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CATALYSTS OF CHANGE

Interventions and service pathways for gay, bisexual, trans and queer (GBTQ) men who have used family violence in Victoria, Australia

LA TROBE UNIVERSITY
thorne harbour health
Q switchboard

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La Trobe University proudly acknowledges the Traditional Custodians of the lands where its campuses are located in Victoria and New South Wales. We recognise that Indigenous Australians have an ongoing connection to the land and we value their unique contribution, both to the University and the wider Australian society.

La Trobe University is committed to providing opportunities for Aboriginal and Torres Strait Islander people, both as individuals and communities, through teaching and learning, research and community partnerships across all of our campuses.

The wedge-tailed eagle (*Aquila audax*) is one of the world's largest.

The Wurundjeri people — traditional owners of the land where the Australian Research Centre in Sex, Health and Society is located and where our work is conducted — know the wedge-tailed eagle as Bunjil, the creator spirit of the Kulin Nations.

There is a special synergy between Bunjil and the La Trobe logo of an eagle. The symbolism and significance for both La Trobe and for Aboriginal people challenges us all to 'gamagoen yarrbat' — to soar.

Catalysts of change: interventions and service pathways for gay, bisexual, trans and queer (GBTQ) men who have used family violence in Victoria, Australia

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TERMINOLOGY

Language is constantly evolving and often contested. Communities help to define and redefine language. Around the sensitive topic of family violence, we have sought to be careful with how we use language, noting that it is something that can potentially perpetuate harm, discrimination and violence. We feel it is important to explain our use of the following terms:

Family violence describes "any violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships" (1). Such usage is consistent with how policy and practice stakeholders in Victoria refer to the range of situations involving violence (7).

User of violence or person who has used violence both emphasise that family violence is a choice and that no one is inherently violent. Participants referred to in this study using those terms acknowledged their use of violence as a condition of taking part in an interview. We have avoided the term "perpetrator" unless directly quoting a participant or published research.

The acronym LGBTIQ+ refers to people who identify as lesbian, gay, bisexual, trans and gender diverse, intersex, queer and/or other minority genders and sexualities.

GBTQ refers to people who identify as gay, bisexual, trans and gender diverse and/or queer and access Men's Behaviour Change Programs (MBCPs) and/or associated services.

Variations of these acronyms are used occasionally in this report to reflect how communities are described by research participants or represented in other research publications.

KEY TERMS

AOD: Alcohol and other drugs

AOD clinician: A professional working in alcohol and other drug counselling services

Clear Space: An online MBCP for GBTQ men at Thorne Harbour Health

Family violence: "Any violent, threatening, coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships" (1)

Family violence specialist: A professional working in family violence services, including MBCPs, at an LGBTIQ+ community-controlled organisation, mainstream service, private practice or as an independent facilitator or consultant to MBCPs

GBTQ: Gay, bisexual, trans and queer, used primarily in this report to refer to GBTQ men

Legal practitioner: A lawyer or other legal professional working on GBTQ family violence matters in a community legal centre setting

LGBTIQ+: Lesbian, bisexual, trans and gender diverse, intersex, queer and/or other minority genders and sexualities

LGBTIQ+ community-controlled organisation: Organisation based in LGBTIQ+ communities that is initiated by, governed by, operated by and accountable to its communities

MBCP: Men's Behaviour Change Program, for users of violence

Other practitioner: A professional working in general counselling, intake and assessment, including at an LGBTIQ+ community-controlled organisation; also includes employees of a court-based LGBTIQ+ family violence practitioner service offering advice to clients

Rainbow Door: Switchboard Victoria's LGBTIQ+ peer-run specialist helpline offering support, advice and referrals, including for family violence

ReVisioning: An MBCP for GBTQ men at Thorne Harbour Health

Switchboard Victoria: An LGBTIQ+ community-controlled organisation headquartered in Melbourne, providing services across Victoria

Thorne Harbour Health: An LGBTIQ+ community-controlled organisation headquartered in Melbourne, providing services across Victoria

User of violence: A person who has used violence in the context of an intimate or family relationship

Victim survivor: A person who has experienced violence in the context of an intimate or family relationship

CONTENTS

EXECUTIVE SUMMARY

About this study

This report explores how gay, bisexual, trans and queer (GBTQ) men who have used violence in an intimate or family relationship are encouraged to change their behaviour and commit to a life of non-violence. Drawing on interviews with users of violence, victim survivors and practitioners (many at LGBTIQ+ community-controlled organisations) in Victoria, Australia, this research identifies how users of violence access services and the approaches utilised by service providers to engage and retain them in behaviour change programs.

Awareness of family violence involving GBTQ men is not widespread. This report makes a significant contribution to knowledge about the service experiences and motivation to change of GBTQ men who have used violence in an intimate or family relationship. We hope that it can contribute to improved outcomes for victim survivors and others at risk of family violence.

Methods

What interventions and service pathways support GBTQ men who have used violence in their intimate and/or family relationships to change their behaviour?

This is the main question that this report seeks to answer. We do this by exploring how LGBTIQ+ family violence services and associated therapeutic services, legal services and helplines in Victoria create conditions that encourage users of violence to engage with programs, take accountability for their actions and commit to non-violence.

We draw on data from a total of 40 in-depth interviews, including with eight GBTQ men who have used violence, six victim survivors and 26 professionals (family violence practitioners, AOD clinicians, counsellors, helpline workers, community lawyers and legal professionals) who work with users of violence along service pathways. The eight GBTQ men who took part in a "user of violence" interview did so on the condition that they first accepted that they had used family violence.

This report is a partnership between the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University and LGBTIQ+ community-controlled organisations Thorne Harbour Health and Switchboard Victoria.

The La Trobe University Human Research Ethics Committee (HEC22270) and Thorne Harbour Health's Community Research Endorsement Panel (THH/CREP 22-017) both approved this study, independent of the researchers and authors involved.

Key findings

This study demonstrates that engaging GBTQ men who have used violence in services can be complex. It also shows how service responses that encourage **early engagement and clear pathways to LGBTIQ+ community-controlled organisations and other appropriate services** can lead to behaviour change.

GBTQ users of violence interviewed for this report have **faced challenges** accessing appropriate interventions such as Men's Behaviour Change Programs (MBCPs). Contributing to this have been factors such as low levels of awareness across society of family violence in GBTQ relationships; limited family violence service options for LGBTIQ+ people; safety concerns relating to "mainstream" MBCPs; and co-existing issues relating to AOD use, mental health and homelessness.

> *I had no concept of it beforehand. There is nothing we're exposed to in society, even anecdotally, or in stories … There's nothing equivalent to the "wife beater". Because you're not a wife beater – you don't know what you are. (User of violence)*

GBTQ men who have used violence in the context of intimate and/or family relationships **have complex – and sometimes contradictory – understandings of their harmful behaviour.** They have embarked on change processes from different vantage points, with some seeking to justify their behaviour, identify as victims of violence and/or attribute their use of violence to anger, AOD issues and toxic relationships.

I'm not a violent person that wakes up every day and chooses violence. I just happened to be in that situation where everything was just going to shit, basically. But … you have to make those choices to not do those things. (User of violence)

GBTQ men who have used violence have spoken of **seeking support for assorted reasons**, including through concern for the safety and welfare of a partner or former partner, and with diverse **motivations**, such as wanting to be a better person, control their anger and/or engage in a group setting.

A broad lack of awareness about the nature and prevalence of GBTQ family violence at times has resulted in misidentification of users of violence and victim survivors, especially in the initial stages of service engagement.

There are so many factors that piece together whether or not you believe that person may or may not be the primary aggressor of violence … It's the whole picture … It's hard to make generalisations because it's case by case. (Legal practitioner)

These factors present **challenges to family violence practitioners, other professionals and service providers** who seek to engage users of violence in services that encourage and contribute to meaningful behaviour change, accountability and commitments to non-violence. Users of violence changing is vital to the safety of victim survivors, including those who choose to stay in a relationship.

Individual practitioners, from legal professionals to MBCP facilitators, with sophisticated and nuanced understanding of LGBTIQ+ health and wellbeing issues, relationships and family violence, have played **important roles in identifying users of violence**, holding space for clients with complex needs while also challenging problematic narratives that seek to justify or excuse harmful behaviour. Encouraging users of violence to **stay engaged with services** while attempting to **avoid collusion** is a delicate balancing act for many practitioners.

Beyond the efforts of individual practitioners, a range of factors have influenced GBTQ men to engage with LGBTIQ+ community-controlled service providers and other programs that encourage behaviour change. These include:

- **supportive pathways** from legal settings, LGBTIQ+ helplines and AOD services, to family violence services and MBCPs
- **"social" mandates to change,** driven by community expectations of what is acceptable behaviour and accountability
- **tailored, innovative programs** that meet the needs of GBTQ men
- **integrated services** that help users of violence to access support for AOD and other issues alongside behaviour change programs

Victim survivors interviewed have been supportive of users of violence accessing family violence and associated services, particularly MBCPs. Some have observed positive results arising from a user of violence undertaking structured behaviour change work.

I believe it [attendance] was ordered by the court or he had the impression that it would benefit him in terms of the court and his sentence. So, he was doing the [MBCP] and he was really quite enjoying it … I could see that even just the way he spoke, the things he was saying, that he was getting something out of it … I could tell that, "OK, something's really clicked with him." (Victim survivor)

However, victim survivors interviewed tended not to be informed as well as they might be about the content or focus of MBCPs, while some questioned their effectiveness, especially when a user of violence was resistant to change.

Catalysts of change along service pathways

Service responses can significantly shape the extent to which a user of violence accepts the need to change. Interventions tailored to the needs of LGBTIQ+ individuals, relationships and communities have the potential to be **catalysts of change** for GBTQ men who have used family violence. We define a "catalyst of change" in a service context as *an aspect of the service experience that precipitates a user of violence making better choices, including addressing their behaviour and committing to non-violence.*

Early engagement with legal professionals, family violence practitioners and AOD counsellors, among others along service pathways, can be instrumental in identifying GBTQ men who have used violence, engaging them in services and creating the conditions in which they might seek to reflect on and change their behaviour.

Services that practitioners say "meet people where they are at" help to address issues related

to GBTQ men's recognition of family violence and encourage change, though also present challenges for service providers.

> *There is a very strong focus on accountability in the men's behaviour change sector. I for a large part agree with it … But at the same time, I feel like there's also that part of group work and therapeutic work and if you don't meet someone where they're at, they're not going to change anyway. So, the tension for us is, "how do you be relational and not collude?" (Family violence specialist)*

In answering our primary research question, we have explored the **key role that LGBTIQ+ specialist family violence service providers and practitioners play in identifying users of violence, engaging them and encouraging them to change through education, awareness and accountability.**

We have identified **five features of service access**, engagement and provision that, when present, are potential catalysts of change for GBTQ men who have used family violence.

1. Professionals that help facilitate early identification and engagement
Early identification of GBTQ users of violence was crucial to engagement. Culturally competent, LGBTIQ+–affirming professionals skilled and experienced at recognising GBTQ family violence, users of violence and misidentification played pivotal roles early in service engagement.

2. GBTQ/LGBTIQ+ specialist services
Services tailored specifically to the needs of GBTQ men were able to assess situations, gain the trust of users of violence and assuage their concerns about entering potentially hostile or unsafe service environments. Practitioners having the freedom to transform and tailor family violence services, especially MBCPs, to the needs of GBTQ people, including trans participants, helped create safe environments that encouraged behaviour change.

3. Integrated and connected services that encourage ongoing engagement
Integrated service models and service providers working closely with one another supported users of violence to engage with programs and change their behaviour. Service providers with safe and smooth pathways from legal, mental health, AOD, sexual health and/or other programs to family violence services and MBCPs provided users of violence clarity and consistency of service.

4. Program content and environments that deepen understanding of GBTQ family violence and harmful behaviour
Users of violence benefited from program content, often in MBCPs, designed to increase their knowledge, awareness and understanding of family violence. Emphasis on family violence as a choice proved powerful in terms of helping some users of violence accept responsibility and recognise the need to change.

5. The ability to access additional services that help address co-existing issues
Some GBTQ men who have used family violence have co-existing AOD, mental health and/or other issues that are prevalent at higher rates in LGBTIQ+ communities than the general population. Services that acknowledged co-existing issues and sought to address them through AOD treatment and counselling, before or alongside an MBCP, supported users of violence to improve their wellbeing and focus on deepening their understanding of their use of violence and change their behaviour.

Catalysts of change along service pathways: potential for even better service response

We have also identified five features of service access, engagement and provision that might be developed further.

1. Systems that better support identification and engagement
Identifying family violence involving GBTQ men sometimes relied on individual practitioners in mainstream family violence and legal settings working outside their usual systems, identifying cases that might otherwise "slip through the cracks". Building capacity in both LGBTIQ+ family violence services and mainstream family violences would strengthen identification and engagement efforts across the sector.

2. Family violence service providers that are more GBTQ/LGBTIQ+ inclusive
Practice guidelines for working with GBTQ users of violence were identified as much needed. Such guidelines might consider the diversity of situations involving GBTQ users of violence and do more to challenge the stereotypes around what GBTQ family violence is and who it involves, reducing misidentification of users of violence and victim survivors. This is something relevant to all family violence service providers.

3. A better understanding of motivation to change and other aspects of family violence use specific to GBTQ men

The motivation of GBTQ men who have used violence to change their behaviour remains poorly understood, in part because so few have been engaged in research. It would be worth developing more strategies to help build knowledge about how GBTQ users of violence perceive their behaviour, their need to change and their motivation for doing so.

4. More service options, including AOD and mental health counselling

MBCPs intentionally focus on accountability rather than therapeutic work involving the user of violence. This is justified; however, it does not mean that a user of violence would not benefit from better addressing co-existing issues, including those related to their AOD, mental health or past experiences of trauma, separate from their behaviour change work. More therapeutic options that focus on separate issues of trauma and marginalisation alongside MBCPs could have the flow-on effect of supporting people to engage with behaviour change programs in positive and productive ways.

5. More awareness and understanding of GBTQ family violence across society

Knowledge and understanding of GBTQ and LGBTIQ+ family violence is limited across society. It remains challenging to address these types of violence when so few people are aware of their existence and prevalence, meaning there is potential to create new narratives of family violence that are more inclusive of LGBTIQ+ family violence.

Recommendations

Based on our key findings, we make the following recommendations:

Recommendation 1

Increase public promotion within LGBTIQ+ communities, as well as among family violence, AOD and mental health practitioners, about the nature, extent and impact of family violence within these communities. Such promotion would significantly aid recognition of violence enacted by GBTQ men at the individual, relational, community and societal level

Recommendation 2

Ensure training of the family violence sector workforce to better identify and respond to family violence involving GBTQ men. Such workers include (but are not limited to) the police, legal professionals, counsellors and family violence practitioners. Build capacity in both LGBTIQ+ family violence services and mainstream family violence services so as to strengthen identification and engagement efforts

Recommendation 3

Embed more LGBTIQ+ family violence specialists in mainstream services and strengthen relationships with, and client pathways to, specialist LGBTIQ+ services. Develop more collaborative and co-management approaches, involving government and community stakeholders, that leverage the specialist knowledge of GBTQ family violence that exists in community-community organisations

Recommendation 4

Increase opportunities for practitioners and other professionals to develop more nuanced understanding of power, control and coercion in the context of relationships involving GBTQ men

Recommendation 5

Build capability of both mainstream and LGBTIQ+ community health organisations to deliver one-on-one AOD and mental health support that helps users of violence address co-existing issues alongside behaviour change work

Recommendation 6

Develop strategies to engage more GBTQ men who have used violence in research to better understand how they recognise harmful behaviour, the need to change and experiences of service engagement

Resourcing of this study

This report was supported by the Victorian Government.

1. INTRODUCTION AND AIMS

What interventions and service pathways support GBTQ men who have used violence in their intimate and/or family relationships to change their behaviour?

This is the broad question asked in this report. Drawing on a total of 40 interviews, including with GBTQ men who have used violence, victim survivors, family violence practitioners, counsellors, Men's Behaviour Change Program (MBCP) facilitators and legal professionals, we explore the GBTQ family violence service landscape in Victoria, Australia. We identify service responses that encourage GBTQ men to commit to non-violence and, thus, can be considered "catalysts of change".

LGBTIQ+ people experience family violence at rates comparable to the general population (2–5). Men's Behaviour Change Programs (MBCPs) for GBTQ men, which have operated in Melbourne since the early 2000s, have been a primary intervention tool to address the use of violence.

Since Victoria's Royal Commission into Family Violence delivered its report and recommendations in 2016, awareness of LGBTIQ+ family violence has increased, along with government support to help address it. However, little is still known specifically about how GBTQ men who have used violence come to recognise their behaviour as harmful, how they engage with services or what processes they go through to change their behaviour and commit to a life of non-violence.

In this report, we offer an important contribution to an area of family violence research that has received little attention. We hope that this research can help inform and improve GBTQ family violence intervention efforts and, in turn, support the safety and wellbeing of victim survivors and other people at risk of experiencing violence.

Most of our discussion focuses on intervention after violence has occurred, rather than prevention of violence. Some participants made the point that by the time someone was accessing services for support to change their behaviour, it was "too late" – family violence had already occurred – and that more efforts should be put into prevention of violence. While we certainly support increased efforts to prevent violence, that is not the primary focus of this report, hence we have not been able to focus on it more than our data have allowed us to. We support efforts to expand research in this area and to better understand how prevention efforts can be enhanced.

1.1 Report structure

This report consists of eight chapters. After this introduction (**Chapter One**), we position our study in the context of family violence service responses in Australia (**Chapter Two**). We argue that GBTQ family violence, like LGBTIQ+ family violence more broadly, is highly prevalent but poorly understood; it is not visible in dominant family violence narratives often involving male perpetrators and female victims. We demonstrate that despite GBTQ family violence interventions, such as MBCPs, dating back at least a couple of decades, little has been documented about their impact and effectiveness. Research has barely tackled the questions of how GBTQ men who have used violence come to recognise their behaviour as harmful and how they engage with services and change their behaviour. The dearth of such knowledge – at least beyond the family violence sector itself – coupled with the prevalence of GBTQ violence, provides justification to focus on users of violence in this report.

After outlining our research methods in **Chapter Three**, the details of which are expanded upon in the Appendix, we present four data chapters. In the first, **Chapter Four**, we focus on how users of violence recognise behaviour as harmful, their motivations for wanting to change and how they initially engage with family violence services and associated services. This chapter draws on interviews with eight users of violence.

In the three chapters that follow, we turn to interviews with family violence practitioners, other professionals who work with GBTQ men who have used violence, and victim survivors to explore three main themes: first, how practitioners identify GBTQ family violence; second, how practitioners support users of violence to engage with family violence services; and third, practitioner and victim survivor

perspectives on how behaviour change occurs in users of violence.

In **Chapter Five**, the first of those themes – identifying family violence – is explored. We provide an overview of practitioners' perspectives on GBTQ family violence, in terms of its features, community awareness of its existence and prevalence, and legal interventions and service pathways for users of violence. We consider the ways in which GBTQ men are perceived to recognise their behaviour as family violence, noting that not all do. Practitioner perspectives on identification and misidentification are also considered. Finally, this chapter explores how practitioners invite users of violence to reflect on harmful behaviour and challenge their narratives of resistance.

Chapter Six focuses on the role that practitioners play in assisting users of violence to access services, including legal support, LGBTIQ+ peer helplines, private counselling, counselling at an LGBTIQ+ community-controlled organisation and Men's Behaviour Change Programs (MPCPs). We explore factors that influence engagement, including legal and social mandates to attend MBCPs. Finally, we consider intake processes, engagement and re-engagement with MBCPs and experiences of accessing mental health and AOD services concurrently.

Practitioner and victim survivor perspectives of how users of violence change their behaviour drive **Chapter Seven**. Readiness to change and barriers to meaningful progress account for much discussion in the early part of this chapter. MBCPs as a primary intervention – one heavily relied upon – is explored thereafter. Content, group dynamics, engagement and lessons learned from programs such as Thorne Harbour Health's MBCPs precede a closing conversation about evidence of change, the effectiveness of programs and ongoing engagement with services after MBCP completion.

In **Chapter Eight**, we synthesise our data into a summary about what we consider to be catalysts of change along service pathways. We ask what service responses encourage GBTQ men who have used violence to change their behaviour and commit to non-violence. We provide examples of catalysts of change along service pathways that exist already and suggest what could be done to help facilitate further change. We close out the report with recommendations aimed at strengthening service delivery and, therefore, outcomes for victim survivors, users of violence and society in general.

2. UNDERSTANDING GAY, BISEXUAL, TRANS AND QUEER MEN'S EXPERIENCES OF FAMILY VIOLENCE

2.1 Introduction

In this chapter, we outline a need to focus more on GBTQ men's use of family violence and its impacts. We explore efforts to address LGBTIQ+ family violence since Victoria's Family Violence Royal Commission. This leads into discussion about the existing service landscape for GBTQ men who have used family violence, which includes LGBTIQ+ community-controlled organisations, mainstream family violence services, private practitioners and legal professionals.

2.2 Family violence

Family violence has devastating impacts. An estimated one in three women worldwide has experienced physical and/or sexual violence, often from an intimate partner or former partner (WHO – 2). A dominant narrative often accompanying such data suggests that family violence is something that primarily involves male users of violence and female victim survivors and their children (9). This narrative or "formula story" (10) has been crucial in raising awareness in recent decades about the devastating effects of family violence, underpinning policy frameworks, service delivery and legal responses. Thus, most research into family violence has focused on the need to address the elevated levels of violence inflicted upon women by their male partners or former partners.

2.3 LGBTIQ+ family violence

The dominant gender-based narrative, however, is not the whole story, as it does not account for all types of family violence. Through its focus on cisgender male users of violence and cisgender female victim survivors, it excludes many users of violence and victim survivors (10). Although some features of the dominant narrative of family violence apply to LGBTIQ+ people experiencing or using violence, its underlying assumptions about who uses or experiences violence often renders LGBTIQ+ people invisible (11). There is a need to better understand the existence and prevalence of LGBTIQ+ family violence.

Studies show that LGBTIQ+ people experience family violence at rates similar to (2–4) or even higher than (5,12–13) the general population. LGBTIQ+ violence can be physical, psychological, financial, sexual and/or involve coercive control and stalking (14–17, 7). Some LGBTIQ+ people experience discrimination related to their gender identity and/or sexual identity, which is known as "identity abuse" (18–19). Threatening to out someone is an example of this (18).

More than 40% of LGBTIQ+ people who took part in Private Lives 3, a survey conducted in Australia in 2020, reported having experienced intimate-partner violence (IPV). More than 70% had not reported their most recent experience of family violence to authorities. The dominance of gender-based narratives of family violence can make it difficult for some LGBTIQ+ people to define their experiences as family violence (20).

Research into LGBTIQ+ family violence remains limited (27), especially when it comes to interventions. To date, most LGBTIQ+ family violence research has focused on victimisation rather than perpetration (5). Barnes and Donovan (28:319) highlight the lack of "in-depth academic evidence" about LGBTIQ+ users of violence, especially in terms of "their attitudes, motives, and help-seeking experiences and needs". Learning more about users of violence is a crucial

step towards better understanding and addressing LGBTIQ+ family violence.

"Mainstream" family violence services are often not accessible to LGBTIQ+ people (13,21–23). This is especially the case for GBTQ men who experience violence, as they do not fit into the category of the "ideal or acceptable victim" (24:1702). Australia's legal system is deficient when it comes to supporting the needs of LGBTIQ+ people experiencing family violence (25), including in relation to coercive control (17). In terms of interventions for users of violence, LGBTIQ+ people who perpetrate family violence have significantly fewer opportunities to access services than heterosexual, cisgender men (26).

In many situations involving LGBTIQ+ people, violence in relationships is often dismissed as "mutual abuse" (20). For practitioners such as those at Thorne Harbour Health, the concept of mutual violence in LGBTIQ+ family settings warrants careful consideration and critique within the broader context of intimate-partner violence and sexual assault. While it is essential to acknowledge that any form of violence is unacceptable, applying a blanket term like "mutual violence" can obscure power dynamics and patterns of abuse that may be present in these relationships. The use of such terminology and framework may inadvertently perpetuate the false equivalence of power within the relationship, disregarding the potential influence of societal discrimination and/or internalised homophobia, biphobia and transphobia.

It is crucial to recognise that not all instances of conflict in LGBTIQ+ relationships involve both parties using violence; and assuming mutual violence is deeply problematic. Where violence is observed,

practitioners must operate under the assumption that one partner is using violence, whilst the other is a victim/survivor. Practitioners, advocates and policymakers must approach the issue with sensitivity, avoiding assumptions that might further stigmatise or marginalise individuals within the LGBTIQ+ community and preventing the dilution of efforts to address and respond to instances of family violence within LGBTIQ+ relationships.

2.4 GBTQ users of violence in family violence research

Gay, bisexual, trans and queer (GBTQ) men experience family violence in many different ways. Each individual's experience of family violence varies depending on their intersectionality. This report focuses directly on GBTQ men with the aim of better understanding pathways and programs, such as MBCPs at Thorne Harbour Health, specifically tailored to this group. Exploring family violence through the experiences of GBTQ men who have used violence is an opportunity to advance understandings of LGBTIQ+ family violence (29).

