Exploring training and supervision experiences of facilitators of men's behaviour change programmes: A qualitative study

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Published by Psychreg Ltd
ISSN: 2515-138X

Within Australia, domestic and family violence has both been recognised as exceedingly pervasive and researched widely from a range of perspectives (Mackay et al., 2015). In recent years, with the intention of reducing the risk of reoffending, the focus has moved from prevention strategies to an emphasis on developing and implementing violence intervention strategies that specifically target known violent offenders. Most historical research has focussed heavily on pathologising perpetrators of violence and on the successful participation of perpetrators in men's behaviour change programmes. Little research attention though has been paid to the training and supervision experiences of facilitators of men's behaviour change. The research reported in this paper explored facilitators' experiences of supervision and training in men's behaviour change programmes (MBCPs) through a qualitative approach, Interpretive Phenomenological Analysis. The study was designed to identify how facilitators of MBCPs are supported through ongoing training and clinical supervision to provide best practice while retaining staff, guarding their well-being, and reducing experiences of stress in the workplace. Ten participants from non-government organisations across Western Australia (WA) participated in semi-structured interviews. A six-step qualitative data analysis was utilised to extract findings. These show that, despite the Practice Standards for Perpetrator Intervention (2015), participants consistently noted a substantial lack of clinical supervision and little to no specialised training for facilitators of MBCPs. Further, the findings suggest participants were unaware of well-being strategies for stress prevention in their workplaces.

Keywords: behaviour change; male psychology; supervision programme; violence intervention; workplace

Research across the domestic and family violence (DFV) sector is abundant (Chung et al., 2020; Chavez et al., 2019), yet sustained exploration of training standards, clinical supervision and the well-being experiences of facilitators of men's behaviour change programmes is lacking (Morran, 2006; Vlais et al., 2017). A recent evaluation guide nonetheless highlighted the importance of ensuring that MBCPs are operating according to jurisdiction-wide minimum standards inclusive of DFV-informed facilitator training (Nicholas et al., 2020), while other research has demonstrated the significance of supervision for practitioner longevity across the DFV sector (Vlais, 2010; Vlais et al., 2017). It is argued here that MBCP practitioners might best be supported if awareness of their experiences informs future policy and standards discussions. This research paper offers the reader understandings of those experiences, and the supports accessible through training and supervision in Western Australia (WA). In addition, this research identifies organisational support processes for guarding staff well-being while ensuring good practice in order to reduce the dangers to women and children experiencing or at risk of experiencing domestic and family violence.

Within Australia, domestic and family violence has been recognised as an exceedingly pervasive crisis (Day et al., 2018; Devries et al., 2013, Vlais et al., 2017). The first Australian MBCPs emerged as private, activist, programmes in the early 1980s: even through the 1990s these were sporadic and minimally funded, leading to calls for more standardisation of practices and funding, and to the first minimum standards being developed in Victoria and other states. In 1997 the national Partnerships Against Domestic Violence Strategy emphasized the importance of programme options for perpetrators of family/domestic violence. As reported below, during the following two decades both federal and state initiatives increased in scope and reach. During the COVID-19 pandemic, research across the country indicated associated increases of risk to women and children due to the perpetration of DFV (Boxall et al., 2020; Monash University, 2020; Fitz-Gibbon et al., 2022). This research focussed on an online survey of over 10,000 women and demonstrated that there has been an even larger increase in DFV since COVID-19 (IPV; Bourgault et al., 2021). Studies conducted in Australia and overseas have identified high rates of self-reported IPV victimisation among women during the COVID-19 pandemic (Boxall et al., 2020; Boxall & Morgan, 2021). Australian research has also found that the COVID-19 pandemic has coincided with the onset of first-time IPV within previously non-abusive relationships and an escalation in the frequency and severity of ongoing violence (Boxall et al., 2020). This suggests that the COVID-19 pandemic may have influenced patterns of violence and abuse experienced by women within some relationships.

