



# Defining quality of life indicators for measuring perpetrator intervention effectiveness

HELEN McLAREN

JANE FISCHER

LANA ZANNETTINO

ANROWS

AUSTRALIA'S NATIONAL RESEARCH  
ORGANISATION FOR WOMEN'S SAFETY  
*to Reduce Violence against Women & their Children*

RESEARCH REPORT  
ISSUE 05 | MARCH 2020

### **ANROWS acknowledgement**

This material was produced with funding from the Australian Government Department of Social Services. Australia's National Research Organisation for Women's Safety (ANROWS) gratefully acknowledges the financial and other support it has received from the government, without which this work would not have been possible. The findings and views reported in this paper are those of the authors and cannot be attributed to the Australian Government Department of Social Services.

### **Acknowledgement of Country**

ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge.

© ANROWS 2020

### **Published by**

Australia's National Research Organisation for Women's Safety Limited (ANROWS)  
PO Box Q389, Queen Victoria Building, NSW, 1230 | [www.anrows.org.au](http://www.anrows.org.au) | Phone +61 2 8374 4000  
ABN 67 162 349 171

### ***Defining quality of life indicators for measuring perpetrator intervention effectiveness (Research Report) / McLaren et al.***

Sydney : ANROWS, 2020  
Pages ; 30 cm. (Research report, Issue 05/2020)

I. Quality of life -- women II. Intimate partner violence -- Interventions III. Male Perpetrator Intervention -- Evaluation IV. Domestic violence -- Australia -- Research  
I. McLaren, Helen. II. Fischer, Jane. III. Zannettino, Lana.

**ISBN: 978-1-925925-17-3 (print) | 978-1-925925-18-0 (online)**

**Creative Commons Licence**  
Attribution-Non Commercial



**CC BY-NC**

This licence lets others distribute, remix and build upon the work, but only if it is for non-commercial purposes and they credit the original creator/s (and any other nominated parties). They do not have to license their Derivative Works on the same terms. Version 3.0 (CC Australia ported licence): [View CC BY-NC Australia Licence Deed](#) | [View CC BY-NC 3.0 Australia Legal Code](#) Version 4.0 (international licence): [View CC BY-NC 4.0 Licence Deed](#) | [View CC BY-NC 4.0 Legal Code](#)

Please note that there is the potential for minor revisions of this report.  
Please check the online version at [www.anrows.org.au](http://www.anrows.org.au) for any amendment.

# Defining quality of life indicators for measuring perpetrator intervention effectiveness

**DR HELEN McLAREN**

College of Education, Psychology and Social Work, Flinders University

**DR JANE FISCHER**

College of Education, Psychology and Social Work, Flinders University

**DR LANA ZANNETTINO**

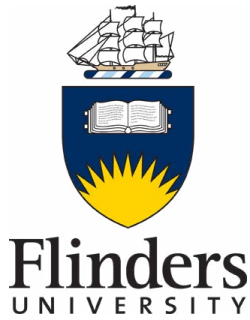
College of Nursing and Health Sciences, Flinders University

This report addresses work covered in the ANROWS research project PI.17.04 *Defining quality of life indicators for measuring perpetrator intervention effectiveness*. Please consult the ANROWS website for more information on this project.

ANROWS research contributes to the six National Outcomes of the *National Plan to Reduce Violence against Women and their Children 2010-2022*. This research addresses National Plan Outcome 6 - Perpetrators stop their violence and are held to account.

**Suggested citation:**

McLaren, H., Fischer, J., & Zannettino, L. (2020). *Defining quality of life indicators for measuring perpetrator intervention effectiveness* (Research report, 05/2020). Sydney, NSW: ANROWS



**Flinders University**  
Sturt Road, Bedford Park,  
Adelaide, South Australia.

### **Author acknowledgement**

We wish to thank the 100 women from Adelaide, Brisbane and Melbourne who participated in this project. Despite the hardships associated with ongoing recovery from intimate partner violence, these women shared the most private of feelings and experiences in their desires to support other women living with violence and research aimed at increasing women's and children's safety. We acknowledge the support and generosity of research advisory members from our partner services: Brisbane Domestic Violence Service; Carinity Talera, Community Baptist Services, Brisbane; Kornar Winmil Yunti Aboriginal Corporation, Adelaide; No to Violence Men's Referral Service, Male Family Violence Prevention Association, Melbourne; SANDBAG Community Centres and Services, Brisbane; Women's Liberation Halfway House Domestic Violence Service, Melbourne; Women's Safety Services SA, Adelaide.

### **Acknowledgement of lived experiences of violence**

ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include: 1800 RESPECT - 1800 737 732 and Lifeline - 13 11 14.

# Contents

<b>List of figures</b> .....	<b>5</b>
<b>List of tables</b> .....	<b>6</b>
<b>Abbreviations</b> .....	<b>7</b>
<b>Definitions</b> .....	<b>8</b>
<b>Executive summary</b> .....	<b>10</b>
<b>Research aims</b>	<b>10</b>
<b>Methodology</b>	<b>10</b>
Phase 1: State of knowledge review	10
Phase 2: Interviews	10
Phase 3: Quantitative and qualitative data analysis	10
Phase 4: Consultation with intimate partner violence (IPV) sector professionals	11
<b>Key findings</b>	<b>11</b>
Current state of knowledge	11
Participant characteristics	11
Women’s Quality of Life (QOL)	11
Women’s expressed fears	12
Women’s perceptions of male perpetrator interventions (MPIs)	12
Consultation with the IPV service sector	12
<b>Conclusion and next steps</b>	<b>13</b>
<b>Recommendations for policy and practice</b>	<b>13</b>
<b>Introduction</b> .....	<b>15</b>
<b>Research aims</b>	<b>15</b>
<b>Background and key concepts</b>	<b>15</b>
Intimate partner violence and women as victims/survivors	15
Interventions with male perpetrators of IPV	16
Understanding the concept of QOL	18
<b>Report structure</b>	<b>20</b>
<b>Summary</b>	<b>21</b>

<b>State of knowledge review</b> .....	<b>22</b>
<b>Search strategy</b>	<b>22</b>
Identifying eligible studies	22
<b>Academic literature on QOL, IPV and MPIs</b>	<b>23</b>
QOL instruments used in the studies reviewed	26
Overall appraisal of the studies reviewed	27
Additional QOL literature associated with MPIs	28
<b>Summary</b>	<b>29</b>
<b>Methodology</b> .....	<b>30</b>
<b>Research design</b>	<b>30</b>
<b>Sampling and recruitment</b>	<b>30</b>
<b>Interviews</b>	<b>32</b>
Composite Abuse Scale (Revised)–Short Form (CAS <sub>R</sub> -SF)	32
World Health Organization Quality of Life scale, short version WHOQOL-BREF	33
Open-ended questions	33
Quantitative analysis	33
Qualitative analysis	34
Data mixing, including a further inductive qualitative analysis	36
Consultation with IPV sector professionals	37
<b>Ethical considerations</b>	<b>37</b>
<b>Summary</b>	<b>38</b>
<b>Key findings</b> .....	<b>39</b>
<b>Participant characteristics</b>	<b>39</b>
Demographics	39
Contexts of IPV	39
Perpetrator participation in interventions	39
Women’s QOL	41
<b>Women’s subjective views on QOL</b>	<b>41</b>
The women’s explanations for their quality of life assessments	41
QOL underpinning principles	43
QOL priorities	44

<b>Women’s experiences of fear</b>	<b>45</b>
Fear of IPV perpetrator	45
Fear and QOL	45
Fear of men participating in MPIs	45
Breadth of fear	45
Impact of fear on QOL	47
<b>Women’s views on men’s participation in MPIs</b>	<b>49</b>
Influence of MPI participation on women’s QOL	49
Content of MPIs	50
Men’s participation in MPIs	51
The broader IPV service system	52
<b>Consultation with IPV sector professionals</b>	<b>54</b>
Conceptualising the potential use of women’s QOL measures	54
Views on barriers to the effective evaluation of MPIs	55
On the benefits of measuring women’s QOL when evaluating MPIs	55
Enabling women’s QOL measures to be integrated into evaluations of MPIs	56
Principles for evaluating MPIs, inclusive of women’s QOL	56
<b>Discussion</b>	<b>58</b>
<b>MPIs and victim/survivor QOL</b>	<b>58</b>
<b>Women’s QOL</b>	<b>59</b>
<b>Applicability of the WHOQOL-BREF</b>	<b>59</b>
Strengths of the WHOQOL-BREF	59
Weaknesses of the WHOQOL-BREF	60
<b>QOL as a victim-centred outcome measure</b>	<b>61</b>
Additional QOL-IPV items	61
QOL-IPV items as a standard set of questions	62
<b>Strengths and limitations of the current study</b>	<b>62</b>
<b>Recommendations for policy and practice</b>	<b>65</b>
<b>Conclusion</b>	<b>66</b>

<b>References</b> .....	<b>67</b>
<b>Appendix A: Overview of the interview schedule</b> .....	<b>79</b>
<b>Appendix B: Coding of qualitative data</b> .....	<b>83</b>
<b>Appendix C: Quantitative data</b> .....	<b>88</b>
<b>Appendix D: WHOQOL-BREF domains and items</b> .....	<b>92</b>



# List of figures

<b>Figure 1</b>	Proposed QOL-IPV items for future testing	13
<b>Figure 2</b>	PRISMA flow diagram	24
<b>Figure 3</b>	Summary of the research design stages	31
<b>Figure 4</b>	Women's overall QOL assessments (N=100)	42
<b>Figure 5</b>	QOL of the women compared with Australian population norms for women	42
<b>Figure 6</b>	Comparison of QOL domains by women currently and not currently afraid of IPV perpetrator (N=63)	46
<b>Figure 7</b>	QOL assessments by mean domain scores of women who were currently afraid of their partners: Compared by recent vs. historical participation in MPIs	46
<b>Figure 8</b>	Principles to guide the development of MPI evaluations	57
<b>Figure 9</b>	Proposed additional QOL-IPV items for testing and validation	62

# List of tables

<b>Table 1</b>	Academic literature on QOL, IPV and MPIs	25
<b>Table 2</b>	Demographic characteristics of women participants (N=100)	40
<b>Table 3</b>	Recent (i.e. in last 12 months) IPV experiences by relationship status (N=70)	40
<b>Table 4</b>	Women's QOL priorities in the context of IPV	36
<b>Table 5</b>	Women currently afraid of IPV perpetrator by relationship status (N=63)	45
<b>Table 6</b>	WHOQOL-BREF domains and items	32
<b>Table 7</b>	Fear and violence theme	83
<b>Table 8</b>	Self-determination theme	84
<b>Table 9</b>	Basic needs theme	85
<b>Table 10</b>	Wellbeing theme	86
<b>Table 11</b>	Social systems theme	87
<b>Table 12</b>	Demographic characteristics of women participants (N=100)	88
<b>Table 13</b>	IPV experiences (ever) of women participants (N=100)	89
<b>Table 14</b>	IPV experiences (last 12 months) of women participants (N=70)	89
<b>Table 15</b>	IPV forms experienced (last 12 months) by women participants (N=70)	89
<b>Table 16</b>	IPV perpetrator's participation (ever) in MPI (N=100)	90
<b>Table 17</b>	QOL of women participants (N=100)	90
<b>Table 18</b>	QOL of women participants, WHOQOL-BREF domains (N=100)	90
<b>Table 19</b>	Fear and QOL amongst women who responded to the question "are you currently afraid of your partner?" (N=63)	91
<b>Table 20</b>	Fear and QOL amongst women who responded in the affirmative to the question "are you currently afraid of your partner?" (N=36)	91

# Abbreviations

<b>ANROWS</b>	Australia's National Research Organisation for Women's Safety
<b>CAS<sub>R</sub>-SF</b>	Composite Abuse Scale (Revised)–Short form
<b>COAG</b>	Council of Australian Governments
<b>HRQOL</b>	Health related quality of life
<b>IPV</b>	Intimate partner violence
<b>ISOQOL</b>	International Society for Quality of Life Research
<b>MBCP</b>	Men's behaviour change program
<b>MPI</b>	Male perpetrator intervention
<b>QOL</b>	Quality of life
<b>SF-12</b>	Short form, 12 item health survey
<b>SF-36</b>	Short form, 36 item health survey
<b>WHO</b>	World Health Organization
<b>WHOQOL-BREF</b>	World Health Organization Quality of Life scale, short version

# Definitions

<b>Composite Abuse Scale (Revised)–Short Form (CAS<sub>R</sub>-SF)</b>	The Composite Abuse Scale (Revised)–Short Form (CAS <sub>R</sub> -SF) self-assesses the incidence and frequency of physical, sexual and psychological intimate partner violence (IPV) (Ford-Gilboe et al., 2016). These 15 IPV forms are: participant blamed for causing violent behaviour; shook, pushed, grabbed or threw participant; tried to convince others that participant was crazy; used or threatened to use a weapon to harm them; made participant perform unwanted sex acts; followed or hung around outside work; threatened to harm or kill someone close to participant; choked participant; forced or tried to force sex; harassed by phone, text, email or social media; told was crazy, stupid or not good enough; hit, kicked or bit; stopped from seeing family or friends; confined or locked in a room or other space; kept from accessing a job, money or financial resources (Ford-Gilboe et al., 2016, pp. 12-13).
<b>Intimate partner violence (IPV)</b>	IPV refers collectively to behaviours such as physical, sexual, psychological, emotional, financial, verbal and spiritual abuse, and controlling behaviours such as reproductive coercion, perpetrated by a current or previously cohabitating or non-cohabitating partner, or combinations thereof. Multiple terminologies are in use to describe IPV (e.g. domestic violence, partner violence, spouse abuse, battering or Aboriginal and Torres Strait Islander family violence). Consistent with the Council of Australian Governments' 'COAG' (2011, p. 2) description of domestic violence, the central feature of IPV is an:  ongoing pattern of behaviour aimed at controlling a partner through fear ... [which] is part of a range of tactics to exercise power and control over women and their children.
<b>IPV sector professionals</b>	Reference is made to IPV sector professionals in this report. This is used to refer to individuals who are skilled workers employed in government and non-government organisations that are delivering services to individuals who are victims/survivors of IPV, or IPV perpetrators. The work of IPV sector professionals may include research, policy and program development, management of services or programs or direct practice with IPV victims/survivors or IPV perpetrators.
<b>IPV service system</b>	The IPV service system refers to the policies, programs, organisations and staff who deliver services for addressing IPV. This ranges from person-centred interventions with victims/survivors or perpetrators, through to group programs, agencies delivering services in response to IPV, policy development and overarching strategies and frameworks. The IPV service system extends across government and non-government sectors, including across health, welfare and justice portfolios.
<b>Male perpetrator interventions (MPIs)</b>	Male perpetrator interventions (MPIs) in this report are inclusive of a wide range of interventions involving men who perpetrate IPV towards their current or previous female partners. MPIs include various forms of individual counselling with men, couples counselling, voluntary/self-referral support groups, mandated (usually by Magistrates Courts) or voluntary men's behaviour change groups, <sup>1</sup> and Family Court programs for parents in the context of IPV and child protection.

<sup>1</sup> Men's behaviour change groups are the most common form of MPI in Australia.

<b>Outcome measures</b>	An outcome is the effect of an intervention on an individual patient, service user, other individuals or client group. Outcome measures are validated instruments administered to individuals to assess an intervention effect (if any) (Bullinger & Quitmann, 2014; Sansoni, 2016). The process of assessing outcomes involves directly asking individuals about the impact (or lack thereof) of interventions (Ridgeway et al., 2013). The first administration of an assessment is used to establish a baseline, while further assessments indicate progress and intervention efficacy (Sansoni, 2016; Williams, Sansoni, Morris, Grootemaat, & Thompson, 2016). Differences between baseline and further assessments represent change.
<b>Quality of life (QOL)</b>	Quality of life (QOL) is “an individual’s perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns” (World Health Organization Quality of Life Group [WHOQOL Group], 1998a, p. 551) <sup>2</sup> at a given point in time.
<b>QOL assessment</b>	In this report, “QOL assessment” is used to refer to victim-reported judgements on their own QOL. This was documented through the completion of a standardised instrument, the World Health Organization Quality of Life scale, short version (WHOQOL-BREF). This self-assessment instrument asks about QOL over the prior 2 weeks.
<b>QOL domains</b>	QOL is a multi-dimensional construct (Bowling, 2005a). In the current study we assessed women’s QOL with the WHOQOL-BREF, which conceptualises QOL as comprising four dimensions: physical health, psychological health, social relationships and environment (Skevington, Lotfy, & O’Connell, 2004).
<b>QOL item</b>	“Item” is a summary term for each question administered as part of the WHOQOL-BREF. For example, the WHOQOL-BREF domain “social relationships” comprises three items: personal relationships, social support and sexual activities. Each item is assessed with a question, for example the question pertaining to personal relationships is “How satisfied are you with your personal relationships?” (See Appendix D for breakdown of QOL items.)
<b>QOL priorities</b>	This refers to an individual’s subjective perspective about the QOL domains and items that are important for improving their QOL.
<b>World Health Organization Quality of Life scale, short version (WHOQOL-BREF)</b>	The WHOQOL-BREF assesses QOL (Skevington et al., 2004). The instrument comprises 26 items: two global items—global QOL and satisfaction with health; followed by questions assessing physical health (seven items), psychological health (six items), social relationships (three items) and environment (eight items).
<b>Victim-centred reported outcomes</b>	The term “victim-centred reported outcomes” derives from the more traditional term of “patient-reported” outcomes. Victim-centred outcomes are reports obtained directly from women about their QOL without interpretation by health and welfare professionals, or by anyone else.

<sup>2</sup> For an expanded explanation of QOL, see the section in this report, “Understanding the concept of quality of life”.

# Executive summary

The primary interest of this study was to inform the development of a quality of life (QOL) intervention outcome measure. As an exploratory study, the intention was to consider how women's QOL as a victim-centred and victim-reported outcome measure could be used in the evaluation of effectiveness of male perpetrator interventions (MPIs). To inform the development of an intimate partner violence (IPV) specific QOL measure, women who have experienced IPV were asked to assess their QOL, identify what aspects of their lives make their QOL either good or bad and describe how MPIs could contribute positively to their QOL.

The guiding research question for this study is as follows:

In what ways can QOL, from the perspectives of women, inform the development of mechanisms to measure the effectiveness of MPIs as part of an integrated system of broader interventions?

## Research aims

The purpose of this study was to inform the development of a QOL IPV intervention outcome measure for application in evaluations of MPIs. Specifically, the study aimed to:

- explore literature on how women's QOL has been used in evaluations of MPIs;
- document the women's QOL assessments, with a particular focus on women whose male partners have participated in MPIs;
- identify the women's definitions of QOL and their QOL priorities; and
- develop a specific IPV-QOL measure for women, for further testing as an outcome effectiveness measure of MPIs.

This research draws from a feminist standpoint in favour of prioritising women's voices and life outcomes in interventions that are ultimately aimed to make their lives better. In the current case, we argue that MPIs should be measuring improvements for women victims/survivors as a result of their interventions with men.

## Methodology

This study comprised four phases, which are outlined below.

### Phase 1: State of knowledge review

An integrative review of existing literature on QOL as an outcome measure in IPV and MPIs captured the current state of knowledge on the topic.

### Phase 2: Interviews

Face-to-face interviews were conducted with a convenience sample of 100 women in South Australia, Queensland and Victoria. Participants were recruited through partner services and via social media. Participants self-identified as victims/survivors of IPV with male partners who had participated in an MPI (interviews confirmed 71% of the men had participated in MPIs). Chief Investigators and Research Assistants conducted interviews (n=68 and n=32, respectively) in each jurisdiction from August–November 2017, involving administering two standardised tools, semi-structured questions and free narrative. The interview schedule (see Appendix A) covered:

- demographic characteristics;
- current and previous IPV experiences, assessed with the CAS<sub>r</sub>-SF;
- QOL assessments, assessed with the WHOQOL-BREF, a standardised tool for assessing QOL;<sup>1</sup>
- women's definitions of QOL and their QOL priorities; and
- experience with MPIs.

### Phase 3: Quantitative and qualitative data analysis

To summarise the main features of participating women, descriptive statistics were conducted. Qualitative data were transcribed and subjected to thematic analysis. This involved

<sup>1</sup> An overview of WHOQOL-BREF domains and items is available in Appendix D. The WHOQOL-BREF standardised tool is available at [https://www.who.int/mental\\_health/publications/whoqol/en/](https://www.who.int/mental_health/publications/whoqol/en/).

a systematic process of data immersion, coding, development of themes and refining, defining and naming themes (Braun, Clarke, Hayfield, & Terry, 2019). The purpose of this analysis was to identify patterns across the women's interviews.

The first three phases of the research informed the development of QOL-IPV specific items (see Figure 9). We propose these items be added to the WHOQOL-BREF used in this study. The strength of the WHOQOL-BREF is that it is a well-recognised, internationally validated instrument that has been validated in Australia with women in the general population (Hawthorne, Herrman, & Murphy, 2006; Skevington et al., 2004). However, to our knowledge, it has not been validated specifically with women who have experienced IPV.<sup>2</sup> The additional items that we propose need to be tested for potential use as a victim-centred reported outcome measure of MPIs in future research. Future testing of the WHOQOL-BREF with the additional QOL-BREF items will entail assessing whether the combined instrument is sound for use with women who have experienced IPV.

#### **Phase 4: Consultation with intimate partner violence (IPV) sector professionals**

In November 2017, a consultation meeting was held with 15 IPV sector professionals in Adelaide, South Australia. Delegates were representatives of each of the nine research partner services<sup>3</sup> from Queensland, South Australia and Victoria, and six additional professionals they recommended. Attendees included policy-makers, managers, frontline practitioners from IPV and MPI services, researchers and a consumer representative/advocate. The purpose of the consultation was to disseminate and to discuss the implications of the research findings and conceptualise the ways in which MPIs could be evaluated based on victim-focused outcome measures.

<sup>2</sup> Validation is the process of examining whether a process or instrument is sound (Feinleib, 2001).

<sup>3</sup> Partner services were: Brisbane Domestic Violence Service; Carinity Talera, Community Baptist Services, Brisbane; Kornar Winmil Yunti Aboriginal Corporation, Adelaide; No to Violence Men's Referral Service, Male Family Violence Prevention Association, Melbourne; SANDBAG Community Centres and Services, Brisbane; Women's Liberation Halfway House Domestic Violence Service, Melbourne; Women's Safety Services SA, Adelaide.

## **Key findings**

### **Current state of knowledge**

QOL as a victim-reported outcome, in the context of IPV interventions, is supported in the literature. However, there is limited literature on its application. How QOL within the context of IPV should be assessed is in its infancy, with little work to date undertaken on its conceptualisation and operationalisation. In particular, how IPV victims/survivors define QOL and what their priorities are for a "good life" is not certain.

### **Participant characteristics**

One hundred women participated in this study. All had been the victims/survivors of IPV. The IPV perpetrator was most commonly a former partner (64%), although for over a third this was a current partner. All participants had experienced multiple forms of IPV (i.e. physical, sexual, psychological, emotional, financial, verbal and spiritual abuse, and controlling behaviours such as reproductive coercion, perpetrated by a current, or previously cohabitating or non-cohabitating partner, or combinations thereof).

Participants were a mean (average) age of 41 years. Most participants were living with children (61%), a spouse/partner/boyfriend (31%) or alone (17%). Approximately half of the participants (52%) were living in rental accommodation, 59 percent were in paid employment, and 85 percent had completed formal education (Year 12 or equivalent). Forty-four percent of participants were currently in a relationship (not necessarily with the IPV perpetrator).

### **Women's Quality of Life (QOL)**

Less than half of participants assessed their QOL as either good (33%) or very good (14%). Over a quarter assessed their QOL as either poor (22%) or very poor (4%). Twenty-seven percent assessed their QOL as "neither good nor poor". For both women who had ever experienced IPV and women currently living with IPV, their QOL assessments were significantly below Australian population norms for women on all four

WHOQOL-BREF domains: mental health, physical health, social relations and environment.

