Submission to the Royal Commission into Victoria's Mental Health System

July 2019

Authorised by:

Jacqui Watt (available for in-person evidence), Chief Executive Officer
Email: jacquiw@ntv.org.au

Prepared by:

Matt Addison (contact author), Research and Policy Officer
Email: matta@ntv.org.au

Ingrid Kirchner, Policy Officer
Email: ingridk@ntv.org.au

Contents

About No to Violence 3
About Our Members 3
Introduction 4
About this submission 5
Methodology 5
Prevention and support for those at risk of mental illness and suicide 5
Delivering the best mental health outcomes and improved access 11
Needs of family members and carers 13
Best practice and person-centred treatment and care models 14
References 18

About No to Violence

No to Violence (NTV) is the largest peak body in Australia representing organisations and individuals working with men to end family violence. We are guided by the values of *accountability, gender equity, leadership, change,* and *respect*. Meaning, we must account for our work by being rigorous and evidence-informed, that all of our work is supportive of gender equity, that we continue to use our platform to lead a national conversation on the need to address men's use of violence and abuse, that we hold hope that change is possible, and that we engage our clients and stakeholders in a manner that respects their dignity and human rights. NTV provides support and advocacy for the work of specialist men's family violence interventions carried out by organisations and individuals. The work undertaken by specialist men's family violence services is diverse and includes but is not limited to; Men's Behaviour Change Programs (MBCP); case management, individual counselling, policy development and advocacy, research and evaluation, and workforce development and capability building. NTV also provides a range of training for the specialist men's family violence workforce including a graduate certificate in partnership with Swinburne University, as well as professional development for all workforces who come into contact, directly and indirectly, with men using family violence. NTV is a leading national voice and plays a central role in the development of evidence, policy, and advocacy to support the work of specialist men's family violence in Victoria, New South Wales and Tasmania.

About Our Members

NTV represents 165 members Australia-wide. Our membership structure is inclusive of individuals and organisations ranging from specialist services, to individuals and groups who have an interest in preventing and responding to men's family violence.

NTV's specialist members are those who provide specialised men's family violence services, including Men's Behaviour Change Programs (MBCP), case management, and individual counselling. All specialist member services that work directly with men who have used family violence include family contact work, which consists of counselling and ongoing risk assessment and risk management directly with victim survivors of family violence. In Victoria, specialist services are funded to provide approximately 4000 places in Men's Behaviour Change Programs and offer support to 1300 men through case management.

NTV's associate members are diverse. They work in community, health, legal and corporate services, often coming into contact with men who have used family violence. Many associate members have developed policy and practices to prevent and respond to staff or clients identified as using family violence. Associate members also advocate in their communities and workplaces against men's use of family violence. All NTV members are committed to changing the social structures that underpin men's use of family violence against women and children.

Introduction

NTV has provided direct counselling interventions to men who have used or have been at risk of using family violence (FV) for over 25 years. NTV has 165 individual and organisation members whom we support through policy development, training, research and advocacy. NTV is dedicated to ending the wicked problem of men's violence towards their families (predominantly women and children), through robust and evidence-informed interventions. Our extensive history in violence interventions with men has taught us that men's mental ill-health may both exacerbate the frequency and severity of violence perpetrated against family members, and that such conditions may also create barriers for men in accessing available treatments. Although our interventions have predominantly taken a psycho-education approach to men's FV, it has become increasingly clear that education is not enough. We have learnt that men in general struggle to seek support until a crisis occurs (Forsdike, Tarzia, Flood, Vlais, & Hegarty, 2018) and that we need to seize opportunities to collaborate with other sectors and services in order to more positively and holistically engage with men, assess the risk they pose to themselves and their family members, and intervene earlier - preferably before harm occurs.

Men and women experience mental illness at approximately the same rates. However, as this submission will make clear, through a complex interaction of biological and social determinants, women and men experience different kinds of mental illness. Commonly, women experience internalising disorders such as depression and eating disorders, and men experience conditions characterised by externalising behaviours, such as substance abuse disorder, conduct, and antisocial disorders (Afifi, 2007). Although such conditions among men can increase the risk, frequency and severity of family violence perpetration, it should be noted by the Commission that the presence of mental-ill health or a mental illness is not a necessary factor for family violence to occur. Indeed, psychopathology is often absent in men who use family violence, and their motivations for such behaviours derive from conscious and unconscious feelings of entitlement to control women and children (Stark, 2009). Nevertheless, as a result of tendencies towards externalisation among men, for most leading causes of death, men and boys of all ages experience higher death rates (American Psychological Association, 2018). These mortality rates are primarily related to risk taking and a lack of help seeking (Mahalik & Burns, 2011), representing a *gender and health paradox,* or the tendency in modern societies for men to experience more life-threatening chronic disease and die younger and women to live longer but experience more non-fatal acute and chronic conditions and disability (National Research Council, 2014).

NTV believes that narratives in the community that seek to explain men's poor health and social outcomes as a cost of women's achievement and social progress, are misguided. These narratives are often employed in the political arena, and are connected to a broader reactionary politics, and an expressed desire for a return to a "simpler time", that was stable and certain, when men were men and women were women (Faludi, 1992). Although NTV rejects these regressive politics, a desire for certainty, stability, and structure is understandable, particularly for individuals who feel at the fringes. An increasing number of NTV members report clients explaining family court decisions, or high male suicide rates as resulting from a perceived social and institutional bias against men. These narratives may be taken up by individual men for a number of reasons, including as a means of accounting for and coping with their station in life (Steele, Spencer, & Lynch, 1993) , an attempt to externalise feelings of low self-worth (Carpenter, 2019), or as a justification for harbouring feelings of hostility towards women (Flood, 2004). In our clinical experience, such discourses do little for individual men, and may in fact lead to greater anger, emotional dysregulation, and social isolation. NTV encourages the Commission to reject such explanations which further harm marginalised men who face significant barriers to the attainment of good mental health, social participation, and wellbeing.

About this submission

NTV's submission will focus on the complex interactions of individual and environmental factors associated with men's poor health outcomes, lack of help seeking, and high rates of suicide and family violence. We will also highlight the impact of men's use of family violence on the mental health of victims and provide guidance and recommendations to assist the Commission to support the Victorian mental health system to become more trauma, gender, and violence-informed, while achieving greater coordination with other community and health services. NTV also emphasises the importance of the reforms within the Victorian family violence system and urges the Commission to use this opportunity to augment and strengthen improvements already underway in our sector. We believe it is critical that recommendations made by the Royal Commission into Mental Health (RCMH) complement the reforms currently taking place in Victoria's family violence system.

No to Violence recognises that the work we undertake with men who use family violence is highly nuanced, as is the work conducted at its intersection with mental health. We welcome this opportunity to offer our insights, learnings, and the growing evidence-base to inform the first stages of the Commission's investigation.

Methodology

All NTV submissions, policy and advocacy takes an evidence-informed approach. This is an approach that NTV has adapted from the public health evidence-informed decision-making methodology (Culyer & Lomas, 2006). NTV's evidence-informed approach consists of a synthesis of research evidence, practitioner expertise, community and political contexts, and the lived experience of those most affected by policy decisions.