DFV has profound emotional, psychological, physical and social consequences for women and children, as well as significant economic consequences for the community (Day et al., 2010). Prior to the COVID-19 pandemic, the estimated costs for Australian governments of keeping women and children safe in Australia ranged between 22-26 billion dollars each year. (KPMG, 2016; Walter & Chung, 2020). Economic costs, higher rates of DFV incidents and increases in community awareness (Day et al. 2019; Mackay et al., 2015;), had created a shift from an emphasis on postvention strategies to developing and implementing violence intervention strategies that specifically target known offenders of violence, with a view to reducing the risk of reoffending.

Even pre-pandemic, effectively since the 1990s, due to increased awareness and reporting of DFV, there had been an increased focus on MBCPs (Mackay et al., 2015). They had become the most deployed group intervention programme for agencies in WA (Andrews et al., 2018; Ruddle et al., 2017; Vlais et al., 2017). The key intention of MBCPs is to increase the safety of women and children experiencing DFV, through encouraging perpetrators of violence both to take accountability for their actions and to put a stop to their abusive patterns (Day et al., 2018; Vlais et al., 2017; Relojo-Howell, 2022). Perpetrator intervention programmes and approaches, through a rolling or closed group of up to twelve men, vary in delivery and in theoretical orientations, and in length and intensity from once weekly for six months to twice weekly for three months, (Mackay et al., 2015). Pathways to MBCPS also differ, with delivery by both government and non-government organisations, and with attendance voluntary or court-mandated (Day et al., 2018; Mackay et al., 2015; Vlais et al., 2017).

Within Australia, the National Plan to Reduce Violence against Women and their Children 2010–2022, endorsed by the Council of Australian Governments (COAG), identified the need to bolster the evidence base of perpetrator interventions and, significantly, that MBCPs are "an essential part of an effective plan to

reduce violence against women and their children" (COAG, 2015, p. 29). MBCPs were based on earlier American models and prior to the COAG, operated individually, although most did focus on therapeutic models. The National Plan included a government commitment to establish a set of National Outcomes Standards for Perpetrator Interventions (NOSPI). The NOSPI highlights six core principles to assist in guiding service systems in the delivery of perpetrator interventions. Of significance for this research is Principle Six which identifies the need for skilled and supported professionals across the DFV sector. In addition to the NOSPI, specific Practice Standards for Perpetrator Intervention in WA were established (COAG, 2015; Department of Attorney General (DotAG) and Justice in 2012; Department for Child Protection and Family Support, 2015).

With an increase in focus on perpetrator accountability through early intervention programmes such as MBCPs, rather than on postvention or crisis intervention strategies (Vlais & Campbell, 2019), professional practice standards have been developed to set out organisational guidelines for facilitators and organisations providing perpetrator interventions (Morran, 2006; Day et al., 2009a; Walter & Chung 2020). The standards address key practices in supporting staff well-being and client outcomes including formal training, supervised practice time, access to fortnightly or monthly supervision, and regular ongoing DFV training (COAG, 2015; DotAG, 2012; Walter & Chung 2020). The standards operate within a government concern not only to increase the availability of behavioural change programmes for perpetrators but also to ensure programmes are evidence based while recognising that, in order to provide programme integrity and appropriately consider the safety and well-being of women and children, facilitators working within perpetrator intervention programmes must be skilled in and supported through the complexities of working with perpetrators of violence. At the same time, facilitators must be knowledgeable about the dynamics and impacts of DFV and have the appropriate training to respond to risks for women and children. (Practice Standards 1.7, 3.1 and 3.3 of the Practice Standards for Perpetrator Intervention in WA) (Department for Child Protection and Family Support, 2015). The gradual development of national standards has enabled the sharpening of practices through evidence-based research.