GBTQ men who have taken part in MBCPs have had limited engagement in qualitative research. We sought to find examples of their voices in academic literature – with little success. We explored seven electronic academic databases plus Google Scholar, as well as conducting some manual searches, including reference list mining. Despite finding important research about GBTQ and LGBTIQ+ family violence perpetration more generally (11,20, 26, 28,30–33), we did not identify any peer-reviewed literature in which the perspectives of GBTQ men who had attended an MBCP after using violence were explored in great depth.

GBTQ users of violence and MBCPs feature in various grey literature publications, some of which have involved Thorne Harbour Health, a partner in this research. McGowan et al's (34) review of Thorne Harbour Health's Clear Space online behaviour change program presents the voices of three GBTQ+ men and non-binary users of violence. These interviews demonstrate that such programs can create the conditions for participants to reflect on their behaviour, accept accountability for their actions and change their behaviour.

Similarly, Worrell et al's (35) report into Thorne Harbour Health's adaptation of ReVisioning (an MBCP) for online delivery during the COVID-19 in 2020 involved interviewing four GBTQ users of violence about their experiences of an MBCP. However, these interviews were focused more on the participants' experiences of an online MBCP – an Australian-first – than their understanding of their behaviour and their motivation to change.

Separately, Gray et al's (36:11) report into developing LGBTQ programs for perpetrators started as a project aimed at tailoring and delivering "an existing perpetrator group program for LGBTQ people who use violence" but was unable to engage as many clients as it sought to. It ended up exploring how LGBTQ users of violence might be "located and engaged". The report includes brief insights from three LGBTQ people considered potentially suitable to attend a behaviour change program.

This research gap presented us with an important opportunity to contribute to better understanding of how behaviour change occurs for GBTQ men who have used violence and how it might be further encouraged.

2.5 Men's Behaviour Change Programs (MBCPs)

Men's Behaviour Change Programs (MBCPs) have been primary intervention tools for engaging users of violence in change processes. They emerged largely from the Duluth Domestic Abuse Intervention Project, founded in the United States in 1981. The project's focus on the importance of understanding men's use of violence through the lens of power and control has helped it to become a primary intervention for family violence (37-38).

Mainstream MBCPs in Australia are heavily relied upon yet seen as limited in what they achieve. As Day et al. (39:501) explain:

> *The Victorian Royal Commission into Family Violence, for example, identified men's behaviour change programs (MBCPs) as the main programmatic intervention to address men's violence against women, but also heard evidence about the limitations of current MBCPs, including those that relate to variations in the assessment of appropriate participants, the content being covered, the roles and responsibilities of partner contact workers, and the duration of the intervention.*

Concerns have been raised about the risk of collusion between program facilitators and users of violence due to the lack of "built-in consequences" for participants who are violent (40). On the other hand, it has been argued that "client-worker

relationships" that involve facilitators offering support and care for participants while also issuing them the challenge to change how they think and act have proven effective in MBCPs (41).

Thorne Harbour Health (formerly the Victorian AIDS Council) established the first MBCP for GBTQ men in Australia 2004 (6). The MPCP, ReVisioning, is a 20-week group program. It employs an LGBTIQ+ framework while adhering to Family Safety Victoria's Men's Behaviour Change Minimum Standards (2017) (35). Despite 20 years of MBCPs for GBTQ men in Melbourne, published knowledge about GBTQ men who use violence remains limited.

More needs to be understood about the role of MBCPs in helping GBTQ men who use violence to recognise the harm they cause, understand their behaviour and commit to being non-violent.

2.6 LGBTIQ+ family violence policy and service landscapes

Growing awareness of family violence and stronger government commitment to addressing it have begun to change the service landscape for LGBTIQ+ communities in Victoria. The state's Royal Commission into Family Violence, which tabled its report in parliament in 2016, has resulted in dedicated funding for LGBTIQ+ people experiencing or using violence. Several recommendations related directly to LGBTIQ+ family violence, such as making mainstream family violence services more inclusive and creating more LGBTIQ+-specific services (42). Increased funding for LGBTIQ+ community-controlled organisations followed. Family Safety Victoria, a state government agency established in 2017, has driven reform (43), including by supporting this report.

It remains challenging, however, for LGBTIQ+ people to access support for family violence. Limited or no awareness of LGBTIQ+ family violence (on the part of either the client or the service provider), stigma and systemic inequities are among the barriers to help-seeking (13). For users of violence, pathways into family violence services, including MBCPs, result from legal and policing interventions and interactions with family violence practitioners, health professionals, mental health professionals and counsellors (44, 35). These types of encounters take place both at "mainstream" services and those catering specifically to LGBTIQ+ people. Interventions often rely heavily on carceral systems, including mandated behaviour change, legal and policing interventions.

LGBTIQ+ community-controlled organisations play a crucial role in providing services to GBTQ men who have used violence. Organisations such as Thorne Harbour Health and Switchboard Victoria have a positive impact on many community members' health and wellbeing (45), offering culturally appropriate services to communities whose members experience significant health disparities while also facing barriers to service access (45).

2.7 LGBTIQ+ community-controlled organisations

This report is the result of collaborative research between the Australian Research Centre in Sex, Health and Society at La Trobe University and LGBTIQ+ community-controlled organisations Thorne Harbour Health and Switchboard Victoria. Both these organisations are established and respected points of contact for LGBTIQ+ communities in Melbourne and across the state (35).

The term "community-controlled" arose out of civil rights movements and is used by a range of movements internationally. Community-controlled organisations are initiated by, governed by, operated by and accountable to their communities. They are based within their communities and deliver safe services that empower their communities.

In Australia, community control is most commonly associated with Aboriginal and Torres Strait Islander community-controlled organisations, recognising and reflecting Indigenous community ownership and meeting the needs of Aboriginal and Torres Strait Islander peoples. The first reference to Aboriginal "community-controlled" health services was in 1978, although use was not widespread until about 1987, following the establishment of the Aboriginal non-government organisation program. Separately, the term "community controlled" was used in Australia in the early 1970s in references to childcare services at a women's centre in Melbourne, which operated as a feminist and lesbian space, and used in reference to healthcare for lesbians in Sydney around the same time. The first documented use of the term for the Victorian AIDS Council (the previous name of Thorne Harbour Health) was in its annual report of 1987.

Both Thorne Harbour Health and Switchboard Victoria recognise the value and significance of the term "community-controlled" for Indigenous peoples of Australia. They share

with Indigenous organisations a belief that services for LGBTIQ+ people are most effective and impactful when they are designed and delivered by organisations that are governed by, led by and accountable to LGBTIQ+ people and communities.

Thorne Harbour Health, formerly the Victorian AIDS Council, was founded in 1983 in response to the AIDS crisis (47). Over the past four decades, it has diversified its service delivery to meet the needs of many LGBTIQ+ community members. Thorne Harbour Health has dedicated family violence, alcohol and other drug (AOD) and counselling services as part of its Therapeutic and Capacity Building program (35). Since the Royal Commission, Family Safety Victoria funding has helped scale up family violence services at Thorne Harbour Health. Programs now include crisis response and brokerage, therapeutic counselling, family safety work, user of violence case management and behaviour change.

Thorne Harbour Health has run ReVisioning, the first MBCP with an LGBTIQ+ framework, since 2004 (6). It introduced Clear Space, another 20-week online group behaviour change program pilot in 2022, in partnership with No to Violence (NTV) (34).

Switchboard Victoria formed in Melbourne in 1991 as a peer-led telephone counselling and referral service, at the time known as the Gay and Lesbian Switchboard (48). Since 2013, it has helped facilitate the anonymous telephone service QLife, a counselling and referral line for LGBTIQ+ people, on behalf of LGBTIQ+ Health Australia (48). An increase in family violence among male couples was observed during COVID-19 (49). During this time, the state government funded Switchboard Victoria to open the Rainbow Door, another peer-run specialist helpline.

Rainbow Door operates mainly during business hours and offers a significant alternative to QLife in that callers can provide their names and peer helpline workers can, sometimes through discussion spanning multiple calls, emails or text messages, refer them to specialist services (35). Offering support, advice and referrals for family violence is one of the helpline's main focuses. Rainbow Door often refers people in family violence situations to Thorne Harbour Health (35).

2.8 Summary: towards a better understanding of intervention and engagement

LGBTIQ+ family violence occurs at similar rates as that which involves cisgender heterosexual women, whose experiences form a dominant narrative of family violence. GBTQ family violence is under-researched, despite some two decades of MBCP delivery at LGBTIQ+ community-controlled organisation Thorne Harbour Health in Victoria. Through in-depth interviews with family violence practitioners; counsellors and other therapeutic professionals; legal professionals; victim survivors; and users of violence, this report offers an opportunity to learn more about how GBTQ men identify their behaviour as family violence, engage with services and choose behaviour that aligns with a commitment to non-violence.

3. METHODS

3.1 Methodology and methods

This is a qualitative study that draws on interviews with eight GBTQ male users of violence, six victim survivors and 26 professionals working with users of violence. Interviews were conducted in three phases during 2022–23 and sought to understand:

- What factors support GBTQ men who have used family violence to recognise their behaviour as harmful
- What push and pull factors enable GBTQ men who have used violence to engage with support programs
- What factors contribute to readiness to change and continued engagement with GBTQ men who have used violence over time

Participants were required to be at least 18 years old and one of the following:

- Identify as a gay, bisexual, trans or gender diverse, or queer (GBTQ) man who has used family violence and engaged with Thorne Harbour Health's MBCP programs in the previous five years
- A victim survivor who has experienced family violence involving a GBTQ man
- A family violence, health or legal practitioner who has worked with GBTQ men who have accessed services after using family violence

ARCSHS is committed to conducting research that is inclusive of LGBTIQ+ communities, not just in terms of participation but also design. This means approaching research with LGBTIQ+ communities that is reflexive and collaborative and, where appropriate, challenges orthodox approaches to scholarship (61). This project is the latest in a series of collaborations between ARCSHS and LGBTIQ+ community-controlled organisations (50) and the second in recent years involving Thorne Harbour Health and Switchboard Victoria that is focused on LGBTIQ+ family violence in Victoria (35).

The research team included a diversity of gender identities and sexual orientations. The report authors had various credentials, including PhDs and counselling qualifications. Two authors were employed by ARCSHS at La Trobe

University, while the others were employed by Thorne Harbour Health or Switchboard Victoria.

Researchers drew on lessons learned from past collaborations to design this study and met regularly to discuss direction, goals and timelines. Due to the research focusing on family violence, AOD and mental health issues – particular concerns to LGBTIQ+ communities – the research team designed support protocols to ensure the research was conducted in a sensitive way and that participants could be supported if they found their involvement to be distressing. The La Trobe University Human Research Ethics Committee (HEC22270) and Thorne Harbour Health's Community Research Endorsement Panel (THH/CREP 22-017) both approved this study, independent of the researchers and authors involved.

Members of the Thorne Harbour Health family violence team provided information about the study to users of violence, victim survivors and practitioners, who were invited to participate. Those interested in taking part either consented to their details being shared with the lead author (not an employee of Thorne Harbour Health) or contacting him directly. They then engaged privately in an interview with the lead author. They were informed that their participation was voluntary and their potential withdrawal from the study would not affect their relationship with Thorne Harbour Health. Interview audio and transcripts were not shared with the family violence team at Thorne Harbour Health.

A similar process was followed with Switchboard Victoria, where a representative provided information about the study to LGBTIQ+ peer workers, primarily at Rainbow Door, but was not involved in the data collection process. The lead author also actively recruited family violence and legal practitioners from other organisations whose work was relevant to GBTQ family violence.

Interviews took place over Zoom, a video-conferencing application, lasting between about 30 and 90 minutes each. One interview was conducted as a group interview with practitioners who worked together. Discussion in all interviews focused on perceptions and self-perceptions of GBTQ men's use of violence, engagement with services and commitment to changing their behaviour. Framing these discussions were themes relevant to each interview cohort.

Transcripts were analysed using NVivo software. Data from the transcripts were arranged into themes using principles of thematic analysis (62). The study also drew on the principles of phenomenology to explore participants' lived experience of services (64). The first author analysed data, arranging them into themes. The last author reviewed data. The research team met regularly to discuss themes and the direction of the report, as well as contribute to and review drafts.

We provide more information about research questions, themes, participants and methods in the Appendix. Our Methods sections have been developed in accordance with the consolidated criteria for reporting qualitative studies (COREQ) 32-item checklist (65).

3.2 Limitations and challenges

Following a literature review (the results of which are outlined in the previous chapter), we set out to interview 15 users of violence and 15 practitioners. Engaging GBTQ men who have used violence in research, as demonstrated earlier, has been challenging. No other study has interviewed 15 GBTQ users of violence. Despite a significant commitment of time, engagement and community consultation on the part of the research team and community partners, extensive efforts to recruit MBCP participants resulted in us interviewing only eight users of violence. All eight had engaged with, or were preparing to engage with, Thorne Harbour Health's MBCP.

A byproduct of the challenge of engaging GBTQ men in the time we had was interacting with – and then interviewing – an expanded number of professionals who work with GBTQ men along family violence service pathways. We increased our practitioner interviews to 26, which helped us learn more about user of violence experiences beyond the eight GBTQ men interviewed. The 26 practitioners included family violence specialists, alcohol and other drug (AOD) clinicians, general counsellors and intake and assessment workers at Thorne Harbour Health. Also interviewed were professionals from Switchboard Victoria's Rainbow Door helpline; community legal centre lawyers; members of a court LGBTIQ+ family violence practitioner service; a practitioner at another organisation supporting LGBTIQ+ people; a family violence practitioner at an independent family services organisation; and private practitioners who provide counselling and behaviour change program training, supervision and consultation. These practitioners, have helped us form a multi-dimensional perspective of service delivery and access.

The six victim survivors interviewed provided important guidance and insight. We felt that it was vital to include these people's voices for a number of reasons. First, we wanted to centre and elevate people with lived experience, acknowledging that their voices, perspectives and experiences must be a part of any review of a service system in which they have been engaged. Second, we sought feedback from them on our framing of a study centred on users of violence (and made some revisions, accordingly). Finally, we wanted to highlight alternative perspectives of service engagement to those offered up by users of violence. All victim survivors interviewed had accessed Thorne Harbour Health's services. There were not necessarily any links between the victim survivors and the users of violence interviewed.

3.3 Use of participant quotations

We relied on participants' direct quotations to discuss experiences of identifying family violence, service engagement and behaviour. Foregrounding the voices of participants is an important part of telling authentic stories in qualitative research. We were mindful, however, of the risks of unintentionally rendering a participant identifiable through details in their quotations.

LGBTIQ+ communities in Melbourne are diverse, vibrant and interconnected. Communities of practitioners and clients at Thorne Harbour Health, Switchboard Victoria and associated services are small. When undertaking research focused on family violence, we have a responsibility to minimise the risk of identifying participants and to protect their safety and privacy.

We have provided limited demographic information about participants alongside their quotations. We have not allocated pseudonyms to interviewees and have also omitted information about their specific job titles, gender identity, sexual orientation, ethnicity and age. Some of this information is presented in the Appendix.

We refer to participants using the following categories:

- **User of violence**
- **Victim survivor**
- **Family violence specialist:** A professional working in family violence services, including MBCPs, at an LGBTIQ+ community-controlled organisation, mainstream service, private practice or as an independent facilitator or consultant to MBCPs
- **AOD clinician:** A professional working in alcohol and other drug counselling services
- **Other practitioner:** A professional working in general counselling, intake and assessment, including at an LGBTIQ+ community-controlled organisation; also includes employees of a court-based LGBTIQ+ family violence practitioner service offering advice to clients
- **Legal practitioner:** A lawyer or other legal professional working on GBTQ family violence matters in a community legal centre setting

4. GBTQ MEN WHO HAVE USED VIOLENCE: THEIR REFLECTIONS AND PERSPECTIVES

In this first data chapter, we explore service pathways for GBTQ men who have used violence. We draw on interviews with eight users of violence, exploring perceptions of their use of family violence, readiness to change behaviour and experiences of accessing family violence services and associated services.

Although some participants may have engaged with LGBTIQ+ community-controlled service providers for a number of years at the time of interview, most participants were in the initial stages of undertaking an MBCP at Thorne Harbour Health in Melbourne. Hence, for many participants, behaviour change remained a work-in-progress. This is reflected in their own perceptions of their use of family violence, readiness to change and service experiences.

We respected participants' willingness to reflect on their behaviour, contribute to research and engage in behaviour change. We were, however,

mindful of the risk of colluding with anyone seeking to construct a narrative that justified or minimised their use of family violence. It is the case that some participants, even after acknowledging they had used family violence, did share experiences and perspectives that at times could be seen to minimise, invisibilise or deny harm. This is vital information to include, though in doing so, we have sought not to give prominence or credence to excuses for violence.

We recognise that some of the content in this chapter is confronting. It might be asked why, in a report that aims to act in the interests of better outcomes for victim survivors and others at risk of family violence, would we foreground the perceptions of users of violence in the way we have, or even at all? Our rationale for doing so, we argue, is not contrary to the aim of supporting better outcomes for victim survivors.

First, it is to begin to unpack the complex ways in which users of violence understand and acknowledge their harmful behaviour (in some cases, with qualification and attempts at justification), as it can be assumed that these perceptions inevitably influence how, why and when they engage with behaviour change programs. Learning more about how users of violence understand family violence, their behaviour and their need to change might contribute to efforts to better engage them in services that encourage meaningful change. Second, it is to contribute new knowledge to a field of study that, due to the difficulties of engaging GBTQ users of violence in research, has been constructed without a detailed understanding of how they perceive their own behaviour and capacity to change.

This chapter explores multiple facets of the service experience, from identification of harmful behaviour and motivation to change, to treatment of AOD issues and participation in MBCPs. We demonstrate how some GBTQ men who have used violence understand their behaviour, their motivation to change and what helps them engage with services, including MBCPs. This knowledge provides a foundation for the ensuing chapters, in which we explore how practitioners in LGBTIQ+ family violence services and associated services seek to work with the complex needs of users of violence in order to engage them in meaningful change processes.

4.1 Recognising family violence and a need to change behaviour

The eight GBTQ men who took part in a "user of violence" interview did so on the condition that they accepted that they had used family violence. Participants had the opportunity, prior to the interview, to state that "user of violence" did not apply to them and effectively end the interview before it began. No one chose to do this. All eight participants acknowledged that they had used violence and, thus, their interview proceeded.

Interviews demonstrated that participants had a much more complex understanding of their behaviour and their use of violence than simple acceptance or rejection of the label "user of violence" (or "perpetrator") indicates. Numerous ways of rationalising and explaining their use of violence – or even accepting it with some attempts at qualification and justification – emerged. Some participants viewed their use of violence as mutualised, self-defence or caused by alcohol and other drug use or an anger issue. In exploring these perceptions in this section, our intention is not to offer credence to them, but rather, to acknowledge their existence; that is, they are thought processes that are present in the minds of users of violence who engage with service providers. Understanding these can aid identification and referral.

4.1.1 Acknowledging use of family violence – often with qualification

All eight GBTQ users of violence accepted that they had used family violence and were (or had been) connected with an MBCP at Thorne Harbour Health.

At the time of being interviewed, one participant had completed an MBCP, another was approaching completion, five others were in a program's preliminary stages and one more had been assessed and was waiting to start.

The eight were at different stages of accepting and understanding their use of violence, but that did not always neatly correspond with how far through the 20-week program they were; often, it also related to their understanding of what family violence was, the type of violence they had used, their relationship and personal circumstances, their pathway into the MBCP and support services surrounding the person.

Practitioner accounts (detailed in Chapter Five) demonstrate that GBTQ family violence can include physical assault, sexual assault, stalking (including the use of digital spyware), emotional and psychological abuse, image-based sexual assault and abuse, financial control, violence against children and identity abuse, such as threatening to reveal someone's sexual identity or HIV status to family, an employer or social circle.

Some participants said that before engaging with an MBCP, they had not thought of violence that occurred in a relationship involving GBTQ men as intimate-partner violence or family violence.

> *I had no concept of it beforehand. There is nothing we're exposed to in society, even anecdotally, or in stories … There's nothing equivalent to the "wife beater". Because you're not a wife beater – you don't know what you are. (User of violence)*

A few acknowledged that they had previously not understood that family violence included more than just physical abuse. The one participant who had completed an MBCP described how his understanding had evolved, saying:

> *I always thought it was just physical. I didn't understand the realms, the extreme realms of violence and what that consists of … It is anything that [makes] another feel fearful or less than or controlled. Be it financial, be it physical, be it spiritual, be it emotional, psychological, geographical – there's so many realms of what violence is. (User of violence)*

Another participant said that "mental violence" was not something he had previously considered to be family violence.

> *I don't feel like before I was a bad person, like violence to me is disgusting, like physical violence is just the weakest thing you can do. In saying that, mental violence is no better … I never considered mental as part of domestic violence, and that's probably where it's changed a little bit for me. I now realise that mental torture can be just as bad as physical. (User of violence)*

For many participants, developing an understanding of the many forms of family violence was an ongoing process – and a lesson learned the hard way.

> *My use of family violence that I'm putting my hand up for today is abusive text messages after [my former partner] started stopping me from seeing my [child], which at the time I totally thought was absolutely justified. And I've paid a dear price for text messages. And I don't mean to minimise … [I] totally agree that's unacceptable – that is violence and I'd like to think that I've changed. (User of violence)*

Some users of violence tried to rationalise their actions in the context of what they described as toxic relationships, mutualised violence or self-defence. While agreeing that violence was not acceptable and that they were responsible for their choices, some still spoke of situations in which they felt they had been "pushed".

> *I wouldn't say it was like my actions were justified. There were times that I probably shouldn't have hit the wall, but I did and, yeah, that wasn't called for and I did leave him scared … I was just frustrated. But in the same regard, or in that same process, he did keep pushing me. I asked him to stop. I told him to walk away. I walked away. It was him agitating and poking the bear, essentially. (User of violence)*

> *Little things piss me off – way more than they should … [but] it's a flipside of a coin as well. Yeah, I have been a terrible person to my ex and I was violent to him but that doesn't leave him blameless either. (User of violence)*

"... IT FELT LIKE IT CAME UP AT A POINT IN MY LIFE WHERE I WAS LIKE, 'NO, YOU COULD ACTUALLY USE THIS [MBCP].'"

(USER OF VIOLENCE)

> *Everybody focuses on the reaction and not the action that creates that reaction, and that's what really pisses me off. Everybody's so quick to jump at the person who's reacting, rather than seeing why they're reacting. (User of violence)*

For others, self-identified issues with alcohol, anger, feelings of inadequacy or their own experiences of trauma were ways of rationalising or trying to justify their behaviour.

> *It escalates based on alcohol, and it goes up by levels ... I know that that is drunk levels, and it is just the alcohol that does that. (User of violence)*

> *It might be one of those things where I may have little-man syndrome. (User of violence)*

4.1.2 Recognising a need to change vs being ready to change

Despite how some users of violence explained their behaviour, all recognised a need to change. In some cases, this was expressed as a need to avoid using violence again, to better control anger or to live in a more positive way. Most participants had begun the process of engaging with Thorne Harbour Health's family violence services with a sense of needing to address harmful behaviour. Only one had been court-mandated to attend an MBCP. The others had attended for assorted reasons but could broadly see that behaviour change might benefit them. Of their behaviour that prompted their service engagement, participants said:

> *The way I react to things can be over the top and bad. (User of violence)*

> *I have had anger problems throughout my life before, so it felt like it came up at a point in my life where I was like, "No, you could actually use this [MBCP]." (User of violence)*

> *It had got to the point where it was a fear for safety, for myself, but it was a considerable fear of safety for my [partner]. (User of violence)*

In the initial stages of service engagement, some were still hesitant to describe their actions as family violence. One user of violence said being issued with an intervention order was the moment when he realised something needed to change. At that stage, however, he did not yet acknowledge his use of family violence.

> *I knew I wasn't in a good space. I knew that before that [intervention order] was issued, I needed help. I was clearly sad. I was clearly angry, upset, violent ... But still when I received that [intervention order] ... I didn't even see my behaviour as violent. (User of violence)*

Some participants noticed a difference between recognising a need for change and actually being ready to change. A gay man who had waited some time to begin a program (and who was undertaking it at the time of being interviewed) said he recognised a need to change before entering the MBCP and had been able to address an alcohol issue.

> *[I saw a] need to change ... And I think there is probably about 12 months between that need to change and when I was really ready to ... [Now] the alcohol consumption has reduced by 90% ... I'm now engaged in the process of change, and now it is just figuring*

that out, and a part of that is the group work. (User of violence)

Another user of violence, a trans man, had reached a point in his life where he felt ready to change.