The current submission comprised of a number of mechanisms to achieve fidelity with our evidence-informed approach, including an online survey of specialist men's family violence practitioners, one-on-one interviews with key stakeholders, and a number of consultations and workshops with NTV members. Key themes were generated from a combination of survey answers and findings from the research evidence, these themes included; *impacts of family violence on the mental health of victims, mental health as a barrier to engagement with family violence services, mental health and family violence system coordination, mental health as a factor in perpetrator functioning,* and *suicidal ideation and behaviours among perpetrators and victims of family violence*, with each theme corresponding to at least one of the Terms of Reference of the commission. From these themes we were able to create a number of workshops to capture the knowledge and experience of practitioners. A notable limitation of our approach in the present submission, was a lack of direct client input, with a reliance on practitioner perspectives and findings in the research literature to capture client experiences.

Prevention and support for those at risk of mental illness and suicide

NTV welcomes the Commission's focus on prevention and early intervention and believes that such a focus has the potential to make a profound difference in the lives of Victorians and lesson the burden on acute mental health services. NTV would like to highlight a number of factors which are crucial to understanding opportunities for early intervention and the promotion of good long-term mental

health outcomes and safe and fulfilling lives for Victorians. First, we would like to direct the Commission's attention to the role that unaddressed violence and trauma play in the acquisition of mental illness, in particular anxiety, mood, and personality disorders (Bruce & Laporte, 2015) and how contextual factors such as an individual's psychological resources, the nature of the relationship between perpetrator and victim, and the environment in which recovery takes place can influence post-trauma adaption (Flannery & Harvey, 1991; Goodman, Koss, & Felipe Russo, 1993). For these reasons, we argue that trauma and violence informed mental health care provided at the point at which family violence or child abuse are identified provide opportunities for early intervention before the development of serious pathology. Greater integration of services that respond to violence, such as Men's Behaviour Change Programs (MBCP) and more holistic assessment procedures (responding not solely to violent behaviour or mental health need, but both) is one such opportunity to respond to the psychosocial needs of victims and perpetrators of family violence and child abuse.

NTV would also like to highlight the lack of help seeking among men as a serious issue in the Victorian community which directly contributes to mental illness and maladaptive coping. For example, men are almost three times as likely as women to have a substance abuse disorder (Judd, Armstrong, & Kulkarni, 2009), men perpetrate 90% of all violent crime in Australia (K. a. Seidler, 2010), and men suicide at rapidly increasing rates (ABS, 2017). This lack of help-seeking, maladaptive coping, and antisocial behaviour can be linked to gender socialisation and gendered values such as stoicism and invulnerability (American Psychological Association, 2018; Maruna, 2001). Any mental illness prevention strategy proposed by the Commission should therefore include a gendered dimension, advocating against the harms of masculine socialisation, while highlighting the prosocial strengths of such identities (Connell, 2005; Heilman & Barker, 2018). The mental health system ought also to apply person-centred and strengths-based principles in meeting men in their socialised context, providing services that are appealing, engaging, and motivating to men, without colluding with harmful narratives that are linked to violence against women (Judd et al., 2009; OurWatch, ANROWS, & VicHealth, 2015). Because individuals are fundamentally constituted by a need to make sense of their worlds (White, 2007), and are evolutionarily driven to survive, individuals will seek out narratives to make sense of their circumstances and any means of coping at their disposal, whether these coping strategies are adaptive or maladaptive. If mental health services are not engaging, men will seek alternative ways of dealing with their mental illness, including substance abuse, self-harm, or narratives such as those offered by Men's Rights Activists (MRAs), which allow men to externalise their distress (Flood, 2004) and continue to blame women.

Violence, abuse, trauma, and early intervention

NTV has a particular interest in the interaction of environmental factors, such as adverse childhood experiences (ACE) and the subsequent development of mental illness (Felitti et al., 1998; Heim & Nemeroff, 2001). Exposure to adverse experiences early in development are well-established as having biological, cognitive, affective, and behavioural effects on individual functioning (Cashmore & Shackel, 2013; Evans, 2014; Felitti et al., 1998). Additionally, exposure to childhood trauma is associated with both future perpetration and victimisation of intimate partner violence (IPV) (Fulu et al., 2017; Whitfield, Anda, Dube, & Felitti, 2003). For both of these reasons, the Victorian Royal Commission into Family Violence (RCFV) recommended that children be given their own voice as victim-survivors to enable professionals to understand their individual needs, risk, and protective factors in order to intervene early and help children recover from their experiences of family violence (State of Victoria, 2014, Vol II). Accordingly, NTV recommend the mental health system assess child

functioning and mental health separate to that of a parent, guardian or carer. NTV also advises that assessment of mental health be considered in the context of violence and trauma in order to manage the risk of parents or guardians exerting pressure over children, and perpetrators of violence exerting control over victims (Quadara, 2015). Indeed, assessment of all clients who may have experienced violence should be mindful that clients may be experiencing ongoing violence and control from an intimate partner or other family member, and that low dosage treatment (such as an hour of psychotherapy per week) may have limited utility for a victim who has to return home to an environment in which they are subjected to ongoing abuse and degradation (Allen, 2012). The cumulative effects of complex and ongoing traumas such as family violence and child abuse are important to assess for several reasons. First, all community and health services have a legislated obligation to assess family violence risk and child abuse; second, timely and responsive interventions may protect against future harms across the lifespan such as family violence victimisation, perpetration, substance abuse, and suicide; and third, such responses validate victim lived experience, uphold the dignity of clients, and have the best chance of supporting recovery from trauma and associated mental health effects.

Blueknot Foundation have reported that complex forms of trauma such as child abuse are seldomly assessed in the mental health system, leading to re-traumatisation and misdiagnosis. Blueknot have emphasised in their "Last Frontiers" practice guidance for working with clients who have experienced complex trauma, that symptomologies characteristic of complex trauma such as emotional dysregulation, structural dissociation, or disorganised attachment are often mistaken for other diagnoses such as schizophrenia, despite the predominantly biological origin of schizophrenia (Kezelman & Stavropoulos, 2012).

In summary, it is important that mental health services assess factors beyond diagnostic criteria and provide coordinated and holistic assessment in partnership with community-based agencies (see below). It is vital that mental health services remain mindful of the unique threat posed by ongoing violence and trauma, because to ignore such factors risks disregarding client lived experience and is likely to pose a threat to treatment engagement and the therapeutic alliance, representing a missed opportunity for early intervention (Ormhaug, Jensen, Wentzel-Larsen, & Shirk, 2014; Sharf, Primavera, & Diener, 2010)

Gender and help seeking

Men are more reluctant than women to seek help regardless of the health concern. In Australia, men's help seeking for emotional distress is consistently lower than that of women. For example, men represent only 40% of Medicare subsided mental health clients, despite rates of mental illness between men and women being approximately equivalent (AIHW, 2019). The literature indicates that lack of help-seeking among men is, at least in part, due to gender socialisation.