As has long been recognised, a natural consequence of trauma work is stress in the workplace (Pearlman & Saakvitne, 1995). While practice standards are in place to support staff well-being through training and supervision (Department for Child Protection and Family Support, 2015), it has also long been argued that specific organisational acknowledgement of perceived stress in the workplace and inclusivity of organisational well-being policies could benefit workers within the field (Choi 2011; Figley, 2002; Pearlman & Saakvitne, 1995; Vlais, 2017). Professional practice standards inclusive of supervision and training support good practice, maintain programme integrity, provide better outcomes for women and children and perpetrator engagement while supporting staff well-being (Day et al., 2019; Morran, 2006; Vlais et al., 2017). Further, access to agency knowledge, strategies, time, skills, resources and funds could mitigate the experience of stress amongst its worker (Sprietzer, 1995; Dalton 2001; O'Brien, 2006; Choi, 2011). The literature suggests that training and supervision within the DFV field is minimal yet is crucial in reducing the experiences of workplace stress (Choi, 2011; Vlais et al., 2017; Day et al., 2019; Walter & Chung, 2020).

The aim of this study was to explore training and supervision experiences of facilitators of MBCPs in WA. The study was designed to identify the ways facilitators of men's behaviour change programmes are supported through ongoing training and clinical supervision to provide best practice while guarding their well-being. Findings may also inform future areas of research and assist in recommendations for reviews of professional practice standards.

METHODS

Methodological approach

To maximise validity and to enable participants to create and share the meaning of their experiences (Alase, 2017; Miles & Huberman, 2018), the study utilised purposive sampling through Interpretive Phenomenological Analysis (IPA). Using an IPA approach has both enabled research participants to understand their own experiences while offering researchers the opportunity to better understand the phenomena of those "lived experiences " (Alase, 2017). Purposive sampling is commonly used in qualitative research to provide information-rich data while maximising validity, working with a smaller group of

participants who share knowledge of the phenomena, rather than a larger, more diffuse but less-engaged group (Patton, 2002; Miles & Huberman, 2018).

Participants

Ten participants who were facilitators of MBCPs were recruited for this study. The essential requirements for participation were a tertiary qualification within the counselling, psychology or related professions, and a minimum of three months working in a MBCP. Eight participants worked in populated metropolitan areas of Perth, and two in remote regional areas within WA. Participants varied in age: three between 20 and 39 years, four between 40 and 50, and three over 51, with experience in counselling and men's behaviour change work ranging from three months to twenty-plus years. Nine participants met all the criteria for the study, while the tertiary qualification of one participant was from outside the designated professions. This was identified during the interview. However, the participant had significant years of experience within the counselling profession as well as working within MBCPs. For this reason, it was deemed appropriate to include this participant in the study.

Data collection

Prior to the interview, participants were provided with a consent form and information sheet outlining the purpose and methods of the study. Additionally, participants were offered an opportunity to ask questions about the study and interview process. Semi-structured interviews were used to enable participants to express, on their own terms, their views and experiences (King et al., 2019). This approach not only offers participants a meaning-making platform of the phenomena (Smith & Osborn, 2007), but also, for the researcher, constructs a platform for richer information collection of the experiences of participants, reliability in the data collected, and an assurance of thorough and comparable qualitative data (Merriam & Grenier, 2019). Due to the COVID-19 pandemic and in line with WA and local Department of Health recommendations, participants were interviewed remotely, by Zoom video interviews.

To further increase confidence in the research findings, the researcher implemented a multiple methodology approach, utilising several complementary theories, methods, data sources and investigators within the study of the phenomena (Turner et al., 2017). To ensure validity, consistency and lack of bias within the study, triangulation, which included the consideration of the data produced through involvement of a range of participants categorised according to their geographical locations across the vast distances of regional WA was used. In addition, thematic analysis was conducted across two co-researchers to consolidate the reliability of findings (investigator triangulation) (Nowell et al., 2017). Further participant validation to explore credibility of the findings took place with all ten participants in support of the findings (Birt et al., 2016).