I'm definitely ready … I don't know if it's because I'm older. Because I have had points in my life where I have acknowledged it … But whatever it is this time, it feels different. (User of violence)

Another participant, a gay man, had recognised the need to change after an incident of family violence and was seeking to make that change, regardless of whether or not he felt ready to:

I mean there really isn't knowing when you're ready, but I was open to it [an MBCP] … I was quite anxious and everything like that. (User of violence)

Some users saw a need and readiness to change first in the context of their AOD use and/or anger issues. The user of violence who was waiting to start an MBCP at the time of being interviewed said growing awareness of harmful behaviour and the receipt of intervention orders had acted as prompts for reflection.

I've seen my behaviour change drastically at times … If you've got two [intervention orders] against you, then there's got to be a problem. (User of violence)

This participant had first associated their behaviour with AOD use and sought treatment for that. Through contact with Thorne Harbour Health, they had begun to understand that they had used family violence and accepted that they needed to address it. Even so, they did not exactly know how an MBCP might help them. They were, however, clear that they wanted to change.

I know I want to be able to understand myself from it, or understand my behaviour, and try to be able to change certain patterns – but pretty much that's all that I know. (User of violence)

4.1.3 Motivation to change

A range of factors motivated users of violence to want to change their behaviour. These sometimes centred on their desire as individuals to be "better" and to live what they considered to be their best lives.

I wanted to be a bigger and better and healthier person and that was my driving factor. (User of violence)

At other times, it was another person close to a user of violence holding them accountable for their actions.

One [friend] was … very good at going, "You're here because of your behaviour … now is the time to change your behaviour then, isn't it?" (User of violence)

A couple of participants said that their motivation to change related to their emotional states, including what they considered "anger issues", and wanting to "free" themselves from various thought processes.

Without sounding cheesy, [my motivation is] to live a bit freer … which means that I understand that some of my actions are being dictated by thoughts and processes that are a bit wonky … I've identified that there's some stuff going on that actually isn't great … I can do better for me as well as other people, and I think that's a big motivator. (User of violence)

I wanted to know how I could control that part of myself. I'm not a violent person that wakes up every day and chooses violence. I just happened to be in that situation where everything was just going to shit, basically. But … you have to make those choices to not do those things. (User of violence)

For some, motivation to change was expressed in terms of concern for the safety and wellbeing of a partner or former partner.

I felt open and curious [about an MBCP] … I also knew [attending] it was an act of goodwill towards my ex-partner … Maybe another thing that's led to some of the transformative processes is just seeing pain and that's wanted me to make sure that [my

ex-partner] knew that I was sorry for the mistakes I'd made. (User of violence)

The prospect of reconciling with a former partner or being in a healthy relationship in the future was at the heart of some participants' motivation to change. One said that their hope was:

that I'd be able to live with somebody again, whether it's my ex or whoever it is … I'm more than fine living on my own and not having to deal with people … [but] if I can't live with people, then that's a problem because I can't form relationships. (User of violence)

For one participant, maintaining a relationship with his child was his primary motivator to address his behaviour.

I'm not very aspirational about my life – all I've ever wanted to be was a dad. I can just see how it's affected my [child] … It scares me a lot, but it's made me a better dad. (User of violence).

The prospect of having children in the future was a driving factor for another participant, a trans man, who spoke of wanting to be a good parent.

The night of the incident … It scared me. And I don't want to have a relationship and kids feeling like that's what I'm going to be putting my kids through. (User of violence)

The threat of legal consequences in and of themselves, although a concern to users of violence, did not seem to be a primary motivator of change. Rather, legal consequences seemed secondary to other factors, such as a person's emotional state, their impact on others, their relationships and their perceptions of the person they wanted to be. As one participant described:

[That incident] was the most serious one that had happened. It was the one that led to police action. Which sounds bad. It's not because I don't want to get in trouble – because I don't obviously – but it's also not who I want to be … I'm wanting to grow into the person I want to be. And anger isn't a part of that. (User of violence)

4.2 Engagement with service providers

GBTQ men who have used family violence may come into contact with police, legal professionals, family violence practitioners and other health services on their pathways to MBCPs. In this section, we explore service pathways, experiences of LGBTIQ+ service providers and services accessed for co-existing AOD and mental health issues.

4.2.1 Service pathways: limitations and enablers

For GBTQ men who have used family violence, services remain limited. Mainstream services often do not accommodate LGBTIQ+ people or, if they do, it is not always with the cultural competence needed to create safe environments and provide relevant support (50). Furthermore, few specialised services catering specifically to LGBTIQ+ people exist.

Some users of violence talked about negative experiences with police and courts, especially when it came to intervention order-related matters. However, others reported positive or mixed experiences.

When [the police] came and they asked me what my name was, they cuffed me and were quite physical … I think because I do present as cis they were just like, "Oh, what's this little bitch dude crying for?" But then as soon as [they were told] that I was trans, they were like … "It's all going to be OK. Sorry, we didn't realise you're trans." … They just became so much nicer. (User of violence)

MBCPs at Thorne Harbour Health are a primary intervention for GBTQ men who have used violence. All users of violence interviewed had been referred or self-referred to Thorne Harbour. One of these was court-mandated to attend an MBCP. Family Safety Victoria's statewide The Orange Door family violence service had referred some GBTQ men who had used violence to Thorne Harbour Health. This was not always as straightforward as it might have been. A trans man described his experiences of being positioned on a path towards a mainstream MBCP before making a point of asking The Orange Door practitioner if any programs catered to trans men. Once openly identifying as a trans man to the practitioner, the participant was immediately linked in with an LGBTIQ+ service.

First, it went through the police, and then the police referred me to The Orange Door, and then The Orange Door referred me to Thorne Harbour Health … I was talking to the person on the phone and they were telling me about their behaviour change programs that they could refer me to, and then I try not to mention it, unless I feel like I have to … and it was right at the end when she was telling me about who she was going to refer me to, and I was like, "Oh, are there any of these programs available for trans men, just because I'm trans?" And she was like, "Oh, OK, yeah, I'll just send you straight to Thorne Harbour. (User of violence)

No To Violence's Men's Referral Service had helped one participant to an MBCP at Thorne Harbour Health after he had accessed counselling and support for his AOD use. The participant had initially self-referred due to his own concerns about his behaviour. A challenge was the length of time he waited to begin the MBCP. In the meantime, he undertook a significant amount of counselling at a mainstream service, which helped meet his needs.

4.2.2 The importance of integrated LGBTIQ+ services

Some users of violence spoke about the safety and support that Thorne Harbour Health practitioners and fellow MBCP participants afforded them; often, interviewees doubted that mainstream MBCPs, with heterosexual participants, would provide the same quality of service to GBTQ men referred there. Participants generally felt that practitioners at LGBTIQ+-focused services had a more nuanced understanding of GBTQ relationships, family violence and other health and wellbeing issues. There was also a sense that practitioners at Thorne Harbour Health cared about their work, clients and LGBTIQ+ communities.

I think we're very lucky to be in Victoria with Thorne Harbour and just very lucky to have the organisation caring for us … It's not just work, it's not just a job – they care. That means a lot to me, anyway. (User of violence)

A number of users of violence referred to an MBCP had already accessed Thorne Harbour Health's other services, including ReWired, a program for gay, bisexual and other men who have sex with men to help assist them to manage methamphetamine use and their mental health; the Positive Living Centre (for people who are HIV positive); AOD programs; counselling; and other family violence services, including as a victim survivor.

ReWired is a non-judgmental group and I like the way I got to connect with other people who have gone through similar issues, because I say the opposite of addiction is connection, not sobriety. (User of violence)

I've accessed the drug and alcohol [services]. I've accessed some psychology a few years back. I've accessed the family violence section a few years back, as the victim. (User of violence)

"BASICALLY, ALL THE PEOPLE THAT ARE LOOKING AFTER ME ARE SPEAKING TO EACH OTHER. SO, THAT IS A GOOD THING BECAUSE EVERYTHING IS JUST CROSS-REFERENCED…"

(USER OF VIOLENCE)

Practitioners working in collaboration with each other made some users of violence more likely to stay engaged with services, they said.

> *Basically, all the people that are looking after me are speaking to each other. So, that is a good thing because everything is just cross-referenced and the moment I walk in there, everybody just knows exactly what's been going down. (User of violence)*

In some instances, users of violence were identified after accessing other services and then enrolled in an MBCP.

> *I started speaking to the AOD counsellor, and recently actually started seeing the family violence person. I'm currently accessing housing support through [an NGO affiliated with] Thorne Harbour … and my GP and sexual health worker as well. (User of violence)*

One participant, a bisexual man, said he was willing to access mainstream services and programs but still preferred attending an MBCP for GBTQ men:

> *My sense was that as a queer person, being in a queer environment would be safer … I thought that being in the environment with violent perpetrators who were much more likely to be in opposite-sex relationships suggested that it was more likely that they were going to be hostile towards me, and so I chose a safer environment. (User of violence)*

Other participants also expressed reservations about attending mainstream MBCPs due to concerns about safety, relating particularly to the perceived risk of homophobia from fellow participants.

4.2.3 Support for co-existing alcohol and other drug (AOD), mental health and health issues

A number of users of violence had accessed other services, both at Thorne Harbour Health and elsewhere, for co-existing issues related to AOD use and their mental and physical health. Being supported for AOD issues before, or alongside, an MBCP, was important to them. Some said that their AOD use had affected their behaviour in their relationships. They accepted they were accountable for their use of violence, though some felt their AOD use had worsened their behaviour.

One user of violence spoke about alcohol "100% causing" the violence he had used. A significant focus of changing his behaviour was reducing his alcohol intake, which he felt would also reduce his use of violence. He did, however, acknowledge problematic thoughts and emotions underlying his use of violence that he needed to address, saying that alcohol only exacerbated rather than created them.

Another participant had initially accessed support for their AOD use at a mainstream service provider before realising that practitioners there did not understand anything about chemsex, the use of stimulant drugs in sexual contexts, most commonly observed among gay and bisexual men (51).

> *After the [mainstream] AOD …I realised that basically, the chemsex and my social side of things were just not being addressed, and I was like, "Hang on, I probably need to find a service that's a little bit more appropriate for me if I want to have any sort of success … It's helped – it definitely has. (User of violence)*

Another participant, who had accessed Thorne Harbour Health's ReWired program, also spoke about chemsex and violence being prevalent in many relationships involving gay men. This participant said it was important that AOD services were available to GBTQ men who had used violence.

> *I definitely don't subscribe to the, "Oh, meth makes you [violent]". That's a choice, that's a behaviour … However, if you're going to address the violence and not the [drug use] … I actually think there's zero point in not addressing both. (User of violence)*

Many had accessed some form of counselling outside of Thorne Harbour Health. They reported mixed experiences with psychologists and counsellors, in terms of their ability to help address issues of concern and understand GBTQ relationships.

4.3 Perceptions of behaviour change and MBCP experiences

MBCPs brought users of violence into group settings with other GBTQ men. Whether these groups met for sessions in person or online, participants shared their experiences of using violence and heard fellow participants describe

theirs. Two facilitators led the groups, delivering content over a 20-week period. Rolling programs could be joined at any time (when not at capacity). This meant that new participants could potentially hear the perspectives of participants who had been in the program up to 19 weeks longer than they had.

Users of violence observed varying degrees of change in themselves. This is to be expected given that they were at various stages of the program when interviewed. A number of participants told positive stories about change that MBCPs and associated services, such as mental health and AOD counselling, had helped to facilitate. Not all users of violence felt that an MBCP had changed them, even if they felt they had addressed their harmful behaviour. In this section, we explore how users of violence felt an MBCP had helped them change, what else they hoped to learn and what they thought of the content, format and group dynamics.

4.3.1 Personal reflections on the effectiveness of MBCPs

Through exploring participants' perceptions of an MBCP alone, we cannot make conclusions about its effectiveness as an intervention. Additionally, we have no way of knowing whether a program helped the participants to change more or less than they realised or how they may or may not have behaved had they not attended an MBCP at all. As such, this section does not represent an evaluation of Thorne Harbour Health's MBCPs; rather, it is an observation based on participants' perceptions.

Each GBTQ user of violence interviewed said an MBCP was a central part of their service engagement. Most, but not all, had agreed to attend voluntarily; however, not all were enthusiastic about doing so or convinced that it would lead to better outcomes. The two who had attended for more than 15 weeks gave broadly contrasting views on their program's effectiveness, insights which themselves can inform continuing intervention refinement.

The first individual who had attended for more than 15 weeks felt that the MBCP had been a valuable tool of change. Getting to the point of recognising harmful behaviour and committing to being non-violent had not been easy. The participant explained that it had taken some weeks for him to recognise that he was not a victim and that his own behaviour had led to an intervention order. He said that the approach of one facilitator had helped him focus on his need to change, not his grievances about a former relationship and his victim stance.

> *It was the beautiful way that [the facilitator] guided me to that recognition and that acknowledgement … It was the acknowledgement and that persistence to go, "No, we're not going to go down that path. We're not going to allow you to still sit in that victim phase because you're here for a reason … You're here because you used violence." And every time that you deviated from that … it was like, "No, no, we're not here to discuss what he did to you – this is about what you did." (User of violence)*

The same participant felt that the change that he had undergone was also down to his commitment and willingness to do the "hard work".

> *I was playing that victim role and not taking responsibility for the violence that I was committing and perpetrating onto another person … You know that saying, "time will heal"? It's not time that heals – it's hard work that heals you … It took a lot of reflection … Every time that we finished a session, I would close my laptop and spend probably half an hour reflecting and doing the work about what that session brought up for me. (User of violence)*

The other participant who had completed more than three-quarters of an MBCP felt he had learned some lessons from the program, in conjunction with his own reflection and engagement with services independent of Thorne Harbour Health, but did not believe the MBCP had been all that effective overall.

> *The questions were generic … I felt like they were preaching to the choir. Every time, I was in a room full of men who were saying, "Oh yes, I agree with all of that" and "Oh, yes I've done the wrong thing" and "Oh yes, I agree with everything you're saying" and yet they weren't asking individual questions. (User of violence)*

The other participants were no further than one-quarter of the way through an MBCP and, so, were still developing their understanding of the content and direction. Program material was described as tailored to GBTQ men's relationships and focusing on social hierarchies and power (something we explore more in Chapter Seven). Some participants said that they had expected more focus on

individual strategies to manage behaviour but also thought that such content might come later.

> *[The facilitators] are really caring and all that, but the content of the course … just doesn't seem related even at all to men's behaviour. It's all about people you admire, hierarchy … I don't get it. I would have thought it would have been strategies about recognising anger … when people try to set you off – developing strategies for that. (User of violence)*

For some users of violence, waiting lists, limited intakes or sessions being postponed meant they did not receive the service continuity they felt they needed.

> *I do wish it [started] sooner. It was a very long time … nine to 10 months is definitely too long. I did have access to supports in other ways. So, I don't feel too affected by it. (User of violence)*

4.3.2 MBCP group learnings

Because Thorne Harbour Health's MBCPs are for GBTQ men, participants tended to perceive programs as affording them the cultural safety that they felt they would not get in a mainstream MBCP. Group dynamics contributed to participants' experiences of MBCPs and appeared to impact on their learning and change processes in positive ways. Emotional connection was identified as an important part of the group experience. One participant acknowledged how constructive a sense of connectedness among group participants could be, saying:

> *Everyone was accepting that they were there, accepting that they'd made a mistake, accepting that they needed to be humble and learn, and there was a satisfying sense of connection between us on that level. (User of violence)*

A gay man who attended an MBCP online said hearing others describe their ongoing use of violence and demonstrating a resistance to change had helped him to reflect on his own situation. It had also encouraged him to reach out to a fellow group member to try to support them to change.

> *I would obviously learn from them and listen to their stories and how they're dealing with their stuff … You'd see people working through [the program] still in that violent relationship … There was one particular person that was so resistant to this, and … I could see myself when I first joined … I had a conversation with that person during one session, going, "I know where you're at. I see what you're displaying because that was me – hang in there, just keep coming." (User of violence)*

Another participant, a trans man, said that although he found it difficult at times to relate to the relationship experiences of gay men, he enjoyed relating to fellow participants in other ways.

> *It's weird coming in as a trans man, and I've not been in a gay relationship, like I've only been in relationships with women … They would talk about relationships with their boyfriends, and the dynamics of that, and that's one part I can't relate to at all. But other than that, it is a lot nicer hearing it from a point of view of like, "We're all in the queer space, so we all understand what it's like not to be a cis het man". I think everyone's got a better view – because of how gays and queers get treated – of trying to be more sensitive to that in our own community as well. (User of violence)*

As we outline more in Chapter Seven, group dynamics also brought the risk of participants colluding with each other through validation of their shared sense of being "victims". Some participants' perceptions that they or fellow group members had been misidentified as users of violence emerged when discussing MBCP group dynamics.

> *They're a good group of guys … It seems like they're in the same situation as me – they're there because of stupid, crappy failures in the law … They seem like really decent, upstanding people – not violent. (User of violence)*

> *The [program's] narrative was "it's very rare that we ever see a person in these groups who actually shouldn't be here because their partner was actually the perpetrator and they're the victim and it's been portrayed the wrong way" … The reality of the participants*

could not have been further from that truth. Every person in the group gave seemingly very credible accounts of their very difficult partner. (User of violence)

4.3.3 What users of violence had learned (and what they still hoped to learn) about change

Some participants had already benefited significantly from an MBCP. The one participant who had completed a program at the time of being interviewed described distinct stages of learning, after enrolling as someone who believed he was a victim of a toxic relationship rather than a user of violence.

I always like to give anything three goes … I think after three times, you can suss out if it's going to work and the first one, I didn't like, the second one I didn't really like, and then the third one I was like, "No, I think I'm going to learn from this." (User of violence)

The same participant described how he came to understand the use of family violence as a choice, rather than something a person was "driven to".

When you understand that [cycle] of violence and how we have that language, "He hit her or he hit him … because they pushed them that far [and] that was the only choice" – it's not true. I think once I got out of that victim mentality to go, "No, this is a choice" … [I realised] this behaviour has to stop. (User of violence)

This knowledge had helped him to understand that he was not inherently a violent or "bad" person but, rather, he had the option to choose not to use violence.

That's what they focus on with your violent behaviour – you always have a choice to do that behaviour. That's a choice. It's not … intrinsically who you are; you're choosing to use that behaviour. (User of violence)

Several users of violence still waiting to start an MBCP or in the initial stages of a program spoke about wanting to learn more strategies for responding to situations in "the heat of the moment," most notably with reference to self-described anger issues.

I'm hoping to learn how to think before I speak or think before I yell. It's the patience thing and unfortunately, I don't really have the ability to think and formulate my thoughts and then say them … I don't even know what's in [the MBCP] but I know I want to be able to understand myself from it or understand my behaviour and try to be able to change certain patterns. (User of violence)

It was becoming important to some participants to develop themselves as "well-rounded" individuals, which meant changing how they thought and acted even when they were not experiencing conflict. This was talked about in terms of "personal growth" and "self-improvement".

I thought it [the MBCP] was strategies for when I get to the point where I feel like I start becoming out of control … I wanted strategies, but I guess I'm trying to mentally get myself in a better frame of mind to be in more control of my choices instead of, "Oh, something's about to happen, I need a strategy to get away." … I just want to feel more in control … But I want it to be more rounded than just being in crisis … I just want to be less angry. (User of violence)

The biggest thing for me was understanding a little bit more about my need [for] control. And how toxic to me that need for control can be, and how that desire for control is part of where a lot of that violence comes from … I managed to figure out, actually, you just don't need a lot of it [control] … It's a work-in-progress because it's not been all that long. (User of violence)

4.4 Summary

This chapter demonstrates that GBTQ men who have used family violence recognise and understand their harmful behaviour in complex – and sometimes contradictory – ways.
Users of violence identified their behaviour as family violence at various stages of engagement with service providers. For some, it was before or simultaneous with engagement with services. For others, it was after their engagement pathway had led them to a Men's Behaviour Change Program (MBCP). Some still viewed their use of violence in the context of circumstances in which they

"... I DON'T EVEN KNOW WHAT'S IN [THE MBCP] BUT I KNOW I WANT TO BE ABLE TO UNDERSTAND MYSELF FROM IT OR UNDERSTAND MY BEHAVIOUR AND TRY TO BE ABLE TO CHANGE CERTAIN PATTERNS."

(USER OF VIOLENCE)

felt they had been "pushed too far", engaged in mutualised violence or acted in self-defence, thus they still held on to a victim stance. They were, therefore, embarking on change processes from different vantage points.

Participants' motivations for accessing support services were complex. They accessed support for various reasons, sometimes (but not always) through concern for the safety and welfare of a partner or former partner and with the aims of wanting to be a better person, be in a healthy relationship, be a good parent, address an AOD issue, control their anger, engage in personal growth and/or enjoy a group setting. These complexities suggest that engaging and retaining GBTQ users of violence in family violence services, including MBCPs, presents a range of significant challenges to those providing behaviour change programs. To support engagement, practitioners and service providers are often challenged to be innovative, flexible and inclusive.

Focusing on the perceptions of users of violence in this chapter has not been without its challenges. We have sought to avoid giving credence to narratives that seek to justify or excuse the use of family violence. Simply describing the ways that users of violence explain their understanding of family violence can be risky. However, documenting these perceptions creates opportunities to better understand how GBTQ men who have used violence understand their harmful behaviour, their motivation to change and their engagement with services. This foundation means we can explore in the next three chapters what service providers and individual practitioners already do – and what more they might do – to encourage GBTQ men who have used violence to positively engage in behaviour change processes and commit to non-violence.

In summary, GBTQ men who have used family violence interviewed for this report:

- Had varying levels of understanding of what family violence was, often initially considering it to be physical violence
- Acknowledged their use of family violence in different ways
- Demonstrated understanding that using violence was a "choice", though occasionally positioned that choice in the context of self-defence, mutualised violence, being "pushed too far" and "toxic relationships"
- Talked about motivation to change in terms of not using violence, but to varying degrees, also in terms of "personal growth", "self-improvement", addressing anger and AOD issues, and wanting to have more positive relationships, including as a parent or potential parent
- Often saw value in integrated services at LGBTIQ+ community-controlled organisations
- Generally, saw the value in group behaviour change in terms of building awareness and connection with others, though sometimes believed content was too sociological and impersonal

5. IDENTIFYING FAMILY VIOLENCE: PRACTITIONER AND VICTIM SURVIVOR PERSPECTIVES

Identifying family violence is crucial to service engagement and processes that support someone to commit to non-violence.

The previous chapter demonstrated that users of violence vary in their understanding and recognition of family violence and the need to change their behaviour, presenting potential barriers to service engagement. Practitioners providing a range of services to GBTQ people play a significant role in helping to identify a situation or relationship involving family violence.

In this chapter, we draw on interviews with practitioners and victim survivors to explore understanding and recognition of GBTQ family violence. We start by exploring specific features of GBTQ family violence, community perceptions of it and what legal interventions and service pathways exist. We then consider the ways in which users of violence are perceived to recognise GBTQ family violence. We conclude the chapter by exploring what strategies family violence practitioners and other professionals employ to help users of violence recognise their behaviour.

5.1 Perceptions of GBTQ family violence

Understanding of LGBTIQ+ family violence has improved in the past decade or so. In Victoria, more attention has been paid to LGBTIQ+ family violence prevalence and service sector response since the Royal Commission. Few studies have focused on GBTQ family violence and virtually none on GBTQ family violence perpetration more specifically, despite behaviour change programs for GBTQ men in Victoria dating back to 2004. As we demonstrate in this section, however, many practitioners have sophisticated understandings of what GBTQ violence is.

5.1.1 Features of GBTQ family violence

Practitioners' understanding of GBTQ family violence had developed through their education, professional experience and lived experience as LGBTIQ+ community members. They tended to think that the broader community was unaware of GBTQ violence. Mainstream family violence services, they felt, had increased awareness of family violence involving GBTQ people since the Royal Commission, but still offered little in the way of support options for victim survivors or interventions for users of violence.

Practitioners identified GBTQ family violence as including physical violence, sexual assault, stalking (including the use of digital spyware), emotional and psychological abuse, systems abuse, image-based sexual assault and abuse, financial control and violence against children. They also described situations and incidents that were considered specific to LGBTIQ+ people, especially GBTQ men. One such example was identity abuse, including threats to reveal someone's sexual orientation or HIV status to family, an employer or social circle. In some cases, using someone's sexuality as a way of making them stay in a relationship was part of a cycle of violence.

> *There's some emerging research around loneliness in gay men in particular – gay, bi and trans men – and I think that's definitely used against them. This idea that you'll never find anyone again, no one wants you … Gay, bi and trans men have a particular experience of trauma growing up that's really reinforced by society … that it is easier to call on this idea that … "I [the user of violence] am the only person that understands you and can help you." (Family violence specialist)*

Similarly, sexual violence described as "sexual shaming" was a tool some users of violence were seen to use to maintain control over a partner.

> *I had one client who would regularly down-talk his partner because his partner was interested in feminising kind of behaviours and just acting a bit more feminine … His partner really didn't like that and he was actually quite shaming about it. (Other practitioner)*

Some practitioners spoke about how GBTQ users of violence employed perceptions of "mutualised violence" (which emerged in the previous chapter) to conceal the control and power they exerted over a partner.