In 2018, Jesuit Social Services and Associate Professor Michael Flood embarked on the *Man Box* project in order to understand the relationship between gender socialisation, help seeking, and health outcomes. The *Man Box* was the first study to focus on attitudes to manhood and the behaviours of young Australian men aged 18-30. The project involved a representative sample of 1000 young men from across the country and found a strong negative correlation between endorsement of what were called "Man Box rules" (e.g. self-sufficiency, toughness, rigid gender roles, aggression etc.) and help seeking. The less respondents endorsed rules of the *Man Box*, the more likely they were to seek help for feelings of sadness and depression from a wide variety of sources including romantic partners,

male friends, female friends, and psychologists. Positively, over three quarters of participants disagreed with the *Man Box* rules of *hypersexuality, rigid household roles,* and *men should use violence to gain respect.* Nevertheless, the study found a minority of participants that personally endorsed many of the *Man Box* rules, and that many more felt social pressure to conform to *Man Box* rules even though they did not personally endorse them (The Men's Project & Flood, 2018).

Levant and Wimer (2013) were interested in the extent to which constructs of masculinity were either protective buffers or risk factors to men's health. The authors found that conformity to masculine norms, as defined by Mahalik et al. (2003), were risks to men's overall health outcomes, principally due to less help seeking and negative attitudes towards psychological treatment. The study also found that men were half as likely to seek help from a GP than women, and Addis (2008) found that men who seek mental health treatment tend to do so late in illness or after entirely expending internal resources (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). These findings are strongly endorsed by NTV members, who report the vast majority of clients who engage in specialist men's family violence interventions are pressured by statutory bodies to do so (anecdotally 80%). These findings also conform with recent Australian findings in *Beyond the Emergency,* which reported that between July 2015 and June 2016 men experiencing acute mental health issues presented to emergency services 110,000 occasions (Turning Point, 2019).

Although initial presentation to services is an important indicator, help seeking should be understood as broader than the act of asking for help or seeking out a service. Indeed, once a man has entered a service or begun a course of treatment, masculine norms related to self-sufficiency may interfere with treatment processes and lead to deficits in the therapeutic alliance (Richards & Bedi, 2015). Fundamentally, clients engaging in services must believe that they cannot fix their problem alone. For men who hold ideals of invulnerability, the treatment process poses very particular challenges and threats to identity and self-concept. In a study in a primary health context, Hegarty and her colleagues reported that men who were using or at risk of using family violence did see a need for early intervention before their behaviour reached the point of police and court-based intervention. The barrier to their help seeking, however, was a lack of knowledge about the specific points, places, and contexts in which opportunities to engage in help might exist (Hegarty et al., 2016). This study, like the *Man Box* study, suggests that a proportion of men are willing to access professional help, but the ways that such help is presented to men is of particular importance. If men are taught that seeking help makes them less of a man, they are less likely to seek it. However, if men are taught that asking for help is brave and their peers endorse this view, they are more likely to ask for help and engage in services (Mahalik & Burns, 2011). Though the mental health service system ought to emphasise the link between masculine norms, avoidant coping, and poor mental health outcomes for men and their families, the Commission should be careful to also emphasise the positive and prosocial aspects of masculinities and the need for gender-sensitive treatments in order to engage more men earlier who may require mental health interventions (Judd et al., 2009).

The American Psychological Association has recently published guidelines for working with men and boys that the Commission should be aware of, and consult, in an effort to provide more engaging, motivating and responsive mental health services to boys and men (American Psychological Association, 2018). NTV directs that Commission's attention to Guideline 7 (*Psychologists strive to reduce men;s aggression, violence, substance abuse, and suicide)*, Guideline 8 (*Psychologists help boys and men engage in health-related behaviours*), and Guideline 9 (*Psychologists strive to build and promote gender-sensitive psychological services*).

The mental health system faces serious challenges in engaging and keeping men engaged in mental health services earlier and more effectively. Male engagement in mental health services becomes

particularly important in light of men representing 75% of all suicides in Australia (ABS, 2017), and the vast majority of perpetrators of family and community violence (Andrews & Bonta, 2015; Kimmel, 2011; K. a. Seidler, 2010). If men are left to cope alone, they pose a risk both to themselves and their families as they are more likely to be living with untreated mental illness, be coping through the use of drugs and alcohol, and are more likely to externalise their symptoms by blaming their partners, families, or society writ large.

Suicide

Cross-culturally men are four times more likely to die of suicide than women (De Leo, Draper, Snowdon, & Kõlves, 2013). Some authors have argued that practitioner stereotypes about men's tendency to externalise emotional distress constitutes a clinical bias among mental health professionals, and partially explains the under-recognition of internalising disorders which may lead to suicide, such as depression (American Psychological Association, 2018). Suicide rates are higher for individuals who have been subject to abuse, or witnessed abuse during childhood (Cashmore & Shackel, 2013; Kezelman & Stavropoulos, 2012), and suicide is more likely among individuals who exhibit problematic drinking (Pompili et al., 2010) .

The Commission should be aware of these risk factors in order to address suicide in the Victorian community, with particular attention being paid to engagement strategies to respond to men, with the understanding that due to gender socialisation men may be more reluctant to reveal internalising disorders, and may more readily report gender normative avoidance strategies such as substance abuse. Seidler et al. (2016) emphasised that masculine norms may impede communicating, recognising, and understanding mental health issues among men, and perhaps most concerningly, suicide was considered as a brave, masculine attempt to gain control over feelings of disempowerment and distress among a sub-population of men. Finally, one practitioner who has been working as a MBCP facilitator for over 15 years reported to NTV that they have had more clients suicide in the last five years than they had seen in the preceding ten. Why this was the case they could not say, but they and their service are deeply concerned about the escalating suicide rates among their clients. As a result, the service has implemented pro-active case management and psychosocial supports for clients who express suicidal ideation. It should be noted by the Commission that this service is not provided any extra funding for this increased level of care.

Suicide-Homicide

In the context of increasing suicide rates across Australia (ABS, 2017) and the murder of over one woman a week at the hands of a partner or ex-partner (AIC, 2017), the Commission should be aware of the relatively rare but significant relationship between suicide and homicide. Suicide and aggression towards others have long been theorised to be related. In 1905, Freud asserted that suicide was an act of aggression turned inwards (Freud, 1953). However, psychodynamic theory notwithstanding, research into aggression and self-harm have largely remained distinct areas of inquiry (O'donnell, House, & Waterman, 2015). Nevertheless, homicide-suicide occurs at the rate of approximately 0.3% per year cross-culturally, and although overall homicide and suicide rates are highly variable across cultures, homicide-suicide remains constant around the world (Hillbrand, 2001). NTV assert the reason for these constant rates are primarily due to the gendered dynamics of homicide-suicide, with the overwhelming majority of homicide-suicides being perpetrated by men (95% in the United States) and victims of such acts being overwhelmingly women (85% in the United States). This stands in contrast

to other forms of homicide, which are primarily perpetrated by men towards other men (Kimmel, 2011). The National Homicide Monitoring Program (NHMP) has monitored homicides in Australia since 1989 and have found that 80% of homicide-suicides in Australia since 1989 occurred in the context of family violence. Out of this 80%, most homicide-suicides were accomplished with a firearm.

