RMIT Classification: Trusted

SAFE RELATIONSHIPS PILOT - REVIEW

Prepared for MacKillop Family Services

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RMIT UNIVERSITY

Clear Horizon

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Contents

1 Executive summary

Background

This report documents the review of the Safe Relationships pilot that was implemented by MacKillop Family Services ('MacKillop'). This pilot was an early intervention program that targeted young people aged 10-17 who used violence in their home, used sexual violence, used violence in a dating context, or were at risk of doing so. The pilot program was implemented for 18 months across early 2020 to mid-2021. When funding completed in mid-2021, MacKillop committed to continuing to fund the program for a further12 months.

In 2020, MacKillop approached Clear Horizon and RMIT University to collaborate on a review of the pilot. The team applied for a grant from the Outcomes, Practice, and Evidence Network (OPEN) to conduct the review and were successful in their grant submission. The review started in January 2021 and was completed in March 2022.

About the pilot

The Safe Relationships pilot was implemented by MacKillop. The pilot opened to referrals within MacKillop on 11 May 2020 and funding for the pilot ended on 20 June 2021. It was an early intervention program that targeted young people aged 10-17 who used, or were are risk of using, violence in their home, used violence in a dating context, or were using sexual violence or sexual violence in the home or in a dating context. The pilot also worked with families of the adolescents who used violence. MacKillop applied for funding from the Lord Mayor's Charitable Foundation in 2019 to fund the implementation of the pilot. The program was delivered by an experienced social worker (1 EFT) who was supervised by a senior member of the MacKillop Clinical Team. During the first year, 28 clients participated in the program. A further 24 clients engaged in the second year, with 17 clients engaging in direct therapeutic work, and 7 referrals requiring intensive care team support.

Young people presented to the pilot with complex issues and needs. They experienced high rates of mental illness, problematic drug and alcohol use, and past exposure to physical violence. Many reported prior engagements with the criminal justice and criminal justice systems.

The pilot used an ecological family systems approach, meaning that the pilot worked with the adolescent who used violence and their family concurrently. With adolescents who used violence, the pilot had a strong focus on tailored psychotherapeutic approaches and therapeutic life story work with adolescents. The assumption was that therapeutic approaches could support young people in identifying why they use violence and provide a supportive environment for encouraging accountability and responsibility for using violence. With families, staff used a functional family therapy approach which is a short-term intervention that seeks to create attitudinal changes in the family followed by support to implement concrete and specific behavioural changes for all affected family members. These approaches recognised that the causes of violence are complex and that no one member is responsible for adolescent family violence. This work was done within a safety-first context, meaning that risk assessments and safety planning happen continuously within the context of the therapeutic work.

During implementation, the delivery of therapeutic approaches took place in one-to-one and two-to-one settings. On some occasions, the entire family was involved in session. However, adolescents who used violence participated on average in 6-8 sessions over a period of 2-6 months. Families also usually received up to three individual or group sessions. Individual sessions provided an opportunity for family members to share their views on family dynamics and perspectives. Two-on-one settings provided

therapeutic approaches for families. The pilot worked with case managers at MacKillop, so that the Safe Relationships practitioner could work collaboratively with a case manager to ensure that the services provided by the pilot had the best chance of being fully embedded with the family.

In the short term, the pilot intended for:

- Adolescents and their families to feel heard, respected, cared for, and supported.
- Adolescents to demonstrate greater self-awareness of why they used violence and the impact of their violence on others.
- Families to have improved skills to manage violence in the home and have improved connections to services they want and need.

In the longer term, the pilot wanted to contribute to:

- Improved family cohesion and communication.
- A reduction in the number and severity of violent incidents.
- Improved family stability and improved capacity of the adolescent, and all family members, to have healthy and positive relationships.

The emergence of the Covid-19 pandemic in March 2020 impacted on the delivery of the pilot. For some families, the disruption of lockdown and isolation contributed to a worsening of violence or abuse in the home. Much of the pilot work pivoted to telehealth delivery, which reduced the capacity of the program work to conduct group work and impacted on program effectiveness.

About this review

This present piece of work is being referred to as a review. The act of evaluation involves making a judgement about the merit or worth of a program, however data limitations have made it difficult to make definitive judgements about the pilot. Conducting a review implies an assessment of program performance to date but does not involve making definitive statements about program worth. Despite the limitations, the review team believes that this review provides a solid emerging picture of program effectiveness and can guide future investigation about program outcomes.

Review methods

Three key frameworks guided the review, these frameworks helped us focus on the purpose of the review, informed the way we developed data collection tools and guided how we analysed data and reported our findings. These frameworks were:

1. Key review questions. These questions helped us analyse data and apply meaning and judgement. This review had the following high-level questions:
    a. What are the observed immediate outcomes reported by families and adolescents?
    b. How does the program create these outcomes?
    c. Is the program best suited to address the needs of the target cohort?

2. A theory of change. This acts as a hypothesis and allows the review team to understand what the program does contribute to change. The theory of change is included at Appendix One.

3. A service blueprint. This is a map of activities, supporting processes, and intended user experiences. Understanding this journey allowed the review team to make recommendations to strengthen processes and improve stakeholder and user experiences.

Key activities included a planning workshop, development of a service blueprint, semi-structured interviews with 13 project stakeholders (three program staff, eight key informants, and two parents/caregivers), and a review of 15 pre and post survey responses provided by young people. A sense-making workshop was held with the review team and program team in September 2021. RMIT also undertook an extensive ethics process with the RMIT ethics committee to obtain permission to undertake the research.

This review experienced limitations in data collection which impact the capacity of the program to make evaluative statements about the program. The RMIT Human Research Ethics Committee determined that the review team could not interview young people. Access to parents and caregivers to interviews was somewhat limited. The emergence of the Covid-19 pandemic also delayed the implementation of this review and resulted in much of the review consultation taking place in online environments.

Review findings

Findings from the document review

The review team conducted an extensive document review of the research, policy and service background as it pertains to adolescent family violence.

Adolescent family violence appears to be a poorly understood phenomenon, and like all forms of violence, the actual incidence and severity of violence are likely to be under-reported. Consequently, the causes of violence and who uses and experiences violence is also poorly understood. We know that adolescent use of family violence is being increasingly reported. Themes emerging from the research, policy and practice literature suggest that the use of adolescent family violence is less gendered than family violence among adults, that males tend to use more severe physical violence, and that mothers and siblings are at greatest risk of experiencing family violence from adolescents. The use of violence is likely correlated with the experience of trauma, past exposure to violence, and a range of developmental and learning disorders. Stigma among parents experiencing violence appears to be a defining feature that impedes help-seeking for parents and violence against siblings is often downplayed.

The Victorian government has consistently acknowledged the need for a systemic response to adolescent family violence across a range of family violence policy documents. While what constitutes a systemic response is not clearly defined, a review of services literature focused on service responses to adolescents who use violence in the home and this provides insight. The following key criteria for best practice were identified:

- A need for increased community awareness
- A skilled police force
- Early intervention approaches
- Justice responses that focus on diversion and restorative justice, and
- Therapeutic family-centred approaches that focus on the individual need of the family which provide parenting skills that are unique to the context

Currently in Victoria, responses to adolescent family violence are primarily seen with the justice system (via police and children's courts) with limited funding for a small number of therapeutic programs across the state.

Conclusions

The review of the Safe Relationships pilot was limited in the extent to which it can make conclusions about program outcomes and effectiveness as the review was limited in the number of caregivers available for interview, and because ethical obligations did not allow for the review team to interview young people who were part of the program. Several external stakeholders who were part of care teams were interviewed. The conclusions emerging from this review constitute a picture of emerging evidence. It is hoped that this review can contribute to an increasingly robust evidence base for the program over time.

Implementation aligned with documented best practice

The review finds that the pilot was implemented in line with documented best practices in responding to adolescent family violence. The pilot implementation had the following characteristics:

- Used therapeutic approaches that focus on support and accountability
- Addressed young people's needs in the context of whole-of-family dynamics
- Focused on collaborating and integrating with care teams to provide holistic support.
- Implemented by staff who have significant skills and experience working with young people with complex needs.

Pilot outcomes

This review found that families:

- Felt more supported because of their involvement in the program
- Had greater access to services and improved skills in effective communication and managing conflict.
- Had greater hope that they could manage family issues in the future.

The review found that after participating young people who used violence in the home:

- Demonstrated improved self-awareness
- Experienced changes in attitudes to violence and improved attitudes to those around them.
- Were learning and applying new skills to manage their behaviour.

Finally, the review found that other services who worked with the program staff have improved understanding of adolescent family violence and improved skills to work with families effectively.

Trauma-informed and integrated approaches were key enablers of pilot effectiveness

This review found that the use and implementation of a trauma-informed tailored therapeutic response that focused on working with every member of the family, and intensive support to the young person

using violence, combined with a focus on integrated care team approaches (working with multiple stakeholders) were the key enablers of effectiveness. It was noted that the delivery of therapeutic interventions requires a specialist focus on avoiding the use of approaches that might lead program staff to overlook accountability for behaviour, which the staff acknowledge and consider when working with young people and their families.

Presenting complex needs necessitates a resource intensive model

This review notes that the program model is resource-intensive, and because of this, the time of implementation was relatively short. The length of program implementation (three months) was identified as a significant barrier to program effectiveness, because young people present with complex needs and because they need time to build trusting relationships with therapeutic workers.

Barriers to effectiveness

Integrated approaches with other services require workers to agree on a common approach to working with the family. Effectiveness is impacted when the team does not agree on the most appropriate approach. This review analysed program documentation and made several recommendations for how documentation could be redeveloped to enable the program to communicate the program goals and methods to other stakeholders. It was recommended that future documentation focus on communicating how the program draws on what is known in the research, the policy directions of the state government, and what is considered best practice in responding to adolescent family violence.

Recommendations for future monitoring activities

Policy and service literature acknowledges that there is limited data regarding the causes, nature, and evidence of best practices in responding to adolescent family violence. The review team considered the pilot's monitoring processes, and this review provides several recommendations for improving how monitoring data is collected and contributing to greater sectoral knowledge and building the capacity of the broader social services sector to respond to family violence.

2 Introduction

This report documents the review of the Safe Relationships pilot program that was implemented by MacKillop Family Services. This pilot was an early intervention program that targeted young people aged 10-17 who used violence in their home, used sexual violence, used violence in a dating context, or were at risk of doing so. The pilot was implemented for 18 months across early 2020 to mid-2021.

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The review methods included interviews with caregivers, MacKillop staff, external staff, and the implementing team; an analysis of pre- and post-survey data of young people who were part of the program was completed, and a literature review of the policy and service delivery context was undertaken. The implementing team provided two case studies which outline how the pilot worked with families, and these are included in this report.

The team experienced some challenges in obtaining a broad cohort of voices for inclusion in this review (this is discussed in detail in the next section). For this reason, the team prefer to call this document a review rather than an evaluation. We can make an assessment and provide guidance about the performance of the pilot, but we cannot make definitive statements about the merit or worth of the program.

This report is comprised of the following sections:

- A description of the methods used in this review
- An overview of the research, policy, and service background on the matter of adolescent use of violence
- A detailed description of the pilot and the activities undertaken
- An overview of the review findings
- A review of the service blueprint and program documentation
- Conclusions

3 Methods

In this section, we provide an overview of how the review was conducted. We discuss the purpose of the review, the frameworks that informed how the review was conducted and outline the key review activities. Finally, we discuss limitations in data collection.

Review scope

Resourcing constraints and constraints in access to participants for data collection resulted in a shift in scope. As such, data collection has been conducted and analysed with the aim of contributing to program improvement and development. In the table below, we describe what was included in the review.

In scope	Out of scope
• Review of Safe Relationships performance to date • Identification of replicable or scalable practice • Documentation of embedded learnings in the delivery of the program • Feedback and reflections on the assumptions underpinning the pilot to date • Review of the relevance of the pilot in the current research and policy context	• Contribution to population-level changes • Definitive statements about causality (based on experimental design, sampling and statistical analysis) • Definitive statements about program outcomes (based on significant sample sizes with young people, parents/carers, and other stakeholders) • Economic valuation • Assessment of medium and long-term outcomes • Experiences of young people who participated in the pilot

Review frameworks

Three key frameworks are guiding this review. These frameworks helped us focus on the purpose of the review, informed the way we developed our data collection tools, guided how we analysed data, and guided how we reported our findings. These frameworks are: key review questions, a theory of change, and a service blueprint.

Key review questions

Key Review Questions are a tool that help us analyse the data and apply meaning and judgement.

High-level review questions ('key review questions' or KRQs) are 'big picture' guiding questions that provide a framework for all review activities and reporting. Ultimately, they are questions that we want to answer by collecting various types of data, then analysing the data against the KRQs. Three high-level questions guided the review:

- ***Outcomes***. What are the observed immediate outcomes reported by families and adolescents?
- ***Effectiveness***. How does the program create these outcomes?
- ***Relevance***. Is the program best suited to address the needs of the target cohort?

A Theory of Change

A Theory of Change (TOC) acts as a map, allowing us to explore what types of outcomes were achieved and to assess the accuracy of program assumptions.

A TOC (or program logic) is commonly used in evaluation. The TOC acts as a hypothesis: we identify what the program does (its activities) and then identify the changes we expect to see as a result of the program. Using a TOC assists the team to test the program theory, identify any unexpected outcomes, and identify whether the two programs are working as intended. The theory of change developed for this program is included in Appendix One.

Traditional TOCs, the type most frequently seen in government programming, can be highly detailed, with very clearly identified causal pathways connecting activities to a hierarchy of changes. These types of TOCs tend to have two key assumptions about how change happens:

1. They are linear – they show a chain of activities and changes that progress as a straight line through time.
2. They are time-bound – they theorise an amount of time between an activity being implemented and a change occurring.

The benefit of linearity is that it can convey complex information about a project relatively straightforwardly. This can help project implementers to understand and articulate project delivery and timelines.

The benefit of a time-bound TOC is that you can build monitoring and evaluation tools that capture different types of change at different times. In this case, the program logic helps to work out what types of change to look for at certain times. A time-bound TOC can also be useful in conveying to external audiences why certain outcomes have not been achieved yet (because not enough time has passed).

The limitation of linear and time-bound logics is that they may not reflect the complexity of how change happens for people - particularly in the context of family violence and working with adolescents. People do not always experience change in a linear fashion, so monitoring and evaluation tools that draw on linear models might not be sensitive enough to gather information about non-linear changes. Non-linear changes can be at odds with the time-bound nature of logic, again throwing off attempts to measure change for stakeholders.

For this reason, we have avoided the use of highly detailed and highly linear models of change in this plan.

A service blueprint

The service blueprint is a map of worker activities, supporting processes, and intended user experiences. It allows us to understand service processes and client journeys.

Review activities

A planning workshop

A planning workshop with the review and pilot teams was held on 26 November 2020. At this planning workshop, the team identified what was not in scope for the review, preprepared review questions, and a theory of change (TOC). The program team reviewed and refined the questions and the theory of change in the workshop.

Development of service blueprint

A service blueprint development workshop was held with the MacKillop team in January 2021. At this workshop, the review team facilitated the development of a service blueprint. Using the service blueprint framework, the MacKillop staff then mapped the psychotherapeutic response over the blueprint, to demonstrate how the psychotherapeutic aspects of the program are integrated with service process and client journey. The service blueprint developed at the beginning of the review is included in Appendix Two.

Ethics approval

The research conducted as part of this review was approved by the Human Research Ethics Committee at RMIT University. All participants were given participant information and consent forms. None are referred to by name, though it is recognised that due to the small number of project staff at MacKillop Family Services, they may be broadly recognisable. Although it would have been advantageous to conduct interviews with the young people who took part in the program, ethical concerns about the merits and benefits of this given their youth and possible vulnerability were taken into consideration and it was determined that on this occasion, the research would proceed without their participation.

Interviews

A total of 13 project stakeholders were interviewed by the review team.

Interviews with staff Semi-structured interviews were conducted with three program staff to better understand their program experiences. Two program staff were interviewed twice: once on their own to provide their assessment and views on the pilot, and once as a team to provide more detail about psycho-therapeutic approaches.

Interviews with key informants (within and external to MacKillop) Key informant interviews were comprised of eight participants, four informants worked for MacKillop and four informants worked for external services.

Interviews with parents and caregivers The review team conducted interviews with two parents of service users.

The review team experienced barriers in finding external staff and parents and caregivers to interview. As is custom with reviews, we rely on access to cohorts to be able to conduct interviews. Many external staff and parents and caregivers were uncontactable. Some stakeholders would agree to be interviewed, and then could not be contacted. This was often due to caregivers and external staff experiencing time constraints or having children present at the home that they needed to supervise.

The participant information and consent form are included in Appendix Three.

The interview guides are included in Appendix Four.

Case studies

The implementing team provided two case studies to the review team, which provide rich information about how the pilot enabled effectiveness and outcomes. These are included in this document.

Review of pilot documentation

The team reviewed the following documents:

- The literature review conducted by the MacKillop team
- The grant application and its updates
- The MacKillop practice manual
- The documentation that was developed to support the implementation of the pilot

The team used this documentation to assist with describing the pilot's intent and providing a picture of what has been done to date.

Review of client surveys

Over the life of the pilot practitioners administered a Common Assessment Tool at the following points: at start of service, mid-term, end of service, and three-month post service. The team reviewed 15 survey responses and triangulated the data with qualitative data to answer the relevant key questions. Survey responses three-months post service were not collected.

Sense-making

A sense-making workshop was held with RMIT staff, Clear Horizon staff, and pilot staff from MacKillop on 30 September 2021. The review team provided preliminary findings to the MacKillop team, and the workshop participants discussed the meaning and implications of the preliminary findings.

Limitations

The review experienced some limitations in data collection which have impacted on the capacity of the team to make judgements about the program. Firstly, RMIT undertook an extensive ethics process prior to data collection starting. The RMIT Human Research Ethics Committee determined that the team could not interview young people who were in the program, and their voices are missing from this document. The team were given permission to interview caregivers, but recruitment was difficult and only two caregivers were interviewed.

The review team undertook an analysis of the pre and post-survey data – reviewing a tool used in the pilot called the Common Assessment Tool (CAT). The review team have made several suggestions and considerations for how the CAT could be improved by adapting the measurements so that they are more appropriate for the context, and more effective in assessing the outcomes of the program. Further detail about this can be found in the Service Blueprinting section and in Appendix Five – which contains a detailed analysis of the survey questions in the CAT. The low sample numbers (approximately 15 participants) combined with the reviewers' concerns as to the effectiveness of the CAT tool in measuring changes for young people make it difficult to make conclusive statements about the program based on the review of this data.

The act of evaluation involves making a judgement about the merit or worth of a program, however, the team feels that the data limitations make it difficult to conduct a formal evaluation. For this reason, we prefer to call this document (and the process leading up to the development of this document) a review. Conducting a review implies an assessment of program performance to date but does not involve making definitive statements about program worth.

4 Research, policy, and service background

In this section, we synthesise information, gleaned from academic and grey literature, about what is known about adolescent family violence. We then discuss policy responses developed by the Victorian Government over the past ten years that have informed a common understanding of what constitutes best practice in delivering services for adolescents who use violence.

Research background

This section provides a brief overview describing some of the research on adolescents who use family violence.

Who is using violence, and who is experiencing violence?

Because all forms of family violence are believed to be underreported, it is difficult to estimate the true extent of adolescent family violence (Phillips and McGuiness 2020). A 2020 data snapshot of adolescent family violence in Victoria provided by the Crime Statistics Agency (based on police data), and covering the years 2014-2019 provides the following information:

- Adolescent family violence accounts for less than ten percent of police reports, but reports increased 11.6% over the past five years.
- Most AFV incidents involve parents, making up over 60% of all adolescent family violence incidents
- Adolescents who use violence are more likely than adult perpetrators to have mental health problems including suicidal ideation
- Half of fathers who experienced adolescent family violence had a history as an aggressor of violence, and two in five mothers had historically been a victim-survivor of intimate partner violence
- Two-thirds of adolescents who used violence have had contact with the justice system before their first family violence incident, and 80% of adolescents who used violence had future contact with the justice system (of which half were further family violence incidents)

It should be noted that an increase in reporting is not necessarily correlated with an increase in violence and that police reporting provides a very limited snapshot into the true extent and nature of adolescent family violence. Consequently, it is difficult from reviewing police and court data to determine the proportion of cases in which parents and siblings are affected by violence and the proportion of correlating factors (Royal Commission, 2015).

A review of the literature found a range of different reporting on the exact proportion of violence used by young people when disaggregated by gender, the type of violence used, and the gender and type of affected family member. Regardless, some themes do emerge. Adolescent violence against family members appears to be less gendered than family violence involving adults (Royal Commission, 2015). Nonetheless, mothers are a high-risk cohort, males are most likely to use violence against mothers and fathers, and males are more likely to be apprehended by police (Boxall and Sabol, 2014, Royal Commission, 2015, Sewlyn and Meakings 2015, Simmons et al 2018). The Royal Commission (2015) notes that '*the severity of violence depends on age and gender, with the severity of abuse by sons increasing incrementally between the ages of 10 and 17, whilst parental abuse cases by daughters increases between the ages of 10 and 13 years and falls after that age.*'

Research from the United States asserts that child and adolescent sibling relationships have the highest levels of violence of any family relationship (Royal Commission 2015). The 2014 DHHS report indicated that younger siblings were involved in 66% of incidents reported to police (DHHS 2014).

Why is adolescent family violence occurring?

Adolescent family violence is not a well-understood phenomenon (Boxall and Sabol, 2014, Royal Commission 2015). There are a range of factors correlated with adolescent family violence, either as factors that contribute to the use of violence or factors that impede families seeking support from external sources. Use of violence is likely correlated with a range of factors that would be unique to each family and could include existing family violence in the home, the experience of childhood trauma, adolescent developmental processes, disabilities and developmental disorders of the adolescent, adolescent and/or parent experience of mental illness, the personality of the adolescent, the personality and parenting skills of the parent, and the nature of the relationship between the parent and the adolescent (Royal Commission 2015).

The Royal Commission reported that an interim evaluation of the Ballarat Adolescent Family Violence program (Step Up) showed the following co-occurring factors for adolescents who use violence: 59% had a history of family violence, 46% had experienced childhood trauma, 49% had behavioural or learning difficulties, 28% had mental health challenges, 28% had alcohol or other substance challenges, and 21% had a disability (including intellectual disability or acquired brain injury).

Stigma

There is a lack of awareness about this type of family violence (Royal Commission 2015). This contributes to stigma for parents, and parents find it hard to engage in help-seeking (Boxall and Sabol 2014). They experience parental guilt and find it difficult to discuss their experiences (Royal Commission 2015). Regarding sibling violence, the seriousness of this type of violence is often underplayed. This often means that parents do not seek assistance until in crisis (Royal Commission 2015).

Exposure to childhood trauma and exposure to existing family violence and its impact on development

Adolescence is a poorly understood developmental process and is not a homogenous state but rather a series of progressive psychological and cognitive stages (Davidson 2020, Christie and Vinner 2005, Onrust et al. 2016, Malti et al. 2016). Researchers claim that children and adolescents who use family violence have often experienced family violence, trauma, or child abuse (Moulds et al., 2016, Simmonds et al. 2018, Early Intervention Foundation 2014). Psychological and cognitive stages of development throughout childhood, including adolescence are likely impacted by exposure to trauma. Adolescents are navigating some of the most complex biopsychosocial-spiritual transitions and developments across the lifespan (Harms, 2020) with trauma potentially contributing to the use of violence (van der Kolk 2003, Campo 2015, Coogan 2017).

Disability, mental health, and neurodiversity

Adolescents with a disability or mental health issue are likely to have a unique experience of emotional and intellectual development into adulthood. Researchers highlight the need for a trauma-informed and developmentally appropriate response for all young people including those with an intellectual disability, learning disabilities, communication disorders, autism spectrum disorder, attention deficit hyperactivity disorder, and mental health issues.

The Royal Commission notes that many families who have children with a disability have not received appropriate support to address issues associated with that disability. The Royal Commission points to a 2012 study that reported that parents are sometimes forced to surrender care of their child with a disability after many violent incidents.

The MARAM risk assessment framework also notes that between 2007 and 2019, 44% of young people who committed suicide were alleged to have used family violence against a family member. When issues are co-occurring with adolescent family violence, a tailored intervention is needed to best suit the developmental and emotional needs of the adolescent (Baidawi 2020, Howard 2018, Coogan 2017, Noam and Hermann, 2002).

What is the impact of adolescent family violence in the home?

Parent victims of adolescent family violence report that the emotional and psychological impacts of the physical violence are more severe and long-lasting than those of the actual physical violence itself. The Royal Commission also notes that the well-known 'cycle of violence' model (violence – apology – forgiveness) is a feature of adolescent family violence. The Royal Commission also noted that sibling violence could be linked with a range of negative youth outcomes for siblings.

Policy background

This section outlines major policy developments in Victoria since 2014 and how they describe best practice in responding to adolescent family violence.

Four key policy drivers have informed how the Victorian Government and Victorian communities respond to adolescent family violence. These are the Adolescent Family Violence Program Service Model developed by the Department of Health and Human Services (DHHS) in 2014; the Royal Commission into Family Violence, the report for which was released in 2016; the Family Safety Victoria Strategic Plan 2021-2024; and the MARAM risk assessment framework, released by the Victorian Government in 2020.

The Adolescent Family Violence Program Service Model

This program service model document was developed as a draft in 2014, and it does not appear that a final version of the document is available on the DHHS website. The document outlines several service delivery principles and describes a model for service response to adolescent family violence.

The service delivery principles are outlined below:

- family violence is unacceptable in any form and within any culture
- using violence is a choice
- the safety of parents/carers and other family members who are experiencing family violence is paramount in any response
- families and communities can support young people who use family violence to take responsibility for their violence
- whilst parents/carers are not responsible for their child's usage of violence, they play an integral role in stopping it
- children's best interests are always paramount
- the safety, stability and development of the young person using violence is a primary focus of the response
- parents may need support to reach decisions and take actions that are in their children's best interests
- 'anger' and 'temper' are not the same constructs as violence and abuse (and should not be regarded as such)
- a secure primary attachment is critical for all children
- children's cultural, spiritual, gender and sexual identities must be respected and affirmed
- children thrive when they have strong, positive relationships with their family members and other significant people
- children's needs are met by a whole-of-system response, involving universal, specialist and tertiary services as required
- all adults share responsibility for working towards children's best interests.

The main referral pathway into the Adolescent Family Violence program is through the Police L17 referral process, but services may also take referrals from Child FIRST, child protection, youth support services, and ACCOs. The program model involves a mix of intensive family case management

(including therapeutic assessment and intervention), collaboration with other services and a group work program for parents and adolescents that focuses on behaviour change and skill development. The DHHS model intends for a program of this nature to be run over 16 to 20 weeks. It also cites the need for ongoing risk assessment and safety planning to ensure the safety of family members throughout their involvement in the program. The document also outlines the need for the service to be implemented by skilled and experienced staff who have the key competencies to work with young people with complex needs.

The document outlines the need for the program to be part of an integrated family violence service network and delivery platform and states that services need to build partnerships that will strengthen service delivery, including proactive collaboration with youth services and criminal justice networks. The model also recommends that services consider adapting the program design for local context, perhaps using local advisory groups to provide guidance and advice.

The Royal Commission into Family Violence

The Royal Commission into Family Violence (2015) noted that there is no systemic response to the needs of young people and their families who experience violence from adolescents. The Commission report states that research indicates that the most effective approach would be systemic, family-centred, and collaborative. The Commission noted that criminal justice system responses were considered to be inadequate and inappropriate and that police lack specialised training to respond to this unique form of family violence. Outside of contacting police, there are no clear avenues for accessing support for families experiencing violence from adolescents in the home. The Commission also noted the following issues and service needs concerning responding to adolescent family violence:

- The need for the development of integrated service responses for vulnerable children and young people, including a coordinated response to adolescent family violence in Victoria between various sites, programs and services, including schools
- The need for sector-specific training to be provided to professionals who are likely first responders in cases of adolescent family violence, including police, primary and secondary school teachers
- That consideration be given to developing interim and short-term respite for families experiencing adolescent family violence, including care options for adolescents who use family violence beyond child protection or residential care
- The Commission recommended that future research explore the different ways in which gender impacts assessments of criminality and how parents experience adolescent family violence to support the development of effective and targeted responses that address different gendered patterns, who violence is used against, the prevalence of violence, and the type of violence used

The Royal Commission made the following five formal recommendations regarding improving responses to adolescent family violence. The Royal Commission maintains a website that provides detail on the status of the recommendations, and information about the recommendations and their status are outlined below.

Recommendation	Status	Details
123 Subject to the evaluation of the Adolescent Family Violence Program, extend this program across Victoria	Implemented	An evaluation of the Adolescent Family Violence program found the young people and parents understanding of their behaviours improved, that the frequency of violence reduced, and that education, work and health outcomes for young people improved.