> *Perpetrators can use that as a way of convincing the person listening to the story, and there's something about the way he uses the gender of his male victim as well to invisibilise the degree of intimidation and control that he has in the relationship … It's a tactic. (Family violence specialist)*

Other family violence described included systems abuse, which refers to the manipulation of legal systems, police responses and welfare services by the person using violence in order to coercively control, harm, harass or threaten a victim survivor. In the LGBITQ+ space, practitioners often saw examples of systems abuse that included:

- The person using violence calling the police and attempting to have a victim survivor arrested by alleging they were the perpetrator or falsely alleging "mutual" violence. The person using violence often presented a calculated narrative to police that made them appear more "rational" or "believable" than the victim survivor
- The person using violence obtained an intervention order against the victim survivor then misled the victim survivor into breaching the order, leading to criminalisation
- Threats to call Immigration and have the victim survivor deported to a country where their gender or sexuality was not accepted, risking imprisonment or death

5.1.2 Perceived community awareness of GBTQ violence and responses to it

Many people in LGBTIQ+ communities had little understanding of the exact nature of GBTQ family violence and the extent to which it occurred, several participants said.

> *A lot of the advertising on TV or in the media suggests or promotes heteronormative services or relationships. A lot of people think that's what family violence is and that's it. So, they actually don't think it applies to us. (Other practitioner)*

GBTQ men's historical experiences of discrimination and violence were cited as a factor shaping how community members dealt with – or did not deal with – violence in their relationships.

> *It can be difficult for folks to identify it as family violence when you are in love with someone and as folks in the queer community, we know how much harm we've suffered, and so, you often see someone's behaviour as just, "this is their trauma" and see it more as a trauma response than a perpetration of harm and family violence. (Other practitioner)*

Past experiences of discrimination and violence also made it difficult, if not impossible, for victim survivors to involve the authorities when family violence occurred. Police and court systems were perceived to lack awareness about GBTQ family violence. At a similarly structural level, some participants felt that Victoria's MARAM did not recognise the intricacies of LGBTIQ+ family violence, particularly in relation to suicide risk.

> *[MARAM] is a tool used to identify key risk factors that are most likely to be associated with serious injury or lethality and where that really misses the point for the LGBTIQ+ community, especially when it comes to family violence experienced by your parents or family members who've identified that someone is gay or trans or whatever and they're being abusive to them because of that ...[is] the lethality risk of LGBTIQ+ people killing themselves because of the violence they're experiencing, and that is really high. (Other practitioner)*

5.1.3 Legal interventions and service pathways

Identification of GBTQ family violence was a catalyst for initial engagement with authorities and services. It was not always the user of violence themselves who acknowledged the family violence. They may have been in denial about their use of violence. Rather, it was often victim-survivors, police, legal professionals, family violence practitioners and/or health practitioners.

Practitioners described many ways in which users of violence came into contact with authorities and services. In some cases, police were called and someone was arrested and charged. Officers made a family violence referral through the "Victorian Police Risk Assessment and Risk Management Report L17" (52) and a court appearance followed.

In other instances, a partner, former partner or family member took out an intervention order against a user of violence, who subsequently breached it. Sometimes, a user of violence themselves took out an intervention order against someone and was later found, through a process of assessment and information sharing (53), to be the user of violence. Referral to a mainstream family violence service or an LGBTIQ+ community-controlled organisation often followed, with MBCPs at Thorne Harbour Health used as a primary intervention.

Some GBTQ men who attended court had accessed legal support through a community legal centre, including those specialising in support for LGBTIQ+ people, and/or support from a dedicated court LGBTIQ+ practitioner. As part of Victoria's court system, LGBTIQ+ family violence referrals are made to the statewide LGBTIQ+ practitioner service. The practitioner service also refers men accused of violence to Thorne Harbour Health's family violence programs. The involvement of the LGBTIQ+ practitioner service helped some users of violence begin to understand what support was available to them.

> *There's one thing about recognising the violence; it's another thing for them to do something about it ... For many of the people that I speak with, they're recognising by the end of the phone call that there has been violence used. (Other practitioner)*

Some practitioners in the mainstream family violence sector with lived experience of being LGBTIQ+ had taken it upon themselves to help connect GBTQ users of violence with services.

One of our practitioners had been reviewing the L17 portal and saw an incident between two gay men and then we followed up with police and The Orange Door because we didn't see that there had been any response. There was a threat – it was fatal risk and it was the seventh really serious incident, which wouldn't happen in any other circumstance. You would never see another circumstance where there would be that level of extreme violence and also that many of them where there hadn't been a referral to any specialist family violence service. (Family violence specialist)

It should be noted that any response from The Orange Door would not have been documented in the L17 portal but, rather, in its Client Relationship Management system (63).

Referrals were sometimes made from court, legal or mainstream family violence services to Switchboard Victoria's Rainbow Door helpline. Itself a referral service, Rainbow Door would often then help people to access Thorne Harbour Health's family violence programs. In some cases, referrals resulted from users of violence calling Rainbow Door directly for help with a legal matter or their mental health, not yet acknowledging their use of violence. Similarly, at Thorne Harbour Health, which offers various therapeutic services, practitioners described situations where someone seeking support for another issue was identified as having used family violence.

5.2 Identifying GBTQ family violence

In this section, we explore how users of violence were perceived as identifying their behaviour once an intervention process began. We also consider misidentification challenges that family violence in the context of GBTQ men and their relationships presented practitioners.

5.2.1 Users of violence recognising family violence – and barriers to this recognition

Practitioners and victim survivors said users of violence acknowledged their use of violence in diverse ways and to varying degrees. Many engaged with services conceded they had used family violence. Others did not. A violent incident was enough for some users of violence to see their behaviour for what it was. One victim survivor, when talking about his partner, said:

In terms of the violence side of things, there was absolute accountability from the moment it happened. (Victim survivor)

Some users of violence who sought AOD support or counselling at LGBTIQ+ community-controlled organisations such as Thorne Harbour Health often did not consider themselves to have used family violence, despite court appearances, an intervention order against them and/or injuring a partner, former partner or family member. Other users of violence resisted the family violence label outright when it came to their situation and/or made excuses for their behaviour, practitioners said.

Practitioners identified barriers to users of violence acknowledging their behaviour, including co-existing issues such as intellectual disabilities, AOD issues and limited education. Shame also played a significant role. One practitioner said that because family violence perpetration remained a "taboo" topic, some users of violence would avoid naming their behaviour even when seeking entry into an MBCP.

People don't like being associated with the term "user of violence" and sometimes really avoid recognising that they're using violence … even if it's explicit. (Other practitioner).

Two victim survivors gave insight into how users of violence understood their behaviour.

I think his understanding is that if he drinks and takes drugs, it changes his personality or it brings out all his frustrations and things become muddled. I'm pretty sure he realises what causes it. (Victim survivor)

In terms of the actions and the violence, he was immediately beside himself as to what he'd done. So, there was an immediate level of awareness and remorse there that probably is more than would be typical in a lot of these situations. (Victim survivor)

Some users of violence had "self-referred" to services following family violence, seeking support. One practitioner said, however, that this was rare:

> *A lot of times they have reached a point where they're noticing patterns in their relationships. Sometimes someone has told them that that's what's happening in their relationship, and perhaps they're starting to recognise it. That's usually the scenarios that I come across when people are self-referring. (Other practitioner)*

Practitioners also described differences in awareness and insight between users of violence mandated to attend MBCPs and those who self-referred or voluntarily chose to attend.

> *Usually, people who are mandated are not as motivated and not as aware and insightful about their behaviour because it wasn't something that started with them making that reflection and reaching out for that support – it started with the system getting them in this program. (Other practitioner)*

5.2.2 Practitioners encountering misidentification challenges and perceptions of 'normalised' violence among GBTQ men

For practitioners and other professionals, misidentification was a significant risk when assessing family violence situations involving GBTQ men. This was in part due to stereotypes about what characteristics aggressors supposedly had. For example, police were seen as sometimes assuming that the "bigger" man in an intimate relationship was the violent one.

Family violence practitioners had seen evidence of GBTQ family violence situations driven by patriarchy and gender norms and others that were the result of more complex power relations. The diversity of these situations presented challenges for practitioners. Mainstream understandings of gendered drivers of family violence were useful for practitioners but so, too, were broader understandings of power.

> *I do think it's really important to name patriarchy and name the harm that flourishes within patriarchy and male dominance over women … But if we're talking about violence that occurs between people of the same gender, the gender framework, it just doesn't fit. You can see that just by looking – because it's like, "Oh, who's the man? Oh, there's two". (Family violence specialist)*

Misidentification worked both ways: sometimes, users of violence were misidentified as victim survivors and victim survivors as users of violence. It often further harmed and prevented victim survivors from accessing pathways to safety.

Two Rainbow Door helpline staff described how users of violence calling the service about "relationship issues" had, through their own storytelling, revealed themselves to be users of violence, even if they did not understand or directly admit it.

"THE GOAL WOULD BE AT SOME POINT IN THE FUTURE, THEY MAY THINK DIFFERENTLY, THEY MAY RETHINK THEIR CHOICE, THEY MAY DO SOMETHING DIFFERENTLY."

(OTHER PRACTITIONER)

They've identified some problematic behaviour and they want to talk about it or they think they're the victim and want to have a space to talk about that or they just don't even have any idea that they're using violence. (Other practitioner)

We attempt to work in a compassionate way in which folks are both [held] accountable but also supported … Sometimes, we will work with people and we identify that they are using harm but that's not how they see it … We are not a behaviour change service and that is work that takes a huge amount of time and effort and trust and we are just a short little point of contact in a moment of time. (Other practitioner)

When misidentification occurred, it could delay the intervention process, which had emotional impacts on victim survivors. A community lawyer described some of the challenges involved in trying to identify users of violence in some GBTQ family violence cases:

We rely on those referral partners who might have written some notes when they make the referral. There might be existing support material, there could be criminal charges as well, so that's a large part. If there's police involvement in a family violence incident, there's often criminal charges that are alongside that if there was assault or stalking or whatever it might be, so that plays a part in it, too. There are so many factors that piece together whether or not you believe that person may or may not be the primary aggressor of violence … It's the whole picture … It's hard to make generalisations because it's case by case. (Legal practitioner)

Some practitioners had observed users of violence attempting to dismiss physical and sexual assault in GBTQ relationships as "normal" or part of existing cultural norms. Users of violence could downplay or contextualise their violence in an attempt to justify their behaviour rather than accept it as harmful and address it.

In complex situations, when it was less clear what violence had occurred, practitioners drew on various strategies and MARAM guidelines (53) to assess situations.

One of the questions that is very key in understanding who is experiencing harm is: "Who's the most afraid?" Who makes all the decisions? Who feels comfortable to say no? And who doesn't? And asking someone, "What are the impacts or what are the ramifications for you when you say no?" Depending on the response to those questions, that can start to give you an understanding of what's going on. (Other practitioner)

5.3 Practitioner strategies to help clients recognise their use of violence

If a client did not acknowledge their use of family violence, practitioners explained to them the concept of family violence while encouraging them to stay engaged with services. Practitioners felt that not challenging narratives justifying harmful behaviour was collusion, but also knew that taking too direct an approach might cause users of violence to disengage from services, especially if they were not court mandated to continue. In this section, we consider some of the strategies different professionals used to overcome challenges to keeping users of violence engaged.

5.3.1 Inviting reflection on behaviour: what does change represent?

Practitioners said that every word mattered when encouraging clients to recognise their use of violence. This was particularly so for staff at Rainbow Door. A phone call to the service was an opportunity for staff to, on the one hand, try to identify a user of violence and engage them in services, and on the other hand, sow seeds that might prompt long-term change.

The goal would be at some point in the future, they may think differently, they may rethink their choice, they may do something differently. (Other practitioner).

This was a demanding task for helpline staff, most of who were LGBTIQ+ peers, not specialist family violence practitioners, but who were nonetheless required to employ a "family violence lens", as one participant described it. Rainbow Door staff spoke about their efforts to identify family violence and invite users of violence to reflect on their behaviour, saying:

And so that's about us as workers … having an understanding of what those behaviours are and typically what things a person who's using violence will do to be in control in a relationship, having that frame of reference all the time and viewing the story through that prism, not viewing it through the prism of this person … is absolutely telling me the truth … So, creating a space where someone can … confront their shame around their behaviour or their thoughts or their feelings. (Other practitioner)

With the system that we have, the best things that I can see are getting people to continue to engage with me. So, not closing somebody down – keep the door open, make sure they know they can keep coming back to me. I am a safe person to talk to about this stuff but enabling them to have the skills to assess when the risk is escalating and how they need to manage that. (Other practitioner)

Organisational support and guidance for staff in such situations was important. One helpline staff member discussed this in terms of referring a case onto a more senior colleague.

Especially because my background is less family violence than some of my peers, I've generally escalated the next contact to a peer with more experience … So, it's generally because it has just been the first contact phone call, my main effort has been building trust in our service and getting consent for a call-back to be able to continue the work, rather than have this person feel judged or to disengage and not be kept in view. (Other practitioner)

Another staff member talked about how inviting users of violence to reflect was incorporated into training.

Knowing that we're not going to change someone's mind in a single conversation … [we] reflect back or ask questions around a caller's values. Often, what we hear in narratives around people using violence is … when they're telling their story, they're talking about that they're actually a good person, as evidenced by x,y and z … So, one of the key pieces of training that we offer to the people who are doing the work is to get someone to talk about what their values are and to be able to hear where there are inconsistencies in those values. (Other practitioner)

Elsewhere, alcohol and other drug clinicians at Thorne Harbour Health said it was not uncommon for clients seeking to address their AOD use to have used violence. Practitioners tried to support these clients to reflect on multiple behaviours.

A lot of the AOD stuff does come back to wanting to have more meaningful relationships. Wanting to have more friendships. Wanting to have better-quality relationships. Wanting to be able to tolerate how messy relationships can be at times without leaning on drugs and alcohol. Wanting to be "a better person" as well – that's something that comes up a lot. So much of the work is connecting with those values – what does this change represent to people, rather than naming the changes that they want to make. (AOD clinician)

In AOD, we think of people at stages of change … We'll meet people who have a real lack of awareness of why anything's happening in their lives … For that person, gaining awareness around their use of violence is going to be really hard … I work with people for 12 sessions, but occasionally we extend those sessions [to 24]. If the relationship has built to a place where there's a lot of safety and trust and I can challenge them … there's possibility then for someone to maybe hear some other ideas about their behaviour or their thoughts and to be open to that. (AOD clinician)

Some private counsellors spent time trying to keep users of violence engaged with their service long enough to help support their pathway to specialised family violence programs. These professionals tried to encourage users of violence to reflect on their behaviour while trying not to cause them to disengage.

"It's a really tricky one if they're paying for you privately to address their mental health issues and they've disclosed information where their partner is at risk … I would open up discussions about family violence …

We can talk about [their] anxiety as well … but I will offer a referral … to encourage him to keep that discussion going." (Family violence specialist)

5.3.2 Challenging problematic and minimising narratives

As well as inviting users of violence to reflect on their behaviour, practitioners also challenged narratives that sought to justify harmful behaviour. This approach encouraged accountability, but it needed to be employed carefully to support continued engagement.

Practitioners engaging with users of violence worked in a range of settings, meaning time spent with them varied. A brief intervention counsellor described how empathy and honesty were vital tools, especially when practitioners had only limited interactions with a user of violence.

It's really hard in three sessions because you're trying to build the rapport and do the work straight away, and you can spend the first session just building the rapport because they don't even really want to be there or talk to you. I use a technique which is called empathic challenging … It's just about being really empathic in your approach. So, rather than being really directive and sort of persecutory, you actually just gently challenge. It's about how you deliver it and what you say … I'm really honest with them at the start, saying, "This is how I work, and we've got three sessions to get a lot of work done. So, I'm going to be really direct with you and I want you to be able to be really direct with me." (Other practitioner)

Similarly, practitioners often challenged users of violence when it came to what services they thought they needed, for instance, if they were seeking individual counselling and resisting joining an MBCP. In such cases, the solid reputation of an organisation like Thorne Harbour Health was a crucial factor in users of violence trusting practitioners' advice.

[A client] said, "I'm not good with group settings," and they just wanted to see a counsellor. We completed an intake, we had a half-hour conversation and I got back to them saying, "Look, by what you're describing to me, I think that a Men's Behaviour Change Program would be more appropriate. You're saying that there are things about your behaviour that you don't like and you want to change and that's the nature of the program." Working at Thorne Harbour Health will have the benefit of really dealing with clients who are part of our community. And so sometimes people feel like they're in a safer place and that we are not judging them. And that's really what we aim to do all the time. I don't think that that's as challenging as it would be if I was an outsider in terms of the queer community. (Other practitioner)

Other practitioners challenged narratives in numerous ways, including by:

- **Naming family violence up front and refocusing the conversation**

I think it's really unfair on clients if we are not naming violence right up front, the very first session, the very first conversation, especially if that's what the referral's for – domestic violence … We're really clear that this is what we're going to be talking about. But also, in individual counselling, what I might do is spend some time preparing for those discussions. How might we have those discussions? "What do you need from me to be able to speak more directly and clearly about the abuse that you've subjected your partner to at home? Is this the first time you've ever talked about your abuse or have you been asked questions directly about your abuse?" (Family violence specialist)

- **Challenging stereotypes and misconceptions about using violence, such as "losing control"** (explained by a helpline staff member, who described using a particular line of reasoning with users of violence)

"You're able to hold it … until the second you got in a private space and then you let it go, and you've got this idea that you're out of control, but, actually, you're demonstrating a lot of control to me and I'm interested in that." Or asking them, "OK, would you do that if there was a police officer standing right in front of you, would you keep hitting?" or "If the person you admire most in the world … was standing in front of you, is that how

you would act?" And usually people are able to say, "You're right, I wouldn't do that." I'm trying to get people to understand the difference between being out of control and taking control – which is what is actually happening – and that they have capacity to choose differently … it's usually a really effective way of talking about things. (Other practitioner)

- **Emphasising how taking responsibility and showing genuine remorse might help achieve a favourable court outcome** (explained by a community lawyer representing users of violence)

You've got to be really careful with how you do it because you can lose the trust of the client and it can go pear-shaped, so you do it discreetly. On one hand, you do it very carefully, because there's already the police, the court – everyone's already against them … but at the same time, in reality, it's absolutely in their interest to take responsibility and show genuine remorse and that they're taking steps to change their behaviour … But there are also some clients who just won't hear it. (Legal practitioner)

5.3.3 Challenging violence-supporting narratives, avoiding collusion and ensuring accountability

When seeking to engage users of violence in services, practitioners were at risk of colluding with them, that is, reinforcing narratives that justified harmful behaviour. The risk of collusion was of concern to all practitioners interviewed.

One of a worker's biggest fears will be that they collude with someone using violence … that we will inadvertently support and validate the reasons or the choices that they made to use violence in a situation and that's a fear that we would all carry. And sometimes that fear prevents us from acting at all. (Other practitioner)

A practitioner not naming family violence and allowing it to be talked about as a product of the user of violence experiencing an unhealthy relationship, a stressful life or past trauma was considered collusion, which impeded service delivery and behaviour change. However, a practitioner forthrightly challenging a narrative and labelling behaviour as family violence, without any rapport building, risked angering a user of violence and causing them to disengage from services altogether.

If I was to say, "Well, actually that's wrong. That's not the case" – it's combative. When you're combative with somebody it causes them to double down. And that further reinforces them in this position of, "no one understands me, everybody's on my partner's side, I'm a victim." So, that's just as colluding. (Family violence specialist)

"I THINK IT'S REALLY UNFAIR ON CLIENTS IF WE ARE NOT NAMING VIOLENCE RIGHT UP FRONT … THE VERY FIRST CONVERSATION, ESPECIALLY IF THAT'S WHAT THE REFERRAL'S FOR – DOMESTIC VIOLENCE …"

(FAMILY VIOLENCE SPECIALIST)

The challenge for practitioners, then, was to build rapport with users of violence that allowed honest conversations in which family violence could be named and isolated, associated challenges – such as past trauma, mental health and AOD issues – could also be identified (and addressed separately) and engagement with family violence services could continue.

> *My ongoing query as a therapist is, when I'm working with perpetrators, how do I not collude, keep them involved, keep them engaged in the process, but still hold a line that is non-colluding, that is keeping the victim in the centre while still acknowledging what may be past traumas that client has had? For me, that's the hardest thing. (AOD clinician)*

Practitioners spoke of various strategies they used. Education and training played a significant role in developing these strategies, while support from the organisations that employed them was seen as vital to ensuring practitioners could receive feedback and advice. Individual reflection, including in terms of practitioner positionality in MBCP contexts, was also important.

> *I'm also looking out for ways … that the men are replicating coercive control on the facilitators – bringing their behaviours into the group – and making sure the facilitators are on top of that and can either name it or at least respond to it in a way that ensures that that participant feels safe. (Family violence specialist)*

> *It's [easy] to fall into that collusive practice. I've got to keep myself in check and I know that. [My role] … has me making sure that I'm getting somebody that needs support into a support program as much as I can, and also what keeps me in check is the people that I work with, but also … the effect of family members that I am working for. (Other practitioner)*

The last quote is an example of the way practitioners actively reminded themselves to hold the safety and welfare of victim survivors central in their mind.

Practitioners treated users of violence as people whose experiences had been complex and traumatic, but – fundamentally – who were accountable for their use of violence. When successful, this approach encouraged clients to identify violence and engage further with services.

5.4 Summary

Users of violence often arrived at service providers with complex and varied understanding of their use of violence. Practitioners played a crucial role in recognising when family violence was occurring and how they might encourage a user of violence to themselves recognise or acknowledge harmful behaviour.

Barriers to users of violence identifying their behaviour as harmful were significant. One was a lack of awareness – within the individual, among some mainstream service providers and across society – about the existence and prevalence of GBTQ family violence. In this chapter, we have demonstrated some of the ways in which barriers to GBTQ users of violence acknowledging their harmful behaviour as family violence have been overcome and users of violence can be encouraged to begin on a pathway to meaningful change. It remains, of course, the responsibility of the user of violence to change their behaviour. This chapter, however, demonstrates the importance of service responses that support that process.

Factors that encourage GBTQ men who have used family violence to recognise that their behaviour is harmful include:

- Community awareness of what GBTQ violence is and how frequently it occurs
- Legal professionals, including court practitioners, police and community lawyers who understand GBTQ family violence, identifying users of violence and being visible to LGBTIQ+ communities
- Pathways to well-known and trusted LGBTIQ+ community-controlled helplines and health and wellbeing services
- Access to LGBTIQ+-affirming mainstream family violence services and associated services such as AOD counselling and general counselling
- Knowledgeable and skilled family violence practitioners, counsellors and AOD counsellors who can engage users of violence, identify family violence by naming it up front and challenge problematic narratives, thus avoiding collusion

6. ENGAGING USERS OF VIOLENCE WITH SERVICES: PRACTITIONER AND VICTIM SURVIVOR PERSPECTIVES

Across Victoria, an informal LGBTIQ+ service network, involving legal professionals, private practitioners, peer workers and various counsellors at LGBTIQ+ community-controlled health organisations, has formed around users of violence.

The services these professionals provide play a vital role in encouraging GBTQ men who have used violence to change their behaviour. Factors that support engagement can be thought of broadly as either "push" or "pull". We consider a push factor as something that encourages or compels a user of violence to access services of some sort. A pull factor, on the other hand, is a feature, component or reputation of a service that draws a user of violence towards it. In this chapter, we focus on push and pull factors that support users of violence to engage with service providers. Practitioner perspectives drive much of the discussion in this chapter. To contrast or complement these perspectives, we also draw on victim survivor accounts of how partners, former partners or family members engaged with services.

6.1 Push factors along service pathways

In this section, we focus on "push factors" along service pathways for GBTQ men who have used violence. We explore how legal professionals and mainstream family violence professionals seek to identify GBTQ users of violence and refer them on to service providers. We also explore the role of "social mandates" that encourage users of violence to engage with services.

6.1.1 Engagement via legal services

Professionals with knowledge of GBTQ family violence based at courts and community legal centres not only provided advice to users of violence, but also assisted them to access MBCPs.

Court LGBTIQ+ practitioners described how they sought to identify cases involving GBTQ users of violence so they could counsel and refer users of violence onto specialised services. Other users of violence were referred to the practitioner service from within the court system as well as from other legal and community service practitioners.

> *What we're looking for is what may identify as a case of LGBTIQ+ [family violence] – so, if it hasn't been identified in the L17 process … we're looking at name and gender identification as starting process. (Other practitioner)*

The LGBTIQ+ practitioner service provided more "therapeutic" support than court services typically would, something that was aided by having LGBTIQ+ practitioners who provided professional advice and referral options.