Women were asked to define what “QOL” personally meant to them and what was important to them. What was most important to the women were the aspects of their lives most affected by IPV. This was consistent with research on QOL priorities of older people (Bowling et al., 2003), such that the women most wanted to restore what had been lost as a result of their adversities.

The most common QOL priorities expressed by women in this study were:

1. autonomy;
2. informal supports (family and friends);
3. emotional health;
4. safety (physical and psychological); and
5. children and pets.

While these QOL priorities were not captured in administering the WHOQOL-BREF, the qualitative components of the research were invaluable for documenting aspects of QOL specific to women in the context of IPV. These provide critical indicators for measuring change, as well as for identifying priority areas in which to target IPV interventions or MPIs. The women provided insights into what these particular aspects of QOL might look like for them:

- Autonomy was expressed by the women as having agency, to be able to make their own decisions, having the liberty to live how they choose, and being free to express their own beliefs and live according to their own identities.
- Informal supports were expressed as having friends, and relationships of trust, quality contact and assistance in times of need from family, friends and intimate partners.
- Emotional health related to women’s ability to enjoy life, being at peace with oneself and the relinquishment of feelings of shame and stigma associated with IPV.
- Safety extended to physical, psychological, social and spiritual safety as expressed by the women interviewed.
- Altruism was expressed in women’s worry about the impact of IPV on their children, other family members, friends and animals, and even the perpetrators.

## Women’s expressed fears

Fear permeated QOL assessments. Nearly all women reported having ever been afraid of an IPV perpetrator (98%, N=100). Women were asked whether they were currently afraid of an IPV perpetrator, and 63 women responded to this question. Of these 63 women, over half (57%) indicated that they were currently afraid of an IPV perpetrator, most commonly their current partner (64%) or former partner (28%). Women who were currently afraid of the IPV perpetrator reported poorer QOL than those who were not. Women expressed fear not only in terms of their own personal safety, but also in being judged, and fears related to the IPV service system and processes. Women also expressed fears for their own wellbeing and that of loved ones, fear of loneliness, loses of freedom and autonomy and fear about their future and whether they would recover from IPV.

## Women’s perceptions of male perpetrator interventions (MPIs)

Seventy-one women (71%) had partners who had participated in an MPI, of which 27 had partners participating in the last 12 months. Women whose partners had participated in an MPI were asked whether MPIs had contributed any changes to their QOL. All of the women whose partners had participated in an MPI advised that their partners’ participation in an MPI had changed their QOL, but not necessarily improved it. This was because, in the women’s views, men’s participation in an MPI was a time they experienced fear, with new forms of IPV occurring during interventions and men reverting to their “old ways” at the conclusion of an intervention. Furthermore, the women perceived MPIs to be too focused on physical forms of violence to the exclusion of other forms of IPV and without addressing men’s attitudes towards women. They also perceived that broader societal attitudes and cultural practices of both MPIs and the broader justice system were further harming their QOL.

## Consultation with the IPV service sector

IPV sector professionals (N=15) articulated the potential benefits of using women’s QOL measures to evaluate the effectiveness of MPIs. However, they expressed concerns with



Figure 1 Proposed QOL-IPV items for future testing

Proposed item	Definition
Fear	A feeling induced by a perceived or real threat.
Autonomy	The capacity to act in self-directed ways, which are free from adverse coercion of outside influences and have a relationship with freedom.
Isolation	A diminished contact or inclusion, such as a lack of contact with people or groups, or exclusion from groups, society or structures.
Safety	A condition in which danger, risk or injury are minimised and manageable.
Altruism (care for others)	When individuals have concern for the happiness and wellbeing of others, physically, psychologically, socially, materially and spiritually.

being able to make direct links between women's QOL and the effectiveness of MPIs. For example, they suggested that women's QOL could change as a result of factors unrelated to the MPIs. This is because an increase or decrease in women's QOL does not necessarily mean that MPIs have been responsible. This can be overcome by having women make the links between their own QOL assessments and their partner's involvement in MPIs, which is a victim-centred approach. It was generally agreed that evaluations are meant to improve services. Integrating women's QOL in MPI evaluations would ensure that service improvements prioritise good outcomes for women who are IPV victims/survivors.

## Conclusion and next steps

This study described the QOL of 100 women who have experienced, or who are currently experiencing, IPV in order to identify how QOL may be used as a victim-centred outcome measure. Women expressed their QOL as relating to autonomy, informal supports (family and friends), emotional health, safety (physical and psychological), and children and pets. Fear permeated all QOL assessments. The WHOQOL-BREF was helpful in assessing women's QOL generally. However, it did not seem to capture women's QOL concerns within the context of IPV—namely fear, autonomy, isolation, feelings of safety and caring responsibilities towards others (i.e. altruism). Given the potential weaknesses of the WHOQOL-BREF, as indicated above, there is a need for an additional set of items to assess QOL within the IPV context. This approach, of an additional attachment to the WHOQOL-BREF, is consistent with other sectors, including disability and mental health. Our proposed items for future testing are listed and defined in Figure 1.

The logical next step is to test and validate these items with women who have experienced IPV, and also within an MPI environment.

## Recommendations for policy and practice

Fundamental to this study is the standpoint that any assessment of MPI effectiveness must incorporate the measurement of improvements to the lives of women, or others, who are the victims/survivors of IPV. This is consistent with the perspective of researchers who advocate for women-centred measures to determine the outcomes of IPV interventions, including MPIs (Chang et al., 2005; Kelly & Westmarland, 2014, 2015; O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). Accordingly, the aforementioned authors advocate for a greater emphasis on the improvements to women's lives in the design, delivery and evaluation of MPIs. One way this can be achieved is via IPV victims'/survivors' assessments of their QOL in outcome effectiveness evaluations of MPIs. Incorporating assessments of women's QOL to examine change in association with men's participation in MPIs has the potential to guide improvements to interventions according to women's needs.

There are various models for MPIs, often part of a collection of strategies. These are predominantly aimed at changing the perpetrators' behaviours and stopping the violence (Hunter et al., 2016; Mackay, Gibson, Lam, & Beecham, 2015a; McGinn, McColgan, & Taylor, 2017). Accordingly, evaluation designs of MPIs are predominantly focused on changes to men's behaviour and it may be difficult to influence a paradigm change in favour of broader observed outcomes for women. However, change is necessary when reviews of research into the validity of existing measurements for evaluating MPIs consistently reveal methodological flaws and highlight equivocal results (e.g. Arias, Arce, & Vilariño, 2013; Bates, Graham-Kevan, Bolam, & Thornton, 2017; Eckhardt et al., 2013; Lilley-Walker, Hester, & Turner, 2016; Mackay, Gibson, Lam, & Beecham, 2015b; Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013). It is important to find new ways to

understand what works, for whom and why—and to respond to these questions with appropriate service improvements.

It is also important to prioritise victims'/survivors' QOL outcomes alongside addressing men's violence. Women's baseline QOL assessments can be compared with the women's QOL assessments on MPI completion, and longitudinally, to measure change. Women's QOL assessments can provide indicators of change for women who remain in their intimate relationships while their partners participate in MPIs, and for women who may have no choice regarding ongoing contact with perpetrators (i.e. shared parenting). While some women may not wish to be involved in MPI evaluation, their QOL assessments can assist IPV support services and aid MPIs to identify key areas in which men's violence impacts most on other people's lives. Women's QOL assessments would enable women to discuss their lives and situation without having to directly comment on their male partners' behaviour change, thereby removing women's feelings of further violence if they comment on their partners' behaviour change. Finally, women's QOL can contribute to assessments of child protectiveness and provide insights into possible interventions.

In order to improve the receptiveness of victim-centred evaluation designs, IPV sector professionals consulted for this study advised that a whole of sector shift in thinking was needed. This included clarification of “whose outcomes” were important in the context of IPV and MPIs, for what purpose, and why. While there is merit in the inclusion of QOL measures for women in the evaluation of MPIs, future testing and validation of specific IPV-QOL items for use in conjunction with the WHOQOL-BREF is required. This will enable women's QOL assessments to be considered for incorporation into MPI evaluations and invite discussions of how MPIs may increase their responsiveness to victim-centred QOL outcomes. In summary, measuring change for victims/survivors as a means to evaluate MPIs is promising.

# Introduction

This research explored how women's assessments of their quality of life (QOL), as a victim-centred outcome measure, could be used to evaluate the effectiveness of male perpetrator interventions (MPIs). The intention of the research is to inform the development of an evaluation measure to assess women's QOL in the context of intimate partner violence (IPV). The research focuses on women who are the victims/survivors of IPV. This is premised on evidence that the most common forms of violence experienced by women are at the hands of men who are their intimate partners (Devries et al., 2013; Gilchrist, Canfield, Radcliffe, & d'Oliveira, 2017; Jewkes, Flood, & Lang, 2015; Roberts, Chamberlain, & Delfabbro, 2015; Vaughan et al., 2015).

The experience of IPV is gendered, and patriarchal power relations between women and men are at the root of such violence (Anderson, 2013; Cui, Ueno, Gordon, & Fincham, 2013). To address this power relationship and support women's recovery from IPV, women should have a voice regarding their safety and wellbeing and what they need for a better life. Accordingly, individualised victim-centred approaches and gender sensitive initiatives are consistently emphasised by both researchers and civil society organisations as crucial for women's recovery from IPV (Hegarty & Leung, 2017; Hegarty, Tarzia, Hooker, & Taft, 2016; McCleary-Sills, Crockett, & Cooper, 2018; Saletti-Cuesta, Aizenberg, & Ricci-Cabello, 2018; Wonders, 2018; World Health Organization, 2013; Wozniak, 2009). Given this standpoint, we contend that the voices of women who are victims/survivors of IPV should also be prioritised in the evaluation of MPIs that their male partners are attending.

When considering that the mandate of MPIs is to stop IPV and improve the lives of victims/survivors, then, logically, assessing changes to women victims'/survivors' lives would be an important outcome indicator of MPI effectiveness. However, there are no existing measures that have been tested and confirmed for use with women IPV victims/survivors, especially in the context of perpetrator interventions. The rationale for this study, therefore, is to develop a QOL measure that may be suitable to measure QOL outcomes for victims/survivors resulting from MPIs, and to test its use following completion of the current study. The first step in the process of developing a set of QOL-IPV outcome measures would

involve trialling an existing, generic QOL instrument with women IPV victims/survivors.

In addition to assessing their QOL, a focus of this study was to ask women what comprises their QOL and what aspects of QOL were most important to them. This is because knowledge of women's QOL and their QOL priorities may not be sufficiently appreciated in existing generic QOL instruments. Furthermore, understanding the QOL meanings and priorities of victims/survivors has the potential to inform the delivery of MPIs in ways that are respectful of women's recovery and that are victim-centred.

## Research aims

The aims of this research were to:

- explore literature on how women's QOL has been used in evaluations of MPIs;
- document the women's QOL assessments, with a particular focus on women whose male partners have participated in MPIs;
- identify the women's definitions of QOL and their QOL priorities; and
- develop a specific IPV-QOL measure for women, for further testing as an outcome effectiveness measure of MPIs.

## Background and key concepts

This section provides background to the current study, with a brief focus on women as victims/survivors of IPV, interventions with men as perpetrators, and key concepts (such as IPV, MPIs, QOL; and QOL as a potential outcome measure for measuring the effectiveness of MPIs) to assist understanding when reading this report.

### Intimate partner violence and women as victims/survivors

IPV is most frequently and severely perpetrated by men, and most often towards women (Devries et al., 2013; Gilchrist et al., 2017; Jewkes et al., 2015; Roberts et al., 2015; Vaughan

et al., 2015). IPV is highly prevalent, has multiple negative impacts and universally poses considerable social and economic costs (García-Moreno et al., 2015; Keam & Cook, 2016; Walsh, Spangaro, & Soldatic, 2015). Reported IPV in Australia equates to approximately AU\$13.6 billion a year based on costs associated with the administration of law, health care and welfare (COAG, 2011). Estimates such as this do not account for unreported IPV and costs to individuals, families and communities. While it can be said that the impact of IPV on Australian society and the economy is immense, the toll on women living with IPV cannot be quantified.

The pain, fear and suffering incurred by women and their children due to IPV is devastating, incalculable and can be long lasting (García-Moreno et al., 2015; Walsh et al., 2015).<sup>4</sup> Most significant is the denial of “the right to live in freedom and safety” and the “right to a decent life” (United Nations General Assembly, 1948, 1993). When IPV reduces the freedom and safety of its victims/survivors, it diminishes capacity to participate fully in work and life (Hunter et al., 2016; Messing & Thaller, 2015). This can include having limited capacity to make decisions about the future of their relationships, and how to survive their futures (Halket, Gormley, Mello, Rosenthal, & Mirkin, 2014). Whatever decisions women make, and whether they stay or leave, it is critical that women are supported to live in safety and achieve better overall QOL. It is also vital that supports aimed to improve women’s lives are integrated across the IPV service system in interventions with both women and men. This includes that interventions hold perpetrators fully responsible for their behaviours and are responsive to improving the lives of victims/survivors.

There are many types of interventions aimed at changing the behaviours of abusive men and stopping the violence. While historically women may have discursively been held responsible by society for the abuse perpetrated against them, recent trends indicate a substantial shift away from this position (Robbins & Cook, 2017). Consistent with contemporary trends in favour of holding perpetrators

wholly responsible for the abuse, some interventions with men continue to place a certain level of responsibility for the men’s behaviour change on the women. Further, it is not clear whether MPIs are effectively stopping the violence or contributing to broader improvements to the QOL of women affected by IPV.

### Interventions with male perpetrators of IPV

One means of addressing men’s perpetration of IPV is via MPIs. There are various models for MPIs that often comprise a collection of strategies aimed at stopping men’s violence (Hunter et al., 2016; Mackay et al., 2015a; McGinn et al., 2017). The interventions may also use feminist informed strategies to try to bring about change in men’s adverse attitudes towards women (Alderson, 2015; Day & Bowen, 2015; Rivett & Rees, 2013; Zosky, 2016). One example of this is the hallmark Duluth model, which employs psycho-educational strategies to raise consciousness and challenge perpetrators’ beliefs about power and dominance (Pence & Paymar, 1993). Interventions traverse a range of individual, group or couples therapies (Crane & Easton, 2017; Galvani, 2007; Halford & Doss, 2016), and may focus on the criminogenic risk factors across these contexts (Bates et al., 2017). Other examples may be more mediation-based, such as with co-parenting interventions for separating couples in the context of violence and protection orders (McIntosh & Tan, 2017). Variations exist across the breadth of research on MPIs, making it difficult to discern what is effective and what is not. It is often not clear what intervention variables may be responsible for specific MPI outcomes and for whom. Despite this, there have been persistent attempts by researchers and evaluators to measure MPI outcomes, predominantly on the basis of changes to the men.

Strengthening the effectiveness of interventions with men who perpetrate IPV is an essential component of keeping women and children safe. There is existing debate on how to identify intervention variables responsible for men’s behavioural change. Contemporary research on MPIs, particularly from the United States of America (USA), Canada (Babcock et al., 2016; Cannon, Hamel, Buttell, & Fefreira, 2016) and the United Kingdom (UK) (Bates et al., 2017), has tended to favour clinical controlled trials and other quasi-experimental

<sup>4</sup> This research is about women who have experienced IPV. Occasional reference is made to women and children, which is intended to be inclusive of both women who have and who do not have children in their care. Our position is that increasing the safety, wellbeing and QOL of women, including those who are mothers or carers, is essential to strengthening children’s protective environments and keeping them safe.

methods. This may be because random controlled trials and quasi-experimental designs are globally heralded as gold and silver standards for generating credible evidence of program effectiveness (Bickman & Reich, 2015; Gugiu & Ristei Gugiu, 2010). However, these methods have limitations when applied to complex interventions, especially when intervention affected outcomes may not be distinguishable (Greenberg & Morris, 2005). Likewise, review studies on methods used to measure the effectiveness of MPIs, specifically men's behaviour change programs (MBCPs), consistently reveal methodological flaws and highlight equivocal results (for example, Arias et al., 2013; Bates et al., 2017; Eckhardt et al., 2013; Lilley-Walker et al., 2016; Mackay et al., 2015b; Whitaker et al., 2013). In our examination of the research literature, the quasi-experimental methods used to evaluate MPIs rarely integrate the multidimensional characteristics of IPV experienced by women. In addition, these studies do not consider women's priorities for a better QOL in measuring the outcomes of MPIs. Generally speaking, how to best measure the outcome effectiveness of MPIs remains unresolved.

It is broadly understood that stopping violence is a priority outcome of MPIs (Vlais, Ridley, Green, & Chung, 2017). There is also consensus in the literature that perpetrators need to take responsibility for their use of violence, demonstrate behavioural change and cease their violence (Eckhardt et al., 2013; Humphreys & Campo, 2017). However, the main concern in this literature is that most men who participate in MPIs are generally known to do so as a result of Family Court processes, on the advice of legal counsel or by the active referral of professionals (e.g. police and social workers) (Eckhardt et al., 2013; McLaren & Goodwin-Smith, 2016), and not necessarily of their own volition. Some men may also initiate their own attendance at an MPI in the hope that their participation will reflect positively in court hearings or sentencing (McLaren & Goodwin-Smith, 2016). This means that their participation may not be completely voluntary or without motive (McLaren & Goodwin-Smith, 2016; Moss, 2016), as perpetrators of IPV generally want to avoid subsequent legal attention or incarceration (Eckhardt & Utschig, 2007; Hamby, 2016; Helfritz, Stanford, Conklin, & Greve, 2006). Such motivations among men call in to question the validity of some existing evaluation measures, especially perpetrator self-reports (Eckhardt & Utschig, 2007; Hamby, 2016; Helfritz et al., 2006). Further, conclusions about the

effectiveness of MPIs are frequently based on reductions in men's legal involvement (Coulter & Van de Weerd, 2009; Eckhardt et al., 2013), or inferences drawn from recidivism rates (Fitzgerald & Graham, 2016; Haggård, Freij, Danielsson, Wenander, & Långström, 2015; Migliore, Ziersch, & Marshall, 2014). These, too, do not provide insights into the men who may curb criminal forms of violence towards women and continue to abuse their victims/survivors in less detectable ways, or influence women not to report subsequent abuse.

Previous research and evaluation on the effectiveness of MPIs has predominantly focused on perpetrators of the most violent physical or sexual acts, those who are court-mandated to attend and therefore involuntary. Furthermore, it has been suggested that the outcome measures of these programs are likely to give greater insight into violent men's avoidance of future scrutiny (Day & Bowen, 2015; Hester & Westmarland, 2006), as opposed to violence reduction or intervention effectiveness. For example, in an analysis of Tasmanian police records, the Australian Institute of Criminology recently found that IPV reoffending increased in frequency in the days to months immediately following an initial IPV incident but declined over the duration of 6 months (Morgan, Boxall, & Brown, 2018). The authors of this study emphasised the importance of concentrated efforts with perpetrators in the first 2 months following an initial IPV offence. However, the study failed to consider that decreases in reported reoffending could be associated with changes in victims'/survivors' reporting behaviours, or changes to offenders' acts of coercive control over their victims/survivors. Associations between MPIs, reoffending and changes to the lives of victims/survivors were outside the scope of this study.

As an alternative to perpetrator self-reports and recidivism studies to evaluate MPIs, some studies have examined the perceptions of IPV sector professionals (Cannon et al., 2016; Morrison et al., 2016) or have asked intimate partners, who are cohabitating with perpetrators, to report their observations of the men's behavioural change (McGinn, Taylor, McColgan, & Lagdon, 2016); however, women may fear the consequences of reporting negatively on their partners (Kelly & Westmarland, 2015), for example, being subject to further violence, as well as being concerned about family breakdown and feelings

of shame and guilt (McLaren, 2016a; Wendt & Zannettino, 2014). Further, feminist critics have argued that women are being required to monitor and report on perpetrators' behaviours during participation in an MPI which puts the focus of responsibility for change onto women, as opposed to men (McLaren, 2013b, 2016b; Tollefson, Webb, Shumway, Block, & Nakamura, 2009). Women's monitoring of men also reinforces gender stereotypes in which women are held responsible for their intimate partners and relationships, including any failings that may occur (McLaren, 2013b; 2016b; Tollefson et al., 2009). Such studies are problematic due to a misalignment of responsibility, for both determining intervention effectiveness and for stopping the violence.

Assessing changes in perpetrators' behaviours as an indicator of "stopping the violence" has limitations. Kelly and Westmarland (2015) suggested that "stopping violence" does not address the ways in which women live with harm from IPV or how they move on from those harms. This is consistent with the standpoint underpinning the current study, such that the outcome measurement of broader changes to the lives of IPV victims/survivors is an important indicator of the effectiveness of MPIs, alongside safety, wellbeing and other outcomes that may be associated with stopping the violence. Understanding which aspects of MPIs contribute to safety, wellbeing and the QOL of others who remain in the perpetrators' lives, is needed. Valid measures are critical for developing knowledge about what works in MPIs, why it works, for whom and from whose perspective. These should be based on victims/survivors' priorities on what a better life would look like. As a victim-centred measure, the use of women's QOL assessments to measure the effectiveness of MPIs is one such way this could be achieved.

Measuring changes to the women's QOL has the potential to shift service design power to women, especially if charged to achieve overall program goals in favour of QOL improvements for victims/survivors in conjunction with behaviour changes in the men. However, assessing QOL also poses challenges in terms of the concepts and methods used and the application of measures (Bullinger & Quitmann, 2014). For this reason, program evaluation and research literature increasingly recommend that victim-centred measures, such as QOL assessments, are used in the outcome measurement of MPIs

(O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). Of the few reported evaluations that state women's QOL is considered as an outcome measure of MPIs (Bates et al., 2017; Vall, 2017), there is a lack of consistent definition of QOL, and a lack of standardised QOL instruments or measures. Further, no QOL measure has been specifically validated for use with women experiencing IPV, or for women whose partners are attending MPIs.

## Understanding the concept of QOL

QOL is an overarching individual assessment of "the goodness of life" (Campbell, Converse, & Rodgers, 1976). It traverses many life domains, which may include physical health, psychological health, social relations and environment. While the term QOL means different things to different people (Bowling, 2005b), the World Health Organization (WHO) defines the concept as:

individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. (WHOQOL Group, 1998a, p. 551)

QOL is a subjective evaluation of an individual's life, moderated by a range of objective factors at a given point in time (Andrews & Withey, 2012; Phillips, 2006). For example, objective factors may include social, legal and political systems, an individual's immediate physical environment or the existence of medical conditions. Individuals evaluate these factors variously according to their own perspectives on life. While QOL may be conceptualised diversely by individuals, there is some agreement among researchers on the underpinning principles.

### QOL principles

There is international consensus that QOL has three distinct underpinning principles. These are that:

1. QOL is a multidimensional construct comprised of complex interactions between individual, social, health and spiritual conditions (Bowling, 2005a; Fischer, Clavarino, Plotnikova, & Najman, 2015a), which transcend singular domains (Fakhoury & Priebe, 2002; Zubaran & Foresti, 2009). In examining the QOL experienced by IPV

victims/survivors for this study, it is likely that QOL will encapsulate more than the character or effects of the violence itself. This is because life experiences, in general, rely on an individual's subjective interpretation in a context unique to the individual assessor (Andrews & Withey, 2012; Phillips, 2006), for example, in terms of their physical health, mental health, social relationships and living environment.

2. QOL is a uniquely individual self-assessment. Self-assessments draw on an individual's sense of self and self-regard, their relationships with others, level of autonomy, life purpose and sense of control over their immediate environment (Ryff & Singer, 2013; Verdugo, Schalock, Keith, & Stancliffe, 2005). Individuals may subjectively assess their QOL as satisfactory when objective criteria suggest that their QOL should be low, and vice versa (Brown & Brown, 2005; Maremmani, Pani, Pacini, & Perugi, 2007). For women living with IPV, QOL must be understood in the context of these self-assessments. This includes their experiences of IPV, responses from within informal social networks and interactions with the formal IPV service system (laws, policy, victim/survivor and perpetrator services and interventions). A victim-centred approach appreciates how women assess their QOL and the changes they perceive need to occur to improve their QOL.
3. QOL assessments are dynamic and change across the life course according to life events and circumstances (Schwarz & Strack, 1999; Wood-Dauphinee, 1999). This is because individuals assess their QOL based on broad, or even specific, changes to their life. These changes may include different coping methods and altering expectations regarding what life has to offer (McClimans et al., 2013; Schwarz & Strack, 1999). Both women's experiences of IPV and their perspectives on the worth of MPIs may affect their subjective QOL self-assessments, which may differ from other women and populations.