		The Victorian Government provided $700,000 in 2016-17 to the existing Adolescent Family Violence Program. The 2021-22 State Budget provided funding to expand services for Adolescent Family Program.
124 Develop additional accommodation options for adolescents who use violence at home	In progress	The House Outcomes and Pathways branch in the Department of Families, Fairness, and Housing has funded the development of the Kids Under Cover facility, which the Royal Commission website states were to be completed in July 2020. The Victorian Government has also made investments into expanding the supply of youth refuges, with $10.1 million investment in youth housing.
125 Victoria Police determine a baseline model for family violence teams and consider youth resource officers	Implemented	Victoria Police commenced implementation of the Family Violence Investigation model in July 2018. The model provided for Police to utilise existing structures to ensure greater support for adolescents who use family violence, including working with Family Violence Liaison Officers, Youth Resource Officers, and Youth Specialist Officers.
126 Melbourne Children's Court establish family violence applicant and respondent worker positions	Implemented	The Children's Court is working with Merri Health to develop the service delivery model to provide Applicant and Respondent Practitioner Services. The Melbourne Children's Court refurbishment project was completed in April 2018 to provide children and court users a secure environment. The Court is current scoping options for a family violence area.
127 Subject to the pilot program, establish a statutory youth diversion scheme	Implemented	The 2018-2019 budget provided $12.9 million for the Children's Court Youth Diversion (CCYD) service. The Government committed to the state-wide rollout of the CCYD and was informed by the findings of an evaluation of similar programs.
128 Trial a new model to link Youth Justice Group Conferencing with an Adolescent Family Violence Program	Implemented	The Department of Justice and Community Safety and Family Safety Victoria implemented a service model to link the Adolescent Family Violence Program with the Youth Justice Group Conferencing to develop a model that links the two services and provides a restorative justice approach. The trial commenced in 2018 and ran for 12- months. The evaluation found that there was low uptake in numbers. Further work needs to be done to consider the adaptation of restorative processes to address the needs of families experiencing family violence.

The Family Safety Victoria Strategic Plan has three strategic priorities: 1) victim-survivors, children, and families are safe and supported to recover and thrive; 2) perpetrators are held accountable, connected, and take responsibility for their violence; 3) system change: prevent and respond to family violence is systemic and enduring.

Adolescent family violence is directly mentioned at two points in the strategic plan:

- At Strategic Priority One, the strategic plan states that it intends to expand the adolescent family violence program and specialist therapeutic programs or victim-survivors or family violence state-wide.
- At Strategic Priority Three, the strategic plan intends to deliver a coordinated system and service response for adolescents who use violence in the home, including workforce capacity building and referral pathways into therapeutic services.

The Multi-Agency Risk Assessment and Management (MARAM) framework

The redevelopment of the Common Risk Assessment Framework was one of the recommendations resulting from the Royal Commission into family violence. To redevelop the framework, over 1300 stakeholders from public, private, and non-government sectors provided input into the redevelopment of the framework. The framework is intended to be used by all services that contact individuals and families experiencing family violence and establish a shared system and sectoral understanding of family violence. The MARAM framework covers all aspects of service delivery, including early identification, screening, risk assessment management, safety planning, collaborative practice, and recovery. The MARAM framework is comprised of four pillars: 1) create a shared understanding of family violence; 2) contribute to consistent and collaborative practice; 3) provide clear guidance on responsibilities for risk assessment and management and 4) support organisations to engage in system-wide data collection, monitoring, and evaluation.

The MARAM framework recognises that adolescent family violence is a form of family violence that requires a distinct response and risk assessment that recognises the young person's developmental stage, their own safety needs, and their own experience of trauma and violence. The MARAM framework recognises that adolescents who use violence benefit from therapeutic and diversionary approaches that focus on the adolescent's individual risk factors, including assessing if the adolescent using violence is also experiencing violence in the home or in the family. The MARAM framework also highlights that service responses should prioritise the safety and well-being of family members and that workers should work with adolescents to assist them in identifying why they use violence and be able to take responsibility for their behaviour.

The MARAM framework has a range of tools and resources to assist organisations in implementing the framework. These include organisational focused resources and practice guides.

Organisational resources include:

- An organisational readiness checklist
- A responsibilities decision guide for leaders of services providing family violence responses
- An organisational embedding guide is currently in development
- An organisational audit tool that measures the performance of the organisation/program/project against the four pillars of the framework

- An excel spreadsheet that can be used for implementation planning
- A tool for reviewing implementation activities
- External partnerships guidance for organisational leaders

Practice guides include:

- A foundational knowledge guide for child or adult victim-survivors and adult perpetrators – this guide includes a 1.5-page section on responding to adolescent family violence.

At the time of writing, the Centre for Excellence in Child and Family Welfare was developing the MARAM best practice guide for responding to family violence.

Conclusions

The review team notes that whilst both Family Services Victoria and the Royal Commission declare the need for a systemic and integrated response, neither document provides much detail regarding what this systemic and integrated response might look like when considering the issue of adolescent family violence. In the Royal Commission recommendations that centred on adolescent family violence, it is noted that only one of the recommendations focuses on integration across services: the Adolescent Family Violence Program was to partner with the Youth Justice Group Conferencing program. Youth Justice Group Conferencing involves group discussion after a young person has pleaded guilty to a crime. The outcome involves a report sent to the Magistrate for consideration when sentencing. The evaluation of this pilot noted that the two programs seem at odds, given that the Adolescent Family Violence Program is intended to act as an early intervention program. The evaluation also noted low uptake of the program and the need for further thinking around systemic and integrated responses to adolescent family violence.

The review notes that the Royal Commission recommended the expansion of therapeutic responses for adolescents. However, much of the investment in responding to adolescent family violence in the Royal Commission recommendations focused on justice responses and capital investments for youth housing. None of the recommendations in the Royal Commission or strategic goals in the Family Services Victoria strategic plan focused on responses for adolescents experiencing some type of mental health issue, disability, or other developmental disorder.

The MARAM framework provides comprehensive information and guidance to services about how to respond to family violence. While the framework acknowledges the need for a specialised response to adolescent family violence, it does not provide substantive or detailed documentation of what a systemic or sector-wide response adolescent family violence might look like. However, it should be noted that at the time of writing, The Centre for Excellence in Child and Family Welfare was working with Family Safety Victoria to develop a MARAM Practice Guide to support professionals working with adolescents using violence in the home.

The family violence documentation across Government consistently mentions adolescent violence. Although various documentation is consistent in its messaging about best practice responses to adolescent family violence, it does not appear that the investments provided by the Victorian Government have made a substantive contribution to upskilling a variety of systems and sectors to respond to the issue of adolescent family violence, nor facilitated the development of a state-wide integrated system that responds to the issue of adolescent family violence.

Service environment and background

This section focuses on what is considered best practice in responding to adolescent family violence and then provides a brief overview of the current service environment for adolescent family violence programs in Victoria.

Background

Research and policy support approaches focusing on restorative justice, therapeutic approaches, and whole-of-family approaches. Whole-of-family approaches can include focusing on working with parents to develop skills and implement parenting strategies that can ameliorate the violence, however, the research notes that it is important that this is done in a way that does not seek to blame the parent. Whole-of-family approaches also need to be implemented to understand how adolescent family violence interacts with a range of other issues (Frieverts and Bautista 2017, Pereria 2016, Royal Commission 2015).

The Royal Commission (2015) noted that the first program to address adolescent family violence was Peninsula Health who established the Keeping Families Safe program in 2011 using a grant from the Legal Services Board. It was the first program of its kind in Victoria. In November 2012, the Ian Potter Foundation provided funding to Child and Family Services Ballarat to develop a 'Step Up Victoria, Preventing Adolescent Violence in The Home' program. This was a pilot program and reached 60 adolescents and their families.

Current programming context

Funding for early intervention and adolescent family violence programs in Victoria comes mainly through Family Safety Victoria, the Department of Families, Fairness and Housing and philanthropic organisations.

Currently, there are a small number of services that provide specialist services for adolescent family violence in Victoria, using a range of parent, family-centred, adolescent-centred, individual, and group-work approaches. Many of these services use therapeutic and restorative justice processes (Davidson, 2020). These services tend to operate independently and do not appear to be part of a systemic state-wide response.

Outside of therapeutic approaches, funding is then allocated to Court Services and criminal justice responses and then further funding is allocated for youth housing or respite care.

Department of Families, Fairness and Housing

Today, the Department of Families, Fairness and Housing funds three adolescent family violence programs in Geelong, Ballarat, and the Peninsula. All three programs focus on whole-of-family approaches and a mixture of case management and group work. These programs are informed by the Step-Up program which is a model for addressing adolescent family violence that was first implemented in the United States in 2004. The Step-Up program focuses on restorative group intervention for young people and their caretakers, offering support groups for young people, parents, and multi-family groups. The programs provide restorative justice services at Court. Finally, the programs provide community education about adolescent family violence.

Family Safety Victoria

Other programs currently operating in Victoria include the Supporting Families With Adolescents Using Family Violence which is implemented by Berry Street Victoria, funded by Family Safety Victoria, and which services the Northern suburbs of Melbourne. Anglicare runs a 'Breaking the Cycle' program, which offers an eight-week therapeutic program for parents and adolescents in the home and services the Eastern region of Melbourne. Baptcare runs a therapeutic program for families living in the Western Suburbs of Melbourne.

What makes a good program, and what are the needs of service users?

The Centre for Excellence in Child and Family Welfare (2021) notes that there are a range of programs working on the issue of adolescent family violence and that they use different approaches. Some programs have a greater focus on group work; some programs are more trauma-informed than other programs and programs differ in the extent to which they focus on the adolescent and the parent or work with the whole family. Evaluation data is sometimes not publicly available, which makes it difficult to assess how different approaches inform program effectiveness and outcomes (Centre for Excellence in Child and Family Welfare 2021).

A review of the literature and policy finds that the following services and responses are considered to be optimal when responding to the issue of adolescent family violence:

Awareness

- There is a need to raise awareness about adolescent violence in the community and find information on options and services to address adolescent violence.

Early intervention

- If Police are involved and respond appropriately, they can have a beneficial impact by providing a firm response that is taken seriously by the adolescent and the parent, and police are often an effective point of referral into services.
- Early intervention responses are desirable so young people understand the consequences of their actions and family members are protected. Whole-of-family and therapeutic approaches are considered to be best practice – these approaches are widely reported in research and policy as being best practice for this cohort.

Unique aspects of responding to adolescent family violence

- Responses to adolescent family violence should look different to responses for family violence involving adults.
- Responses need to be tailored to the individual context of the family and the adolescent, including a detailed assessment of experiences of trauma and violence, mental health, disability, the developmental needs of the adolescent, and the history and needs of other family members.
- Removal of the adolescent from the home should only happen as a last resort.
- Criminal justice responses should focus on diversionary and restorative options.

Supporting parents

- Group work can be beneficial for parents as it reduces shame and stigma as well as provides a place for parents to share experiences and ideas.
- Parents need services beyond standard parenting programs; young people need early intervention and family-centred approaches (DHS 2014)

Need for longer-term interventions

- Many programs that focus on adolescent family violence would benefit from more intensive and longer-lasting interventions (Centre for Excellence in Child and Family Welfare 2021).

5 About the Safe Relationships pilot

Safe Relationships was a pilot project implemented by MacKillop Family Services ('MacKillop'). The pilot was an early intervention program that targeted young people aged 10-17 who used, or were are risk of using violence in their home, used violence in a dating context or has used sexual violence in the home or in a dating context. The pilot also worked with families of the adolescent who used violence. The pilot initially intended to reach families across the Greater Metropolitan area, however, the geographic scope was narrowed to manage the number of referrals received by the Safe Relationships team.

Pilot inclusion criteria included:

- A willingness of the adolescent to engage in the program and an expressed desire to change
- A parent or guardian who can provide legal consent, and the consent of one adult family member willing to engage with the pilot.
- A requirement that the young person who already have a case manager overseeing the coordination of services for the client.

MacKillop applied for funding from the Lord Mayor's Charitable Foundation in 2019 to fund the implementation of the pilot. In the initial grant application, MacKillop reported that adolescent family violence services continue to receive limited support. Additionally, much of the support for adolescents who use violence is provided by services that work in siloed ways. MacKillop outlined in the grant application that it understood that adolescent family violence was distinct from adult use of violence and was correlated with a range of complex needs. The pilot was intended to be implemented for 18 months across early 2020 to mid-2021. When the funding was completed in mid-2021, MacKillop committed to continuing to fund the program for a further 12 months.

This section describes the Safe Relationships pilot in more detail. It describes the goals, the history and design of the pilot, and how it was implemented. The description of the pilot outlined in this section was developed after a review of program documentation and discussion with the staff working on the Safe Relationships project. The following documents were reviewed:

- The grant application made by MacKillop Family Services to the Lord Mayor's Charitable Foundation
- The pilot practice manual
- A range of documentation that was used in the delivery of the pilot (these documents are outlined in greater detail in the Service Blueprint section which is included in Appendix Two)
- The review plan that was co-developed by pilot staff, Clear Horizon consultants, and RMIT staff
- The Service Blueprint that was co-developed by pilot staff, Clear Horizon consultants, and RMIT staff in January 2021
- A presentation made by pilot staff Mark Colletti and Megan Port to the OPEN Symposium that was held on 26 October 2021.

The goals of the pilot

In the short term, the pilot intended for:

- Adolescents and families to feel heard, respected, cared for, and supported.
- Adolescents to demonstrate greater self-awareness of why they used violence and the impact of their violence on others.
- Families to have improved skills to manage violence in the home and improved connections to services they want and need.

In the longer term, the pilot wanted to contribute to:

- Improved family cohesion and communication
- A reduction in the number and severity of violent incidents.
- Improved family stability
- Improved capacity of the adolescent, and all family members, to have healthy and positive relationships.

Who the pilot saw – the client group

Young people involved in the pilot presented with complex issues and needs. Young people presented with high rates of mental illness, higher than average rates of problematic drug and alcohol use, and extensive past exposure to physical violence. A high number of young people in the program have been engaged with the criminal justice system and in the child protection system. Parents also presented with complex issues, and there was a history of familial disruption and a history of difficulty in parents and young people having productive and supportive interactions.

Description of the young people who were in the program
About three-quarters of clients were under 16 (74%), and about three-quarters of clients were male (80%). About half of the young people seen by this program (46%) had a history of placement in out of home care.

Health status of the client group
It appears that many young people had a history of alcohol and drug use and a history of mental health issues. Approximately 19% of young people had a history of alcohol use at the beginning of the intervention. 13% of young people were currently using drugs, and this was impacting on their life. 7% had been referred for assessment of drug and alcohol matters but never assessed. No young person using alcohol or drugs was receiving treatment for their use. 33% of young people were assessed as having a mental health issue, and 27% of the young people had a history of depression and anxiety. 37% of young people reported suicidal ideation (reduced to 21% at the end of the intervention).

Prior exposure to violence
The young people appear to have had extensive exposure to violence. Only a very small proportion of the group had never witnessed or experienced violence: 14% of young people had never experienced violence or physical abuse and 8% of young people had never witnessed violence. 12% of young people reported that they had experienced sexual assault.

Criminal and justice matters
Offending begins relatively early – 57% of young people were 12 or under at the time of the first offence. 21% of young people had been held in secure detention at the beginning of the intervention.

Relationship with family

The staff assessed that 60% of young people have a history of neglect. Nearly half of the young people involved in the program have a history of running away or being 'kicked out' of the home. Nearly all young people (93%) have had some kind of disrupted attachment from a parent/caregiver.

Description of parents/caregivers who were part of the program
Parents/guardians were most likely to present to the pilot with a history of mental health issues (33%), 23% of parent/guardians have a history of problematic alcohol use, 15% have a history of problematic drug use, 15% have a history or poor physical health, 12% have a history of problems with employment. Without knowing what rates for the general population are across these metrics, it is difficult to interpret this data. 20% of families had a household member in custody, a figure which is likely to be quite high when compared to the general population.

What the pilot did

Pilot design

The team indicated that they spent two months planning and designing the pilot. This included extensive research on promising adolescent family violence interventions in Australia and globally. The research showed that systemic, family-centric, and collaborative approaches were effective in responding to adolescent family violence. The output of this design process was a practice manual and a range of supporting program documentation that is described in more detail later in this section.

After a period of design, some changes were made to the pilot as described in the original grant application:

- The client age group was changed from 10-17 years from 12-17 years after review of research and local feedback about need.
- There were changes to the proposed measurement tools that were to be used (discussed in greater detail later this section).
- There were changes to the geographic scope of the project, initially the pilot was to serve MacKillop clients across the Greater Metropolitan area but the geographic scope was revised to manage the number of referrals into the pilot.

The period of intervention was two to six-months, based on need. The focus on providing services to males changed at some point and the program began accepting referrals for young women based on the assessed need of the families.

Pilot approach

The pilot practice manual developed by MacKillop staff indicates that the pilot design intended to uphold the Adolescent Program Service Model principles that DHHS developed in the 2014 Adolescent Family Violence report (this document is described in the policy section).

The pilot used an ecological family systems approach, meaning that the pilot worked with the adolescent who used violence as well as their family. With adolescents who used violence, the pilot had a strong focus on tailored psychotherapeutic approaches and therapeutic life story work with adolescents. The assumption was that therapeutic approaches could support young people in identifying why they use violence and provide a supportive environment for encouraging accountability and responsibility for using violence. With families, staff used a functional family therapy approach which is a short-term intervention

that seeks to create attitudinal changes in the family followed by support to implement concrete and specific behavioural changes for all affected family members.

These approaches recognise that the causes of violence are complex and that no one member is responsible for adolescent family violence. The work was done within a safety-first context, meaning that risk assessments and safety planning happened continuously within the context of the therapeutic work.

During implementation, the delivery of therapeutic approaches took place in one-to-one and two-to-one settings. Adolescents who used violence participated in 6-8 sessions over a period of two to six months based on individual therapeutic treatment plans. Families received up to three individual or group sessions. Individual sessions provided an opportunity for family members to share their views on family dynamics and perspectives. Two-on-one settings provided therapeutic approaches for families.

The pilot worked with case managers at MacKillop, so that the Safe Relationships practitioner could work collaboratively with a case manager to ensure that the services provided by the pilot have the best chance of being fully embedded into the family. The pilot staff worked collaboratively with external services to provide holistic and integrated support to the whole family and intended to focus on providing capacity building and consultation to other service workers.

MacKillop staff acknowledge that the pilot's success relied strongly on staff who had strong skills in providing therapeutic services for adolescents with complex needs. The pilot intended for staff to receive supervision and support from another practitioner with therapeutic experience. The program manual also describes how MacKillop as an organisation employs a therapeutic communities framework (called the Sanctuary Model) to provide safety for staff and clients. The framework is comprised of four key pillars:

- Trauma-theory – recognising the trauma can alter brain functioning and behaviour and affects not just young people but adults, organisations, and systems
- The SELF framework, which refers to Safety, Emotion, Loss, and Future. This is a framework for solving complex problems presented by trauma survivors.
- Seven Sanctuary commitments which include nonviolence, emotional intelligence, social learning, democracy, social responsibility, and growth and change
- Sanctuary tools, which include community meetings, safety plans, red flag reviews, team meetings, psychoeducation, treatment and service planning, supervision and coaching, and training.

Pilot activities

The pilot opened to referrals within MacKillop on 11 May 2020 in the North and West and Brimbank/Melton region. Funding for the initial pilot ended on 21st of September 2021, at this point MacKillop then extended funding for another 12 months.

During the first year, 28 clients participated in the program. A further 24 clients engaged in the second year, with 17 clients engaging in direct therapeutic work, and 7 referrals requiring intensive care team support. Care team support was provided to almost all clients who had an active care team alongside the direct work noted above. Referrals were primarily received internally, with three accepted from either the Royal Children's Hospital or Department of Families, Fairness and Housing due to the numbers of internal referrals received.

The pilot had a detailed and documented processes that began with referral and assessment, then moved to client engagement and further assessment of the family, case planning treatment (and review as needed), implementation and treatment, and case closure.

The pilot was implemented in the following stages:

Stage one: intake and assessment

The pilot received referrals from case managers working within MacKillop (so other programs across the organisation could refer into the pilot). An assessment was then conducted by the pilot team.

Supporting documents at this stage

- Information sheet for referrers

The pilot provided an information sheet that details the pilot program, who the pilot is for, and what services can and cannot be provided.

- Referral form

This form was to be completed by MacKillop case managers. The form assessed if the young person meets the eligibility criteria. Asks if the family is aware the referral is being made, asks if the referee is willing to engage, and asks what other services are being provided.

The referral form then asked for information about the demographics of the clients who will be engaged.

Stage two: conduct referral and screening

Staff conducted referral and screening to assess immediate safety needs and contribute to the development of a therapeutic plan, which would include targeted levels of support to reflect individual needs. Staff also conducted a risk assessment to ensure that the environment is safe to work in and likely to yield positive outcomes for the family. Staff used the following strategies during first contact with the family:

- Extensive consultation with the referrer so that the staff have a good understanding of the situation
- If possible, first contact was facilitated by the referrer who then completed a referral for the pilot staff
- The pilot staff used an approach that focused on clear communication about the pilot and how it works, development of trust-building with the adolescent and the family, and the use of empathetic and supportive language.

At this point, the client may or may not continue. If the young person was assessed as ineligible, discussions were held with the referring care team to determine other forms or avenues of support including, possibly secondary consultation or sharing resources with professionals who are engaged with the young person.

Supporting documents at this stage

- Participation letter – adult and participation letter – adolescent

The pilot had two one-page documents, one for the adult, and one for the adolescent, that described the nature of the pilot, what the pilot hopes to achieve, and provided brief information about matters pertaining to privacy, consent, and permission. Staff estimate that this material was provided to

approximately 50% of clients. The other 50% of the client group received information about the program verbally.

- Risk assessment

This tool was to be completed by the worker based on initial information from the referrer and discussion with the client if required. It was intended to be reviewed regularly. The tool reviewed property hazards, history of violence and weapon possession, history of drug and alcohol use. Risk was ranked according to a matrix and a final risk assessment is assessed as being low, moderate, high, or extreme. The pilot documentation stated that the pilot does not continue when risk is assessed as being extreme.

Stage three: delivery of therapeutic services

Based on the initial assessment, services were tailored and included counselling and relational psychotherapy with both young people and other family members. These sessions intended to assist family members to take responsibility for their actions, identify triggers for violence, and identify positive strategies for addressing violence.

The first activity that occurred at this stage was the co-development of a therapeutic contract between the staff and the client. Staff support clients to identify their own personal goals and align these with presenting issues identified by the family and staff. There is a focus here on informed consent, a full understanding of the process, and that the process is client-centred and facilitates the client's voice. At this point, the staff may identify other services that could be involved in collaborative service delivery for the family.

The below are examples of items that may be included in Therapeutic Plan/Goals

- Client to engage with Safe Relationships Practitioner (SRP) individually for several sessions, with SRP worker providing mother updates thereafter.
- Therapeutic tools to be shared to MacKillop Case Manager to complete with the mother individually, providing update to client and SRP where appropriate.
- Sessions to occur at the office to ensure adequate private space.
- Goal: To decrease family violence in the home by engaging client in psycho-education respective of FV, identifying potential triggers, phases of escalation, and learning strategies to manage big emotions in the home.
- Goal: For mother to be afforded the opportunity to seek employment, when safety increases in the home and client increases school attendance.
- Goal: For client and mother to attain a better understanding of one another's needs and work on positive communication to reduce arguments in the family home.
- Potential tools/strategies to include in session planning: Traffic light tool (phases of escalation), jug exercise (therapeutic life story work), assisting mother to implement boundaries and routine safely in the home, restorative justice exercises after incident, life-space interviews (therapeutic crisis intervention), exploration of triggers and emotional regulation techniques with client.

Delivery then focused on review of client behaviour and relational interactions, collaborative review of what has been working and not working for the client, and ongoing communication that is respectful and empathetic whilst also ensuring that an adolescent who uses violence is held accountable for their behaviour.

The pilot utilised a range of strategies that focused on the use of metaphors intended to assist adolescents and families to understand their own and others' behaviour, and the impact of their behaviour on others. The pilot used frameworks, checklists, and questions as a way of helping young people and their families understand how and why people use violence, how people can manage or change their behaviour, and how people can engage in healing and reconciliation.

To this end, the pilot used Therapeutic Life Story Work (TLSW). TLSW was established by Richard Rose and enables children and young people who have experienced the trauma of child abuse and neglect to develop compassion for themselves and begin to process and move past their trauma. The approach is designed to introduce the past as markers for the present and once these are understood the child is supported to consider how to make significant changes. Overall, the focus is to help the client identify how their history has been negatively impacting their present.

An example of a technique used from this model includes:

- The Jug Exercise. The jug exercise is regularly used to assist families in sharing some of their individual stress and anxiety with others, which would be contributing to the use of violence. The concept allows a young person or family member to explain how full their jug is by adding water into the jug for each aspect of their life that is causing them stress and anxiety. This can be used later to explore strategies that may assist with taking water out before it overflows (which may be seen as the young person having an outburst). This often assists in providing a clear understanding about why certain family members are consistently fluctuating between the agitation and outburst phases of escalation.

Examples of other therapeutic tools include:

- Choice points. This tool is utilised in the program as it seems to simplify the basic principles of ACT - acceptance, commitment and therapy. An example of this includes an activity where the young person and therapist draw a boat that is anchored to their happiest place. The young person often writes their name in the boat and describes who they are to create a sense of ownership. The therapist and young person then draw waves and imagine all the things that could take them away from this place and who they want to be. The anchor at the bottom then illustrates what values make them happy and hold them to this place and the person they would like to be. This activity often highlights that although the waves are pulling them off course, values can be used to ground and anchor themselves. This is also a tool to explore protective factors and negative influences that may be impacting young people and their use of violence.

- Restorative justice activity. This tool assists the young person to understand and reflect on the nature of their behaviour, what was happening for them at the time, reflect on the impact of their behaviour on others, and explore options for restoring relationships.

The program also drew on resources from the MacKillop Power to Kids program that was established with the University of Melbourne to identify strategies that enhance the prevention of, and response to, Harmful Sexual Behaviors (HSB), Dating Violence (DV) and Child Sexual Exploitation (CSE). At times the resources from this program were used to target dating violence and promote respectful relationships. These activities alone may not be the catalyst to reduce dating violence, however they open the space to begin asking questions, reviewing the relationships and then engaging the young person in psychoeducation.

Stage four: case closure

Pilot staff prepared the client (be it adolescents or families) for ending from the beginning of the process. The ending of the intervention is planned in collaboration with the client/s so that it is relational, respectful, ethical and not re-traumatising.

Supporting documentation

- Case closure form

This document outlined the reason for case closure, what services are continuing to engage with the family, and what outcomes have been achieved as a result of the pilot.

Cross-cutting activities

Collaboration and consultation

The pilot provided clinical consultation for staff care teams both internal and external to MacKillop who were working with adolescents who use violence. This included participation in collaborative care teams as well as ongoing consultation for individual staff. The pilot staff could be invited into an existing collaborative team or create a collaborative team after conducting a therapeutic contract with a client.

Pilot staff intended to work with care staff and care teams to promote strong stakeholder relationships, guide collaborative action, work on addressing barriers and issues, and advocate when needed for the adolescent and their family. Activities may include co-design of safety plans, debriefing, capacity building and consultation to teams, and coordination of team responses.

The program also engaged in networking with a range of forums, including:

- 'Working with Men to End Family Violence Forum' hosted by the Men and Family Centre
- 'Invisible Practices: Working with Fathers Who Use Violence' hosted by AIFS and ANROWS.
- The Safe Relationships staff presented about the pilot at the OPEN symposium. The program is also linked to the OPEN website Adolescent Violence in the Home (AVITH) Resource Hub.

Monitoring

In the grant application, MacKillop reported that they would use the following tools to measure the effectiveness of the pilot:

- The Strength and Difficulties Questionnaire would be used to screen for mental health issues in adolescents. This was intended to be used at the outset and conclusion of the program.
- The Health of the Nations Outcomes Scale for Children and Adolescents, which intended to identify a range of issues likely to be of significance to an adolescent's wellbeing. This was intended to be used at the outset and conclusion of the program.
- The MacKillop Client Incident Management System was intended to be used to gather quantitative data on the frequency of severity of incidents of violence in the family home.
- The program would conduct a review of program tools, such as a client plan and an exit interview, which could provide more detailed data about the nature of issues and the nature of the interventions.

During the pilot design period, the program team decided to instead implement the Community Assessment tool (which was developed by the Florida Department of Juvenile Justice to measure the likelihood for criminal recidivism). The program team stated in a report to the Lord Mayors Charitable Foundation in August 2020 that this tool was more likely to capture more relevant information and that the CAT was a survey being used to assess Adolescent Family Violence and its outcomes. The CAT tool and the raw pilot results are included in Appendix Five.

6 Findings

The findings of the present review are presented against the key questions that were developed during the review planning phase. The evidence table informing the development of the findings is included at Appendix Six.

The review had three key review questions:

- **Outcomes**. What are the observed immediate outcomes as reported by families and adolescents?
- **Effectiveness**. How does the program create these outcomes?
- **Relevance**. Is the program best suited to address the need?