> *Because we're a team of people with lived experience, what happens, too, is that when you speak with the respondent … it's often the first opportunity they have to really talk about their experience because police don't often take that time and then the lawyers within the courts don't always have time to listen a great deal. So, because we're teasing it out and it's almost a form of incidental counselling… I'm also identifying other factors that might be influencing that family violence such as drugs and alcohol, mental health, homelessness [and] financial abuse. (Other practitioner)*

Lawyers interviewed for this study were based at community legal centres and received referrals from the court practitioner service. They also received referrals from Thorne Harbour Health and Switchboard Victoria. In some cases, they continued to work with LGBTIQ+ community-controlled organisations while guiding a user of violence through a legal case. These legal practitioners felt that collaboration with LGBTIQ+ community-controlled organisations was an important and constructive part of the work they did around GBTQ family violence. This was especially the case in instances where someone had been misidentified as being a user of violence.

> *Working with clients in same-sex relationships creates a really specific issue around police. There will be an issue, police get called and police in that moment are making that assessment and they should never be making that assessment … It's really complex and trying to explain that to the prosecution – that's when it's so important to have family violence workers involved who can provide a professional opinion and basis for that opinion and then police can have that material. (Legal practitioner)*

Legal practitioners, while representing the legal interests of users of violence, saw their role as also helping their clients to be accountable for their actions. One lawyer explained the challenges of trying to hold users of violence to account, saying:

> *I don't allow my time with that person for them to just wax lyrical and make their victim some kind of verbal punching bag. You do get clients that come in and just want to trash talk the other person for an hour. I try as much as possible to have some accountability in that and keep those conversations as respectful towards the complainant as possible. It's difficult, though. (Legal practitioner)*

Legal practitioners sometimes referred users of violence onto other services, such as an AOD program, or Thorne Harbour Health if they needed an MBCP program.

> *A lot of our clients are already linked into support services when they come through, but it's really useful to have us continuing to refer because often they're linked into*

services like the … Neighborhood Justice Centre's LGBTI family violence practitioners who are really short-term crisis support. (Legal practitioner)

We don't often work long-term with perpetrators … I've referred some people to Men's Behaviour Change Programs or alcohol and other drug programs … You want that behaviour to stop, but also if there is a family violence intervention order application or criminal offences, it's about mitigating risk as well. So mitigating risk for preventing violence, but also mitigating risk for the outcome for that client, so if they've got criminal charges, the court is going to want to see that that person who's committed violence is addressing their behaviour … Someone who's more likely to face imprisonment or a harsher penalty is someone that hasn't demonstrated that they're addressing their violent behaviour or the things that cause their violent behaviour. (Legal practitioner)

Even in a justice system that relied heavily on MBCPs as an intervention, legal practitioners spoke of sometimes having to lobby hard to a magistrate for GBTQ users of violence to be able to attend an MBCP at Thorne Harbour Health, rather than a mainstream program.

In finalising a lot of the intervention order matters, attendance to Men's Behaviour Change Programs will come up as a condition of the order …. What we will often raise in that process is that our clients need to be referred to a specialist MBCP and we recommend ReVisioning, but the magistrates aren't really across that … There's no commitment by the courts generally that our clients will get access to the ReVisioning program. (Legal practitioner)

A number of participants spoke about a magistrate ordering someone into a behaviour change or alcohol and other drug treatment program.

Usually, people who are mandated are not as motivated to [change] and not as aware and insightful about their behaviour because it wasn't something that started with them making that reflection and reaching out for that support. It started with the system getting them in this program. (Other practitioner)

6.1.2 Family violence service providers that refer on to LGBTIQ+ services

Having only limited family violence services for LGBTIQ+ people was sometimes a barrier to GBTQ men who had used violence accessing services. This was not only in terms of the availability of dedicated or even inclusive services for LGBTIQ+ people, but also in terms of negative experiences when dealing with various professionals and mainstream services who were not inclusive of LGBTIQ+ people.

Because of the structural limitations and discrimination that our community experiences – lots of dead-ends for people, lots of fear around accessing services, whether that's emergency services, the police, family violence services … there are lots of blockages and barriers for people to access service. (Other practitioner)

Some GBTQ men who used violence were referred to LGBTIQ+ community-controlled family violence services through Family Safety Victoria's statewide The Orange Door family violence service. This was not always as straightforward as it might have been due to a practitioner not seeking to learn a client's gender identity and/or sexual orientation during the referral process (as highlighted in Chapter Four).

One challenge that practitioners in generalist family violence services faced was that cases involving GBTQ family violence were not always specifically identified as such.

It's unusual that we would receive someone with whom we weren't aware of who the person that they used violence against, and we definitely ask questions about gender and gender identity and sexual orientation – but I would say there's probably a large group of men who are perhaps bisexual or even transgender or intersex who would not be identifying – who just wouldn't openly identify with us and maybe it was just that their most recent relationship was with a woman. (Family violence specialist)

Other barriers to participants being referred from mainstream family violence services to LGBTIQ+-specific family violence services included a lack of

"I'VE GOT TO SAY THIS – AND THIS SOUNDS LIKE A STRONG STATEMENT – BUT … I DON'T REALLY MEET MEN WHO COME TO BEHAVIOUR CHANGE PROGRAMS ON THEIR OWN ACCORD …"

(FAMILY VIOLENCE SPECIALIST)

awareness of GBTQ family violence and a lack of options and awareness of services in regional areas.

6.1.3 'Social' mandates leading to self-referral

There were many reasons why people took part in an MBCP. As well as courts ordering people to attend MBCPs, other types of mandates – "social" mandates – also prompted users of violence to access services or enrol in MBCPs, technically of their own volition. In such situations, it was not the requirements of a court but the expectations of a partner, former partner, family member or community that drove their engagement.

> *Even if there's not a court mandate, there's often some other mandate … I would call it a social mandate. Say somebody is like, "OK, my partner's going to leave me. My partner told me I need to work on my aggression, so I'm calling around to see what supports I can get." (Family violence specialist)*

> *It wasn't mandated [for my partner]; it was recommended by the police, and he'd gone, "OK, well, I'm going to try and do all the things I can." I'd gone, "Look, the behavioural change is valid and I support it" and he went. (Victim survivor)*

Users of violence often accessed services in search of support for issues other than family violence. Some individuals who felt socially mandated to change their behaviour sought to do so by addressing their AOD use (as highlighted by users of violence in Chapter Four).

> *We definitely do refer from our internal AOD team to ReVisioning or to Clear Space but most of the time the people are coming for AOD … they've identified that drugs and alcohol are the problem … I think that's part of a broader narrative that "the meth makes me like this and the booze makes me like this," rather than taking responsibility for those actions. (AOD clinician)*

Practitioners were well placed to see how powerful various "mandates" and recommendations to engage with services could be, to the point that some questioned whether users of violence who self-referred to MBCPs programs ever really did so voluntarily.

> *I've got to say this – and this sounds like a strong statement – but … I don't really meet men who come to behaviour change programs on their own accord … It's not really a thing that happens. Either your partner gives you an ultimatum, the courts mandate you, or your counsellor says, "This is abusive. I've got a program for you." … You don't really find people who are coming in on their own saying, "This is what I need to do" without any influence from any professionals or from their partner giving them an ultimatum. (Family violence specialist)*

Personal and professional support networks, therefore, were a crucial part in shaping the self-referral process. Thus, social mandates were a push factor for a person who had used violence to choose to seek help.

6.2 Pull factors along service pathways

In this section, we explore the pull factors of LGBTIQ+ community-controlled service providers, such as Thorne Harbour Health and Switchboard's Rainbow Door – namely the particular features, programs or reputation that draw a user of violence towards them – and how they have encouraged engagement. We also consider the importance of established connections between organisations, integrated services and family violence services that cater specifically to the needs of GBTQ men.

6.2.1 LGBTIQ+ peer helpline Rainbow Door

Switchboard Victoria's Rainbow Door played a crucial role in providing support and guidance to GBTQ men who have used violence and referring them onto programs at Thorne Harbour Health and elsewhere. Users of violence made up only a small percentage of people who contacted Rainbow Door, but LGBTIQ+ community members who answered calls and responded to text messages and emails played a significant role in helping to facilitate service engagement that potentially led to behaviour change.

Since its inception in 2020, the service experienced steady demand from people seeking information, referrals and support. According to one helpline worker, Rainbow Door was meant to be a "call-in service" but also functioned as a "call-back service". LGBTIQ+ community members contacted Rainbow Door to discuss a range of challenges, many of them impacting their mental health. Family violence featured in many situations described.

> *I would say suicidality and family violence are probably our two most frequent points of contact … Those contacts around suicidality and family violence probably also feel bigger because they're usually not single contacts. There's a lot of work that then happens with the client. (Other practitioner)*

Those contacting the service could provide their name and details and Rainbow Door staff could engage with them over multiple conversations. As discussed in the previous chapter, this enabled practitioners to hold a client's engagement and build rapport so that they could then introduce a discussion about the use of violence. This process supported users of violence to understand their behaviour and what family violence services existed. Workers could then help connect users of violence with these services.

Other organisations, such as legal and mainstream family violence services, also contacted Rainbow Door seeking information about family violence support. Callers included people who associated Rainbow Door with The Orange Door family violence service – as well as The Orange Door staff themselves.

> *We get a lot of secondary consults from workers at The Orange Door asking for information and also asking about … how Rainbow Door can actually support people, what that scope of support looks like. Probably when you search "LGBTQ and family violence," it must be something that comes up or that's well known. (Other practitioner)*

When it was deemed appropriate, Rainbow Door referred clients to LGBTIQ+-friendly mainstream counselling services. A practitioner at one such service said:

> *I'm part of the counselling team at [a mainstream service] and most of the referrals that come to us from Rainbow Door I tend to take on. It's this situation where you're the only queer in the village at a mainstream service, so they send you most of the referrals, which is fine with me. (Family violence specialist)*

Some Rainbow Door staff talked about the misconceptions that existed in the community about what its service was and what it could provide. At times, those contacting the service assumed that staff were qualified counsellors, that Rainbow Door provided specialist family violence services (rather than offering information and referrals) and that it was part of, or intricately connected to, The Orange Door. Although such assumptions provided challenges for Rainbow Door staff, the strength of relationships the service had with other organisations usually helped provide callers with relevant referral options.

> *One of the real benefits of the partnerships has been that Thorne Harbour Health and Drummond Street are inundated and have long waitlists, and so we've become a queer-friendly holding space. We often work together by completing MARAM risk assessments, which then saves one piece of work … and it means that we've then got*

rapport with the person seeking support and continue to hold them to monitor risk, to manage risk as best we're able to as a teleweb service … until they are connected with the supports that they really need and deserve. (Other practitioner)

A Rainbow Door staff member outlined two main pathways a user of violence might take from Rainbow Door to Thorne Harbour Health's MBCPs. The first involved a direct referral from Rainbow Door when it was clear that a person was using violence:

There would be having a conversation with someone on Rainbow Door and making that identification about who's the person experiencing harm or who's using it and then an offering from a worker about, "Would you like to hear about these particular programs at different places?" [Or] … a referral. It could be, "Here's the number – call yourself" or "Would you like us to provide a warm referral into the program?" (Other practitioner)

The second involved Rainbow Door referring to the family violence team at Thorne Harbour Health when it was not immediately clear that the person was the one using violence in their relationship.

It might not be apparent in that conversation that the Rainbow Door staff member has about who is actually using or experiencing violence and a referral into the family violence team might pick that up … It might be in the course of a conversation with the family violence team that there's an offer made for a partner to go into ReVisioning or for the identification of someone using violence to go into that program. (Other practitioner)

6.2.2 Thorne Harbour Health: the appeal of an integrated service model

As discussed in previous sections, users of violence were referred to Thorne Harbour Health in numerous ways and for assorted reasons. Not all users of violence were referred explicitly due to their use of violence. They may have been referred for an AOD issue, for instance, or they might have self-referred, seeking mental health or relationship counselling.

Thorne Harbour Health providing a variety of services had created an environment where family violence identification and internal referrals could occur in ways that might prove more challenging for organisations with a more limited service remit and expertise in LGBTIQ+ issues.

Many users of violence accessed other services before or alongside an MBCP. These services were accessed within Thorne Harbour Health and elsewhere. As shown in Chapter Four, users of violence generally felt it was convenient to access multiple services at a single LGBTIQ+ community-controlled organisation. Practitioners tended to agree that integrated services enabled efficient service delivery and that information sharing between practitioners contributed to better outcomes. Many participants noted that GBTQ men who used violence often required support for other issues, such as AOD use, mental ill health, experiences of trauma and homelessness.

The family violence and drug and alcohol teams work quite closely because often our clients are mandated to attend drug and alcohol counselling and are perpetrators of violence … So, a lot of our content already is acknowledging that the client needs behavioural change … There's an opportunity in those referrals because it's all on the table. (AOD clinician)

Often, users of violence were identified for referral to an MBCP after starting out in other programs at Thorne Harbour Health. The organisation had made the most of practitioners' capacity to share information and their expertise in a range of areas, not least of all LGBTIQ+ lived experience.

Integrated services are the name of the game and I think you get more bang for your buck if people are able to address things concurrently, because they're so often interrelated. And we've had some really good results … We've got a dynamic waitlist and we prioritise clients from ReVisioning and Clear Space who are already engaged in the programs who identified that drug and alcohol is playing a role, both in the use of violence and it may possibly inhibit their ability to engage in those services. So, the idea is can we do good harm-reduction work? Can we do some interventions that enable people to lower their risk around substance use in ways that will increase their capacity to engage in a change process around violence? (AOD clinician)

The service environment at Thorne Harbour Health, therefore, was one in which various practitioners – from AOD specialists to family violence workers – regularly worked with users of violence. Practitioners described how integrated services functioned and how they relied both on collaboration and developing their skills as "all-rounders":

> *Having an integrated approach is really helpful … I rarely go outside of this organisation for clinical support. In my last job, I was always contacting services for consultations and things like that, whereas with this, there's such a wealth of knowledge that it saves a lot of time … The clinicians can hold really nuanced, complex views of family violence, drugs and alcohol and the messiness that queer relationships can be. (AOD clinician)*

> *I may be an AOD counsellor but I have to be proficient in family violence. I have to be a counsellor, a generalist counsellor as well and I have to be a dual diagnosis counsellor. (AOD clinician)*

Many participants felt that one advantage of integrated LGBTIQ+-specific services was an ability to understand how AOD use and family violence intersected, particularly in terms of chemsex.

> *There are some particular difficulties in the chemsex community where people can be substance affected to a level where they're not able to actively consent … Lots of people who are using GHB can't necessarily remember what's happened and so there's a sense of a lot of this happening in very sort of dark and unspoken places in people's lives. (AOD clinician)*

It was, therefore, important for services to create environments in which behaviour change could be talked about free from stigma around AOD use, gender identity and sexual orientation.

> *Being an AOD [service], we have a lot of conversations around sex and chemsex and out-of-control sexual behaviours and often that can be in a context of family violence or relationships, and clients have reflected on feeling like they're able to be more honest with the queer service around sexual violence or sexual behaviours. (AOD clinician)*

6.2.3 Thorne Harbour Health: the appeal of specialist GBTQ family violence services

Being able to access behaviour change programs at LGBTIQ+ community-controlled organisations was important for many GBTQ users of violence, practitioners said. Some noted that Thorne Harbour Health's family violence program was a rare yet crucial service for GBTQ men who otherwise might not have engaged with any kind of behaviour change program.

> *Thorne Harbor Health is one of the only organisations that's providing an LGBTQ-specialised program and I think that for a country of the population that we have that's just not enough … because it does really make a huge difference if people access the service or not. In my experience with clients, they will hardly engage with [an MBCP] if it's not specialised for LGBTQ people because it won't feel safe. (Other practitioner)*

More broadly, Thorne Harbour Health was considered a safe place for GBTQ men to access family violence services due to a history of supporting LGBTIQ+ people that went back decades. The organisation's reputation of being "for community, by community", developed through

"I MAY BE AN AOD COUNSELLOR BUT I HAVE TO BE PROFICIENT IN FAMILY VIOLENCE."

(AOD CLINICIAN)

its response to the AIDS crisis of the 1980s, was something that individual practitioners identified with and themselves came to represent.

> *It is about trust and I think it is about judgment as well. Men using violence will always be hesitant about feeling judged and if we can minimise that, it will work well for the client and for ourselves. So, when I'm speaking with clients, I'm not trying to make excuses for their behaviour, but [I say] … "This is a program that has been designed for what you're describing to me, and I think it will be good for you." (Other practitioner)*

Although community-controlled services were respected, practitioners said some people had concerns that accessing them might reveal the truth about their behaviour to other people in their networks.

> *Our community is really small and even in a metropolitan city like Melbourne you could walk into the reception area of Thorne Harbor Health at some point and know five people in there. You could have dated two of them or something like that. So, being exposed in that way in community is a real fear for some people. (Other practitioner)*

While helping to engage GBTQ users of violence, Thorne Harbour Health also offered services for their partners, former partners and family members, among them both LGBTIQ+ people and non-LGBTIQ+ people. An important part of this was family safety contact work, which a number of participants spoke about as important to both the safety of victim survivors and the engagement of users of violence in MBCPs. Victim survivors talked about what their experiences with Thorne Harbour Health were like once their partner, former partner or family member was enrolled in an MBCP.

> *They contacted me as a former partner and offered me services like a check-in to let me know whether or not he was going or just to work through safety plans … There's also an element where they get ongoing information so that the partners or ex-partners can be centred throughout the program long term. Also, I was put on a waitlist for counselling, but I haven't been able to access any of that yet, because unfortunately the waitlist is just too long. (Victim survivor)*

> *I was approached by Thorne Harbour because my ex-partner was using the service. He was doing the Men's Behaviour Change Program and they wanted to know if I needed any support. And to be honest, at first, I ignored the messages because I was on a waiting list for a mainstream family violence program. But then it was suggested that I take them up on their offer because obviously they had the capacity to take me on … [The counsellor] became a really great support for me. (Victim survivor)*

6.3 Service experiences: ensuring and enabling retention

One of the goals of GBTQ family violence intervention in Victoria is to engage users of violence in services, particularly MBCPs. At organisations such as Thorne Harbour Health, practitioners who work with users of violence have certain responsibilities, including to engage respectfully, identify risk, offer secondary consultations and referrals and share information (55). These responsibilities are a central part of effective identification, assessment and management of family violence risk (56). Accepting and adhering to these responsibilities, however, does not guarantee that practitioners will be able to effectively engage users of violence in services and programs that lead to meaningful behaviour change.

In this section, we explore how practitioners sought to engage users of violence in services with the aim of encouraging change. We attempt to move beyond identification and initial service access to focus on the importance of good-quality service that encourages engagement. In doing so, we focus on practitioners' individual strategies, warm referrals and guided pathways, the nature of MBCPs at Thorne Harbour Health and how those who have disengaged from services have sought, or been encouraged, to re-engage.

6.3.1 Practitioners' individual strategies

As we began to highlight in Chapter Five, individual practitioners often faced the task of having to identify family violence and challenge a user of violence's narrative about their situation, while also highlighting how service engagement might help them change their behaviour and address issues such as their AOD use.

Practitioners spoke about the importance of early engagement.

If we can get them at the first court engagement, it's nice … [During] the second court engagement, they've got the opportunity to respond to the allegations … I got a lot of really good feedback just based on that they were able to have a discussion about their experience and talk to someone who listened to provide them with those referrals, to just explain the court process, to be that person that touched based with them every time that matter comes back [to court]. (Other practitioner)

One family violence specialist described the challenges of dealing with "the majority" of users of violence who were yet to confront their own behaviour and the importance of:

grabbing them while you've got them and then trying to build enough of a relationship … for them to stay with you just for a little bit longer this time, so that you can start to have enough of a relationship that you can leverage that relationship to start having conversations about accountability and responsibility, and that's the focus. (Family violence specialist)

A Thorne Harbour Health practitioner said it was difficult but possible to refer to an MBCP a client who had not yet acknowledged their use of violence.

[Intake] would present it to the client that, actually, we can't help you with this, but we've got this particular program or group that's available for you … I've had a client who's like, "No, I'm not going to do that" and then at the end of the third session he said, "I think that would actually be really helpful for me and I'd really like to be able to be referred to that program." (Other practitioner)

Practitioners said it was important to speak directly to the realities of GBTQ men's relationships, families and social situations when trying to engage users of violence, while also centring the wellbeing of the victim survivor. One practitioner said the role of an MBCP facilitator, for example, was to "be the voice of this man's partner":

[It's about] the simple realities of all relationships, where there's love and, especially with queer people who have to decide how they are going to fall in love with another man if every message that they've had in their life was to not do that very thing because being gay is wrong and bad. There are ways of working with queer men that we bring in that context … Advocating for the partner's experience … That is always the best strategy, but it's sometimes going to be met with a lot of resistance and pushback … but centering the experience of their victim, their partner, is always the safer way of doing the work and also the one that ends up for some men making a real difference. (Family violence specialist)

6.3.2 Warm referrals and guided pathways

Warm referrals to other organisations, including LGBTIQ+ community-controlled health and wellbeing services, were an important part of helping a user of violence engage. Their importance – and success – underscored the value of collaboration between service providers.

I don't think I've ever had the situation where the person was like, "Just give me the number and I'll call" … I would always try to facilitate a warm referral. I remember at one point, the person was just worried about what I was going to say to them and I just said, "Why don't I [copy] you in the email?" and they were like, "Oh, you can do that" – I said, "yeah". We usually talk about what I have permission to pass on. (Other practitioner)

When setting up Clear Space, a nationwide online MBCP at Thorne Harbour Health, facilitators put a lot of work into strengthening referral pathways from associated service providers to ensure users of violence were receiving "multidisciplinary support" to access behaviour change programs.

Because we were a pilot project … we had to build all those pathways and relationships from scratch … In terms of referrals in, we did a lot of work reaching out to community legal centres and criminal law firms, and we did have some referrals come through those legal pathways … or we had a referral come through the courts, through the LGBT Family Violence Court practitioner person … AOD was a very, very important part of the program and so we built a fast-tracked referral pathway internally at Thorne Harbour so that men who joined group were

able to … be fast tracked for AOD support … All the allied case work support was essential in terms of making group possible. (Family violence specialist)

We discuss change processes in relation to MBCPs more in Chapter Seven.

6.3.3 Ongoing engagement and re-engagement

Once engaged with Thorne Harbour Health, users of violence often spent months accessing MBCPs and associated services. Thorne Harbour Health's MBCPs are 20-week programs in which regular attendance is required for completion. Service access involved a significant commitment of time and energy. Continued engagement was not guaranteed, even for GBTQ men mandated by a court to attend. Practitioners worked hard to meet clients "where they were at" and provide a supportive environment in which clients could make mistakes – such as miss a session – and still be supported to feel safe discussing their use of violence in honest, frank ways.

I would say a real strength of mine and [a co-facilitator's] is we were very flexible. With this willingness to work with people where they're at, we did a lot of work, both in terms of all the work it takes to scaffold people's participation, and to build relationships and have one-on-one check-ins and work that really enables people to show up to group. There were people who if we'd gone by a "two strikes and you're out" model, they would have been gone very early on, but we were much more flexible in terms of supporting and allowing people's ongoing engagement. (Family violence specialist)

Multidisciplinary support and integrated services were seen as important to helping users of violence stay engaged. For those with complex needs, additional support, such as AOD counselling, helped support engagement, practitioners said. Being mandated to attend was enough motivation for many users of violence to keep engaging with MBCPs for up to 20 weeks.

Some users of violence found it challenging to attend every session and disengaged with Thorne Harbour Health before completing an MBCP. Practitioners, where possible, tried to help clients re-engage with programs with some success. One participant described how practitioners had helped one such user of violence feel heard while also challenging their resistance:

[Thorne Harbour Health] ideally reaches out to him and invites him to come back and hopefully works with him on what it is that he's wanting to achieve. Also, they offer individual sessions to get him back to feeling group ready or just sort of address any of his concerns, but sometimes his concerns are actually bullshit and they're just a block to taking responsibility. (Family violence specialist)

Other practitioners or professionals, such as helpline staff at Rainbow Door, also played a role in helping to re-engage users of violence who had withdrawn from an MBCP. This sometimes involved reassuring a user of violence that re-engagement was possible and that there was no shame in trying again.

I can think of one person who had started ReVisioning and they stopped and then came back through the helpline with the same problems and it was a similar conversation again, but also talking about what was the barrier with them continuing with ReVisioning and thinking through that, and you know [saying], "We could just reconnect you with ReVisioning – it is OK to stop something and then start again. (Other practitioner)

Some users of violence who completed programs returned to Thorne Harbour Health at a later date, seeking more support, demonstrating that family violence and other issues could recur and that community-controlled organisations remained trusted points of contact.

We have a lot of clients who circle back. We'll see them after a couple of years … Part of that is that people do broadly have a positive experience of the service and having an LGBT+-specific service and a queer-affirming service [makes it] safer to talk about these things at Thorne Harbour than in a lot of other settings. (AOD clinician)

6.4 Summary

GBTQ men who have used family violence can experience significant barriers to meaningful engagement in services. A range of factors encourage GBTQ users of violence to engage – and stay engaged – with service providers in meaningful ways. Identifying a user of violence, building trust through displays of cultural competence, educating them about the available service options to support behaviour change, making referrals to trusted services, helping to address concurrent needs and delivering programs that promote reflection, accountability and change are all factors that encourage service engagement. Outside of services, "social mandates" can have a positive effect on service engagement through community expectations of what steps a user of violence should take to accept responsibility for their behaviour and commit to non-violence.

