountable through regular check ins with those affected by their abusive behaviours. There was consensus that the quality and extent of family safety contact varied across MBCPs throughout Australia. However, interviewees believed it is a core component when delivering perpetrator interventions and should equally be prioritised in combined

interventions. In this context, interviewees raised that varying quality and extent of family safety contact across other programs has several reasons, including a lack of dedicated funding for this role and at times a lack of priority placed on this component of perpetrator interventions. Interview participants emphasised that in order to do this component justice, funding needs to be allocated to a dedicated family safety contact worker role; whether this is a role allocated within the program provider's agency or externally contracted for this particular purpose.

As addressed earlier on in this report, in the particular context of U-Turn, the family safety contact was provided by an externally contracted FV practitioner in group one of the program. For the duration of the second group, the contracted FV practitioner was unavailable. As a result, the family safety contact role was filled by one of the service provider's AOD clinicians on top of her usual work and case load. The AOD clinician filling the role during group 2 had less capacity and flexibility in initiating and maintaining family safety contact with AFMs due to her usual workload and being limited to clinical AOD work office hours. In group 2, the service provider and evaluation team noticed decreased uptake of family safety contact along with evaluation participation by AFMs. While this may partly be the result of varying needs among AFMs across program groups, it does suggest that family safety contact work may be done more efficiently and effectively in a dedicated role with greater flexibility around contact hours and frequency. Regardless of whether the family safety contact role was allocated internally or externally, there was consensus among those who discussed the importance of this role that it should always be provided by a practitioner external to the program facilitation team and never by a program facilitator. This ensures the ability to maintain clear and ethical boundaries between practitioners working directly with men as perpetrators and practitioners providing support to AFMs.

Interviewees further noted that family safety contact work in combined interventions should equally provide AFMs with support around regaining and maintaining family safety as well as offering relevant referral pathways. Here, interviewees discussed that where a combined intervention is situated somewhat determines the nature of support available to AFMs. While interviewees agreed that any relevant referral pathways can be initiated for AFMs to meet their individual needs (e.g. around immediate safety, housing stability, counselling, support for children), referral pathways made via the Orange Door were described as 'clunky' and inefficient at times. Internal referrals were seen as more streamlined and timely although limited to the support offered by the program service provider. In the case of U-Turn, the service provider is able to offer AOD related support to AFMs, should women disclose their own problematic AOD use. In the case of U-Turn groups 1 and 2, no such disclosures were made and any referrals were therefore made externally to other support services via the Orange Door where relevant.

Some interviewees noted that if a combined program was situated with a FV service provider, this would offer the benefit of internal access to counselling and recovery support for AFMs. On the other hand, these interviewees also noted that if the program is situated with a FV service provider, this requires external referrals to an AOD service provider where male program participants benefit from one on one clinical AOD work in addition to or in preparation for their group participation. This point is further discussed in the next section.

4.2.5 Situating combined interventions in different service sectors

Interviewees were asked to reflect on whether there is a rationale for situating combined interventions in a particular sector or whether one sector may be better placed to lead such interventions than another. Overall, interviewees did not feel that one sector was necessarily better placed to lead or offer combined intervention programs than another. As discussed under key ingredients for combined interventions, interviewees felt that one of the key elements to successfully developing and delivering such interventions is to bring together expertise from both sectors and ensure co-facilitation by practitioners that bring together qualifications, skills, expertise and experience around FV, MBCPs and clinical AOD work. As noted under the discussion of the role of family safety contact, interviewees further raised that where a program is situated to some extent determines referral pathways and direct access to different types of support for program participants and AFMs.

In addition to these aspects around where to situate combined interventions, a number of interviewees raised the issue of potential stigma associated with one or the other service sector. These interviewees argued that in the context of male FV violence perpetration and comorbid problematic AOD use, men who come in contact with police or court may be more open to the idea of accessing support via an AOD as opposed to a FV service provider. As some interviewees put it, 'even the employed, middle class men may be quite comfortable acknowledging that they frequently drink two bottles of wine whereas they may be less forthcoming about their abusive behaviours'. Interviewees therefore believed that situating a combined intervention with an AOD service provider may offer access through a door that is attached with less stigma and reluctance to engage. A smaller number of interviewees further discussed whether it may be beneficial to fund a more 'independent' sector or community service provider that draws on expertise from the AOD and FV sector but is not associated with the stigma of either area of required support. Interviewees emphasised that regardless of where an intervention is situated, bringing together relevant expertise was a key criteria and where this can be assured, funding community organisations known for providing more general community and family welfare services may be able to minimise stigma associated with FV perpetration as well as problematic AOD use. Interviewees agreed that in any scenario the aim was to offer 'multiple access points to getting men into one and the same room', meaning that the final destination is a MBCP, which employs a gendered framework while acknowledging and addressing intersectionality in relation to FV perpetration. Overall, there was consensus that if funding future service providers to offer combined interventions, these could be situated in either sector or based with community organisations separate to the FV and AOD service sector as long as the key ingredients of combined experience, expertise and facilitation skills from FV, MBC and AOD work are adhered to.