It is important to be cognizant of the limitations of the data when reviewing these findings. The review is not able to make definitive statements about the merit of the program. These findings are intended to be presented as early assessment and feedback about the pilot, with the intention that the program can use this information to make decisions about how to continue to improve and grow the program and continue to build an evidence-base about program effectiveness and contribution to outcomes.

Outcomes

The following high-level outcomes were identified:

- Changes for the family – the review saw limited but emerging evidence of reductions in levels of conflict within the family
- Changes for young people – the review saw limited but emerging evidence of improvements in self-awareness, self-control, and changing attitudes towards violence. It was also noted that young people's attendance at school improved.
- Changes for parents – the review saw limited but emerging evidence that parents/caregivers have improved capacity to manage the behaviour of the young people in their household.
- Changes in the way services are delivered – some external service staff reported that the program team provided valuable advice and information about their approach and assisted coordinated care among services for the family and the young person.

Changes within the family

Interview participants reported that families felt more supported because of their involvement in the program. It was also reported that families had greater access to appropriate services that could provide support to the whole of the family. It was reported that families had learnt and applied new skills to manage conflict in the family. Interview participants reported improved communication between family members and a reduction of conflict in some families. Interview participants reported that families had greater hope that they could proactively manage issues and address ongoing issues in the future.

Changes for young people

Interview participants observed the following changes for young people: improved self-awareness, changes in attitudes to violence, learning and applying new skills, improvements in attitudes to authority figures, and increased engagement in school.

Improved self-awareness

Interview participants reported that young people appeared to demonstrate improved self-awareness because of their interaction with the program. These interview findings were supported by the CAT survey findings:

- 40% of young people were assessed as not understanding consequences to actions at the beginning of the intervention compared to 7% at the end of the intervention. 13% of young people were assessed as demonstrating good consequential thinking at the beginning of the intervention compared to 50 at the end of the intervention.
- 40% of young people were assessed as not being able to identify problem behaviours at the beginning of the intervention compared to 7% at the end of the intervention. No young people were assessed as being able to apply appropriate solutions to problem behaviours at the beginning of the intervention compared to 29% of young people at the end of the intervention.
- 64% of young people were assessed as lacking skills in dealing with feelings and emotions at the beginning of the assessment compared to 7% at the end of the assessment.
- 33% of young people were assessed as being able to identify internal and/or external triggers at the beginning of the intervention compared to 100% at the end of the intervention.

Changes in attitudes to violence

Young people appeared to experience changes in attitudes to violence.

- 33% of young people believed that physical aggression is never appropriate at the beginning of the intervention compared to 64% at the end of the intervention
- 20% of young people believed that verbal aggression is rarely appropriate at the beginning of the intervention compared to 71% at the end of the intervention

Learning and implementing skills to manage behaviour

Young people appear to demonstrate improved self-control and ability to manage emotional regulation.

- 33% were identified as having some self-control at the beginning of the intervention compared to 79% at the end of the intervention
- 40% were identified as being impulsive at the beginning of the intervention compared to 14% at the end of the intervention
- 27% were identified as being highly impulsive at the beginning of the intervention compared to 7% at the end of the intervention
- No young people were assessed as rarely getting upset over small things or having temper tantrums at the beginning of the intervention compared to 36% of young people at the end of the intervention. 40% of young people were assessed as often getting upset or having temper tantrums at the beginning of the intervention compared to 7% at the end of the intervention
- 7% of young people were assessed in setting realistic goals at the beginning of the intervention compared to 43% at the end of the intervention.
- 40% of young people were assessed as lacking social skills at the beginning of the intervention compared to 7% at the end of the intervention. 7% were assessed as using advanced social skills at the end of the intervention.

Young people's use of violence and aggression was reduced

The survey data indicates emerging evidence of behaviour change among young people.

- 73% of young people were assessed as not being able to control impulsive behaviour at the beginning of the intervention compared to 43% at the end of the intervention.
- No young people were often using alternatives to aggression at the beginning of the program compared to 50% of young people at the end of the program

Improved engagement with adults and institutions

The CAT survey data indicates that young people experience changes in attitudes regarding how they interact with adults and support services. There were changes in attitudes towards people in authority, and greater faith in their ability to engage with systems.

- 47% had respect for authority figures at the beginning of the intervention compared to 71% at the end of the intervention
- There was evidence of improvements in attendance and school behaviour. 47% of young people were enrolled full-time at the beginning of the intervention compared to 71% at the end of the intervention. 40% of young people did not believe that school was encouraging at the beginning of the intervention compared to 36% of young people believed that school is encouraging (and 43% of young people believed somewhat that school is encouraging).
- 100% of young people under court supervision were unsure if they would be successful at the beginning of the intervention compared to 67% of young people at the end of the intervention

Changes for parents

Interview participants reported that parents felt supported, felt less shame, were learning skills so that they could improve the way they communicated with their children, and learning effective strategies for parenting. Interview participants reported that parents felt empowered to parent in ways that supported healthy boundaries.

The findings above were supported by the CAT responses, which showed that:

- 33% of parents at beginning of the intervention and 71% of parents at end of intervention were consistently applying appropriate punishment
- 40% of parents at beginning of the intervention and 71% of parents at end of intervention were consistently providing appropriate rewards for good behaviour

Changes in the way that services are delivered to the family

Interview participants reported improved pathways between the program team and other external services who were reporting support to the family. External providers reported that the program team educates other providers about adolescent family violence, about the use of therapeutic services, and works with other services to provide coordinated responses for the family.

Effectiveness

This section focuses on barriers and enablers to effective program implementation. At the end of this section, we include a detailed case study, told from the perspective of a program staff member, which illustrates how the program operated, and the subsequent outcomes.

Enablers of program effectiveness

Interview participants identified three key enablers that supported program effectiveness and enabled change:

- The use and implementation of therapeutic response which focused on the history of the family and whole-of-family dynamics.
- Interview participants indicated that the calibre of the worker is critical to the successful implementation of the therapeutic approach. The worker needs to have extensive experience working with young people with complex needs.
- The program team are effectively engaging with external services to provide holistic and coordinated wrap-around support to the family.

Implementation of a therapeutic response

The program team used therapeutic approaches and tools that allowed the practitioner to engage in sensitive conversations with young people and their families. Interview participants identified that successful implementation of a therapeutic responses utilises the following strategies:

Trauma-informed

- The work is trauma-informed, meaning that the practitioner acknowledges (either explicitly or implicitly) the contribution of past trauma or intergenerational trauma to present-day family dynamics.

Unconditional positive regard

- The program workers must adopt an approach that embeds unconditional positive regard[1] for the individuals in the family – including the young person using violence. This unconditional positive regard allows for open and transparent discussion, application of therapeutic tools and skill development, and support to the young person to identify why they use violence. Discussions about accountability for violence are more effective if they are underpinned by unconditional positive regard, as this provides space for the young person (or other family members) to critically examine their behaviour and identify how to change their behaviour.

Whole-of-family approach

Interview participants reported that the program staff were very effective in engaging with the whole of family and building trust with the family. The program staff conduct holistic assessments that seek to develop a deep understanding of the family and how the family as a whole function. They speak individually with all members of the family. The program focuses not just on reducing conflict within the

[1] *Unconditional positive regard is a concept introduced by Stanley Standal and Carl Rogers. It involves the basic acceptance and support of a person regardless of what the persons says or does, especially in the context of client-centred therapy. Source: https://en.wikipedia.org/wiki/Unconditional_positive_regard*

family but focuses on family wellbeing. Interview subjects noted that it is unusual for services that focus on adolescent family violence to employ whole-of-family approaches.

The following quote highlights the purpose and significance of using a whole-of-family approach:

> *Often families will heavily blame the adolescent for the issues in the family. You know, the young person is certainly using violence and using behaviours that are very challenging for everyone involved. But what the systemic lens allows us to do is to go yes, the adolescent is using this behaviour and it's extremely challenging for you. But as parents or carers, you have a responsibility in the way you interact with a young person. Which can have an impact on their behaviours. So, we try and shift that blaming perspective to one of inclusivity in responsibility. We share responsibility for what's going on in the family right now and we support everyone in that family system with tools and techniques and ways of trying to restructure that power dynamic by implementing boundaries in the home, by adapting language that's used to be more positive or more respectful. A range of things to support everyone to hold some level of accountability and be responsible. The other aspect of that is supporting adolescents to take responsibility through mediation, through taking remedial actions to apologise and so on. Remedial action supports building empathy and reducing pressure on the young person. Rather than there being a high-intensity pressure point on the young person, that pressure is spread throughout the family. Then, each person can play a role in what needs to be done to fix the problem. Rather than all of the accountability being on the young person. Even just that reduction in pressure can see a reduction in the use of violence.*
>
> MacKillop staff member

Skilled staff who use a range of therapeutic approaches

Interview participants reported that program staff were very effective at building relationships with young people. Staff noted that the program staff are highly skilled and experienced in working with young people with complex needs. Some interview participants reported that their young clients refused to engage with any other services except for the Safe Relationships program staff.

In the context of a whole-of-family approach, the program staff use a range of approaches to build a positive and collaborative relationship with the young person who is using violence and aggression:

- They employ staff who bring significant experience and expertise into their work. These staff are making rapid yet complex assessments about how to engage and when and how to implement therapeutic approaches, and what therapeutic activities would be effective.
- They embed unconditional positive regard into their work.
- They use simple and clear language that is accessible.
- They are friendly and approachable in their dealings with the young person.
- They use tools and metaphors to assist the young person to safely explore and understand why and how they respond to their environment, and how they can regulate their behaviour.

Interview participants reported that the calibre of the program staff is essential to building a trusting and collaborative relationship with the young person. The staff member needs to have significant experience and expertise in working with young people with complex needs. The worker is continuously undertaking complex assessments and decisions from the time they are first introduced to the young person until the time that the program ends with the client.

Support to parents

Interview participants reported that the program staff use a trauma-informed, whole-of-family, and therapeutic approach with parents. The program staff work with parents to develop safety plans, and provide advice, tools, and assistance with skill development to support the parent to be able to respond effectively to the young person.

> *The [Safe Relationships] worker was very good, so professional. She reminded me that his cup is full. As soon as she kept raising my awareness. I felt more compassion. I felt safe with her. It just kept me grounded a bit on what was happening for him – especially. When the worker came in, she always made a really nice compliment. When you are not feeling good, your self-esteem is low. She made a big difference. Made me feel I am not as bad as how I feel. Those interactions with the worker were therapeutic. They are not things you can measure. To help a person and help them realise they have value, does help you take the next step. She was never judgemental. Never felt judged by her. Felt very accepted. That made me feel safe. She was very skilled. I really appreciated that.*
>
> Parent

Engagement and coordination with external services

Interview participants reported that the program team use a systems approach in their work, working with other services so that multi-disciplinary care teams can provide coordinated support to the family. The program staff will advocate for the family with services as required. Interview participants reported that the program staff spend a lot of time working with other services to build a picture of what is happening. They reported that the program staff are very good at providing updates and information across the care team. Some interview participants did not work with the program on care teams but would rely on the program for clinical advice and support. Participants reported that the program team provided valuable information about how they work with families and how they apply their therapeutic approach.

Service staff reported that it has been very valuable to understand and learn from how the pilot staff worked with the family. The quote below outlines the value of the Safe Relationships team to external care staff:

> *Lots of children and young people who present with adolescent family violence often come to us for mental health support – we are not always the right or only place they're meant to be, and we're not always the expert. I came across the Safe Relationships program, they were highly valuable because they have a clear trauma-informed lens. When a young person comes to us who uses violence, we're being asked to diagnose and treat, ultimately label them and medicate them. Enhancing capacity to also ask 'can we understand' their experience, can we piece together their behaviours and expression so that we can help them and not just medicate them?' This is something that the Safe Relationships program has supported the service to develop capacity around. It helped us reflect on how we change the way we work. Initially, I was just consulting with the team around cases. We realised joint consultations would be better and we opened it up to the clinicians and it started opening up their eyes to the pathways to shared service arrangements. The Safe Relationships program helped strengthen our understanding and literacy around that trauma-informed family response. There's a benefit in being able to connect someone who thinks about it from that lens, building connections between clinicians around language and not blaming, and it was about coming together and having a space to grow mutual understanding*

> *We're usually the only service in a care team that has that specialist knowledge of psychotherapeutic responses and systemic responses. We really advocate for the clients through those lenses.*
>
> External service provider

Barriers to effective program implementation

Interview participants identified the following barriers to effective program implementation:

- The program model is resource-intensive
- The length of time of intervention is relatively short
- Services need more guidance on how to reach consensus on whole-of-family approaches
- Risk of the program not adequately ensuring accountability for use of violent behaviour

The program model is resource-intensive

Using a whole-of-family and integrated approach to delivery is resource and labour intensive. Working individually with parents and the young person and focusing solely on the provision of a therapeutic approach, is much easier and less time and resource-intensive to implement. Understanding the long-term benefits of these resource intensive approaches (so as to justify the use of the approaches) could be an interesting area for research across a range of support sectors.

Length of time of intervention

The limit of three months for program intervention is a significant barrier to effectiveness. It was noted by a participant that long-ingrained familial patterns (especially ones informed by intergenerational trauma) cannot be fully addressed in three months. Caregivers reported that by the time the program staff have built a strong rapport with the young person the program has reached its conclusion.

> *It takes a while to build up trust with young people, it doesn't just happen like a cancer treatment. It's all limited by the funding. It takes six months to build relationships. One of my big aversions for participation is that the service will pull the pin, or the worker won't turn up. By the time my son was ready to engage with the [Safe Relationships] program staff, the program stopped. I think that is the biggest problem. The program staff were professional. They turned up. They communicated very well. But it takes time.*
>
> Parent

What happens when services don't agree

An integrated approach that focuses on whole-of-family requires coordinated efforts with services that all agree on a common response when working with the family. Effectiveness is impacted when the teams cannot agree on the most appropriate strategies, and this can create conflicting messages for the family. Services working with the program sometimes need to be convinced that the program is using approaches that a) are evidence-based, and b) are in line with the policy and strategic directions outlined across a range Victorian Government policies and platforms. Some interview participants reported on the need for stronger guidance about how care teams can work together and agree on approaches. The quotes below speak to the conflict that can emerge across care teams when the teams don't agree on

the most appropriate approaches. Stronger policies and guidance around managing differences in opinion on approaches could assist care teams to work more collaboratively.

> *Some people are more difficult to build a working relationship with and some services are more difficult to build a working relationship with. Some services are more concerned about withholding and protecting their integrity than they are about working collaboratively in the best interest of the clients. It's not that common but it definitely happens. The person in this [Safe Relationships] role needs to be highly skilled in building relationships and navigating relationships.*
>
> External service provider

> *The biggest challenge was that the care team was divided, half thought a tough approach was better, half thought a softer approach was better. We weren't really working together. There was not a clear goal of what we were working towards. It was making [the] Mum confused. I told her she can be honest too. She was trying to navigate two different approaches. The [Safe Relationships] team did collaborate well in the sense they were wanting to provide recommendations and support - and even when we disagreed it was respected. Their communication was good. Collaborative responses can be strengthened by being very clear about what your service can and cannot do.*
>
> External service provider

Potential for the program to not fully address accountability for behaviour

Some interview participants expressed concern that the focus on the therapeutic model, and a focus on unconditional positive regard, can lead to the pilot staff being perceived to overlook accountability for violent behaviour. Program staff acknowledge that this is challenging to manage and report that it is part/inclusive of their work and planning with families.

> *Working with adolescents, it's a tricky balance between holding the child accountable while also acknowledging the parent's responsibility. In that adolescent male violence towards mother dynamic, it's hard to respond to the relational dynamic and also the gender dynamic at the same time. The main way that we address this is through psychoeducation. To the males especially but also the mothers. One area where I've done a lot of is work is with mothers who have often had past experiences of family violence and are manipulated into blaming themselves for the situation. I work to address some of those false responsibilities they feel, and it can change the dynamic between parent and child.*
>
> Program staff member

Impact of Covid

Interview participants reported that the pilot was able to continue during the Covid-19 lockdowns in Melbourne. The pilot staff were sometimes able to visit families during lockdown and were also able to use telehealth services. The telehealth services were not seen to be as effective as face-to-face contact, but telehealth allowed the program to continue implementation. Clients who experienced issues using technology experienced barriers to participation in the pilot. Groupwork that has been scheduled to be implemented was cancelled because of Covid.

Case studies

Staff provided two case studies which highlight effectiveness and outcomes of the pilot. These are included below.

Case Study One: whole-of-family lens - working with siblings

The Safe Relationships program worked with a sibling group to respond to the violent behaviours of the oldest sibling. At the time the eldest sibling was referred to the program, they were frequently engaging in aggressive and unsafe behaviours toward their younger brother. It was noted that the young person was engaging in verbal aggression daily, and physical aggression and threats to harm on several occasions a week.

After engaging with the eldest brother for several weeks in intensive work focused on emotional regulation, the practitioner identified that the youngest brother's response to the violence was also escalating the rate of incidents in the family home. The youngest brother completed 'Choice Point' activities that focussed on his values and the protective and contributing factors to his responses. Following this the practitioner worked through 'the Jug Exercise' to identify his level of tolerance and how the accumulated stress the adolescent violence in the home was impacting on him. Independent safety planning then commenced, and plans were formed for both his emotional regulation and the practical safety in the home (e.g. modifying bedroom doors).

Due to this age, the youngest brother found it difficult to identify strategies to assist with his own emotional regulation, and a 'Choice Wheel' was created. This entailed drawing a wheel that was divided into 5-6 sections, which had drawings of different strategies he could utilise when the wheel landed on it. Examples included: 'Talk to mum and ask for help', 'Go do another activity', 'Leave the bedroom', 'Think about my own response, how I am reacting and meet brother with kindness'. The youngest brother also had capacity to engage in talk therapy where discussions occurred in relation to his role in family incidents, as he often felt he needed to provide care to his mother after incidents and was not addressing his own needs as a survivor of family violence. Further discussions continued about the relationship dynamics (what is his brother needing/wanting, how else can he ask for this). In addition to this, re-structuring perceptions was also explored such as shifting perspective from 'I hate my brother', to' I hate how he is acting today').

Initially it was also difficult for both brothers to engage in pro-social activities together and therefore a box was made that provided friendly suggestions on how they can begin to shift their relationship into a more trusting and positive space. Both young people were asked to pick something out of the box once a week. Some of the suggestions included playing short games together, saying good morning to one another and providing a compliment.

Without the above collaborative planning and whole-of-family approach, the incidents of adolescent violence would have continued a trajectory of increasing frequency and intensity.

The rate of family violence incidents in the home decreased by the time the program ended. Verbal aggression was occurring on occasion, however physical altercations had reduced significantly. Due to the complexity of this case, the family was also referred to an ongoing family violence support program.

Case Study Two: therapeutic practice with adolescents – the jug exercise

The Jug Exercise is commonly used with clients engaged in the Safe Relationships program. The Jug Exercise assists families in sharing their individual stress and anxiety with others – factors that may be contributing to family violence. The tool allows a young person or family member to explain how 'full' their jug is by adding water into the jug for each aspect of their life that is causing them stress and anxiety. The therapist can then later explore strategies to assist with taking water out before it 'overflows' (such as when the young person having an outburst).

This worked well with a mother and her son who was engaging in significant physical family violence. The mother was experiencing exhaustion and experiencing feelings of being overwhelmed and wanting to relinquish care of her child. Her experience of parenting and other stressors has led to her level of tolerance being very low. She would become agitated and use aggressive language towards her son, which precipitated his use of violence.

As part of the work with the family, the therapist was able to complete the jug exercise in a private session with her son, which included a focus on both - what was filling his own jug, and what he thought may be in mother's. The work focused on building the young person's empathy and understanding for his mother and the impact of the use of violence. The son spoke of his school refusal and how this created financial instability for his mother as she was unable to work. He also reflected that this contributed to verbal abuse in the home, and the use of violence. The therapist and young person were able to plan for how they could reduce what was in mother's jug, noting that she may be quick to escalate due to her jug already overflowing.

The son was able to make plans to re-attend school, and Sanctuary Model safety plans were established that he could be used for his own self-care and emotional regulation.

After this activity was completed, the young person's school attendance increased significantly, and positive communication increased between the young person and his mother.

Relevance

In this section, we assess the extent to which the program performs in line with documented best practice about responding to young people who use violence. We then assess how MacKillop as an organisation could (if it wishes to) provide knowledge and information that contributes to system and sector improvement. The criteria in these sections are drawn from the literature review at the beginning of this document

Assessment of the effectiveness of the program against documented best practice

Based on the data available to the review team, the review team finds that the implementation of the Safe Relationships program is in line with documented best practices in responding to adolescent family violence.

Best practice as identified in policy and research	Assessment of pilot against these criteria
Therapeutic responses support adolescents whilst supporting them to be accountable for violence.	The interview and survey data indicates that the Safe Relationships program has been very effective in utilising therapeutic approaches that focus on non-judgment and lack of blame but which still focus on holding the young person using violence accountable for their behaviours.
Whole-of-family approaches that address family dynamic and context individualised assessment and tailored response.	The interview data indicates that the Safe Relationships program effectively integrates whole-of-family approaches into their work. Their work focuses on family wellbeing and understanding the historical context for the family and how this has contributed to current presenting issues for the family.
Provision of support for parents including support to respond effectively to issues in the home.	The interview and survey data indicate that the Safe Relationships program effectively provides therapeutic support for parents and that parents are able to better parent their children as a result of their involvement with the program.
Collaborative and integrated responses that include a range of partner organisations.	The interview data indicates that Safe Relationships has placed a high value on the need to facilitate collaborative and integrated responses into their work. Service providers reported that their interactions with Safe Relationships have been beneficial for families. Additionally, service providers reported that the Safe Relationships team have been instrumental in building the capacity of other service workers to understand how therapeutic approaches can assist families to experience violence from young people in the home.
Implementation is conducted by staff who have significant expertise and skill in applying therapeutic responses with adolescents with complex needs.	Program staff reported that the experience and expertise of the staff is instrumental in program implementation. Service providers reported that the Safe Relationships team have extensive knowledge and expertise in their roles and demonstrate professional high-quality practice.
Programs include clinical support to workers across a range of sectors and conduct community awareness.	The Safe Relationships program functions best if a case manager is present. This is primarily due to the Case Manager being able to implement strong safety measures and plans, whereas if this was completed by the safe relationships program it may impact the relationship and trust with the client. The team can then

	work with the case manager to ensure that workers across a range of sectors are involved with cases to ensure all of the client's needs are met. It appears that when the staff do work in care teams, they provide capacity building and awareness-raising to the care teams. The program informally provides secondary consultations to other service workers.

Assessment of the ways in which MacKillop could contribute to sector and system improvement

Victorian research and policy has identified a number of gaps and issues that impact on the effectiveness of adolescent family violence services across the state.

In the table below, the review identifies opportunities for the Safe Relationships program, and MacKillop Family Services, to collaborate with organisations, work together to contribute to sector and system improvement, and improve how services for young people who use violence are resourced and implemented.

Issues for the adolescent family violence sector that have been identified in Victorian policy and research	**Implications of future implementation of the Safe Relationships program**
There is limited data available on the extent of adolescent family violence, who is using violence, the nature and type of violence, the victim of the violence, and the interrelationship with a range of correlating factors.	The program is unlikely to be able to contribute to population-level data about the scale of adolescent family violence. However, the program is well placed to be able to provide information about what adolescent family violence looks like and the pathways into the use of violence. It is well placed to provide rich qualitative data on the interrelationship of adolescent family violence with a range of correlating factors.
Limited practice knowledge regarding how to respond effectively to adolescents who live with mental illness, disability, developmental disorder, or learning disorder.	The Safe Relationships program may benefit from collaborating with other services that specialise in responding to young people with disabilities and learning disorders to better document how to respond and work with young people who have disabilities, developmental disorders and learning disorders. The program design could benefit from strengthening in regard to articulating and codifying approaches to working with these cohorts. There may be room for the program to conduct qualitative research into these issues in partnership with specialist providers.
Limited practice knowledge regarding how to assess the developmental stage of adolescents and implications for practice.	The Safe Relationships program may benefit from collaborating with other services to better document how to assess developmental stages and understand the implications of this assessment when working with adolescents who use violence. The program design could benefit from strengthening regarding articulating approaches to assessing developmental stages and implications for program implementation.

	There could be opportunities for the program to conduct qualitative research into these issues in partnership with specialist providers.
Lack of systemic response for adolescents who use violence, despite this being identified as a policy goal.	The Safe Relationships program is well-positioned to work with other agencies that also provide adolescent family violence services. Together, these services could build a picture of what systemic response could look like, and then conduct research and advocacy to promote the design and implementation of systemic approaches. The AVITH Community of Practice that is managed by the Outcomes Practice Evidence Network would be an ideal site to lead the ideation and codesign of possible systemic responses.
Adolescent family violence continues to be poorly understood among wider sectors and across the criminal justice system.	The Safe Relationships program could investigate opportunities to provide formalised training and awareness-raising for sectors. Again, they could consider partnering with other services that provide adolescent family violence services to strengthen awareness and provide a systemic and structured awareness raising and capacity building response.
Programs that provide adolescent family violence services could benefit from cross-organisational collaboration for sharing of evidence and advocacy.	This review surmises that Safe Relationships, and other programs that work in the same space, could benefit from establishing collaborations to strengthen the evidence-base, advocate for implementation of systemic responses, and collectively build the capacity of the broader social service and justice sectors.

Ideas for future research goals

The review team has identified recommendations for future research goals.

Building a collaborative research agenda

The Centre for Excellence in Child and Family Welfare is undertaking work on the MARAM practice guide for responding to Adolescent Family Violence. The Centre could be a good convenor of adolescent family violence programs in Victoria, building a consortium that develops a shared research agenda. There would be value in MacKillop collaborating with the other Melbourne based organisations working on adolescent violence (e.g. informal conversations or sharing evaluations to establish learnings) to pursue an ARC Linkage Grant. Additionally, Victorian government policy continues to assert the need for systemic approaches – a consortium of specialist services working together to generate strategic research could assist with advocacy around progressing this policy direction.

Further qualitative research on whole-of-family therapeutic approaches

The MacKillop project appears to be unique in its whole of family approach to delivering therapeutic approaches - more qualitative research on this could be beneficial for contributing to improvements across the sector.

Further investigation into international best practice

There is value in extending the desk-based review to include more international literature

7 Review of service blueprint and program documentation

The Clear Horizon team developed a service blueprint to better understand the client journey at the beginning of the project. This service blueprint can be found at Appendix Two. Based on the review findings, the review team presents a draft revised service blueprint for the program. Additionally, the review proposes possible changes to program documentation that could contribute to improved program effectiveness.

Review of service blueprint

A review of the service blueprint that was co-developed by Clear Horizon and the pilot staff in January 2021 finds that the service blueprint accurately describes what happens in the program. Feedback provided by informants indicates that the way the service is delivered aligns with the blueprint and also that service implementation is high quality and effective.

If the program decides it would like to keep and maintain a service blueprint, the review team suggests that the service blueprint could be redesigned using the following rubric. This new proposed rubric has a stronger focus on the integration of therapeutic approaches and collaboration with services and care teams across the user/client journey.

Stream	Intake	Engagement and assessment	Planning and goal setting	Implementation	Review and closure
Experience of adolescents and their families					
Application of program model by staff					
Collaboration with services					
Supporting processes					
Supporting documentation					
Monitoring and evaluation					
Potential issues, barriers, and gaps					

The review team completed a revised service blueprint using the rubric above, and it is included over the page.

Revised example service blueprint

On this page we provide a summary service blueprint. On the next page we provide a more detailed service blueprint.