For many users of violence, pathways from early engagement with the justice system to completion of an MBCP were made much more navigable by individual practitioners and service providers dedicated to making service engagement more meaningful and accessible for LGBTIQ+ communities, despite a range of challenges, including a lack of resources. Although the decision to change is the responsibility of a user of violence, this chapter demonstrates the importance of appropriate pathways and practices that encourage engagement for extended periods.

Push and pull factors that influence GBTQ men who have used violence to engage with family violence services include:

- Police who understand GBTQ family violence and can accurately identify, assess and manage incidents
- Lawyers, legal professionals and LGBTIQ+ court practitioners who understand GBTQ family violence and can provide advice, representation and referrals
- Supportive pathways from initial contact with police or helplines, all the way to completion of MBCPs
- Committed professionals, in both mainstream and LGBTIQ+ community-controlled services, who can hold space for users of violence, invite reflection on behaviour and link them into services
- Social mandates, driven by community expectations of acceptable behaviour and the importance of accountability
- Visible, trusted and active LGBTIQ+ community-controlled organisations that are perceived to offer culturally competent, multi-faceted and integrated services
- The ability for users of violence to access services, such as AOD treatment and counselling, while completing a MBCP
- Freedom for practitioners working with GBTQ users of violence to innovate service delivery and tailor content according to the needs of LGBTIQ+ individuals and communities
- Practitioners working in associated service delivery, such as AOD programs, having the ability to support and refer on clients who reveal they have used family violence

7. BEHAVIOUR CHANGE PROGRAMS: PRACTITIONER AND VICTIM SURVIVOR PERSPECTIVES

Once a person's behaviour has been identified as family violence and they have engaged with services, they are expected to be accountable for their actions.

Accountability means acknowledging the harm that they have caused a partner, former partner and/or family member and changing their behaviour. Although many GBTQ men who attend MBCPs and engage with associated services understand and accept the principles of behaviour change, it can be difficult for some to apply the lessons learned to their own situations. An awareness of violent behaviour is different from accepting responsibility, expressing a readiness to change and committing to that change.

In this chapter, we consider how users of violence are perceived to accept a need to change their behaviour and what motivates them to make that change. We also explore the role of MBCPs and associated services in helping users of violence understand their behaviour. We document participant experiences of what happens after service engagement; in doing so, we consider what evidence of change users of violence

have demonstrated and the degrees to which practitioners and victim survivors believe MBCPs to be effective. Users of violence committing to non-violence and the services they can access post-MBCPs are also considered.

7.1 Readiness to change

A user of violence's unwillingness to acknowledge their behaviour as harmful is a significant barrier to successful family violence intervention (57). In contrast, some evidence suggests that readiness to change leads to better engagement and outcomes in treatment programs (57). In this section, we explore practitioner and victim survivor observations of readiness to change in users of violence.

7.1.1 GBTQ-focused MBCPs

For GBTQ men, ReVisioning has been the main MBCP in Melbourne for almost two decades. In 2022, Thorne Harbour Health, in partnership with No To Violence, launched Clear Space, an online MBCP pilot program for GBTQ men across Australia. Despite efforts to provide suitable options for GBTQ men, practitioners said that it remained difficult to engage people in MBCPs.

> *It feels like the only time you ever have luck with getting someone into ReVisioning … is when it's really driven by them, like they want to make a change around it … It needs to be something that they know what they're signing up for and they know what the program is for. (AOD clinician)*

For those willing to engage, the importance of MBCPs being GBTQ-specific and run by community-controlled organisations was a significant "pull" factor, practitioners said.

> *I think [it's] very important not that it's necessarily Thorne Harbour, but that it's a "for us, by us" model. For a queer-specific MBCP, I think it's really different if that's delivered by a mainstream organisation. Again, I don't necessarily think it's wrong … but I do think there is something very unique and special about a group being housed within a queer organisation and also run by queer facilitators. (Family violence specialist)*

A number of practitioners said it was fairly common for GBTQ men who had used violence to initially be reluctant to fully accept their harmful behaviour as family violence and be actively resistant in the early weeks of an MBCP.

> *Generally, there is resistance … About halfway through the program is when men start to have some realisations. The curriculum, the message, the program starts to get absorbed that little bit more each session that by about halfway through, men start to really change the way that they might be reacting to this idea that they are abusive … I think that there is something about centering the experiences of victims in perpetrator programs because they really need to hear it week after week before they actually start to absorb what they're actually hearing when we're talking about their experiences. (Family violence specialist)*

7.1.2 Practitioner perspectives: acknowledging trauma and stages of change

Practitioners said users of violence began engaging with services at various stages of accepting that they had used family violence. Therefore, they were also at various stages of acknowledging a need to change and being ready to change (which is consistent with the findings in Chapter Four). One MBCP facilitator and counsellor felt that determining whether or not a user of violence was ready to change was less important than actually engaging them in services, where they could begin walking a path towards change.

> *I think that as a sector we get too preoccupied with that [readiness to change]. And I don't think that that's necessary for us to determine whether or not someone's ready to change or not to be able to do effective work with them. (Family violence specialist)*

The same practitioner felt that a "stages of change" model had been adapted from the AOD space to try to understand how users of violence sought to understand and modify their behaviour, which risked placing too much focus on users of violence at the expense of victim survivors.

> *It's an OK way of trying to think about whether or not someone is really ready to do the work, because you can feel that in the room in the assessment. If a bloke's saying, "Yeah, I've done all this stuff, I want to change. I've been thinking about it and*

I'm really upset. I've now been charged and I don't want to get in trouble again" – we might consider him to be more than contemplative; he might be actually in the planning stage to do something about it. But there's a preoccupation now with trying to work out whether men are pre-contemplative and contemplative and how do we get him to contemplative? How do we get him to planning? What it misses is the victim's experience. (Family violence specialist)

The practitioner felt that "ultimatums", or what we refer to in a previous chapter as social mandates, often drove users of violence to change their behaviour and access services and that they very rarely, if ever, engaged with MBCPs wholly of their own accord.

A barrier to being ready to change for some users of violence was their own experiences of trauma, which is particularly pronounced in LGBTIQ+ communities, whose members experience higher levels of discrimination, violence and mental ill health. Trauma often presented challenges for those engaging with family violence services, as one practitioner explained:

One of the hallmarks of use of violence is the tendency to minimise that violence. I think one of the biggest challenges is people's own experiences of violence and many people do see themselves as having experienced worse things than they've done, and that's a really challenging thing to work with because you want to honour people's very real traumatic experiences, many of which occurred when they were young people. (AOD clinician)

Some practitioners questioned how much MBCPs could help a user of violence who was not accepting responsibility or open to change. In contrast, a willingness to change was something considered to be a powerful and supportive facilitator of change.

From what I know, there's been one really good study – that Mirabel study from Durham University in the UK – that concluded that if he wants to change, great, come onboard, but if not, it's going to be a lot harder. It's a joint project, really. If he's up for it, we've got the frameworks – he needs to be very invested in it. If he's not willing to change … Oh God, it's such a complex question, isn't it? (Family violence specialist)

The same practitioner said that, for facilitators, MBCP work in mainstream settings was about trying to help users of violence who were resistant to identify motivations for change appropriate to them. For heterosexual men who continued to be hostile to women, an entry point to finding motivation to change was often their children and the relationship they could still have with them, while:

the motivations for change are a little harder to find in queer men. It probably is a bit more work for them to really think about how to get from the point of admitting or acknowledging that they've caused harm. (Family violence specialist)

It should be stated, however, that a number of users of violence and victim survivors interviewed for this study did have children and one participant, a trans man, cited the potential to have children as one of his motivators to change.

Another practitioner noted how motivation to change could be grounded in an individual's own sense of self and the standards by which they wanted to live. Such motivation presented something for both the user of violence and a practitioner to work with.

When you have the opportunity to say what your preferred way of being in the world is, and that you're not living up to that, usually that comes with a whole lot of loss and grief, where you're absolutely confronted with who you are in spaces … If you can be scooped up at that point and you want something different … you've got the possibility of movement. (Family violence specialist)

Practitioners gave examples of users of violence wanting to change and driving their own service engagement. This was something that users of violence might not have articulated as "readiness to change", but which nonetheless involved some reflection on their part and a willingness to address their behaviour. One practitioner described one such situation as including:

an understanding that they are using violence in their relationships and an ability to have language around that and wanting to do something about that in really overt terms. (AOD clinician)

7.1.3 Victim survivor perspectives: ensuring reflection and accountability

Victim survivors described how family members, partners and former partners varied in their willingness to engage with an MBCP. Resentment at having to attend for 20 weeks and reluctance to engage with the content were what some victim survivors had witnessed. It led them to question whether an MBCP would make much difference to how users of violence thought and behaved.

> *I think the evidence suggests that 20 weeks is not probably going to be long enough for behaviour change to happen, and I certainly was a bit sceptical that my ex could sit on a Zoom call and may or may not have listened to anything or contributed to the discussion. (Victim survivor)*

Others, however, observed a user of violence willingly engaging with an MBCP at Thorne Harbour Health and benefiting from doing so.

> *I believe it [attendance] was ordered by the court or he had the impression that it would benefit him in terms of the court and his sentence. So, he was doing the [MBCP] and he was really quite enjoying it … I could see that even just the way he spoke, the things he was saying, that he was getting something out of it … I could tell that, "OK, something's really clicked with him." (Victim survivor)*

Victim survivors varied in their assessments of whether a partner, former partner or family member had taken responsibility for their actions and expressed a readiness to change. Some victim survivors did not see any change in a person's awareness of their harmful behaviour, even after an MBCP.

> *I've never in my life met somebody that has been able to hold zero accountability for doing what he's done … In fact, after the program, I actually think he got worse. A lot of the things that I saw during our time together … those behaviours have been brought to the surface a lot more often. (Victim survivor)*

Others felt that the person who had been violent to them had taken responsibility for their actions more or less straight away and expressed a readiness to change before engaging with LGBTIQ+ community-controlled services.

> *In terms of the violent side of things, there was absolute accountability from the moment it happened … I'm not saying that the program had no value. I think he took benefit from certain things along the way … It wasn't mandated – it was recommended by the police – and he'd gone, "OK, well I'm going to try and do all the things I can." (Victim survivor)*

Victim survivors also differed in their assessments of why their partner, former partner or family member had used violence and what they needed to do to address it. Some victim survivors felt that the person needed to address an AOD issue as their first priority. Two victim survivors explained their experiences of this, saying:

> *My view was it was an issue with alcohol, depression and anxiety that … caused the situation that was domestic violence be it family or otherwise and it was violence that occurred in the home, so it would meet the definition of domestic violence … I was like, "Well, you're not coming back if you drink again" … That's just got to be a line. (Victim survivor)*

> *I think his understanding is that if he drinks and takes drugs, it changes his personality or it brings out all his frustrations and things become muddled … I'm pretty sure he realises what causes it … I don't know that he's motivated enough to do it yet … The addiction is a little bit hard to overcome … I've always been taught that the more family support you get, the more you're likely to change … [But] I don't know what would motivate him to change. (Victim survivor)*

Some victim survivors were in situations where children were involved. In most cases, the victim survivor interviewed had custody of a child or children. One victim survivor, who did not feel that a former partner had shown a readiness to change, said that the user of violence in question had apparently not been motivated to change in order to have regular and ongoing contact with his children.

"IT'S VERY DIFFICULT TO GET HIM TO THAT POINT IF HE'S NOT ALREADY THERE BECAUSE IT'S ONLY 20 WEEKS AND IT'S NOT A LOT OF TIME."

(FAMILY VIOLENCE SPECIALIST)

7.2 Enabling change in MBCPs

Victim survivors and practitioners interviewed were generally supportive of the role of MBCPs as an intervention option, especially when programs were tailored to meet the needs and reflect the situations of LGBTIQ+ people.

Some participants were less convinced of the effectiveness of MBCPs, including in terms of their ability to engage resistant participants in a process of change, and the overreliance on them as an intervention. In this section, we consider practitioner and victim survivor perspectives, focusing on MBCP content and format; group dynamics; and perceived effectiveness.

7.2.1 Meeting participants where they are at

Both ReVisioning and Clear Space, an online, nationwide pilot program launched in 2022, are 20-week MBCPs whose content has been carefully tailored for GBTQ men. ReVisioning was an entirely face-to-face program running from Thorne Harbour Health's head office prior to the COVID-19 pandemic. Since then, it has operated mainly online, but has recently returned to being an in-person program.

Some practitioners spoke about using the programs to meet GBTQ men who had used violence "where they were at", including by deviating from some of the gender-based understandings of violence that drove mainstream MBCPs.

> *There is a very strong focus on accountability in the men's behaviour change sector. I for a large part agree with it – I also identify as a feminist … [and] think if you identify anywhere in the male-ish spectrum there's a certain amount of privilege … But at the same time, I feel like there's also that part of group work and therapeutic work and if you don't meet someone where they're at, they're not going to change anyway. So, the tension for us is, "how do you be relational and not collude?" I don't think there's enough focus on that. (Family violence specialist)*

An MBCP facilitator said it was important to encourage users of violence, especially those showing some resistance, to attend and engage as much as possible. Another goal was to encourage participants to have a dialogue with each other and, thus, try to avoid facilitators having an "authoritative presence".

> *I actually found when you just allow people to talk to each other and you're less authoritative, people are more naturally forthcoming and naturally honest and naturally open to change. It was something that I really learned from doing this group. (Family violence specialist)*

MBCP content has focused on encouraging participants to find reasons to change based both on individual motivations to be better and the desire to have more healthy relationships. One practitioner said that could be a challenging task in such a brief time.

> *It's very difficult to get him to that point if he's not already there because it's only 20 weeks and it's not a lot of time. And because the [MBCP] group is not a mandated cohort, they don't always come every week. (Family violence specialist)*

Since the Royal Commission, MBCPs at Thorne Harbour Health have begun to be aligned more with No To Violence's minimum standards

around accountability work with users of violence, one practitioner said. That presented some challenges initially for GBTQ men who were attending a community-controlled service expecting to feel affirmed and safe.

> *Now, they're being challenged about their abuse, their violence in their relationship with their partner and they're not experiencing this kind of softer, supportive, "I'll follow you and support anything you say" kind of response as they would have in a counselling service … So, we found that we were having to challenge these men on their abuse, but also wanting them to feel like, "This is still your community, we're still here to support you." (Family violence specialist)*

No To Violence, a peak body for organisations and individuals working with men to end family violence (58), funds Clear Space whereas Family Safety Victoria funds ReVisioning. When developing Clear Space, facilitators took the opportunity to build something LGBTIQ+-centred from the ground up. The starting point was the Duluth Model; however, facilitators were determined not to simply transplant Duluth principles, but to use the model to design something LGBTIQ+ focused.

> *I think ReVisioning takes the gender-based violence curriculum and critiques of masculinity – all of those things that are really relevant, of course – but [in Clear Space] we wanted to see what would happen if we applied an intervention in power and hierarchy on lots of different levels. (Family violence specialist)*

> *I'm really wary of MBCPs for gay men that just take a mainstream straight hetero Duluth model and just change the pronouns or something like that – it doesn't work … We started with the lived experience of the men in the group and all the complexities that that entails, including their complex experiences of also having experienced violence in other contexts or their experiences of drug use and homelessness and being disenfranchised. (Family violence specialist)*

Facilitators sought to "see what's possible when it [an MBCP] is developed as an online program". Another of their initiatives was to be more "trans-centred" in their approach and practice, which they saw as differentiating Clear Space from ReVisioning.

> *Trans people absolutely engage in ReVisioning, but it hasn't been built for trans people. (Family violence specialist)*

7.2.2 Group dynamics contributing to change

As discussed in Chapter Four, for many users of violence, GBTQ groups provided the perception of safety they felt they would not get in a mainstream MBCP. One practitioner gave an example of a user of violence attending a program with peers only because he felt safe enough to reveal aspects of his identity, employment and health status without being discriminated against.

> *This person a) would not have engaged [with a mainstream program]; he said straight up he was just too scared to engage with other cis men and b) he actually wouldn't have disclosed a lot of his experience, like that he was a sex worker … He's really hearing the shared experiences of other people and reflecting on his own experiences because of that. So, when he's in a group with peers … his voice has been appreciated rather than seen as being problematic or like a weirdo or the odd one out. (Other practitioner)*

In contrast, some users of violence felt ashamed by the thought of attending an MBCP for GBTQ men and what impact it might have on their reputation.

> *There's a lot of fear of judgment … Before they even get to week one, the men are very anxious, especially about Thorne Harbour, about bumping into someone they know from community. [They ask], "What are the confidentiality requirements and who else is going to be there? I've had men ask, "Can I see the other men's names before I come to week one, just in case I know someone?" (Family violence specialist)*

Once participants made it into programs, connection with others was often a key factor in overcoming the shame of having to attend. Group dynamics helped to shape how participants experienced MBCPs and, often, also contributed to learning and change.

Facilitators and other practitioners noticed that many group participants had the potential to

find common ground, even if they came from dissimilar backgrounds.

> *The people we ended up with were all cisgender men but had really different life experiences … There was one moment when one of the participants said to another one, "Oh, it's been really nice to have this conversation with you because I think we have really similar experiences" and that other participant's face just lit up … The only thing they have in common is that they're both gay men. They have completely different lives and access to resources. Stuff like that was cool – people connected across difference. (Family violence specialist)*

In some instances, group dynamics brought the risk of participants validating each other's sense of being a "victim", rather than encouraging accountability.

> *Definitely, there were some people in the beginning who very much saw themselves in the victim position, and who didn't at all identify with using violence. (Family violence specialist)*

One MBCP facilitator argued that descents into victim blaming were not as apparent in GBTQ MBCPs as they were in mainstream programs designed for heterosexual men who had been violent towards women.

> *It happens quickly and it's so edgy and it's actually awful to see how much, how quickly they can all join in that narrative – that women are problematic, they're liars, they can't be trusted and even to go as far as declaring that men are the true victims of domestic violence. These are men who have even hospitalised their female partners, right? … I've got to say in ReVisioning with queer men I never really got that level of men being that problematic about their male victims, their partners at home. And I do think that there is something about queer people understanding oppression and structural disadvantage and daily realities of discrimination … Not with every single man but generally. I just felt that the group could understand that and empathise more readily and in ways that I don't think mainstream groups can or have not in my experience. (Family violence specialist)*

Facilitators felt that rolling groups and closed groups, where participants went through an entire 20-week program together, both had their advantages. Some practitioners also said it was important to try to attract more LGBTIQ+ people to perform facilitation roles, feeling they could contribute to more meaningful end effective change.

7.2.3 Victim survivor and practitioner perceptions of MBCP programs

We now consider what victim survivors and practitioners thought of MBCPs for GBTQ men. Like the corresponding sections about users of violence, this should not be considered an evaluation of the programs. Victim survivors were not aware of exactly how MBCPs were designed and facilitated. Thus, their perceptions about the programs' effectiveness were drawn from their interactions with Thorne Harbour Health through family/partner safety contact or other family violence programs; their interactions with a partner, former partner or family member; or their observations of that same person's behaviour after enrolling.

One victim survivor described not having noticed any improvement in a former partner's behaviour after an MBCP.

> *There was some limited contact, but it was still quite blaming of me, and I didn't feel that there was a change and there were some ongoing controlling behaviours. I didn't feel like the program made much difference that way. (Victim survivor)*

The same victim survivor had hoped that the MBCP would focus more on changing behaviour around children, but it seemed to have made no difference to how the former partner acted.

> *I still remain concerned that his behaviour change program wasn't able to do much towards his use of violence as a parent. I don't know exactly how much a hetero men's behaviour change program incorporates violence against children, but I understand it's not built into the standard program at [Thorne Harbour Health]. (Victim survivor)*

Another victim survivor, who was sceptical of his partner's need to engage with an MBCP due to a view that a single act of violence he had enacted was primarily the result of an AOD issue, nonetheless felt that the program had been useful.

I recall he got off one meeting around gaslighting … Look, it's very on trend in the media at the moment, and then it's like, "Maybe I'm getting too old, but to me, sometimes some of the conversations didn't feel very authentic" … [But] in terms of setting some of those boundaries and talking about how to approach things, that definitely did come through as a result of the program … That's been beneficial for us. (Victim survivor)

Practitioners also reported mixed feelings about MBCPs. Many felt they were a useful intervention, especially in the absence of something better. Some felt their effectiveness was contingent on how much they could be tailored to the needs and circumstances of GBTQ men. One facilitator said:

One of our reflections at the end of our group is we noticed that when you prioritise creating a really, really queer affirmative space … where we prioritise queer ways of being in this world and … [a] non-punitive approach and non-judgmental approach, people were actually able to be honest and show up as their full selves and talk about things that are never spoken about ever … I think it went well. (Family violence specialist)

An independent practitioner who was supervising an MBCP at Thorne Harbour Health said:

My role was to reflect with them [and] understand what was working and what wasn't … They had a framework around the program, but [the facilitators] … were very flexible; they were very committed in their approach. They obviously had very good engagement online … But what has that meant in these men's lives? I don't know because we don't do that follow-up evaluation. (Family violence specialist)

An MBCP becoming a rolling group had also helped facilitate new ways of encouraging users of violence to learn about violence and accept the need to change, especially through learning from others at various stages of their change process.

When it became a rolling group, it's like, "Amazing, it's going to be so much easier because you've got men who have been there for three months who have figured some stuff out and new guys who are highly resistant and this guy can bring him along a little bit." … You also have guys who are somewhere in the middle who will see this new guy and think, "I don't want to be like that". (Family violence specialist)

7.3 After service engagement

Users of violence undergo a process of learning and reflection during an MBCP. In doing so, they might fulfill the requirements of a family violence counselling order, issued by a magistrate (59). They might also fulfill "social mandates", driven by a partner, former partner or family member who expects them to take accountability for their use of family violence.

Changing behaviour and committing to non-violence, however, do not follow naturally for all

… [BUT] IN TERMS OF SETTING SOME OF THOSE BOUNDARIES AND TALKING ABOUT HOW TO APPROACH THINGS, THAT DEFINITELY DID COME THROUGH AS A RESULT OF THE PROGRAM …

(VICTIM SURVIVOR)

users of violence. Practitioners and victim survivors spoke about a range of different outcomes for users of violence following completion of an MBCP. In this section, we explore some of these experiences, focusing on evidence of change, becoming and staying non-violent and ongoing support for users of violence post-MBCP.

7.3.1 Practitioners and victim survivors seeing evidence of change

MBCP facilitators said they had seen considerable progress in participants who appreciated both the content of a program and the approach of the facilitators. A supportive environment was something participants had responded well to, one facilitator said. In terms of encouraging change, a focus on interrogating "unhelpful beliefs" that users of violence carried had held a prominent place in MBCPs. Included in this was an emphasis on everyone's capacity to cause harm – and the importance of choosing not to.

> *All of our participants, even the ones who had to leave earlier, had big leaps in their own ways. For one participant, it was a really big leap from, "I'm a good person, therefore I can't cause harm" to "Everyone can cause harm, including me" – that's pretty big. (Family violence specialist)*

Some victim survivors saw little change in a partner, former partner or family member who attended an MBCP, even if the person had engaged well with the program's content. These victim survivors generally felt that a participant had connected intellectually but not applied what they had learned to their own behaviour.

> *I think what's happened is he's sat in that program, and he's looked at other men and probably heard things that weren't great, and I absolutely think he could not identify with other people's behaviour, because he wouldn't put himself in that box. (Victim survivor)*

Another participant acknowledged that a former partner had taken accountability for his behaviour after attending an MBCP but had since experienced a decline in his mental health.

> *His mental health has deteriorated so much now that it's hard to know what could have been if his mental health was still good. I could see improvements in the way he spoke, the things that he said at that time … My frustration was and still is that … I feel like I can't go to the police, for instance, when he's breaching because I know it's his mental health and if he wasn't having an episode, he wouldn't be doing these things … I feel like if I report it to the police, they're just going to lock him up and that's not in his best interest. (Victim survivor)*

7.3.2 Committing to non-violence

Many practitioners were confident MBCPs and associated services offered to users of violence could contribute to meaningful change that could last well beyond completion of programs. One, for example, felt that group work could be "life changing", while another said that MBCPs could achieve significant results and that more investment in them would result in more users of violence committing to change.

> *I honestly do think if resources are given to people who actually want to implement this kind of change in people's lives, you can do it; the possibilities are endless … I don't even know what they are because we haven't done them yet. (Family violence specialist)*

Some practitioners spoke about the limitations of not knowing what happened to many users of violence once they completed programs. Users of violence not coming into contact again with police, courts and family violence services could be interpreted as a good sign but not definitive evidence of change.

