
*Increasing the Effectiveness of Stopping Violence Dunedin Programmes*

Preliminary Report
For the Lottery Grants Board

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**Abstract**

This document pulls together five strands of research. The first is a collection of demographic data concerning 502 participants who were referred to and attended programmes at Stopping Violence Dunedin (SVD) between July 2014-July 2015. The second project involved following up all Corrections Department referrals that could be traced through the appropriate systems by asking the Department for data on re-offending in the year following July 2015. The third strand is a focus group project describing conclusions gleaned from discussion in four focus groups drawn from the participants and facilitated by an external group leader. Fourth, a series of phone interviews using a structured interview template was conducted with a random sample of participants. The results were analysed for themes by an external researcher, who also designed the template. The fifth element is a clinical picture, obtained by using a Psychiatric Diagnostic Screening Questionnaire, of participants who attended programmes during Monday-Friday 14-18 November 2016. This latter was not part of the original research design, but deepens and adds to the significance of the results from the four other projects.

Overall, stopping violence programmes seem to be effective in that lower recidivism rates are associated with programme completion. Specifically, participants report reduced anger and violence, better self-control, greater capacity for empathy and improvements in communication associated with social functioning and family relationships. The clinical data obtained from the one-week 'snapshot' suggests elevated levels of distress above population norms. There are questions about alternative interpretations of results, and improved design for further study is suggested.

**Background**

SVD is contracted by the Community Corrections, the Ministry of Justice (Family Court) and the Ministry of Social Development, Child Youth and Family (CYF) to deliver their services to participants. There are three avenues for referral:

1. The Department of Community Corrections:
    - Men and women are referred as part of their bail conditions on their release from prison back into the community.
2. Family Court:
    - The Family Violence Court has intervened and directed a person to attend the non-violence program as part of a sentence or when a Protection Order has been issued.
    - The person is mandated under the Domestic Violence Amendment Act 2013 section 51D to attend an assessment and non-violence program as part of a court directed Protection Order (Domestic Violence Amendment Act 2013).
    - Finally if a person is on parole and a requirement of their probation is to attend a non-violence programme.
3. Self Referral:
    - A person who wishes to attend a programme to address violence in their lives, either their own, a partner's or their family members'.

**Introduction from the Manager of Stopping Violence Dunedin**

***"Kāore te kumara e kōrero mō tōna ake reka"***

Cinnamon Boreham, March 2017

Stopping Violence Dunedin grew up through the voluntary sector. Its ancestor was known as the Men's Action Collective, a group who wanted to address issues of power within the home. They decided that it was worth talking about this in the context of a group. That focus has not shifted over the years, though the methodology has.

*The Act*

During the 1980s when this organisation was born, the political climate was changing, consciousness of women was growing, as was the awareness of domestic violence and the need to protect its victims. In 1995 the Domestic Violence Act came into force.

The Act directed perpetrators of domestic violence to attend Stopping Violence programmes. Our agency, like others, adopted a programme that originated with a group of women in Duluth, Minnesota. It was highly manualised, which is to say each session was described in advance. Feminist theory underpinned the programme and cognitive behaviour therapy was the main method of intervention. It was innovative for its time.

*The dominant discourse – the Duluth method*

We would deliver a 25-week programme for 2 hours per session using the Duluth model, which is based on a "Power and Control Wheel", dealing in turn with intimidation, emotional abuse, using isolation, minimizing, denying, blaming, using children, economic abuse, economic abuse, male privilege and coercion and threats. There was an emphasis on the men taking responsibility for their actions. This was good in theory; however, the interventions were frequently judgemental and blaming. Assumptions were made that all those who used violence found its genesis in male privilege. The man who believed it was his right to have power and control within a heteronormative relationship was seen as typical.

*Typical clients*

The idea that male privilege was the central reason underpinning domestic violence within our community eventually seemed too simplistic. There was no account taken of the mental health issues people were presenting with - depression, anxiety, drug addiction, post-traumatic stress disorder, not always diagnosed but clear in self-report. These findings are supported by a brief questionnaire SVD undertook spanning the seven groups in May 2016, which illustrated that 'co-existing problems' (Todd 2010) including anxiety, depression, PTSD and addictions are common among people referred to the service.

Alongside the mental health issues there are the social factors that influence people's capacity to function well in relationships, including isolation, poverty, poor education, colonisation, unemployment and a history of childhood trauma and neglect. A majority of our clients grew up with violence, and many within state systems, including Child Youth and Family facilities, foster homes, borstal or youth justice facilities, and finally prison. So the client profile turns out to be significantly different from that predicted by the Duluth model.

There are of course others, people in high status roles. This is a dark figure however, as these men seem often not to be reported, or perhaps the courts find other ways to manage their offending and sentencing. It is possible that recourse to good legal representation will lead to more settlement out of court, and that the victims have an investment in this outcome.

*Development of skills*

As our understanding of the factors influencing the client group has changed and developed so has our understanding of the level of skill required to work dynamically with people in the group context.

One of the prerequisites for an effective facilitator of these groups is that they understand the dynamics of family violence in its social and cultural context. They must understand group and family systems, and be able to make an assessment of the functioning of each individual within the group, bearing in mind these background factors. They must understand and be able to talk about their own use and abuse of power. The facilitator are required to attend to their ongoing

personal and professional development, including regular supervision. We are all a work in progress, both clients and staff. This ideology encourages practitioners to work more authentically with our clients.

*How the programme is delivered now*

Over the years, programme delivery has changed. The group is still the preferred vehicle In essence we threw away the Manual, but maintained a focus on family violence and its impacts. Victim empathy and privileging the victim's stories continues to be a theme throughout the sessions. What we do differently is that rather than delivering a pre-planned programme, we have started to listen to the clients. They provide the content for the groups for the facilitators to work therapeutically, attending to issues in the here-and-now. The development of emotional literacy, self-soothing, role development, learning how to relate to each other, managing points of difference in the group with the support of the facilitators, weave through the sessions.

The client's ability to be in relationship inside the group becomes integrated. This ability can then translate into other aspects of their lives and most importantly in their relationships with their loved ones.

The feedback we receive regularly is that attending the group reduced their social isolation. They do not feel so alone in their struggle to relate, nor in their yearning to be both better parents and partners.

Clients appear to yearn for the intimacy that the group setting offers when we work dynamically. Individual issues brought to the group become alive. For example group members report times where in the past week they have had narrow escapes, and chosen not to be violent, or where they might have slipped up. Skilled facilitators work with this content and the group derives more meaning from the session than working from a manualised one size fits all programme. There are themes that emerge from the groups around physical violence, sexual violence, sexuality, violence towards children, identifying different forms of violence, learning to communicate in a healthy way, victim empathy, and antecedents to violence or abuse. Personal histories become woven into the narrative. Addiction, low self-esteem, and misguided beliefs are typical threads in conversations about violence.

Thus the ideology behind our programmes, and their design, has shifted considerably away from the idea that violence is a manifestation of power and control in relationships, to an approach based on the more solid body of theory and research concerning trauma and attachment theory (Wallin 2007, Owen 2017).

These men and women do not want to be violent or abusive; in some cases, they do not know other ways to communicate their misery. They want to be good parents, good partners. Some are involved in 'toxic relationships' where they do not have the capacity to exit, in part because of the social isolation they live with. A toxic relationship can be identified by a number of characteristics. The following, taken from a description of Borderline Personality (American Psychiatric Association. DSM-5 task force 2013, pg:663) and applied to relationships, are some examples describing what we observe among clients.

1. There is no agreement by both parties to look at their own behaviour and make necessary changes to improve the safety and quality of the relationship.
2. There is a real or imagined fear of abandonment; this could be present in both parties or more strongly in one.
3. There is a tendency to fluctuate between extremes of idealisation and devaluation.
4. One or both parties experience chronic feelings of emptiness. Impulsivity is a theme where we see threats of suicide.
5. These individuals may suddenly change from the role of a needy supplicant for help to that of a righteous avenger of past mistreatment.

These characteristics can be present in the either the clients' partners, or the clients or both. If the righteous avenger wins, then the risk factors increase significantly. This type of relationship is difficult to exit, and often results in multiple arrests and sometimes serious injury or death.

As we developed these ideas, we began to apply the principles of attachment theory, focussing our work on the adult manifestations of childhood attachment trauma. From this perspective the programme is focussed on the creation of secure attachment patterns, requiring long-term commitment as people learn to build a coherent sense of community and family.

The client attaches to the group and the organisation. SVD becomes a 'safe place'. It became unethical and a duplication of their own trauma to require that they leave after 25 weeks. This thinking of course results in tension between the practitioners, management, governance, Social services and Government, sitting uneasily beside a business model when the business is seen from a narrow perspective – the choice seems like cost versus sustainable change. However, taking a long view and considering profit to the community at large, the approach makes very good business sense. One of our board members, the late Michael Laufiso, once said, "Any intervention we make requires us to be thinking seven generations ahead."

We now encourage people to stay on longer than they have to (and longer than they are funded for). This has allowed for better integration of new behaviours and thinking and increases the client's safety. There is good evidence from many sources that belonging to a group that has meaning for an individual is strongly and positively related to wellbeing, which in turn acts as a protective factor in the prevention of family violence.