Summary service blueprint

PATHWAY	INTAKE	ENGAGEMENT AND ASSESSMENT	PLANNING AND GOAL SETTING	IMPLEMENTATION	REVIEW AND CLOSURE
FAMILY EXPERIENCE	Referral process (from case manager to program team) supports positive and informed referrals	Positive and productive first engagement and assessment with families - who feel heard	Goals developed in consultation with the family, each family member feels ownership and control over goals.	Staff implement therapeutic approaches to help the family understand why violence occurs, assist the young person to manage their violence, and assist parents and family to safely respond to violence.	The family is prepared for closure. The program team are able to celebrate achievements with the family.
THERAPEUTIC MODEL	Program staff are warm, inclusive, and clear in their initial contact with the family and with services.	Program staff begin establishing conditions for a trusting collaborative relationship with the whole family. A trauma informed focus on 'what happen' rather than 'what is wrong with you'.	The nature of the therapeutic approach, how it is implemented and the program pathway is clearly understood by the family.	Program staff utilise therapeutic tools which focus on the use of visual metaphors, checklists, and talk as tools for reflection.	Family have set of tools and processes that can continue to use to manage family dynamic post-program.
CARE TEAM COLLABORATION	Program staff effectively communicate the program to other services and all parties understand how the program is implemented. They understand the program aligns with research and policy goals.	The program works collaboratively with services to ensure a safe and supportive introduction.	Program staff are proactively communicating the goals of the therapeutic journey to other services and developing shared care team goals	The program team support other care team activities as needed and advocate for therapeutic goals for the family as needed.	Family is now embedded within a supportive care team and the care team have understanding of family dynamics and tools to assist the family.
PROCESSES	Formalised referral process Routine conduct of awareness-raising and capacity-building processes, within MacKillop and in the broader sector.	Warm referral with case manager and family. Clear criteria for assessment of safety planning Clear criteria for therapeutic assessment and planning	Program team have criteria and process for planning Care team have criteria and formal and informal processes for coordination	Formalised supervision of MacKillop program staff Formalised processes for check-in and assessment with the care team.	Processes that support formal and informal case closure Processes that support formal and informal handover to the care team.
DOCUMENTATION	• Information form for referrers • Referral form • Booklet that describes the nature of adolescent family violence and best practices in responding to adolescent family violence[2]	• Information sheet for adolescents • Information sheet for parents/caregivers • Risk/safety assessment tool • Pre-program survey • Proforma engagement tool and criteria	• Therapeutic proforma agreement for family • Proforma agreement for the care team	• Case files • Risk/safety assessment tool • Therapeutic tools • Assessment tool/criteria	• Review tool, which can be completed with family. • Handover form for service handover.
MONITORING	Details of all referrals are stored in a database so the program can monitor types of referrals, track reasons for acceptance and reasons for denial into the program	A strong and well-designed survey which MacKillop research team apply analysis to.		Use of online database to track therapeutic interventions, and track what types of activities were conducted.	A strong and well-designed survey which MacKillop research team apply analysis to. Collect stories of change to provide rich picture of qualitative change (when appropriate)
POTENTIAL ISSUES	Referring services do not properly understand how the program works	Family is too high-risk to work with or do not have the capacity to engage in the therapeutic process.	Parents and children are not able to or do not have the capacity to participate in therapeutic planning.	Family and/or adolescent does not demonstrate insight into behaviour. The care team does not communicate so services are not coordinated. Risk management and safety planning are not regularly conducted.	Family experiences loss and grief over the departure of program staff. There are no suitable services to connect the family to on completion. The length of therapeutic engagement was not enough to contribute to substantive change.

[2] This could be the MARAM adolescent family violence best practice guide once it is published by the Government of Victoria

Detailed service blueprint

Stream	Intake	Engagement and assessment	Planning and goal setting	Implementation	Review and closure
Experience of adolescents and their families	**Positive and informed referrals** The referral form provides useful information so that the program staff can have a positive initial engagement with the adolescent and their family	**Positive and productive engagement with families who feel heard** • Adolescents and their parents/caregivers/family members feel heard and listened to. • Adolescents and their parents/caregivers enjoy speaking with the program team. • Adolescents and parents/caregivers want to continue to engage.	**Goals developed in consultation with the family, who feel ownership and control over goals.** • Adolescent feels that they have agency and control over how they engage with the program. • Family members feel safe and are comfortable reaching out to the case manager or program team if circumstances change. • Adolescents and families have a shared understanding of therapeutic goals for the adolescent and family.	**Staff implement therapeutic approaches to help the family understand why violence occurs, assist the young person to manage their violence, and assist parents and family to respond to violence.** • Adolescents participate in therapeutic activities and begin to understand triggers for their use of violence, why they use violence and alternative strategies for using violence. • Where appropriate, the adolescent begins to plan for how they can make amends for their actions • Family members have improved their understanding of contextual factors that correlate with the use of violence. Family members have improved skills to address violence when it occurs.	**The family is prepared for closure. The program team are able to celebrate achievements with the family.** • The adolescent and family have a solid understanding of the agreed therapeutic pathway so is prepared for final review and closure. • The program staff, having seen empirical evidence of behaviour change, discuss what they have observed with the adolescent, and discuss with the family. Reasons for the changes in behaviour are discussed. This allows the adolescent and family to celebrate achievements, consolidate understanding of how change happened, and allow the family to prepare for closure.

Application of therapeutic program model by staff	**Program staff are warm, inclusive, and clear in their initial contact with the family and with services.**
	Program staff adopt the use of approaches similar to the communication of the program with families when describing the program or describing therapeutic approaches, this ensures that internal and external staff are able to learn about the program in an engaging, simple, and clear way.
		Program staff begin establishing frameworks for a trusting collaborative relationship with the family.
		• Balance need for describing program with the need to listen to the needs and issues raised by adolescent and family
		• Program staff build a therapeutic alliance, involving trust-building with the adolescent and family.
		• Program staff assess the current situation with a view to building a framework for therapeutic intervention.
			The nature of the therapeutic approach and pathway is clearly understood by the family.
			• Program staff develop a therapeutic plan in collaboration with the adolescent. This involves the description of the therapeutic approach, tools that are recommended for use. Number and nature of meetings with all members of the family. The goals of the therapeutic plan are developed.
			• The pathway to program closure is designed with the family at this time.
			• Safety plans are developed with family members if needed.
				Program staff utilise therapeutic tools which focus on the use of visual metaphors, checklists, and talk as tools for reflection.
				• Use of therapeutic tools, which focus on:
				  ○ Use of visuals and metaphors as tools for understanding behaviour
				  ○ Use of resources to help the adolescent and family to understand concepts being introduced - and as a tool for reflection.
				• Focus on accountability for violence.
				• Ongoing risk and safety is monitored and planning updates as needed.
					Use of therapeutic tools, which focus on:
					• Use of visuals and metaphors as tools for understanding behaviour
					• Use of resources to help the adolescent and family to understand concepts being introduced - and as a tool for reflection.
					• Focus on accountability for violence.
					• Copy of activities provided to family where relevant.
					• Integration of therapeutic work and psychoeducation learnings in day to day living.

Collaboration, integration, and support to other services	**Program staff effectively communicate the program to other services and all parties understand how the program is implemented.** • Program staff provide relevant documentation to staff who are referring or asking for secondary consultation • Services have a good understanding of the program, what it does	**The program works collaboratively with services to ensure a safe and supportive introduction.** • Referrer and program staff work collaboratively on an introduction to the program that is safe and supportive. • Program staff develop a therapeutic plan in collaboration with the referrer and other relevant services.	**Program staff are proactively communicating the goals of the therapeutic journey to other services and developing shared care team goals** • Program staff proactively describe planned activities and goals with services. • Program staff proactively listen to the questions and concerns raised by other internal and external staff and seek input and feedback	**Program team support other care team activities as needed and advocate for therapeutic goals for family as needed.** • Program staff and other service staff stay in communication. • Program staff identify service needs and bring in other supports as needed. • Program team act as an advocate for the adolescent in care team environments where needed.	• Program staff discuss the outcome of engagement with family and share information about ongoing challenges and achievements. • Program staff work with case manager and care teams to ensure that handover of the family to other services is seamless and integrated.

	• Services have improved understanding of adolescent family violence and how to respond to adolescent family violence	• If the family is assessed as not being suitable for service, the referrer and the program staff work on a way to communicate the exit of the program in a way that does not upset the family.	• Program staff describe the ways in which the proposed approach aligns with research and policy directions. • Program staff and relevant services/case manager have shared goals for family		
Supporting processes	**Referral** • Formalised referral process • Program staff conduct a verbal interview with the referrer to better understand the circumstances of the family. **Awareness-raising** • Informal networking within MacKillop to spread awareness of the program, awareness of formalised referral process, and awareness of process for seeking secondary consultation • Program staff host case consultation and workshops for interested staff at MacKillop • Program staff host external case consultation • Program staff presenting at OPEN Symposium and other conference platforms to raise awareness.	**Referral** • Warm referral – referrer discusses the program with the family and introduces the program staff **Assessment** • Initial interview and assessment conducted by program staff with adolescent and family • Risk assessment conducted in collaboration with the referrer **Development of the therapeutic plan** • Therapeutic plan developed	**Implementation of the therapeutic plan** • Program staff develop a therapeutic plan with relevant services, so that services understand what program staff are doing, and promote coordination of services **Program staff integrate services into the implementation of the therapeutic plan** • Program staff share the therapeutic plan with the case manager and care team (if one is involved). **Program staff have process for coordination** • The program team, case manager/ care team develop a plan for communication, risk assessment, and coordination of services	**Working with family** • • Whole-of-family sessions. • Direct with young person. • Parent/Young Person session. **Integration with other services** • Formal and informal communication with internal and external services. **Support to program staff** • Program staff engage in supervision with management at MacKillop.	• Final review meeting with adolescent • Final review meeting with family • Final risk assessment for the family which is shared with other staff • Discussion with the case manager and/or care team to formalise handover process
Supporting documentation	• Information form for referrers • Referral form • Booklet that describes the nature of adolescent family violence and best practices in responding to adolescent family violence[3]	• Information sheet for adolescents • Information sheet for parents/caregivers • Risk assessment • Pre-program outcomes tracking survey • Proforma that outlines proposed therapeutic plan that can be shared with the care team.	• Therapeutic agreement with the adolescent, including an agreed pathway to closure. • Therapeutic plan shared with relevant staff and services • Proforma written agreement with care team that outlines activities, communication, risk management, and shared goals.	• Case files • Risk assessment tool • Safety planning tool • Therapeutic tools	• Review tool, which can be completed with family. • Handover form for service handover.
Monitoring and evaluation	Details of all referrals are stored in a database so the program can monitor types of referrals, track reasons for acceptance and reasons for denial into the program	• Pre-program survey is easy to understand, of a short length. The survey captures relevant information (construct validity) and the questions are clear and understandable to the adolescent (inter-rater reliability). • Survey details provided in an online database and shared with an internal research team who can provide assistance with analysis and produce disaggregated data.	Some parts of the therapeutic plan should be included in an online database to track: • Number of sessions • Length of engagement • Types of tools used • Number of planned consultations with internal and external services • Therapeutic goals	• Observation of empirical evidence (e.g., observed behaviours which demonstrate improvement or lack of improvement) which are cross-referenced with other family members and staff. • Program staff should keep a log of empirical behaviours (that is, behaviours that are observable and can be verified by other stakeholders) that demonstrate change for the adolescent and for the family. The purpose of the log is to build an evidence-base overtime over what	• Post-program survey is easy to understand, of a short length. The survey captures relevant information (construct validity) and the questions are clear and understandable to the adolescent (inter-rater reliability). • Survey details provided in an online database and shared with an internal research team who can provide assistance with analysis and produce disaggregated data. • The review team suggests that a Most Significant Change process be conducted with the

[3] This could be the MARAM adolescent family violence best practice guide once it is published by the Government of Victoria

				measurable changes look like when an adolescent (and their family) are demonstrating improvement.	adolescent and their family on completion. Over time, this qualitative data can become a rich source of evidence providing insight into how adolescents can change their behaviour.
Potential issues, barriers, and gaps	• Service not well-known among MacKillop staff Referring services do not properly understand how the program works	• Adolescent and/or their family find the introduction to the program overwhelming • Adolescent and/or family do not demonstrate awareness of issues or desire for change • Family is deemed too high risk to work with • Written description of the program is not accessible to intended audiences (adolescents and parents/caregivers) • Adolescents do not understand the nature of questions in the pre-program survey but not do disclose lack of understanding	• Adolescent does not take or feel ownership over proposed therapeutic plan or does not understand what is being proposed. • Parent does not engage in a positive way and does not understand or agree with therapeutic goals. • Services do not agree on the best approach for the family to achieve goals. Services do not agree on goals.	• Adolescent does not demonstrate insight into behaviour. • The program team, in the implementation of therapeutic approaches, provide emotional support to the adolescent at the expense of holding them accountable for their behaviour. • There is no empirical evidence (observed actions) of changes for the adolescent of their family. • The service team does not communicate as planned and so services are not coordinated. • Risk management and safety planning are not regularly conducted. • Needed services are hard to access or not available for the family.	• The adolescent experiences loss and grief over the departure of program staff. • There are no suitable services to connect the family to on completion. • The length of therapeutic engagement was not enough to contribute to substantive change.

8 Review of program documentation

This section focuses on a review of existing program documentation and recommendations for how program documents and monitoring tools can be amended or changed to contribute to program effectiveness.

Overarching principles for a redesign of program documentation

Some overarching principles that the program could consider when reviewing program documentation are outlined below. These principles were considered by the review team when assessing the program documentation.

Utilise the communications strategies in the therapeutic approach and embed these into communicating how the program operates in its documentation

When working with adolescents, parents/caregivers, and families, the pilot uses communication methods that focus on metaphors and visual aids to assist people to understand their situation, case studies and examples to provide insight into what is happening and tools and checklists that break down larger concepts into smaller concrete fundamentals – which aids in understanding and discussion. The pilot team could consider reworking the future program documentation so that it aligns with the same principles that the team use in their therapeutic work. This would ensure that documentation is engaging, clear, easy to read, and provides an accurate depiction of the program. It could also assist with a care team approach, other care team members could use these documents to assist with communicating the program's approach with the family.

Review documentation to see if the documents could be completed more efficiently

Some of the existing program documentation is quite lengthy and the review team suggest that the program team could shorten some of the existing documentation and consider what written information is critical and what parts of the documentation could be shortened for ease of use.

Review of program documentation

This section provides suggestions for how the following program documentation might be changed or adapted:

- Practice manual
- Information sheet for referrers
- Referral form
- Consent for exchange of information
- Participation letters for young people and adults in the family
- Case closure

Finally, we make some suggestions about further program documentation that could be created to support program implementation.

Practice Manual

The review team suggests that the practice manual be reviewed. The following inclusions/deletions/adaptations could be considered:

- A visual overview of the journey of the program
- Redeveloping the description of the program so that theoretical descriptions of the program are accompanied by practical information about how these approaches are applied. Case studies and examples could assist here.
- Develop a model that outlines how the program provides capacity building to other service providers. Develop tools and materials that can be shared with service providers as part of facilitating capacity building. This documentation should draw on the research and policy documentation so that staff can understand that the program responses are aligned with and located in a broader research and policy context.
- Develop a model that outlines how the program practically implements and facilitates an integrated service response. Develop tools, materials, and resources that can be distributed across collaborative teams so that teams have a clear understanding of the program, how it can support collaborative team work, and the role of program staff in a collaborative team. This documentation should draw on the research and policy documentation so that staff can understand that the program responses are aligned with, and located in, a broader research and policy context.
- Provide more detail and information about how the program engages with the following known correlated factors:
  - Mental health, disability, and developmental issues
  - The developmental stage of the adolescent
  - The cultural background of the family

Information sheet for referrers

The information sheet could be reviewed to ensure that it uses simple and clear language. When technical terms are used, such as ‘relational therapeutic approach’ – there could be clearer detail about what this looks like practically. Case studies and examples of activities here would be very helpful for referrers to better understand the details of the program.

The review team recommends that the information sheet be expanded from one to two pages to accommodate the following:

- A visual flowchart that shows the journey through the program.
- A simple and clear statement that outlines the short-term benefits of the program.
- When tools are discussed, the information sheet should provide more detail (no more than one paragraph per tool) about why the program uses this tool and how it is implemented. Referrers should have an opportunity to see these tools before they make a referral (if they prefer).
- The information sheet should provide information about how the program can work collaboratively with services. Again, use of examples, activities, and case studies would help.

- The sheet should provide a little more detail (one paragraph per type of service) about what types of services are offered, and what are the benefits and potential drawbacks of each approach. Again, the use of case studies or examples would be beneficial.
- The sheet could provide a description of the program's views of who this program is beneficial for (some case studies might be helpful)
- The information sheet could provide information about the referral form and then provide advice about what follow up questions will be asked of the referrer, for instance, program staff may contact the referrer to gain more detail about the following
- the willingness of the family to engage in conversations about the violence, the perceived desire of the adolescent to engage in discussions about the violence
- the developmental stage of the adolescent, mental health, disabilities, any developmental issues, and how the referrer perceives these interact with the situation.
- Verbal assessment will ask in more detail about family dynamics, history of violence, and how the referrer perceives these to interact with the situation.
- more detail about other services involved, how these services are collaborating, and ask for advice about how the services should be working together to provide integrated support.
- types of services that the program can offer, and conduct and assessment with the referrer what might be an effective initial approach

Referral form

The referral form asks for simple responses (through ticking a box) to questions that are likely to be quite complex to answer. Some questions ask for a ranking but do not describe the nature of the ranking or provide guidance on the ranking. The ranking is just listed as 1-5. These questions need to provide more detail about what kind of assessment is being expected here.

The review team recommends that the program team review the referral form to determine what information is needed in the referral form and what information is needed to conduct a verbal assessment. A verbal assessment tool could then be developed which would guide the initial conversation between the referrer and the program team. The risk assessment tool could be included as a tool to include in the referral form. This means that program documentation will align and also provides the referrer with some understanding of how the program is going to assess and manage risk.

Consent for exchange of information

The review team recommends that the program team review this document to ensure that the purpose of the document and the implication of signing this document is clear and unambiguous to the reader. This could include examples and case studies about how information could or might be shared. There should also be clear information and direction on the sheet about how consent can be revoked.

The statement on privacy could also be reviewed to ensure that the meaning of the information is clear to the reader. There should be a direct link to the privacy statement. The role of the privacy officer and what service they can provide should be detailed.

Processes for a verbal explanation regarding consent of information should also be documented, and this documentation can be used as a tool for practitioners when explaining these policies and procedures.

Participation letter adult, and participation letter adolescent

The review team suggests considering the need for written documentation for the adult and adolescent, and the extent to which this information is useful in a written document or better communicated verbally and then the verbal exchange documented by the program team.

The review team recommends that both these documents be reviewed with the following considerations in mind:

- A greater use of visuals to convey information
- The use of visual overview of the journey of the program
- Use of documentation to provide information verbally, and integrated into the getting to know you and setting goals parts of the program
- Providing more practical information about what the program looks like in practice, using examples and case studies
- The developmental stage of the adolescent, and any learning or developmental matters that would necessitate written information being provided in form that is appropriate for them.
- The language could benefit from being simplified. Examples here include wording such as goals, consent/permission or safety planning. These phrases appear simple and clear to workers but may not have the same meaning for the reader, and the reader may not understand the implications of what is being discussed.

Case closure report

The outcomes section of this report could be redesigned. When an outcome is determined to have happened, it would be best practice to ensure that there is some type of corresponding evidence to support the substantiation of the outcome. This could include something as simple as providing an example of observed change, or detailing reporting from other service workers. The outcomes in the document should be aligned to any monitoring tools that are being implemented by the program.

Consideration for further supporting documentation

The review team acknowledges that maintenance of documentation can be time-consuming and when it is extensive can have a negative impact on the functioning of a program. Having completed a revised service blueprint, the review suggests that the program team consider the worth or merit of having the following additional documentation:

- Booklet for service staff that describes the nature of adolescent family violence, and best practice in responding to adolescent family violence
- Proforma that outlines the proposed therapeutic plan that can be shared with the case manager and care team
- Proforma for therapeutic agreement with the adolescent, including an agreed pathway to closure

- Proforma that documents agreement on how case manager and care teams will coordinate services
- Review tool, which can be used with family on completion
- Proforma for servicer handover at case closure

To avoid excessive written documentation, a suggestion is that there is a focus on short documentation that covers the most needed information and is developed with the same principles that inform how the program staff communicate in a therapeutic environment.

Review of monitoring tools

In this section, we discuss the CAT tool, and we provide guidance and suggestion regarding how qualitative data and qualitative methods could also be used as an effective monitoring tool.

Review of the survey instrument: the CAT tool

The pilot used the Common Assessment Tool at the beginning of the program and at the end of the program. The CAT was selected as it was a validated survey tool that was used for a program that also focused on the use of adolescent family violence in the United States.

The review team notes that the CAT tool is very long and was not adapted for use in the Australian context. The CAT is included in Appendix Five. In Appendix Five the review team have conducted a close and thorough analysis of where and how the questions in the CAT tool could be further developed to generate a more meaningful and reliable survey tool.

Some examples of some of the issues in the current CAT relate to the relevance of the questions in measuring the success of the program, the extent to which some of the questions could be interpreted differently by different respondents, the lack of framing for interpretation of some of the constructs being asked in the tool, and issues with the timeframe of questions not being clear.

Examples of some issues with the CAT tool include:

- Asking to measure a person's interaction with pro or anti-social people or pro or anti-social experiences is open to interpretation. A survey asking about pro or anti-social behaviour needs to break down the questions into questions that define pro and anti-social behaviour or a pro or anti-social experience, to lessen the possibility that people will understand the meaning of the question in different ways.
- There is a question about problems with school conduct but what constitutes a problem is not adequately defined.
- Questions about school marks may or may not have any bearing on the success of the intervention, and questions about school activities is too broad to provide useful information.

Suggestions for reviewing the CAT tool

The review team suggests that the program team review the CAT tool and for each question, conduct a review of the relevance and usefulness of the question in regard to measuring the success of the program. For each question, the program team should consider the following:

Consideration	Why we suggest this
Is this question asking about a change that is desirable or likely to happen at the end of the therapeutic intervention?	The changes being measured in the survey need to align with what types of changes that could reasonably be expected to be observed at the conclusion of the intervention.
Is this question likely to be understood in the same way by all stakeholders involved in the program? This is not the same as agreeing on the answer. If not, how could the question be changed to increase the likelihood that there will be a common agreement about the meaning of the question?	Surveys in general experience issues in accuracy and reliability when the person responding to the question does not apply the same interpretation as the person responding to or completing the question.
Is answering this question likely to yield information that can be used as evidence of the success of the program?	For efficiency and ease of use, the program could focus on strategic targeting of questions that yield information that will contribute to program development and potentially research goals.
Does the question align with what the research tells us about Adolescent Family Violence?	This would increase the likelihood the questions are relevant for the context, and could also assist with contributing to further research or validating existing research.
Does this question align with the priorities for knowledge and evidence as outlined in the MARAM framework?	The program would benefit from generating data that is strategically aligned to Victorian Government policy directions.
Based on what we know about the performance of the pilot, is this a useful question for us to ask and for us to know the answer to?	The survey design needs to consider the following: • What kinds of changes can be realistically be expected to be observed at the conclusion of the program? • What kinds of issues, and what kinds of changes does the research literature tells us is important to look for? • What information can we collect that could inform program and policy development?
Are there any changes that the team see happen for young people that are not included in the current CAT tool?	This would strengthen the construct validity of the survey. The survey provides a comprehensive overview of the subject being tested.
What empirical evidence (e.g., observation of behaviour) would be evidence that would inform the response to this question? Sometimes changing the survey to focus on discrete, unambiguous, and observable behaviours may yield more insightful results.	The survey questions need to be as precise as possible to minimise the risk of misinterpretation of the question, or the possibility of multiple interpretations of the question. One way to do this is to focus survey questions on empirical observations of behaviours. This lessens the risk of misinterpretation.

Principles for good survey design

When reviewing the CAT tool, the review team considered principles for good survey tools:

- A good survey tool describes what kinds of changes should be measured at certain points in time. For instance, application of the tool at the end of the program may not yield evidence of changes, because some types of changes take time, and have some changes have multiple causes. This is

why a time-bound theory of change can assist with ensuring that a survey is asking the right questions at the right point in time.

- A good survey tool relevant to the local context. Although a survey can be validated in one context, taking it out of its validated context can alter the relevance of the survey.
- The questions are clear, simple, unambiguous, and describe one construct at a time.
- The survey writer and the person completing the survey have a common understanding of the meaning of the survey question.
- When a survey question is asked, the respondent is able to provide some type of empirical evidence (e.g., an observation of behaviour) that would verify the survey response.

Suggestion for qualitative addition to monitoring and evaluation

The review team suggests that the survey be complemented with a small qualitative exercise which is adapted from the Most Significant Change technique.

Most Significant Change is an evaluation tool that involves collecting stories of change and then bringing a group of stakeholders together to review stories of change and have a discussion of what is significant about each story. The process concludes with the group selecting the story the represents the most significant change for the program.

The review team suggests that the program staff conduct the story-gathering part of the most significant change process at the review and closure stages of the program. The same questions could be asked of all family members.

The use of the tool would involve asking the following questions:

- Thinking about your time as part of the Safe Relationships program, what have been the most significant changes for you personally, as a result of being part of this program?
- How did the program help you change in this way?
- Thinking about all the changes you mentioned, which of these changes is most significant for you?

The program team could write the answers down as dot points, or the adolescent or family member could write their response. The review team suggests a log could be kept of all changes identified, how the program enabled change and a log of most significant changes. Over time, this could yield great insights and potentially demonstrate a more complex and nuanced view of how the program creates change.

9 Conclusions

Adolescent family violence appears to be a poorly understood phenomenon, and like all forms of violence, the actual incidence and severity of violence are likely to be under-reported. Consequently, the causes of violence and who uses and experiences violence is also poorly understood. We know that adolescent use of family violence is being increasingly reported. Themes emerging from the research, policy and practice literature suggests that the use of adolescent family violence is less gendered than family violence among adults, that males tend to use more severe physical violence, and that mothers and siblings and high-risk cohorts. The use of violence is likely correlated with the experience of trauma, past exposure to violence, and a range of developmental and learning disorders. Stigma among parents experiencing violence appears to be a defining feature that impedes help-seeking for parents and violence against siblings if often downplayed.

The Victorian government has consistently acknowledged the need for a systemic response to adolescent family violence across a range of family violence policy documents. What constitutes a systemic response is not clearly defined. Still, it is likely to include sector-specific training, provision of specialist respite care, integration with justice responses, and expansion of therapeutic services for families experiencing violence from adolescents in the home. The bulk of responses to adolescent family violence is currently conducted by the justice system (via police and children's courts) and funding for a small number of therapeutic programs across the state.

A review of service literature reveals a body of thinking about what constitutes best practice in providing services responding to adolescents who use family violence. Key criteria for best practice includes a need for increased awareness in the community, a skilled police force, early-intervention approaches, justice responses that focus on diversion and restorative justice, and therapeutic family-centred approaches that focus on the individual needs of the family and which provide parenting skills that are unique to the context.

The review of the Safe Relationships pilot was limited in the extent to which it can make conclusions about program outcomes and effectiveness as the review was limited in the number of caregivers available for interview, and because ethical obligations did not allow for the review team to interview young people who were part of the program. Several external stakeholders who were part of care teams were interviewed. The conclusions emerging from this review constitute a picture of emerging evidence. It is hoped that this review can contribute to an increasingly robust evidence base for the program over time.

The review finds that the program is being implemented in line with documented best practices in responding to adolescent family violence: the program uses therapeutic approaches that focus on support and accountability; the program addresses whole-of-family dynamics, it provides support for young people, and it focuses on collaborating and integrating with care teams to provide holistic support. The program is implemented by staff who have significant skills and experience working with young people with complex needs.

This review found that families felt more supported because of their involvement in the program. It was reported that families had greater access to services and improved skills in effective communication and managing conflict. Families had greater hope that they could manage family issues in the future. The review found that young people demonstrated improved self-awareness, changes in attitudes to violence, learning and applying new skills, improved attitudes to those around them. The review found that other services who worked with the program staff have improved understanding of adolescent family violence and improved skills to work with families effectively.

This review found that the use and implementation of a trauma-informed tailored therapeutic response that focused on working with every member of the family and intensive support to the young person and parent using violence, combined with a focus on integrated care team approaches (working with multiple stakeholders) were the key enablers of program effectiveness. It was noted that the delivery of therapeutic interventions requires a specialist focus on avoiding the use of approaches that might lead program staff to overlook accountability for behaviour, which the program staff acknowledge and consider when working with young people and their families.

This review also notes that the program model is resource-intensive, and because of this, the time of implementation was relatively short. The length of program implementation (three months) was identified as a significant barrier to program effectiveness.

Integrated approaches with other services require workers to agree on a common approach to working with the family. Program effectiveness is impacted when the team does not agree on the most appropriate approach. This review analysed program documentation and made several recommendations for how documentation could be redeveloped to enable the program to communicate the program goals and methods to other stakeholders. It was recommended that program documentation focus on communicating how the program draws on what is known in the research, the policy directions of the state government, and what is considered best practice in responding to adolescent family violence.

Policy and service literature acknowledges that there is limited data regarding the causes, nature, and evidence of best practices in responding to adolescent family violence. The review team reviewed the program's monitoring and evaluation data processes, and this review provides several recommendations for improving how monitoring data is collected and contributing to greater sectoral knowledge and building the capacity of the broader social services sector to respond to family violence.

10 Appendices

1 References

Anderson and Routt (Revised 2016a) *Step Up: Building Respectful Family Relationships. Parent Group Facilitator Manual.* King Country Superior Court. Seatlle, Washington, United States.

Anderson and Routt (Revised 2016b) *Step Up: Building Respectful Family Relationships. Parent Group Workbook.* King Country Superior Court. Seatlle, Washington, United States.

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2 Pilot program logic

- Provision of counselling and relational trauma-informed psychotherapy to adolescents and their families
- Coordinate with services to provide an integrated response for the adolescent and their family, including coordinated response alongside case management services

What the program does

- Works with adolescents who use violence – either in the home and/or in their dating relationships
- Engage adolescents (and their families) who have insight into their violence and commit to change
- Develop whole-of-family safety plan (for adolescents using violence in home)
- Provision of counselling and relational trauma-informed psychotherapy to adolescents and their families
- Coordinate with services to provide an integrated

Immediate outcomes

- Adolescents and families feel heard, respected, cared for, and are supported
- Adolescents develop greater self-awareness and awareness of their use of violence and impact of violence
- Families have improved skills to manage safety in the home
- Adolescents and their families have increased connection to a range of services that they need

Medium-term outcomes

- Family communication and cohesion is improving
- Adolescents and their families are getting the support they need across a range of issues
- Reduction in number and severity of violent incidents – either in the home and/or in dating situations

APPROACH

Strong focus on holistic, psycho-education, therapeutic life story work, and development of tailored resources around psychoeducation which sets framework for engagement

Highly indivualised, based on capacity of young person and family.