Data analysis

Consistent with IPA methodology (Alase, 2017), analysis of data was undertaken in six stages. Stage one required the researcher to read and re-read transcripts in order to identify significant or meaningful information. The use of this strategy allows significant information to be identified until data saturation has been reached (Merriam & Grenier, 2019). In stage two, highlighted significant information was added to a table, allowing for exploratory comments to be made. Each participant transcript was subject to this process. Stage three involved clustering comments from all participant transcripts into common themes, and in stage four, each emerging theme was clustered into groups, so creating master themes and subthemes. During the fifth stage, the researcher analysed the themes that had emerged and connected the themes through discussion and narrative meaning making. Here it is suggested that the researcher's background, experience, and knowledge, developed within working with perpetrators (11 years) and in MBCPs (2 years) as a clinical interviewer, forensic report writer, group facilitators and state-wide co-ordinator, adds to the depth and validity of the interpretations within this study (Merriam & Grenier, 2019). Finally, in order to validate the accuracy of findings, stage six welcomed feedback from participants through individual validation of their own themes as identified within their transcripts (Byrne, 2001). All 10 participated in this process, and confirmed the accuracy of the findings, bringing considerable confidence to the credibility of the themes identified, and arguments made, in this research.

FINDINGS

This section shows the analysis of the data and highlights those key themes which emerged strongly across participant sharing of experiences: (1) absence of training; (2) variance to clinical supervision received; and (3) staff well-being. Within these three key themes, subthemes emerged. These include: lack of cultural training, complications due to lack of supervision, and the impacts of funding issues. The themes and subthemes are explored in detail below. Quotations (using pseudonyms) are included to support and illustrate findings.

Absence of training

From early in the interview process, it became apparent that the study participants had received varying levels of specialised training, both at formal and informal levels. However, participants shared an overarching desire to receive more or ongoing training. Only one participant had received DFV specific formal training. Three received work offers after their university practicum placements in the role. Significantly, all participants declared that most of the training or learning occurred in the workplace.

Amy: *Informal training happens just constantly... I learned by doing*

Adam: *All my training has been on the job.*

Sarah*: I haven't been given any training in the metro area.*

All ten participants agreed that initial formal training, professional development, and in-house training as facilitators were needed, but not easily accessible. Training would have greatly benefited them. In addition, the widespread understanding of the facilitators was that ongoing professional development would be crucial for them in their current positions.

Sarah: *Continuous training and refreshers are really important to level with your staff and get where they are at.*

Matthew: *I didn't have a lot of background in family and domestic violence itself... I would love to get some more training in terms of different theories that are used.*

Amy: *Recognising the importance of training and supervision and, really protecting and nurturing the people that do this kind of work.*

Cassandra: *So even though I feel I have come so far, I feel like I could easily go back to the beginning and be trained from the ground up.*

The two regional participants offered insights into the necessity for culturally-appropriate training for rural and remote workers, most particularly for those working with Indigenous people.

Sarah: *I work with primarily Indigenous people in the regions and they have a lot of generational trauma. So, it's a massive learning curve for me learning about trauma and how to deal with perpetrators who have deep seated trauma.*

Adam: *For me, being thrust into this whole environment has just been massive ... It's never going to work cause they are measuring the wrong things ... Aboriginal people have a much better emphasis on different measurement systems.*

This recognises that mainstream service providers and their outcome measurements currently do not align with Aboriginal priorities and outcomes (Blagg et al., 2018; Andrews et al., 2018; Olsen and Lovett, 2016). Government focus is on a behavioural approach to western law which does not consider Aboriginal lore (Blagg, et al., 2018).

As part of minimum standards, MBCPs are to be delivered in a co-facilitation, usually, male-female, model. Facilitators build a reliance on each other but as yet there no compliance monitoring mechanism exists. Participants spoke highly of their co-facilitators, with great respect and gratitude. A marked change in tone when speaking of these co-facilitators suggested that participants, particularly those who were new to men's behaviour change facilitation or those who worked regionally, specifically valued the support they were given. Further, a number of participants discussed the importance for them of a supportive, aligning co-facilitator relationship when working within MBCPs. The significance of this relationship was highlighted when participants also shared their negative experiences in workplaces where a productive facilitator/co-facilitator relationship was not present, and the consequent impacts for them personally and within their work.