Given that most homicide-suicides occur in the context of family violence, it is important that mental health clinicians hold a clear understanding of family violence risk when assessing risk of suicide. The best, albeit limited evidence, suggests that homicide-suicide represents a distinct phenomenon. Homicide-suicides are most likely to be perpetrated by men, who are older, exhibit paranoid thinking, depression and abuse alcohol (Meloy, 1998). Other common clinical characteristics among individuals who commit homicide-suicide are histories of impulsivity, violence, prior suicide attempts, despair and hopelessness (Hillbrand, 2001). It is this latter characteristic that, anecdotally, contributes to specialist men's family violence services' assessment of escalated risk and the need for immediate risk management. Reduction in access to firearms may also help to reduce the rates of homicide-suicides, given that a large proportion of these incidents involved a firearm. This profile suggests that risk of suicide among a sub-population of individuals may also represent a risk of violence towards intimate partners and children, in some cases this violence may become lethal. Although rare in comparison to all homicides and suicides, being killed by a partner or ex-partner represents 50% of all murders of women in Australia (Forsdike et al., 2018). The Victorian community is rightly appalled by such senseless and tragic deaths. Consequently, the RCFV highlighted the responsibility of all Victorians and services in reducing the frequency and severity of family violence in the Victorian community. NTV therefore believes that the present Royal Commission has an opportunity to expand the Victorian community's knowledge about homicide-suicide and assist clinicians to more readily identify when homicide is an associated risk of suicide. NTV acknowledges that the prediction of dangerousness is fraught and an issue that has perplexed forensic psychologists for as long as the discipline has existed (Kozol, Boucher, & Garofalo, 1972). However, we believe that further analysis of Coroner's reports by the Commission may illuminate this issue and assist mental health professionals to more effectively prevent homicide-suicides from occurring.

Recommendation 1-4

1. Adopt a theory of trauma that acknowledges complex and ongoing traumas and associated symptoms.
2. Develop a mental illness prevention campaign that is gender sensitive and engaging and inclusive of all Victorian men and their varied gender performances.
3. Develop a suicide prevention campaign that asserts that asking for help is brave and includes male peers supporting and encouraging help-seeking.
4. Research is conducted into prevalence and qualitative properties of homicide-suicides with particular attention being paid to risk factors associated with perpetration of homicide-suicide.

Delivering the best mental health outcomes and improved access

Strengthening pathways and interfaces between Victoria's mental health system and other services

Literature exists cross-jurisdictionally on strategies to increase sector and service collaboration between mental health and family violence services (New South Wales Health, 2004; United Kingdom, 2003). The literature highlights the importance of coordinated and holistic responses in situations which involve the intersection of family violence and mental ill-health. Potential exists in Victoria for full or partial replication of these approaches in order to enhance system responses to achieve the primary objectives of the family violence system - namely victim safety and perpetrator change - while also addressing the mental health needs of both client groups.

Cross-collaboration, training and supervision has the potential to improve the skills of mental health professionals to identify and respond to family violence risk and improve literacy of mental illness presentations in the family violence service system. Evidence shows that better outcomes for clients can be achieved through collaboration, however there is a need for services to be aligned in their goals and understand their own roles and responsibilities (Victorian Government, 2006). NTV heard from members regarding concerns about mental health system responses to family violence. Members expressed concern that mental health responses were overly diagnostic and failed to recognise family violence as an antecedent to mental illness and failed to work with victims safely and perpetrators non-collusively. Mental health and specialist family violence services must overcome this distrust if system pathways are to be improved and effective collaboration between sectors is to occur. These tensions are further discussed in Domestic Violence Victoria's submission to the RCMH and require urgent attention by the Commission if collaboration between the two sectors is to be achieved.

Collaboration exists in some member services although these arrangements remain informal and the product of personal relationships. While pockets of good practice exist through such arrangements, reliance on these initiatives is unsustainable over the long-term. Lack of formal frameworks for collaboration is concerning at both the practice and policy levels. First, at the practice level, because the absence of such models decreases the likelihood of holistic responses to clients, which may result in neglect of client mental health needs, and the potential of inadvertent collusion and endorsement of violence supporting narratives by mental health professionals (George, 2019). Second, at the policy level, because a lack of clear plans for collaboration, change management strategies, theories of change, and program logics cause such arrangements to be inured to evaluation, falsification, and ultimately replication.

Holding more promise in the strengthening of system pathways are co-location models such as those at NTV member organisation, *Bethany Community Support*. At Bethany, family, disability, family violence, financial, housing, and kindergarten services all sit within the same service to respond to community members' complex and intersecting psychosocial needs. During consultations, members believed that a similar model in which family violence (victim and perpetrator), mental health, alcohol and other drug, and housing services were co-located holds potential to better provide mental health, trauma, and violence informed interventions in the lives of Victorians. Members believed that such a model has greater potential for those clients who are excluded from MBCP on the basis of mental illness, given that when they are left to self-refer into appropriate services, they were assessed as unlikely to do so.

Throughout NTV's member consultations, the theme of stronger pathways between community family violence services and community mental health services was consistently emphasised, with a number of members expressing a desire for more community mental health referral options to

address the mental health needs of clients unable to access Medicare subsidised care due to instability (and being unable to consistently make it to appointments) or exhausting their entitled sessions under the scheme. Other members also suggested they saw a number of clients for whom subsidised private psychology was out of reach due to not being able to afford private psychology, even at a subsidised rate. Members expressed a need for private psychology to be fully subsidised in order to increase accessibility for the most vulnerable Victorians. Such a move was recently endorsed by the Australia Psychological Society[1]. While NTV is cognisant that Medicare sits outside of the Victorian jurisdiction, we urge the Victorian government to advocate for fully subsidised private psychology Australia wide. We also urge that it is critical that these mental health clinicians are trained and skilled in identification of family violence and best practice is responding to victim-survivors and perpetrators.

Better service and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements

As outlined above, NTV believes that any infrastructure and planning of Victoria's mental health system needs to include clear direction for how the system will incorporate trauma and violence informed approaches to the mental health needs of all Victorians. NTV believe that theory-driven approaches with clear policy and practice prescriptions and realist evaluation approaches hold the greatest promise in designing and evaluating reforms as complex as those needed in the Victorian mental health system (De Silva et al., 2014; Nurjono et al., 2018).

NTV directs the Commission's attention to *The Family Violence Reform Implementation Monitor* reports to understand the strengths and weaknesses of the reform process undertaken in the family violence sector in Victoria. NTV and our members believe there are significant lessons to be learnt from the comprehensive reform that has been undertaken in Victoria's family violence sector. NTV has heard from our members about the difficulties in implementing many of the reforms recommended by the RCFV and committed to by the Victorian government, due primarily to the lack of a change management strategy. Members have made it clear to NTV that any proposed changes to the mental health system require clear change management strategies, especially when working across service systems, staffed by professionals with diverse training backgrounds, client populations, and theoretical models through which clinical practice is undertaken.

A particularly illustrative example of the need for a change management strategy is the implementation of the Family Violence Information Sharing Scheme, by which mental health and other health, statutory and community services are tasked with, and authorised to assess and respond to family violence risk by sharing risk relevant information with other agencies. The Family Violence Information Sharing Scheme is created through the newly established Part 5A of *the Family Violence Protection Act 2008 (FVPA).* NTV believes that this legislative change provides the necessary authorising environment, however we have heard from our members that issues have emerged in the implementation of the scheme due to cultural and practice issues, rather than legal ones.