#### QOL as a victim-centred outcome measure

QOL assessments are recognised as an important outcome measure in the medical and health sciences (Bullinger & Quitmann, 2014; Higginson & Carr, 2001; Sansoni, 2016; Strada et al., 2017). In the medical and health sciences, patient-reported outcome measures are reports that come directly

from individuals on how they feel or function in relation to a condition or an intervention, without interpretation by service providers, or anyone else (Patrick, Guyatt, & Acquadro, 2008). Here we have coined the term "victim-centred" outcome measure. This term derives from the more traditional term of "patient-reported" outcome measures. Consistent with the term "patient-reported", victim-centred outcomes in the context of the current study are reports obtained directly from women who have experienced IPV about their QOL, and without interpretation by anyone else.

Akin to patient-reported outcomes, victim-centred outcome measures are predicated on the belief that victims/survivors are best able to judge the impact of an intervention on their QOL (Dijkers, 2003; Higginson & Carr, 2001; Williams et al., 2016). Asking individuals directly which aspects of QOL are important to them can improve communication and engagement with service providers, and could result in better outcomes, particularly in complex situations (Higginson & Carr, 2001; Ridgeway et al., 2013). For example, Verdugo et al. (2005) and others (Dijkers, 2003; Higginson & Carr, 2001) recommend that individuals are directly involved in the measurement of their QOL as this offers them an opportunity to indicate the importance of various life domains or events. This can involve selecting life domains that are salient to an individual's feeling of wellness, expressing opinions about those areas or assessing overall QOL using standard evaluation metrics (Dijkers, 2003).

The International Society for Quality of Life (ISOQOL) guidelines provide peer standards for assessing and measuring QOL outcomes (Reeve et al., 2013; Strada et al., 2017). In brief, to be considered reliable, QOL outcome measures must be suitable and relevant to the population under investigation (Reeve et al., 2013; Strada et al., 2017). QOL should also be clearly defined within a given study or evaluation and measures should be validated with the target population (Reeve et al., 2013; Sansoni, 2016). Finally, measures also need to include relevant QOL domains, be able to identify participants' QOL priorities and detect change (Reeve et al., 2013; Sansoni, 2016).

This means that even if a QOL instrument has been validated with another population, it does not necessarily mean that it

will be a reliable assessment measure, or relevant to the target population. Upon researching available QOL standardised instruments, O’Doherty et al. (2014) have previously recommended the WHOQOL-BREF as the instrument of choice in the context of IPV. This was because the WHOQOL-BREFs questions in the environmental QOL domain seek assessment of financial resources, freedom, physical safety, home environment, participation and opportunities in life, which are likely to be impacted by IPV. Despite this, there has been no QOL instrument validated for use with women who have experienced IPV.

### Women’s QOL as an outcome measure of MPIs

While women are not the clients of MPIs, it is possible to likewise conceptualise the logic and benefits of victim-reported QOL for use in measuring the effectiveness of MPI outcomes. This is because measuring changes to victims/survivors’ QOL is pertinent when the aim of MPIs is principally to stop the violence, but also to support perpetrators in repairing the harm they have done (Jewkes et al., 2015; Spencer, 2016; Westmarland, McGlynn, & Humphreys, 2018). As a restorative justice approach, this means that MPIs could have a greater role in restoring the QOL of victims/survivors.

In the context of MPIs, victim-reported outcome measures are questionnaires that women themselves would complete. Such questionnaires would obtain the women’s assessment of how men’s participation in MPIs have affected their QOL over time. This would fill a vital gap in knowledge about outcomes through indicating whether, how, and in what QOL domains the MPIs are making a difference to women’s lives. At the simplest level, when MPIs result in improvements to women’s QOL then inferences can be drawn about an intervention’s effectiveness. When MPIs do not achieve this, then women’s assessments of their QOL will offer indications of where systems and practice models with men may need to change. Furthermore, in conceptualising women victims/survivors as consumers of MPIs, especially women who remain in relationships with IPV perpetrators, indicators of effectiveness must be understood and designed according to the perceived needs of these women.

Women’s voices have predominantly been used to inform emergency responses and victim-focused interventions (Chang et al., 2005; Evans & Feder, 2016; McLaren, 2013a; McLaren & Goodwin-Smith, 2016; Morrison et al., 2016), with few examples in the development of MPIs (Kelly & Westmarland, 2015). Using women’s QOL assessments is consistent with consumer-led recovery models that are sympathetic to the notion of “getting your life back” (Gehart, 2012a, p. 430). Such models are well established in mental health, general health (Bowland, Hensley, Johnson, & Fleming, 2010) and alcohol and drug literature (Fischer, Najman, Plotnikova, & Clavarino, 2015b). Recovery oriented services are viewed by consumer movements to have relevance and meaning as they reflect the lived experiences and life priorities of consumers (Gehart, 2012b). It is not suggested here that women experiencing IPV become direct consumers of MPIs. However, a rationale exists to favour perpetrators and MPIs becoming more responsive to achieving improvements to victims/survivors’ QOL as a measurable outcome.

Finally, understanding victims/survivors’ QOL and their priorities for a better life has the potential to shift the power for service design to women. The aim of this approach would be to prioritise women’s voices in the provision of support to men at various points in the IPV service system. Furthermore, investigating the women’s QOL provides a more nuanced understanding of what life is like beyond the immediate experience of abuse and violence. Examining women’s QOL and QOL priorities in the context of IPV and men’s engagement in MPI, presents an important opportunity to conceptualise the effectiveness of MPIs. This is important for program developments that are aimed at restoring the QOL of victims/survivors.

## Report structure

This research report is structured in five sections. The next section presents a review of the current state of knowledge on the use of QOL measures in the context of IPV and MPIs. The methods are then described. The findings comprise participant characteristics, women’s subjective understandings of what constitutes QOL, how fear permeates QOL, and perspectives of MPIs. The discussion and conclusion recommend how



QOL may be used as a victim-centred outcome measure of IPV, and particularly of MPIs. Qualitative coding outcomes and quantitative data are presented in Appendix B and Appendix C respectively.

## Summary

Any meaningful assessment of MPIs must include consideration of victims'/survivors' subjective QOL experiences, definitions and priorities. A better understanding of the QOL of women experiencing IPV can inform the development of more sensitive and informative assessment measures. This, in turn, can contribute to broader endeavours to prevent violence against women, stop re-offending by men, promote the best interests and safety of women and children and enable women's recovery from IPV.

# State of knowledge review

This section presents the findings of an integrative review of existing literature on QOL as an outcome measure in IPV and MPIs. This drew on some principles of systematic literature reviews, by using, for example, Preferred Reporting Items for Systematic Reviews and MetaAnalysis guidelines (PRISMA) (Moher, Liberati, Tetzlaff, & Altman, & The PRISMA Group, 2009). The review examined how researchers in the area of IPV have measured women's QOL, formulated questions on their QOL priorities, and analysed changes in their QOL that are associated with MPIs. In undertaking the review, the researchers were considerate of the International Society for Quality of Life Research (ISOQOL) guidelines on QOL measurement outcomes (Reeve et al., 2013; Strada et al., 2017). This was an important consideration for assessing the validity of QOL studies, and for screening out records purporting to be QOL studies when actually they were not.

The aims of the state of knowledge review were to:

- document the application of women's QOL in the measurement of MPI outcomes;
- identify studies that enabled women to prioritise what was important to their QOL to inform the development of face-to-face interview protocols; and
- ensure that the QOL of women who have experienced IPV is located alongside the most current evidence.

## Search strategy

A systematic search was initially undertaken in March 2017, and then repeated and expanded in December 2017. The search included qualitative, quantitative and mixed-method research publications in English only. Search terminology included "intimate partner violence" AND "quality of life" AND "perpetrator intervention", repeated across synonym combinations. The search was conducted in:

- specific QOL journals (Applied Research in Quality of Life, Journal of Happiness Studies, Social Indicators Research and Quality of Life Research);
- generic data bases (ProQuest, PsycINFO, Informit, Scopus, PubMed);
- social and human services specific databases (Family,

Social Work Abstracts, Social Services Abstracts, Family and Society Studies);

- a search engine (Google Scholar); and
- ancestry searching of the reference lists of obtained articles.

The information sources that were searched included peer reviewed journal articles, conference papers and abstracts, and materials produced by government and non-government organisations in the IPV and MPI service sector.

## Identifying eligible studies

There is increasing agreement in the research literature on the importance of understanding QOL (which traverses multiple life domains) independently of health related quality of life (HRQOL) (Davis & Madden, 2006; Kamenov, Twomey, Cabello, Prina, & Ayuso-Mateos, 2017; Maciuszek & Shahmehri, 2003). QOL is considered similar to subjective wellbeing (Andrews & Withey, 2012; Camfield & Skevington, 2008; Campbell et al., 1976; Ryff & Singer, 2013; WHOQOL Group, 1998a), but conceptually different to HRQOL with its pathology focus (Bowling, 2005a; 2005b; De Maeyer, Vanderplasschen, & Broekaert, 2010; Patrick et al., 2008; Zubaran & Foresti, 2009), due to the focus of HRQOL on functioning and the ability to perform tasks (Patrick & Erickson, 1993; Patrick et al., 2008). Arguably assessments of HRQOL reflect self-reported health status and not QOL at all (Muldoon, Barger, Flory, & Manuck, 1998; Apers, Luyckx, & Moons, 2013; Karimi & Brazier, 2016). According to Camfield and Skevington (2008), there is no conceptual agreement or certainty among researchers on whether QOL and subjective wellbeing are synonymous, whether subjective wellbeing is nested in QOL or QOL a component of subjective wellbeing. They highlight that researchers variously use the terms QOL or wellbeing from both subjective and objective dimensions, using a range of standardised tools interchangeably to do so. For example, studies on health related QOL have assessed subjective QOL perspectives, but over time health related QOL instruments have largely become measures for objective functioning.

Nevertheless, the terms QOL and HRQOL are sometimes used interchangeably in studies, or articles that purport to be examining QOL when they are indeed examining HRQOL

(De Maeyer et al., 2010; Farquhar, 1995; Felce & Perry, 1995; Skevington et al., 2004). This means that the identification of eligible studies could not rely on the language or the standardised instrument used. Instead, a lengthy process of reading was required to discern that articles were focused on QOL. Consequently, studies that examined either concept (i.e. QOL or HRQOL) were assessed for inclusion. However, they were only considered eligible for inclusion if they examined QOL (or a related concept, such as wellbeing) as an overall or a multidimensional construct, and with a focus on QOL of women in association with interventions with IPV perpetrators. Studies that treated QOL as a singular domain (e.g. such as those addressing health related QOL) were ineligible.

An initial search of the literature based on the eligibility criteria (i.e. the use of QOL and not HRQOL, as well as a focus on IPV and MPIs) resulted in zero articles. In the screening process there were articles identified that referred to QOL in the context of IPV but did not address MPIs or other forms of interventions with male partners.

The search scope was subsequently broadened, and a new systematic search undertaken. Inclusion criteria were extended to include literature based on original research, theoretical papers and review studies of IPV intervention programs for women (e.g. women's shelters and judicial interventions). Literature was included if it examined QOL or subjective wellbeing from women's perspectives. Studies that examined HRQOL were included only if they also focused on QOL or subjective wellbeing. The search resulted in 4,696 articles. Duplicates were removed, which resulted in 362 unique articles. Screening was then undertaken and this resulted in six studies, including one that examined the QOL of women whose male partners had participated in MPIs (Austin & Dankwort, 1999).

In December 2017, the search criteria were subsequently expanded to include studies with constructs that are often conflated with QOL, but are recognised as conceptually different; for example, wellbeing (see De Maeyer et al., 2010; Farquhar, 1995; Felce & Perry, 1995; Skevington et al., 2004). One further article was later identified (Gondolf, 1999). The search strategy is provided in a PRISMA diagram (Moher

et al., 2009) (see Figure 2). The rationale was to capture any articles reporting on wellbeing, which may have also examined the QOL of women whose male partners had been involved in MPIs (see Table 1).

An appraisal of the design, focus, and quality of the included studies was then made. This commenced with data extraction of study characteristics, the concepts of QOL that were adopted, and findings. Extracted data were compared item by item, with the intention to group similar data together. However, different terminologies and varying methods meant that cross-comparison of the seven studies was limited. The appraisal of the studies is discussed in detail below.

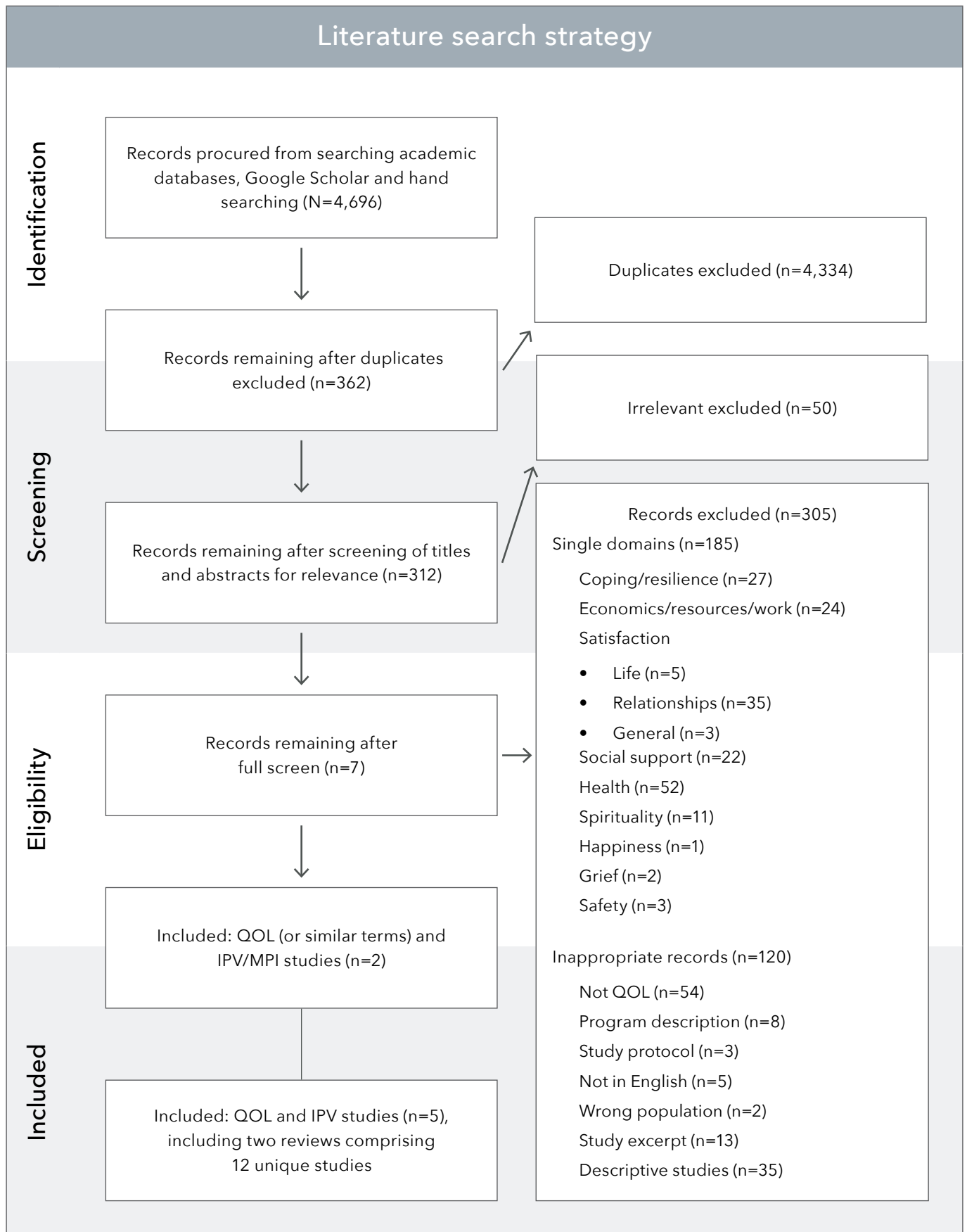
## Academic literature on QOL, IPV and MPIs

An overview of the seven relevant located studies are presented in Table 1, followed by a brief description of each of these studies.

In Canada, Austin and Dankwort (1999) applied a qualitative phenomenological approach to examine the QOL of women whose male partners had previously participated in MPIs. Austin and Dankwort (1999) considered that interviews with individuals about their QOL were a way for participants to voice their own meanings on what mattered to them in life. This cross-sectional study comprised 25 in-depth interviews. Common themes that emerged from the interviews as important to the women were personal safety (most important), enhanced personal wellbeing, validation and knowledge acquisition regarding IPV.

In the United States, Gondolf (1999) examined women's assessments of their QOL (definition not stated) (N=208). The women who participated had a former or current partner (N=840) involved in one of four MPIs. The MPIs consisted of one pre-trial MBCP and three post-conviction MBCPs, with individual and group interventions ranging from 3–9 months in duration. The study asked women three QOL related questions using a Likert scale. When asked, "Would you say that your life is generally better, worse, or the same?",

Figure 2 PRISMA flow diagram



Source: PRISMA Flow Diagram (Moher et al., 2009).

Table 1 Academic literature on QOL, IPV and MPIs

Article	Research design and focus
<p>Alsaker, K., Moen, B. E., Nortvedt, M. W., &amp; Baste, V. (2006). Low health-related quality of life among abused women. <i>Quality of Life Research</i>, 15(6), 959-965. <a href="http://doi.org/10.1007/s11136-006-0046-4">http://doi.org/10.1007/s11136-006-0046-4</a></p>	<p>Cross-sectional study of shelter residents (N=87) in Norway, involving a comparison of one QOL (WHOQOL-BREF) and one health related QOL (HRQOL) instrument (SF-36). The research aim was to identify which instrument was best correlated with reported physical and psychological violence.<sup>a</sup></p>
<p>Austin, J. B., &amp; Dankwort, J. (1999). The impact of a batterers' program on battered women. <i>Violence Against Women</i>, 5(1), 25-42. <a href="http://doi.org/10.1177/10778019922181130">http://doi.org/10.1177/10778019922181130</a></p>	<p>Qualitative study of shelter residents (N=25) in Canada, involving in-depth interviews with women whose partners had participated in MPIs during the prior 12 months. As a phenomenological study, it involved examination of women's perceptions of their partners' change on completion of MPIs and associations with their QOL.</p>
<p>Gondolf, E. W. (1999). A comparison of four batterer intervention systems: Do court referral, program length, and services matter? <i>Journal of Interpersonal Violence</i>, 14(1), 41-61. <a href="http://doi.org/10.1177/088626099014001003">http://doi.org/10.1177/088626099014001003</a></p>	<p>A comparative multisite follow-up survey of 208 women in the United States who were the initial or new partners of men who participated in an MPI, interviewed 15 months after the men commenced intervention.</p>
<p>Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., &amp; O'Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence. <i>Women's Health Issues</i>, 25(5), 561-569. <a href="http://doi.org/10.1016/j.whi.2015.04.006">http://doi.org/10.1016/j.whi.2015.04.006</a></p>	<p>Qualitative study of low-income earning women (N=41) in Canada who have experienced IPV. Recruited from shelters &amp; community housing, the study engaged women in semi-structured interviews in an effort to understand the women's mental wellbeing as an aspect of HRQOL.</p>
<p>O'Doherty, L. J., MacMillan, H., Feder, G., Taft, A., Taket, A., &amp; Hegarty, K. (2014). Selecting outcomes for intimate partner violence intervention trials: Overview and recommendations. <i>Aggression and Violent Behavior</i>, 19(6), 663-672. <a href="http://doi.org/10.1016/j.avb.2014.09.010">http://doi.org/10.1016/j.avb.2014.09.010</a></p>	<p>International narrative review of studies (N=9) that used QOL/HRQOL as an outcome measure for examining IPV intervention trial effectiveness (studies included: Brierley et al., 2013; Cripe et al., 2010; Falb et al., 2014; Hegarty, et al., 2013; Klevens et al., 2012; Krishnan, Subbiah, Chandra, &amp; Srinivasan, 2012; MacMillan et al., 2009; Tiwari et al., 2010; Tiwari et al., 2005).</p>
<p>Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., . . . Feder, G. (2015). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review). <i>The Cochrane Database of Systematic Reviews</i>, 12. <a href="http://doi.org/10.1002/14651858.CD005043.pub3">http://doi.org/10.1002/14651858.CD005043.pub3</a></p>	<p>Cochrane review (N=6) of international studies that explored QOL/HRQOL as an outcome measure in review of advocacy intervention effectiveness (studies included: Cripe et al., 2010; Sullivan, Bybee, &amp; Allen, 2002; Sullivan, Tan, Basta, Rumpitz, &amp; Davidson, 1992; Taft et al., 2013; Tiwari et al., 2010; Tiwari et al., 2005).</p>
<p>Wittenberg, E., Joshi, M., Thomas, K. A., &amp; McCloskey, L. A. (2007). Measuring the effect of intimate partner violence on health-related quality of life: A qualitative focus group study. <i>Health and Quality of Life Outcomes</i>, 5, 1-7. <a href="http://doi.org/10.1186/1477-7525-5-67">http://doi.org/10.1186/1477-7525-5-67</a></p>	<p>Mixed methods study from the USA involving four focus groups with women recruited via flyers at IPV shelters and service providers. The research sought to determine aspects of life affected by IPV and analysed responses in the context of existing HRQOL instruments.</p>

Note: <sup>a</sup> To document for comparison women's reported physical and psychological violence, Alsaker, Moen, Nortvedt, & Baste (2006) used the Norwegian versions of the Severity of Violence against Women Scale (SVAWS), comprising 46 items in nine categories, and the Psychological Maltreatment of Women Index (PMWI) comprising 58 questions related to emotional, verbal, coercive control and isolation abuse.

12 percent of women reported that their life was generally better, 22 percent the same, and 12 percent worse as a result of their partner's participation in an MPI. Further, 72 percent of the women reported feeling very safe, while 66 percent of participants also believed they were very likely to be hit in the near future. Gondolf (1999) recognised that the effect of MPIs transcended individual aspects of women's lives and that subjective experiences of violence, safety and QOL accounted for diverse survey responses from women.

Both Austin and Dankwort (1999) and Gondolf (1999) had similar approaches to QOL. Gondolf (1999) observed that QOL (or wellbeing) was a personal construct predicated on what was individually important to women. Austin and Dankwort (1999), however, found that women reported an improved sense of wellbeing only so as long as their partners were involved in the batterer programs. While wellbeing was not defined in either of the research studies (Austin & Dankwort, 1999; Gondolf, 1999), enhanced wellbeing was expressed by many women as having the ability to assert their personal needs or feel more empowered in Austin and Dankwort (1999). Some women expressed enhanced wellbeing as a temporary "relief or easement gained" because their partners were receiving some form of intervention (Austin & Dankwort, 1999, p. 34), or feeling safe while their partners were in intervention even where the abuse was ongoing (p. 37). The same levels of wellbeing were not necessarily reflected post-intervention. Consequently, Austin and Dankwort (1999) suggested that subjective wellbeing and QOL changed for women according to whether the perpetrators were engaged in intervention and not necessarily according to whether the abuse had stopped. The authors in both studies noted that wellbeing and QOL were reliant on women's perceptions of the meaning of safety, information and validation, and increased capacity to make decisions about their lives. Despite variation across time and intervention contexts, Austin and Dankwort (1999) concluded that women's QOL assessments offered potential for measuring change in association with the men's interventions.