Program conducted by experienced practitioners.

Problem

Limited and/ or siloed support services that are appropriate for adolescents that use violence – both in the home and in their dating relationships

- Complex relationship between experience of violence and use of violence
- Use and experience of family violence is intensified by complex needs that are correlated with a range of issues associated with cultural and socio-economic status
- Violence often follows gendered patterns
- Needs of individuals affected by family violence is compromised by the systemic challenges

Principles

Relational and targeted care for adolescents ***and*** families (systemic and dynamic-based)

Supporting the system (adolescent and families) to uphold accountability for violence use and interpret trauma lens

Work in in a caring way for adolescents, their families, and their relationships

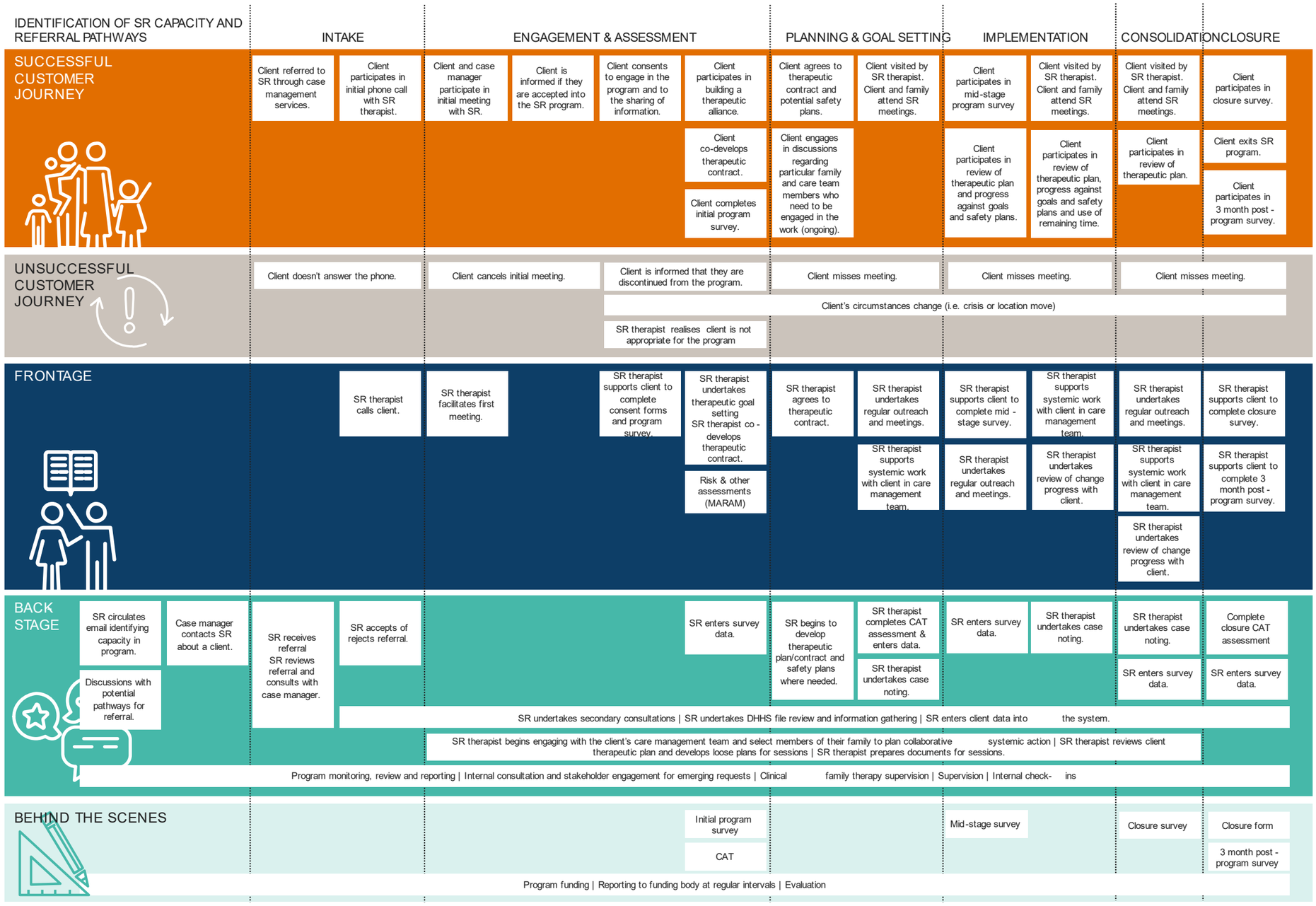
Embed responsibility and accountability within the therapeutic response

Understand and identify gendered patterns of violence

Long-term outcomes

- Reduction of stress associated with complex needs
- Safe and respectful relationships in families
- Cease use of violence
- Improved family stability
- Adolescents have improved relationships

3 Service blueprint



MacKillop Family Services

Clear Horizon

Identification of therapeutic response and skills inputs in the service blueprint

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
Customer Journey	**Initial phone call to make introductions**	Introduce the worker and the program in a graded way that makes sense to the individual client. Balance the need for describing the program with the beginning need to listen to the client's circumstances, while also ensuring all imperative program info is described.	
	Client participates in building a therapeutic alliance through direct work with Safe Relationships	Therapist encourages client to be actively involved in the trust-building process of a therapeutic relationship. This is done by meeting the client where they are at. i.e. going at their own pace with information exchange, supporting them to stay on task relevant to the program and individual goals, clarifying the program process and therapist method of working.	
	Client completes initial program survey	Describes importance of Guiding client through the survey with empathetic language and manner. Ensuring the process is not re-traumatising.	Therapist uses information collected from program survey to support the identification of target points for therapeutic plan.
	Client engages in discussions regarding particular family members/care team members that need to be engaged in the work	Through history taking and exploration of current circumstances, client and therapist will identify family members, related individuals, or care team members who are able to influence the reduction of abuse through program engagement. This might be due to reduction of specific behaviours (eg. Family member's use of abusive language), provision of extra support (eg. Individual therapy provided), provision of extra supervision for children (eg. Change of care roster), further engagement of a specific service (eg. Case management or DHHS), or to address specific family/home dynamics that are related to and upheld by specific individuals, pairs, or groups of people. This could include parents, grandparents, siblings, extended family members, partner family members and a broad range of care team stakeholders. Engagement of these individuals may be ongoing or may be for a short period of client progression through the program	

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Client co-develops therapeutic contract	Support client to identify their own personal goals for engaging in the program, describing program goals, and marrying the two. Therapist identifies methods of working with presenting issues in circumstance and relationship dynamic to address so as to reduce abuse/violence.	
	Client agrees to therapeutic contract	Therapist ensures informed consent, full understanding, informs of ongoing review of therapeutic plan, advocates for the client's own voice to be spoken and heard (by the therapist) throughout engagement.	
	Client visited by Safe Relationships therapist at home or elsewhere	Therapist engages in professional judgement regarding best practice meeting coordination, including who should be present in a specific meeting, ensuring discussions regarding abuse are not conducted with children present, responding to environmental factors such as safety in client homes & dogs, client safety in regard to domestic violence risk, client preferences for meeting, client capacity for meeting and so on.	

	Client and family members attend Safe Relationships' meetings	Therapist engages in professional judgement regarding best practice meeting coordination, including who should be present in a specific meeting, ensuring discussions regarding abuse are not conducted with children present, responding to environmental factors such as safety in client homes & dogs, client safety in regard to domestic violence risk, client preferences for meeting, client capacity for meeting and so on.	Meetings are ongoing. Regularity increases depending on level of risk in the home, and especially in the beginning stages of engagement. Focus of specific meeting is determined based on the therapeutic plan, and the presenting issues for the client in the meeting. Meetings may involve: -family violence risk assessments -one-on-one, dual or family therapy sessions -history taking These sessions will: -build client's awareness of historical and current, individual and relational, factors that contribute to abuse/adolescent use of violence in the home. -support individuals within the client group to understand and take responsibility for their part in the relationship dynamics that lead to abuse. -support individual clients to understand specific actions they can take to contribute towards the cessation of violence/abuse, and to create a healthy relational living environment -support client group with safety plans to manage the risk of potential harm related to adolescent use of violence or other concerns -support individuals in the client group to develop skill in managing personal challenging emotions as well as

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
			interpersonal conflict in a non-harmful way. -provide psychoeducation on child development, impact of trauma (violence, neglect, other forms of abuse & other traumas), family violence, adolescent violence, and cycles of violence.
	Review of therapeutic plan/relationship, progress against goals and use of remaining time in program	Apply learnt knowledge of the client / client group to collaboratively review the client's progress through the goals/plan agreed upon in the beginning of client engagement. Empathetically reflect on what's been working, what hasn't, and make a new plan of how to proceed.	
	Client enacts change based on goals	Client enacts change in their behaviour and relational interactions on a day-to-day basis. This occurs based on the impacts of therapy alongside the therapeutic plan, safety plans and other plans set in place by therapist and client group.	
	Client participates in mid-stage program survey	Describes importance of Guiding client through the survey with empathetic language and manner. Ensuring the process is not re-traumatising.	Therapist uses information collected from program survey to support the identification of target points for ongoing therapeutic work.
	Client change of circumstances (e.g. crisis or location move)	Therapist attends to the clients change of circumstances through respectful acknowledgement. Client may no longer meet the program eligibility criteria and the therapist will explain this. If other services (e.g. Family violence crisis response) are required the therapist will make a referral.	Therapist must use their professional and ethical judgement to decide on how to best respond to the client so as to serve the best interests of the client (harm reduction) as well as the best interests of the program.

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*

Frontstage	**Initial phone call to client**	Offer support for historical and present abuse/traumas experienced
		Begin to build a therapeutic alliance – creating a professional therapeutic bond between client and therapist. Formed primarily through acknowledging client's life experiences with attention, respect and care.
			Make professional therapeutic judgement/assessment on (to whatever extent is possible):
			• Client willingness to engage in program.
			• Client capacity to engage in program
			• Client awareness of:
			  ○ Current abuse in household
			  ○ Personal role in abuse dynamics
			  ○ Understanding adolescent or parent role in dynamics
			Historical circumstances contributing to abuse

	First meeting/consent forms	Guiding client through the survey with empathetic language and manner. Ensuring the process is not re-traumatising.	Make professional therapeutic judgement/assessment on (to whatever extent is possible):
			• Client willingness to engage in program.
			• Client capacity to engage in program
			• Client awareness of:
			  ○ Current abuse in household
			  ○ Personal role in abuse dynamics
			  ○ Understanding adolescent or parent role in dynamics
			Historical circumstances contributing to abuse

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Therapeutic engagement, goal setting and contract co-development	Establish appropriate therapeutic goals in partnership with the client. Therapist must ensure these are relevant to both the program goals (relating to adolescent use of violence and related issues) and the client's experienced issues.	
	Agrees to therapeutic contract/supports program survey completion	Ensures client is cognisant of the goals/plan identified, and is able to provide informed consent & agreement upon the therapeutic goals/plan.	
	Therapist supports mid-stage program survey completion	Guiding client through the survey with empathetic language and manner. Ensuring the process is not re-traumatising.	Therapist uses information collected from program survey to support the identification of target points for therapeutic plan.
	Attend care team meetings with the client	Collaboratively engage in CTM's, advocating in the client's best interest to address violence/abuse in the home, based understandings gained through therapeutic work. Support client to self-advocate in care team meetings.	Balance the needs of each stakeholder in the care team meeting and respond to each with skill towards supporting best interests for the client, in the context of their abuse-related family/home/relationship dynamics, current life situation, and circumstances relevant to care team stakeholders.
	Therapist supports systemic work with clients in care teams	Advocate for client's best interests, and for the client's voice and experience to be heard in the care team meeting context. Encourage client perspective and experiences to be incorporated into decision making processes and action plans.	

	Continue regular outreach visits to homes/ therapy meetings (individual and systemic therapy)	Therapist engages in professional judgement regarding best practice meeting coordination, including who should be present in a specific meeting, ensuring discussions regarding abuse are not conducted with children present, responding to environmental factors such as safety in client homes & dogs, client safety in regard to domestic violence risk, client preferences for meeting, client capacity for meeting and so on.	Meetings are ongoing. Regularity increases depending on level of risk in the home, and especially in the beginning stages of engagement. Focus of specific meeting is determined based on the therapeutic plan, and the presenting issues for the client in the meeting. Meetings may involve: -family violence risk assessments -one-on-one, dual or family therapy sessions -history taking These sessions will: -build client's awareness of historical and current, individual and relational, factors that contribute to abuse/adolescent use of violence in the home. -support individuals within the client group to understand and take responsibility for their part in the relationship dynamics that lead to abuse. -support individual clients to understand specific actions they can take to contribute towards the cessation of violence/abuse, and to create a healthy relational living environment -support client group with safety plans to manage the risk of potential harm related to adolescent use of violence or other concerns -support individuals in the client group to develop skill in managing personal challenging emotions as well as

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
			interpersonal conflict in a non-harmful way. -provide psychoeducation on child development, impact of trauma (violence, neglect, other forms of abuse & other traumas), family violence, adolescent violence, and cycles of violence.
	Continual review of change progress with client	Therapist regularly discusses the clients progress in their daily lives in relation to change they are enacting and the presence of adolescent use of violence. The therapist guides the client to reflect on what is working for them and what isn't, provides therapy to process any arising challenges emotionally and relationally, and upskills the client's capacity through psychoeducation.	
	Review of therapeutic plan/relationship and goals (ongoing)	Apply learnt knowledge of the client / client group to collaboratively review the client's progress through the goals/plan agreed upon in the beginning of client engagement. Empathetically reflect on what's been working, what hasn't, and make a new plan of how to proceed.	
	Therapist supports closure survey completion	Guiding client through the survey with empathetic language and manner. Ensuring the process is not re-traumatising. Guiding the client towards ending the program well in relationship with the therapist.	Therapist uses information collected from program survey to support the understanding of program and therapy effectiveness for the client.
	Therapist ends work with client	Therapist prepares client for ending from the beginning of work. As the client progresses through the program, ending is discussed along the way. Ending is planned in collaboration with the client so that it is relational, respectful, ethical and non-(re)traumatising.	

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
Backstage	**Safe Relationships review referrals and consult case manager**	Therapist reviews referrals to further determine referral appropriateness for acceptance into the safe relationships program. Therapist assesses the referral against the program eligibility criteria and makes a professional judgement on the suitability of the referral, and the program's capacity to support the client and their presenting issues. Therapist may consult with program manager for supervisory support in decision making and with the referrer for further information gathering.	
	Safe Relationships accepts of rejects referral	Final review of referral form. Decision is made and referrer is informed of decision via a phone call or meeting.	
	Safe Relationships undertake CAT assessment	CAT is completed within the first three sessions from intake, and is completed again within a week after closure. Therapist must use knowledge of client and therapeutic judgement to respond to the assessment questions. Assessment results can be used to support understanding of best practice approach for working with the client, as well as the intervention outcomes / effectiveness.	
	DHHS file review and information gathering (ongoing)	Therapist will collect information from what sources are available, as needed, for the to understand the historical and current aspects of the client (group's) relational dynamic and traumas. The therapist will identify relevant information that can inform the direction and focus for therapy work in addressing AFV. Information sources include: DHHS file review, speaking with current and previous stakeholders, professionals, and family members.	
	Begin engagement with care teams	Therapist begins engagement in care teams to: contribute a specialist lens on adolescent use of violence; to learn about the client and best methods of working with them; to identify priorities in the program's work with the client, and to collaborate towards achieving best client outcomes.	

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Deep engagement with care teams (includes advocating for specific collaborative action)	Once well established in the care team with strong stakeholder relationships and collaborative practice, the therapist (where useful and appropriate) may guide the care team towards collaborative action to enact systemic change that can flow on to impact clients (generally by increasing available supports) and reduce adolescent use of violence. Examples of this have included: calling a red flag meeting to raise a more robust response to client risks; addressing systemic barriers to useful services and support being provided to the family, including raising funding and advocating for the client to child protection an other agencies; and engaging the relevant members of the care team in a joint family meeting to transparently address issues and engage all stakeholders in action planning to address adolescent use of violence.	
	Regular contact with care team members and family members in a 'need to' basis for collaborative planning before sessions	Preparation is sometimes needed for collaborative practice such as that described above. Planning may relate to establishing safety plans, debriefing, psychoeducation, preparing individuals for a specific meeting type, coordinating individual members to play a specific role in a specific meeting type, and coordinating a specific angle in advocating for a client towards a specific audience.	

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Review of therapeutic plan and development of loose therapeutic plans for each session (ongoing)	Apply learnt knowledge of the client / client group to collaboratively review the client's progress through the goals/plan agreed upon in the beginning of client engagement. Empathetically reflect on what's been working, what hasn't, and make a new plan of how to proceed. Therapist makes a loose plan to map the clients progression through the program session by session. These plans will ensure assessments, psychoeducation and surveys are completed on time, and will be adapted to include methods for completing goals, such as history taking, individual, dual, and family therapy formats with different configurations of relevant members of the client group. These plans are purposely loose to allow therapeutically significant emergent issues/topics to arise in session. The relational therapeutic method of this program acknowledges that resolving emerging issues for clients can have a significant impact on adolescent use of violence even if they don't initially seem related.	
	Program development and review (ongoing)	Continual review of effectiveness of program processes, forms, and therapeutic impact. This review is continued informally and formally in an ongoing way. This may involve collaboration with program stakeholders including in the policy and procedures team.	The therapist is required to review the program in the context of the therapeutic effectiveness of interventions, including ethics in program processes. The therapist must incorporate these perspectives into any changes made to existing documents, processes and therapeutic approaches, and present these therapeutic perspectives to other stakeholders who become involved in program reviews and development.

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Program monitoring (ongoing)	Supplementary to program development and review, there are formal processes set in place in the timeline of the program. These are the Steering committee meetings, and the reports to the Lord Mayors Charitable Foundation (the philanthropic funder of the program).	The therapist must present therapeutic perspectives to other stakeholders who become involved in program reviews and development, ensuring the best interests of the client are kept forefront of mind. The therapist must also meet the requirements and respond to the interests of the stakeholders involved in program funding, development and review.
	Therapist supervision (ongoing)	Therapist undergoes regular supervision with the program manager. This includes general supervision in the role, and clinical supervision specifically oriented to therapeutic work with the current client cohort. Clinical supervision can consist of: scope of therapeutic engagement, therapeutic prioritising, specific client issues and methods of responding; ethical concerns and conflicts of interest; personal emotional processing/debriefing;	Technical therapeutic insight are applied in this setting, relevant to the entire range of issues addressed in therapy within the scope of the program.
	Clinical family consult (ongoing)	Therapist engages in regular (monthly) family therapy supervision to support best practice therapy with the client cohort. This serves to upskill the therapist, and supportively provide new perspectives.	Technical therapeutic insight are applied in this setting, relevant to the entire range of issues addressed in family therapy.
	Internal / external consults and stakeholder engagements for emerging requests (ongoing)	The therapist will occasionally respond to one-off requests to provide specialist adolescent family violence practice perspectives in a consultative setting regarding a specific client / client group. This may be conducted for an individual case manager or other professional, or to a team of professionals such as a residential care team. In these cases the Consult Survey will be employed to be completed by participants before and after the consult is provided. These consultations may progress into referrals. The therapist may also engage in industry workshops, meetings, think-tanks and consultative spaces, with organisations such as RCH, CFECFW, WIFVC & Brimbank Melton Child & Family Services Alliance	Technical therapeutic knowledge of child development, impacts of trauma, power dynamics, parenting strategies, adolescent family violence and its currently identified causal factors, individual therapeutic responses and systemic responses are applied in these contexts.

		Application of therapeutic response *(Description)*	Application of therapeutic skills *(Description)*
	Secondary consultations with previous case managers, counsellors, psychiatrists (ongoing)	The therapist will consult with previously involved stakeholders in the clients service journey to further understand the circumstances and personal experiences and traits that are relevant to the adolescent's use of violence and potential therapeutic interventions.	

4 Participant information and consent form

Participant Information And Consent Form

Mackillop Staff

Title	Evaluation of Safe Relationships Program Project
Principal Investigator/Senior Supervisor	Ceridwen Spark
Associate Investigator(s)/Associate Supervisor(s)	Lauren Siegmann and Shani Rajendra

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What does my participation involve?

You are being invited to take part in this research because of your work with the Safe Relationships program and in your capacity as a staff member at Mackillop Family Services. The research is an evaluation and we are seeking to interview you in order to gain insight into your perspectives and experiences of the Safe Relationships Program.

1 Introduction

You are invited to take part in this research project, which is called Evaluation of Safe Relationships Program. You have been invited because you have experience with running or managing the program. Your contact details were obtained through our work with Mackillop Family Services.

This Participant Information and Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether to take part, you might want to talk about it with a relative or friend.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The Evaluation of the Safe Relationships Pilot Program will a provide a review of the process to establish this new and innovative program at MacKillop Family Services (MFS).

This evaluation will promote learning that enables MFS to adapt and improve the program for future implementation. It will also be used to

- Establish a monitoring and evaluation system and tools to be used in a future outcomes evaluation of the program.

• Support the potential upscale of the project.

• Develop a model to guide and assess program implementation across MacKillop.

Where the research project is funded by a grant:

This research has been funded by a Learning Systems Grant.

Where the research is being coordinated outside the institution:

This research is being conducted by Associate Professor Ceridwen Spark (RMIT University), Lauren Siegmann and Shani Rajendra (Clear Horizons Consulting)

3 What does participation in this research involve?

You will be asked to participate in an interview which explores your perceptions and experiences of the Safe Relationships Program. The interview is expected to last between 30-45 minutes and be audio recorded. You will be interviewed online (using Microsoft Teams) or in person, whichever is more convenient for you.

There are no reimbursements for participating.

4 Other relevant information about the research project

We anticipate that 4-5 staff members will take part in the project. There may also be additional interviews with young people and their carers. The project represents a research collaboration between Mackillop Family Services, RMIT University and Clear Horizons.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with the researchers or with RMIT University.

Interview

You may stop the interview at any time. You may also refuse to answer any questions that you do not wish to answer during the interview.

6 What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, you may appreciate contributing to knowledge. The aim of the evaluation is to provide Mackillop with information that will assist them to improve the Safe Relationships Program.

7 What are the risks and disadvantages of taking part?

We do not anticipate any risks with taking part in this interview.

Psychological distress

You may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately. If you become upset or distressed because of your participation in the research project, members of the research team will be able to discuss appropriate support for you.

8 What if I withdraw from this research project?

Provide information regarding how participants withdraw and implications for them if they do so.

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team.

Where appropriate, explain that if a participant withdraws part-way through a research project that data collected to that point may not be able to be deleted.

You have the right to have any unprocessed data withdrawn and destroyed, providing it can be reliably identified.

How is the research project being conducted?

10 What will happen to information about me?

Information should be provided regarding the following:

- The data collected will be individually identifiable as there are only a small number of staff involved in the program
- The information you provide in the interview will be recorded for analysis that will contribute to the evaluation. You are being asked to provide consent for the use of the data for this project only.
- The data will be kept on password protected computers and only the named researchers will have access to it
- The data will be stored for five years

By signing the consent form, you consent to the research team collecting and using information from you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. The identifiable data will only be accessible to the researchers who will have electronic access to it.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

Any information that you provide can be disclosed only if (1) it is protect you or others from harm, (2) if specifically allowed by law, (3) you provide the researchers with written permission. Any information obtained for the purpose of this research project and for the future research described that can identify you will be treated as confidential and securely stored.

11 Who is organising and funding the research?

Organising and funding research

This research project is being conducted by RMIT University and Clear Horizons and is funded by a Learning Systems Grant.

12 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). This research project has been approved by the RMIT University HREC.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

13 Further information and who to contact

If you want any further information concerning this project, you can contact the researcher, Ceridwen.Spark@rmit.edu.au

14 Complaints

Should you have any concerns or questions about this research project, which you do not wish to discuss with the researchers listed in this document, then you may contact:

Reviewing HREC name	RMIT University

HREC Secretary	Vivienne Moyle
Telephone	03 9925 5037
Email	humanethics@rmit.edu.au
Mailing address	Manager, Research Governance and Ethics RMIT University GPO Box 2476 MELBOURNE VIC 3001

Consent Form

Title	Evaluation of Safe Relationships Program
Principal Investigator/Senior Supervisor	Associate Professor Ceridwen Spark
Associate Investigator(s)/Associate Supervisors Research Student(s)	Lauren Siegmann and Shani Rajendra Associate Investigator(s)

Acknowledgement by Participant

I have read and understood the Participant Information Sheet.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my relationship with RMIT.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____

Signature _____ Date _____

Declaration by Researcher*

I have given a verbal explanation of the research project; its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher* (please print) _____

Signature _____ Date _____

* An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

5 Interview guides

Staff interview guide

This interview will be comprised of two parts:

- We would like to hear a story about a time you think that the program has been particularly successful.

- We have some standard interview questions.

Part one: sharing a story

We are wanting you to tell us a story about a time that program has been particularly effective in its activities with young people.

The story has a beginning, a middle, and an end. The beginning of the story describes what things were like before, the middle describes the actions that the program took, and the end describes what changes have happened.

To help give you some prompts for your story, we have included a story template below.

- You don't have to follow the story template, if you already have a great story, feel free to share it with us in any way you like
- You don't have to tell us the story in the order of beginning, middle, and end, you can change the order you tell us the story in if that works better for you
- The dot points below are just a guide to prompt thinking, you don't have to respond to each dot point
- You can choose to write your story, or just tell us

STORY TEMPLATE

Beginning – what things were like before Prompts • The persons relationship with their family • What is happening at school • Any other issues impacting on them (health, work, relationships) • What other services they were involved with • What are the reasons why they were introduced to the service • What was your initial assessment of the situation
Middle – what the program did Prompts • What were your goals • How did you apply the psychotherapeutic model to your work and what was the impact of this on your relationship with the person • What other services the young person was connected to, how you connected the young person to services, and how you worked with other services • Did you work with people around the young person and what happened
End – what change happened

[Instruction to interviewer- please write out the changes as the person lists them]

- What changes did you observe for the young person (think about: changes in self-awareness, changes in attitudes, changes in behaviour)
- What changes did you observe in the young person's family?

CONTRIBUTION TO CHANGES

Now you have shared your story, we would like to understand more how you believe the program contributed to the changes that occurred

- The interviewer will read out all the changes that were listed in the story
- For each change that is read out, we would like to hear from you:
  a. What you believe the program did to create the change
  b. Any other factors external to the program that created the change

a. **Part two: interview questions**

INTRODUCTION

- Tell me a little about yourself, and your role, and the program

PRINCIPLES

Below we have listed out the key principles informing each program. For each principle, we would like to understand:

- How this principle is applied practically in the delivery of the program
- How the application of this principle contributes to outcomes

Program principles

- Relational and targeted care for adolescents **and** families (systemic and dynamic-based)
- Supporting the system (adolescent and families) to uphold accountability for violence use and uphold trauma lens
- Work in in a caring way for adolescents, their families, and their relationships
- Embed responsibility and accountability within the therapeutic response
- Understand and identify gendered patterns of violence

COLLABORATION WITH SERVICES AND ADVOCACY

- Could you describe the ways in which the program collaborates with other services to provide wrap around support to the young person.
- What does a good integrated service response look like?
  - What are the challenges in achieving an integrated service response and how do you work to overcome the challenges?
- What percentage of the your client group receives a 'good integrated response' from services?
- Do you have any recommendations as to how the facilitation of integrated responses could be strengthened?

PSYCHOTHERPEUTIC MODEL

Could you explain to us what the psychotherapeutic model looks like, how was it developed and what theories does it draw on

What does the application of the psychotherapeutic model look like practically

How does the use of the psychotherapeutic model contribute to positive outcomes for young people
What are the challenges in applying the model
What recommendations do you have for improvements in the ways the model is conceptualised and implemented?
HOLISTIC APPROACHES

Could you describe what a holistic approach looks like and how you implement it in your work?
How does the application of holistic approaches contribute to outcomes
What are the barriers to using holistic approaches in your work?
What recommendations do you have for how to strengthen the capacity of the program to implement holistic approaches?
OUTCOMES

Below, we have listed some of the expected outcomes for young people as a result of their engagement in the program. For each outcome, we are interested to hear your thoughts on the extent to which these outcomes are being achieved for young people.