> *For instance; "Overall, research from the social psychology field is building an increasingly compelling argument that group memberships are important to wellbeing*" (Jetten, Haslam et al. 2012).

*The whakatauki*

The whakatauki above, *Kāore te kumara e kōrero mō tōna ake reka - The kumara (sweet potato) does speak of its own sweetness*, is applied to the organisation in many ways. One way is through the progression of clients staying on in the groups once they complete a round of treatment of twenty-five weeks. These long-term group members have a powerful influence on the orientation of new members to the norms of the group. If the long-term clients say that the programme is sweet, it has much more weight than if the practitioners say it.

There is a phenomenon of identification that occurs when people settle into the groups. We repeatedly hear the statement, "we are all the same". While there is both truth and fiction in the statement, this internal identification in the group seems to serve to lift the isolation so often experienced by people coming to the programme. In time it seems to assist in the development of secure attachment and behavioural change.

> *"Individuals who identify more strongly with their group are more likely to engage in behaviours that are normative of the group* (Terry and Hogg 1996).

Along with a shift in thinking about duration and philosophy of treatment, the Government has recognised the need of families to have some autonomy over what treatment and support they receive, resulting in the Ministry of Social Development tendering for Family Centred Services. The Family Centred Services contract has allowed SVD more flexibility in how we work. Our services have grown to encompass working with couples and families.

Our services now consist of group and individual stopping violence programmes, personal therapy, couple therapy, group therapy, and family therapy.

We are seeing current trends that lean towards manualised programmes again, this generates some fear, because our agency has come to understand that this type of approach may address issues in the short term but does not have the long-term impact needed to create sustainable change.

As part of our reflective practice SVD is committed to evaluating what we are doing and how, in both narrative and data-driven ways.

## Review of Literature

In June 2017, Auckland University's New Zealand Family Violence Clearinghouse[1] reported in a press release:

> Police family violence investigations reached a record high in 2016, data published today by the New Zealand Family Violence Clearinghouse show.
>
> Police investigated 118,910 incidents of family violence last year, an increase of more than 8000 on the year before. This is up from 110,126 in 2015 and 101,955 in 2014.
>
> Dr Pauline Gulliver from the New Zealand Family Violence Clearinghouse said "We don't know whether this is due to an increase in violence or an increase in people coming forward. However it is clear that demand on services continues to increase." (NZFVC 26.07.2017)

The Data Summaries collected by NZFVC cover family violence, intimate partner violence, adult sexual assault and violence against children and young people. Recent snapshots of the statistics of family violence show that in 2016 police investigations took 41% of frontline police officers' time. 5461 Protection Orders were made, 90% by women and 10% by men. There were 6377 recorded male-assaults-female victimisations and 4852 prosecutions for breaches of protection orders. 35% (one in three) of ever-partnered women report intimate partner physical or sexual violence in their lifetime. This rises to 55% if emotional and verbal abuse is included. In 98% of deaths from intimate partner violence there is a known history of abuse. In 2014, 24% of women and 6% of men reported having been sexually assaulted in their lifetime. Depending on the source, betwee one in three and one in five New Zealand women and one in ten men report having experienced sexual abuse as a child. (NZFVC June 2017). In 2015, there were 10 recorded homicides by a family member of young people under 20 and there were 63 admissions to hospital involving children under 16 having been assaulted by a family member. The total

[1] The New Zealand Family Violence Clearinghouse (NZFVCH), which is updated regularly, offers current information and research reports on Family Violence. It is operated by the University of Auckland under a contract funded by the Families Commission. The project emerged in association with *Te Rito: New Zealand Family Violence Prevention Strategy (2002)*.

social, economic and fiscal cost is estimated at between $4.1-7.0 billion per annum (Fairhall 2016, p2).

While one cannot interpret raw data like this without a point of comparison, this is an unenviable picture of current and historical violence in Aotearoa New Zealand society. It is therefore vital that responses to family violence are evaluated. We need to know what works, and how well it works.

Stopping violence programmes as we know them today arose as a consequence of the Domestic Violence Act 1995, s14.[2] Violence was to be addressed 'not only through protection orders but also by offering domestic violence programmes pursuant to sections 29 through 44 of the Domestic Violence Act 1995, thus providing mechanisms for both protected persons and perpetrators of violence to attend programmes.' (Boshier 2009). The parameters of these programmes grew and changed over the years. However, as a review of the legislation's effectiveness stated in 2016:

> 'There is a lack of clear and convincing evidence for what works in responding to family violence. This is impacted by a range of factors including inconsistent understandings of what constitutes family violence, and low reporting of family violence to Police. The lack, and variability, of evidence has required assumptions to be made about the scale of the problems identified, and the effectiveness of options and expected impacts are uncertain.' (Fairhall 2016, p1)

This review focusses pure on legislative responses – civil orders, criminal justice system response and cross-government information sharing – and conceds that:

> 'The continued high rates of family violence and reoffending indicate that the current justice system is not as effective as it could be at reducing family violence.' (p8)

It also emphasises that

[2]Information pertaining to the Domestic Violence Act 1995 can be found on the website http://www.legislation.govt.nz/

> ‘Punishing perpetrators without additional intervention is not effective at reducing reoffending .. The law should reduce the risk of future violence by challenging perpetrators to change their behaviour.’ (p10)

However, the evidence in relation to stopping violence programmes seems to be as mixed as it is in relation to legislative responses. Robertson (1999) questioned whether programmes were enhancing the safety of battered women or producing better educated batterers. Outlining various preventative courses and looking at how success was measured, Robertson found that the literature he reviewed had poor programme specification (it is often difficult to tell what was evaluated): wide variation of definitions of ‘success’ an over reliance on self-report data, short follow up periods and a common failure to distinguish programme effects from other factors in participants lives, such as separation, arrest or prosecution. Robertson does allow that the literature revealed a growing consensus favouring the useful role that treatment programmes for batterers are playing as a wider intervention.

Statistics regarding the effectiveness of stopping violence programmes have been hard to find. Slabber (2012) writes that the Domestic Violence field is dominated by the Domestic Abuse Intervention Project - the ‘Duluth Programme’ (Pence and Paymar 1993) a feminist psycho-educational model that attempts to teach participants to engage in or develop relationships on the basis of respect, equality and non-violence. This programme is commonly combined with the cognitive behavioural therapy (CBT) approach. The Duluth model is a ‘one-size-fits-all’ approach based on a feminist analysis of violence as resulting from ‘socio-political forces that are influenced by patriarchal philosophy’ (Slabber, p1). Cognitive-behavioural approaches assume that domestic violence is learned behaviour that can be unlearned and replaced with pro-social, relationship-building behaviour. Slabber notes increasing dissatisfaction with the Duluth socio-political stance, and increasing interest in CBT-based approaches, ‘modifying faulty cognitive processes, and building behavioural skills to reduce anger (e.g. timeout, relaxation training and changing negative attributions), to manage conflict and to increase positive interaction (such as active listening and assertiveness)’ (p5). In other jurisdictions, particularly in the United Kingdom, a ‘Risk-Needs-Responsivity’ approach, developed from working with the larger population of general offenders. Largely cognitive-behavioural in nature, this approach targets various level of risk with methods appropriate to that group, and depends on

careful assessment, particularly of risk.

McMaster & Wells, (2003) referred to both Duluth and CBT as having influenced local programming. McMaster found only four evaluation studies and while they were all positive, none met the criteria for adequate study design or follow up. It is difficult to compare programmes, as they often have different lengths. Morgan and O'Neill (2001) documented an outcome evaluation of a New Zealand stopping violence programme for men using an analysis of pre- and post-programme interviews. They found that men's accounts demonstrated movement towards taking greater ownership and responsibility for their actions, although '…the trend was not universal and was mitigated through other pre-programme discursive resources'.

Eden & Nilsson (2014) challenged the effectiveness of the long standing Duluth-inspired programmes, finding that '…overall, most reviews of intervention programmes for men inclined to violence have reported quite pessimistic efficacy reports, inviting additional research and improvement'.

Slabber concludes that there is, over a number of meta-analyses, evidence for a weak positive impact on recidivism rates, although there are few studies, and methodology is often weak. More robust research designs tend to show smaller effects. Studies comparing the Duluth with CBT approaches suggest no difference in effectiveness. Citing Babcock et al. (2004), effectiveness rates between 5% and 15% are reported, which seems low, though the authors comment that even small improvements are welcome considering the cost and impact of domestic violence. Citing Feder and Wilson (2005), Slabber reports that results can be even more mixed, with a 7% decrease in recidivism reported, but when partner reports were used as the measure, this dropped to zero.