### QOL instruments used in the studies reviewed

For consistency and validity, the International Society for Quality of Life Research (ISOQOL) recommends as a

minimum standard that research studies using QOL measures commence with a clear QOL definition (Reeve et al., 2013). However, there is no common understanding of the term, some authors provide a QOL definition and others do not, and there is variation in the contexts that it is applied. As Dijkers (2003, p. S3) stated, "many investigators bypass the difficulty in defining what QOL means and go right ahead with developing a measure". The lack of studies that define QOL calls in to question the validity of studies examined in the current review of research, which makes comparison across studies challenging. For example, some relevant studies that were included in the current review appear to report on QOL and then, upon examining the literature, were found to have based their findings on health related QOL instruments (see Table 1).

The most common measures administered by the studies included in this review, inclusive of the studies reviewed by O'Doherty et al. (2014) and Rivas et al. (2015), were the SF-12 and SF-36 health related QOL measures (Alsaker, Moen, Nortvedt & Baste, 2006; Brierley et al., 2013; Cripe et al., 2010; Falb et al., 2014; Klevens et al., 2012; Tiwari et al., 2010; Whittenburg et al., 2007), and the WHOQOL-BREF (Hegarty et al., 2013; Krishnan et al., 2012; MacMillan et al., 2009). However, the WHOQOL-BREF and other QOL instruments have not been validated with the intended population (i.e. women who have both experienced IPV and whose male partners are participating in an MPI). The WHOQOL-BREF has been validated on large populations of women globally, some of whom may have experienced IPV. However, IPV and MPIs were not the population focus of these studies.

This brings to attention the content validity of administered measurements. Content validity is the extent to which an instrument measures the constructs that developers or users purport it to assess (Patrick et al., 2011). Domains assessed in the most commonly used instruments (WHOQOL-BREF and SF-12/36) were:

- physical and mental functioning/activities;
- role limitation/mobility;
- bodily pain;
- general health;
- vitality;

- social functioning/activities/relationships; and
- physical or social environment.

There are two limitations with these instruments, which are:

- what these domains mean to experts may not necessarily be the same as what they mean to research participants (Bowling et al., 2003); and
- other items, such as safety (located within the QOL domains) may be equally (if not more) important to participants.

Both the SF-36 and the WHOQOL-BREF are well-established, reliable and relevant cross-cultural instruments comprising a core battery of items designed, principally, to assess HRQOL<sup>5</sup> in the former and QOL in the latter. Both assess aspects of life across several domains. O’Doherty et al. (2014) compared the two instruments and considered the WHOQOL-BREF to be the instrument of choice for use in measurement of women’s QOL in the context of IPV due to the inclusion of an environment domain. The environmental QOL domain measures financial resources, freedom, physical safety, home environment, participation and opportunities, which are aspects of life that are frequently impacted by IPV. As such, these QOL items are relevant to IPV victims/survivors’ subjective QOL assessments.

While both the SF-36 and the WHOQOL-BREF have been used to assess the QOL of women with IPV experiences, neither instrument has actually been assessed for reliability and validity with women who have IPV experiences. In addition, neither instrument has been used to systematically measure changes for women associated with their own or their intimate partner’s intervention. In initiating this approach, it is crucial that women are actually asked what QOL means to them. This includes qualitative questions about what is good or not good about their lives, and their priorities for a better QOL (for example, Bowling et al. [2003] examined the subjective QOL assessments and qualitative responses to a question of what individuals needed to achieve a better life).

<sup>5</sup> QOL is conceptually different to the narrower concept of HRQOL. HRQOL has a pathology focus (Bowling, 2005a) and a function focus premised on a person’s ability to perform different tasks (Patrick & Erickson, 1993). The SF-36 is not discussed substantially as this instrument was not used in the current study.

## Overall appraisal of the studies reviewed

It is uncertain whether the studies reviewed accurately represent participants’ assessments of their QOL and what aspects of QOL are important to them. This is because the definitions of QOL, HRQOL and wellbeing were conceptualised variously across the studies. Two of the studies reviewed commenced with a definition of QOL in accordance with ISOQOL standards for QOL research (Matheson et al., 2015; Wittenberg Joshi, Thomas, & McCloskey, 2007). Matheson et al. (2015) described QOL as a wellbeing concept that included self-esteem and self-identity. In contrast, Wittenberg et al. (2007, p. 2) suggested that HRQOL was a general term to describe the impact of an illness, disease or condition on the overall wellbeing of an individual who is affected by such a condition. It was unclear in the other original research studies reviewed what was referred to as QOL or HRQOL, as operational definitions were not provided (Alsaker et al., 2006; Austin & Dankwort, 1999; O’Doherty et al., 2014; Rivas et al., 2015).

While three studies researched women’s priorities for a better life (Austin & Dankwort, 1999; Matheson et al., 2015; Wittenberg et al., 2007), the factors that were identified as most important to QOL or HRQOL differed in each study. For example, Austin and Dankwort (1999, p. 38) reported that “enhanced safety” was important to women across all QOL domains. Enhanced safety was described as having a sense of enhanced personal welfare, feeling validated by program counsellors and increased knowledge regarding abusive behaviours. In Matheson et al. (2015, p. 564) a sense of “erosion of the self”, as a result of IPV, was viewed by the women as detrimental to their QOL. The authors reported that women articulated “self-awareness”, “self-evaluation” and “recovery” from IPV as being critical to improving their QOL (Matheson et al., 2015, p. 566). Wittenberg et al. (2007, p. 4) found that women most commonly wanted to improve HRQOL items that were related to “physical symptoms”, and to relieve their emotional and psychological symptoms, especially fear. Finally, our sub-analysis of studies in the review articles by O’Doherty et al. (2014) and Rivas et al. (2015) found that while the studies reported on participants’ assessments of their QOL, women’s priorities for a better QOL were not the focus of these studies.

## Additional QOL literature associated with MPIs

In December 2017, the literature search was repeated and expanded to general searching of the Internet. The purpose of repeating and expanding the search was to ensure that we captured all possible articles relevant to the current study prior to completion. Two additional items worthy of mention were located via the Google search engine and one via ancestry tracking. Three additional studies included research known as Project Mirabal (not focused on QOL but relevant to victim-centred measurement) (Kelly & Westmarland, 2015), an evaluation report (reported on QOL, but had limited service data available) (Vall, 2017), and a journal article reporting a review of perpetrator programs in the UK (Bates et al., 2017). These items are worthy of note as they provide indications of how QOL and victim-centred measures are being considered by researchers in relation to the latest studies that examine MPIs.

Project Mirabal was undertaken between 2009–2015 in the UK by Kelly and Westmarland (2014, 2015; Westmarland & Kelly, 2012) to look at perpetrator program outcomes from the perspectives of women and children. The project considered perspectives that were broader than the reduction of violence by exploring what women thought should be indicators of success from MPIs.

The results from Project Mirabal indicated that women wanted the following as outcomes from MPIs:

- respectful/improved relationships;
- expanded space for action;
- support/decreased isolation;
- enhanced parenting;
- reduction or cessation of violence and abuse; and
- for men to understand the impact of domestic violence. (Kelly & Westmarland, 2015)

While Project Mirabal did not specifically explore QOL, or attempt to measure MPI outcomes for women, the findings begin to speak to the construct. The findings give an indication as to women's perspectives on how MPIs could improve

their lives into the future. Therefore, the project invited consideration of changes to aspects of victims'/survivors' QOL as indicators to evaluate in determining the outcome effectiveness of MPIs.

Specific to QOL, two authorships from Europe were identified that indicated how women's QOL had become part of a contemporary outcome narrative for a few services that delivered MPIs. The evaluation reports indicated positive advancements in the use of victim-centred measures to assess the effectiveness of men's intervention outcomes. In the first, Vall (2017) undertook both summative and outcome evaluations of MPIs in Nordic counties (Finland, Iceland, Sweden, Denmark, Greenland and Norway). She advised that evaluations of program processes and outcomes should triangulate information sources and include women's voices on MPI outcomes. In addition, Vall (2017) suggested that evaluations should identify improvements to safety and QOL for women and their children where possible. Despite this advice, service data has predominantly focused on the QOL of men engaged in the MPIs.

Of the programs Vall (2017) evaluated (N=45), most service providers administered measures of QOL with male perpetrators at program completion (n=37; 82.2%). A few administered QOL measures at 3–12 months follow-up (n=7; 18.9%), with more conducting the measures at 12–24 months (n=15; 40.5%). While the QOL of the perpetrator's women partners was a specific stated outcome measure, Vall (2017, p. 76) highlighted that only 11 (29.7%) of the services documented details about women's QOL outcomes at any stage. Furthermore, most measures of women's QOL were conducted at the men's program completion. Across service providers, women's and men's QOL were generated by self-reports with no standardised definition of QOL to guide reporting, no standardised instrument to assess QOL, and no baseline assessment at program intake. Without baseline measures and no operationalisation of a QOL definition, improvements to the women's lives associated with the MPIs included in the evaluation could not be measured.

In another study, Bates et al. (2017) reviewed the characteristics of 21 MPIs in the UK, specifically those involving MBCP group models. One program mentioned was the Building



Better Relationships Program in the UK. This 24-week group program consists of four modules, with the aims articulated in the review as follows:

- helping men to achieve a better understanding of why they perpetrate IPV;
- enhancing men's motivation to engage, identify and build on their strengths and skills;
- developing men's practical and sustainable strategies for change; and
- promoting to men how the QOL of those around them are impacted by their violence (Bates et al., 2017, p. 21).

Bates et al. (2017) found that less than two per cent of the programs collected pre-, post- or follow-up data of any type either from men engaged in the program or others. While the Building Better Relationships Program acknowledged that IPV affected people's QOL, there was no information on how victims'/survivors' or perpetrators' QOL was evaluated by this service, if at all.

In both the Nordic and UK reviews of MPIs, there were no definitions of QOL provided, no baseline QOL profiles established for the victims/survivors and no use of standardised QOL tools. None of the women's QOL reports, therefore, could be used to make valid associations between the women's QOL and the men's interventions.

## Summary

QOL as a victim-reported outcome in the context of IPV interventions is supported in the literature. However, few IPV studies asked women about their QOL, and there is no consistent definition or measurement of QOL. How QOL within the context of IPV should be assessed is in its infancy with little work to date undertaken on its conceptualisation and operationalisation. In particular, documentation on how victims/survivors define QOL and what their priorities are for a "good life" is limited.

The next section explains the research methods designed to assess QOL and explores QOL priorities among women experiencing IPV. An understanding of women's QOL priorities, in particular, will provide future opportunities to test the outcomes of MPIs in victim-centred ways.

# Methodology

This section details how this study was conducted. The section commences by describing the research design. This is followed by stating participant eligibility criteria, recruitment and interview procedures. This section concludes with a description of how the data collected were examined.

The primary research question for this study was:

In what ways can QOL, from the perspectives of women, inform the development of mechanisms to measure the effectiveness of MPIs as part of an integrated system of broader interventions?

Research aims were to:

- document women's self-assessments of their QOL (women whose male partners have participated in MPIs);
- identify the women's priorities for improving their QOL, and how these may inform evaluations; and
- consult with IPV sector professionals, including those working in MPIs, on the use of women's QOL in evaluations of MPIs.

## Research design

The research design was mixed methods. A mixed methods approach comprises a combination, and subsequent synthesis, of qualitative and quantitative methods. The decision to adopt a mixed method design was made to produce valid and factually relevant knowledge while concomitantly giving a "voice to underprivileged populations" (Sorde Marti & Mertens, 2014, p. 207). The semi-structured interview schedule, comprised of both qualitative and quantitative questions, enabled women to both articulate how MPIs have impacted on their safety and other aspects of QOL, as well as how MPIs could be more effective in improving their lives.

A theoretical framework is normally not provided in research such as this. However, the research is informed by a feminist standpoint in favour of prioritising women victims'/survivors' voices and life outcomes in interventions that are ultimately aimed to make their lives better. In the current case, women's outcomes associated with MPIs are key. The research design involved a series of distinct, yet interacting, stages (see Figure 3).

The original intentions for the research were to identify a data collection instrument from the literature review. This would have involved drawing on how researchers in the area of QOL, IPV and MPIs have formulated questions on women's assessments of their QOL and QOL priorities to measure MPI effectiveness. However, as reported above, the systematic search for literature did not result in this outcome. Furthermore, literature concerned with QOL among other populations is mostly derived from studies of HRQOL. These studies tend to focus on patients' expressed needs in regards to health conditions, predominantly examining populations with terminal or acute illness (for example, see Asadi-Lari, Tamburini, & Gray, 2004; Bengtsson-Tops & Hansson, 1999; Bonevski, Sanson-Fisher, Hersey, Paul, & Foot, 2000; Galushko et al., 2014; Zollfrank et al., 2015).

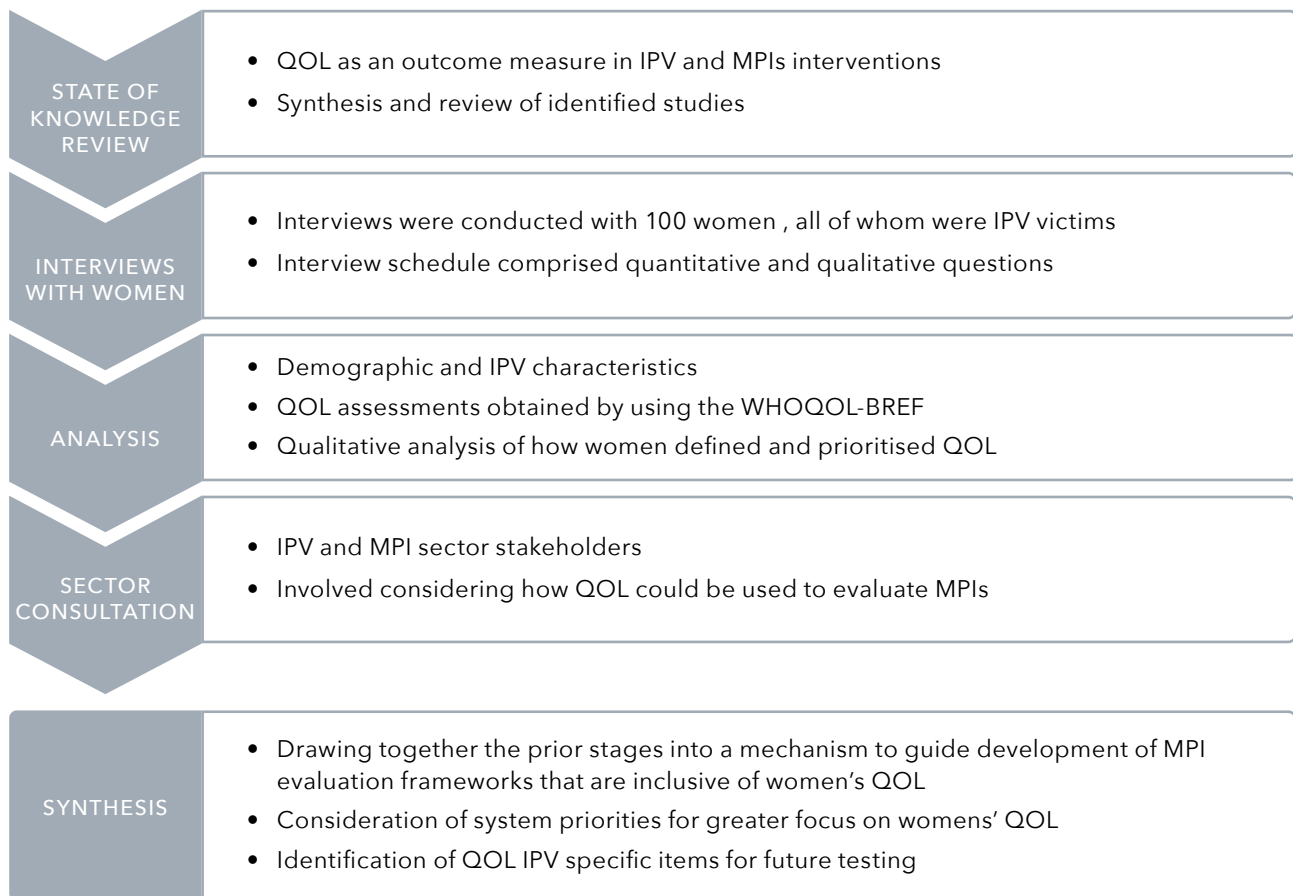
In the course of the literature review process, a study was located and assessed as having a similar approach to that required for the current study. Bowling et al. (2003) undertook a mixed methods approach to garner both quantitative and qualitative information with the express objective of determining what was important to the QOL of their population of interest. In particular, this study adapted Bowling et al.'s (2003) qualitative questions on what QOL meant to the women, what made their life good or bad, and what it was about the MPIs that contributed to their QOL.

## Sampling and recruitment

Participants were a convenience, non-representative sample of 100 women who self-identified as currently living with or as having historically lived with IPV. The sample size of 100 was pre-determined. This is a sufficient sample size for descriptive analysis and for informing the development of an outcome measure for further testing. A large sample for high statistical power or population generalisability was not the intention of the current study. Rather it aimed to explore what QOL may mean for women who have experienced such circumstances as IPV, to inform the development of a potential measure.

Participants were recruited from three Australian capital cities and associated wider metropolitan regions (Adelaide: n=45, Brisbane: n=25, Melbourne: n=30). These locations were

Figure 3 Summary of the research design stages



chosen because they were the regions in which this study's nine partner services providing IPV and/or MPI services were located.<sup>6</sup> Budgetary constraints prevented the research being extended to other cities, rural or remote regions.

Recruitment occurred in two ways. Nine partner IPV agencies that provide a range of services including interventions to women victims/survivors and male perpetrators of IPV distributed recruitment material inviting women to self-nominate for participation in the study. Thirty-six participants were recruited via the partner agencies (Adelaide: n=9, Brisbane: n=14, Melbourne: n=13). Additionally, women were recruited via social media advertising. Social media recruitment was conducted through paid Facebook advertising by the Flinders University media department<sup>7</sup> and targeted

geographically to within a 100 kilometre radius (restricted due to limited research budget) of each of the three jurisdiction's capital cities. Fifty-four women were recruited via social media (Adelaide: n=29, Brisbane: n=11, Melbourne: n=14). Facebook metrics indicated that there was multiple sharing of the study advertising by social media users. The number of reposts by Facebook users and shares to external social media sites is unknown. A further six women were recruited by unsolicited snowballing<sup>8</sup> (Adelaide: n=5, Melbourne: n=1). It was unknown how four women received information calling for participants (Adelaide: n=2, Melbourne: n=2).

6 This study's partner services, providing representatives for the study's advisory committee, were: Brisbane Domestic Violence Service; Carinity Talera, Community Baptist Services, Brisbane; Kornar Winmil Yunti Aboriginal Corporation, Adelaide; No to Violence Men's Referral Service, Male Family Violence Prevention Association, Melbourne; SANDBAG Community Centres and Services, Brisbane; Women's Liberation Halfway House Domestic Violence Service, Melbourne; Women's Safety Services SA, Adelaide.

7 Facebook advertising has capacity for a 25-character headline and three-line expanded description. The headline was "Domestic

Violence Study" and character headline, "Our researchers are seeking women for confidential interviews about domestic violence and quality of life". Clicking "Learn more" took people to a web page with the study's information, participant criteria, consent forms and researcher contact information. The use of "domestic violence" was used in advertising upon recommendation by social media analysts of it being a more commonly used language in Australia for IPV. Demographic targeting was to women aged 18-65+. There were 1,010 clicks recorded and advertising was stopped upon the sample being reached, taking approximately 1 month.

8 Snowballing is when a participant passes on the study information to another person known to them, who may meet the participant criteria, and that person contacts the researchers to participate.

Recruitment sought women who had experienced IPV and who had a current or former partner who had participated in an MPI. Many women who enquired about the research did not initially identify their partners with languages associated with IPV. For example, women inquired whether non-physical abuse types such as financial abuse, emotional or psychological abuse, employment sabotage, controlling behaviours or the silent treatment, met the criterion of “domestic violence” or IPV. This indicates that lay understandings, which inform the idea that IPV is predominantly physical abuse, are influential and may have impacted recruitment.

Additionally, it was often difficult to discern whether participants’ current or former partners had participated in an MPI until the interviews were underway. Many women who contacted the researchers were unsure whether their partners had participated in an intervention. On clarification it was established that many of the men had done so (but may not have engaged for the duration of a given program or intervention) and the women were recruited to the study. Other women contacted the researchers advising that their partners had engaged in an MPI, but during interviews it was established that the men had not. Once this issue became known, women were recruited to the study if they self-identified as meeting the participant criteria. Twenty-nine women who responded to recruitment material did not have partners who participated in an MPI. Nineteen of these women were of a strong belief that their partners did not attend an MPI following referral or court mandate. Ten women advised that their partners “could have” or “should have” participated in an MPI, but that uncertainty was due to the women having severed ties with these men.

Across the sample, the majority of women (71%, n=71) were known to have a male partner who had participated in an MPI: twenty-seven (38%) in an MPI during the 12 months prior to interview and 44 (62%) more than 12 months ago. Most women (80%, n=57) advised that their partners had participated specifically in a group MBCP (one type of MPI), with others receiving individual counselling, couples counselling, or a Family Court parenting program that focused on the men’s violence in the context of IPV. Men who participated in an MPI did not necessarily engage for the duration of a mandated or recommended program

(e.g. MBCP), or sustain their engagement with other intervention types.

## Interviews

Face-to-face interviews were conducted with all 100 women using a semi-structured interview schedule (see Appendix A). The interview schedule was administered by either one of the study’s three researchers or a research assistant. Each interview took approximately 45 minutes to complete. The semi-structured interview schedule obtained both quantitative and qualitative information. Open-ended questions were interspersed around the administration of the survey instruments: the WHOQOL-BREF and the CAS<sub>R</sub>-SF. For example, the question, “When anyone mentions the term ‘quality of life’, what does QOL mean to you?” was asked prior to administering the WHOQOL-BREF. This was intended to generate meanings about what constitutes QOL from the perspectives of the women, and without the influence of the researchers’ definitions, or for other questions (e.g. experiences of IPV) to influence QOL assessments. Free discussion was supported whenever initiated by the women. The vast majority of women took the lead in describing their IPV experiences and their partners’ participation in MPIs at commencement of interviews.

The interview schedule covered the following:

- demographic characteristics (household composition, accommodation type, employment status, highest education obtained and relationship status);
- current and previous IPV experiences, obtained by administering the CAS<sub>R</sub>-SF;
- QOL, obtained by administering the WHOQOL-BREF and asking open ended questions; and
- experiences and satisfaction with MPIs (see Appendix A).

## Composite Abuse Scale (Revised)–Short Form (CAS<sub>R</sub>-SF)

The CAS<sub>R</sub>-SF was administered to self-assess the incidence and frequency of physical, sexual and psychological IPV (Ford-Gilboe et al., 2016). The CAS<sub>R</sub>-SF is designed to capture

life-time, recent (last 12 months) and current experience of 15 forms of physical, sexual and psychological abuse. The IPV perpetrator may be one or multiple, current or former partners, or both. The 15 CAS<sub>R</sub>-SF items are:

- blamed me for causing their violent behaviour;
- shook, pushed, grabbed or threw me;
- tried to convince my family, children or friends that I am crazy or tried to turn them against me;
- used or threatened to use a knife or gun or other weapon to harm me;
- made me perform sex acts that I did not want to perform;
- followed me or hung around outside my home or work;
- threatened to harm or kill me or someone close to me;
- choked me;
- forced or tried to force me to have sex;
- harassed me by phone, text, email or using social media;
- told me I was crazy, stupid or not good enough;
- hit me with a fist or object, kicked or bit me;
- kept me from seeing or talking to my family or friends;
- confined or locked me in a room or other space; and
- kept me from having access to a job, money or financial resources (Ford-Gilboe et al., 2016, pp. 12-13).

### World Health Organization Quality of Life scale, short version WHOQOL-BREF

To assess participants' QOL the WHOQOL-BREF (WHOQOL Group, 1998a) was administered. The WHOQOL-BREF is an internationally validated generic assessment of QOL (Skevington et al., 2004). The instrument comprises 26 items: two global items—global QOL and satisfaction with health; followed by the remaining items that measure across four QOL domains—physical health (seven items), psychological health (six items), social relationships (three items) and environment (eight items) (see Appendix D).