Attempts to change the policy and practice of services and professionals through legislation is not unique to either Victoria or the family violence sector (see Hudson, 2005). While NTV welcome such legislative changes, issues remain at cultural, ideological, organisational, and ethical levels. For example, a number of NTV members have reported differences of opinion between family violence professionals and mental health professionals when it comes to client confidentiality. NTV members

[1] https://www.smh.com.au/politics/federal/psychologists-demand-universal-access-to-mental-health-treatment-20190605-p51urj.html

have reported a rigidity among mental health professionals in adhering to principles of client confidentiality, even in circumstances where family violence professionals have held concern that a mental health client may be at risk of harming his family members. These differences are not easy to resolve. Client confidentiality is a crucial component in providing safe and trustworthy services, which is important for reducing re-traumatisation, upholding the dignity and right to privacy of clients, and establishing the therapeutic alliance. However, NTV members and the family violence sector broadly, hold the principles of safety for victim survivors first, and the RCFV found that in circumstances where a victim survivor's safety is at risk, the confidentiality of the perpetrator of harm is secondary. Indeed, it is for this reason that the information sharing scheme was implemented in the first place.

It is clear that legislation is insufficient for the implementation of safe and ethical practice that upholds the rights, and privileges the safety, of all clients. Without a clear change management process, agencies are left to haphazardly draw up Memoranda of Understandings (MOUs) between one another leading to a lack of systematic implementation of the processes required to operationalise legislation across services.

Recommendation 5-6

5. Investment in building relationships between mental health and family violence services and investment in the planning and development of co-location models
6. Legislation is not relied upon to implement new service plans, governance structures and information sharing schemes. To achieve this, systematic change management plans are implemented which account for cultural, ideological, policy, and practice differences across sectors and services

Needs of family members and carers

The needs of carers supporting family members with physical, cognitive, and behavioural challenges have recently been highlighted in a number of important policy and research documents focusing on the co-occurrence of these issues with family violence in the Victorian context. Brain Injury Australia in partnership with NTV, Domestic Violence Victoria, the Centre for Excellence in Child and Family Welfare, and Monash University undertook an inquiry into the prevalence of Acquired Brain Injury (ABI) among victims and perpetrators of family violence in response to Recommendation 171 of the RCFV (Brain Injury Australia, 2018). We discovered that ABIs were common in both victims (40% of victims attending Victorian hospitals over a ten-year period) and perpetrators (who were twice as likely as matched community samples to be living with an ABI). We established a clear relationship between experiencing family violence and the acquisition of a brain injury, and that ABI may lead to the development of problematic behaviours, that if untreated, have the potential to escalate to violence and abuse. We also found that ABI increases the risk of individuals coming into contact with Victoria's mental health and justice systems. We found unique challenges for carers who had to transition from living with a neurotypical family member, whom in many cases was patient and emotionally available, to a family member who was dependent, distant, and in some cases, violent and aggressive. We found very limited support for these carers, and support was often dependent on the means through which an injury was sustained (e,g, work-related injury compensation schemes). If support was available, it was usually sporadic and provided through work, sports, or road/traffic

insurance schemes, and if an injury was sustained in private as a result of family violence, support was unavailable.

Carers reported to us that the co-occurrence of violence or aggression isolated them further from accessing health or community support services. Carers felt lost and exacerbated, unable to navigate the health system alone, trying to negotiate their own safety and dignity, and not wanting to report violence to police due to fear of their family member becoming emmeshed in the justice system or becoming homeless. Fitz-Gibbon, Elliot, and Maher (2018) found similar barriers to reporting and support for carers in the contexts in which mental illness, cognitive impairment, autism, or complex trauma was co-occurring with adolescent violence towards parents, siblings, or other family members. Parents were very clear that they did not want their children to become involved in the criminal justice system, as they saw this as making things worse for their family member and themselves. Parents were also clear that they required psychosocial support. However, non-criminal justice support for carers experiencing adolescent violence was virtually unavailable. As 10% of all family violence incidents in Victoria involve a perpetrator below the age of 18 (Fitz-Gibbon et al., 2018), there is a need for the mental health system to coordinate with family violence and child welfare services in order to develop responsive services which address the underlying causes of adolescent violence, change behaviour, and support carers and families.

NTV members caution that the carer relationship is one constituted by an unequal distribution of power, which may be misused against victims. Examples given to NTV include exaggerations about victim symptomology by carers in order to justify using coercive or controlling behaviours against them, and "weaponizing" a victim's diagnosis against them by making vexatious claims to statutory bodies such as child protection (CP). This second example is also supported in the literature (e.g. Brownridge, 2006; Cooper et al., 2009). Therefore, as well as providing support for carers of individuals experiencing mental illness, it is also incumbent on the Commission to make recommendations to the mental health system to put protections in place to mitigate against the potential for abuse of power that may occur in relationships in which an intimate partner or family member is dependent on another. NTV urge further analysis of deaths recorded against both family violence and mental health involving a caring relations within Coroners reports.

Recommendation 7

7. Publicly funded psychosocial support is provided for carers supporting someone with a mental illness. Assessment of need should be coordinated with specialist family violence services to assess risk of violence, abuse, and coercive control. Policy should be developed that includes protections to ensure carers don't abuse their position of power to control or make decisions against the will of the person in their care.

Best practice and person-centred treatment and care models

Victims and perpetrators of family violence

NTV would like to highlight the mental health needs of victims and perpetrators of family violence. Family violence is a significant antecedent to many mood, anxiety, and personality disorders, which may develop as a result of maladaptive coping in response to complex traumas (Kezelman & Stavropoulos, 2012; Lagdon, Armour, & Stringer, 2014). Correlation studies indicate a strong

association between exposure to family violence and mental illness with victim survivors at risk of clinical depression, generalised anxiety, phobias, PTSD and alcohol and drug abuse disorders (Chandon et.al 2019). Mental illnesses in men identified as using family violence is also prevalent. These conditions include anxiety disorders such as generalised anxiety disorder, panic disorder, social phobia, PTSD, and substance abuse disorders (Shorey, Febres, Brasfield, & Stuart, 2012) Personality disorders have also been frequently observed in men who have used family violence (specifically IPV), with the presence of such conditions being predictive of recidivism (Ehrensaft et al., 2003; Gondolf, 1999; Amy Holtzworth-Munroe & Meehan, 2004; Amy Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart, 2000; A. Holtzworth-munroe & Stuart, 1994). Family violence is also associated with suicide. In a study of all suicides in Victoria over the period of 2009 to 2012 family violence was established as a factor in the lives of more than one third of all individuals who suicided (MacIsaac et al., 2018). The authors found that family violence was present in almost half of female suicides and in one third of male suicides, with men more likely to have perpetrated violence and women more likely to have been victims of violence.

Twenty per cent of family violence incidents recorded by Victoria police between 2013 and 2014 identified mental illness as a risk factor among perpetrators of family violence. There was a particularly strong association between recidivist-identified perpetrators and mental illness (Thomas, 2019). Though it is important to note the overwhelming majority of people with a mental illness are not violent, there are nevertheless some significant associations between, in particular, anxiety and trauma-derived conditions, and violence perpetration. The literature has identified the presence of personality disorders, distorted and antisocial thinking, and psychopathy as presenting significant challenges in engaging corrections and forensic clients and delivering effective interventions (Chambers, Eccleston, Day, Ward, & Howells, 2008; Day, Casey, Howells, Vess, & Ward, 2011; Howells & Day, 2007). Clients exhibiting significant symptomologies associated with these conditions are likely to be excluded from MBCP.