Immediate outcome	**Amount of population who experiences this outcome (some/most/all/none)**	**What is the critical success factor contributing to this outcome.**
Adolescents and families feel heard, respected, cared for, and are supported		
Adolescents develop greater self-awareness and awareness of their use of violence and impact of violence		
Families have improved skills to manage safety in the home		
Adolescents and their families have increased connection to a range of relevant services that they need		
Intermediate outcome	**Amount of population who experiences this outcome (some/most/all/none)**	**What is the critical success factor contributing to this outcome.**
Family communication and cohesion is improving		
Adolescents and their families are getting the support they need across a range of issues		

Reduction in number and severity of violent incidents – either in the home and/or in dating situations		

Key informant interview guide

INTRODUCTION

- Tell me a little about yourself, and your role, and your relationship to the program

OUTCOMES

- What do you think have been the key achievements of the Safe Relationships program
- Do you have any recommendations for how the Safe Relationships program could be improved?
- Have you personally observed any young people or their carers experience significant change as a result of their involvement in the program?

1. Probe: ask to tell a story about these changes, and how Mackillop contributed to the changes

PRINCIPLES

Below we have listed out the key principles informing each program. For each principle, we would like to understand:

- Do you believe that the way that the Safe Relationships program works in line with these principles?
- How does working in line with these principles contribute to outcomes

Program principles

- Relational and targeted care for adolescents **and** families (systemic and dynamic-based)
- Supporting the system (adolescent and families) to uphold accountability for violence use and uphold trauma lens
- Work in in a caring way for adolescents, their families, and their relationships
- Embed responsibility and accountability within the therapeutic response
- Understand and identify gendered patterns of violence

COLLABORATION WITH SERVICES AND ADVOCACY

- In general, what does a good integrated or a collaborative service response look like?

1. What are the challenges in achieving an integrated or collaborative service response and how do you work to overcome the challenges?

2. Do you have any recommendations as to how the facilitation of integrated and collaborative responses could be strengthened?

- Could you describe the extent to which the Safe Relationships program collaborates with other services to provide wrap around support to the young person? Is it working as it should and what have been the challenges?

PSYCHOTHERPEUTIC MODEL

- The Safe Relationships program uses a psychotherapeutic model as part of its approach

- What is your understanding of what a psychotherapeutic model? What are the benefits and drawbacks of this approach?
- Do you have any comment on the effectiveness in the way that the Safe Relationships program uses the psychotherapeutic model in its work with young people?

HOLISTIC APPROACHES

- The Safe Relationships program also uses a holistic approach in its work with clients

- Could you describe what a holistic approach looks like? What are the enablers and barriers to the deliver of holistic approaches in your experience?

- DO you have any comment on the effectiveness of the way that the Safe Relationships team uses holistic approaches to engage in work with young people and families?

IMPROVEMENTS

- Do you have any feedback for the Mackillop team or recommendations for changes to the way they deliver the program?

Parents and caregivers interview guide

1. Tell me a little about yourself.
2. Can you tell us a little about the reason what you, your child and your family became involved in the program?
3. What do you think your child's experience of the program was like? What did they tell you about their experience of the program? Was there anything they liked or did not like?
4. What was your experience of the program? Was there anything you liked or did not like
5. When you look back on your time with the program, what do you think the most significant changes you experienced were, as a result of being part of this program?
    a. Interview: probe about reasons for the changes
6. When you look back on your time with the program, what do you think were the most significant changes that your child experienced, as a result of being part of the program?
    a. Interview: probe about reasons for changes
7. Is there anything else you would like to share with program staff?

6 Common assessment tool- results and analysis

DOMAIN 1: Record of Referrals	INTAKE		CLOSURE	
Commentary • Offending is occurring early – 57% of young people were 12 or under at time of first offence. • About one-quarter to one-fifth of the clients have had some kind of contact with the justice system • Misdemeanour and felonies are legal terms used in American legal system. There is not direct term used in the Victorian legal system. The survey should change legal language to reflect language used in Victorian legal system • The post question needs have a clearer boundary of time. We would want to know if there has been new contact with the justice system since the intervention started.				
1. Age at first offense:				
O Over 16	-		-	
O 16	-		-	
O 15	-		-	
O 13 to 14	6	43%	4	31%
O 12 and Under	8	57%	9	69%
	14		**13**	
2. Misdemeanour referrals:				
O None or one	10	71%	9	75%
O Two	1	7%	-	
O Three or four	3	21%	2	17%
O Five or more	-		1	8%
	14		**12**	
3. Felony referrals:				
O None	13	93%	11	85%
O One	1	7%	1	8%
O Two	-		1	8%
O Three or more	-		-	
	14		**13**	
4. Confinements in secure detention where youth was held for at least 48 hours:				
O None	11	79%	11	85%

O One	2	14%	1	8%
O Two	-		-	
O Three or more	1	7%	1	8%
	14		**13**	
5. Commitment orders where youth served at least one day confined under residential commitment:				
O None	11	79%	11	92%
O One or more	3	21%	1	8%
	14		**12**	
DOMAIN 2: Demographics				
Commentary • About three-quarters of clients were under 16 (74%) • About three-quarters of clients were male (80%)				
1. Youth's Gender:				
O Male	12	-80%	11	79%
O Female	3	-20%	3	21%
	- **15**		**14**	
2. Youth's Current Age:				
O Over 16	4	27%	3	21%
O 16	-		-	
O 15	1	7%	2	14%
O 13 to 14	5	33%	5	36%
O 12 and Under	5	33%	4	29%
	15		**14**	
DOMAIN 3: School				
Commentary • Small evidence of improvements in attendance and school behaviour. 47% of young people were enrolled full-time at the beginning of the intervention and 71% of students were enrolled full-time at the end of the intervention. 40% of young people did not believe that school was encouraging at the beginning of the intervention. 36% of young people believed that school is encouraging (and 43% of young people believed somewhat that school is encouraging). • Note use of American terms for education (e.g. GED is a term used in American education system • Questions about youth conduct in question two very broad, makes it difficult to interpret the result. Would be better to be more specific (e.g. young person has had detention, been suspended, been expelled, moved to another school).				

- Questions about school attendance could benefit from being more precise. It can be approximate, but it would be helpful to know if the student misses one, two, three, four days a week on average.
- The evaluation queries the merit or worth or asking a question about grades. There is no evidence in the literature that academic performance is linked to use of violence.
- Questions 5 and 6 appear too broad to be able to determine the findings. Terms like 'value in getting and education' and 'encouraging environment' appear to be broad. Might be better to simplify this question. Does the young person like school? Does the young person have a teacher/s that they like (this is question) 7.
- Question 8. Seems to show small shift from not wanting to participate in school activities to considering the possibility, which the evaluation team believes is the most likely outcome to be attained after a three-month intervention.
- Question 9 shows that staff believe the young person is more likely to remain engaged in school. It might be helpful to understand how the staff make this assessment.

1. Youth's current enrollment status, regardless of attendance:				
O Enrolled full-time	7	47%	10	71%
O Enrolled part-time	5	33%	2	14%
O Dropped out/Expelled	3	20%	2	14%
O Has Diploma/GED and NOT pursuing further education	-		-	
O Has Diploma and IS pursuing further education	-		-	
	15		**14**	
2. Youth's conduct in the most recent term: Fighting or threatening students; threatening teachers/staff; overly disruptive behavior; crimes (e.g., theft,vandalism); lying, cheating, dishonesty.				
O Youth not in school in current term	3	20%	2	14%
O No problems with school conduct	5	33%	7	50%
O Problems with school conduct	7	47%	5	36%
	15		**14**	
3. Youth's school attendance in the most recent term:				
O Youth not in school in current term	3	20%	2	14%
O No problems with school attendance	4	27%	6	43%
O Problems with school attendance	8	53%	6	43%
	15		**14**	
4. Youth's academic performance in the most recent school term:				
O Youth not in school in current term	3	38%	1	25%

O Mostly As, or mostly As and Bs	-		-	
O Mostly Bs and Cs, no Fs	3	38%	2	50%
O Some Ds and/or Fs, or worse	2	25%	1	25%
	8		**4**	
5. Youth believes there is value in getting an education:				
O Believes getting an education is of value	3	20%	2	14%
O Somewhat believes education is of value	9	60%	10	71%
O Does not believe education is of value	3	20%	2	14%
	15		**14**	
6. Youth believes school provides an encouraging environment for him or her:				
O Believes school is encouraging	-		5	36%
O Somewhat believes school is encouraging	9	60%	6	43%
O Does not believe school is encouraging	6	40%	3	21%
	15		**14**	
7. Teachers, staff, or coaches the youth likes or feels comfortable talking with:				
O Not close to any teachers, staff or coaches	7	47%	2	50%
O Close to 1 or 2	8	53%	2	50%
O Close to 3 or more	-		-	
	15		**4**	
8. Youth's involvement in school activities during most recent term:				
O Involved in 2 or more activities	-		-	
O Involved in 1 activity	-		-	
O Interested but not involved in any activities	-		1	7%
O Not interested in school activities	15		13	93%
	15		14	
9. Interviewer's assessment of likelihood the youth will stay in and graduate from high school:				
O Very likely to stay in school and graduate	3	20%	5	36%

O Uncertain if youth will stay and graduate	7	47%	6	43%
O Not very likely to stay and graduate	5	33%	3	21%
	15		14	
DOMAIN 4: Use of Free Time				
Commentary • Question 1 shows a small shift from non-interest in structured activities to interest in or participation in structured activities. • Question 3 is very broad and difficult to interpret (what constitutes a pro-social hobby? This construct would benefit from a clear and precise description)				
1. Current interest and involvement in structured recreational activities:				
O Currently involved in 2 or more structured activities	-		1	7%
O Currently involved in 1 structured activity	-		-	
O Currently interested but not involved	1	7%	3	21%
O Currently not interested in any structured activities	14	93%	10	71%
	15		**14**	
2. Types of structured recreational activities in which youth currently participates: (Check all that apply)				
¨ None	14	93%	12	86%
¨ Community/cultural group	-		-	
¨ Hobby, group or club	1	7%	1	7%
¨ Athletics	-		1	7%
¨ Religious group/church	-		-	
¨ Volunteer organization	-		-	
	15		**14**	
3. Current active involvement in pro-social unstructured hobbies:				
O Currently involved in 2 or more pro-social hobbies	-		1	7%
O Currently involved in 1 pro-social hobby	1	7%	1	7%
O Not interested or involved in any pro-social hobbies	14	93%	12	86%
	15		**14**	
DOMAIN 5: Employment				
Commentary				

- Query need for inclusion of employment questions, given employment is not identified as a correlated factor associated with use of Adolescent Family Violence and the age of the cohort.
- Question 2 is broad and difficult to interpret. What does understanding what it takes look like? This question would benefit from a more precise and clear description of what is being measured.
- There appears to be an increase in understanding 'what it takes' to be in a job. Would be interesting to understand how the practitioners assessed this, would recommend a review of the wording of the question.

1. Youth's employment history: (Check all that apply)				
¨ Too young for employment consideration	11	73%	9	64%
¨ Never been employed	4	27%	4	29%
¨ Has been successfully employed	-		1	7%
¨ Has been fired or quit due to problems	-		-	
	15		**14**	
2. Youth understands what is required to maintain a job:				
O Lacks knowledge of what it takes	13	87%	8	57%
O Has knowledge of what it takes	2	13%	6	43%
O Has demonstrated ability to maintain a job	-		-	
	15		**14**	
3. Youth's employment status:				
O Too young for employment consideration	11	73%	9	64%
O Not employed and not interested in employment	2	13%	3	21%
O No employed but interested in employment	2	13%	2	14%
O Employment is currently going well	-		-	
O Having problems with current employment	-		-	
	15		**14**	
4. Current positive personal relationship(s) with employer(s) or adult coworker(s):				
O Not currently employed	15	100%	14	100%
O Employed but no positive relationships	-		-	
O At least 1 positive relationship	-		-	
	15		**14**	
DOMAIN 6: Relationships				

Commentary

- The terms pro-social and anti-social and positive relationship would benefit from a more precise definition.

- Query about if the program is likely to have an impact on relationships domains outside the family.

1. History of anti-social friends/companions: (Check all that apply)				
¨ Never had consistent friends or companions	6	21%	5	17%
¨ Had pro-social friends	11	38%	12	40%
¨ Had anti-social friends	9	31%	11	37%
¨ Been a gang member/associate	3	10%	2	7%
	29		**30**	
2. Current friends/ companions youth actually spends time with: (Check all that apply)				
¨ No consistent friends or companions	6	25%	4	20%
¨ Pro-social friends	9	38%	11	55%
¨ Anti-social friends	9	38%	4	20%
¨ Gang member/associate	-		1	5%
	24		**20**	
3. Current positive adult non-family relationships not connected to school or employment:				
O No positive adult relationships	3	20%	1	7%
O 1 or 2 positive adult relationship	11	73%	7	50%
O 3 or more positive adult relationships	1	7%	6	43%
	15		**14**	
4. Current pro-social community ties:				
O No pro-social community ties	4	27%	3	21%
O Some pro-social community ties	11	73%	10	71%
O Has strong pro-social community ties	-		1	7%
	15		**14**	
5. Currently in a “romantic”, intimate, or sexual relationship:				
O Not romantically involved with anyone	10	67%	10	71%
O Romantically involved with a pro-social person	3	20%	2	14%
O Romantically involved with an anti-social person	2	13%	2	14%

	15		**14**	
6. Currently admires/imitates anti-social peers:				
O Does not associate with anti-social peers	4	27%	6	40%
O Does not admire, imitate anti-social peers	5	33%	5	33%
O Admires, emulates anti-social peers	6	40%	4	27%
	15		**15**	
7. Current resistance to anti-social peer influence:				
O Does not associate with anti-social peers	5	33%	6	43%
O Usually resists going along with anti-social peers	6	40%	4	29%
O Rarely resists or leads anti-social peers	4	27%	4	29%
	15		**14**	
DOMAIN 7: Family				

Commentary

Nearly half of young people involved in the program have history of running away or being kicked out of home.

Nearly all young people (93%) have had some kind of disruption in their parenting.

20% of families had household member in custody, likely to be quite high when compared to the general population

About half of young people (46%) had history in out of home placement

Parents/guardians most likely to have a history of mental health issues, 23% of parents guardians have a history of problematic alcohol use, 15% have a history of problematic drug use, 15% have a history or poor physical health, 12% have a history of problems with employment. Without knowing what rates for the general population are, it is difficult to interpret this data.

Survey questions indicate that parents are more effective at discipline:

- 33% of parents at beginning of intervention and 71% of parents at end of intervention were consistently applying appropriate punishment
- 40% of parents at beginning of intervention and 71% of parents at end of intervention were consistently providing appropriate rewards for good behaviour

Questions that ask about history need to reword the post-intervention question, to provide a clearer reference to time-frame (e.g. has not run away or been kicked out since the program began)

Question 1: Running away and being kicked out have two very different implications (one the child chooses to leave, second the parent forces the child to leave) so should be separated

Question 2: losing a parent to separation, abandonment and death all have very different implications and should be separated. Also need to specify in survey question if this took place during the time of the intervention

Question 3 about the jail time of family members requires further detail. Which parent or family member was in jail, was the criminal matter related to family violence. Did any further incarceration take place during the time of the intervention?

Question 4 and 5 about issues with parents and sibling needs to be disaggregated by type of parent and sibling, if the parent is main caregiver or if the parent or sibling are living in the house. Question at the end needs to be clear about timeframe (e.g. further or new issues identified during intervention period)

Questions 7, 8, 10, 12, 13, 14, 15, 16 would all benefit from improved clarification about the constructs being measured. What is the practitioner observing when they are assessing these questions?

1. History of running away or getting kicked out of home: Include times the youth did not voluntarily return within 24 hours, and include incidents not reported by or to law enforcement.				
O No history of running away/being kicked out	8	53%	8	57%
O 1 instance of running away/being kicked out	-		-	
O 2 to 3 instances of running away/kicked out	2	13%	2	14%
O 4 or more instances of running away/kicked out	5	33%	4	29%
	15		**14**	
2. Youth lost a biological parent to separation, divorce, abandonment, or death:				
O No	1	7%	1	7%
O Yes	14	93%	13	93%
	15		**14**	
3. History of jail/imprisonment of persons who were ever involved in the household for at least 3 months:				
O No jail/imprisonment history in family	12	80%	11	79%
O Jail/imprisonment history in family	3	20%	3	21%
	15		**14**	
4. History of jail/imprisonment of persons who are currently involved with the household:				
O No jail/imprisonment currently in family	14	93%	13	93%
O Jail/imprisonment currently in family	1	7%	1	7%
	15		**14**	

5. Problem history of parents/guardians who are currently involved with the household: (Check all that apply)				
¨ No problem history of parents in household	1	4%	2	8%
¨ Parental alcohol problem history	6	23%	5	20%
¨ Parental drug problem history	4	15%	4	16%
¨ Parental physical health problem history	4	15%	4	16%
¨ Parental mental health problem history	8	31%	7	28%
¨ Parental employment problem history	3	12%	3	12%
	26		**25**	
6. Problem history of siblings who are currently involved with the household: (Check all that apply)				
¨ No siblings currently in household	8	44%	8	50%
¨ No problem history of siblings in household	3	17%	2	13%
¨ Sibling alcohol problem history	1	6%	1	6%
¨ Sibling drug problem history	1	6%	1	6%
¨ Sibling physical health problem history	1	6%	1	6%
¨ Sibling mental health problem history	4	22%	3	19%
¨ Sibling employment problem history	-		-	
	18		**16**	
7. Family willingness to help support youth:				
O Consistently willing to support youth	7	47%	7	50%
O Inconsistently willing to support youth	4	27%	6	43%
O Little or no willingness to support youth	3	20%	1	7%
O Hostile, berating, and/or belittling of youth	1	7%	-	
	15		**14**	
8. Family member(s) youth feels close to or has good relationship with: (Check all that apply)				
¨ Does not feel close to any family member	6	27%	3	12%
¨ Feels close to mother/female caretaker	8	36%	10	38%
¨ Feels close to father/male caretaker	4	18%	5	19%

¨ Feels close to male sibling	1	5%	1	4%
¨ Feels close to female sibling	2	9%	2	8%
¨ Feels close to extended family	1	5%	5	19%
	22		**26**	
9. Level of conflict between parents, between youth and parents, among siblings:				
O Some conflict that is well managed	-		7	39%
O Verbal intimidation, yelling, heated arguments	10	45%	6	33%
O Threats of physical abuse	7	32%	3	17%
O Domestic violence: physical/ sexual abuse	5	23%	2	11%
	22		**18**	
10. Current parental authority and control:				
O Youth usually obeys and follows rules	-		4	29%
O Sometimes obeys or obeys some rules	8	53%	8	57%
O Consistently disobeys, and/or is hostile	7	47%	2	14%
	15		**14**	
11. History of out-of-home DCF placements:				
O No	8	53%	7	50%
O Yes	7	47%	7	50%
	15		**14**	
12. Support network for family:				
O No support network	2		-	
O Some support network	10		11	
O Strong support network	3		3	
	15		**14**	
13. Parental supervision:				
O Consistent good supervision	8	53%	9	64%
O Sporadic supervision	3	20%	5	36%
O Inadequate supervision	4	27%	-	
	15		**14**	
14. Consistent appropriate punishment for bad behavior:				

O Consistently appropriate punishment	5	33%	10	71%
O Consistently overly severe punishment	-		1	7%
O Consistently insufficient punishment	5	33%	1	7%
O Inconsistent or erratic punishment	5	33%	2	14%
	15		**14**	
15. Consistent appropriate rewards for good behavior:				
O Consistently appropriate rewards	6	40%	10	71%
O Consistently overly indulgent/overly protective	3	20%	1	7%
O Consistently insufficient rewards	1	7%	2	14%
O Inconsistent or erratic rewards	5	33%	1	7%
	15		**14**	
16. Parental characterization of youth's anti-social behavior:				
O Disapproves of youth's anti-social behavior	15	100%	13	100%
O Minimizes, denies, justifies, excuses behavior, or blames others/circumstances	-		-	
O Accepts youth's anti-social behavior as okay	-		-	
O Proud of youth's anti-social behavior	-		-	
	15		**13**	
DOMAIN 8: Alcohol and Drugs				

Commentary:

19% of young people had a history of alcohol use at the beginning of the intervention. 13% of young people were currently using drugs, and this was impacting on their life. 7% had been referred for assessment of drug and alcohol matters but never assessed. No young person using alcohol or drugs was receiving treatment for their use.

Questions that ask about the history of use need to have a post question that specifies if new use has occurred during the time of intervention. Asking a pre and post question about the history of use can only increase between pre and post question. Asking a question about no history of use can only decrease over the time of the intervention.

1. Alcohol use:				
O No history of alcohol use	11	69%	12	80%
O History of alcohol use	3	19%	1	7%
O Currently using alcohol	1	6%	1	7%

O Alcohol is negatively impacting the youth's life	1	6%	1	7%
	16		**15**	
2. Drug use:				
O No history of drug use	11	69%	11	73%
O History of drug use	-		-	
O Currently using drugs	1	6%	2	13%
O Drugs are negatively impacting the youth's life	4	25%	2	13%
	16		**15**	
3. History of assessment/ diagnosis:				
O Never referred for drug/alcohol assessment	14	93%	11	79%
O Referred but never assessed	1	7%	3	21%
O Diagnosed as no problem	-		-	
O Diagnosed as abuse	-		-	
O Diagnosed as dependent/addicted	-		-	
	15		**14**	
4. Current participation in treatment:				
O Alcohol/drug treatment not warranted	11	73%	11	79%
O Not currently attending needed treatment program	4	27%	3	21%
O Currently attending treatment program	-		-	
O Successfully completed treatment program and no longer needing treatment	-		-	
	15		**14**	
DOMAIN 9: Trauma and Mental Health				
Commentary: • 14% of young people had never experienced violence of physical abuse • 8% of young people have never witnessed violence • 12% of people have experienced sexual assault • 60% of young people have a history of neglect • 27% of history of depression and anxiety • 33% of young people have some kind of mental health issue • 37% of young people had had serious throughs of suicide (reduced to 21% at the end of the intervention)				
1. History of violence/physical abuse: (Check all that apply)				
¨ Not a victim of violence/physical abuse	4	14%	5	19%

¨ Victim of violence/physical abuse at home	9	31%	8	31%
¨ Victim of violence/physical abuse in a foster/group home	3	10%	2	8%
¨ Victimized by family member	7	24%	7	27%
¨ Victimized by someone outside the family	4	14%	2	8%
¨ Attacked with a weapon	2	7%	2	8%
	29		**26**	
2. History of witnessing violence: (Check all that apply)				
¨ Has not witnessed violence	2	8%	2	8%
¨ Has witnessed violence at home	12	48%	11	46%
¨ Has witnessed violence in a foster/group home	5	20%	5	21%
¨ Has witnessed violence in the community	5	20%	5	21%
¨ Family member killed as a result of violence	1	4%	1	4%
	25		**24**	
3. History of sexual abuse/rape: (Check all that apply)				
¨ Not a victim of sexual abuse/rape	14	88%	13	87%
¨ Sexually abused/raped by family member	1	6%	1	7%
¨ Sexually abused/raped by someone outside the family	1	6%	1	7%
	16		**15**	
4. History of being a victim of neglect:				
O Not a victim of neglect	6	40%	6	43%
O Victim of neglect	9	60%	8	57%
	15		**14**	
5. History of anger or irritability:				
O No history of anger/irritability	-		-	
O History of anger/irritability	15	100%	14	100%
	15		**14**	
6. History of depression/anxiety:				
O No history of depression/anxiety	11	73%	10	71%
O History of depression/anxiety	4	27%	4	29%
	15		**14**	

7. Current mental health problem status:				
O No current mental health problem	10	67%	8	57%
O Complying with mental health treatment	1	7%	3	21%
O Not complying with recommended treatment	4	27%	3	21%
	15		**14**	
8. Current suicidal ideation: (Check all that apply)				
¨ Has never had serious thoughts about suicide	7	37%	8	57%
¨ Has had serious thoughts about suicide	7	37%	3	21%
¨ Has made a plan to commit suicide. If yes, describe _____	1	5%	-	
¨ Has attempted to commit suicide. If yes, describe attempts and dates_____	1	5%	-	
¨ Feels life is not worth living - no hope for future	3	16%	3	21%
¨ Knows someone well who has committed suicide. If yes, who, when, and how _____	-		-	
¨ Engages in self-mutilating behavior _____	-		-	
	19		**14**	
DOMAIN 10: Attitudes and Behaviours				

Commentary

Changes in self-control

- 33% were identified as having some self-control at the beginning of the intervention and 79% were identified as having some self-control at the end of the intervention
- 40% were identified as being impulsive at the beginning of the intervention and 14% were assessed as being impulsive at the end of the intervention
- 27% were identified as being highly impulsive at the beginning of the intervention and 7% were identified as being highly impulsive at the end of the intervention

Changes in respect for authority figures

- 47% had respect for authority figures at the beginning of the intervention and 71% has respect for authority figures at the end of the intervention

For young people under court supervision

- 100% of young people under court supervision were unsure if they would be successful at the beginning of the intervention, and 67% of young people under court supervision believed they would be successful at the end of the intervention

Questions about attitudes difficult to interpret, the survey would benefit from increased understanding of how the practitioners who complete the survey make the assessment, what are they observing to assist them in making the assessment.				
1. Attitude toward responsible law-abiding behaviour:				
O Abides by conventions/values	10	67%	10	71%
O Does not abide conventions/values	5	33%	4	29%
	15		**14**	
2. Accepts responsibility for anti-social behaviour:				
O Accepts responsibility for anti-social behaviour	7	47%	12	86%
O Does not accept responsibility of anti-social behaviours	8	53%	2	14%
	15		**14**	
3. Optimism:				
O High aspirations: sense of purpose, commitment to better life	-		1	7%
O Normal aspirations: some sense of purpose	3	20%	10	71%
O Low aspirations: little sense of purpose or plans for better life	11	73%	3	21%
O Believes nothing matters	1		-	
	15		**14**	
4. Impulsivity:				
O Uses self-control; usually thinks before acting	-		-	
O Some self-control; sometimes thinks before acting	5	33%	11	79%
O Impulsive; often acts before thinking	6	40%	2	14%
O Highly Impulsive; usually acts before thinking	4	27%	1	7%
	15		**14**	
5. Empathy:				
O Has empathy for others	3	20%	5	36%
O Has some empathy for others	12	80%	9	64%
O Does not have empathy for others	-		-	
	15		14	
6. Respect for property of others:				
O Usually or always respects property of others	9	60%	10	71%
O Sometimes respects property of others	6	40%	4	29%

O No respect for property	-		-	
	15		**14**	
7. Respect for authority figures:				
O Respects most authority figures	7	47%	10	71%
O Does not respect or resents authority figures	7	47%	3	21%
O Defies or is hostile toward most authority figures	1	7%	1	7%
	15		**14**	
8. Youth's belief in successfully meeting conditions of court supervision:				
O Believes he or she will be successful	-		2	67%
O Unsure if he or she will be successful	4	100%	1	33%
O Does not believe he or she will be successful	-		-	
	4		**3**	
DOMAIN 11: Aggression				

Commentary:

- 33% of young people believed that physical aggression is never appropriate and 64% of young people believed that physical aggression is never appropriate at the end of the intervention
- 20% of young people believed that verbal aggression is rarely appropriate at the beginning of the intervention and 71% believed that verbal aggression is rarely appropriate at the end of the intervention
- No young people were assessed as rarely get upset over small things or have temper tantrums at the beginning of the intervention and 36% of young people were assessed as rarely getting upset over small things or having temper tantrums at the end of the intervention. 40% of young people were assessed as often getting upset or having temper tantrums at the beginning of the intervention and 7% were assessed as often getting upset over small things or having temper tantrums at the end of the intervention.

Similar to earlier questions, some of the questions would benefit from improved understanding and description of the construct and what the practitioner observes when assessing against the construct.