Daniel described the staff, especially his co-facilitator, as helpful and generous in sharing their DFV knowledge and skill: *My co-facilitator is quite great. She is on the ball and she knows her stuff* [DFV knowledge]. *I'm grateful for her and I'm learning a lot from her.*

Cassandra, new to her role, talking about her co-facilitator: *I ask him a lot of questions and he shows me a lot … we sort of deal with things as they come up* [suggesting that he supports her with client-related concerns, planning and any administrative questions she may have].

Anna unpacked the relationship and the issues for women at risk of DFV from the men in the group in a quite different way: *I truly feel that whoever is the male facilitator has so much more responsibility and if they drop that ball… the impact that it has most on, is not* [only] *me* [being] *the woman in the group but also the women and children outside of the group.*

Further, *Without that relationship with the co-facilitator my experience of running the men's groups can be completely horrendous* [recognising her sense that the relationship with the male facilitator needs to be one of trust and is essential to the therapeutic process in holding men accountable for their actions within the group space.

Several participants voiced their concern about the lack of systemic or institutional DFV learning prior to entering the workforce, before becoming a MBCP facilitator and directly engaging with perpetrators of violence.

Ryan focussed this through his experience of a single issue: *I have concerns about the nature of some training that gets offered. I think universities do not train people to deal with domestic violence.*

And after being asked to make a presentation to students at a university: *I asked … what else do they have on domestic violence within the course and they said they don't have anything.*

Variances of clinical supervision received

In this paper, clinical supervision is defined as an ongoing working alliance between two practitioners with the common goal of enhancing their clinical knowledge through best practice standards (Kuhn, 2019; Rothwell, 2021). Clinical supervision ensures all decision making was held to ethical standards, assists and builds upon skills-based competency, and provides a space for well-being (Lamb et al., 1991).

The findings of this research reveal that facilitators' experiences of MBCP clinical supervision levels varied in several significant ways, from styles of supervision to consistency of supervision, as well as complications with supervision itself. Indeed, only one participant was receiving specifically DFV-informed supervision. An increase in the desire to receive more consistent ongoing clinical supervision was also specifically identified. Of the ten participants, only two received regular clinical supervision. The remaining eight participants

reported inconsistent clinical supervision, irregular contact with supervisors, months between sessions and no online contact, effectively no supervision at all.

Adam: *So, we've had over twelve months of no clinical supervision. I'm really lucky to have such a great colleague. We are just really honest with each other and that relationship is really the main reason I have been able to continue with a year's absence of supervision.*

Cassandra: *Well I hadn't been in the facilitation role very long. So, it was my understanding that there was no clinical supervision until recently. I've had two supervision sessions now with my supervisor.*

Facilitators who did not receive regular supervision, highlighted a number of complications, including a lack of support, isolation, job dissatisfaction and well-being concerns.

Sarah: *I'll just push on…It might be that your staff seem fine, but they might not be, and you won't know that because you don't do supervision with them often enough.*

Amy: *So, it was almost easier to just like keep going … but I remember distinctly having "what's the point of utilising supervision because it feels like it's not going to be enough. "*

All participants experiencing inconsistent clinical supervision voiced both the intrinsic importance of this learning practice, and their need to participate in it more fully, and on a regular basis.

Staff well-being

Four themes appeared: facilitators' feelings of isolation; understandings by facilitators of agency supports; their awareness of agency well-being strategies; and concerns over lack of programme funding to provide adequate supports. Participants were able to identify supervision and employee assistance programmes as a means for providing staff well-being: beyond this, however, all reported feelings of isolation and lack of agency support.

Amy: *EAP* [Employee Assistance Programme] *access … the culture of the workplace seemed really nice … there was a fair bit of isolation working … I remember just feeling really isolated.*

Sarah: *I struggled a bit in Metro with this agency. I'll just push on.*

Matthew: *Because I am in a remote office … So, there's no real impact often from the organisation's well-being initiatives on me.*

Anna: *I couldn't tell you to be honest. I feel very unsupported in that.*

Outside of supervision and EAP counselling, facilitators were not informed about any specific agency strategies or policies already in place. Further, their understanding was that the agency they worked for had no strategies in place to support their well-being in the workplace.