In general, Slabber concludes that the more effective interventions are those that draw on work with other types of criminality, following the principles of the Risk-Needs-Responsivity approach, matching intensity of intervention to the risk level of the offender. 'Criminogenic Needs' – the individual needs and risk factors of each offender, such as employment, marital and family relationships, associations, substance abuse, community functioning, personal and emotional stability and criminal attitudes – should be assessed and individually targeted in the same way as is done for general criminal behaviour. The more aggression, in general, the greater

the criminogenic needs. Citing McMaster and Wells, (2003) Slabber notes that the limits on community-based programmes set by New Zealand legislation, allowing a maximum of 50 hours, may be inadequate for some high-risk offenders. Gulliver & Fanslow (2016) conclude that:

> 'There is no single causal factor for intimate partner violence that, if modified, will eliminate violence from occurring. Instead, the likelihood of violence being perpetrated or experienced is influenced by a constellation of factors working at a number of different levels, from historical and macro-social factors, to factors unique to the individual.'

These considerations suggest a shift in thinking, away from treating domestic violence offenders as a separate group motivated by patriarchal socio-political forces, and seeing them as 'not profoundly different from other offenders' (p13), and also towards more complex assessment of potential programme participants. Citing Polaschek (2011) again, Slabber suggests that current community programmes may not offer the level of assessment and skilled intervention required by high-risk offenders. There are cautions against overly simplistic philosophy, and warnings that if programmes are not assessing complexity, they may be less effective. Citing Baker (2011), programmes should focus on 'motivating change and exploring desirable behaviours' rather than fitting the participant's behaviour into an established model. Models with high integrity – using available models of criminal behaviour, with staff who are skilled and well supervised, with desired practice explicitly described in written materials, which deliver programmes as intended – are more likely to be successful. Citing Wales and Tiller (2011), flexibility and complexity in service delivery by skilled workers, rather than a 'tick-box' approach, is recommended. Thus integrity of programme delivery is important, but not to the point of delivering a highly manualised product. Multi-skilled, well supported workers who can adapt what they do to varying risk levels and other idiosyncratic characteristics of whoever is in the room, so to speak, and at the same time abide by clearly-stated principles of programme delivery, seem, on the basis of this literature, to be likely to obtain positive outcomes. Collaborative rather than confrontational approaches are recommended.

Thornley (2013), in another review of literature, suggests that 'Cross-sector, multi-agency preventions are required to address the complex causes of and impacts on intimate partner

violence' (p3). In line with this societal-based approach, she finds that success-factors for primary prevention include multi-level intervention (societal, community, family/whānau, individual), a theory-of-change basis (a conclusion shared by Slabber, above), local design and cultural specificity, 'positive, strengths-based approaches', community-driven interventions and the involvement of community leadership, addressing 'structural factors' such as gender and income inequality, racism, ageism, and incorporating evaluation of the impact of the programme (p5).

Principle Family Court Judge Peter Boshier (2009) questions the long term effect of programmes stating that 'increased wellbeing experienced by programme participants during and immediately after the programme declined significantly within a few months of the end of the programme'. This suggests that pastoral care following completion may be vital. Cross sectional studies and cohort studies were used to identify risk and protective factors for IPV. It became apparent that because IPV research is such a young field, few cohort studies have been designed to understand specifically how early life factors have enhanced, reduced or predicted the likelihood of IPV.

This literature both supports and casts doubt on the benefits of stopping violence programmes. The findings are often the consequence of poor methodology, though the three major reviews cited here – Slabber, Thornley and the legislative review by Fairhall – do build up a picture of what is likely to work. The need for programmes to be engaged in evaluation, such as the current study, is emphasised in several sources.

**Methodology**

The aim of this study is to capture a cross-section of data for Stopping Violence Dunedin, to illustrate strengths and weaknesses of the SVD programmes. Both quantitative and qualitative data were sought. The database of all participants kept on file is useful, but does not tell us of the experiences of participants whilst attending courses. Focus groups were used in the hope that combining the information on file with the information from focus group sessions, we would form a picture of outcomes, with data enriched by the participants stories, offering context and meaning as well as figures. In addition, a series of follow-up structured interviews were conducted. It was rather difficult to collect useful data, however, as it proved impossible to persuade service users to come into the facility for a follow-up interview, though phone interviewing proved more successful. A structured interview was designed by psychologist Jacob Ashdown, who agreed to a modified form based on one developed for his Master's thesis, and although it proved impossible to make complete recordings of interviews, the interviewer attempted to write a verbatim account as the interview proceeded. The results were analysed by an external Researcher and are presented below.

Information was collated from the SVD database. In total there were 678 participants recorded between 05/04/13 - 22/12/15. We eliminated any file that was pre 2014 and also removed 42 participants who are solely attending the Kaiwhakaruruhau (Family Therapy) programme. Other files eliminated were duplicates, and files that were held at other offices. This left 502 files which were used to collect data.

There was also data from a follow-up survey. Unfortunately, this proved less useful, as there was no 'before' measure and no long term follow up, so there is nothing with which to compare the results. The data will be useful, however, in constructing a future tool, as it identifies those questions which elicit variation in answers as opposed to those that appear to invite unanimous responses.

A further impromptu study was conducted in response to a question about co-existing problems. It seemed to workers in the field that they were often dealing with violence in the setting of other important factors. Posttraumatic stress disorder, depression, substance abuse and social phobia were often thought to be present, so durin a single week, everyone attending a stopping violence

programme at SVD, which included five male and two two female groups, was invited to complete a Psychiatric Diagnostic Screening Questionnaire (Zimmerman and Mattia 2001). This is a tool consisting of 101 yes/no questions, indicating symptomatology in thirteen diagnostic areas, based on DSM-IV.

**Demographic Data**

*Table 1: Percentage of Referrals to SVD programmes 2014 – 2015*

| | CC | FC | SR | Total |
|---|---|---|---|---|
| Male | 129 | 156 | 147 | 432 |
| Female | 20 | 1 | 41 | 62 |
| Unknown | 0 | 3 | 5 | 8 |
| Total | 149 | 160 | 193 | 502 |
| % | 29.7 | 31.9 | 38.4 | |

This table shows that while the the combined Court and Family Court referrals, including those resulting from a total of 204 Protection Orders, make up the majority, there was a significant number of self-referrals. Anecdotal reports from facilitators suggest that these are people asking to join a group because they are worried about their own violent tendencies. Many of them have previously completed a programme and after some time has elapsed have noticed warning signs and returned voluntarily. Others have completed the mandated requirement but wish to remain in the programme for longer than is required by the courts. Of a total of 502 referrals, 63 were women, 20 of whom were Court Ordered, 1 woman was referred by the Family Court and 42 were Self Referred.

*Table 2: Ethnicities of Participants of SVD:*

| | Māori | Pākeha | Pacifica | Indian | Unknown | Total |
|---|---|---|---|---|---|---|
| Male | 78 | 220 | 16 | 3 | 115 | 432 |
| Female | 15 | 24 | 3 | 0 | 20 | 62 |
| Unknown | 0 | 0 | 0 | 0 | 8 | 8 |
| Total | 93 | 244 | 19 | 3 | 143 | 502 |
| % | 18.5 | 48.6 | 3.8 | 0.6 | 28.5 | 100.0 |

The largest group of SVD participants whose ethnicity is known during 2014 - 2015 is Pākeha, with a significant minority of Māori, and 28.3% either not knowing or choosing an ethnicity. It is worth comparing these figures with Census data for Dunedin city, shown in Table 3 below[3].

[3]http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-a-place.aspx?request_value=15022&tabname=

*Table 3: Census Data 2013*

| Ethnic group | Dunedin City (%) |
|---|---|
| European | 88.3 |
| Māori | 7.7 |
| Pacific peoples | 2.5 |
| Asian | 6.2 |
| Middle Eastern, Latin American, African | 1.0 |
| New Zealander | 2.1 |

The ratios of Pākehā (European) to Māori, measured as numbers of Pākehā to one Māori is shown in Table 4 below.

*Table 4: Pākehā-Māori Ratios*

| | |
|---|---|
| National Census 2013 | 11.47:1 |
| SVD data | 2.62:1 |

Māori are disproportionately represented, by more than four times what the population data would predict.

Māori are also over-represented among self-referrals - over one third of the total - the other two-thirds comprising combined other ethnicities, including Pākehā. It is possible that a cultural sensibility and some elements of a Te Āo Māori framework within SVD practice may be a factor attracting Māori to the programme.

The Ministry of Health on 8 October 2015[4] reported that Māori adults were more likely than non-Māori adults to suffer adverse health effects as the victims of violence. Māori adults were more than 2.5 times as likely as non-Māori to die from assault and homicide. The disparity was greater for males: the Māori male rate was nearly four times as high as that of non-Māori males.

[4]Statistics found for Interpersonal Violence found on the Ministry of Health Website at http://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/interpersonal-violence

*Table 5: Age of participants:*

| Age | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+ | U/K | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N= | 15 | 81 | 111 | 55 | 41 | 40 | 26 | 23 | 7 | 3 | 3 | 97 | 502 |

The average age of our participant database was 33 years old, the youngest being 16 and the oldest 75. 16 -20 year olds made up 5.18%. The percentage triples to 18.33% for the ages 21 -25 year olds and peaks with the 26 - 30 group, at 20.52%, and then reduces dramatically as participants head towards their forties.