While NTV members acknowledged the high prevalence of some mental health conditions among the perpetrator clients with whom they work, they also emphasised that serious mental illness (SMI) is relatively rare in this client group. Members did however report that sometimes it is necessary to exclude clients from MBCP on the basis of mental illness. Members said they would exclude clients from MBCP due to client inability to sit physically or psychologically in the group, concentration deficits (which may or may not be associated with mental illness), client's experiencing frequent triggers in the group environment, or frequent disruptions to group processes due to hypervigilance or other trauma-associated symptoms. Exclusion of clients due to mental illness was characterised by one member as sometimes necessary but had the effect of "disadvantaging the disadvantaged". NTV members expressed a desire to be able to provide alternative options to this client group, including coordinated interventions that build over time to address both mental illness and family violence perpetration.

Those in contact with the justice system

NTV members work, almost exclusively, with clients that are in some way involved in Victoria's criminal or civil justice systems. Although many clients come to access our member services as a condition of civil or corrections orders, a preponderance of clients lack an understanding of (a) the court process, (b) the conditions of their orders, and (c) the behaviours for which they have been referred to services (Vlais & Campbell, 2019). Clients often report perfunctory motivations for participation in services, and often harbor resentment towards partners, family members, police, or

the broader intervention system for forcing them to participate in, what are perceived to be, unnecessary or unjustified treatment programs (A. Day, Tucker, & Howells, 2004; Forsdike et al., 2018; Vlais & Campbell, 2019). As discussed above, gendered socialisation may lead to men lacking insight into their own cognitive and emotional processes, as well as the effect of their behaviour on others (Seidler et al., 2016). This social context may lead to cognitive distortions (e.g. people are out to get me) which support continued violent and abusive behaviours and may represent significant barriers to both treatment readiness and behaviour change (Chambers et al., 2008), particularly among antisocial clients (Howells & Day, 2007).

Treatment readiness and motivation

Increasing motivation and the assessment of readiness for treatment is an under-researched and under-funded aspect of the work that our member organisations provide. This is the case despite consistently high attrition rates from MBCP (Jewell & Wormith, 2010) and findings in forensic and coerced treatment settings that enhancing client motivation prior to treatment commencement leads to reductions in recidivism, decreases in psychopathology, increases in community/victim safety, and generally positive treatment outcomes across a range of programs, addressing a number of offending behaviours, compared to controls (Addison & Hegarty, 2019; Day et al., 2011). However, in order to more robustly measure and target treatment readiness in the forensic and corrections settings, further development and validation of the multifactor offender readiness model (MORM) is required (Ward, Day, Howells, & Birgden, 2004). Addison and Hegarty (2019) found that, because of the self-report operationalisations of the MORM (such as VTRQ), current instruments fail to capture the variables likely to effect readiness that are not cognitively available to clients. obscuring, in particular, the ways that institutional and treatment contexts impede or facilitate treatment readiness and engagement.

Punishment and rehabilitation

People in prison are twice as likely than those in the community to have a mental illness, 15 times more likely to have a psychotic disorder, and a third of people taken into police custody are likely to be receiving psychiatric treatment at the time (J. R. Ogloff et al., 2013). Prisoners with mental illness often do not fare well in custodial settings. Individual and social deterrence is often cited as the justification for imprisonment, but this is based on the assumption that individuals commit offences after an evaluation of the risks and rewards of taking a particular action. For individuals with disordered thinking, this is unlikely to be true. In any case, for punishment to be effective, it must be predictable, comprehensible, and immediate, conditions that are very difficult to facilitate outside of a laboratory environment (Lydon, Healy, Moran, & Foody, 2015), and certainly absent from Victoria's justice system.

While punishment plays an important role in setting normative standards in society, and NTV welcome the strengthening of accountability measures for perpetrators who use violence and abuse towards their families, we have found that punishment absent opportunities to reflect on and change behaviour in evidence-informed psychosocial programs does not have a deterrent effect. The Commission should be aware, however that punishment (especially imprisonment) alone does not have a neutral effect either. Indeed, the literature suggests punishment absent rehabilitation makes recidivism more likely (McGuire, 2002; Trevena & Poynton, 2016).

There is also evidence that rehabilitative approaches to behaviour change are more effective than punishment alone for all kinds of offending behaviours. This point is thoroughly outlined in the highly influential *Psychology of Criminal Conduct (*Andrews & Bonta, 2015*)*. Professor Andrew Day has also laid out in *The Conversation* the reasons why punishment is an unreliable mechanism through which to seek behaviour change and the need for justice systems to utilise strong theoretically and empirically supported rehabilitation programs[2]. Day recommends funding and development for innovative and community based rehabilitation programs, development of specialist Aboriginal and Torres Strait Islander programs, who are grossly overrepresented at all levels of the justice system, including forensic mental health (J. Ogloff et al., 2013). The proper selection, training, supervision, and resourcing of staff, and robust and complex evaluation designs that include cross-jurisdictional collaboration, large samples, and a national approach. NTV second all of Professor Day's recommendations and would like to emphasise that whether programs are delivered in custodial or community settings they should be evidence-informed, uphold the dignity of participants, consider the safety of victims, and seek to reduce the pathology and enhance the wellbeing of all clients.

Recommendation 8

8. Recommendations for improving the mental health outcomes of:
   a. Victims of family violence: System-wide training is rolled out for mental health workers on the prevalence of mental illness and vulnerabilities faced by victims of family violence. This training is provided by specialist family violence services with steps taken over the long-term to develop specialist roles that are located in the mental health system that includes a focus on victims of family violence.
   b. Perpetrators of family violence: System-wide training is rolled out for mental health workers on the prevalence of mental illness and risks and needs of perpetrators of family violence. This training is provided by specialist family violence services with steps taken over the long-term to develop specialist roles that are located in the mental health system that includes a focus on perpetrators of family violence.
   c. Those within the justice setting: Greater investment in research, development and staffing of community rehabilitation programs and a concerted effort to reduce the number of low risk offenders with mental illness in Victorian prisons and a divestment from punitive approaches to psychosocial problems.

[2] https://theconversation.com/crime-and-punishment-and-rehabilitation-a-smarter-approach-41960

References

ABS. (2017). *Causes of Death*. Canberra.

Addis, M. E. (2008). Gender and Depression in Men. *Clinical Psychology: Science and Practice, 15*(3), 153-168. doi:10.1111/j.1468-2850.2008.00125.x

Addison, M., & Hegarty, K. (2019). *Traetment readiness among perpetrators of IPV: A systematic review*. Manuscipt in preperation.

Afifi, M. (2007). Gender differences in mental health. *Singapore Med J, 48*(5), 385-391.

AIC. (2017). National Homicide Monitoring Program. *Australian Institute of Criminology*.

AIHW. (2019). *Mental health services in Australia*. Canberra.

Allen, M. (2012). *Narrative therapy for women experiencing domestic violence supporting women's transitions from abuse to safety*. London.