Sarah: *Really, I wouldn't say that well-being practice and self-care are held in higher regard as it would be with company procedures ….*

Matthew: *I think the organisation has some initiatives that they provide but they don't really impact me, mostly because I am part time. Secondly because I am in a remote office … So there's no real impact often from the organisation's well-being initiatives on me.*

Interestingly, several participants shared their concern about levels of funding within their MBCPs, recognising this as a reason for limitations on training, supervision or support.

Amy: *We don't really have the luxury of having really in-depth supervision* and *This was really valuable work … it's just constantly being restricted or held back by funding issues, or it being a Non-Government Organisation. It felt like you were always the little guy trying to do these really big things and there was never enough. Whether it's funding or staff turnover. It just felt like at every turn, there was a limitation.*

Adam discussed not receiving any supervision for 12 months: *It goes to show how stretched the organisation is.*

DISCUSSION

This research aimed to explore facilitators' experiences of training and supervision in MBCPs. The study was designed to identify how facilitators of men's behaviour change programmes are supported through ongoing training and clinical supervision to provide best practice while retaining staff, guarding their well-being and reducing stress in the workplace. The study found that participants consistently noted a significant lack of clinical supervision and equally consistently highlighted the lack of professional training that had been provided to them. Further, the findings suggest participants were unaware of organisational staff well-being strategies in preventing stress in their workplaces.

Absences of training and supervision

Practice Standards for Perpetrator Intervention (Department for Child Protection and Family Support, 2015), emphasise the importance of formal DFV training. In this research, facilitators' experiences of training and supervision were compatible with the limited previous research findings (Vlais, 2011; Vlais et al., 2017; Walter & Chung 2020). Participants in this current research experienced little to no formal training during their time as a facilitator of a MBCP. Participant experiences of training were found to be inconsistent and predominantly learning on the job. Only one participant indicated that they had received specific DFV training beyond the standard agency induction, prior to becoming an active facilitator. Three participants working within MBCPs were employed as a result of their university practicum placement, while others had limited (if any) experience within the DFV sector prior to entering the programme.

Participants expressed an overwhelming desire to receive training and supervision. The lack of training and supervision identified here, spotlights participants' concerns about whether agencies have the resources to provide staff with the opportunities for ongoing professional development as advised in the Practice Standards for Perpetrator Intervention (Department for Child Protection and Family Support, 2015). The participants' voices as expressed through the research findings of this study echo and confirm recent research which identifies several service training gaps within the DFV sector in Australia (Eastman et al., 2007, Vlais, 2011; Vlais et al., 2017; Walter & Chung, 2020). Without sound foundations or an avenue to provide foundational training and supervision, however, programme integrity comes into question (Wales & Tiller, 2011; Vlais, 2011; Day et al., 2019; Walter & Chung 2020).

The importance of facilitators having a sound understanding of not only the theoretical orientations but also the programme outcomes and ongoing adaptions to each learning module is echoed in existing research (Day et al., 2019; Mackay e al., 2015). Programmes lacking in integrity, whether through inconsistent delivery, adaptations of components of programme or varying specialist knowledge from staff, can limit or decrease programme effectiveness (Day et al., 2009; Vlais, et al., 2017). In this study, participants specifically expressed the need to receive DFV-informed training. Further, participants identified the need for greater awareness of theoretical models and their application to support programme delivery and maintain programme integrity.

The experiences relayed by regional participants within this research are of particular importance. Despite a long-recognised need for organisations and workers to have a sound understanding of the cultural needs of each individual participant as well as their community (Zellerer 2003, Brown & Languedoc 2004; Olsen & Lovett 2016), both regional participants highlighted the absence of cultural training in their own experiences. Both specifically pointed to a lack of culturally-appropriate training within the context of working with First Nations people. One also voiced concern over the lack of culturally-appropriate programmes for First Nations men in his region. The lack of training for facilitators and the lack of specialised

programmes for communities identified here is sadly congruent with repeated findings over the past two decades, which have emphasised that facilitators need sound understandings of historical impacts and cultural needs when working with First Nations men in a behaviour-change setting (Andrews et al., 2018). Such understandings have identified deeply specific cultural aspects such as the welcoming of healing amongst individuals and community members; community involvement and ownership; the modelling of healthy and respectful relationships; the incorporation of cultural aspects throughout programme delivery; community and individual safety planning, and culturally-specific behaviour-change programmes, as well as the necessity for highly-skilled facilitators for the programme delivery itself (Andrews et al., 2018; Olsen & Lovett 2016; Prince, 2015).