*Table 6: Week of Withdrawal*

| Withdrawal Date | Total |
|---|---|
| Week 1-5 | 67 |
| Week 6-10 | 32 |
| Week 11-15 | 16 |
| Week 16-20 | 9 |
| Week 21-25 | 7 |

The majority of withdrawals occurred in the first week of the 25-week programme, when the intake appointment was made, where a high percentage would either not show or not return. Thereafter the greatest risk of withdrawal was at between five and seven weeks suggesting that if a person makes it through the first 6 weeks they are more inclined to complete the programme.

*Table 7: Marital status and referral source*

| | CC | FC | SR | Total | % |
|---|---|---|---|---|---|
| Married/ De Facto | 44 | 27 | 66 | 137 | 27.3 |
| Separated/ Single | 76 | 88 | 67 | 231 | 46 |
| R/ship Unknown | 29 | 45 | 60 | 134 | 26.7 |
| Total | | | | 502 | 100.0 |

A high percentage of participants were separated or single, or the information was unknown at the time of collating the data. Comparing the referrals by status suggests that Family Court and Corrections participants are more likely to be separated while self-referrals are more likely to be in relationship, married or de facto.

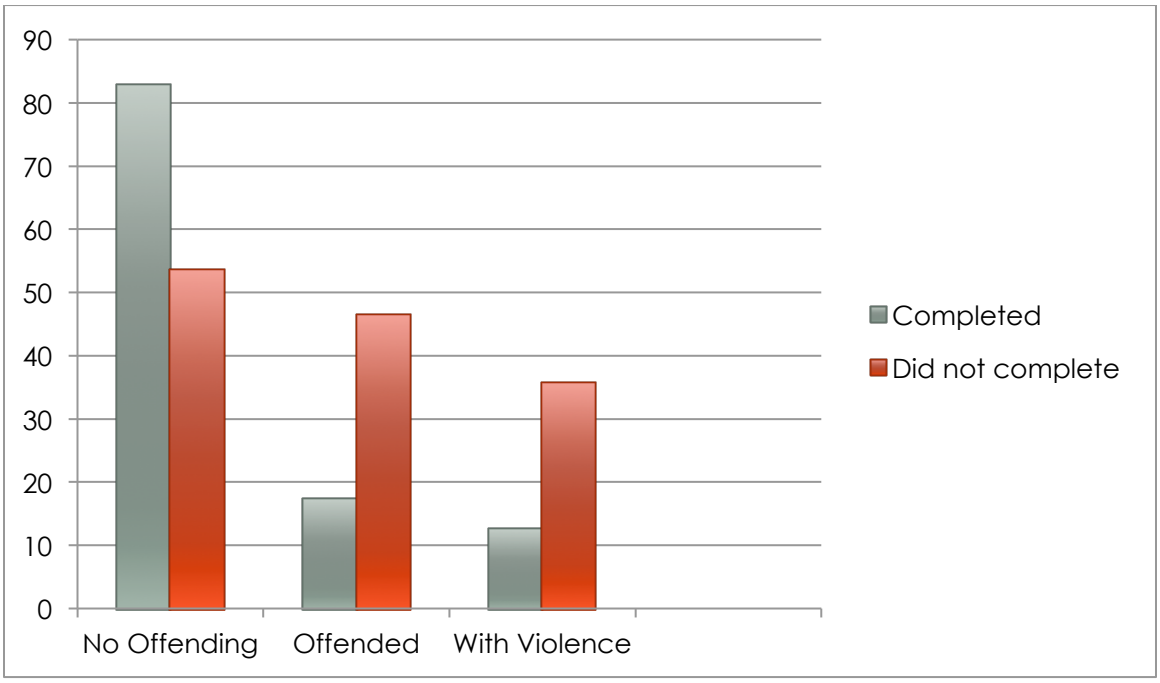
**Recidivism Rates for Court Ordered Participants**

A list of referrals covering the period 1 July 2014 to 30 June 2015 from the Department of Corrections – people who had been sentenced in court for a violent offence and compelled to attend a stopping violence programme - was compiled both from data in the files of SVD and from data held by the Community Probation Service, who oversee such referrals. A total of 115 people were identified for whom reoffending data could be established on 30 June 2016. To establish a comparison, we were able to establish whether or not they had completed a programme. The results are given below in Table 8 and visually in Chart 1 below.

*Table 8: Recidivism*

| | No re-offending % | Re-offended % | With violence % |
|---|---|---|---|
| Completed N=87 | 83.0 | 17.2 | 12.6 |
| Did Not Complete N=28 | 53.6 | 46.4 | 35.7 |

*Chart 1: Recidivism*




This chart looks, on the surface, reasonably positive. Those who completed a programme were less likely to have re-offended than those who did not. Caution is needed with this interpretation,

however, as causality cannot be assumed. It may indeed be that completing a programme lowers the risk of offending, but equally it may be that those who carry a low risk for offending are more likely to complete a programme, because they may be less impulsive, delinquent or angry.

A further weakness is that the follow-up period varies. A group programme is 25 weekly sessions, or something over six months. The subjects, being referred before the end of June 2015, may have completed a programme anything from six months to a year before the data were sampled. Some subjects, beginning a programme just before the end of June 2015, would, if they completed it in early 2016, have had less than six months post-programme to offend before the data collection date. Some, being referred early in July 2014, could have completed almost a year before the collection date. However, we can assume that the spread is random over both populations (completed and not completed), evening out the effect of some people having had longer in which to offend.

Finally, the Department of Corrections did not separate men from women, so we do not have separate data according to gender.

**Clinical Picture**

For a period of one week, 14-18 November 2016, each of the group programmes at Stopping Violence Dunedin was asked to participate in taking a 'snapshot' of possible psychiatric disorders currently measurable. There were five men's groups, providing 44 responses, and two women's groups, providing 10. The tool chosen was the Psychiatric Diagnostic Screening Questionnaire (PDSQ), a 101 (yes/no) item questionnaire indicating the possible presence of 13 diagnostic categories based on DSM-IV-TR (American Psychiatric Association 2000). The test was administered by reading each question to the group and asking each participant to tick either the 'yes' or 'no' box for that question on a standard answer sheet.

Seven additional yes/no questions were asked:

- Have you ever been diagnosed with depression?
- Have you even been diagnosed with anxiety?
- Have you ever been diagnosed with bipolar disorder?
- Have you ever been diagnosed with posttraumatic stress disorder?
- Have you ever been prescribed an antidepressant medication?
- Have you ever been prescribed sleeping pills?
- Have you ever been admitted to a psychiatric ward?

A summary of the results, showing what proportion of the participants met or exceeded the criterion on each diagnostic category, is given in Table 9 below.

*Table 9: PDSQ-Indicated Diagnosis – Percentages*

| Diagnosis | All N=54 | Women N=10 | Men N=44 |
|---|---|---|---|
| MDD | 31.5 | 80 | 20.4 |
| PTSD | 41.8 | 70 | 43.2 |
| Eating Dis. | 7.4 | 10 | 6.8 |
| OCD | 40.7 | 80 | 31.8 |
| Panic Dis. | 18.5 | 40 | 13.6 |
| Psychosis | 48.1 | 80 | 40.9 |
| Agoraphobia | 13.0 | 40 | 6.8 |
| Social Phobia | 37.0 | 60 | 31.8 |
| Alcohol | 31.5 | 30 | 31.8 |
| Other Drug | 33.3 | 80 | 25.0 |
| GAD | 31.5 | 80 | 20.5 |
| Somatization | 29.6 | 80 | 18.1 |
| Hypochondiasis | 27.8 | 40 | 25.0 |

A clearer picture emerges if we group anxiety and depressive disorders together (Depression, PTSD, OCD, Panic Dis, Agorophobia, Social Phobia) and addictive disorders (Alcohol and Other Drug) together, as is commonly done in mental health surveys (for instance, Adamson, Todd et al. 2006). For this purpose PTSD is grouped with anxiety disorders, as is done in DSM-IV-TR (the PDSQ questionnaire is based on DSM-IV) as opposed to being grouped on its own or in a category of trauma-related disorders, as is done in DSM-5. The results are displayed in Table 10.

*Table 10: Selected PDSQ Diagnostic Categories Grouped - Percentages*

| **Diagnosis** | **All N=54** | **Women N=10** | **Men N=44** |
|---|---|---|---|
| Any Mood or Anxiety Dis. | 64.8 N=37 | 90.0 N=9 | 63.6 N=28 |
| Any Substance Use Dis | 48.1 N=26 | 80 N=8 | 40.9 N=18 |

These figures represent a 'snapshot' picture of what psychological distress the participants may be carrying. The 7 additional questions represent an attempt to look at lifetime prevalence. This data is given in Table 11 below.

*Table 11: Responses to Lifetime Prevalence Questions*

| Question | All N=54 | Women N=10 | Men N=44 |
|---|---|---|---|
| Diag. Depression | 44.4 | 90 | 34.0 |
| Diag. Anx. | 33.3 | 70 | 25.0 |
| Diag. B Dis | 7.4 | 10 | 6.8 |
| Diag. PTSD | 11.1 | 20 | 10.0 |
| Prescr Anti-D | 51.9 | 90 | 43.2 |
| Prescr Sleep | 38.9 | 70 | 31.8 |
| Admitted | 18.5 | 20 | 18.1 |

This is simplified below in Table 12 by grouping depression, anxiety, PTSD and bipolar disorder. An additional figure is obtained by adding those who had been prescribed an antidepressant drug, whether or not they were aware of a diagnosis of depression.