American Psychological Association, B. a. M. G. G. (2018). APA guidelines for psychological practice with boys and men.

Andrews, D. A., & Bonta, J. (2015). *The psychology of criminal conduct* (5th ed.. ed.): New York: Routledge.

Australia, B. I. (2018). *The prevalence of acquired brain injury among victims and perpetrators of family violence*. Sydney, Australia: Brain Injury Australia.

Brownridge, D. A. (2006). Partner Violence Against Women With Disabilities: Prevalence, Risk, and Explanations. *Violence Against Women, 12*(9), 805-822. doi:10.1177/1077801206292681

Bruce, M., & Laporte, D. (2015). Childhood trauma, antisocial personality typologies and recent violent acts among inpatient males with severe mental illness: Exploring an explanatory pathway. *Schizophrenia Research, 162*(1-3), 285-290. doi:10.1016/j.schres.2014.12.028

Carpenter, C. J. (2019). Cognitive dissonance, ego-involvement, and motivated reasoning. *Annals of the International Communication Association, 43*(1), 1-23. doi:10.1080/23808985.2018.1564881

Cashmore, J., & Shackel, R. (2013). *The long-term effects of child sexual abuse*. Canberra: Child Family Community Australia.

Chambers, J. C., Eccleston, L., Day, A., Ward, T., & Howells, K. (2008). Treatment readiness in violent offenders: The influence of cognitive factors on engagement in violence programs. *Aggression and Violent Behavior, 13*(4), 276-284. doi:https://doi.org/10.1016/j.avb.2008.04.003

Connell, R. W. (2005). *Masculinities* (2nd ed.. ed.): Crows Nest, N.S.W. : Allen & Unwin.

Cooper, C., Selwood, A., Blanchard, M., Walker, Z., Blizard, R., & Livingston, G. (2009). Abuse of people with dementia by family carers: representative cross sectional survey. *Br. Med. J., 338*. doi:10.1136/bmj.b155

Council, N. R. (2014). *Sociality, Hierarchy, Health: Comparative Biodemography: A Collection of Papers*. Washington, DC: The National Academies Press.

Culyer, A., & Lomas, J. (2006). *Deliberative Processes and Evidence-Informed Decision Making in Health Care—Do They Work and How Might We Know* (Vol. 2).

Day, Casey, S., Howells, K., Vess, J., & Ward, T. (2011). *Transitions to Better Lives : Offender Readiness and Rehabilitation* (1st edition. ed.): Cullompton : Willan Publishing.

Day, A., Tucker, K., & Howells, K. (2004). Coerced offender rehabilitation – a defensible practice? *Psychology, Crime & Law, 10*(3), 259-269. doi:10.1080/10683160410001662753

De Leo, D., Draper, B. M., Snowdon, J., & Kõlves, K. (2013). Contacts with health professionals before suicide: Missed opportunities for prevention? *Comprehensive Psychiatry, 54*(7), 1117-1123. doi:10.1016/j.comppsych.2013.05.007

De Silva, M. J., Breuer, E., Lee, L., Asher, L., Chowdhary, N., Lund, C., & Patel, V. (2014). Theory of Change: a theory-driven approach to enhance the Medical Research Council's framework for complex interventions. *Trials, 15*(1), 267. doi:10.1186/1745-6215-15-267

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational Transmission of Partner Violence: A 20-Year Prospective Study. *Journal of Consulting and Clinical Psychology, 71*(4), 741-753. doi:10.1037/0022-006X.71.4.741

Evans, A. (2014). *Trauma-Informed Care : How Neuroscience Influences Practice* (1st edition. ed.): London : Routledge.

Faludi, S. (1992). *Backlash : the undeclared war against women*: London : Vintage.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258. doi:10.1016/S0749-3797(98)00017-8

Fitz-Gibbon, K., Elliot, K., & Maher, J. (2018). *Investigating adolescent family violence in Victoria: Understanding experiences and practitioner perspectives*. Faculty of Arts, Monash University.

Flannery, R. B., & Harvey, M. R. (1991). PSYCHOLOGICAL TRAUMA AND LEARNED HELPLESSNESS: SELIGMAN’S PARADIGM RECONSIDERED. *Psychotherapy: Theory, Research, Practice, Training, 28*(2), 374-378. doi:10.1037/0033-3204.28.2.374

Flood, M. (2004). Backlash: Angry men's movements [Chapter 21]. In R. Stacey Elin (Ed.), *The battle and backlash rage on: Why feminism cannot be obsolete* (pp. 261-278): Xlibris Corporation.

Forsdike, K., Tarzia, L., Flood, M., Vlais, R., & Hegarty, K. (2018). "A Lightbulb Moment": Using the Theory of Planned Behavior to Explore the Challenges and Opportunities for Early Engagement of Australian Men Who Use Violence in Their Relationships. *Journal of Interpersonal Violence*, 886260518780778. doi:10.1177/0886260518780778

Freud, S. (1953). *The standard edition of the complete psychological works of Sigmund Freud*: London : Hogarth Press.

Fulu, E., Miedema, S., Roselli, T., McCook, S., Chan, K. L., Haardörfer, R., & Jewkes, R. (2017). Pathways between childhood trauma, intimate partner violence, and harsh parenting: findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *The Lancet Global Health, 5*(5), e512-e522. doi:10.1016/S2214-109X(17)30103-1

Gondolf, E. W. (1999). Characteristics of Court-Mandated Batterers in Four Cities: Diversity and Dichotomies. *Violence Against Women, 5*(11), 1277-1293. doi:10.1177/10778019922183372

Goodman, L. A., Koss, M. P., & Felipe Russo, N. (1993). Violence against women: Physical and mental health effects. Part I: Research findings. *Applied and Preventive Psychology, 2*(2), 79-89. doi:10.1016/S0962-1849(05)80114-3

Hegarty, K., Tarzia, L., Forsdike, K., Vlais, R., Flood, M., Feder, G., & Humphreys, C. (2016). *Final Report: Promoting early intervention with men's use of violence in relationships through primary care (PEARL study)*. Canberra.

Heilman, B., & Barker, G. (2018). *Masculine norms and violence: Making the connections*. Washington DC: Promundo-US.

Heim, C., & Nemeroff, C. B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. *Biological Psychiatry, 49*(12), 1023-1039. doi:10.1016/S0006-3223(01)01157-X

Hillbrand, M. (2001). Homicide–Suicide and Other Forms of Co-Occurring Aggression Against Self and Against Others. *Professional Psychology: Research and Practice, 32*(6), 626-635. doi:10.1037/0735-7028.32.6.626

Holtzworth-Munroe, A., & Meehan, J. C. (2004). Typologies of Men Who Are Maritally Violent: Scientific and Clinical Implications. *Journal of Interpersonal Violence, 19*(12), 1369-1389. doi:10.1177/0886260504269693

Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the Holtzworth-Munroe and Stuart (1994) Batterer Typology. *Journal of Consulting and Clinical Psychology, 68*(6), 1000-1019. doi:10.1037/0022-006X.68.6.1000

Holtzworth-munroe, A., & Stuart, G. L. (1994). TYPOLOGIES OF MALE BATTERERS - 3 SUBTYPES AND THE DIFFERENCES AMONG THEM. *Psychological Bulletin, 116*(3), 476-497.