A further, and equally crucial, overarching absence identified here, which echoes previous research, is the lack of DFV training offered in WA through tertiary courses (Day et al., 2019). The findings of this research concerning the necessity that facilitators should be trained within the DFV sector prior to becoming a facilitator of MBCPs, indicate that earlier research has not yet been operationalised (Vlais et al., 2017; Day et al., 2018; Day et al., 2019). In addition, however, the findings of this research strongly indicate that as a larger, state based, sector-wide issue, through universities and state government, as yet no emphasis has been placed on providing accredited training or compliance monitoring should tertiary institutions develop and begin delivery of an accredited training package.

Variances of clinical supervision

This research indicates that facilitators′ experiences of MBCP clinical supervision levels varied in consistency of supervision, style of supervision, and the complications of supervision. There was also an identifiable increase in the desire to receive more consistent, ongoing, specialised supervision.

The literature addressing this is clear and emphatic: clinical supervisors hold several responsibilities in providing supervision (Geraghty, 2013; Kuhn et al., 2019; Rothwell et al., 2021). These include ensuring all decision making complies with ethical standards, assisting in building skills-based competencies and importantly, providing a space for practitioner well-being (Lamb et al., 1991; Kuhn et al., 2019). These are all elements echoed by participants in this research.

At a formal professional level, the Western Australian Practice Standards for Perpetrator Intervention (Department for Child Protection and Family Support, 2015), require facilitators to take part in formal, individual clinical supervision, either fortnightly where experience is limited, or monthly for more experienced facilitators. Yet, for most participants, this amount of supervision was not reported to have occurred, even though the lack of supervision received by participants in this research could lead to a loss of programme integrity and subsequent increases in risk for women and children (Day et al., 2019; Mackay 2015; Vlais et al., 2017;). Further, absence of supervision can lead to increases in workplace stress and feelings of isolation (Rothwell et al., 2021). While it is a sector standard that MBCPs are delivered to at least the minimum standards to ensure safety for victim-survivors of violence, this applies also for organisational staff who are delivering front line services (Walter & Chung, 2020).

These findings are also congruent with those of the Victorian studies discussed above, in which practitioners were also not receiving adequate clinical supervision (Vlais, 2010). Yet, as providers/funders and scholars alike recognise, consistent supervision supports staff well-being while reducing attrition rates (Vlais et al., 2017). A particular issue in this study, and one which again is consistent with the findings of others, such as Geraghty (2013) and Vlais et al. (2017), is that participants who received consistent supervision presented as feeling more supported by their agency in terms of well-being than those who had little to no supervision.

Staff well-being

As prior research has also found in other field sites (Vlais 2010; Vlais et al 2017; Walter & Chung 2020), outside of clinical supervision and Employee Assistance Programmes (EAP), most participants in this study were unable to identify any additional supports that their organisation offered. Further, no participant interviewed was able to show any awareness of strategic plans or organisational policies that ensured staff well-being in the workplace. The absence of scaffolding of staff well-being through professional DFV-

informed training and clinical supervision not only highlights the potential impacts of stress in the workplace (Choi, 2011) but also strongly indicates the potential for programme drift, bringing the core effectiveness of MBCPs into question (Mackay, 2015).