The WHOQOL-BREF, to our knowledge, has not been validated with women who have experienced IPV. Validation is the process of examining whether a process or instrument is sound (Feinleib, 2001). Administering this instrument and analysing the women's QOL priorities provides the opportunity

to assess the comprehensiveness of the WHOQOL-BREF for use with women in the context of IPV.

### Open-ended questions

The open-ended questions focused on QOL and men's involvement in an MPI (see Appendix A). Corresponding with Bowling et al.'s (2003) study, women were asked the following open-ended questions pertaining to their QOL:

- When anyone mentions the term “quality of life”, what does QOL mean to you?
- Thinking about your life as a whole, what is it that makes your life good—that is, the things that give your life quality?
- What is it that makes your life bad—that is, the things that reduce the quality of your life?

Women were also asked about how their partners' participation in an MPI had contributed to change in their QOL, not contributed to change, or otherwise could in the future. Specifically, women were asked “What are some of the things the MPIs could change that would make life better for you?”

### Data analysis

Data analyses involved four phases. In turn, these entailed analysing quantitative data, qualitative data, data mixing and consultation with key stakeholders.

### Quantitative analysis

To summarise the main features of participating women, descriptive statistics were conducted. For categorical data this entailed determining the frequency and proportion of women, in terms of:

- each demographic characteristic;
- IPV experiences;
- IPV perpetrator's participation in MPI; and
- QOL assessments.

Where calculating proportions was inappropriate (i.e. for continuous data), mean (average), median (mid-point of all

responses), mode (most common response) and range (the lowest and highest score) were calculated.

Sub-group comparisons were also undertaken to examine QOL domain scores of:

- women participants vs. Australian general population norms for women;
- women who currently fear an IPV perpetrator (yes vs. no); and
- women who currently fear an IPV perpetrator who has been engaged in an MPI (recent, i.e. last 12 months vs. historical, i.e. 12 months or more, or never).

In each of these three instances, to obtain an indication of whether there was a real difference between sub-groups, t-tests were undertaken to test for differences in mean QOL domain scores.

### CAS<sub>r</sub>-SF

For each participant, the sum total of abuse items was calculated (the possible range was 0-15). Data were treated as a continuous variable. Measures of central tendency (e.g. mean, median, mode and range) were calculated. The mean represents the average number of abuse items experienced by women in the sample, the median is the midpoint number of abuse items, and the mode is the number of abuse items experienced by the greatest number of women. Finally, the range represents the minimum and maximum number of abuse items experienced by women in the sample.

### WHOQOL-BREF

Prior to obtaining descriptive statistics from administering the WHOQOL-BREF, additional steps were undertaken as per the established guidelines for analysing and interpreting WHOQOL-BREF data. To account for missing data, the mean of each answered item was substituted, consistent with recommendations (Murphy, Herrman, Hawthorne, Pinzone, & Evert, 2000; WHOQOL Group, 1998a, 1998b). For ease of interpretation, WHOQOL-BREF domain scores were transformed into a score from 0 to 100 with higher scores indicating a better QOL (WHOQOL Group, 1998a).

No total WHOQOL-BREF score is recommended (WHOQOL Group, 1998a, 1998b). Nevertheless, Hawthorne et al. (2006) and colleagues have determined that the Cronbach  $\alpha^9$  for the WHOQOL-BREF instrument for the Australian population (gender comparison unavailable) was 0.91 with QOL domains ranging from 0.68 (social relationships) to 0.87 (physical) (Hawthorne et al., 2006). In a Norwegian shelter of IPV survivors, WHOQOL-BREF domains ranged from 0.46 (social relationships) to 0.76 (environment) (Alsaker, Moen, & Kristoffersen, 2007). In our study, Cronbach  $\alpha$  for the WHOQOL-BREF was 0.96 with individual QOL domains ranging from 0.61 (psychological health) to 0.89 (environment), suggesting overall good internal reliability.

### Qualitative analysis

Qualitative data analysis allowed for the women's QOL priorities to be documented, then understood in the context of their QOL assessments and IPV experiences. Qualitative data on what QOL meant to them and on how MPIs could constructively contribute to improvements in women's QOL were examined. This offered further insights into what was important to women in respect to their QOL priorities, as well as perceptions on how MPIs had contributed to changes in their QOL.

Qualitative data was transcribed and subject to thematic analysis. This involved a systematic process of data immersion, coding, development of themes and refining, defining and naming themes (Braun et al., 2019). The thematic analysis was completed in multiple stages, with minor variation according to the purpose of analysis. Inductive analysis was used to theme both the women's QOL priorities and perceptions of the contribution of MPIs to changes in the women's QOL. Inductive analysis allowed findings to emerge from the content of the women's interviews.

In order to systematically transform the large quantity of textual data from the women's interviews into a concise

<sup>9</sup> The formula  $\alpha$  is a coefficient of equivalence (Cronbach, 1951). As a general formula, Cronbach's  $\alpha$  provides a "measure of the internal consistency of a test or scale...Internal consistency describes the extent to which all the items in a test measure the same concept or construct and hence it is connected to the inter-relatedness of the items within the test" (Tavakol & Dennick, 2011, p. 53).

summary of key results, within a timeframe, thematic analysis was completed in two rounds. The first round involved data immersion by two members of the research team of the first half of qualitative data collected. This involved reading, re-reading and examining qualitative data in detail, and applying codes (i.e. words and short phrases in the transcripts) and descriptive labels generated by the researchers that represented larger segments of the transcripts.

As an inductive process, the codes emerged from the interviews with the women and they represented core meanings generated from the perspectives of women. When the women provided their meanings for QOL, or what makes their life good or bad, an interpretive approach helped the researchers to engage in data immersion and develop an appreciation of the women's QOL priorities during coding. Codes were examined and clustered together into thematic concepts (i.e. codes with similar meaning), then concepts further organised into broader potential themes. Upon completion of this first round of immersion, coding and theming, the two researchers cross-checked their analyses. In this phase, themes were discussed and those that did not contribute to the research aims (i.e. understanding of women's QOL priorities) were discarded. Some concepts in the themes were split and some themes combined.

The second half of data immersion, coding and theming of the qualitative analysis was completed by one of the two researchers. As the results were relatively consistent in the first round of coding and theming across the two researchers, analysis by a second researcher was deemed not to be required. Codes were organised into 19 thematic concepts, then further refined into five broad themes (arguably QOL domains for this group of women):

- fear and violence;
- self-determination;
- basic needs;
- wellbeing; and
- social systems (see Appendix B).

The five tables in Appendix B tally the codes and thematic concepts, situating these within the broad QOL thematic domains that have come from the women themselves.

The women's perceptions on how MPIs had contributed to changes in their QOL contributed to the development of the QOL thematic domains.

### Deductive qualitative analysis

A further deductive analysis of qualitative data focused specifically on women's fear once it became known that, while many had fears related to partners and former partners, the women's fear extended well beyond fear of these men. This involved searching the transcripts for women's statements about fear, organising these statements according to what they feared, and describing how women perceived these fears to impact their QOL.

### Interpretation of QOL for documenting QOL priorities

Women's QOL priorities were identified based on:

- the frequency of codes within each of the themes;
- how women articulated the importance of some QOL items over others; and
- changes to QOL, for better or worse, that the women articulated either since the occurrence of IPV or a partner's participation in an MPI.

The women's meanings of QOL and their viewpoints about what is good or bad for QOL provided viewpoints that could be coded in relation to their QOL priorities. Following Bowling et al. (2003), if women are asked "What makes life good?" and the reply is "choose who I go out with and where", then to "What makes life bad?" the reply is "not having to answer to others", both are related to autonomy. This would provide insights into autonomy being a QOL item that may be important to them and, therefore, a QOL priority. However, the reply "choose who I go out with and where" may also prove that social relations are important and indicate that the women's QOL priorities are not clearly linear—they overlap and interconnect. Frequency and the ways in which the women articulated the importance of some aspects of QOL over others, however, were interpreted as QOL priorities for the sample under study.

Table 4 Women's QOL priorities in the context of IPV

Thematic concepts as QOL priorities	Frequency of codes across the women's interviews <sup>a</sup>
Autonomy	177
Informal supports (family and friends)	101
Emotional health	94
Safety (physical and psychological)	86
Children and pets	82
Mental health	74
Employment	58
Money	55
Meaningful life	49
Physical health	43
Formal supports	40
Fear	35
Isolation	34
Community engagement	25
Food	23
Housing	21
Education	10
Transport	8
Clothing	3

Note: <sup>a</sup> These frequencies do not add up to 100 as it was possible for women to mention multiple QOL priorities, and to mention and be counted for the same QOL priority up to three times in their interviews (i.e. when stating what QOL meant to them, and when advising what would make their QOL good or what would make their QOL bad).

To this end smaller thematic units (see Appendix B) were ordered into a set of QOL priorities. This was undertaken by the research team and reinterpreted following a consultation<sup>10</sup> with IPV and MPI sector professionals. This resulted in agreement on the researchers' ranked set of QOL priorities (Table 4) that valued the women's voices, but which maintained women's safety as paramount.

### Data mixing, including a further inductive qualitative analysis

Further analysis involved the comparison of quantitative and qualitative findings. This involved a side-by-side comparison of quantitative results with themes generated from the qualitative

data (Creswell, 2015). While the quantitative data measured the QOL assessments and IPV experiences of women, the qualitative data enabled the researchers to engage in an iterative immersion in the transcripts to examine the personal experiences of the women. The purpose of this was for the qualitative data to validate and build upon the quantitative findings, add depth of meaning to these results (Creswell, Shope, Plano Clark, & Green, 2006), and improve the quality of the scientific QOL data (Klassen, Creswell, Clark, Smith, & Meissner, 2012). Iterative readings of qualitative data enabled the researchers to develop an interpretive account using verbatim examples to illustrate the quantitative findings. In doing so, the women's statements about what was good, bad and what could improve their lives were paramount to how they made sense of their QOL and subsequent development of a set of QOL priorities for this group.

Comparisons of the QOL assessments of participants were also made on the basis of the women's fear of their current or former

<sup>10</sup> The purpose of the consultation was a knowledge translation activity. It was intended to gain the perspectives and feedback of sector representatives in relation to preliminary research findings, including how they thought women's QOL could be used to evaluate MPIs. In being for consultation purposes only, it was not a form of data collection. However, the consultation process and outcomes of discussion are provided as a prologue in this report.



partners, and the participation of current or former partners in MPIs. The decision to mix qualitative and quantitative data related to fear was in consideration of “behaviour aimed at controlling a partner through fear” (COAG, 2011, p. 2), and because QOL is known to have associations with IPV and fear (Alsaker, Moen, Morken, & Baste 2018; Jewkes, 2013; Kulkarni, Mennicke, & Woods, 2018). However, once it became known that the women’s fears associated with IPV extended beyond fear of their partners, a further deductive qualitative analysis was performed. This involved searching for representative examples in the qualitative data to illustrate the breadth of women’s fears arising from IPV, and to highlight relationships with their QOL.

These preliminary findings were subsequently disseminated to Australian IPV sector professionals for feedback.

### Consultation with IPV sector professionals

A meeting with 15 sector professionals was held in Adelaide in November 2017 over a period of two days. This included nine members from IPV and MPI partner services from Adelaide, Brisbane and Melbourne, as well as four additional professionals working in IPV and MPIs, one researcher and one consumer representative/advocate. The six additional individuals were recommended by the partner services.

Using a workshop style approach, the consultation involved:

- presentations of, and an iterative discussion of, preliminary research findings;
- identifying any measures of effectiveness of MPIs that the sector professionals knew were currently being used in Australia;
- consideration of the worth associated with measuring MPI effectiveness based on women’s QOL;
- a discussion of barriers that currently exist in measuring the effectiveness of MPIs; and
- listing and prioritising actions that would need to occur in MPIs in order for women’s QOL to be integrated into evaluations as an outcome measure.

### Ethical considerations

This research was approved by the Flinders University Social and Behavioural Research Ethics Committee (project no. 7550) and conformed to standard research ethics conventions, including informed consent, voluntariness, confidentiality and anonymity, burden and risk management, participant nomination of safe places in which to be interviewed, safe storage and de-identification of data, and anonymous data reporting. Mechanisms have been applied to minimise the potential to re-identify participants; these include recruiting women from across three Australian states, and the use of pseudonyms against women’s quotes to ensure that particular women’s stories were not identifiable.

A critical aspect of ethical considerations was to ensure that women who had experienced or had ongoing experiences of IPV self-nominated their participation without pressure to do so. Partner agencies supporting recruitment disseminated the recruitment material to women who had utilised their agencies, were on a database of women willing to participate in research and assessed as being safe to participate. Self-nomination meant that, once recruitment material was received, women were tasked with the decision on whether they wanted to contact the researchers. Informed consent, voluntariness and understanding what the study was about were confirmed in person before any interviews were commenced.

In organising research interviews, women nominated the locations where they wished to meet. Some women opted to be interviewed at women’s services, being where they felt safe, while others were interviewed at coffee shops, libraries or public parks. Some women wanted the interviews to take place at their homes; while this was not the researchers’ preference, these women were interviewed once it was established that there were no perpetrators living with them. Women recruited via social media were provided with a time, location and identifying features of the researcher, giving them the power to approach the researcher if they felt safe to do so, and then to nominate a nearby location to undertake the interview.

## Summary

The research design was mixed methods. Participants were a convenience, non-representative sample of 100 women who self-identified as either living with, or having previously lived with, IPV, recruited from three Australian capital cities and associated wider metropolitan regions. Face-to-face interviews were conducted with all 100 women using a semi-structured interview schedule with free discussion supported whenever initiated by the women. The vast majority of women took the lead in describing their IPV experiences and their partners' participation in MPIs at commencement of interviews. Data analyses entailed three phases—quantitative, qualitative and data mixing. The key findings from these analyses are presented in the next section.

# Key findings

This section presents the key findings from this study. These findings are organised into five sub-sections:

1. an overarching description of participant characteristics;
2. women's subjective views on what constitutes QOL;
3. QOL and fear of IPV perpetrators;
4. QOL and MPI; and
5. consultation with key stakeholders.

## Participant characteristics

This section describes the characteristics of the 100 women who participated in this study. Participant characteristics described cover demographic characteristics, women's IPV experiences, IPV perpetrators' participation in MPI and women's overall QOL.

### Demographics

Participants were a mean (average) age of 41 years. Most participants were living with children (61%), a spouse/partner/boyfriend (31%) or alone (17%). Just over half (52%) of participants were living in rental accommodation, 59 percent were in paid employment, 85 percent had completed formal education (Year 12, or equivalent) and 44 percent were currently in a relationship (not necessarily with the IPV perpetrator) (see Table 2).

### Contexts of IPV

All women participating in the study had been victims/survivors of IPV, with a former partner most commonly being the perpetrator (64%). A further 28 percent reported that the IPV perpetrator was their current partner, whilst for 8 percent the IPV perpetrator was both former and current partners. Participants identified through administration of the CAS<sub>R</sub>-SF that they had experienced a mean (average) of 10.8 different forms of IPV (median: 11.0; range: 3–15),

most commonly experiencing all 15 listed forms of abuse<sup>11</sup> (table not shown).

In the last 12 months (recent), 70 participants had experienced IPV. Recent IPV was perpetrated most commonly by a former partner (51%), whilst for 39 percent IPV was perpetrated by a current partner (table not shown). Recent IPV involved a mean of 7.0 CAS<sub>R</sub>-SF abuse types (median: 7.5; range: 1–15) (see Table 3).

The most common forms of recent IPV experienced by the women were:

- being blamed for causing violent behaviour (81%, n=57);
- tried to convince others that participant was crazy, stupid or not good enough (84%, n=59);
- being harassed by phone, text, email or social media (71%, n=50);
- stopped from seeing family or friends (51%, n=36); and
- kept from accessing financial resources (e.g. job, money) (63%, n=44).

### Perpetrator participation in interventions

Most women (71%, n=71) reported that a male partner had participated in an MPI. Of the women whose partners had participated in an MPI (N=71), for 38 percent (n=27) this had been in the last 12 months. Most women (80%, n=57) advised that their partners had participated in a group MBCP (one type of MPI). Other men had received individual counselling, couples counselling, or a Family Court parenting program that focused on the men's violence in the context of IPV (further breakdown not available).

<sup>11</sup> The 15 composite IPV abuse items contained in the CAS<sub>R</sub>-SF (Ford-Gilboe et al., 2016) include: blamed participant for causing violent behaviour; shook, pushed, grabbed or threw participant; tried to convince others that participant was crazy; used or threatened to use a weapon to harm them; made participant perform unwanted sex acts; followed or hung around outside work; threatened to harm or kill someone close to participant; choked participant; forced, or tried to force sex; harassed by phone, text, email or social media; told was crazy, stupid or not good enough; hit, kicked or bit; stopped seeing family or friends; confined or locked in a room or other space; kept from accessing a job, money or financial resources (Ford-Gilboe et al., 2016, pp. 12-13).

Table 2 Demographic characteristics of women participants (N=100)

Demographic characteristic		%
Living arrangements <sup>a</sup>	With children	61
	With a spouse/partner/boyfriend	31
	Alone	17
	With relatives	11
	With friends/house mates	4
	Homeless	2
	Other	1
Accommodation	Renting	52
	Mortgage/own home	35
	Other	13
Work	Yes, casual	16
	Yes, part-time	25
	Yes, full-time	18
	No paid work	18
	Student	8
	Government support	12
	Other	3
Education	Completed Year 12 or equivalent	85
	Did not complete Year 12 or equivalent	15
Currently in a relationship	Yes	44
	No	56

Note: <sup>a</sup> This characteristic does not sum to 100 as multiple responses were possible.

Table 3 Recent (i.e. in last 12 months) IPV experiences by relationship status (N=70)

Relationship status	Measure			
	Mean	Median	Mode	Range
Current partner only (n=27)	9.0	10.0	6	1-15
Former partner only (n=36)	6.9	7.0	4	1-15
Both current & former partners (n=7)	7.7	6.0	6	4
Total (N=70)	7.8	7.5	4	1-15

## Women's QOL

Women (N=100) were asked to assess their overall QOL with the question “how would you rate your quality of life?” Possible response options were ranged from “very poor” to “very good”. Overall QOL was most commonly assessed “good” (33%). A further 27 percent assessed their QOL as “neither good nor poor”, 22 percent as “poor”, 14 percent as “very good” and 4 percent as “very poor” (see Figure 4).

### QOL compared with Australian women

Women's QOL assessments in all four WHOQOL-BREF domains (scaled to 100) were compared with Australian general population norms for women (Hawthorne et al., 2006, N=487). On all four WHOQOL-BREF domains, the women's QOL was below these population norms: physical health 15 percent lower; psychological health 20 percent lower; social relationships 25 percent lower; and 15 percent lower on the environment domain (see Figure 5).

## Women's subjective views on QOL

This section describes women's QOL as described by them. In doing so, women's own definitions of QOL are considered first. This section then turns to examining women's QOL perspectives in the context of its underpinning principles (i.e. QOL is multidimensional, innately individual and dynamic), and concludes with what the women self-reported as important to their own QOL.

### The women's explanations for their quality of life assessments

In qualitative interview responses, with reference to diminished QOL resulting from IPV, women expressed how their QOL could never be the same. The women had no expectations that IPV interventions or MPIs should or could “get their life back”. However, the women were also angry that the broader IPV prevention system (inclusive of MPIs) did not respond earlier. With earlier intervention, many women contended that their QOL would not have ended up so bad, as represented in the following statement:

I have acquired a brain injury. Not being able to get back my life ... because I am unwell and will never be the same. Not being able to work, drive or look after my children without help. While the courts have not given him access to the children because of his violence, we all had to get beaten, stabbed and burned before things changed. He shouldn't have been allowed access a lot earlier.

Other women expressed, so long as they were safe, that they were content with a “good enough” QOL. For some women this meant “having him out my life”, while others spoke of having a job, sufficient income, positive health, good relationships with family and friends, enough to eat, and “a sense of purpose in life”. Not a single woman spoke of wanting to get their life, and their worldly possessions, back to the level of QOL that they enjoyed before the IPV occurred. Having a “good enough” life constituted a good QOL after surviving IPV.

People can assess their QOL as acceptable even when it may fall short of dominant societal ideals, or their own once held ideals, about QOL. Considering that QOL assessments are dynamic and change across the life course according to life events and circumstances (Schwarz & Strack, 1999; Wood-Dauphinee, 1999), one would expect that women's QOL assessments would likewise change along with their experiences of life events, supports received, their coping methods and altered expectations. The notion of what constitutes a “good enough” QOL, and how this may alter with life changes, was expressed eloquently by one woman. Post-IPV, she expressed her definition of QOL as:

Happiness, sense of peace and contentedness. To have enough plenty [sic]. The reason: there were lifestyle changes that came with separation. One life had changed along with the separation and to find new direction peacefully.

The woman providing this statement placed no expectations on MPIs to be responsible for changing her partner or her QOL. Rather, along with many other women, she articulated that men's participation in MPIs “does not work”.

Figure 4 Women’s overall QOL assessments (N=100)

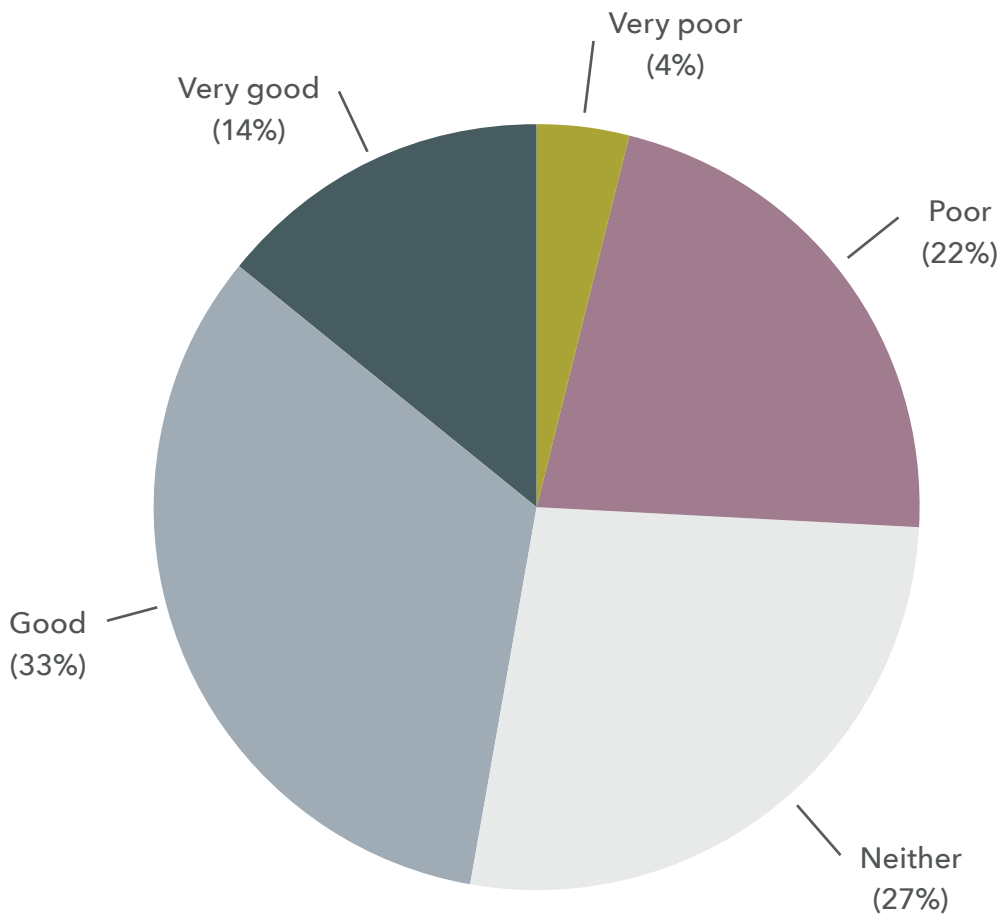
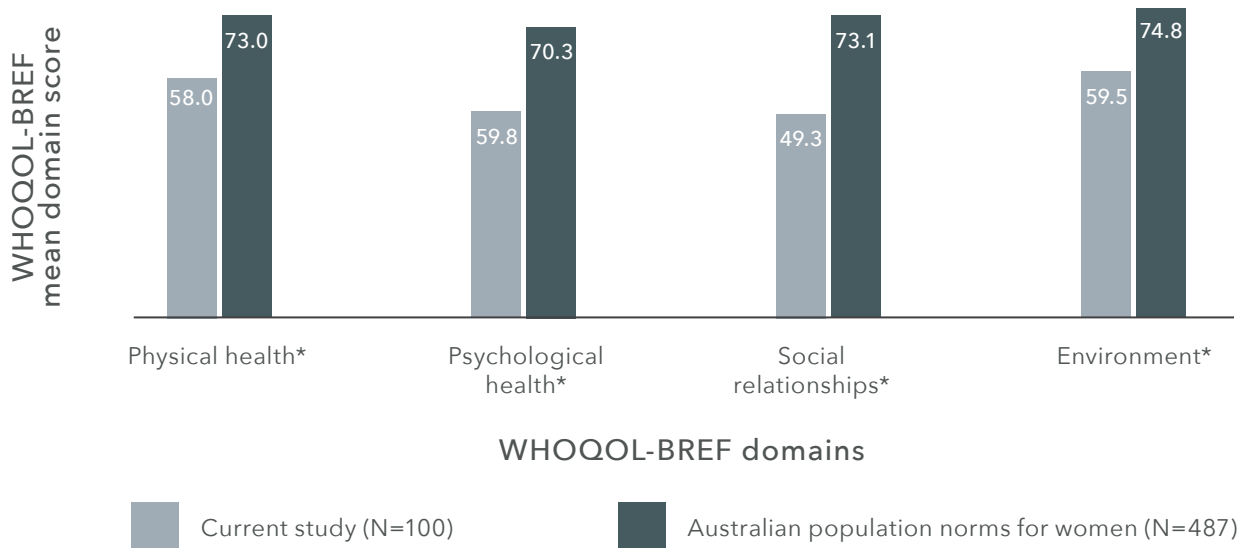


Figure 5 QOL of the women compared with Australian population norms for women



Note: \* Statistically significant  $p < 0.0001$

## QOL underpinning principles

QOL is recognised to be a multidimensional, dynamic construct of unique self-reflections at a given point in time. This section considers women's subjective meanings about QOL in the context of these principles.