*Table 12: Responses to Lifetime Prevalence Questions, Grouped*

| Question | All N=54 | Women N=10 | Men N=44 |
|---|---|---|---|
| Diagnosed Mood or Anxiety Dis | 48.1 N=26 | 90 N=9 | 38.6 N=17 |
| Diagnosed or prescribed | 57.4 N=31 | 90 N=9 | 50 N=22 |

To help understand these figures, population data was used as a comparison. The NZ Mental Health Foundation 2014[5] report suggests that 16% of New Zealanders are diagnosed with a common mental disorder in their lifetimes, including depression, anxiety and bipolar disorder.

[5] https://www.mentalhealth.org.nz/assets/Uploads/MHF-Quick-facts-and-stats-FINAL.pdf

The most extreme measure in the figures above – those who have been admitted to a psychiatric ward – exceeds this figure, at 18.5%, and the lifetime prevalence of diagnosis, at 48.1%, and of either being diagnosed or prescribed for, at 57.4%, is much higher. All of these measures suggest that this population far exceeds the norm in their levels of psychological distress. The Mental Health Foundation's lifetime prevalence of 20% for women and 13% for men are compared with 90% for women and 50% for men in this sample. (The percentage of men actually reporting having been diagnosed with a mood or anxiety disorder is 38.6%, but when one adds having been prescribed an antidepressant this jumps to 57.4%. The sample is small, but 5 men, or 11%, it would seem, are prescribed an antidepressant without realizing or accepting that this means a diagnosis of depression. There are no women in this category. It is possible that antidepressants are prescribed for other reasons, but perhaps more likely that men are simply less aware of their own mental state than women.)

The Mental Health Foundation report also suggests that women are more frequently diagnosed with a mental health problem, by a factor of 1.6. In the data above, the ratio is similar for the PDSQ data on mood and anxiety disorders, with women exceeding men by a factor of 1.4, but for substance use disorders women have almost twice the incidence, and for depression the ration is almost four to one.

These conclusions must be tempered, as the sample is small, particularly the sample of women, at only 10 participants. Nevertheless, one must wonder why the figures for women, especially for depression, are so much higher than the male sample. One possible explanation is that the bar may be somewhat higher for women to be referred to a stopping violence programme. There is evidence that court responses to similar crimes vary according to gender, with men tending to be held to account, while the court seems more willing to listen to explanations for the behaviour of women (Jeffries 2001). Violent men will readily be referred, but there may be a reticence on the part of referring agencies concerning violent women. Thus the women who are referred may have rather extreme behaviour patterns.

**Follow-up interviews**

*Method:*

The intention in this section of the research was to use a structured interview format to conduct follow-up interviews with participants from the 2014-2015 sample. The Interview format used was a modification of a format developed by the external researcher for an MSc thesis studying outcomes in a residential therapeutic community programme for male offenders (Appendix A). In the event, it proved almost impossible to persuade participants to attend face-to-face interviews – people were unwilling to give up their time - so those who were willing were interviewed by phone. 11 interviews were conducted, the respondents selected by working through a list of possible respondents, selected by taking every fifth person from the list of original participants. A great many were uncontactable, either because their contact details had changed or they would not respond. The interviewer manually transcribed each interviewee's answers as closely as possible (recording the phone calls proved technically too difficult) and the notes were sent to an external researcher for analysis. The results are as follows.

***Participants perceived that the programme was successful and that they experienced less anger, violence and had increased self–control.***

Participants perceived that the programme helped them make positive changes in their day-to-day lives. Some participants reported improvements in self-control while others reported feeling *"calmer"* since attending the programme:

> *"Um before I started Stopping Violence I was under a lot of stress and used to take it out on my partner um but now that I have done SVD and I have actually come right, a lot better and control myself a bit better than what I did"*

> *"Um I suppose life in general probably has changed a wee bit some of the stresses aren't as prominent and just in general being a bit calmer"*

***Participants learned various strategies that helped improved self-control***

The programme has helped participants to become more aware of their patterns of behaviours that can lead towards violence. Participants perceived that this increased self-awareness has been beneficial in helping them to manage their behaviour in difficult situations:

> *"Um it sort of forced me to have a lot of personal reflections it created more of a self-awareness of my actions"*

Participants perceived that they had an increased awareness in regards to *"triggers"* that lead to difficult situations and this helped them to avoid confrontations where they might react with violence:

> *"Learning about trigger signs stuff like that. When I do get winded up, how to deal with it, I know how to walk away from situations that I don't want to be in"*

Participants perceived that they learned how to *"walk away"* in situations where they felt they were becoming angry and this was a beneficial strategy for helping them to avoid reacting with violence:

> *"How to handle problems a bit better. Somebody kinda talking smartly to you just smirk and walk away. Last night I had a few problems of with a couple of flat mates getting their gear out and we got into a bit of a tiff and I just wanted to knock him out but instead I just walked away. All these little things keep coming back up where I use them"*

***Participants perceived that the SVD programme enhanced their capacity for empathy***

Participants described how group therapy was beneficial for helping them to understand how their actions impact on others. Hearing the perspectives from other group members enabled them to view situations and events from another person's perspectives:

> *"We'd discuss how it could've been done better and why and try and see the other person's point of view"*

One participant described how the programme enabled him to have an increased awareness on how his behaviour affects others:

> *"I think I am more aware of moods I am in and the effects it has on others"*

***Participants reported improvements in communication***

Participants described how the SVD programme helped improved their ability to communicate in pro-social ways. In particular, participants perceived that they were able to talk their way through stressful situations and this was beneficial for preventing them from reacting with violence:

> *"Really just made me again see that a conversation was heading down a path or I was going to a get into heated argument giving me the tools to use the right words to get out of that situation before I got there"*

Participants also described how they were able to resolve issues after being in an argument or becoming angry:

> *"My skills now if I find myself getting worked up is I normally go for a walk, I have learned not to drive cause when you have that anger feeling get angry you go fast, I have learned to go for a walk and that might be 20/30 minute walk and go back and talk"*

Participants perceived that the programme was particularly beneficial in helping them to communicate with family and partners:

> *"I have practiced quite a bit of it when if me and my partner have a bit of fight and that I stay calm and try not to raise my voice try and talk about it properly"*

***Participants perceived that relationships with family and partners had improved***

Participants described how the programme helped improved their communication in relationships with family and partners and perceived that these relationships had improved. Participants also reported how friends, family and partners had noticed a difference in their behaviour since attending the SVD programme:

*"Well it's been a lot better with me and my partner my partner has noticed a big difference in myself and same as my friends also have noticed a big impact of the way I am and the way I do things yea."*

*"Um they just noticed that I am more likely to stay calm in a tense environment my sister observed the other day about the brother I had an argument with , winding up my 77 old year old mum sending her letters to wind her up. Comes to dinner once a week and I stayed calm and discussed it, and my sister was surprised with the way I handled it. Didn't fly off the handle like I used to"*

***Participants were satisfied with the SVD environment and atmosphere***

Participants described the atmosphere as "friendly" and "warm" which enhanced the therapeutic environment. This atmosphere helped them to feel comfortable to share and participate in the group therapy sessions:

*"Friendly atmosphere nothing violent well the courses aren't meant to be are they ...quite good, all kept above board nothing serious nothing big going on. Friendly atmosphere and all had their say. Found it quite good"*

One participant described how he found the SVD programme enjoyable:

*"I enjoyed it I looked forward to coming all the time, towards the end when i was coming to the end of my five years, I was getting past it, I thoroughly enjoyed what it did for me and I enjoyed being here"*

Some participants said that they had recommended the SVD programme to others:

*"Actually I've just actually recommended it to a couple of people"*

***Participants were satisfied with the service provided by the SVD facilitators***

Participants perceived the facilitators "helpful", "understanding" and "easy to talk to":

*"The facilitators made an inviting environment, if you have a problem they would encourage you to tell them either in group or privately"*

*"Very good. Very helpful and understanding very easy to talk to"*

Participants described the therapy sessions as well prepared and felt that they created a positive atmosphere and therapeutic environment:

*"Facilitators were good, well prepared, brought it out in the open as it was, what I got here and what i gotta do..well spoken pretty good"*

*"They were really welcoming. They helped me get things off my chest. I actually burst into tears"*

***The majority of participants felt that the length and timing of sessions was appropriate and the overall duration of the course was adequate, however responses varied***

The majority of the 11 participants were satisfied with the length and timing of the sessions as well as the overall duration of the 25 week course:

*P: "The length and timing of the two hours is pretty good, we get a ten minute break in the first hour and then have a coffee and a smoke and we come back in and do the other hour"*

*R: "and the 25 weeks?"*

*P: "That's a good length of time I have been going for 25 weeks three times over"*

Some participants thought the length of the overall programme was too long:

*"A bit long, christ I was counting the weeks and went to Tuesday night and was like jeeze only 10 to go, or 4 to go you know quite a long course, I suppose people need the long course to get it through their heads you know"*

While others thought it needed to be longer:

*"The two hours is plenty but I think the 25 weeks course is only half of what should be required. I don't think that after 25 weeks you are only starting to look at it? I look at it this way I was dealing with 55 years of crap some of the other fellas only a few years, I don't think you can deal with it all in 26 weeks. In fact I am absolutely certain of it"*

***Some participants reported reductions in alcohol consumption:***

Some participants described how they had reduced their alcohol consumption since attending the SVD programme as they were aware of the relationship between their drinking behaviours and violence:

*"I have cut my drinking back...yeah. I don't drink as much now, and we still go to the pub and don't drink as much"*

*"sometimes when you get drunk it can bring on the violence side of ya. Yeah that's what I thought, cut it back"*

***Participants were satisfied with the SVD programme but two participants had minor suggestions for improvement:***

The majority of participants did not have any recommendations to improve the SVD programme:

*"No I don't. It was quite good as it was"*

Two of the 11 participants would have preferred to undertake 1:1 counseling as opposed to group therapy. One participant said that 1:1 would have been preferable as he had difficulties with concentration and reading and writing:

*"I did group I wanted to do one on one because I can't really read or write that well and thought it might help, thought it would have helped but I just sat there a wee bit and sat there and didn't pay too much attentions. The first time I was young. I was only 18 for the first group, at a group as well"*

One of the participants described how he felt that the name of the programme was stigmatising:

*"Um on the whole pretty well, um probably the hardest part not the programme the name itself the Stopping Violence because violence indicates that it carries with it a label and that was the hardest as it brings with a whole lot of connotations that might not be true"*

***Conclusions and summary of participants' recommendations from the follow-up interviews***

The qualitative data from the interviews with clients of the SVD programme presented in this evaluation provides important evidence of participants' experiences of the SVD programme. Four key findings are reported from the qualitative data that serve as recommendations that reflect the participants' voices.

*Key finding 1:* Participants perceived that the programme was successful and experienced less violence and more self-control since attending the programme. Participants were able to learn a number of strategies that helped them manage themselves more appropriately in stressful or volatile situations in their everyday living. These strategies included pro-social communication and avoiding confrontation by walking away. Participants perceived that they had increased self-awareness around "triggers" and an increased capacity for empathetic thinking as well as self-control. Additionally, some participants reported reductions in alcohol consumption.

*Key finding 2:* Participants experienced improved social functioning in their relationships with family, partners and friends. Participants perceived that their relationships with family, partners and friends had improved and that others close to them had noticed positive changes in their behaviour. Furthermore, participants perceived that communication with family and partners had improved.

*Key finding 3:* Participants were satisfied with the facilitators of the SVD programme. Participants perceived that the facilitators were understanding, well-prepared, and provided and warm and inviting atmosphere where they were able to comfortably share their experiences and participate in group discussions.

*Key finding 4:* Participants valued the SVD programme overall however there were some minor variations in regards to the appropriateness of the overall programme duration. Most were

satisfied with the length, while two participants thought that the 25 weeks was inadequate and three participants thought the programme was too long. One participant perceived that the name "Stopping Violence" was associated with negative connotations and recommended it be changed and two participants preferred 1:1 counselling over group therapy. It is recommended that there be consultation with SVD stakeholders in regards to the name of the programme. Lastly, it is recommended SVD consider how to facilitate the needs of those who prefer 1:1 counselling over group therapy. Despite these minor suggestions, participants valued the SVD programme overall.

**Focus Groups**

6 focus groups of between two and eight people were formed from those accepted an invitation at attend. They were invited, by means of four questions, to provide feedback on the effect of the SVD programmes. There were one men's and one women's 'Completed' groups, and one men's and 1 women's 'Non-completed/ongoing' groups, and two individual interviews with two 'Completed' women. The groups were facilitatd by a psychiatric nurse and registered counsellor who is an experienced group facilitator, not employed by SVD. A record was kept by a social worker employed by SVD. All participants were guided through an informed consent process by completing a form and giving their consent. They were advised of their right to withdraw at any time and assured that their information will be treated with confidence, other than the case of this report, in which no names are mentioned.

Men's Completed Focus Group: eight men

Men's Non-Completed/Ongoing: seven men

Women's Completed: two women

Women's Non-Completed/Ongoing: two individual interviews

The interviews were semi-structured and the groups were asked:

1. Did the programmes create a difference in their lives?
2. Did their wider community notice a change in them as people since doing the courses?
3. Thinking back what did they find useful about the courses?
4. What could be done to make the SVD courses better?

An interesting phenomenon emerged at this point - those who had not completed were more prone to having changed their phone numbers, and were therefore more difficult to contact, than those who had completed. This group was the most difficult to organise – it was harder to find people who would commit to coming. It is worth noting of course that there were far fewer women than men, resulting in fewer willing to participate in focus groups.

*Key Themes from Focus Group Discussions:*

*Facilitation Style*

The most common positive comment was that people found the facilitation styles, as opposed to the structured content, either the key to coming to groups and completing or the reason for wanting to leave the group. Facilitators who were perceived as having had life experience backed up by academic knowledge had more positive reviews than those who were perceived as purely 'academic'.

*Integration of new techniques for self-regulation*

Both completed and non-completed/ongoing participants all reported having learned new techniques to integrate into their daily lives and also that family and community had noticed the changes.

- "*that's what I love about my family because I have been sent here through family violence and my sons love that I come here still. If I have time away, I will go recluse and not want to go anywhere and my son will be on the phone and encourage me to keep coming back. So they must be able to see a difference.*"

*Families*

Families were important - participants seemed motivated to make change because of their families.

- *"So what made me stick the program was my children. Because basically I was in a position, that if I hadn't have sorted myself out, and get the help that I needed, I could have lost my boys, and I could have probably lost them for good to CYFS. And I didn't want that. Like what's been my whole life I know people that have come from families like that. So that's what pushed me to get into Stopping Violence. They are my motivators, like honestly, my boys are my motivators. And that was why I kept coming.."*

*Trust*

There was feedback that a feeling of trust within the SVD environment was an important factor in completing a programme.

*Mentors*

Many participants agreed that to have a designated mentor (mentors are participants who have completed a programme with positive results and who have skills in supporting others) for the first few weeks would be very helpful in overcoming the anxieties of the first few sessions.

*Psychodrama*

The use of psychodrama as a tool to encourage self-awareness and change was a focus of discussion. Initially participants felt reserved about it, but the majority found that trust of the facilitators made it easier to participate. The method was reported as allowing them to experience aspects of their lives from another point of view, or alternatively assist someone else see their behaviour patterns. The women were more inclined to appreciate the value of psychodrama more than the men.

*One-to-one and family services*

There were a number of positive statements about the one-to-one services available (a 12-week one-to-one programme was a possible alternative to a group, and family counselling is offered under the Kaiwhakaruruhau programme) when a group seemed inappropriate due to social phobia, or when working with the family seems a useful adjunct.

*Reciprocity*

A sense of reciprocity sometimes developed - a number of people returned or kept attending beyond what was required because they wanted to continue to help other people in the group. They found that the support that they received was helping to empower them in other aspects of their lives:

- *"I guess we no longer really are a burden on society. We are actually functioning members of society now. I love giving back, like I would do lots of events, and talk to a lot of people. Really push this place, promote this place. And do a lot. I reckon that working with the community together we can actually make a difference."*

*Welcome*

Many also found that as soon as they walked in they were warmly welcomed from their first contact at reception all the way through to the group rooms.

*Anxiety*

Commonly discussed was the anxiety that occurs for the participants upon first attending and how the first few group sessions are the hardest to come to.

- "*a bridge between here and there it would probably be a lot nicer with a progression into here, I think a lot of people come in here with a lot of fear of stopping violence, am going to be pigeon holed am I a woman basher blah blah it needs to be a little more broken down than meeting one on one with another member."*

Some participants left because of the anxiety created by walking into a large group of people (groups can contain up to 16 participants, plus two facilitators). Many participants thought that they were just coming to learn information from the whiteboard and were not prepared for the interactive style of groups. Some participants said when the groups got too big they felt unheard and rushed. Many preferred smaller groups of 7 -8 people.

Some participants worried about the confidentiality of the group and that there could be more done to appease anxieties concerning this.

*Complaints about other participants*

There was discussion about participants who do not talk and how unnerving that is.

One complaint was that some long term participants seem to be taking up space in the groups when other more desperate people could be attending the SVD programmes.

Some wanted to see a regular review to ascertain if participants are coping and able to implement the techniques and tools learned through the programme, and if not, to be given the option of one on one to enable further growth for themselves. Returning members were adamant that a review process should be in place for those who had been here for a long time, and for those who rarely participated in the groups sessions. A suggestion was;

- "*I think that's when that quarterly check would help cause really at the end of the day when it comes to funding and stuff you could have someone roll on here for as long as they feel like, you may as well have check points along the way."*

**Commentary on matters raised in the focus group process**

*Facilitation Style*

Generally facilitators who are recognisably similar to participants – who have similar histories and life difficulties, have been through similar programmes or have been to jail, are rated highly by participants. Facilitators who are from backgrounds that are not familiar, who have more academic qualifications, are more likely to be viewed with some suspicion. This seems natural, but it is an expression of *liking*, not a measure of effectiveness. That would require another project to determine, though it is likely that effective facilitators are similar to effective therapists, that is, high in empathy, warmth, genuineness, concreteness, immediacy and confrontation (Truax and Carkhuff 1967) or open-ended questioning, affirmation, reflection and summarising (Miller and Rollnick 2012) depending which model one prefers.