A complicating factor within this study found that standardly participants worked part-time. Participants identified feelings of isolation or stress, due to remote, part-time, and/or evening work, which often left them feeling removed from other staff in their organisation. These findings are consistent with previous research which identified the barriers and challenges for staff working in MBCPs in receiving supports or feeling supported in the work (Vlais, 2010; Vlais et al 2017; Walter & Chung, 2020). Participants reported that due to their teams being small and scattered across varying sites and regions, they felt disconnected from their service, and so relied over-heavily on their co-facilitator for support. Further, most were impacted by isolation due to their work hours and workloads which placed significant limitations on crucial networking and exchanges of ideas within their own or external agencies, adding to their feelings of isolation and lack of support (and see Vlais et al, 2017; Day et al, 2019; Walter & Chung 2020, for congruent reporting). The early findings of researchers such as Spreitzer (1995; 1996); O′ Brien (2006;) and Choi (2011) identified that enabling staff to have resources made available to them, and actively involving them in well-being strategies, may prevent or reduce the experience of workplace stress. The availability of such well-being strategies and resources or active inclusivity in their services/agencies for participants in the current research was clearly lacking in the findings of this current research.

In bringing together the participant engagement in this research and the overarching literature from previous studies, a disconnection between the minimum standards required for facilitators to engage in MBCPs and their provision across organisations in WA has become evident. In practice, this disconnection has led to participants voicing concerns over lack of training and supervision, organisational culture and funding assumptions within their workplaces. The previous research literature demonstrates that this is not a novel situation, rather that it has been permitted to exist over a period of time, and in other jurisdictions (Vlais et al, 2017; Day et al, 2019; Walter & Chung 2020). This rupture between intention and real-life practice is brought into sharp focus through the words and experiences of participants in MBCPs in this research. A persistent lack of accessible resources for organisations to support their staff almost guarantees that service providers of MBCPs are unable to maintain programme integrity at the most appropriate level, nor to provide facilitators with accredited training and ongoing expert clinical supervision despite minimum standards in place.

As a final note to this narrative of good intentions and good will and failures of implementation, it would appear that there are as yet no accreditation processes to ensure DFV compliance across organisations that administer MBCPs in WA (Vlais et al, 2017; Day et al, 2019).

CONCLUSION

This research explored facilitators′ experiences of supervision and training in MBCPs, through a qualitative approach. The study was designed to identify how facilitators of MBCPs are supported through ongoing training and clinical supervision to provide best practice while retaining staff, guarding their well-being and reducing experiences of stress in the workplace. Overall, the accounts of participants interviewed established that they experienced informal training (learning on the job) rather than formal, systematic training, and that, for most, clinical supervision often did not take place or was sporadic at best. Indeed, the accounts of all participants established that they were unaware of organisation strategies in place to support their well-being.

From the research findings and the context of the literature review, it can be concluded that staff of MBCPs in WA have limited access to supports such as accredited DFV training and ongoing specialist clinical supervision. Lack of training and supervision can have consequences to programme integrity, perpetrator outcomes and where practitioners are not adequately trained or equip to identify and respond to risk, increase risk to victim-survivors (Day et al., 2019; Vlais et al., 2017). Participants expressed an overwhelming favour for accredited training through a whole of system response, to support organisations providing MBCPs. This included adequate resources to support ongoing professional development and supervision support. Despite Practice Standards for Perpetrator Intervention (Department for Child Protection and Family

Support, 2015). in WA, an DFV training strategy supporting accreditation needs to be considered. Accreditation would support longevity of programmes, provide safer and consistent interventions in WA while ensuring all staff are DFV-informed and supported through specialist supervision in their roles.

Various key matters need to be investigated further. For example, exploring the disconnection between the Practice Standards for Perpetrator Intervention and their provision across organisations in WA, should be a priority. In addition, given the possible opportunities for programme providers to expand intervention across the state, accreditation of facilitators and the funding structures of MBCPs need to be explored. Focus should be given to their effectiveness in supporting programme integrity through training and supervision in both metro and regional landscapes while guarding staff well-being. This study therefore raises further considerations for future research in expanding the understanding of how MBCPs are funded, how organisations balance training and supervision while ensuring programme integrity and how inclusivity around staff well-being can best support staff in preventing stress in the workplace.

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