### Multidimensional construct

When the women were initially asked what QOL meant to them, their responses were consistent with formal understandings of QOL being a multidimensional construct (Bowling, 2005a; Bramston, Chipuer, & Pretty, 2005; Cummins, 2005; Felce, 1997; Fischer et al., 2015a; Fischer, Conrad, Clavarino, Kemp, & Najman, 2013; Najman & Levine, 1981). Without prompting, the women consistently articulated that QOL was “not just one thing.” All of the women articulated explanations for what constitutes QOL by providing examples of many QOL items that could be located across QOL domains albeit in different combinations, consistent with QOL being a subjective construct.

Three statements from three different women are presented below to demonstrate the ways in which QOL was described as a multidimensional construct by the women. In the first statement below QOL was articulated as multidimensional by suggesting good health (e.g. physical and psychological health QOL domains), enjoyment in life (e.g. social relationships QOL domain) and a desire to feel financially secure and safe (environment QOL domain). The second statement incorporates elements of physical and psychological QOL domains, expressed in relation to both basic needs and future opportunities for a better life. Finally, the third example highlights the interconnections between physical and psychological health, social relationships and environmental aspects of QOL:

A life that you have chosen to live, and have the health, finances and capacity to enjoy and feel safe in.

Having food to eat, somewhere to sleep, feeling safe and opportunity for the future.

Being able to live independently, and enjoy getting around, to taste my food, to communicate with friends, being able to socialise, including having someone to socialise with, being part of the world and healthy enough to do so.

A synthesis of the qualitative data from the interviews highlighted another aspect of QOL as a multidimensional construct: that of safety. The qualitative interviews affirmed that the safety of women experiencing IPV should always be a priority with the women consistently articulating their need for safety. For example:

how comfortable you feel in your existence—safe, money to do things in your life, stress-free life to do things—balance ...

This point was also emphasised by IPV and MPI professionals who were engaged in consultancy throughout the project (see the section “Consultation with IPV sector professionals” for further detail).

### Unique self-assessments

QOL assessments are innately individual, representing unique self-reflections of one's own perspectives and experiences at a given point in time (Blanc, Boyer, Le Coz, & Auquier, 2014; Bonomi, Patrick, Bushnell, & Martin, 2000; Cummins, 2005; Ryan & Deci, 2001; Schlenk et al., 1997; Von Ah et al., 2012). The uniqueness of QOL to the individual was represented across the women's narratives. The women articulated what QOL meant to them and, in doing so, reflected on their personal life history, background, values and experiences. In the three representative examples below, the first statement acknowledges the uniqueness of QOL to the individual by saying that “everyone's quality is different”. The second example locates the meaning of QOL as unique to an individual's own perspective by saying that QOL is “subjective”. Finally, the third example describes QOL in respect to her individual life, herself and her life choices:

When you can enjoy your life, everyone's quality is different. Depends on your background, lifestyle ...

Life measuring up to your expectations. All relative—what is a good life for one may not be for another—subjective ...

Being respected in my community. Having the freedom to go out and be myself and not have to hide what is going on. Being happy, being social, being at ease with myself and my life choices.

### QOL is dynamic

QOL assessments change across time and context as individuals re evaluate what is important to them (Bowling, 2005a; Fischer et al., 2015a; Schwarz & Strack, 1999; Wood-Dauphinee, 1999). For example, the women who had left their abusive relationships often discussed their QOL in such ways that it gave insights into their past experiences of being controlled by a perpetrator. The following examples describe the recent freedoms expressed by the women in their interviews. These accounts highlight dynamic changes in the women's QOL:

Making my own decisions, not answering to anyone ...  
How I spend money, see my family, pets close to me, go on holidays ...

Capacity to live my life without the shadow of being controlled and dominated and managed. The capacity to have a life with self-agency. Compartmentalise life. On one hand my public life is very good quality of life and happy on the other behind closed doors my life is very difficult.

The women also indicated how their QOL priorities have changed as a result of their experiences of IPV. While the women may have once wanted to achieve more in life, on re evaluation the women articulated that they simply needed enough food, housing, socialisation, income and security and for the aspects detrimental to QOL to be gone. For example, two women made the following comments about their QOL after experiencing IPV:

Being healthy enough to socialise with my close friends.

That I have enough to support my needs in life. The basic essentials, food, emotional needs, happiness, the removal of the bad things in life.

Many women described QOL in terms of having hopes for a better life, a sense of purpose or something to live for. This was despite the ongoing adversity arising from their experiences of IPV. For example, one woman said:

Hope. That's the only thing I got to live for. I have a brain injury as a result of the violence and don't have much quality of life at all. However, if I can help others and help stop the violence, I will eventually develop a sense of purpose out of this. So, from now on it is about redefining

myself, learning to live better despite my disability and developing a new sense of purpose that will help me get through this and be part of the world.

Understanding women's visions for a better QOL, informed by hope, is important. Hope can provide insight into women's QOL priorities, intervention priority areas and future possibilities for working with each of the women. Likewise, it can also offer insights for MPIs working with men to ensure that women's achievement of a better life is valued and incorporated in men's intervention plans.

### QOL priorities

Women were asked an open-ended question pertaining to what was important to their own QOL (see "Methods"). The most commonly reported QOL priority was autonomy. This was followed by informal supports (i.e. family and friends), followed by emotional health, safety and children and pets (see Table 4).

The listing of the women's QOL priorities in table form is intended for ease of presentation (see Table 4). However, the QOL items are not discrete but often interconnected and interdependent. For example, the second most frequently mentioned QOL priority by women related to re-engaging in relationships with friends and family. This required the women to have a certain level of autonomy in their lives. The next most frequently mentioned QOL priorities were emotional health, physical and psychological safety, and relationships with children, pets or extended family. These findings suggest that the more material aspects of life (i.e. food, housing, education, transport and clothing) had become less important to women than a sense of freedom and connection to others. The changes in women's QOL experiences means that conducting one QOL assessment with women at one point in time is insufficient to inform interventions. Instead, periodic QOL assessments across the duration of MPIs would ensure improvements and change to interventions according to the women's evolving QOL.

All women who were mothers indicated that their children's safety, and enabling their children to have some positive



Table 5 Women currently afraid of IPV perpetrator by relationship status (N=63)

Relationship status	Currently afraid		Not currently afraid	
	<i>n</i>	%	<i>n</i>	%
Current partner only (n=28)	23	64	5	19
Former partner only (n=30)	10	28	20	74
Both current & former partner (n=5)	3	8	2	7
Total (N=63)	36	57	27	43

QOL involving good relationships, was integral to their own QOL. For example, the following comments were made by three women: “Having my children around me, watching them develop and do well in life and relationships gives me meaning for my life”; “Being able to financially support, provide and nurture children”; and “Knowing my children are now safe. Having him out of my life. Nothing else.” Likewise, many women talked about pets, extended family and friends having been taken from them as impacting on their QOL. They highlighted the importance of these relationships in their QOL priorities.

Safety, and fear as its antithesis, was not ranked the highest priority in terms of QOL as this did not appear to be an immediate feature in women’s lives at the time of interview. Fear and QOL is explored further in the next sub-section.

## Women’s experiences of fear

Comparisons of the QOL assessments of women participating in this study were made on the basis of their fear of current or former partners, and the participation of current or former partners in MPIs. When directly asked, nearly all women (98%) reported having ever been afraid of an IPV perpetrator. The decision for these comparisons were in consideration of “behaviour aimed at controlling a partner through fear” (COAG, 2011, p. 2), and because QOL is known to have associations with IPV and fear (Alsaker et al., 2018; Jewkes, 2013; Kulkarni et al., 2018). This sub-section examines fear of IPV perpetrators and its associations with QOL.

### Fear of IPV perpetrator

Women were asked whether they were currently afraid of an IPV perpetrator, which is a question in the CAS<sub>R</sub>-SF standardised tool (see Appendix A). Sixty-three women responded to this question. Of these 63 women, over half (57%) indicated that they were currently afraid of an IPV

perpetrator, most commonly their current partner (64%). A further 28 percent were currently afraid of a former partner, and 8 percent of both a current and former partner (see Table 5).

### Fear and QOL

The QOL of women who were currently afraid (yes) of an IPV perpetrator were compared with women who reported they currently were not (no) (N=63). On all four WHOQOL-BREF domains, women who were currently afraid were significantly more likely to have poorer QOL compared with those who were not afraid. Figure 6 provides a comparison of QOL mean domain scores of women currently and not currently afraid of a partner and/or former partner who perpetrated IPV.

### Fear of men participating in MPIs

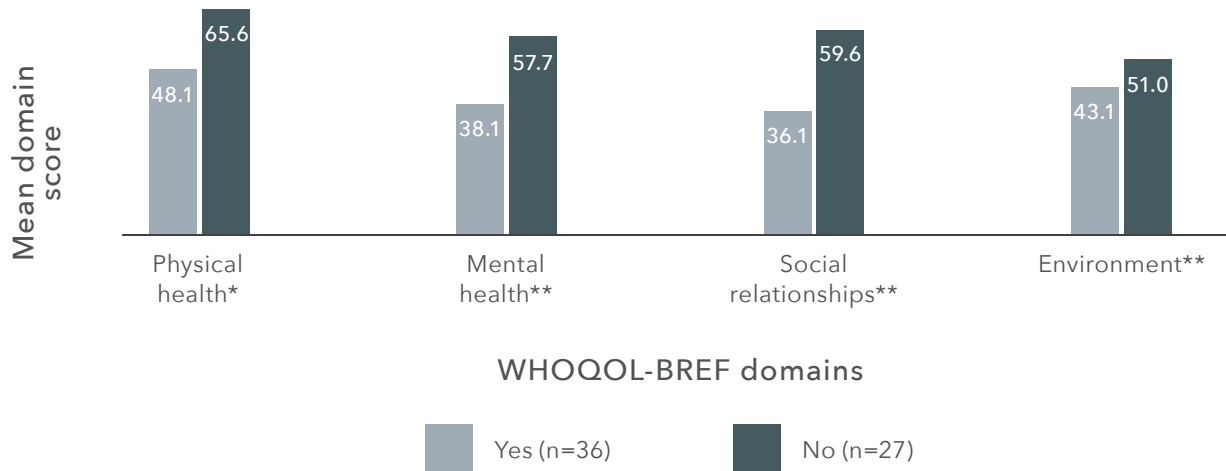
Amongst the women participants who currently feared an IPV perpetrator (N=36), we examined whether the IPV perpetrator was ever an MPI participant (recent: in last 12 months vs historical: more than 12 months, or never). Women whose IPV perpetrator had recently participated in an MPI reported lower QOL on all four WHOQOL-BREF domains. However, apart from the environment<sup>12</sup> QOL domain, these differences were not statistically significant (see Figure 7).

### Breadth of fear

The women talked about their experiences of fear in the interviews, relating feelings of fear to their general QOL, as well as IPV and the participation of their partners in MPIs. Many women expressed that they were afraid of partners who perpetrated IPV against them, including fear for their physical safety. However, the women more often discussed fear as it related to their broader lives (and as a longer-term outcome of the IPV). In these instances, the women’s experiences of

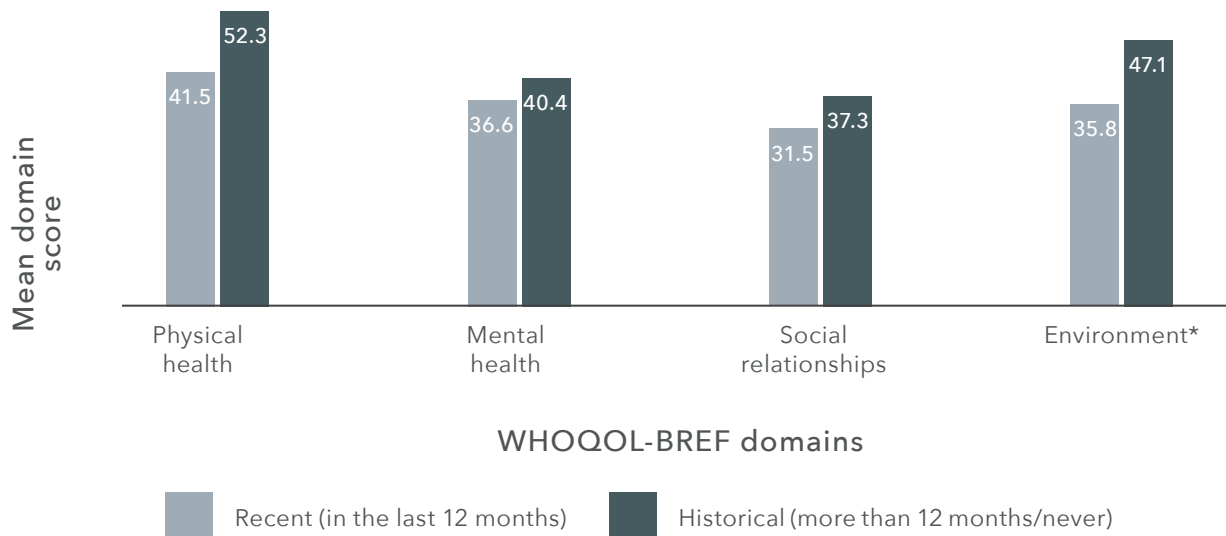
<sup>12</sup> The environment QOL domain measures financial resources, freedom, physical safety, home environment, participation and opportunities that are frequently impacted by IPV.

Figure 6 Comparison of QOL domains by women currently and not currently afraid of IPV perpetrator (N=63)



Note: \* Statistically significant p=0.05; \*\* statistically significant p≤0.0001

Figure 7 QOL assessments by mean domain scores of women who were currently afraid of their partners: Compared by recent vs. historical participation in MPIs



Note: \* Statistically significant p=0.05

fear were not necessarily related to the perpetrators of IPV. Rather, they had fears that were related to social relations, service systems as well as how they imagined their future QOL. The women also expressed fear for the wellbeing of others, especially their children.

Fear was expressed in many different ways by the women and was mentioned repetitiously across their interviews. Some examples of the broad range of fears the women experienced included:

- **Fears about physical safety of self or others:** “fear about the next time he hits me”, “fear of him breaking court orders and coming to get me”, “fear of physical and mental abuse”, “fear that he will hurt my family or friends”, or “fear he will kill the dog”.
- **Fears related to formal systems and processes:** “fear of not feeling safe with authorities”, “fear the court system will continue abusing me”, “fear of the child protection system blaming me for his abuse”, or “fear of child removal by child safety even though I didn’t do it”.

- **Fear in response to women’s imagined futures:** “fear of co-parenting”, “fear that my child will be scared”, “fear of the impact of fear on my children”, “fear my child will blame me for not having a positive image of him”, “fear that all this will impact on being able to care for my children”, “fear for my own children’s QOL”.
- **Fear associated with discursive power:** “fear of people judging me”, “fear of being a drain on society”, “fear of leaving and failing at it”, “fear of staying and being blamed for it”, or “fear of not coping with life”.
- **Socio-emotional fears:** “fear of loneliness”, “fear of being without good friends”, or “fear of not belonging generally”.
- **Socio-economic fears:** “fear of no financial stability and security”, “fear of things getting worse and living in third-world conditions”, “fear of being hungry”, “fear of not having enough money and having to say to my children ‘I cannot afford it’”.
- **Fear and uncertainty:** “fear of not recovering”, “fear that life won’t get better”, and “fear of the unknown”.

With respect to the women’s physical safety, a few women suggested that their fears were only diminished when their partners moved on to a relationship with another woman. However, even in these circumstances the women expressed fear for people they did not know (i.e. the perpetrator’s subsequent intimate partner). For example:

When I left him, he was scary, used to break into my house, violent and horrible things. I like to think he doesn’t know where I am, but I’m sure he could find me. He has a new partner and is violent to her. It makes me feel safe that he is with someone else, but I fear that my safety is causing harm to someone else and is at her expense.

The breadth of women’s expressed fears provide insight into the impact of IPV on their lives. Their accounts of fear also provide an indication of the changes that need to occur to improve their QOL.

## Impact of fear on QOL

Almost all of the women advised that they were living in fear of their partners in qualitative interview responses. For example, many of the women described constant feelings of

“living in fear”, “living on the edge of danger”, or “walking on eggshells”. Living in fear of a partner was expressed by both women who were currently living with perpetrators and by women who had left their relationships. It was also expressed by women whose partners were participating in an MPI, as well as those who were not.

The women described how fear significantly altered their QOL and subsequently dictated the way in which they were compelled to live. For example, one woman, whose partner was participating in an MPI, when asked to describe what made her QOL “bad” talked about the extent to which fear had debilitated her life. Her experience of overwhelming fear extended across physical, psychological, social relations and environmental QOL domains by limiting her day-to-day freedoms, financial wellbeing, self-esteem and the ability to have formal and informal relations. What’s more, unsuccessful attempts to leave the abusive relationship manifested in ongoing fear about her confidence to escape, irrespective of her partner’s participation in an MPI. She said:

Having no freedom to go and do what I want, having to walk on eggshells. Being scared. Scared to get help. Scared to leave. Being threatened, put down, psychologically abused, and limited in what I can do. I have no money; it is hard to leave. My friends and family and supports have diminished. It is hard to leave. I am scared to leave. I don’t know how to. I have tried three times and not been successful.

Other women whose partners had participated in an MPI highlighted how their lives had been drained by fear. This was most often attributed to the need for the women’s ongoing vigilance. For example, the women made comments including, “[I] have to watch my back”, “unable to let your guard down”, “constant bad thoughts”, “not being able to function”, “you are immobilised”, “not able to achieve everyday life tasks” and “unable to relax”. These women advised that their partner’s participation in an MPI had not alleviated their fears, nor improved the quality of their lives more broadly.

Women who had formally ended their relationships with perpetrators likewise expressed intense levels of fear. They explained how being scared of their partners limited the extent to which they could live a normal life. For example,

one woman was still fearful of her partner nearly 10 years after formal separation and, therefore, scared to be alone. In her statement below, she illustrated the ongoing influence that his violence has on her QOL, in particular, her fear, limitations to physical and emotional functioning, and her ability to be part of the social world (e.g. psychological, physical and social relationships QOL domains):

Feeling scared, alone and vulnerable. When I get this way, I just crumble into a dark place and don't want to do anything. Not being able to function sufficiently to achieve everyday life tasks. I get depressed, shut people out. This isolates me. It spirals and gets worse. When it gets this bad, it is so bad and difficult to get out of.

All of the women described having attempted to leave their violent relationships at some point. When they were unable to leave and MPIs did not change the men's behaviour, some women talked about a variety of strategies they used to escape their fear. For example, one woman whose partner had participated in an MPI talked about engaging in activities that she perceived to improve her psychological QOL by redirecting her mind away from her relationship and the violence. She said, "I read and do cryptic crosswords to escape. They take me to a different place where the violence does not exist and where I'm not scared of him." In a second example, another woman perceived prison as a place where she could alleviate her fear through improved physical safety (physical QOL) and emotional wellbeing (psychological QOL). Subsequently, when faced with gaol time, she did not resist being convicted:

I went to the women's prison because I get charged with assault, more than once, on my husband [sic]. I was basically defending myself, but he always told police I started it and because I split his head open police believed him. I didn't fight the charges. Going to gaol is safer than being out.

However, in contrast to these accounts, the vast majority of women appeared to be unsuccessful in finding a space to alleviate their fear and its impact on their QOL. Rather, the women described experiences of IPV in ways that were consistent with patterns of escalating occurrence, severity and chronicity that are reported in the IPV literature, including a heightened sense of fear (e.g. Cunha & Goncalves, 2016; Lysova, 2018; Mendez, Horst, Stith, & McCollum, 2014; Thompson et al., 2006). Furthermore, there was a relationship

between escalating violence and escalating fear in the women's interviews, especially anxiety related to leaving the relationship. For example, the statement below is a representative example of associations between increasing violence and increased feelings of fear in the women's interviews:

It goes around in swings and roundabouts. You know, get depressed, isolate myself, then get a mouthful for it. Next time it's worse. I get a hit for it. It's like 'snap out of it'. This is what he says. Then he puts me in this place of fear, I get depressed and isolate myself. I got nowhere to go. If I had the courage to leave I would.

Even those women who had left their violent relationships remained in a position where ongoing fear ensured that their QOL remained poor. For example, the following is a statement which is representative of many of the women who had left their relationship and were enduring fear that ensured the status quo of diminished QOL:

I live from minute to minute just to survive and I cannot adjust from that. Sleep goes from crap to very crap. When really tired, you don't have the capacity to protect yourself. I sleep in a protective way as I'm always feeling vulnerable. Fear, memories, nightmares, pain due to injuries from severe abuse, loneliness ... I have difficulty showering due to flashbacks and being kicked, pushed over in the shower when pregnant and when not.

In contrast to the accounts from the majority of women, there were a few women who advised that after ending their relationships their fear diminished and their lives got better. As demonstrated in the example below, these women made associations between improvements to their QOL and "feeling safer":

I want it noted [that] my life looks good now. It wasn't like this 2 years ago. Domestic violence impacted all elements of my life and I was scared. Having a better QOL means that I'm now comfortable in my existence, feeling safer, money to do things, stress free ...

Women were led to discuss how MPIs could contribute to the enhancement of their QOL, including through the alleviation of their fears. The next section explores women's responses related to MPIs in association with perceived changes to their QOL.

## Women's views on men's participation in MPIs

This section examines women's views of IPV perpetrators' participation in MPIs. This section comprises views on:

- the influence of MPI on women's QOL;
- MPI content;
- IPV perpetrator participation in MPIs; and
- the broader IPV intervention system.

### Influence of MPI participation on women's QOL

Seventy-one women had partners who had participated in an MPI at some time. They were asked to comment on whether their partner's participation in an MPI had improved their QOL. Of these women, 75 percent (n=53) were either very dissatisfied (45%, n=32) or dissatisfied (30%, n=21) with the contribution of MPIs to positive change in their lives (table not shown).