*Integration of new techniques for self-regulation*

As this is the major desired result of stopping violence programmes, it is not surprising to see it mentioned in focus groups. Caution is needed as this reporting can be idealistic and biased – participants who have invested considerable effort in attending a programme will ant there to be positive results, so self-reporting needs to be supported by more objective data.

*Families*

A major issue with stopping violence programmes is that they tend to focus on violent individuals out of context, so there has been a movement, funded through the Kaiwhakaruruhau initiative, to involve families, or at least to offer a service to them. It is gratifying that it is mentioned here.

*Trust and Anxiety*

These two factors, though reported one in positive and one in negative findings, seem to go together, one balancing the other. Bearing in mind that violent people can be expected to be more anxious – see the preceding section on clinical data, trust will be a major issue. The means to achieve it represent a major topic in the training and supervision of programme facilitators, which is somewhat beyond the scope of this document, but it can be expected to be related to outcome.

*Mentors*

The mentor programme, whereby experienced and successful participants attend groups in a supportive role, is deservedly popular, but depend on the availability of mentors. Such people, who are successful in this context, can be expected to build on that and be successful in other contexts, so naturally tend to move on in their careers, the mentor role serving as a stepping stone for them. This was also supported in research conducted by Devon Polaschek who states 'One avenue that has been little explored is the use of peer supports, 'buddies' (Polaschek 2016).

*Psychodrama*

Not all facilitators use psychodrama, but it is a popular technique, allowing for variety in group activities and serving several functions – being educative, integrative and absorbing. Its downside is that it can be exposing and cathartic, thus producing anxiety in participants who are more inhibited, but this can be overcome by skilled facilitation and it may be worth noting that specific methods like psychodrama are always delivered by staff with adequate training and supervision.

*One-to-one services*

There is a preference for group programmes rather than working one-to-one. Groups are seen as more effective, more efficient and more economical. There are times, nevertheless, when some flexibility is needed, as when a participant is very inhibited, schizoid or socially phobic to the extent that they are not able to participate. Also when a person's history is so alienating, as in the case of infanticide, a one-to-one alternative may be safer.

*Welcome*

It is good to see this variable emerge, as it is very much a core value of SVD.

*Reciprocity*

It is interesting to see this variable emerge from the focus groups. Yalom (2008) identifies altruism as a healing factor in groups – the ability to be useful to others is an established building block in self-esteem, and an antidote to violence.

*Complaints about other participants*

This can perhaps be taken with a pinch of salt. People do not come to a stopping violence programme because they are model citizens and though most are likeable, it can be expected that some will be irritating. This is not a reason for exclusion. Nor is having attended for a long time. There is no evidence that allowing people to continue in these groups indefinitely has any negative effect, and, as mentioned in the literature review above, it may be that the funded 50 hours is too short for some. The presence of people who have found the group useful and who know how to use it is likely to be a very positive and reassuring element for newcomers. At the time of writing about half of the participants in group programmes are self-referred, most of them having in the past completed a programme they were mandated to attend by either District or Family Court, and having remained or returned.

## Discussion

> *"It's a little embarrassing that after 45 years of research & study, the best advice I can give people is to be a little kinder to each other." Aldous Huxley*

The data collected on outcome is discussed above, the essence being that those who completed stopping violence programmes are less likely to re-offend than those who do not, although the causal relationship is less clear. It is possible that the argument is the other way round – those less likely to re-offend are more likely to complete a programme and to learn from it.

Interview data reinforces a positive view of outcome, with participants describing learning strategies that helped them manage themselves more appropriately in stressful or volatile situations, and reporting improved social functioning with family, partners and friends.

Picking this apart, trying to establish what it is about the programme that works and whether it works with a wide range of people as opposed to those who will change in any case, would require a different kind of research design. It is not possible to use control groups in this field, first because denying access to treatment would be unethical, and because even if we could show that completing a programme did cause a reduction in offending, we still would not know which aspect of the programme made it effective, and we could not control for all the possible curative factors in a programme, given that we could even define them. A 'practice-based evidence' approach (as opposed to evidence-based practice) might be more appropriate (Holmqvist, Philips et al. 2015). By this method, used in psychotherapy, both therapist and patient evaluate treatment as it proceeds. Some topics previously thought difficult to measure have been successfully researched, including the working alliance (Doran, Safran et al. 2012, Owen, Reese et al. 2013), transference, countertransference, therapist emotional expression, session quality (Markin, McCarthy et al. 2013), and therapists' and patients' attachment styles. Factors which have been teased out in this work, such as facilitator popularity, perceived welcome, anxiety and anxiety reduction strategies, alongside other possible candidates such as structured teaching, individual participation and comfort, could be investigated alongside extended personal clinical data.

The clinical data collected here suggest rates of anxiety and depression that are much higher than population norms. The implied degree of emotional distress – implied because the instrument used is designed to provide a guide only, being a tool to indicate to clinicians where they might look – suggests that the mental state of the participants deserves much more attention if we are to design effective programmes tailored to the needs of those attending, whether of their own volition, or sent by the courts. This would be a departure from tradition. It is unusual for stopping violence programmes to perform clinical or mental state assessments, most assessment data being, understandably, on the topic of safety. This kind of investigation might entail a more extended assessment on intake, using easily administered tools such as The Kessler K10 Psychological distress Scale (Kessler 2002), the Mini International Neuropsychiatric Inventory (Alexander 2008) and perhaps a measure of impulsivity. This could be re-administered on leaving or completing a programme and on follow-up, say six months or a year later.

Another note of caution is appropriate here. Instruments designed to gather data on symptomatology will do exactly that, but the significance of the findings is not necessarily clear. As Allen Frances, the chair of the task force on DSM-IV points out, in primary care, anything between 25% and 50% of patients present with emotional distress as part of the reason for going to see the doctor (Frances 2013, page 101). Frances is emphasising that emotional distress is a normal part of life, and in most cases is not a cause for treatment, but for patience, as it will in most cases get better with time. The data presented here are collected from a group who are currently experiencing difficulties in life – they are, after all, attending a stopping violence programme – and perhaps it should not be a surprise to find that they tend to carry more emotional distress than the norm. There is no way to tell how long-term that distress is, and how it relates to the fact that they all have, in one way or another, had dificulties with self regulation. Intuitively, and from a wide literature on self-regulation and attachment, it seems likely that these two factors (psychologial distress and self-regulation) are connected, but the data obtained here is not enough to establish that. We are also comparing data collected quickly by means of a symptom-sampling measure with national data obtained by careful assessments done by qualified clinicians, and we do not have a comparative study to guide us as to the reliability of our results, other than the item-by-item probabilities indicated by the (American) standardisation of the PDSQ, which indicates considerable room for skepticism.

Nevertheless, the pre-post-follow-up design suggested above would get around these objections, as we would be comparing apples with apples, so to speak, rather than drawing inferences from a single sampling.

The demographic data presented here describes a population varied in ethnicity, although with a disproportionate representation of indigenous people; marital status, with an expected high proportion of separated people; age, with people in their 20's over-represented; referral source, indicating about one third each from Corrections, Family Court, and self-referrals, but with large gaps in data for ethnicity (28% missing data) and marital status (27% missing data). Māori being over-represented is not surprising, as they are over represented in courts in general (Corrections 2007, Bolza 2016), and young males will predominate, being generally more extreme in their behaviour (for instance, Wilson 1985). It is also possible that the programme, which contains bicultural elements – both Māori and Pākehā facilitators, the occasional use of Māori language and protocol – is comfortable for Māori, and that young men predominate for a similar reason, that some effort is made to achieve an informal and non-judgmental atosphere. This latter hypothesis is supported by the self-referral data, where Māori are also over-represented

The demographic chart on the point of withdrawal for those who did not complete a programme is also an expected result, with most withdrawals occurring early in the programme, and those who make it past the first few meetings tending to stay. Observations drawn from the focus group project expand on this, suggest that anxiety about being in a group, or in any programme, is an important factor. The importance of feeling welcomed emerged from the focus groups and suggests that programme design should focus on the early stages, on inducting new group members and welcoming them.

In the wider context, a 'silo-ing' system whereby a person is directed to one agency to deal with their violent behaviour, to another to deal with their use of drugs and alcohol, to yet another to have their depression attended to, and so on, will have this effect. The factors assessed by any agency will reflect the job of that agency, as opposed to being focussed on the person referred in a holistic manner. This focus on single-issue problems (mental health *or* addiction *or* violence *or* relationship issues) prevents whānau-centred, Whānau Ora (Te Puni Kōkiri 2015), or holistic approaches, which are clearly indicated in the area of domestic violence. There is indication

here that people referred to a stopping violence programme in general carry more psychological distress, are more anxious, more depressed, more traumatised and have more issues with addiction than the population at large. Some recent funding strategies, for instance, the Kaiwhakaruruhau initiative, allow for family counselling, and there is limited allowance under Family Court and Corrections funding strategies. There is a reasonable argument to suggest that outcomes could be improved if interventions targetting relationship issues, sleep disorders, substance use, low mood, hyperarousal, low self-worth, and so on could be delevoped within or alongside stopping violence programmes as we know them.