Howells, K., & Day, A. (2007). Readiness for treatment in high risk offenders with personality disorders. *Psychology, Crime & Law, 13*(1), 47-56. doi:10.1080/10683160600869767

Hudson, B. (2005). Information sharing and children's services reform in England: Can legislation change practice? *Journal of Interprofessional Care, 19*(6), 537-546. doi:10.1080/13561820500412114

Jewell, L. M., & Wormith, J. S. (2010). Variables Associated With Attrition From Domestic Violence Treatment Programs Targeting Male Batterers: A Meta-Analysis. *Criminal Justice and Behavior, 37*(10), 1086-1113. doi:10.1177/0093854810376815

Judd, F., Armstrong, S., & Kulkarni, J. (2009). Gender-sensitive mental health care. *Australas Psychiatry, 17*(2), 105-111. doi:10.1080/10398560802596108

Kezelman, C., & Stavropoulos, P. (2012). *"The Last Frontier" Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.

Kimmel, M. S. (2011). *The gendered society* (4th edition. ed.): New York : Oxford University Press.

Kozol, H. L., Boucher, R. J., & Garofalo, R. F. (1972). The Diagnosis and Treatment of Dangerousness. *Crime & Delinquency, 18*(4), 371-392. doi:10.1177/001112877201800407

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: a systematic review. *European Journal of Psychotraumatology, 5*, 10.3402/ejpt.v3405.24794. doi:10.3402/ejpt.v5.24794

Levant, R. F., & Wimer, D. J. (2013). Masculinity Constructs as Protective Buffers and Risk Factors for Men's Health. *American Journal of Men's Health, 8*(2), 110-120. doi:10.1177/1557988313494408

Lydon, S., Healy, O., Moran, L., & Foody, C. (2015). A quantitative examination of punishment research. *Research in Developmental Disabilities, 36*, 470-484. doi:10.1016/j.ridd.2014.10.036

MacIsaac, M. B., Bugeja, L., Weiland, T., Dwyer, J., Selvakumar, K., & Jelinek, G. A. (2018). Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia. *Asia Pac J Public Health, 30*(1), 36-44. doi:10.1177/1010539517743615

Mahalik, J. R., & Burns, S. M. (2011). Predicting health behaviors in young men that put them at risk for heart disease. *Psychology of Men & Masculinity, 12*(1), 1-12. doi:10.1037/a0021416

Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P. J., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity, 4*(1), 3-25. doi:10.1037/1524-9220.4.1.3

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC, US: American Psychological Association.

McGuire, J. (2002). Criminal sanctions versus psychologically-based interventions with offenders: A Comparative empirical analysis. *Psychology, Crime & Law, 8*(2), 183-208. doi:10.1080/10683160208415005

Meloy, J. R. (1998). *The psychology of stalking : clinical and forensic perspectives*: San Diego : Academic Press.

Nurjono, M., Shrestha, P., Lee, A., Lim, X. Y., Shiraz, F., Tan, S., . . . Maria Vrijhoef, H. J. (2018). Realist evaluation of a complex integrated care programme: protocol for a mixed methods study. *BMJ Open, 8*(3), e017111. doi:10.1136/bmjopen-2017-017111

O'donnell, O., House, A., & Waterman, M. (2015). The co-occurrence of aggression and self-harm: Systematic literature review. *Journal of Affective Disorders, 175*, 325-350. doi:10.1016/j.jad.2014.12.051

Ogloff, J., Patterson, J., Cutajar, M., Adams, K., Thomas, S., & Halacas, M. (2013). Koori prisoner mental health and cognitive function study. *Centre for Forensic Behavioural Science Monash University & Victorian aboriginal community controlled health organisations*.

Ogloff, J. R., Thomas, S. D., Luebbers, S., Baksheev, G., Elliott, I., Godfredson, J., . . . Moore, E. (2013). Policing Services With Mentally Ill People: Developing Greater Understanding and Best Practice. *Australian Psychologist, 48*(1), 57-68. doi:10.1111/j.1742-9544.2012.00088.x

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The Therapeutic Alliance in Treatment of Traumatized Youths: Relation to Outcome in a Randomized Clinical Trial. *Journal of Consulting and Clinical Psychology, 82*(1), 52-64. doi:10.1037/a0033884

OurWatch, ANROWS, & VicHealth. (2015). *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*. Melbourne, Australia.

Point, T. (2019). *Beyond the emergency: A national study of ambulance responses to ment's mental health*. Melbourne.

Pompili, M., Serafini, G., Innamorati, M., Dominici, G., Ferracuti, S., Kotzalidis, G., . . . Lester, D. (2010). Suicidal Behavior and Alcohol Abuse. *Int. J. Environ. Res. Public Health, 7*(4), 1392-1431. doi:10.3390/ijerph7041392

Project, T., & Flood, M. (2018). *The Man Box: A study on being a young man in Australia*. Melbourne.

Quadara, A. (2015). *Implementing trauma-informed systsems of care in health settings: The WITH study*.

Richards, M., & Bedi, R. P. (2015). Gaining perspective: How men describe incidents damaging the therapeutic alliance. *Psychology of Men & Masculinity, 16*(2), 170-182. doi:10.1037/a0036924

Seidler, Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review, 49*, 106-118. doi:10.1016/j.cpr.2016.09.002

Seidler, K. a. (2010). *Crime, culture & violence : understanding how masculinity and identity shapes offending* (1st edition. ed.). Bowen Hills, Qld.: Bowen Hills, Qld. : Australian Academic Press.

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). DROPOUT AND THERAPEUTIC ALLIANCE: A META-ANALYSIS OF ADULT INDIVIDUAL PSYCHOTHERAPY. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 637-645. doi:10.1037/a0021175

Shorey, R. C., Febres, J., Brasfield, H., & Stuart, G. L. (2012). The Prevalence of Mental Health Problems in Men Arrested for Domestic Violence. *Journal of Family Violence, 27*(8), 741-748. doi:10.1007/s10896-012-9463-z

Stark, E. a. (2009). *Coercive Control : How Men Entrap Women in Personal Life*: Oxford : Oxford University Press.

Steele, C. M., Spencer, S. J., & Lynch, M. (1993). Self-Image Resilience and Dissonance: The Role of Affirmational Resources. *Journal of Personality and Social Psychology, 64*(6), 885-896. doi:10.1037/0022-3514.64.6.885

Thomas, K. (2019). Research brief: Family violence perpetration and mental health. *Monash Gender and Family Violence Prevention Centre*.

Trevena, J., & Poynton, S. (2016). Does a prison sentence affect future domestic violence reoffending? , 12 p.

Vlais, R., & Campbell, E. (2019). *Bringing pathways towards accountability together: Perpetrator journeys and system roles and responsibilities*. Melbourne: RMIT University.

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior, 9*(6), 645-673. doi:10.1016/j.avb.2003.08.001

White, M. (2007). *Maps of narrative practice* (1st ed.. ed.): New York : W.W. Norton & Co.

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent Childhood Experiences and the Risk of Intimate Partner Violence in Adults: Assessment in a Large Health Maintenance Organization. *Journal of Interpersonal Violence, 18*(2), 166-185. doi:10.1177/0886260502238733