Many of the women advised that their partners' participation in an MPI had changed their QOL, but not necessarily improved it. In particular, men's participation in an MPI was described by many women as a time for increased feelings of fear. These women talked about how they accommodated men and their violence in ways that they thought would minimise adverse outcomes for their already diminished QOL. The next two statements are examples from women who were engaged with IPV services concurrent to their partners' participation in weekly group MPIs (specifically MBCPs). In both cases the IPV services, in conjunction with the MPIs, sought the women's observational feedback on their partners' behaviour changes at home associated with the MPIs. The first woman observed that his violence and control over her increased when she provided assessments of his behaviour. She advised that her partner prevented her from being able to fully participate in an IPV service that operated in conjunction with her partner's MPI. She said:

They phoned me and asked me to rate his behaviour change. Nothing has changed. He makes me tell them he is doing fine at home. I'm still scared, so I don't say

the truth. I don't think he likes going to group but he did it to stay out of gaol. He has no intention to change.

This woman withdrew from the IPV service part-way though her partner's participation in the MPI. In a second example, another woman was coerced by her partner to do his MPI "homework". She indicated that the MPI provided no improvement to her QOL; instead, it added an additional life burden:

My husband participated in a 10-week court mandated program. Good that he had to do the program, but it did not help at all. He would make me do his homework. They [MPI facilitators] thought he got it, but his attitudes and behaviour stayed the same. They got him to help other men in the group program; this was superficial. They need to test him to see if he really did get it. My husband was back in court after 6 months. He is a major factor impacting on my quality of life. The system is unable to help.

A few women expressed having little understanding of what was involved in the intervention that was conducted with men. As stated above, those whose partners were participating in an MPI did not report positive change in the men's behaviour, nor experience improvements to their own QOL. Many women advised how their partners' IPV perpetration changed in terms of types of abuse and patterns of behaviours for the duration of MPIs, but that the IPV did not stop. Women consistently reported that men reverted back to their "old ways" upon completing MPIs. They advised that MPIs did not alleviate their fears, which led to the women feeling uncertain about their safety. Subsequently, many women expressed how they felt let down by both the MPIs and the IPV service system generally. For example, one woman said:

Nothing will change him. They [service providers] phone me up and offer options and also engage me in reporting back his changes during the group and for 12 months after. He came back to how he was before. This was not long after and then I got to deal with the same old shit plus the threats if I report him. This time the neighbours called the cops. Good as I'd never go away from him as he watches everything I do. He's got his sessions now. If he was not in the behaviour group, I'd have never got the chance to pack a few things and go. My neighbour got the extra set of keys for the car and gave me money

for petrol. We'd been planning it for a couple of weeks. That's all the group is good for. Tied him up for a couple of hours a week so I could escape. No good for nothing else. I don't know what the group does with him. They say it's about him taking responsibility. He might say that, but it is just so he doesn't go to gaol. They say they address the emotional abuse, but he still does it. He changes but does it differently. It's still abusive. Then it goes back in no time as soon as the group is over. Not sticking around this time. I don't trust the group is doing anyone any good.

This woman's story was typical of many others who advised that service providers in the IPV service system, including IPV supports to women, had given them false hope that their partners would change due to participating in an MPI and their own lives would improve. She continued:

It gives women a sense of belief that things will get better. They [women's IPV service] got to tell their women that these men never change. They give me a safety plan. But it is a bit difficult to mobilise that when he doesn't let you out of his sight and you got young kids and kids in school. This is not a good life. They need to put these men in gaol and do the stuff [MPI] in there and put them back in gaol if they do not change.

The role of MPIs in improving their own QOL was expressed by women as being inseparable to that of significant others (e.g. children, extended family and family pets) when providing meaning to their own QOL. The statement below is from an Aboriginal woman who asked police to help get her partner into an MPI. She was met with a response that left her feeling unsupported, and she continued to live in fear. Her daughter featured consistently in her QOL narrative:

We have asked him to leave and he will not ... police say, 'Will you leave?' And he won't. We have no choice but to bunker down. My daughter is in Year 11 and leaving due to domestic violence is disruptive and it impacts on quality of life. I have asked about a program for him and I am told they are not worth the paper they are written on. There is no service for my partner. No one is holding him accountable. Me and my daughter are living in hell every day.

Similarly, in the following statement, a woman makes connections between her own sense of wellbeing and her capacity to ensure her children's healthy emotional development following IPV. The final paragraph of the statement below is a representative example of women who spoke about the importance of being part of making better lives for their family, children and pets:

He attended ten sessions out of 12, as required by Family Court, but did not require a report. They knew they were dealing with a psychopath and there were two young children involved. There were support systems set up to help me and the children tolerate the abuse rather than stopping the abuse. This approach did nothing for improving the children's and my lives.

It took until my children were in their 30s until they could see their father as the problem. They blamed me for the supervised access, but it was not appropriate for me to taint them back when they were children. I had to protect them. It was important to my wellbeing to give them positive images of their father while they were still developing, and I was scared for them and me if I did not.

The impact [of IPV] is on my whole family, my parents, children and pets. He is the one that has done this, but I am the one who works hard to ensure the lives of my family are not also ruined. That is important to me.

## Content of MPIs

Women articulated concerns with MPI content and structure, and the broader IPV, welfare and justice systems in which MPIs are located, which need to be addressed in order to better meet women's QOL priorities. Until systemic issues are addressed, according to the women, men's participation in MPIs would remain ineffectual in improving their lives.

While many women did not know what took place in the range of MPI interventions, many others were specifically critical of MBCPs, couples therapies and one-on-one psychosocial interventions with men. The women who indicated they had some content knowledge of these MPIs suggested that the interventions did not sufficiently improve men's attitudes towards women generally. In addition, they thought that these MPIs focused too much on the men's physical behaviours as opposed to other forms of IPV. For example: "His behaviour needs to be resolved, not only stopping the hitting".

Other women, while not excusing their partners' perpetration of IPV, suggested that men would benefit from MPIs that had a more holistic focus. They suggested that a "wrap around MPI" would enable interventions that also focused on the men's issues, for example, the man's trauma, childhood abuse, mental health, substance use and his own stress and insecurity. The women perceived these factors to interact with the men's use of IPV. By not addressing the men's broader issues, this hindered the success of interventions aimed at stopping the violence. For example:

To learn strategies before the violence gets to the really intense physical violence. He grew up on DV [domestic violence] as a child, significant abuse, he has no extended family support. He has mental health [issues], estranged from his family, alcohol and drugs.

It is not good if they do not help him in all of his problems. His drinking, smoking dope, financial pressure, work stress, his impotence, mental health, extended family relations; nothing helps unless all the issues underpinning it are managed. So, going to the men's behaviour change group is like pruning the branches of a tree.

Some women who were no longer in their IPV relationships advised that MPIs needed to also help men to accept when relationships had ended and to leave them alone. For example, one woman said:

From the time he [sic] separated to his death, he had been seeing a psych and also went to a behaviour change program at [organisation's name removed]. They [MBCP workers] need to tell the men to leave the women who have left them alone. They need to address all the other issues going on for the men.

Another woman had ended her relationship and perceived that the MPI did not support her ex-partner to stay away from her. Rather, her ex-partner used the MPI to try and get her back in the relationship. She described her situation, as below:

He started the men's program when I left. He was texting, phoning and hanging out near my work to tell me that it was working, to get me back. It was not working as he was stalking me. He was using the program language, was writing it in letters to me and forcing them on me and pushing me to get back. The program needs to focus on

helping men understand that the men's intervention is not a mechanism to be used to get their partner back. They need to also focus on separating safely ... I did contact the program because he was harassing me so much. I felt I could go there and ask them to tell him to stop. They said I had to go into counselling, then a session with him to ask him to stop. They didn't get it—I'm not with him and just wanted them to tell him to stop. I had to send him a text myself.

This quote indicates some potential confusion by the facilitators of MPIs in terms of the aims of their services. Specifically, in terms of focusing on being there to help their client (the perpetrator) as opposed to achieving good outcomes for their clients' victims/survivors.

## Men's participation in MPIs

The women consistently advised that MPIs need to engage men for longer in their interviews. Some women said that this was because their partners were prone to relapse in their use of IPV. Other women suggested that the men could sustain false behaviour change for the short duration of the MPI, with one woman saying, "Of course, he was able to behave for the [MPI] duration". Many women also understood that the men had developed their violent behaviour over a lifetime, and this could not be "undone" in a 10–20 week program. For example, the following two comments were made: "As soon as the program ended, he went back to his old ways", and "[It is] incredibly difficult to change men in their 40s". Other women expressed concern about the lack of intervention continuity, particularly if their partners were incarcerated: "He was in a program then went to gaol and there was not a program in prison, so it [intervention] stopped."

For women whose partners participated in MPIs, the amount and type of contact they desired with service providers varied. For example, one woman said that she wanted direct contact with the service delivering the MPI, not via a third-party women's IPV service. Her experience in the IPV service system had led to her perception of a lack of coordination between services provided to women and to men. The woman felt that it was important for her recovery from IPV and to improve her QOL to have communication directly with

the professionals providing interventions to her partner, as exemplified in her statement:

The [MPI] service needs to verify what he is saying with the women. They believe his lies that he has changed and fail to find out the other story. If they asked me directly, I could tell them the truth and they could challenge him.

This was consistent with other women who wanted direct contact with MPI services, especially when the men had not been truthful in their relationships. The women did not believe that their partners would be honest in the MPIs.

A few women advised that they were from non-English speaking backgrounds or from communities where traditions reinforced patriarchal authority.<sup>13</sup> This presented barriers to both the women's help-seeking and the men's MPI outcomes. For example:

My family is Muslim but not as conservative in views as my husband. I didn't cover up [with a hijab], but I now cover up because he demands it. I am meant to be in control of my own earnings, but he takes it all. He tells his family in [country removed] whenever what I do doesn't suit him. He locks me up so I cannot go out. I don't speak with my family because he doesn't approve of their [religious] interpretations ... I cannot talk to my friends about it because they are women and won't go against their husbands. I am not part of the world and my society because of my husband's control over me.

This woman suggested that her partner did not change as a result of the MPI. Her view was that MPIs needed to work together with religious leaders (e.g. his Imam) when intervening. Other women, too, suggested that MPIs would benefit from working more closely with the men's religious and cultural leaders, or otherwise in more integrated ways.

## The broader IPV service system

MPIs are part of a broader IPV service system that provides frontline services to men, women and their families.

<sup>13</sup> While cultural and linguistic diversity was not collected as part of demographic data, a few women offered this information in free discussion.

Services include MPIs and shelter and crisis responses to victims/survivors. Some services are integrated, providing interventions to both perpetrators and victims/survivors. The women suggested that services could be improved by implementing interventions earlier, having greater integration between services and engaging with men longer. As previously noted, the women believed that these changes could prevent men from relapsing in their use of IPV. If MPIs are not currently prepared to deliver a wrap-around service, then the system in which MPIs are located was identified by the women as needing to be strengthened in an integrative way. For example, the following statement describes a persistent struggle from one woman, who endured a lengthy journey with her partner in a system that could not support him, prior to their eventual separation:

He had counselling, psychology, couples therapy, two times he did men's behaviour change group, and gaol. The interventions were useless. Each time they helped to alleviate things, but he slowly became violent and paranoid and jealous each time until it would build up again. It wasn't until he had support to address his own childhood abuse that other therapies were implemented; trauma counselling, mental health, alcohol and drug counselling and things got a bit better ... and one in the men's behaviour interventions considered addressing these other crises going on for him. Men's behaviour change needs to be integrated with interventions focused on men's other crises. All need addressing before the men's behaviour change can take effect.

While the women understood that primary responses (MPIs, integrated approaches with perpetrators and victims/survivors, and wrap-around services) were necessary to respond to IPV, they said that more was needed. This included an obligation for the IPV service system to engage more in prevention and early interventions, and to work with other entities and with society as a whole, alongside holding men responsible for IPV. For example, a few women provided examples of societal practices and attitudes that condoned men's power over women and, thereby, contributed to sustaining negative attitudes towards women, gender violence and IPV. The following example is from a woman who spoke about co-locating the responsibility for IPV with industries that predominantly employ men:



He is in the building industry and there is a culture of [men] drinking and being harmful and controlling to their wives. [A] culture of after work drinks then sending the men home to their wives. There is a corporate responsibility required of large male dominated industry not to facilitate engaging employees in masculine behaviours that are detrimental to women and families.

Related to the comment above, this woman explained how MPIs could extend their work to engage with industry to address cultures of masculinity that are detrimental to women and their families. In fact, employing organisations were not the only entities that the women expressed as participating in discourses that privileged men, even IPV perpetrating men, over women. Many of the women held the view that court systems colluded with men by overturning orders or not requiring men to attend mandated MPIs. For example, the following comments were made by women regarding MBCP groups: “[The Judge said] ‘Oh you poor man’ and he did not have to go to the behaviour change group”; “He moved to a suburb where there was no program so the courts said he did not have to go any more”; and:

He was employed and the program was during work hours, so he did not have to go. The court values him more and his job than me and my children’s safety.

Likewise, poor integration across the IPV service system (state-based) and processes in the Family Court system (federal) were reported by the women to be detrimental to their safety. Many women shared their experiences where the Family Court required them to attend group interventions for parents where IPV had been identified. They advised that better integration of the Family Court with MPIs could help to better hold the men accountable for IPV. The women also stated that IPV victims/survivors should not be placed in the Family Court co-parenting programs with perpetrators. A representative example from one woman, with respect to women separating from their partners following IPV, is provided:

We got told in Family Court to do a parenting program, which is about co-parenting. It is completely inappropriate as we cannot co-parent where there is IPV. We both then completed separate classes. I was put in a group of 11

men who were domestic violence perpetrators of quite significant abuse and all bragging about it.

Women frequently perceived that the court system and associated MPIs advantaged men. This was irrespective of whether the systems were state- or federal-based. Men’s advantage was perceived in two ways: as engaging insensitive practices in response to women who were experiencing IPV, as per the quote above; and enabling perpetrators to use court systems to continue abusing their victims/survivors, as stated below:

There is no end to the abuse. The violence, then the ongoing victimisation that the court system enables him to continue abusing me ... the court system makes it less safe. It has got to the point that I need psychology weekly to help me function, the trauma I experienced from him and now the court has resulted in lack of concentration to the point I cannot do basic maths ... I am in court against his whole family and I have no one ... It is like David and Goliath.

While courts were often seen to advantage men, many women expressed how the broader IPV system (police, MPIs, courts, etc.) did not engage men for a sufficient enough time to achieve either parenting or IPV related behavioural change. Women who reflected on the impact of IPV on their own lives, and the long duration of recovery from IPV, resented this when comparing how men perceptibly were left to get on with their lives:

Men need to engage for as long as the women takes [sic] to recover—whether together or not. Long-term rehab same as alcohol and drugs, removal from society, men’s behaviour change groups need to continue in gaol when they are breached.

The majority of women talked about how legal and service systems were not sufficiently responsive to women, especially women who had diminished capacity or power as a result of the IPV. The women consistently expressed that the “system was not set up for women who had been punished” and that the broader IPV service system, in engaging men, “re-victimises” and “traumatizes women”.

These concepts were further explored with key stakeholders in the Australian IPV field. This consultation is considered below.

## Consultation with IPV sector professionals

A consultation with 15 sector representatives was held in Adelaide in November 2017, to introduce the idea of measuring the effectiveness outcomes of MPIs based on measurable improvements to victims'/survivors' QOL. The consultation included members from IPV and MPI partner agencies from Adelaide, Brisbane and Melbourne, as well as additional professionals working in IPV interventions and MPIs, researchers and a consumer representative.

The purpose of the consultation was to gain the perspectives and feedback of sector representatives in relation to preliminary research findings. This included findings on the women's QOL assessments and priorities, and how women's QOL assessments could be used to evaluate MPIs. Discussion points from the consultation were not intended to be generalisable to other professionals working in the IPV sector or in MPI programs. Rather, the purpose was to have initial discussions to inform how thinking about evaluation of outcomes could shift from changes observed in perpetrators to changes observed for victims/survivors. The outcomes of discussion points with recommendations are summarised below.

### Conceptualising the potential use of women's QOL measures

Overall, the IPV sector professionals agreed that the inclusion of women's QOL assessments in the evaluation of MPIs had value. However, they were less certain about how this could be implemented. They grappled with the relationship between women's QOL assessments and the development of tools for evaluating MPIs. This may have been due to entrenched practices of measuring men's behaviour change as the predominant outcome measure of MPIs.

In tackling these concepts, IPV sector professionals suggested that, at the very least, women's QOL assessments could support

a holistic approach to IPV interventions that is attentive to safety, health, welfare and social needs. However, they could not conceptualise MPI evaluations beyond a focus on addressing the men's behaviour either during intervention or as an outcome of an intervention. All of the professionals suggested that the IPV service system would need to change to accommodate women's QOL assessments in MPIs, but they did not offer insights into what that change might look like. However, they suggested that incorporating women's QOL assessments into the measurement of MPIs could provide some consistent outcome measurement across interventions.

Participating professionals emphasised and agreed that women's safety is a priority. As QOL was a relatively new concept in the context of IPV and MPIs, they appeared to conceptualise safety as a discrete concept as opposed to a QOL item located in the broader QOL environment domain. They did not know how to use women's QOL as a measure in the current system framework in which MPIs are located, particularly the non-safety related QOL items. Imagining an alternative system framework that incorporated the use of women's QOL was similarly difficult.

The IPV sector professionals were consulted about the evaluation processes that were currently in use for MPIs. They advised that they were not aware of current evaluation standards or tools in Australia to support the outcome measurement of MPIs. They perceived that there was little consistency in intervention approaches across agencies delivering MPIs, which would make difficult the use of sector-wide standardised tools for measuring the behavioural outcomes of men. After much discussion, they conceded that there was some value in measuring changes to women's QOL assessments, as opposed to changes in the men's behaviours. They also agreed that women's QOL assessments could indicate to service providers working with either victims/survivors or perpetrators where best to direct their intervention efforts according to victims'/survivors' needs.

As a result, professionals present at the consultation were guided by the researchers to translate the knowledge from the preliminary research findings into a set of potential action priorities for IPV service system change. This included identifying what may need to change for MPIs to be more

responsive to the integration of women's QOL assessments as an outcome measure of MPI effectiveness. This process involved small group discussions of the philosophies in favour of victim-centred measures and listing all potential actions that could enable victim-centred assessment measures to be used in evaluating outcomes of MPIs. Each participant selected the five top priorities they perceived to be most important to enable the use of victim-centred evaluation measures. In consolidating these, the top five priorities identified by the group were:

1. To strengthen collaborations in the IPV service system, particularly between men's and women's services.
2. To develop measures for MPIs that are accountable to the QOL of women and their children.
3. As women's QOL is intimately connected to that of their children, to also consider outcomes based on the QOL of children.
4. To maintain safety of women and children as a priority of MPIs.
5. To measure women's and children's risk, safety and other QOL at the commencement of MPIs, during, at exit and 6 months post-exit.

### Views on barriers to the effective evaluation of MPIs

There was general agreement among the representatives that barriers to the successful evaluation of MPIs exist. They identified the following:

- There are no universal management or standardised measures for evaluating MPIs currently in use at their services, and it was unknown what instruments existed that could potentially serve that purpose.
- Current evaluations of MPIs are anecdotal and are not well documented.
- It was difficult to know what outcomes should be considered as indicators of the effectiveness of MPIs, including outcomes that might be particular to men, women or children.
- MPIs often assume that when men do not return to courts or to MPIs that the intervention was successful. However, this does not provide evidence of improvement to the lives of women, children or others. In addition, current

practices that prioritise criminal forms of abuse fail to acknowledge men who are participating in MPIs that may change their abuse tactics rather than stop all forms of abuse. There is a lack of follow-up with both men and women after an MPI to determine long-term outcomes and benefits for all those involved.

- Current evaluations are largely limited in their focus on changes to the person involved in the MPI. Hence, agencies' understandings of broader MPI outcomes are limited. Stakeholders considered that poor interagency collaborations regarding MPIs is a contributing factor to this situation.

The IPV sector professionals advised that there is a high level of variability across MPIs which made it difficult for them to conceptualise how best to measure interventions. In addition, the heavy focus on men's behaviour change eclipsed possibilities related to measuring changes to women's lives as a result of interventions with men. Even the delegates from women's IPV services were preoccupied with evaluating the men's behaviours. However, all members present at the consultation agreed that system barriers needed dismantling to enable more effective evaluations of MPIs. Some barriers included:

- poor information sharing and collaboration between IPV and MPI services, especially when the men are in intervention; and
- the focus of the IPV service system on crisis and short-term intervention, meaning that follow-up and longer-term support for perpetrators and victims/survivors is not possible.

### On the benefits of measuring women's QOL when evaluating MPIs

There was some consensus among the IPV sector professionals that measuring women's QOL has an important and relevant role to play in evaluating the effectiveness of MPIs. They identified several ways that women's QOL could be utilised to improve current practices in evaluating the effectiveness of MPIs, as well as in IPV services to women:

Prioritising women's QOL allows for a more holistic approach to understanding women's lives. This would

enable MPIs to focus on what women identify as important for improving their lives alongside addressing men's violence.

Women's QOL assessments could be used as an intervention tool in MPIs to assist men to understand the impact of their violence on other people's lives.

Women may not want to be involved in MPI evaluations, but their QOL assessments can still inform the women's support services.

When there are children involved, women may have no choice regarding their ongoing contact with the perpetrating partner. Women's QOL assessments can inform practitioners of changes that require professional responses due to ongoing contact with him.

Women's QOL assessments would enable women to discuss their lives and situations without having to directly comment on their male partners' behaviour change. This could also remove women from feeling at risk of further violence if they comment on their partners' behaviour change.

Obtaining women's baseline QOL would assist in measuring change at both the end of MPIs and longitudinally.

Women who are mothers are part of their children's protective environment. Measuring women's QOL can therefore contribute to assessments of child protectiveness and provide insights into possible interventions.

However, the IPV sector professionals suggested that women's QOL assessments had greater potential to inform IPV interventions with women, as opposed to MPIs with men. They suggested this was due to poor information sharing across agencies in the IPV and MPI service sectors. As well, IPV sector professionals reiterated a preoccupation of MPIs in measuring behaviour changes in the men as opposed to accepting that they had a role to play in achieving broader QOL changes for victims/survivors that extended beyond women's physical safety.

## Enabling women's QOL measures to be integrated into evaluations of MPIs

The professionals consulted engaged in discussion on what would need to occur for women's QOL to be integrated into evaluations of MPIs. As a group, they developed a list of priorities and ranked these in order of importance.

The top five priorities identified by the IPV sector professionals were ranked as follows:

1. Interagency collaboration is crucial to the successful integration of women's QOL assessments in program evaluations.
2. A reliable way of measuring interventions with perpetrators that ensures accountability to the needs of women and children.
3. Measurement needs to consider children's QOL because of the interconnections with their mothers' lives.
4. The safety of women and children needs to remain the priority QOL outcome of MPIs.
5. Interval measurement of QOL is required to sufficiently assess change.

## Principles for evaluating MPIs, inclusive of women's QOL

A set of principles to guide the development of MPI evaluations was developed in consultation with IPV sector professionals. This included consideration of perspectives from women on poor MPI outcomes for them. The principles combine accepted person-centred evaluation processes from across health and human services (for e.g. see Frost, Abbott, & Race, 2015; Gavrielides & Loseby, 2014; Miller, 2017; Nyström, Strehlenert, Hansson, & Hasson, 2014; Schalock & Verdugo, 2012) (see Figure 8).