1. Belief in fighting and physical aggression to resolve a disagreement or conflict:				
O Believes physical aggression is never appropriate	5	33%	9	64%
O Believes physical aggression is sometimes appropriate	10	67%	5	36%
	15		**14**	
2. Belief in yelling and verbal aggression to resolve a disagreement or conflict:				
O Believes verbal aggression is rarely appropriate	3	20%	10	71%

O Believes verbal aggression is sometimes appropriate	12	80%	4	29%
	15		**14**	
3. Tolerance for frustration:				
O Rarely gets upset over small things or has temper tantrums	-		5	36%
O Sometimes gets upset over small things or has temper tantrums	9	60%	8	57%
O Often gets upset over small things or has temper tantrums	6	40%	1	7%
	15		**14**	
4. Aggressive behavior being exhibited by youth: (Check all that apply)				
¨ No reports/evidence of aggression	1	2%	4	19%
¨ Violent outbursts, displays of temper, uncontrolled anger indicating potential for harm	14	34%	10	48%
¨ Deliberately inflicting physical pain	6	15%	2	10%
¨ Using/threatening with a weapon	5	12%	1	5%
¨ Fire starting	2	5%	1	5%
¨ Violent destruction of property	12	29%	2	10%
¨ Animal cruelty	1	2%	1	5%
	41		**21**	
5. Problems with sexually aggressive behaviours: (Check all that apply)				
¨ No reports/evidence of sexual aggression	15	94%	14	100%
¨ Aggressive sex	-		-	
¨ Sex for power	-		-	
¨ Young sex partners	1	6%	-	
¨ Child sex	-		-	
¨ Voyeurism	-		-	
¨ Exposure	-		-	
	16		**14**	
DOMAIN 12: Skills				
Commentary				

- 40% of young people were assessed as not understanding consequences to actions at the beginning of the intervention and 7% were assessed as not understanding consequences to actions at the end of the intervention. 13% of young people were assessed as demonstrating good consequential thinking at the beginning of the intervention and 50% were assessed as demonstrating good consequential thinking at the end of the intervention.
- 73% of young people were assessed as not setting goals at the beginning of the intervention, and 7% were assessed as not setting goals at the end of the intervention. 20% of young people were assessed in setting unrealistic goals at the beginning of the intervention and 50% of young people were assessed as setting unrealistic goals at the end of the intervention.
- 40% of young people were assessed as not being able to identify problem behaviours at the beginning of the intervention and 7% were assessed as not being able to identify problem behaviours at the end of the intervention. No young people were assessed as being able to apply appropriate solutions to problem behaviours at the beginning of the intervention and 29% of young people were identified as being able to apply appropriate solutions for problem behaviours at the end of the intervention.
- 40% of young people were assessed as lacking social skills at the beginning of the intervention and 7% were assessed as lacking social skills at the end of the intervention. 7% were assessed as using advanced social skills at the end of the intervention.
- 64% of young people were assessed as lacing skills in dealing with feelings and emotions at the beginning of the assessment and 7% of young people were assessed as lacking skills in dealing with feelings and emotions at the end of the assessment.
- 33% of young people were assessed as being able to identify internal and/or external triggers at the beginning of the intervention and 100% of young people were assessed as being able to identify internal and/or external triggers at the end of the intervention.
- 73% of young people were assessed as not being able to control impulsive behaviour at the beginning of the intervention and 43% were assessed as using techniques for controlling impulsive behaviour at the end of the intervention.
- 33% of young people were assessed as lacking alternatives to aggression at the beginning of the intervention. 43% of young people were sometimes using 50% of young people were often using alternatives to aggression at the end of the intervention.

1. Consequential thinking:				
O Does not understand consequences to actions	6	40%	1	7%
O Understands and/or identifies there are consequences to actions	7	47%	6	43%
O Acts to obtain desired consequences—good consequential thinking	2	13%	7	50%
	15		**14**	
2. Goal setting:				
O Does not set goals	11	73%	1	7%
O Sets unrealistic or somewhat realistic goals	3	20%	7	50%
O Sets realistic goals	1	7%	6	43%
	15		**14**	
3. Problem-solving:				

O Cannot identify problem behaviors	6	40%	1	7%
O Identifies and/or thinks of solutions for problem behaviors	9	60%	9	64%
O Applies appropriate solutions to problem behaviors	-		4	29%
	15		**14**	
4. Dealing with others:				
O Lacks basic social skills in dealing with others	6	40%	1	7%
O Has basic social skills, lacks or sometimes uses advanced skills in dealing with others	9	60%	12	86%
O Often uses advanced social skills in dealing with others	-		1	7%
	15		**14**	
5. Dealing with difficult situations:				
O Lacks skills in dealing with difficult situations	7	47%	4	29%
O Sometimes uses skills in dealing with difficult situations	8	53%	9	64%
O Often uses skills in dealing with difficult situations	-		1	7%
	15		**14**	
6. Dealing with feelings/emotions:				
O Lacks skills in dealing with feelings/emotions	9	64%	1	7%
O Sometimes uses skills in dealing with feelings/emotions	5	36%	13	93%
O Often uses skills in dealing with feelings/emotions	-		-	
	14		**14**	
7. Monitoring of triggers:				
O Cannot identify internal and/or external triggers	10	67%	-	
O Identifies internal and/or external triggers	5	33%	14	100%
O Actively monitors internal and/or external triggers	-		-	
	15		**14**	
8. Control of impulsive behavior:				
O Impulsivity is not a major issue for the youth	4	27%	-	
O Youth is not able to control impulsive behavior	11	73%	8	57%
O Uses techniques to control impulsive behavior	-		6	43%
	15		**14**	
9. Control of aggression:				

O Aggression is not an issue for the youth	-		-	
O Lacks alternatives to aggression	5	33%	1	7%
O Sometimes uses alternatives to aggression	10	67%	6	43%
O Often uses alternatives to aggression	-		7	50%
	15		**14**	

7 Evidence table

Evidence
DHS article 2014 • Victorian Police Data since 2006 shows an annual increase of family violence incidents where the alleged perpetrator is aged less than 18 years old. 14% of incidents involved the use of direct physical violence against the caregiver. Younger siblings are involved in 66% of incidents. Criminal action takes place in 16% of incidents. (DHS 2014) • Parents need a specific service that is not adequately addressed by parenting programs. Young people need early intervention and family-centred approach. • A number of determinants of adolescent family violence. (e.g. existing violence in home, wellbeing of parents, lack of social supports) *S1s literature review (2020)* • Adolescence is a poorly understood developmental process. Key indicators are biological, cognitive, emotional, social. • Specialist AFV responses function in the context of community services organisations and youth justice systems. They are aimed at creating a safe home environment—Psychoeducation of the whole family. Uphold a restorative approach – adolescents have developmental needs that rely on families. *Adolescent Family Violence: Findings From a Group-Based Analysis 2021 Boxal and Sabol.* • Currently, understanding of family violence is fragmented. • Mothers are a high-risk cohort, Most likely to be afraid of the offender. • A larger proportion of males are likely to be apprehended by Victoria Police. Both genders are likely to be violent to their mother. Males are more likely to be violent to fathers. Don't always use physical violence. • Parents find it hard to access help-seeking. • Need to understand the relationship between family violence and adolescent use of violence • Need to understand the relationship between adolescent use of violence and other criminal offending • Need to understand the relationship between developmental process and use of violence • Need to understand why mother is most at risk *Stopping Adolescent Violence in the home: an outcome evaluation of Breaking the Cycle (Anglicare)* • It tends to begin with verbal abuse and can increase • Significant improvement in the quality of the parent-adolescent relationship may not be measurable until some time later parents start to understand the circumstances and implement changes *Safe Relationships Program Update 2020*

- It developed over two months and consisted of extensive research into AFV.
- Research suggests that a systemic, family-centric and collaborative framework is most effective. (Evaluator note: none of these terms is defined)

Royal Commission into Family Violence

- Adolescent violence against family members is less gendered than adult family violence, however, the majority of victims are women and the majority of those using violence are young men. Around 64% of those aged 17 years or younger towards their parent are male (compared to adult males – 77%).
- Lack of awareness of this particular type of family violence among the community, family violence prevention and support services, youth services, and the justice system are obstacles for victims who need support.
- Currently, there is no systemic response to the needs of those young people and their families.
- Trialling initiatives based on the step up program.
- 80% of victims were female parents.
- Sibling violence: Data shows that young people aged 10 to 19 years are the reported users of violence in just under 20 per cent of Victoria Police family violence incidents against victims aged 17 and younger.18 Due to the age patterns, the majority of these family members are likely to be siblings; however, it is noted that the data does not distinguish between sibling and other family member victims. For this group, the gender profile has also remained fairly consistent. Over the five years to June 2014, male other parties accounted for between 81 and 84 per cent of incidents.19 Children's Court data shows that in nine per cent (n=162) of family violence applications in 2013–14, the affected family member was a sibling of the respondent. This proportion has remained fairly steady over the last five years.20 It should be noted that this data is not confined to users of violence under the age of 18, as the Children's Court deals with a number of adult family violence perpetrators.21 From 2009–10 to 2013–14, males made up between 70 and 76 per cent of respondents in applications where both the affected family member and the respondent were aged 17 years and younger.22
- The literature indicates that severity of the violence depends on age and gender, with the severity of abuse by sons increasing incrementally between the ages of 10 and 17, whilst parental abuse by daughters increases between the ages of 10 and 13 years, and falls after that age.26 This suggests that whereas young women cease using family violence as they get older, young men are more likely to continue using violence.
- The Commission consistently heard that victims of adolescent family violence also experience parental guilt, finding it particularly difficult to articulate their experiences due to 'cultural expectations of unconditional parental love'.32 Adolescent violence was also described as a 'hidden and shameful' subject, resulting in parents not seeking support until at crisis point.33 There is also a lack of awareness amongst parents of the support services that are available to them.
- Research demonstrates the seriousness of sibling conflict, including aggression and violence, which has been linked 'to a wide range of negative youth outcomes'.47
- Professor Mark Feinberg, Research Professor at the Prevention Research Centre, Pennsylvania State University, claimed that sibling relationships have 'the highest levels of violence of any family relationship'.50 In their joint submission, the Centre for Behavioural Science and Forensicare noted that US studies have shown that sibling violence is a common form of family violence.

- Parent victims of a young person's violence 'consistently report that the emotional and psychological impacts have a more profound and long lasting impact than the physical violence itself, with the most significant effects relating to the shock, incredulity and disbelief that their own child is using violence against them'.58 The ongoing cyclical nature of the violence—violence, apology and forgiveness—is a feature of both adult and adolescent family violence.59 While fear and control is present in both adult intimate partner violence and adolescent violence in the home, parent victims tend to have greater control and freedom than victims of intimate partner violence; they are more easily able to maintain privacy and confidentiality and are likely to have greater economic and social resources than their child.60 The young person's legal status as a child affects how the justice system responds, with an appropriate focus on rehabilitation. However, 'the competing needs of family safety, protecting children and adults and rehabilitating young offenders mean that the criminal justice system struggles with how best to juggle these'.61 A further difference between adult and adolescent family violence is that most parents view reconciliation as the ideal outcome in adolescent violence situations, whereas this is less often the case for victims of intimate partner violence.
- There is no single cause of adolescent violence in the home; instead, as with other forms of family violence, it is the result of 'a range of multifaceted and interconnected dynamics'.63 Adolescent violence in the home can be exacerbated by factors such as mental illness, the use of drugs and alcohol, and acquired brain injuries.64 Local studies have shown that existing violence escalates with drug and or alcohol use, and that escalation is also associated with school refusal or being removed from school because of behavioural issues, particularly in the transition to secondary school.
- An interim evaluation of the Ballarat Adolescent Family Violence Program (Step Up), discussed below, shows the following proportion of co-occurring risk factors for the 39 adolescents participating in the program: 59 per had a history of experiencing family violence 46 per cent had experienced childhood trauma 49 per cent had behavioural or learning difficulties 28 per cent had mental health challenges 28 per cent had alcohol or other substance misuse 21 per cent had a disability (including acquired brain injury).
- The Commission heard that many young men who use violence in the home have an intellectual disability and their families have not received appropriate support to address issues associated with that disability.68 Other disabilities identified in the research as present where adolescent violence has been used include autism spectrum disorder, attention deficit hyperactive disorder and various mental health disabilities.69 Lack of support for parents of children with disabilities can have profound consequences. For example, a 2012 study found that parents may be forced to surrender care of their child after (usually a series of) violent incidents towards parents or siblings, which result in parents having to call the police:70
- The Commission was told that adolescents who use violence in the home are often victims (or have been victims) of family violence themselves.82 Experiencing family violence as a child is a strong predictor of adolescent male abusive behaviour.83 In its submission, Victoria Police stated that a high percentage of children who used violence against a parent in 2014 had previously been victims of family violence.84 The correlation between experiencing family violence during childhood and later perpetration of adolescent family violence means that the victims may experience violence at the hands of more than one person.
- The Commission was told that adolescents who use violence in the home are often victims (or have been victims) of family violence themselves.82 Experiencing family violence as a child is a strong predictor of adolescent male abusive behaviour.83 In its submission, Victoria Police stated that a high percentage of children who used violence against a parent in 2014 had previously been victims of family violence.84 The correlation between experiencing family violence during childhood and later perpetration of adolescent family violence means that the victims may experience violence at the hands of more than one person.
- The Commission was also told that the seriousness of sibling violence is not recognised. The Commission heard evidence from Professor Feinberg that parents often believe it is normal or expected for siblings to fight.104 Parents may not seek help for sibling abuse because of their

desire to preserve the family.105 The Commission also heard that if police are called they are sometimes reluctant to intervene in this type of violence because they view it as 'just a kid's fight'.

Fitz-Gibbon, K., Elliott, K. and Maher, J. (2018) Investigating Adolescent Family Violence in Victoria: Understanding Experiences and Practitioner Perspectives. Monash Gender and Family Violence Research Program, Faculty of Arts, Monash University.

- Adolescent family violence describes violence perpetrated by young people against family members, including parents, siblings, carers and other members of the family. Adolescents who use violence in the home engage in a range of different strategies to control, coerce and threaten family members that create harm. Our participants had experienced a combination of physical violence, property damage, verbal abuse, coercive and controlling behaviours, and financial abuse. In some cases, physical violence was used to achieve broader goals, such as to change the household rules, to avoid household tasks, to frighten and achieve control over members of the household, or to extract money from a parent. Verbal abuse and coercive behaviours were used in many incidents to establish power and control over a parent and/or sibling. For many affected parents the early stages of victimisation were fraught with concerns over what distinguishes 'normal' adolescent tantrums from behaviours that constitute abuse. While for some incidents of abuse were isolated and occurred infrequently, for other parents the violence became part of their everyday lives
- The findings of this project support previous research that concludes that adolescent males more commonly use violence in the home than their adolescent female counterparts, and mothers are more likely to be victimised than male adults within the home. This is not to overlook the experiences that were shared through our survey of males who had experienced adolescent family violence as victims and parents who had been victimised by their adolescent daughter but rather to highlight the importance of gendered understandings in this area. A number of service providers who participated in this research noted that the types of violence committed were influenced by gender, with girls more commonly using verbal violence and property damage as mechanisms for control, while male adolescents were more commonly reported using physical violence. This research found that adolescent family violence has long term health and wellbeing implications for those affected. Our report documents a range of impacts, including negative educational outcomes for the adolescent as well as affected siblings, affected parental work patterns, relationship breakdown including parental separation and family estrangement, health impacts for families that live in fear, social isolation, as well as the economic, physical and emotional impacts associated with experiencing violence. As one mother described to us, 'it impacts on every aspect of your life. I sleep with my handbag under my pillow'. In many cases for the 120 persons who responded to our survey, these impacts were not alleviated through any help-seeking behaviour in either therapeutic, service or criminal justice contexts. The detailed reflections of the 120 people experiencing family violence who participated in this research reveal the barriers that women experience when seeking help for adolescent family violence particularly as they work to maintain their care relationship with their child, experiences of shame and fear of stigma, and a reluctance to engage police as primary responders
- To date, in Victoria specifically and Australia more broadly, there are few tailored responses and programs to address adolescent family violence. This Report reiterates the finding by the Victorian Royal Commission into Family Violence that we need specialised service responses and programs for this unique form of family violence. Criminal justice system responses are typically viewed as inadequate and inappropriate given the acknowledged risks associated with criminalisation, the lack of specialised police training for responding to adolescents who use family violence and the unwillingness of parents victimised to support an intervention order being taken out against their child. For those families that did report contacting the police it was often framed as a 'last resort' decision, one made only when safety risks presented to other children in the home reached a critical level. Acknowledgement of the police as not the first port of call, but rather the very last, reaffirms the urgent need in Victoria for early intervention and support services for parents experiencing adolescent family violence. The complex needs of adolescents who use violence in the home and those caring for them require specialist service responses outside of the criminal justice system. At present, there are few Australian

programs that specifically address adolescent family violence. The dearth of targeted resources and specialist responses for adolescent family violence means that many parents are left on their own to manage and maintain their families' safety and security. There are no clear avenues for accessing effective support or responses, particularly in cases where the child using violence is under 12 years of age. This research identifies the critical role that schools and other education institutions can play in operating as an interface between families and services, and providing support for families experiencing adolescent family violence.

Key recommendations:

- • Establishing systematic and comprehensive data collection strategies on AFV in a range of service contexts to generate an evidence base which can support the development of new programs, and risk sensitive service responses
- • The development of integrated service responses for vulnerable children and young people, including a coordinated response to adolescent family violence in Victoria between various sites, programs and services, including schools
- • Sector-specific training be provided to professionals who are likely first responders in cases of adolescent family violence, including police, primary and secondary school teachers
- • Consideration be given to developing interim and short term respite for families experiencing adolescent family violence, including care options for adolescents who use family violence beyond child protection or residential care
- • Future research explores the different ways in which gender impacts assessments of criminality and how parents experience adolescent family violence to support the development of effective and targeted responses that address different gendered patterns and prevalence.

Guide to promising programs for adolescents using violence in the home Centre for Excellence in Child and Family Welfare. June 2021.

Outlines context for adolescent family violence:

Trauma

- Studies have repeatedly shown that children and adolescents using violence in the home are often themselves victims of family violence, trauma or child abuse (Moulds et al 2016).
- Childhood exposure to trauma can impair various cognitive and developmental trajectories including attachment, behaviour regulation, affect regulation and maturation (van der Kolk, 2003), the effects of which can manifest in hypervigilance, excessive aggression, poor emotional control and increasing the risk of developing substance abuse (Campo, 2015).
- The impact of trauma can significantly interfere with the child-parent bond and how the child forms other interpersonal relationships in future. Where young people have been victims of abuse or neglect in their home, anger, blame and resentment can result in violence towards parents or carers (Coogan, 2017).
- In adolescents, violence in the home has also been seen to escalate where substance abuse is present, with a downward spiral of worsening mental health, lack of impulse control and conflict over money often triggering more frequent outbursts of physical anger and aggression and selfish and controlling behaviour (Coogan, 2017). This context of trauma is complex and highlights the need for interventions to be supported by trauma-informed processes that seek to repair ruptured relationships.

Victim survivor of family violence

- Previous experiences of family violence have consistently been related to adolescent use of violence in the home (Simmons et al., 2018). Various studies have highlighted that witnessing intimate partner violence between parents and caregivers can increase risk of a child externalising behaviours including oppositional defiance, aggression, and impulsivity (Early Intervention Foundation, 2014).
- Social cognitive theory highlights the importance of the role played by the social environment on an individual's learning, motivation and self-regulation (Schunk and DiBenedetto 2020).
- Based on Bandura's (1973) Theory of Social Learning, for observational or vicarious learning to occur, 'individuals must attend to a model, cognitively retain what the model did, be able to produce the modelled behaviour, and be motivated to do so' (Schunk and DiBenedetto 2020, p.1). Social cognitive theory suggests that children will learn to imitate the ways in which caregivers resolve conflict, and therefore be more accepting of using violence as a solution. The young person might legitimate the power and control techniques that have been modelled to them through attitudes and behaviours they have observed. Data from Victoria Police indicates that adolescents using violence in the home are usually male and that the person harmed by their violence is usually female and often a single caregiver (Elliot et al., 2017).
- Despite these findings, it is evident that the issue of adolescent violence in the home does not fit squarely within the established gendered conceptualisation of adult intimate partner violence (Selwyn & Meakings 2015). The direct relationship between adolescent violence in the home and gender remains inconclusive; studies from Spain indicate that where young people have been exposed to family violence, young males are more likely than young females to use family violence, whereas where family violence has not been experienced, there is 'gender symmetry' among young people using violence (Simmons et al., 2018).
- The reasons for a young person's use of family violence should not be automatically dismissed as being like adult men's use of family violence. To do so would be to overlook other confounding factors and over-simplify what is an inherently complex issue.
- Programs catering primarily to this context of violence seem more likely to employ program models based on the Duluth Model, restorative justice approaches, and motivational interviewing techniques.

Disability & Developmental Delay

- Disability and developmental delay, sometimes referred to as neurodisability, include a range of disorders such as intellectual disability (ID), learning disabilities (e.g., dyslexia), communication disorders (e.g., language and speech disorders), autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and foetal alcohol spectrum disorder (FASD) (Baidawi, 2020).
- Howard (2018) cites authors such as Evans (2016) and Pereira (2016) who highlight the need to provide special consideration for young people with significant mental health disorders, developmental conditions or other situations diminishing self-control over their behaviour.
- The RCFV found that young people using violence in the home are commonly living with mental health problems and various forms of disability and developmental delay. Similarly, results from the consultation phase of this project found that many practitioners reported among their caseloads high levels of ASD, ADHD, or severe manifestations of trauma, which places many young people using violence in this category of having diminished control over their behaviours.
- More recently, the Positive Interventions for Perpetrators of Adolescent violence in the home (PIPA) Report found through legal case file analysis that 47 per cent of young people brought before Victorian courts for using violence in the home had a diagnosis (Gleeson, 2020). Understanding violence through this lens demonstrates that behaviours can be expressive and reactive, rather than deliberately and overtly controlling. Through a lack of power in familiar relationships, young people with disability or developmental delay might be more likely to demonstrate reactive behaviours. Such conditions create a number of challenges in a young person's life including difficulties with emotional and behavioural regulation and poor functioning across social, academic and occupational domains (Baidawi, 2020).

- Co-occurrence of multiple disorders might further elevate challenging behaviours. While a family might find a diagnosis of a behavioural or mental health condition useful in understanding their child's violence, access to timely and effective support services is critical for these children to learn to cope with or resolve difficulties without using violence (Coogan, 2017).

Developmental considerations

- When considering this context, developmentally tailored intervention strategies are crucial because a mismatch between a child's capacities and a practitioner's perceptions of those capacities can compromise the effectiveness of the intervention process (Noam & Hermann, 2002, cited Malti et al., 2016, p. 7).
- Program designers might regard adolescence as a homogenous state rather than as a series of progressive psychological and cognitive stages
- Pre-adolescence: Concrete operational thinking. Children are capable of tasks involving problem-solving, self-control, and social skills and will benefit from continuous encourage and reinforcement.
- Early adolescence: Formal operational thinking. Increases in self-awareness, metacognition allow children to begin to consider abstract, hypothetical concepts and consequences (Christie & Viner, 2005). Self-control and decisionmaking activities are helpful.
- Mid-adolescence: Neurocognitive increases and marked fluctuations in emotional state. Capable of considering different perspectives. This stage is marked by distrust of authority; peer programs may be most useful at this age.
- Late adolescence: Stage of enhanced executive functioning, including tasks such as response inhibition, self-regulation, thinking ahead, and considering multiple inputs at the same time; late adolescents have an increasing sense of individuality, and will benefit from activities involving establishing identity and future planning (Onrust et al., 2016).
- It is important to remember that a young person's developmental stage might not correlate to their physiological age.
- Nevertheless, applying a developmental approach to program design reminds us to consider a child's developmental capacity to carry out the tasks and activities being asked of them (Malti et al., 2016).

Parenting practice

- Child-parent attachment, parental involvement and supervision, and developmentally appropriate disciplinary practices are factors that might protect against aggressive and violent behaviours (Hong et al., 2012).
- This context for adolescent violence in the home considers elements of parenting practice that might contribute to a child's propensity to exhibit violence. Importantly, this view doesnot seek to blame parents for their children's behaviour. Instead, it examines how particular parenting styles might be conducive to setting up patterns of behaviour. Clear boundaries, structure and age-appropriate guidance are required to help navigate a young person through the rapid changes they experience as they approach adulthood; 'when this is lacking, young people do not feel safe and are burdened by the power they hold over their parents (resentful and at the same time contemptuous of the parent's lack of authority whilst diminishing it through abuse and violence)' (Freiverts & Bautista, 2017).
- These family dynamics can be further impacted where a parent/carer has their own experience of trauma or violence, or is living with a mental health issue, disability or AOD issue; the young person's use of violence may be a means of emotionally distancing themselves from the relationship with their parent (Pereira, 2016). Implications for programs and practice

- For a program to provide an effective intervention, there needs to be a solid understanding of the key risk and protective factors that influence the behaviour. In the case of adolescents using violence in the home, the beliefs and understandings of the context of violence will greatly determine who the intervention is aimed at, the duration of the intervention, the mode of delivery and the content that is included in any coursework.

Policy Environment

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- In February 2014, DHHS released an adolescent family violence program.
- They identified AFV as an ongoing social issue.
- Services need the ecological and systemic approach.

Royal Commission Into Family Violence

- Identifies young people and adolescents as victims and perpetrators of family violence. Notes exposure to family violence can result in behavioural and mental health problems, disrupted schooling, homelessness, poverty, intergenerational family violence. Also notes resilience of young people. Notes that adolescents experience violence in intimate relationships.
- Identified adolescent family violence as a distinct form of family violence. Can include parent on child violence, sibling violence, and problem sexual behaviours.
- Accounts for a relatively small proportion of overall family violence incidents recorded by Victoria Police.
- Can co-exist with family violence perpertrated by parent or other family member and can be manifestation of disability and mental health
- Parents reluctant to report childrens behaviour to police because of feelings of shame, self-blame
- Requires specialist responses that is far more comprehensive that current responses, requires systemic response
- Priority should be given to early intervention therapeutic and diversionary responses. Government trialling community Adolescent Family Violence program. Initial evaluations are positive. Trialling youth diversion program in Children's Court.
- Removal of young person from family should be avoided.

Recommendation 123
The Victorian Government, subject to successful evaluation of the Adolescent Family Violence Program extend the program across Victoirs.

Recommmendation 124
The Victorian Government develop additional crisis and longer-term supported accommodation options for adolescents who use violence in the home. This should be combined with therapeutic support provided to end the young person's use of violence in the family.

Recommendation 125
Victoria Police determine its baseline model for family violence teams and consider appointing dedicated youth resource officers to provide support to young people and their families following police attendance at an indicdent in which an adolescent has used violence in the home.

Recommendation 126
The Melbourne Children's Court establish family violence applicant and respondents positions to assist young people and families in situations where adolescents are using violence in the home.

Recommendation 127
The Victorian Government, subject to successful evaluation of the Youth Diversion Program Pilot, establish a statutory youth diversion scheme.

Recommendation 128
The Victorian Government trial and evaluate a model of linking Youth Justice Group Conferencing with an Adolescent Family Violence Program to provide an individual and family therapeutic intervention for young people who are using violence in the home and are at risk of entering the youth justice system.

Service environment

Royal Commission Into Family Violence

The review of the CRAF should include a specific focus on young people and the risk factors associated with their use of violence. Guidance for those working with adolescents who use violence should be included as a new element of the CRAF

Other services

- Adolescent Family Violence Program In 2011, Peninsula Health established the Keeping Families Safe program, using a grant from the Legal Services Board. This was the first program of its kind in Victoria
- In November 2012, the Ian Potter Foundation provided funding to Child and Family Services Ballarat to develop a program called 'Step Up Victoria—Preventing Adolescent Violence in the Home'. The program was piloted with 60 adolescents and their families in the Ballarat region.
- There are now three sites for these specialist adolescent and family services in Victoria— Geelong, Ballarat and Frankston funded by the Department of Health and Human Services. Each of these have different names.
- These are therapeutic approaches that operate on a case management and group-work model, with each program aiming to deliver services to 48 young people and their families each year.
- Each program runs for approximately four to six months, depending on the organisation and the group requirements.
- Police can make a L17 referral to these three programs. 162 When adolescents use violence in the home The target group for the program is young people aged between 12 and 17 years of age and their families living within the designated program catchment area where: the young person is using violence against a parent or carer that is frequent and ongoing, resulting in the young person being at increased risk of homelessness, criminal justice involvement, disengagement from education and mental health vulnerability, and the parent/carers are likely, without additional support, to experience an increase in the frequency and severity of family violence, resulting in reduced safety and wellbeing (for themselves and other children living in the family home).

- Priority is given to families being parented by a sole female parent or carer, Indigenous families, and families in which the young person has younger siblings.
- The program uses cognitive behavioural and skill development strategies and involves adolescent group work, parent group work and multi-family group work.
- It aims to increase the safety of all family members by preventing the escalation of family violence, supporting parents and assisting adolescents to improve their communication and problem solving skills.
- The program is broadly based on the US court-mandated program Step Up.
- The Commission was told that the US program has been evaluated several times and has been found to contribute to preventing violence and restoring family relationships.
- The Victorian program has a number of features that differentiate it from other services such as Youth Support Service, men's behaviour change programs, Child FIRST and Integrated Family Services, namely a 'specific focus on adolescent family violence, and whole-of-family and integrated service delivery model using Victoria Police as the primary referral source'.
- Unlike the US program, attendance is voluntary and is not linked to a court process such as an intervention order
- An independent evaluation of Victoria's Adolescent Family Violence Program is currently being conducted by the Australian Institute of Criminology.An interim evaluation report, providing initial process review findings, was provided to the Commission. Initial findings suggest that the program is having a positive impact on family relationships.
- The main outcomes had been: improving adolescents' understanding of their violent behaviour, including identifying and managing triggers for violent or aggressive behaviour parent's increased confidence in managing the young person's behaviour a reduction in the nature and frequency of violence and aggression Other positive initial findings include improved education, work and health outcomes for young people.Participants attributed many of these positive changes to the support of their case manager, while some parents and carers reported difficulty in maintaining these positive outcomes over time.
- The Australian Institute of Criminology reports that 'this reflects the complex nature of adolescent family violence and the need for effective transition processes and ongoing support'.
- The existence of these programs shows that community organisations are responsive to the issue of adolescent family violence. However, it is also apparent that there is no comprehensive system to assist families and young people using family violence; instead ad hoc programs have attempted to fill the gap.