> *I do know from listening to the facilitators talking is that there are some men who start to understand; you see that as planting seeds. The problem with that is that we don't always see what happens with those seeds and because there's no ongoing engagement beyond the group, we just don't know how that's maintained, particularly if they go back into a community that denies the existence of family violence or that perpetuates it, or that minimises it or calls it a toxic relationship or something. (Family violence specialist)*

We might evaluate the program, but what happens, you know, three months, six months, 12 months, two years, five years down the track? What's that looking like? (Family violence specialist)

Victim survivors interviewed differed in their accounts of how much a partner, former partner or family member had committed to change and non-violence once an MBCP or associated service engagement had finished. One victim survivor, whose partner had attended an MBCP while also seeking treatment for an AOD issue, had noticed a strong, steady commitment to change in the year since the program had ended.

There are points where he's struggling with not drinking in the longer term, which we're working on, but he's been pretty level since and I think he's seen things really turn for him in a positive way. Last year was pretty low for him, in terms of an emotional state … Now we're seeing the benefit of actually working towards things and committing to changes. (Victim survivor)

Another victim survivor, however, had noticed no change in a former partner.

He's got a very large ego and … always knows more than everybody else, has done more and he [believed he] didn't need it [the MBCP]. And, actually, one of his comments to me was, "You should have been the one doing something like this, not me." So, it was pretty clear his take is that it was my fault, not his. (Victim survivor)

7.3.3 Ongoing support for users of violence post-MBC

Some practitioners felt that although change was very much possible in MBCPs, service options to help users of violence remain committed to this change in the longer term were limited. Few psychologists and counsellors had expertise in working with users of violence and those who did were likely overburdened, one practitioner said.

Within the group for men who want to be there and who want to change, that change can begin. My concern and I think everybody's concern for a very long time is, "But then what? Where do they go now?" Because going to an individual psychologist is not a great option because so few psychologists have specialist family violence frameworks, especially working with perpetrators. So, there's a huge gap after a group … I think the options are so limited for where he can go. (Family violence specialist)

An option that existed for some users of violence who had remained with a partner throughout MBCP was couples therapy. One practitioner, who provided this type of support privately, said that for some users of violence, couples therapy had been their pathway into Thorne Harbour Health and an MBCP in the first place.

They might have come for couples therapy and we'd identified some power and control issues and some abuse. We'd separated them, seen them individually again just to determine more thoroughly what was going on and referred him to ReVisioning. Then we'd we let them know … that he'd need to complete that program and then they'd come back to having joint work that way after. (Family violence specialist)

As demonstrated in previous chapters, integrated services, including those at Thorne Harbour Health, had helped users of violence address issues concurrently. Some participants spoke of the value of a user of violence being able to access AOD treatments and/or other counselling (at Thorne Harbour Health or elsewhere) as well as an MBCP. However, others described AOD and mental health issues that were ongoing after a user of violence had exited an MBCO. Several victim survivors were in situations where a partner, former partner or family member continued to experience AOD or mental health issues that affected their behaviour and impacted upon victim survivors.

More broadly, concerns about what happened after MBCPs were indicative of some practitioners' views these programs, despite their apparent effectiveness, were too heavily relied upon as a family violence intervention.

We've got to be careful not to put all our eggs in the MBC basket … It can't be the only thing that's on offer. It needs to be one of the things that exists, not the only thing, and I think for a long time it's been the only thing … It's not enough – it's only 20 weeks. (Family violence specialist)

7.4 Summary

Men's Behaviour Change Programs provide crucial education and support to encourage users of violence to commit to non-violence. Service providers that are accessible and programs tailored to GBTQ men and their relationships encourage engagement and meaningful change. GBTQ men who have used violence enter MBCPs at Thorne Harbour Health at various stages of accepting the family violence they have used and recognising a need to change.

In this chapter, we have demonstrated that family violence services and MBCPs build on the important identification and engagement work highlighted in Chapters Five and Six. Practitioners who "meet users of violence where they are at" reported success with engaging participants in processes of change. MBCPs that are tailored to GBTQ men can help deepen their understanding of family violence, their behaviour and the tools needed to change. Such services can emphasise the diversity of experiences within GBTQ communities – for example, the different experiences of gay men and trans men – while also speaking to shared, community experiences, especially in terms of discrimination and trauma. Services accessed concurrently, such as AOD treatment and trauma counselling, can help users of violence address other issues that are often more prevalent among LGBTIQ+ communities than the general population, thus ensuring that MBCPs remain focused on accountability and change.

Some uncertainty remains about the effectiveness of MBCPs in helping to achieve change, especially in users of violence who are resistant. Content that is relevant to GBTQ men, which holds users of violence accountable without being combative, as well as programs that encourage them to be introspective and to "do the work" in their own time help create conditions in which change is at least possible. MBCPs are heavily relied upon as a family violence intervention yet are limited due to funding constraints and inconclusive evidence as to their overall effectiveness.

With participants talking about the immense potential of MBCPs to contribute to change, even to "change lives", it seems likely that more capacity building to "meet users of violence where they are at", provide supportive environments and strengthen post-MBCP services would contribute to more GBTQ men committing to non-violence.

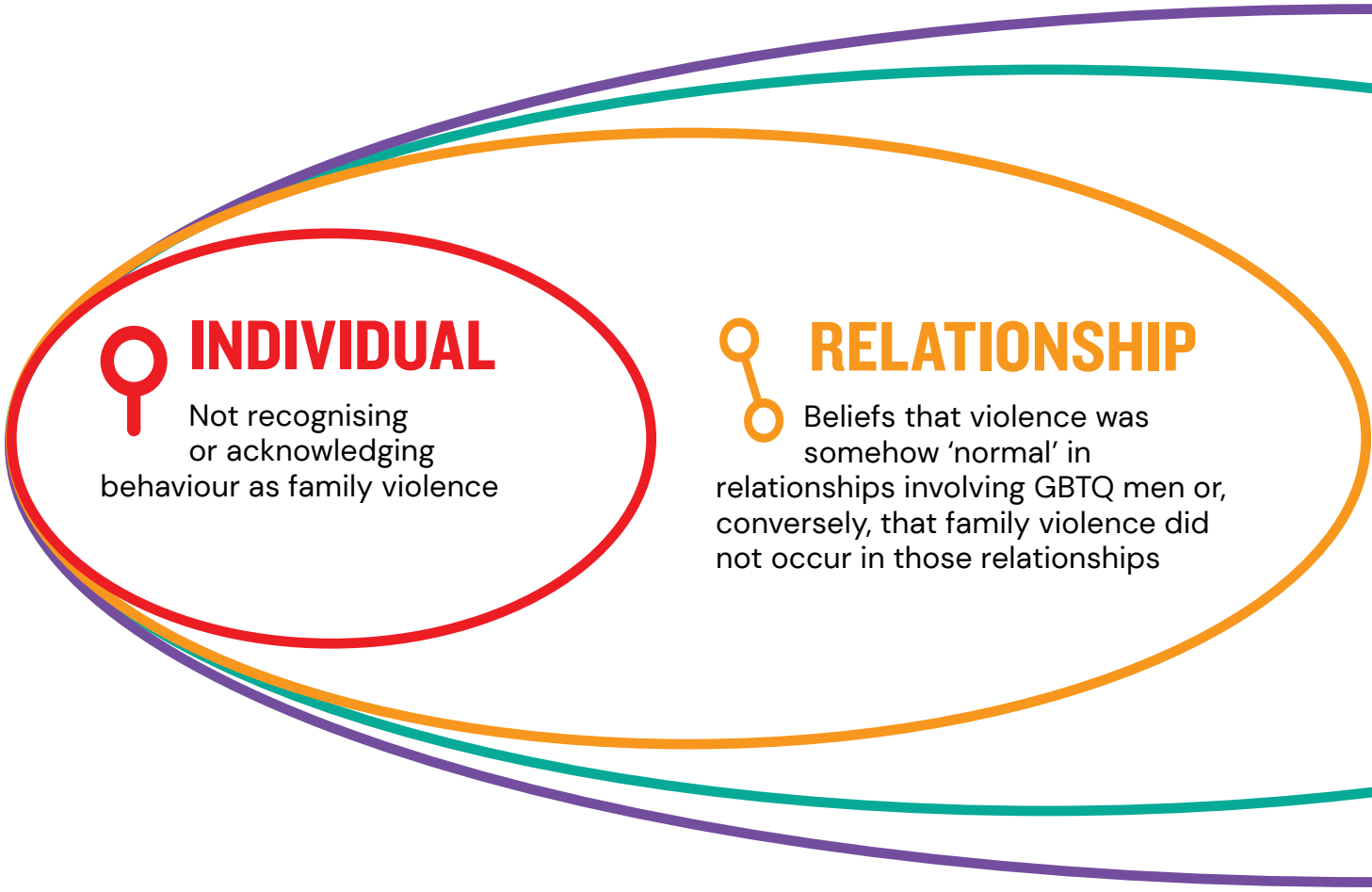
In summary, factors that contribute to readiness to change and continued engagement include:

- Services and MBCPs that meet the needs and situations of GBTQ men in culturally supportive environments
- Integrated services that allow users of violence to address AOD, mental health and trauma in therapeutic environments (away from MBCPs)
- Content that deepens understanding of family violence and the link between a user of violence's choices and their outcomes
- Content that is tailored to GBTQ users of violence, including by focusing on trans and gender diverse lived experiences and issues of hierarchy and power (not only gender and patriarchy)
- Facilitators that understand LGBTIQ+ lived experiences and centre the wellbeing of victim survivors
- Non-punitive approaches to behaviour change that "meet users of violence where they are at" (while still holding them accountable)
- Group environments that encourage users of violence to learn and change together

8. SUMMARY AND RECOMMENDATIONS: CATALYSTS OF CHANGE FOR GBTQ MEN WHO HAVE USED FAMILY VIOLENCE

What interventions and service pathways support gay, bisexual, trans and queer (GBTQ) men who have used violence in their intimate and/or family relationships to change their behaviour?

The previous four chapters have demonstrated the challenges of engaging GBTQ users of violence with family violence services (and associated services). But they have also shown the ways in which individual professionals, service providers and programs for GBTQ men overcome these challenges by creating conditions that encourage engagement.

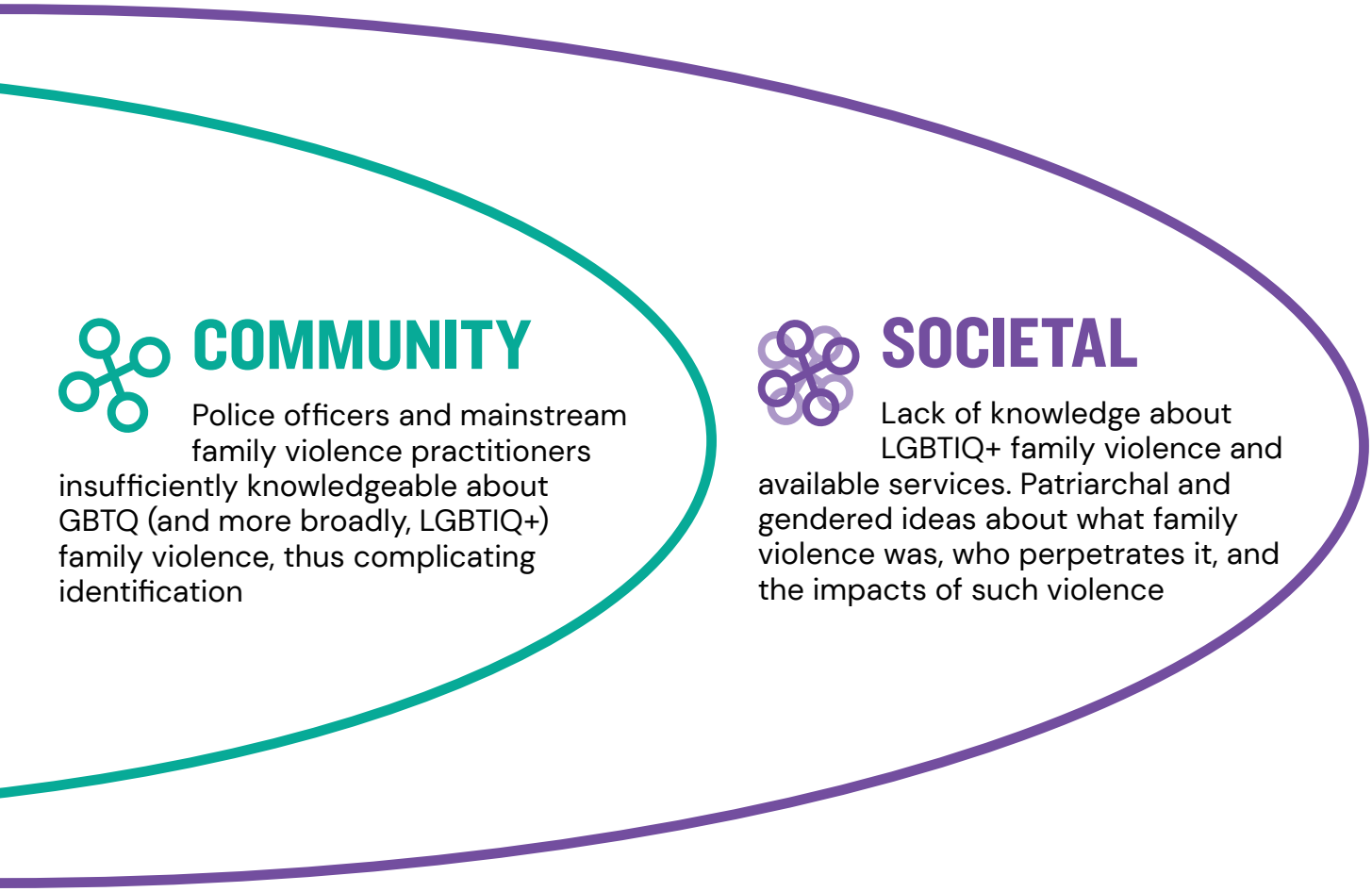


Thus, in answering our main research question, we argue that appropriate service responses – involving practitioners, service providers and relevant programs – function as catalysts of change for GBTQ men who have used family violence. In this concluding chapter, we synthesise findings from Chapters Four to Seven into a discussion about these catalysts of change and what potential exists to further engage GBTQ users of violence in services and programs that encourage behaviour change and non-violence. Such change can contribute significantly to ensuring the safety of victim survivors, including those who choose to stay in a relationship.

First, it is important to explain the definition and parameters of our use of the term "catalyst of change". In the service engagement context of this research, a catalyst of change is something we consider to be an aspect of the service experience that precipitates a user of violence making better choices, including addressing their behaviour and committing to non-violence.

The scope of our research is limited to interventions and service pathways that support behaviour change and, so, our use of "catalyst of change" relates only to service engagement contexts. Other catalysts of change might include factors in someone's personal life or relationship or legal consequences such as imprisonment. These catalysts, though also important, are not the primary focus of this research, except in terms of how they prompt users of violence to engage with services.

Using family violence is a choice, and so, too, is changing behaviour and committing to being non-violent. Users of violence, therefore, are responsible for their actions. That much is unequivocal, though it is hardly the end of the story. Many factors influence the choices a person makes – and some of those factors can be considered as having the potential to positively influence a person's decision-making. This does not absolve an individual of responsibility for the choices they make. Rather, it indicates that they can be encouraged to make better ones. Catalysts of change along service pathways encourage better choices.



8.1 Barriers to engaging GBTQ men in change processes

This report has demonstrated barriers to engaging GBTQ men who have used family violence in services and behaviour change programs. These barriers can be understood in terms of a social-ecological model of human development (60). The key characteristics of each level are summarised in the figure below.

- **At the individual level**, a user of violence not recognising or acknowledging their behaviour as family violence was a significant service barrier. Another barrier was down to users of violence buying into stereotypes about who could and could not be a "perpetrator". For instance, some had believed they were not capable of perpetrating family violence due to their size. Once engaged in with services, some users of violence maintained narratives that positioned them as victims.
- **At a relationship level,** beliefs that violence was somehow "normal" in relationships involving GBTQ men or, conversely, that family violence did not occur in those relationships were barriers to recognition and engagement. Attitudes about a partner "pushing them too far" or a relationship being "toxic" similarly served as barriers to users of violence acknowledging their use of violence.
- **At the community level,** participants identified barriers to service engagement that often occurred in the initial stages of dealing with a professional, from police officers and lawyers to counsellors and LGBTIQ+-community controlled organisations. Police officers and mainstream family violence practitioners were often perceived as not educated enough about GBTQ (and more broadly, LGBTIQ+) family violence.
- **At the societal level,** participants identified numerous barriers to service engagement, such as a widespread lack of knowledge about LGBTIQ+ family violence and available services, patriarchal and gendered ideas about what family violence was and who perpetrated it, limited or no service options for people in rural and regional areas and the presence of other challenges that disproportionately impacted on LGBTIQ+ communities, such as homelessness. Many participants said a lack of public messaging about GBTQ family violence affected how users of violence engaged with services, when they did at all.

RECOMMENDATION 1.

Increase public promotion within LGBTIQ+ communities, as well as among family violence, AOD and mental health practitioners, about the nature, extent and impact of family violence within these communities. Such promotion would significantly aid recognition of violence enacted by GBTQ men at the individual, relational, community and societal level.

8.2 Catalysts of change along service pathways

Individual practitioners, from legal professionals to MBCP facilitators, with sophisticated understanding of LGBTIQ+ health, wellbeing, relationships and GTBQ family violence, play important roles in identifying users of violence. They hold space for clients with complex needs while also challenging problematic narratives that seek to justify or excuse harmful behaviour, referring them onto and/or retaining them in relevant services, such as MBCPs at Thorne Harbour Health.

Beyond the efforts of individual practitioners, various push and pull factors encourage GBTQ men who have used violence to engage with LGBTIQ+ community-controlled service providers and programs that support behaviour change. These include supportive pathways from legal settings, helplines and AOD services to family violence services and MBCPs; "social" mandates to change, driven by community expectations of acceptable behaviour and accountability; tailored, innovative programs that meet the needs of GBTQ men; and integrated services that allow users of violence to access support for AOD and other issues.

Service responses tailored to the needs of LGBTIQ+ individuals, relationships and communities have the potential to be catalysts of change for GBTQ men who have used violence. Early engagement with legal professionals, peer workers, family violence practitioners and AOD counsellors, among others along service pathways can be instrumental in helping GBTQ users of violence access services and programs that can lead to meaningful behaviour change.

Services that "meet users of violence where they are at" are important in helping to address issues relating to GBTQ men's understanding and recognition of family violence as well as peripheral issues, including AOD use and experiences of trauma (such as discrimination and violence based on their gender and/or sexuality).

In this section, we identify five features of service access, engagement and provision that are potential catalysts of change for GBTQ men who have used family violence. While we have demarcated these for the sake of clarity, these catalysts share characteristics that overlap.

8.2.1 Professionals that help facilitate early identification and engagement

Early identification of GBTQ users of violence was identified as crucial to engaging them in services. Competent, LGBTIQ+-affirming professionals skilled and experienced at recognising GBTQ family violence and identifying users of violence played pivotal roles in the preliminary stages of service engagement. Participants talked about the importance of police, lawyers, legal professionals, LGBTIQ+ helpline workers, counsellors and family violence practitioners engaging users of violence and setting them on pathways to change. Professionals with lived experience of LGBTIQ+ issues had much to offer in such situations, including when systems were not designed to recognise or acknowledge GBTQ family violence. It was suggested that some users of violence would not have engaged with services further had they not come into contact with a professional supportive of LGBTIQ+ identities.

During court interactions, timely access to legal professionals, including court practitioners and community lawyers who understood GBTQ family violence, could help users of violence not only manage their legal challenges but also link in with family violence services and other services. LGBTIQ+ peers who worked on Switchboard Victoria's Rainbow Door specialist helpline were examples of the importance of services that identified suspected users of violence and engaged them quickly through affirmation of their GBTQ identities while beginning to challenge their narratives around their behaviour. Such professionals referred users of violence onto trusted LGBTIQ+ community-controlled health and wellbeing services. Once there, knowledgeable and skilled family violence practitioners, counsellors and AOD clinicians could identify family violence by naming it up front, challenging narratives of resistance and treating complex client needs.

RECOMMENDATION 2.

Ensure training of the family violence sector workforce to better identify and respond to family violence involving GBTQ men. Such workers include (but are not limited to) the police, legal professionals, counsellors and family violence practitioners. Build capacity in both LGBTIQ+ family violence services and mainstream family violence services so as to strengthen identification and engagement efforts.

8.2.2 GBTQ/LGBTIQ+ specialist services

Service providers who catered to the needs of GBTQ men played a significant role in engaging users of violence in ways that led to behaviour change. Court-based LGBTIQ+ FV practitioner services, community legal centres, helplines and mainstream family violence services that were LGBTIQ+ inclusive and knowledgeable, and community-controlled organisations all played important roles. They were able to assess situations, gain the trust of users of violence and assuage concerns about potentially hostile or unsafe service environments.

Once a user of violence was engaged with service providers, other factors created conditions that encouraged ongoing engagement, critical reflection and education as part of a change process. Practitioners having the freedom to tailor family violence services, including MBCPs, to the needs of GBTQ communities helped create a safe environment. Central to this was content tailored to trans and gender diverse participants and communities and a focus on intersectionality. Other conditions that supported engagement and change included non-punitive approaches to behaviour change that "met users of violence where they were" (while still holding them accountable); group environments with GBTQ peers that encouraged users of violence to learn and change together; and, where relevant, access to associated services such as AOD and general counselling. These conditions encouraged ongoing engagement with service providers and re-engagement if a user of violence withdrew from services.

8.2.3 Integrated and connected services that encourage ongoing engagement

Integrated service models and service providers working closely with one another created conditions that supported users of violence to engage with programs and change their behaviour. Service providers that provided safe and smooth pathways from legal, mental health, AOD, sexual health and/or other programs to family violence services and MBCPs appeared to offer users of violence clarity and consistency of service.

Practitioners being able to share information about clients in ways that helped them to access services was crucial to engagement and change. This was often perceived as an advantage at an organisation like Thorne Harbour Health, where AOD clinicians, for example, became aware of a client using family violence and were able to seek advice from, and/or make referrals to, the family violence team. This was an efficient way of helping a user of violence to access the most appropriate services.

It also meant that more eyes remained on the user of violence. Some users of violence found it less daunting and more manageable to engage with services at only one organisation. This increased the likelihood of engagement not just with the service provider itself, but also its programs that promoted behaviour change. Less formally, established relationships between professionals at services such as Rainbow Door and Thorne Harbour Health resulted in smooth pathways between services. Similarly, individual community lawyers who interacted professionally with family violence practitioners helped guide users of violence through court cases and into appropriate services such as an MBCP.

RECOMMENDATION 3.

Embed more LGBTIQ+ family violence specialists in mainstream services and strengthen relationships with, and client pathways to, specialist LGBTIQ+ services. Develop more collaborative and co-management approaches, involving government and community stakeholders, that leverage the specialist knowledge of GBTQ family violence that exists in community-community organisations.

8.2.4 Program content and environments that deepen understanding of GBTQ family violence and harmful behaviour

Users of violence benefited from program content, often in MBCPs, designed to increase their knowledge, awareness and understanding of family violence, especially in terms of their own behaviour. Participants spoke about the importance of these educational processes. They were described as helping users of violence recognise the link between their choices and their outcomes. The emphasis on using violence as a choice proved powerful in terms of helping some users of violence accept responsibility for their actions and recognise the need to change. Accountability narratives also helped encourage users of violence to challenge perceptions of their own behaviour. This helped them realise that having grievances about a relationship did not make them a victim or justify their choice to use violence. Further research among this population to refine behaviour change models would be advantageous.

Tailoring MBCP content for GBTQ participants, including by focusing on issues such as power and hierarchy (not only gender and patriarchy), was something many participants supported. Emphasising the diversity of experiences within GBTQ communities – for example, the different experiences of gay men and trans men – while also speaking to shared, community experiences was also seen to be effective. Facilitators who understood LGBTIQ+ lived experiences and who were able to centre the wellbeing of victim survivors in discussions about family violence were talked about as having a positive impact on users of violence. Finally, environments where group members could share experiences and encourage each other to change were beneficial to some users of violence.

RECOMMENDATION 4.

Increase opportunities for practitioners and other professionals to develop more nuanced understanding of power, control and coercion in the context of relationships involving GBTQ men.

8.2.5 The ability to access additional services that address co-existing issues

MBCPs are designed to hold users of violence accountable for their behaviour; they focus on the use of violence as a choice and, so, are not therapeutic programs. Many GBTQ men who have used family violence, however, also have co-existing AOD, mental health and other issues that are prevalent at higher rates in LGBTIQ+ communities than the general population. Services that acknowledged co-existing issues and sought to address them through AOD treatment and counselling, before or alongside an MBCP, supported users of violence to improve their wellbeing in ways that made some more willing and able to deepen their understanding of their use of violence and change their behaviour. (We are not, however, saying that these co-existing issues caused violence in the first place.)

Practitioners working in associated service delivery, such as AOD counselling and therapeutic programs, often identified family violence and provided some support around service pathways. Additionally, services and practitioners that understood how GBTQ men engaged in activities such as chemsex, at the intersection of substance use and sex, seemed equipped to respond to clients who revealed situations in which they had used violence. Some participants felt it would not have been possible to discuss such issues in mainstream family violence services.