This also supports an argument against highly manualised programmes. Programme design must be flexible, based on good assessment and a high level of skill among programme staff rather than on a one-size-fits-all programme design. As Cinnamon Boreham writes in the Introduction, this is the direction in which the current SVD service is developing. It would seem we are on the right track.

## Bibliography


Adamson, S. J., F. C. Todd, S. J. Douglas, T. Huriwai and J. Porter (2006). "Coexisting psychiatric disorders in a New Zealand outpatient alcohol and other drug clinical population." Australian and New Zealand Journal of Psychiatry(40): 164-179.

Alexander, M. J., Haugland, G., Lin, S.P., Bertollo, D.N., and McCorry, F.A. (2008). "Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS." International Journal on the Addictions **6**(1): 105-119.

American Psychiatric Association (2000). DSM-lV-TR: Diagnostic and Statistical Manual of Mental Disorders (4th Edition, text revision). Washington, DC, Americal Psychiatric Publishing.

Babcock, J. C., C. E. Green and C. Robie (2004). "Does batterers' treatment work? A meta analytic review of domestic violence treatment." Clinical Psychology Review **23**(8): 1023-1053.

Baker, G. (2011). Effective programmes for men who use family violence. Effective interventions with offenders: Lessons learned K. M. D. Riley. Christchurch, Hall McMaster & Associates and Steele Roberts Aotearoa**:** 191-206.

Bolza, M. (2016). Tackling Māori over-representation in the justice system. NZ Lawyer.

Boshier, P. (2009). Are stopping violence programmes worthwhile? Domestic Violence Hui. Awataha Marae, Auckland.

Corrections (2007). Over-representation of Māori in the criminal justice system: An exploratory report. D. o. Corrections. Wellington.

Doran, J. M., J. D. Safran, V. Waizmann, K. Bolger and C. Muran (2012). "The Alliance Negotiation Scale: Psychometric construction and preliminary reliability and validity analysis." Psychotherapy Research **22**(6): 710-719.

Edin, K., & Nilsson, B. (2014). "Men's violence: Narratives of men attending anti-violence programmes in Sweden." Women's Studies International Forum **46**: 96-106.

Fairhall, R. (2016). Review of family violence legislation: Regulatory impact statement. M. o. Justice. Wellington, Ministry of Justice.

Feder, L. and D. B. Wilson (2005). "A meta-analytic review of court-mandated batterer intervention programs: Can courts affect abusers' behavior?" Journal of Experimental Criminology **1**: 239–262.

Frances, A. (2013). Saving normal : an insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life. New York, NY, William Morrow, an imprint of HarperCollins publishers.

Gulliver, P., and Fanslow, J. . (2016). "Understanding research on risk and protective factors for intimate partner violence." from https://nzfvc.org.nz/seminars/intimate-partner-violence-understanding-research.

Holmqvist, R., B. Philips and M. Barkham (2015). "Developing practice-based evidence: benefits, challenges, and tensions." Psychotherapy Research **25**(1): 20-31.

Jeffries, S. (2001). Gender judgments: an investigation of gender differentiation in sentencing and remand in New Zealand. PhD, Universoty of Canterbury.

Jetten, J., C. Haslam and S. A. Haslam (2012). The Social Cure: Identity, Health and Wellbeing, Psychology Press.

Kessler, R. C., Andrews, G., Colpe, .et al (2002). "Short screening scales to monitor population prevalences and trends in non-specific psychological distress." Psychological Medicine, 32, 959-956. **32**: 956-959.

Kōkiri, T. P. (2015). Understanding whānau-centred approaches: analysis of phase one whānau ora research and monitoring results. T. P. Kōkiri.

Markin, R. D., K. S. McCarthy and J. P. Barber (2013). "Transference, countertransference, emotional expression, and session quality over the course of supportive expressive therapy: The raters' perspective." Psychotherapy Research **23**(2): 152-168.

McMaster, K. and A. Wells (2003). Preface. Innovative approaches to stopping family violence. K. McMaster and A. Wells. Wellington, Steele Roberts Aotearoa.

Miller, W. R. and S. Rollnick (2012). Motivational Interviewing, Third Edition: Helping People Change. London, NY, Guilford Press.

Morgan, M., & O'Neill, D. (2001). "Pragmatic Post-Structuralism (II); an outcomes evaluation of a stopping vilence programme." Journal of community & applied social psychology **11**(4): 277-289.

NZFVC. (26.07.2017). "NZFVC Data Summaries 2017: Family violence reports reach record high." from https://nzfvc.org.nz/news/nzfvc-data-summaries-2017-family-violence-reports-reach-record-high.

NZFVC. (June 2017). "Data Summaries 2017: Snapshot." from https://nzfvc.org.nz/sites/nzfvc.org.nz/files/Data-summaries-snapshot-2017.pdf.

Owen, I. R. (2017). On Attachment: the view from developmental psychology. London, Karnac.

Owen, J., R. J. Reese, K. Quirk and E. Rodolfa (2013). "Alliance in action: A new measure of clients' perceptions of therapists' alliance activity." Psychotherapy Research **23**(1): 67-77.

Pence, E. and M. Paymar (1993). Education groups for men who batter: The Duluth model. New York, Springer Publishing.

Polaschek, D. L. (2016). "Responding to perpetrators of family violence." New Zealand Family Violence Clearinghouse.

Robertson, N. (1999). "Stopping violence programmes: Enhancing the safety of battered women or producing better-educated batterers?" New Zealand Journal of Psychology **28**(2).

Slabber, M. (2012). Community-based domestic violence interventions : a literature review. D. o. Corrections. Wellington, Psychological Services, Department of Corrections.

Terry, D. J. and M. A. Hogg (1996). "Group norms and the attitude-behaviour relationship: a role for group identification." Pers Soc Psychol Bull **22**(8): 776-793.

Thornley, L. (2013). What Works to Prevent Intimate Partner Violence and Elder Abuse? M. o. S. Development. Wellington, NZ Government.

Todd, F. C. (2010). Te ariari o te oranga: the assesment and management of people with c-existing mental health and substance use problems. Wellington, Ministry of Health.

Truax, C. B. and R. R. Carkhuff (1967). Toward Effective Counselling and Psychotherapy. Chicago, Aldine.

Wales, D. T., N. (2011). The changing nature of interventions. Effective interventions with offenders: Lessons learned. K. M. D. Riley. Christchurch, Hall McMaster & Associates and Steele Roberts Aotearoa.**:** 33-52.

Wallin, D. J. (2007). Attachment in Psychotherapy. New York, London, The Guilford Press.

Wilson, M. a. D., M. (1985). "Competitiveness, risk taking, and violence: the young male syndrome." Ethology and Sociobiology **6**(1): 59-73.

Yalom, I. (2008). Theory and Practice of Group Psychotherapy 5th edition, Basic Books.

Zimmerman, M. and J. I. Mattia (2001). "The Psychiatric Diagnostic Screening Questionnaire: development, reliability and validity." Comprehensive Psychiatry **43**(3): 175-189.

## Appendix A: Structured Format for Follow-Up Interviews

| Topics | Questions | Prompts |
|---|---|---|
| Past | How would you describe the way things were before you attended Stopping Violence? | Were there particular issues that you remember?<br><br>What kinds of problems did you have as a family? |
| Motivation | What brought you to the Stopping Violence programme? | Did something happen that made you come to Stopping Violence?<br><br>How did you find out about it? |
| Learning outcomes | How has the Stopping Violence Programme helped you to learn about yourself?<br><br>What have you learned about who you are since you have been at Stopping Violence? | How has your behavior changed?<br><br>What have you learned about yourself?<br><br>What did you learn about anger management?<br><br>What skills have you learned to manage? |

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| | | What did you learn about drugs and alcohol?<br><br>What did you learn about your criminal offending? |
| Experience of stopping violence | Can you tell me a bit about what the programme involved?<br><br>How does the Stopping Violence programme compare to other programmes that you may have done before?<br><br>What aspects of the programme have been important for you?<br><br>What aspects of the programme have been challenging for you?<br><br>How do you find the facilitators? | Run me through a typical group. What issues would you discuss? |

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| | What kind of atmosphere did the facilitators create?<br><br>What did you think of the length and timing of the sessions? And the whole programme<br><br>What skills were discussed in the programme?<br><br>Do you have any real life examples of how the programme has benefited you? | |
| Whanau | How has the programme impacted on your relationships with others such as friends, partners and whanau? | How has the programme enabled you to reconnect with your family?<br><br>What have you learned about your relationship with your family? |

| | | |
|---|---|---|
| | | How has your relationship changed? |
| Recommendations | What recommendations would you have for the stopping violence programme? | What didn't you like?<br><br>Was there anything that put you off attending the programme?<br><br>What would you improve? |
| Overview | What do you think are some important issues that we have discussed today? | How has this interview been relevant to you? |