Police responses.

- The options available to police when a report is made of adolescent violence in the home are to: issue an informal or formal warning to the adolescent make a referral to a family violence service, Child FIRST or to Child Protection (for example, where there is sibling abuse) take out a family violence intervention order against the young person charge the young person with a criminal offence.
- A 2013 Victorian study shows that police attendance was most positive for parent victims when this attendance resulted in a 'firm' result, such as an application for an FVIO, or removal of the adolescent from the family home for a limited period of time (even just a few hours).114 The study also shows that parents were most positive about the outcome where the adolescent was linked to and engaged with a support service to address the violence. The Commission heard that there is potential for police to play a positive role in addressing adolescent violence in the home, simply by attending the home and speaking to the young person.

Court responses

- The Criminal Division of the Children's Court hears criminal matters against a child arising from a family violence incident. There are a range of sentencing options available including the following: dismissal and accountable undertaking good behaviour bond fine probation order 160 When adolescents use violence in the home youth attendance order youth supervision order youth residential centre order youth justice centre order.132 In sentencing, a child's rehabilitative prospects and the need to preserve a child's familial relationships are priority considerations.
- Victoria does not have a legislated court-based youth diversion scheme for children charged with a criminal offence. Instead this currently occurs through police cautioning and referral to an informal diversion program— for example the ROPES program. The Commission heard that this informal system results in inconsistency across the state, with availability being largely dependent on a young person's geographic location.
- Victoria does not have a legislated court-based youth diversion scheme for children charged with a criminal offence. Instead this currently occurs through police cautioning and referral to an informal diversion program— for example the ROPES program. The Commission heard that this informal system results in inconsistency across the state, with availability being largely dependent on a young person's geographic location.

Principles

- Having regard to the submissions and evidence put to the Commission and to the scholarship in this area, the Commission finds that adolescent violence in the home must be better recognised as a form of family violence, and so better resourced across all systems—including police, courts, youth justice, human services and specialist family violence, integrated family mental health, and disability services.
    - The Commission believes that the following principles should guide Victoria's approach to addressing adolescent violence in the home:
    - There is a need to raise awareness about adolescent violence in the community, along with easy to find information about the options and services available to address adolescent violence.
    - Adolescent violence in the home should be recognised by the family violence system as different from adult-perpetrated family violence. Involvement with the criminal justice system for adolescents who use violence in the home should be a last resort—therapeutic responses should be adopted. Priority should be given to specialist therapeutic responses that work with the young person and their families as early as possible.
    - The underlying causes of the violence should be addressed to prevent any further violence and involvement in the criminal justice system
    - Responses should be flexible and tailored to the particular circumstances of each family. For example, the intensity of any intervention should be appropriate to the level of risk posed to family members.
    - There is a need for an immediate response to adolescent violence in the home so that young people understand the consequences of their actions and family members can be protected.
    - Removal of the young person from the family home should be avoided as much as possible. Where there is no other option but for the young person to leave the home, appropriate supported accommodation should be provided to them. Improvements need to be made to our justice system so that greater use can be made of diversionary and restorative options when the family wants this.

Guide to promising programs for adolescents using violence in the home Centre for Excellence in Child and Family Welfare. June 2021.

Programs being implemented throughout Victoria and Australia operate according to different theories of change, and therefore have vastly different approaches.

Duration

- Programs vary greatly in the length of time they are delivered. Length of interventions range from workshops lasting a couple of hours to more intensive interventions lasting a number of months. For programs that are information-heavy and aim to build skills and confidence or participants, the greater the number of instructional sessions, the greater the likelihood of the message being reinforced.
- It is also possible that for programs involving groupwork, an increased number of sessions would allow participants to get to know each other, which would change the dynamics of the work being conducted. Target audience Some programs target interventions solely at the young person who is using violence. These programs use educative activities to develop interpersonal awareness and skills such as empathy, active listening, respectful relationships, and motivational strategies to challenge the young person's beliefs about acceptable behaviour and alternative ways they can handle conflict.
- Such programs vary in scope about the extent to which they hold the young person accountable and whether a trauma informed lens is applied. Programs operating on the belief that educating and empowering parents will resolve the violence typically focus on working (sometimes exclusively) with parents.
- Understanding violence through the context of parenting practice favours supporting parents to reduce their feelings of guilt, shame and isolation, whilst offering practical parenting tips to manage a young person's behaviour including de-escalation techniques and stabilising their own emotions to regain control of a situation.
- Other programs that use family systems theory to understand the violence will likely seek to involve work with both young person and parent. Whole-of-family approaches might include family therapy family to gain insight into family dynamics and strengthening communication strategies, and nonviolent resistance models.
- This work could occur either together in the form of family therapy or there might be concurrent group programs where young people and parents attend sessions with separate facilitators.

Delivery Format

- Some programs use individualised work with young people and/or parents, while others rely on group work models. Outreach case management Effective engagement and building rapport with a young person can take considerable time and effort on the part of the practitioner. Providing an outreach component to the work can assist in this process: 'Meeting at a youth-friendly, non-threatening venue, providing food and gaining quick wins such as offering to link them to something in which they are interested can facilitate engagement'.

Group work

- Many programs are run on a set structure of course work delivered via groupwork. Research suggests that, particularly for parents, group work can be destigmatising and allow them to feel comfortable in help-seeking behaviours. A study by Correll et al. (2017) investigating parents' perceptions of an intervention for adolescent violence in the home found that: 2 FSV Consultation paper, 2019 15
- Having a routine with a regular format (e.g. weekly session) is helpful
- The group provided a supportive environment where participants felt empathy and concern for other's experiences. • Listening to other family's difficulties helped participants to view their own challenges more objectively.

- Participants receive useful feedback and advice from others. For young people, strong peer relationships are important during these developmental years. However, some research suggests that negative peer relationships are associated with violence toward caregivers, suggesting that a lot of careful thought must go into the planning of the groups and group dynamics (Hong et al., 2012).
- While groupwork is generally recognised as appropriate for working with adult perpetrators of family violence, young people who are using violence in the home require a more nuanced approach: 'the need to respond to the unique history of how the young person came to occupy multiple and overlapping positions – as both perpetrator and ''victim''; as ''powerful'' and ''oppressed'' – may mean that one-to-one intervention work is more appropriate' (Holt, 2015, p.9).

Development

- For interventions to effectively reach this target audience of young people, program design should consider the relevant developmental phases a young person is navigating. Incorporating a range of visual and kinaesthetic cues instead of relying solely on discussions can be useful. For example, the Name. Narrate. Navigate. program operating in New South Wales deliberately employs a variety of methods to communicate and self-regulate emotions of young participants.

Outcomes monitoring and evaluation

- While many service providers reported that evaluations have been completed, evaluation data is not publicly available in the majority of these cases, which makes it difficult to assess. In some cases, service providers might be collecting formative data (e.g. participant feedback questionnaires), which is helpful to inform reviews of future courses. However, in the absence of having developed a program theory and incorporating targeted pre and post measures, it is difficult to determine whether programs have achieved their outcomes and affected any real change for participants.\The absence of follow-up data collection means that it is unclear whether the program effects lead to longer-term change in reducing recidivism and supporting individual and family wellbeing. Service providers delivering established EBPs need to outline their implementation, including any adaptation, and collect locally-sourced outcomes data to make sure that the program is suitable and effective in their local context.

Young People Who Use Violence In The Home. CFECFW summary report on sector data collection as part of the Building the Evidence Project. March 2020. Centre for Excellence in Child and Family Welfare.

The data collected through the Building the Evidence project work has implications for future policy and practice approaches.
Several themes have emerged, including the need for:

- A common language and understanding of the drivers and nature of adolescents who use violence in the home
- Training in specific areas – working with adolescents with a disability who use violence in the home; understanding the developmental stages that occur between 10-18 years; applying an intersectional lens to better understand the gender and other dynamics of adolescent violence; service availability
- Training and tools to accompany the proposed MARAM Practice Guide so risk assessment and management can be seen through the lens of a young person, who might also be a victim survivor, rather than an adult perpetrator lens
- Earlier intervention, including identifying points where this might occur and having a dedicated service or program for children under 12 years who are showing early signs of violence in the home
- A state-wide approach to care team coordination to support better information sharing and collaboration across workforces and disciplines.

Program Logic
Approach (*psychoeducation, therapeutic life story work, highly individualised, experienced practitioners*)
Principles *(relational*, supporting the system, embed responsibility, gendered patterns**)**
What the program does

Practice manual

What the program does

- Adolescents must have parents or caregivers do programs with them. Adult ensures engagement.
- Clients required to have active case management involvement.
- The program intends to work with other workers and services.
- The client age group is 10-17.

Uses a range of tools for assessment and outcomes

- Open on 11 May to internal services.
- Mix of living at home, in residential care

TAFVS program logic

The program targets:

- Young people aged 13-19
- Reside in the Metro West or North Regions
- Young people using, or at risk of using, violence in the home environment or dating context

Inclusion criteria

- Young people must be willing to engage in the program, have a desire to change and are prepared to present in a safe manner
- There must be a parent or guardian who can provide legal consent for participants under the age of 18
- There will be one adult family member or carer who is willing to engage in the program alongside the young person

Priority access

- Priority will be given to adolescents who are parents or expectant parents

The program requires:

1. One Therapeutic Adolescent Family Violence Specialist and Coordinator
2. 1:8 staff–client ratio, flexible hours of service, after hours support
3. Program oversight by a Steering Committee
4. Ongoing program and clinical supervision for TAFV Specialist

5. Access to a Pool car
6. Therapeutic practice informed by the MARAM, Best Interests Case Practice Model, and the AFV Program Service Model developed by DHHS in 2014.
7. Structure for ongoing review of program and practice efficacy
8. Marketing material
9. Referral Pathways
10. Brokerage

The program uses the following processes & functions:

- Referral and screening (risk assessment) to assess intake and address immediate safety needs.
- The development of a Therapeutic Plan including targeted levels of support to reflect individual needs, flexible and active service delivery.
- Services may include:
    - Counselling/relational psychotherapy (individual, family, dyad, and small group) focussed on resolving family/home concerns relevant to the adolescent's use of violence, to strengthen family relationships, reduce violence, and enhance safety of those impacted.
    - Psychoeducation regarding the use of and impact of violence (individual and in small groups)
    - Clinical consultation for care teams working with adolescents who use violence
    - Clear referral or exit pathways into relevant support networks
- Ongoing assessment and periodic review (SDQ, HoNOSCA and client survey) – continuous system for assessment, planning, information sharing and action incorporating information gathering; analysis and judgments; decisions and agreements for action; review of outcomes and processWork collaboratively and systematically with other organisations that are engaged in service provision with the client.
- Establish and uphold referral pathways and relationships.
- Fulfil reporting requirements.

Referral

- SR receives referral form – provides information about the client
- SR contacts referrer and decides to accept referral
- Conducts assessment of family with a worker

Contacting family

- Liaise with referrer for advice
- Contact client, introduction program. Provide information.
- Comment assessment – to understand the ecological and systemic understanding of situation that adolescent is experiencing
- Understanding of family dynamics
- Understanding of adolescent development

. (Practice manual)

Assessment

- Decide on a combination of services based on what is happening in the home. (Practice manual)

- Can't work in situations where adult in family is still continuing to be unsafe (S2 and S3)
- Can't work in situation where mental illness is significant factor (S2 and S3)

Safety planning
- Understand dynamics and risks in the family. Purpose to support the family but also focus on understanding family dynamics.
- Ideally done with case management of care team. (Practice manual)
- Often huge number of risk factors (S1)

Approach
This part is usually led by Mackillop

Relational therapeutic outreach program for adolescents aged 10-17. The therapeutic delivery is delivered in one on one or on two settings.

Purpose for young people:
- Purpose to support adolescents but also focus on understanding family dynamics. (Program Update 2020)
- Purpose is to build an understanding of self, power dynamics in the family, repairing family dynamics. (Open symposium).
- Understand impact of past and move past trauma. Understand impact on others. Young person supported to make changes.

Purpose for family
- Build understanding of what is happening in family. Create shared understanding in family. Allow family to grieve together. Connecting family together. Have to be colourful and creative.

Staffings
- Needs strong relationship with the therapist. Requires highly skilled therapists. (OPEN presentation)
- Staff member needs significant experience working with young people from challenging backgrouds (S2 and S3)
- Highly experience staff member has variety of tools that get used based on expertise on rapid assessment of situation (S2 and S3) Like a game of chess (S1)

Principles
- Safety
- Relational and empathetic. – extremely important, very short program, requires expertise from the worker (S2 and S3 – S1)
- Non-judgemental – focus on people and why they are acting the way they are.
- Focus on restorative practice (needs to happen with the entire family and across teams)

Approaches

- Psychoeducation is the practice of educating about trauma and understanding the impact of trauma. Allows clients to learn and use the same language as staff, understand emotions and behaviours in the context of experiences. Individuals are empowered to take greater control over their lives. Incorporate learning of emotional regulation (OPEN SYMPOSIUM)
- Trauma-informed approach. (Program Update 2020) Trauma alters brain functioning. Use SELF Framework for trauma recovery. Use Sanctuary Toolkit Sanctuary psychoeducation is teaching people about young people about trauma.
- Gestalt: use a strengths-based approach where appropriate, practical and focused on behaviour. Aligns with neuroscience and trauma-informed practice.
  (S1)

Examples of tools:

- Therapeutic Life Story Work – jug exercise – identify triggers
- Choice points / Restorative Justice – identify protective factors
- Respecting Sexual Safety Material
- Relational psycho-therapeutic approaches and psychoeducation.

(open presentation)

Challenges

- Holding the perpetrator accountable whilst acknowledging behaviour. Holding family accountable whilst acknowledging their trauma and history. This is addressed through psychoeducation (S1) Have to challenge clients sometimes, it is difficult. Requires great skill from therapist to not interrupt relationships. (S1)
- What to do when parents don't agree on approaches (S1)

Family-centred

- Ecological approach to work with who family and supporting care givers and parents.
- Systemic family therapy approach: no one cause of violence. Functional family therapy is short term intervention. Focus on behaviour changes. It involves helping the family understand their behaviour and how they contribute to family dynamics—delivered by formalised family sessions.

. (Practice manual)

- Need to understand how power and control work within the family (OPEN SYMPOSIUM) (S1 interview)

Integrated

- Building good relationships with stakeholders important part of program (S1)
- Usually only people on team with psychotherapeutic knowledge (S1)
- It is understood that adolescent usually lives with adults who require support. Necessitates need for care team. (Program Update 2020)
- Worker usually engages with other staff in the first instance. Often safety plans are developed here in unison with family and workers.
- Work across care teams or with case management. Ongoing conversations with other staff. (S1)

. (Practice manual)

- Important that young people and family have other people to go to if they need support. (S2 and S3)
- Coordinator has important role to play in coordination with other services (S1)

Closure

- All cases are closed. Many reasons for case closure. . (Practice manual)
- Can't work in situations where adult in family is still continuing to be unsafe (S2 and S3)
- Can't work in situation where mental illness is significant factor (S2 and S3)

Description of the client group

- About three-quarters of clients were under 16 (74%)
- About three-quarters of clients were male (80%)
- About half of young people (46%) had history in out of home placement

Health

- 19% of young people had a history of alcohol use at the beginning of the intervention. 13% of young people were currently using drugs, and this was impacting on their life. 7% had been referred for assessment of drug and alcohol matters but never assessed. No young person using alcohol or drugs was receiving treatment for their use.
- 27% of a history of depression and anxiety
- 33% of young people were assessed as having some kind of mental health issue
- 37% of young people had had serious throughs of suicide (reduced to 21% at the end of the intervention)

Prior exposure to violence

- 14% of young people had never experienced violence or physical abuse
- 8% of young people have never witnessed violence
- 12% of people have experienced sexual assault

Criminal and justice matters

- Offending is occurring early – 57% of young people were 12 or under at the time of the first offence. 21% of young people had been held in secure detention at the beginning of the intervention.

Relationship with family

- 60% of young people have a history of neglect
- Nearly half of the young people involved in the program have a history of running away or being kicked out of the home.
- Nearly all young people (93%) have had some kind of disruption in their parenting.
- 20% of families had a household member in custody, likely to be quite high when compared to the general population
- Parents/guardians most likely to have a history of mental health issues, 23% of parents guardians have a history of problematic alcohol use, 15% have a history of problematic drug use, 15% have a history or poor physical health, 12% have a history of problems with employment. Without knowing what rates for the general population are, it is difficult to interpret this data

Effectiveness
(psycho-social model, integrated response, holistic with family, safety planning, examples of the application of principles

What the program does

Building skills for managing emotions and behaviour:

- Address emotional regulation, self-care, how to identify triggers, identify own behaviours, how to respond in stressful situations, work on strengths and weaknesses, hold them accountable for actions, provide skills for more constructive behaviours
- Staff work from place of unconditional positive regard or parents and children

Value of therapeutic response

- Work with trauma, and address grief and sadness, important part of the process, acknowledges intergenerational trauma and its contribution
- Need to understand experience of family in order to provide effectiveness response
- Focus on wellbeing as opposed to just reducing conflict and violence
- Unconditional positive regard
- Builds empathy and trust between family and staff

Working with entire family

- Unusual for program to work with parents and children and to work with them together

Communication/integration with services

- SR spend a lot of time working with other services to build a good picture of what is happening. They also focus on working in an integrated way with other services.
- For families: benefit of having a key person who understands systems. Parent doesn't feel like they have to keep saying same story. Can do advocacy with services – more validity when worker reaches out.
- Other staff report that SR staff good at providing updates and information, open and honest communication between partieis
- Some stakeholders reporting value of learning how SR works, the therapeutic approach has been useful for them to learn about
- Focus on system needing to support the family rather than leaving it to family to resolve - providing support for the care team work together better

Enablers of effectiveness:

- Therapeutic response
- Calibre of worker is critical – need to understand and work with complexities, adaptable and flexible, can build rapport
- Quality of communication – using language that is accessible

- Unconditional positive regard

Barriers to effectiveness:

- The limit of three-months is a significant barrier to effectiveness. Long ingrained patterns can't be fixed in three months. Takes time for young people to build rapport with staff
- Not all services are open or receptive to concept of care team coordination or therapeutic responses - issues when care team do not agree on appropriate approaches, creates conflicting messages for the family
- Relies on willingness of family to engage
- Some concern that focus on therapeutic model overlooks accountability for behaviour and does not address serious entrenched issues

What the program does

- Fills a significant gap – little research and few services.
- Service not long enough – need six-months minimum (C1) (C2) (M2)
- Practitioner very supportive to parents. (C1) (C2) Helped her to activate safety plan (M1).Helping caregiver understand emotional reactions and triggers (M1) (M2) (E1)
- Would like better referral process – more information (M1)

Integration

- Services more likely to listen when SR staff contact (C2) Supporting access to the system (M2)
- Staff feel supported (E1) SR staff communicating with services and providing information. (M1) (M3) External services really value capacity to consult with SR (E1). Appreciate approach – not labelling and treating (E1) Have trauma informed lens which is really useful (E1) Helps us reflect on our work. SR work effectively to provide wrap around approach (E3)
- Open honest communication important (E2) – SR does this. (E3)
- Able to use plain language to describe their work, very helpful for clinical teams. (E1)
- Safety assessments happening.
- Needing case manager for family is barrier to accessing (M2)
- Not all services easy to work with (E2) (E3)
- Need structure around how people work together (E3, E2, M1) Services need more guidance on how to work together (E1) Services need to agree on approach (E1) (E2)

Approaches

- One on one support valued (M1) (M2)
- SR do holistic assessment (M1) (E2) – Saw every member of family. (E3) (M2) Appreciate staff working with whole family (M1)
- Staff excellent at building relationship with young people (C1) (C2) (E2) (M2) Engagement style really important (E2) (E3)
- Trauma informed assessment helpful (E1) (E3)Therapeutic tools very helpful for entire family (M2) (E1) (E2) (E3) (M2) Tools used by staff effective (C1) Able to help young people understand their behaviour (C2)

- Support accountability – embed it in holistic response (M1) (M2) Used two pronged approach: parent and child. (M2) (E1)
- Level of skill if SR practitioners – have skills needed to engage with entire family (E3)
- Term psychotherapeutic or trauma-informed not specific enough (E3)
- Felt like would like to see more work with parents (M2)

Assumptions

- Very difficult to get into services (C1)(M1) (E1)
- Not enough capability in the system (C1)
- Many clients have issues with ADHD, Aspergers – what is program approach? (C2)
- Most families have complex needs. (M2)
- Services need more guidance on how to work together (E1)
- Services need to agree on approach (E1) (E2)
- SR can't work in unsafe environments (E2)

COVID

- No significant impact. Use of telehealth session. Not as effective as face to face contact. (Program Update 2020)
- Grateful staff able to visit during lockdown. (C2)

Outcomes

A significant limitation in reporting on these findings because we have only spoken to two parents. Most of the impact findings come from reports from staff. We also don't know the extent to which the outcomes happen across all the groups.

The following outcomes were identified:

- Staff reporting that some young people will work with the SR worker when they wont work with other families
- There is a reduction of conflict in some families.
- Staff reporting better communication in families and between family members
- Staff reporting that young people are showing improved self-awareness and learning skills to manage behaviour
- Staff reporting that parents feel supported, feel less shame, are learning how to communicate with their children, learning effective strategies for parenting
- Staff reporting improved pathways between SR team and their services, SR educating others about their approach and this helps other services

Evidence:

- Some workers reporting improved engagement in school (S1) (M2)
- Children and family feel more supported (C1, C2, M1, M2, E1, E2)
- Families feel empowered by skills they learn (M2), and bringing things out into the open (M2) (E3)

- Parents empowered to parent in ways that support boundaries (E1)
- SR able to bring all services together to focus on family (E1)
- Gives family hope for the future (E1)
- Improvement in behaviour of young people (E2, M2)

Survey (CAT tool)

Changes for parents

- Survey questions indicator that parents are more effective at discipline:
- 33% of parents at beginning of the intervention and 71% of parents at end of intervention were consistently applying appropriate punishment
- 40% of parents at beginning of the intervention and 71% of parents at end of intervention were consistently providing appropriate rewards for good behaviour

Changes for young people

Internal changes

Self-awareness

- 40% of young people were assessed as not understanding consequences to actions at the beginning of the intervention and 7% were assessed as not understanding consequences to actions at the end of the intervention. 13% of young people were assessed as demonstrating good consequential thinking at the beginning of the intervention and 50% were assessed as demonstrating good consequential thinking at the end of the intervention.
- 40% of young people were assessed as not being able to identify problem behaviours at the beginning of the intervention and 7% were assessed as not being able to identify problem behaviours at the end of the intervention. No young people were assessed as being able to apply appropriate solutions to problem behaviours at the beginning of the intervention and 29% of young people were identified as being able to apply appropriate solutions for problem behaviours at the end of the intervention.
- 64% of young people were assessed as lacking skills in dealing with feelings and emotions at the beginning of the assessment and 7% of young people were assessed as lacking skills in dealing with feelings and emotions at the end of the assessment.
- 33% of young people were assessed as being able to identify internal and/or external triggers at the beginning of the intervention and 100% of young people were assessed as being able to identify internal and/or external triggers at the end of the intervention.

Self-control

- 33% were identified as having some self-control at the beginning of the intervention and 79% were identified as having some self-control at the end of the intervention
- 40% were identified as being impulsive at the beginning of the intervention and 14% were assessed as being impulsive at the end of the intervention
- 27% were identified as being highly impulsive at the beginning of the intervention and 7% were identified as being highly impulsive at the end of the intervention
- No young people were assessed as rarely get upset over small things or have temper tantrums at the beginning of the intervention and 36% of young people were assessed as rarely getting upset over small things or having temper tantrums at the end of the intervention. 40% of

young people were assessed as often getting upset or having temper tantrums at the beginning of the intervention and 7% were assessed as often getting upset over small things or having temper tantrums at the end of the intervention.

Changes in attitudes to violence

33% of young people believed that physical aggression is never appropriate and 64% of young people believed that physical aggression is never appropriate at the end of the intervention

20% of young people believed that verbal aggression is rarely appropriate at the beginning of the intervention and 71% believed that verbal aggression is rarely appropriate at the end of the intervention

Applying new skills

73% of young people were assessed as not setting goals at the beginning of the intervention, and 7% were assessed as not setting goals at the end of the intervention. 20% of young people were assessed in setting unrealistic goals at the beginning of the intervention and 50% of young people were assessed as setting unrealistic goals at the end of the intervention.

40% of young people were assessed as lacking social skills at the beginning of the intervention and 7% were assessed as lacking social skills at the end of the intervention. 7% were assessed as using advanced social skills at the end of the intervention.

73% of young people were assessed as not being able to control impulsive behaviour at the beginning of the intervention and 43% were assessed as using techniques for controlling impulsive behaviour at the end of the intervention.

33% of young people were assessed as lacking alternatives to aggression at the beginning of the intervention. 43% of young people were sometimes using 50% of young people were often using alternatives to aggression at the end of the intervention

Changes in respect for authority figures

47% had respect for authority figures at the beginning of the intervention and 71% has respect for authority figures at the end of the intervention

Changes at school

- Evidence of improvements in attendance and school behaviour. 47% of young people were enrolled full-time at the beginning of the intervention and 71% of students were enrolled full-time at the end of the intervention. 40% of young people did not believe that school was encouraging at the beginning of the intervention. 36% of young people believed that school is encouraging (and 43% of young people believed somewhat that school is encouraging).

Changes in criminal and justice matters

100% of young people under court supervision were unsure if they would be successful at the beginning of the intervention, and 67% of young people under court supervision believed they would be successful at the end of the intervention

Relevance (assumptions underpinning model integration with policy, integration with literature, who is best target group)

Most families are dealing with intergenerational trauma and/or have highly complex needs

- Therapeutic response addresses causes of issues and provides a non-judgemental space for the family
- Focus on skill development assists people to manage their behaviour
- Focus on whole-of-family approach addresses family dynamics
- Working in an integrated way with services allows for a care team to provide coordinated care to work across multiple issues

Recommendations from interviewees:

- Maybe more of a focus on parenting strategies

- Barrier is also needing a case manager at same time. Not all families need a case manager
- Query about where this approach is most effective – is this for families experience moderate or extreme levels of violence?
- Think about where and when this program works and its role in the care team

Assumptions about program

- Young person shows some insight and willingness to engage in a safe manner.
- Must have an adult willing to be part of the program.
- Services interested in collaborating together, agree on approach (S1) Relationships led by coordinator critical to building these relationships (S1)
- Staff need strong support and structures (S1)

Assumptions about perpetrators

- Can't just be the criminal response. Need support. Younger perpetrators can be supported.
- Services often blame young people in family. (S1)

Implications for Service Blueprint

Intake	Engagement and assessment	Planning and goal setting	Implementation	Consultation	Closure
Need a documented process for the role of informal relationships with external services, and informal consults – how do these contribute to program goals? Role of coordinated response - service relationships need to be formalised with documented processes Programs would benefit from some type of document that explains what the program does – this is accessible and easy to read. Would benefit from use of case studies/stories. Safety planning happens at every stage.- has to take into consideration: - gender of person using violence and person	Engagement and assessment needs to happen with the service team.- the blueprint suggests that the worker calls the client – should happen with the referrer The role of skill of the practitioner needs to be documented. This includes a description of experience needed as well as type of personality needed, Recommendation for analysis of the developmental stage of adolescent to be documented Recommendation for analysis of nature and type of violence to be documented Need description/documentation of how diagnoses such as ADHD or Autism	The service care team and/or case management team should have an agreed approach for planning and goal setting. Should be documentation for this. SR team need to prepare ways of describing their approach to the team, explaining how they make decisions about approaches and providing tools that they use. This is for consistent messaging over time. Using examples is a good way of communicating this. This probably happens informally but would benefit from being documented Planning and goal setting looks different for:	Role of services in supporting the implementation Description of actual approaches used – how decisions are made. (Using case studies helps here) Describe tools and benefit of using each tool. (Again, using case studies helps here) Acknowledgement that it is highly intuitive process based on skill and personality of practitioner.	Needs to happen across the life of the program. Service team need to agree on coordinated plan at the time engagement and assessment starts. Need structures for how team work together across planning and goal setting, implementation, and their role in closure.	How does closure happen?

experiencing violence - developmental issues of person using violence - general development assessment of adolescent	impact on engagement, assessment, planning, and goal setting.	- Client - Parent - Service team Description of planning and goal setting should be adjusted based on nature of violence and developmental stage of adolescent.			

Analysis of documents

Welcome to TAFVS	More description of therapeutic approach (obviously in layman's terms and how this could helo) Should be much more visual – assist for young people or parents with low literacy
TAFVS information sheet for referrers	More description of approaches used and why they are used. Stronger description of the program. Description of skill of the practitioner, and their personality and how this informs program outcomes
TAFVS participant letter	Language needs to be simplified, and document would benefit from being more visual
Case closure	In the outcomes section, there needs to be evidence provided as how this outcome was observed. Need more description about how it is decided that a case should be closed.