One noteworthy benefit of the current U-Turn program being situated with an AOD service provider is the internal access to one on one clinical AOD work for referred men who may need AOD related support prior to or parallel to their participation in the U-Turn group format. This may be in form of parallel one on one support or initial one on one work while supporting a referred client towards group readiness for an upcoming program group. If combined programs are situated in other service sectors, additional AOD related support would require an external service referral, which may increase the risk of men's disengagement after their initial referral uptake and intake assessment process unless there is close collaboration between service providers along with a closed feedback loop to avoid clients falling through 'referral gaps' as a result of their additional support needs. This along with the referral

pathways available for AFMs discussed above highlights the need for combined interventions to form part of integrated or at the very minimum closely coordinated holistic service responses to minimise client disengagement.

4.2.6 Offering combined interventions in residential AOD treatment

Given the emerging approach to funding and delivering combined group based interventions addressing FV and problematic AOD use, we asked interviewees whether they had a view on offering combined, group based interventions in longer term residential AOD treatment settings (i.e. residential rehabilitation facilities as opposed to shorter term detoxification facilities). Views of interviewees were mixed, with some raising concerns around how such group based interventions would be offered in settings that often support both female and male clients and clients who may have experienced and/ or used FV. These interviewees raised that careful consideration should be given on how to provide group based interventions in settings where residents include a broad range of clients without singling out or further stigmatising some residents.

However, some interviewees were generally supportive of extending combined interventions situated with the AOD sector to residential support settings. These interviewees felt there was a clear need to address FV in these settings due to the substantial known overlap of problematic AOD use and FV among clients accessing AOD support services. Interviewees felt that residential rehabilitation settings would therefore be a suitable environment to extend available onsite support services to MBCPs addressing the intersection of FV perpetration and problematic AOD use.

4.2.7 Voluntary versus mandatory program referral and participation

Interviewees were asked to share their views regarding referral pathways into combined group based interventions. While some were equally supportive of voluntary and mandatory referral pathways, especially AOD sector representatives felt that voluntary participation is likely going to be more beneficial than court mandated program attendance. This was specifically framed around addressing problematic AOD use. Interviewees had fewer concerns around mandating MBCPs but felt that behaviour change around AOD use requires initial motivation to change, which was described as less present in court mandated populations. However, other interviewees felt that there is sufficient evidence to suggest that AOD as well as FV focused interventions have demonstrated significant levels of effectiveness in mandated populations, thus arguing that with skilled motivational interviewing at program intake, referred clients should develop a readiness to change regardless of their initial referral pathway.

4.3 Summary

Focus group findings identify a shift in readiness for combined group based interventions addressing FV and AOD use among key stakeholders from justice, FV service/ MBCP providers, AOD and mental health services. Interview participants unanimously identified a clear need for combined interventions due to the substantial overlap of FV perpetration and problematic AOD use. While representatives from all areas felt that both sectors needed to invest in further upskilling to ensure a FV and AOD

informed development of future group based interventions, interviewees equally felt that both sectors had already made substantial improvements in terms of developing a clearer understanding of intersectionality and especially in the AOD sector an increasingly FV informed approach to client work.

While interviewees felt that either sector would be well placed to offer future combined interventions, strong emphasis was placed on the need to ensure a gendered framework, combined with a harm minimisation approach and clinical AOD expertise, regardless of where combined interventions are situated. Further, findings clearly highlight the need to ensure combined expertise from the AOD and FV/ MBCP sector in the development of combined interventions as well as their delivery through qualified, skilled co-facilitators. The combination of expertise, experience, qualifications and skills in the development and delivery of combined interventions was seen as crucial in order to ensure that programs offer a balance of accountability work, harm minimisation and education with the ultimate goal of increasing the safety of AFMs.

Findings further highlight the importance placed on the family safety contact component of perpetrator interventions. Interviewees strongly emphasised the need for adequate resourcing of dedicated family safety contact worker roles across programs. Findings regarding the family safety worker component along with where programs may best be situated further highlight the need for integrated service systems. Where referral pathways for additional support to program participants as well as AFMs require the involvement of external support services, a close coordination of referrals and service uptake along with relevant information exchange that keeps victims and perpetrators in view is crucial. In the longer term, preliminary focus group findings further support findings from a number of other FV program evaluations and clearly point towards the need to transition to fully integrated service responses to FV to minimise the risk of victims and perpetrators falling into service and referral gaps as the result of multiple referral pathways across different service sectors.

5. Evaluation Progress Update

All the stakeholder focus groups and interviews are complete. Group 3 of the U-Turn program is due to commence in March 2020, with group 4 commencing in the second half of 2020. At this point participants will be recruited through TaskForce using the same recruitment strategies outlined above and AFMs will be recruited with the assistance of the family safety contact worker. Data collected from group 1 participants around parenting skills and relationships for the purpose of the Monash honours student project in 2019 will not be included in further data collection as this project has been completed. Instead, a personal responsibility scale has been added in consultation with the program facilitators and will be administered by TaskForce at program intake and halfway through program participation and by the Monash evaluation team at program exit. Further, six months follow up interviews with program participants and AFMs from group 1 are due to commence at the end of March 2020 with participants who consented to a further follow up at their Wave 2 interview. The same follow up interviews will be conducted with consenting men and AFMs from group 2 and 3 six months post program conclusion. Six months follow up data will not be collected from group 4 participants as the six months follow up timepoint for the final group of the U-Turn trial will fall outside of the contracted evaluation timeframe.

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