RECOMMENDATION 5.

Build capability of both mainstream and LGBTIQ+ community health organisations to deliver one-on-one AOD and mental health support that helps users of violence address co-existing issues alongside behaviour change work.

8.3 Catalysts of change along service pathways: potential for even better service response

Participants spoke about the potential for more change to occur if services were better resourced and orientated to help engage users of violence. In this section, we identify five features of service access, engagement and provision that might be developed further.

8.3.1 Systems that better support identification and engagement

Identifying cases of family violence involving GBTQ men sometimes relied on individual practitioners in mainstream family violence and legal settings working outside their usual systems. These practitioners had an interest in LGBTIQ+ issues or were community members themselves and pored over court lists and L17s to identify cases that might otherwise "slip through the cracks". While this demonstrates the importance of dedicated practitioners, it appears, more broadly, to be representative of a family violence sector that has yet to sufficiently adapt to the needs of LGBTIQ+ victim survivors, including through interventions targeted at GBTQ users of violence.

Along the service pathways that users of violence travelled, practitioners who were LGBTIQ+ community members or interested in the wellbeing of LGBTIQ+ people were perceived to be going "above and beyond" their professional roles to encourage service engagement and behaviour change. Many of these practitioners, through employers such as Thorne Harbour Health, helped deliver services and programs that encouraged change and supported victim survivors. However, they also faced challenges providing services due to resourcing and workload challenges (and due to the challenging nature of the work itself).

8.3.2 Family violence service providers that are more GBTQ/LGBTIQ+ inclusive

Building capacity in family violence services (both mainstream and those that are LGBTIQ+ community-controlled) would help make programs for GBTQ users of violence (and LGBTIQ+ people more generally) more inclusive and relevant to needs. Practice guidelines for working with users of violence were identified as much needed. It is important that such guidelines consider the diversity of situations involving GBTQ users of violence. For example, this report

found that a number of victim survivors that Thorne Harbour Health worked with as part of its family/partner safety contact work were themselves not LGBTIQ+; only their partners, former partners or family members who had used violence were. Also, children were often involved in situations of GBTQ family violence. There is an opportunity to do more to challenge the stereotypes around what GBTQ family violence involves – and who it affects – and pay more attention to developing service practices for diverse situations.

8.3.3 A better understanding of motivation to change and other aspects of family violence use specific to GBTQ men

This report underscores the fact that the motivation of GBTQ users of violence to change their behaviour remains poorly understood. Few GBTQ men who have used family violence have been included directly in research, especially that which asks them to describe their understanding of their behaviour and their readiness to change. This report makes a small contribution to this area of study, but much more is still to be learned. We found it exceedingly difficult to engage users of violence. It would be worth developing more strategies to help to do this, so that more could be understood about how GBTQ users of violence come to recognise their behaviour as harmful and seek to change it.

RECOMMENDATION 6.

Develop strategies to engage more GBTQ men who have used violence in research to better understand how they recognise harmful behaviour, the need to change and experiences of service engagement.

8.3.4 More service options, including AOD and mental health counselling

MBCPs intentionally focus on accountability rather than therapeutic work involving the user of violence. This is justified. It does not mean, however, that a user of violence would not benefit from addressing co-existing issues, including those related to their AOD, mental health or past experiences of trauma, separate from their behaviour change work. More service options for co-existing issues could be provided in ways that do not detract from the accountability work needed to complete a MBCP or divert resources away from similar services for victim survivors.

More diverse service options are also needed. In some interviews, participants spoke about the need for services options to pay closer attention to the needs of neurodiverse clients to ensure programs, including MBCPs and treatment for co-existing issues, encouraged them to change in ways relevant to their needs. Participants often talked about the lack of services or follow-ups after MBCP completion. More options for users of violence to support them to remain non-violent might also be considered for development.

8.3.5 More awareness and understanding of GBTQ family violence across society

Knowledge and understanding of GBTQ and LGBTIQ+ family violence is limited across society. It remains challenging to address these types of violence when so few people are aware of their existence and prevalence. There is potential to create new narratives of family violence that are more inclusive of LGBTIQ+ family violence. What LGBTIQ+ family violence is, what forms it takes, who it affects and what can be done to address it could feature more prominently in public awareness campaigns.

LGBTIQ+ communities better understanding what family violence is might help raise awareness around what is acceptable behaviour and the social mandates expected of a person who uses family violence. Visible, trusted and active LGBTIQ+ community-controlled organisations that are perceived to offer culturally competent, multi-faceted and integrated services are vital to GBTQ family violence intervention and change processes. More awareness of these service providers would support better engagement with programs that encourage commitments to non-violence.

REFERENCES

1. Victorian Government. What is family violence? [Internet]. Cited 2023 Dec 12. Available from: https://www.vic.gov.au/what-family-violence
2. McKenry PC, Serovich JM, Mason TL, Mosack K. Perpetration of Gay and Lesbian Partner Violence: A Disempowerment Perspective. J Fam Violence 2006;21(4):233–43.
3. Baker NL, Buick JD, Kim SR, Moniz S, Nava KL. Lessons from Examining Same-Sex Intimate Partner Violence. Sex Roles 2013;69(3–4): 182–92.
4. Finneran C, Stephenson R. Antecedents of Intimate Partner Violence Among Gay and Bisexual Men. Violence Vict 2014;29(3):422–35.
5. Decker M, Littleton HL, Edwards KM. An Updated Review of the Literature on LGBTQ+ Intimate Partner Violence. Curr Sex Health Rep 2018;10(4):265–72.
6. Lekkas A, Speirs J. ReVisioning Partner Contact Support Project. 2019. Melbourne: Thorne Harbour Health.
7. Amos N, Hill AO, Lusby S, Carman M, Parsons M, McNair R, et al. Preferences for Types of Inclusive Family Violence Services Among LGBTQ People in Australia. J Fam Violence 2023:1–14.
8. Yates S. Gender, Context and Constraint: Framing Family Violence in Victoria. Womens Stud Int Forum 2020;78:102321:1–11.
9. Cannon C. Illusion of Inclusion: The Failure of the Gender Paradigm to Account for Intimate Partner Violence in LGBT Relationships. Partn Abuse 2015;6(1):65–77.
10. Barocas B, Emery D, Mills LG. Changing the Domestic Violence Narrative: Aligning Definitions and Standards. J Fam Violence 2016;31(8):941–7.
11. Donovan C, Barnes R. Domestic Violence and Abuse in Lesbian, Gay, Bisexual and/or Transgender (LGB and/or T) Relationships. Sexualities 2019;22(5–6):741–50.
12. Hill AO, Bourne A, McNair R, Carman M, Lyons A. Private Lives 3: The Health and Wellbeing of LGBTIQ+ People in Australia. 2020. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.
13. Calton JM, Cattaneo LB, Gebhard KT. Barriers to Help Seeking for Lesbian, Gay, Bisexual, Transgender, and Queer Survivors of Intimate Partner Violence. Trauma Violence Abuse 2016;17(5):585–600.
14. Stults CB, Brandt SA, Hale JF, Rogers N, Kreienberg AE, Griffin M. A Qualitative Study of Intimate Partner Violence Among Young Gay and Bisexual Men. J Interpers Violence 2022;37(3–4):NP2251–87.
15. Frankland A, Brown J. Coercive Control in Same-Sex Intimate Partner Violence. J Fam Violence 2014;29(1):15–22.
16. Langenderfer-Magruder L, Walls NE, Whitfield DL, Kattari SK, Ramos D. Stalking Victimization in LGBTQ Adults: A Brief Report. J Interpers Violence 2020;35(5–6):1442–53.
17. Reeves E, McGowan J, Scott B. 'It was Dangerous, Corrosive and Cruel but not Illegal': Legal Help-Seeking Behaviours Amongst LGBTQA+ Domestic and Family Violence Victim-survivors Experiencing Coercive Control in Australia. J Fam Violence [Internet]. 2023 May 4 [cited 2023 Jun 1]; Available from: https://link.springer.com/10 1007/s10896-023-00569-9
18. Woulfe JM, Goodman LA. Weaponized Oppression: Identity Abuse and Mental Health in the Lesbian, Gay, Bisexual, Transgender, and Queer Community. Psychol Violence 2020;10(1):100–9.
19. Woulfe JM, Goodman LA. Identity Abuse as a Tactic of Violence in LGBTQ Communities: Initial Validation of the Identity Abuse Measure. J Interpers Violence 2021;36(5–6):2656–76.
20. Donovan C, Barnes R. Queering Narratives of Domestic Violence and Abuse: Victims and/or Perpetrators? 2020. Cham: Springer International Publishing.
21. Guadalupe-Diaz XL, Jasinski J. "I Wasn't a Priority, I Wasn't a Victim": Challenges in Help Seeking for Transgender Survivors of Intimate Partner Violence. Violence Women 2017;23(6):772–92.
22. Rollè L, Giardina G, Caldarera AM, Gerino E, Brustia P. When Intimate Partner Violence

Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. Front Psychol 2018;9:1506.

23. Goldberg JM & White C. 2011. Reflections on Approaches to Trans Anti-violence Education. In J. Ristock, editor, Intimate Partner Violence in LGBTQ lives. New York: Routledge: 56–77.
24. Wheildon LJ, True J, Flynn A, Wild A. The Batty Effect: Victim-Survivors and Domestic and Family Violence Policy Change. Violence Women 2022;28(6–7):1684–707.
25. Reeves E & Scott B. 'Can't You Girls Work This Out?': LGBTQ+ Victim-survivors' Experiences of Victoria's Family Violence Intervention Order System 2022. Melbourne: Monash University.
26. Cannon CEB. What Services Exist for LGBTQ Perpetrators of Intimate Partner Violence in Batterer Intervention Programs Across North America? A Qualitative Study. Partn Abuse 2019;10(2):222–42.
27. Edwards KM, Sylaska KM, Barry JE, Moynihan MM, Banyard VL, Cohn ES, et al. Physical Dating Violence, Sexual Violence, and Unwanted Pursuit Victimization: A Comparison of Incidence Rates Among Sexual-Minority and Heterosexual College Students. J Interpers Violence 2015;30(4):580–600.
28. Barnes R & Donovan C. Developing Interventions for Abusive Partners in Lesbian, Gay, Bisexual and/or Transgender Relationships. In Hilder, S, Bettinson, V, editors. Domestic Violence: Interdisciplinary Perspectives on Protection, Prevention and Intervention. Palgrave Macmillan. 2016. p. 297–320.
29. Donovan C & Barnes R. Making Sense of Discourses of Sameness and Difference in Agency Responses to Abusive LGB and/or T Partners. Sexualities 2019;22(5–6):785–802.
30. Donovan C & Barnes R. Conclusion: Telling Different Stories About Intimate Partner Violence and Abuse. In: Queering Narratives of Domestic Violence and Abuse [Internet]. Cham: Springer International Publishing; 2020 [cited 2023 Oct 1]. Available from: http://link.springer.com/10 1007/978-3-030-35403-9_6
31. Cannon C, Hamel J, Buttell F, Ferreira RJ. A Survey of Domestic Violence Perpetrator Programs in the United States and Canada: Findings and Implications for Policy and Intervention. Partn Abuse 2016;7(3):226–76.
32. Cannon C, Buttell F. Research-Supported Recommendations for Treating LGBTQ Perpetrators of IPV: Implications for Policy and Practice. Partn Abuse 2020;11(4):485–504.
33. Ford CL, Slavin T, Hilton KL, Holt SL. Intimate Partner Violence Prevention Services and Resources in Los Angeles: Issues, Needs, and Challenges for Assisting Lesbian, Gay, Bisexual, and Transgender Clients. Health Promot Pract 2013;14(6):841–9.
34. McGowan J, Helps N, Fitz-Gibbon K, Athwal-Yap A, Williamson H. "You Can't Just … Add a Bit of Rainbow Dust": A Review of the Clear Space Online Family Violence Behavioural Change Program for GBTQ+ Men and Non-Binary People. 2023. Melbourne: Monash University.
35. Worrell S, Fairchild J, Gillespie C, Fooks A, Lusby S, Carman M, et al. Responsive Pandemic Practice: LGBTIQ+ Family Violence Service Innovation in Victoria During COVID-19. 2022. Melbourne: La Trobe University.
36. Gray R, Walker T, Hamer J, Broady T, Kean J, Ling J, et al. Developing LGBTQ Programs for Perpetrators and Victims/Survivors of Domestic and Family violence. 2020. Sydney: ANROWS.
37. Corvo K, Dutton D, Chen WY. Do Duluth Model Interventions With Perpetrators of Domestic Violence Violate Mental Health Professional Ethics? Ethics Behav 2009;19(4):323–40.
38. Wynn M. Ellen's Hand. Violence Women 2010;16(9):1055–60.
39. Day A, Vlais R, Chung D, Green D. Standards of Practice in Domestic and Family Violence Behaviour Change Programs in Australia and New Zealand. Aust N Z J Fam Ther 2018;39(4):501–13.
40. Costello S. Invitations to Collusion: A Case for Greater Scrutiny of Men's Behaviour Change Programs. Aust N Z J Fam Ther 2006;27(1):38–47.
41. Reimer EC. "Growing To Be A Better Person": Exploring The Client-Worker Relationship In Men's Behaviour Change Program. 2020. Sydney: ANROWS.
42. Royal Commission into Family Violence. Royal Commission into Family Violence: Summary and Recommendations. 2016.
43. Victorian Government. Family Safety Victoria Strategic Plan 2021-2024. [Internet]. Cited 2023 Sep 22. Available from: https://content.vic.gov.au/sites/default/files/2021-11/Family%20Safety%20Victoria%20 Strategic%20Plan%20 2021-2024. PDF

44. Bell C, Coates D. The Effectiveness of Interventions for Perpetrators of Domestic and Family Violence: An Overview of Findings From Reviews. 2022. New South Wales: ANROWS
45. Carman M, Rosenberg S, Bourne A, Parsons M. Research Matters: Why do we need LGBTIQ-inclusive services? 2020. Melbourne: Rainbow Health Victoria.
46. Lim G, Lusby S, Carman M, Bourne A. LGBTQ Victim-Survivors' Experiences and Negotiations of Service Worker and Service System Discrimination. J Fam Violence 2023:1-15.
47. No to Violence. Working for Change: Perpetrator Interventions in LGBTI Communities. [Internet]. Cited 2023 Oct 1. Available from: https://ntv.org.au/wp-content/uploads/2020/06/NTV1731_ LGBTQI-Report_ screen-ready_FA4. pdf
48. Switchboard Victoria. Our History. [Internet]. Cited 2023 Oct 1. Available from: https://www.switchboard.org.au/our-history
49. Walsh AR, Sullivan S, Stephenson R. Intimate Partner Violence Experiences During COVID-19 Among Male Couples. J Interpers Violence 2022;37(15–16):NP14166–88.
50. Lusby S, Lim G, Carman M, Fraser S, Parsons M, Fairchild J, & Bourne A. Opening Doors: Ensuring LGBTIQ-inclusive Family, Domestic and Sexual Violence Services. 2022. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University.
51. Bourne A, Reid D, Hickson F, Torres-Rueda S, Steinberg P, Weatherburn P. "Chemsex" and Harm Reduction Need Among Gay Men in South London. Int J Drug Policy 2015;26(12):1171–6.
52. Victorian Government. 2019. L17 Family Violence Portal User Guide. Melbourne: Victorian Government.
53. Victorian Government. Family Violence Multi-agency Risk Assessment and Management Framework. 2018. Melbourne: Victorian Government.
54. Magistrates' Court of Victoria. LGBTIQ Family Violence Applicant and Respondent Practitioners. [Internet]. Cited 2023 May 9. Available from: https://mcv.vic.gov.au/sites/default/files/2020-10/Brochure%20LGBTIQ%20FV%20Practitioner%20Services.pdf.
55. Victorian Government. Maram Practice Guides Foundation Knowledge Guide: Guidance For Professionals Working With Child or Adult Victim Survivors, and Adults Using Family Violence. 2021. Melbourne: Victorian Government.
56. Victorian Government. Family Violence Multi-Agency Risk Assessment and Management Framework. [Internet]. Cited 2023 Sep 27. Available from: http://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management
57. Maldonado AI, Murphy CM. Readiness to Change as a Predictor of Treatment Engagement and Outcome for Partner Violent Men. J Interpers Violence 2021;36(7–8):3041–64.
58. No To Violence. What we do. [Internet]. Cited 2023 Oct 25. Available from: https://ntv.org.au/about-us/what-we-do/
59. Magistrates' Court of Victoria. Counselling Orders. [Internet]. Cited 2023 Oct 18. Available from: https://www.mcv.vic.gov.au/intervention-orders/family-violence-intervention-orders/counselling-orders
60. Bronfenbrenner U. Toward an Experimental Ecology of Human Development. American Psychologist 1977:32(7):513–531.
61. Roffee JA, Waling A. Resolving Ethical Challenges When Researching With Minority and Vulnerable Populations: LGBTIQ Victims of Violence, Harassment and Bullying. Res Ethics 2017;13(1):4–22.
62. Braun V, Clarke V. Using Thematic Analysis in Psychology. Qual Res Psychol 2006;3(2):77–101.
63. Victorian Government. The Client Relationship Management System. [Internet]. Cited 2024 Jan 31. Available from: https://www.vic.gov.au/orange-door-service-model/client-relationship-management-system
64. Rodriguez A, & Smith J. Phenomenology as a Healthcare Research Method. Evidence-Based Nursing 2018;21(4):96–98.
65. Tong A, Sainsbury P, & Craig J. Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care. 2007. 19(6): 349–357.

APPENDIX

Methods

This is a qualitative study that applies the concepts of thematic analysis (62) to 40 semi-structured in-depth interviews with GBTQ men who have used family violence, practitioners who have worked with them and victim survivors of GBTQ family violence.

Study design and research methods

ARCSHS is committed to conducting research that is inclusive of LGBTIQ+ communities, not just in terms of participation but also design. This means approaching research with LGBTIQ+ communities that is reflexive and collaborative and, where appropriate, challenges orthodox approaches to scholarship (61). This project is the latest in a series of collaborations between ARCSHS and LGBTIQ+ community-controlled organisations (50) and the second in consecutive years with Thorne Harbour Health and Switchboard Victoria focused on LGBTIQ+ family violence in Victoria (35).

The research team included a diversity of gender identities and sexual orientations. The report authors had various credentials, including PhDs and counselling qualifications. Two authors were employed by ARCSHS at La Trobe University, while the others were employed by Thorne Harbour Health or Switchboard Victoria.

Researchers drew on lessons learned from past collaborations to design this study and met regularly to discuss direction, goals and timelines. Due to the research focusing on family violence, AOD and mental health issues – particular concerns to LGBTIQ+ communities – the research team designed support protocols to ensure the research was conducted in a sensitive way and that participants could be supported if they found their involvement to be distressing. The La Trobe University Human Research Ethics Committee (HEC22270) and Thorne Harbour Health's Community Research Endorsement Panel (THH/CREP 22-017) both approved this study, independent of the researchers and authors involved.

Research questions and rationale

We began with three main research questions.

1. **What factors support GBTQ men who have used family violence to recognise that their behaviour is harmful?**

Understanding how GBTQ men recognise their use of violence is central to halting it at the earliest opportunity and for retaining men within programs.

2. **What are the push and pull factors that enable GBTQ men who have used family violence to engage with support programs?**

   Included in this were these additional questions:

   a. How are GBTQ users of violence identified by different professionals and referred into perpetration programs?

   b. Why might some GBTQ male men who have used family violence self-refer?

   c. What systemic and/or intrapsychic factors impede engagement with support services?

3. **What are the factors that contribute to readiness to change and continued engagement with and other behaviour change and other family violence programs for GBTQ men over time?**

   Included in this was the additional question:

   a. What lessons can be learned in this context for application to other populations?

Research interviews

Interviews were conducted in three phases. In total, 40 people were interviewed. This included eight GBTQ men who had used family violence, six victim survivors with experiences of family violence and 26 practitioners with experiences of working with GBTQ men who have used family violence.

Eligibility

We set eligibility requirements for anyone interested in taking part in an interview. They were required to be at least 18 years old and one of the following:

- Identify as a gay, bisexual, trans or gender diverse, or queer (GBTQ) man who has used family violence and engaged with Thorne Harbour Health's MBCP programs in the previous five years
- A victim survivor who has experienced family violence involving a GBTQ man
- A family violence, health or legal practitioner who has worked with GBTQ men who have accessed services after using family violence

Recruitment and interviews

Members of the Thorne Harbour Health family violence team provided information about the study to users of violence, victim survivors and practitioners, who were invited to participate. Those interested in taking part either consented to their details being shared with the lead author (not an employee of Thorne Harbour Health) or contacting him directly. They then engaged privately in an interview with the lead author. They were informed that their participation was voluntary and their potential withdrawal from the study would not affect their relationship with Thorne Harbour Health. Interview audio and transcripts were not shared with the family violence team at Thorne Harbour Health.

A similar process was followed with Switchboard Victoria, where a representative provided information about the study to LGBTIQ+ peer workers, primarily at Rainbow Door, but was not involved in the data collection process. The lead author also actively recruited family violence and legal practitioners from other organisations whose work was relevant to GBTQ family violence.

Participants were selected using purposive and convenience sampling (65). Some people approached chose not to participate, while a couple did not attend scheduled interviews after initially expressing interest in taking part. The first author, who has extensive experience interviewing people from marginalised communities, conducted all interviews. The first author provided participants with information about his research and professional experience prior to the interview. Interview guides were pilot tested prior to data collection.

Interviews took place over Zoom, a video-conferencing application, lasting between about 30 and 90 minutes each. One interview was conducted as a group interview with practitioners who worked together. Discussion in all interviews focused on perceptions and self-perceptions of GBTQ men's use of violence, engagement with services and commitment to changing their behaviour. Framing these discussions were themes relevant to each interview cohort.

For users of violence, these included:

- How they came to recognise their harmful behaviour as family violence
- Their readiness to change
- Their experiences of behaviour change programs

For victim survivors:

- A user of violence's perceived readiness to change
- A user of violence's engagement with services and the perceived effectiveness of those services
- What steps researchers could take to ensure research with users of violence supported victim survivors' safety and wellbeing, and avoided collusion

For practitioners:

- Strategies for recognising GBTQ family violence use
- Strategies for engaging GBTQ men who have used violence in services
- Experiences working with other professionals providing a service to GBTQ men who have used violence

Audio was taken from the Zoom interviews (the video was immediately deleted) and transcribed. Participants were interviewed alone (except in the case of one team interview) and were offered the opportunity to review the transcript of their interview.

Participant demographics

Eight GBTQ men who had used family violence took part in an interview. They were aged between 30 and 50. Three had been born outside Australia and two identified as being from a diverse ethnic background. None were from an Aboriginal or Torres Strait Islander background. Education levels varied, from completion of Year 10 to completion of a post-graduate degree. Employment also varied, with three employed full-time, three part-time, one casual and one unemployed. One had completed an MBCP at Thorne Harbour Health, six had commenced an MBCP and one was waiting to begin. One had a child. Four identified as a gay cisgender male, two as a bisexual cisgender male, one as a pansexual trans man and one as a gay man who was questioning their gender identity.

Six victim survivors were interviewed. All had accessed services from Thorne Harbour Health due to a partner, former partner or family member attending an MBCP after using violence. Some participants were male, some female and sexual orientations varied. None were from an Aboriginal or Torres Strait Islander background. Due to the small size of the sample and the risk of identifying a participant, we have chosen not to provide further details about victim survivors.

We interviewed twenty-six practitioners from a combination of LGBTIQ+ community-controlled health organisations, a mainstream family violence service, community legal centres, the Magistrates' Court of Victoria and private practice. The vast majority of practitioners interviewed identified as LGBTIQ+. Education levels among practitioners were high, with most having earned university degrees and other qualifications. Practitioners were aged between 20 and 70.

None identified as being from an Aboriginal or Torres Strait Islander background. Most participants were white with European ancestry and were Australian citizens. About one-quarter identified Asian, North American, South American or Oceanic ancestry when asked about their ethnicity. All interviews were conducted in English, a language in which all practitioners were proficient.

Of the 26 practitioners, seven identified their sexual orientation as queer, five as bisexual, four as gay, two as lesbian, one as same-sex attracted, one as a dyke, one as pansexual and one as queer women- and trans men-attracted. One used multiple terms to describe their sexual orientation. Three identified as heterosexual. In terms of gender identity, eleven identified as transgender, non-binary, gender queer or gender non-conforming; 10 were cisgender female and five cisgender male.

Analysis

Transcripts were analysed using NVivo software. Data from the transcripts were arranged into themes using principles of thematic analysis (62). The study also drew on the principles of phenomenology to explore participants' lived experience of services (64). The first author analysed data, arranging them into themes. The last author reviewed data. The research team met regularly to discuss themes and the direction of the report, as well as contribute to and review drafts. Our Methods sections have been developed in accordance with the Consolidated criteria for reporting qualitative studies (COREQ) 32-item checklist (65).

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