**Figure 8** Principles to guide the development of MPI evaluations

### Ten principles in MPI evaluations

- 1 Agencies delivering MPIs should be informed by a program logic or a theory of change model<sup>a</sup> that is plausible, feasible and testable.
- 2 The development of program logic or theory of change models for MPIs is best developed collaboratively in a representative IPV stakeholder group, inclusive of women's and men's agency representatives.
- 3 Program logic or theory of change models should be considerate of the priorities of the IPV sector, women's and children's need for protection and improvements to the QOL of women.
- 4 Assumptions about interventions with men and how they relate to improving women's QOL should be clearly articulated in the program logic and/or theory of change model. This indicates that inputs and outcomes or intervention points and assumptions should be identified, so these can then be tested and evaluated.
- 5 Self-reports and observations of attitude changes of men should be excluded from the evaluation of MPIs as these are not valid indicators of men's behaviour change, nor do they indicate positive QOL changes for women (and children).
- 6 It is optimal to measure the QOL of women who remain in relationships with men participating in MPIs at various points: at commencement, mid-point, end-point, and 6 months following the men's completion (women who have ended their relationships should not be pressured to participate in these evaluations).
- 7 Evaluation of MPIs should prioritise assessing the women's safety, followed by the women's other QOL priorities, including:
  - women's (and children's) safety;
  - women's health (physical, mental and emotional);
  - women's levels of autonomy;
  - the quantity and quality of women's informal relationships (friends and family);
  - quality of women's relationships with children (as relevant);
  - freedom for women to engage in employment (as relevant);
  - unobstructed access to formal supports; and
  - other QOL priorities identified by women on the men's program intake.
- 8 The women's QOL measure should be brief in order to reduce the burden on the women, but also be considerate of women's QOL priorities (e.g. one global QOL question and 10 questions using Likert scales; the WHOQOL-BREF in conjunction with additional IPV specific QOL items to assess the QOL of women in the context of IPV and MPIs).
- 9 Evaluation of MPIs based on women's QOL priorities can be adapted to include other QOL priorities identified by women at men's program intake. This may include other QOL priorities such as financial security, meaningful life, physical health, formal supports, levels of fear, isolation, community engagement and basic needs.
- 10 MPIs that do not facilitate improvements to women's lives need to be transparent about service failures in order to avert the uptake of ineffectual interventions by other agencies delivering MPIs.

Note: <sup>a</sup> A program logic, or a theory of change model, is optimally developed at program planning stage. They set out what a program will do, the interventions, and the short- medium- and longer-term desired program outcomes (inputs, activities and outputs). When theory and/or assumptions inform interventions in the program, these need to be identified. It is these theories and/or assumptions, as program components, that can be tested for their effectiveness in evaluation (Connell & Kubisch, 1998).

# Discussion

Any intervention with men who perpetrate IPV needs to evaluate whether women's lives have improved as a consequence of that intervention. This is consistent with contemporary literature that advocates for women's QOL and other victim-centred measures in MPIs (Chang et al., 2005; Kelly & Westmarland, 2014; 2015; O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). This section therefore considers the ways in which QOL can be used as a victim-centred outcome measure. The section commences with a discussion of the difficulties that participants have encountered with MPIs in their efforts to obtain a good life. What is important to women in terms of QOL are then considered. The applicability of the WHOQOL-BREF in assessing women's QOL is subsequently examined. In light of this, items for assessing QOL in the context of IPV are proposed.

## MPIs and victim/survivor QOL

All of the women whose partners had participated in MPIs (n=71) said that their own QOL did not benefit from his participation. This raises questions about the purpose of MPIs: whether they exist merely to stop men's use of violence or whether they are meant to serve a broader function to improve victims'/survivors' lives. Further, many of the women attributed escalation or different forms of abuse to their partner's participation in MPIs, whether or not they were still in a relationship. While this finding cannot be generalised to other women, it signals a need for further research to explore whether MPIs are sufficiently considerate of the QOL of women who are IPV victims/survivors.

Previous research has argued that MPIs need to be more considerate of contributing towards positive outcomes for victims/survivors of IPV (Matjasko, Niolon, & Valle, 2013; Shorey et al., 2012). For example, many multi-agency coordinated approaches and victims'/survivors' advocates have adopted models involving IPV sector coordination of victim/survivor and perpetrator services, and victim/survivor advocacy (Pence & Paymar, 1993; Robinson & Payton, 2016). This includes the Duluth model's psycho-educational approach to intervention with men that seeks to challenge perpetrators' beliefs about power and dominance over their victims/

survivors, while engaging victims/survivors in reporting their observations of change in men's behaviours (Pence & Paymar, 1993). However, feminist critics have called for alternatives, suggesting that women's monitoring of men's behaviour change places additional burdens on women (McLaren, 2013b, 2016b; Tollefson et al., 2009). Likewise, many of the women in this study expressed concern for their safety when asked to report on men's behaviour. Other women said that reporting their observations to IPV services was simply an additional burden, as opposed to receiving support to escape or recover from IPV. As presented in the findings, some of the women avoided IPV services that sought to engage them while their partners (current or former) participated in MPIs. If women are at risk when reporting on the men's behaviours, or burdened by reporting, this highlights a need to find alternative ways to engage them in the process of interventions. Focusing on changes for the women across QOL domains, as opposed to monitoring of men by the women, is an alternative.

Internationally, there is a shift in focus away from women reporting on men's behaviour change, towards evaluating MPIs based on improvements for women. For example, Kelly and Westmarland (2015) sought to understand what women thought should be the outcomes of the men's behaviour change programs. Others, too, have argued that evaluations of the effectiveness of MPIs would benefit from the measurement of improvements to women's safety and wellbeing, as well as improvements to women's QOL more broadly (Chang et al., 2005; Kelly & Westmarland, 2014; 2015; O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). As a result, some MPIs in Europe have asked women about their QOL in association with their partners' participation in MPIs (Bates et al., 2017; Vall, 2017). However, the quality of evidence and the valid measurement of changes for women is either still developing or is flawed.

Women are generally not conceptualised as the clients of MPIs and, therefore, there are few links made between men's behaviour change and women's improvements to QOL. Many women whose partners (current or former) were participating in MPIs advised of avoiding contact with their support workers who were associated with the MPIs. This was frequently due to fear of the men and the desire to move

forward with their lives. Some women wanted more contact with MPIs, and others wanted none. Some women expressed opinions that the MPIs were not challenging the men and their behaviours sufficiently. Other women felt disregarded by an intervention process for men that was ultimately meant to be of benefit to women. As suggested by previous studies, this is due to the focus in MPIs on men-as-clients and men's behaviour change, which does not acknowledge the underlying purpose of MPIs as being to protect women and restore their lives (Westmarland & Kelly, 2012; Westmarland et al., 2018). These findings were echoed in the difficulties that professionals working in IPV and MPIs experience (see the section "Consultation with IPV sector professionals" for further details) in terms of making connections between MPIs and women's QOL, in all QOL domains.

## Women's QOL

QOL is dependent upon individual circumstances (Andrews & Withey, 2012; Bowling, 2005a; Fischer, et al., 2015a; Phillips, 2006; Schwarz & Strack, 1999; Wood-Dauphinee, 1999). For women who have experienced IPV, it is possible that certain items within QOL measures will become more or less important to them over time. Both women who remained in their relationships with perpetrators and women who left appeared to place less importance on some of the material aspects of their QOL (i.e. food, housing, education, transport and clothing). Rather, they placed greater emphasis on recovering from the social, emotional and psychological effects of the abuse. This, too, reinforces how QOL is subjectively constructed, and that what is important to women may change over time and according to context. In responding to what victims/survivors emphasise as important to them, victim-centred measures (i.e. QOL assessments) can help keep track of changes in QOL that occur for the women and inform where MPI interventions may need to change.

As QOL is dynamic (Bowling, 2005a; Fischer et al., 2015a; Schwarz & Strack, 1999; Wood-Dauphinee, 1999), women's experiences of, and recovery from, IPV may cause them to re evaluate what is most important to them in their lives. In the current study, self-determination, informal relationships and being emotionally and psychologically well enough to

participate in life far outweighed the physical comforts and practical necessities. This was despite the women experiencing a broad range of abuse types that can affect material aspects of QOL such as physical wellbeing, property and their capacity to meet their own basic needs. Although women suggested that greater autonomy would make them feel safer, it was outside of the scope of this study to validate a correlation between the two.

## Applicability of the WHOQOL-BREF

The few research and evaluation studies, mainly from Australia and the UK, that were identified in the state of knowledge review recommended the use of women's QOL measures in the context of IPV but not necessarily in conjunction with MPIs (O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). A few services in Europe have written women's QOL into their program logics for interventions with the men (Bates et al., 2017; Vall, 2017). However, we found no valid QOL definitions or standardised instruments were reported as having been used in these studies. While narratives exist in favour of using women's QOL assessments to measure MPIs, to date there are actually no standardised instruments currently being used to measure improvements to women's lives in association with MPIs.

Nevertheless, in the context of IPV, the WHOQOL-BREF has been recommended as an outcome measure for IPV intervention trials (O'Doherty et al., 2014). The WHOQOL-BREF has also been administered in several studies of women who have experienced IPV (Alsaker, Moen, Baste, & Morken, 2016; Hegarty et al., 2015; Leung, Leung, Ng, & Ho, 2005). Here we consider the strengths and limitations of administering the WHOQOL-BREF to a population of women with IPV experiences.

## Strengths of the WHOQOL-BREF

The WHOQOL-BREF is an internationally sound generic measure of QOL (Skevington & McCrate, 2011, p. 49). Researchers involved population groups in WHOQOL-BREF item development and validation (Strada et al., 2017). This person-centred process meant that the WHOQOL-BREF has

fulfilled perhaps the most important prerequisite for a good patient-reported outcome measure, namely the involvement of its users (Skevington & McCrate, 2011, p. 50).

A further advantage of the WHOQOL-BREF is that the QOL of the study population can be compared with the general population and other population groups. For example, the QOL of women who participated in the current study were much lower when compared with women in the general Australian population (Hawthorne et al., 2006). Similarly, our study's population WHOQOL-BREF assessments can be compared with other IPV studies (Alsaker et al., 2007; Hegarty, et al., 2013). Subsequently we found that QOL assessments in our study were similar to others, suggesting that the QOL profile of women who experience IPV is fairly consistent internationally.

In our study, Cronbach's  $\alpha$  for WHOQOL-BREF domains was 0.96 with individual QOL domains ranging from 0.61 (psychological health) to 0.89 (environment); this was similar to only one other study which has reported internal reliability (Alsaker et al., 2007). This means that in terms of assessing the QOL of IPV populations, the WHOQOL-BREF is illustrating that it is measuring what it is purporting to measure in terms of the domains it assesses—physical health, mental health, social relationships and environment. Indeed, there are a number of WHOQOL-BREF questions that are consistent with women's meanings of QOL, as highlighted in italics in the following questions:

- How would you rate your quality of life? (a global question of QOL)
- How satisfied are you with your health? (a global question of health status)
- How *safe* do you feel in your daily life?
- To what extent do you have the opportunity for *leisure* activities?
- How much do you *enjoy* life?
- To what extent do you feel your life to be *meaningful*?
- How often do you have *negative feelings* such as blue mood, despair, anxiety, depression?

## Weaknesses of the WHOQOL-BREF

The WHOQOL-BREF, to our knowledge, has not been validated with women who have experienced IPV. Validation is the process of examining whether a process or instrument is sound (Feinleib, 2001). Critical to the reliability of findings, administered instruments need to be relevant and suitable to the population of concern (Reeve et al., 2013; Sansoni, 2016). In our study the WHOQOL-BREF did not fully capture what women expressed as important to their QOL in the context of their IPV experiences, namely fear, autonomy, isolation, feelings of safety and caring responsibilities towards others (see Table 4 and Appendix B).

Fear, autonomy, isolation, feelings of safety and caring responsibilities towards others were aspects of life that women wanted most help in to “get their lives back”. In the area of IPV, where the safety of women and those who they care for is paramount, these aspects of life become crucial elements in assessing the effectiveness of MPIs. Indeed women in this study who reported being scared of their partners, regardless of their relationship status, had much poorer QOL than women who were not currently afraid of their partner. For those women who had partners who were participating in MPIs, many held additional fears. These included fears related to the impact of IPV on their social circumstances, justice system responses toward them, fears for others they cared for and fear about their own recovery.

Participants who were mothers indicated that their children's safety and enabling their children to have a positive QOL involving good relationships was integral to their own QOL. For example, the following comments were made by three women: “Having my children around me, watching them develop and do well in life and relationships gives me meaning for my life”; “being able to financially support, provide for and nurture children”; and “knowing my children are now safe. Having him out of my life. Nothing else.” Likewise, many women talked about pets, extended family and friends having been taken from them as impacting on their QOL. In expressing their QOL priorities, the women highlighted the importance of such relationships and the security that came from knowing of the wellbeing of others near to them.



In terms of a potential role of MPIs in alleviating women's fears to improve women's QOL, there exists an argument in favour of baseline and outcome measurement of victims/survivors in association with men's interventions. With consideration of an outcome measure, a more nuanced assessment of women's QOL within the context of IPV and men's participation in MPIs is required. A more detailed understanding of QOL from the perspective of a person in particular circumstances is not a new development. Efforts have been made in other fields to addend questions to the WHOQOL-BREF. Such an approach has the benefit of being able to build upon the strengths of the WHOQOL-BREF, whilst addressing its limitations for specific populations, in this case women with IPV experiences.

## QOL as a victim-centred outcome measure

Given the potential weaknesses of the WHOQOL-BREF as a QOL outcome measure within the IPV context, as outlined above, there is a need for an additional set of items to assess QOL within the IPV context. How these items could form a standard set of questions is then described.

### Additional QOL-IPV items

Derived from this study, these potential QOL items for testing and validation are:

- fear;
- autonomy;
- isolation;
- safety; and
- altruism (care for others).

#### Fear

Fear is a feeling induced by a perceived or real threat. Women participating in this study reported being fearful of their partners irrespective of their relationship status, however, this was an aspect of overall fear expressed. Fear, for example, was related to:

- the women's sense of physical safety;

- fears about their future and whether they would recover from IPV;
- fear about their ability to navigate their environment and engage in social life; and
- fear about the impact of the IPV on their family and social networks.

#### Autonomy

Autonomy relates to the capacity to act in self-directed ways, which are free from adverse coercion by outside influences, and has a relationship with freedom. Autonomy was expressed by the women as:

- having agency;
- being able to make their own decisions;
- having the liberty to live how they chose; and
- being free to express their own belief and live according to their own identities.

They expressed the need for autonomy with reference to intimate relationships, their social worlds, how and where they lived, and in their navigation of IPV services.

#### Isolation

Isolation can be described as diminished contact or inclusion, such as a lack of contact with people or groups, or exclusion from groups, society or structures. The women expressed isolation resulting from IPV in relation to their connections with family, friends and community.

#### Safety

Safety is a condition in which danger, risk or injury are minimised and manageable. It extends to physical, psychological, social and spiritual safety as expressed by the women interviewed. This was inclusive of women's perception of legal and courts systems contributing to increased risk.

#### Altruism (care for others)

Altruism exists when individuals have concern for the happiness and wellbeing of others, physically, psychologically, socially, materially and spiritually. Altruism was evident in

**Figure 9** Proposed additional QOL-IPV items for testing and validation

We now would like you to think about your IPV experiences in the past 2 weeks.

To what extent have you felt ...	Not at all	A little	Moderately	Mostly	Completely
Fear?	1	2	3	4	5
Autonomous?	1	2	3	4	5
Isolated?	1	2	3	4	5
Lonely?	1	2	3	4	5
Safe?	1	2	3	4	5

How satisfied are you with ...	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
The safety of your children, family and animals?	1	2	3	4	5
The wellbeing of your children, family and animals?	1	2	3	4	5
Your capacity to care for children, family and animals?	1	2	3	4	5

the women's narratives, expressed in their worry about the impact of IPV on their children, other family members, friends and animals, and even the perpetrators. The women's acts of altruism, often described in their actual care for others or meeting their self-defined responsibilities to care of others, was stated as integral to their own QOL.

### QOL-IPV items as a standard set of questions

Figure 9 shows the items discussed above as a standard set of questions for testing and validation. The format of the questions is consistent with the WHOQOL-BREF layout, that is:

- instructions for responding to each question are clearly provided;
- questions are clear and concise; and
- double-barrel questions have been avoided, with each question addressing one item for fear, autonomy, isolation and safety, and several questions to cover aspects of altruism.

Responses are options are on five-point scales. For the questions pertaining to the extent to which they have felt certain things, each response option ranges from "not at all" to "completely"; for altruism (i.e. care for others) items, response options range from "very satisfied" to "very dissatisfied".

### Strengths and limitations of the current study

The strengths of the research lie in the following:

- Its ability to address the gap in research into the development and incorporation of victim-centred measures into MPI evaluations. In this study we have examined in detail one arguably crucial victim-centred outcome measure—QOL. We have in this study assessed the QOL of 100 women who are victims/survivors of IPV and, in the process, enabled them to elucidate what QOL means to them and their hopes for a "good life".
- Its generation of a (proposed) set of items which may be used to assess women's QOL in the context of IPV.

- Its innovation in applying the WHOQOL-BREF to women who have experienced IPV albeit with caution, as the instrument has not been validated with women who have experienced IPV and therefore its soundness has not been tested. However, QOL assessments found in this study were comparable with other studies conducted in Australia and elsewhere.

Even so, the study has several limitations. The purpose of this study's literature review was to understand how researchers in the area of women's experiences of IPV and QOL have formulated research questions, collected data and analysed changes to QOL in association with men's participation in MPIs. Findings from the literature review were intended to inform survey designs and mechanisms to measure the outcome effectiveness of MPIs from a victim-centred perspective. However, the limited literature made it difficult to situate this research in the context of existing knowledge. This restricted opportunities to draw on the expertise of previous studies when designing this study's data collection instruments. With little foresight on the limitations of the WHOQOL-BREF in measuring IPV victim/survivor QOL outcomes, learning about the women's QOL priorities was important for enabling the development of specific IPV-QOL items (Figure 9) that can be tested in future research.

Second, there were aspects of the study design that may have led to more negative accounts of MPIs. In particular, asking research participants about their perceptions of MPIs after asking, "What is it that makes your life bad?" may have unintentionally prompted women to provide more negative responses about MPIs. In addition, it is possible that there was a self-selection bias to take part in the study from women who were dissatisfied with MPIs, thereby influencing the results related to the negative influence of MPIs on the women's QOL. However, the actual impact of these factors on the study's findings cannot be determined. This does not present implications for future research when seeking to test the WHOQOL-BREF with the IPV-QOL items, as this will involve collection of baseline data before potential participants have formulated any dissatisfaction with MPIs, then end-of-program data for comparison.

The use of the WHOQOL-BREF as a measure of QOL may have also limited the findings from this study. While the WHOQOL-BREF has been used in a few studies to measure the QOL of women experiencing IPV (Hegarty et al., 2013; Krishnan et al., 2012; MacMillan et al., 2009), it has not been validated for use with this population. As a result, the WHOQOL-BREF did not include many QOL items that may have been important to women experiencing IPV, regardless of their partners' participation in an MPI. However, the aim of the current study was not to test the WHOQOL-BREF. Instead, it was to undertake research to contribute to the development of a suitable outcome effectiveness measure to complement evaluations of MPIs. With this intention, the research by Bowling and colleagues (Bowling, 2005a, 2005b; Bowling et al., 2003), which asked older people about their QOL priorities, provided guidance on designing the qualitative interview questions in this study. This approach was respectful of the voices of participants as opposed to relying discretely on pre-existing QOL domains and items in the WHOQOL-BREF.

The WHOQOL-BREF also does not account for interactions between individuals and the state, or the judicial and welfare service systems, such as those associated with IPV or MPIs. This is crucial because it is the power of the state which impacts the QOL of IPV victims/survivors through funding limitations, service systems that may be difficult for women to navigate, programs that may not provide interventions to address women's needs or that are unresponsive to improving victims/survivors QOL. These have not been considered in the development of additional IPV-QOL items in this study due to being outside the scope of what can be considered as a measurable program outcome. Additional limitations to the study included difficulty recruiting a diverse sample of women that included a representative number of Aboriginal and Torres Strait Islander women and women from culturally and linguistically diverse communities. As well, participant recruitment targeted a 100 kilometre radius of three capital cities in Australia which meant that the sample does not include the voices of rural- or remote-living women, nor can the small sample size be generalised to the broader Australian populations of adult women experiencing IPV. This means that the perspectives provided by women in this study are predominantly Anglo-centric and that of urban-dwelling

Australian women. Nonetheless, as an exploratory study, the findings are invaluable for informing intervention priorities aimed at ensuring women's safety and improvements to QOL across QOL domains.

While a set of principles for evaluating MPIs, inclusive of women's QOL, is provided, further research and dissemination activities are necessary to encourage sector uptake of victim-centred measures for evaluating perpetrator interventions and practice change. A victim-centred QOL measure (i.e. the WHOQOL-BREF with additional IPV-QOL items, Figure 6) for use in MPIs could stimulate a shift in focus for MPIs toward improvement for victims'/survivors' QOL. The WHOQOL-BREF with additional IPV-QOL items provides promise, however it requires testing and confirmation via a series of further research studies to assess its useability. Ultimately, strengthening IPV sector understandings of QOL and the value of measuring the effectiveness of MPIs on the basis of victims'/survivors' QOL is needed for stimulating uptake of innovations (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; McLaren, Gibson, Arney, Scott, & Brown, 2008; McLaren & Kenny, 2015), particularly in the implementation of new evaluation designs and IPV sector change.

# Recommendations for policy and practice

As stated in the beginning of this report, there is merit in MPIs focusing on broader QOL improvements to victims'/survivors' lives alongside traditional behavioural change interventions with men. This is consistent with the perspectives of other researchers favouring women-centred outcome measures of both IPV interventions and MPIs (Chang et al., 2005; Kelly & Westmarland, 2014, 2015; O'Doherty et al., 2014; Ramsay et al., 2009; Rivas et al., 2015; Taft et al., 2013). Accordingly, any measurement of outcomes for victims/survivors will require a change in IPV/MPI service sector mindset, service redesign and changes to program logic and theory of change.

whatever victim/survivor measure is used, baseline data is taken when men commence their participation in MPIs, on completion and longitudinally, to enable measurement of immediate change in association with evaluation of interventions and also sustainable change. For women supported by IPV services, not in association with MPIs, victim-centred QOL measures are likewise recommended.

Incorporating assessments of women's QOL to examine changes in association with men's participation in MPIs has the potential to guide program development and improvements to interventions in ways that are responsive to achieving victim-focused outcomes, such as QOL. Change is necessary when reviews of research into the validity of existing measurements for evaluating MPIs consistently reveal methodological flaws and highlight equivocal results (for example, Arias et al., 2013; Bates et al., 2017; Eckhardt et al., 2013; Lilley-Walker et al., 2016; Mackay, Gibson, Lam, & Beecham, 2015b; Whitaker et al., 2013). It is, therefore, timely to explore and test new ways to understand what works in MPIs, for whom and why—and to respond to these questions with appropriate service redesign or improvements.

One way to start is for IPV policy and practice to accede the importance of victim-focused outcome measures as important outcomes of MPIs. We recommend that policy-makers and funders insist that MPIs develop theory of change models focused on achieving victim-centred outcomes alongside men stopping their use of violence. Documenting program assumptions, observable interventions and improvements to victims'/survivors' QOL has the potential to offer insights into what works in MPIs in restoring victims'/survivors' lives. Policy and practice that prioritises women's QOL, we argue, offers a more holistic approach in working with perpetrating men.

We recommend that, while women's and children's safety remain paramount, agencies delivering MPIs develop their program logic and theory of change models with women's QOL outcomes at the forefront. Finally, we recommend, that

# Conclusion

This study described the QOL of 100 women who have experienced or who are currently experiencing IPV to identify how QOL may be used as a victim-centred outcome measure. This study provides insights into women's negative perceptions about the benefits of MPIs, both for their partners' participation and for them. While not generalisable to other women, these findings support the need for further discussions of the benefits of strengthening the victim-centeredness of MPIs alongside existing behaviour-focused interventions with the men.

Women expressed their QOL as relating to autonomy, informal supports (family and friends), emotional health, safety (physical and psychological) and children and pets. Fear permeated all QOL assessments. Although the WHOQOL-BREF was helpful in assessing women's QOL generally, it did not seem to capture women's QOL concerns within the context of IPV. Items which assess fear, autonomy, isolation, safety and altruism (care for others) are proposed. The logical next step is to test and validate these items with women who have experienced IPV, and also within an MPI intervention environment. This will enable advancements in the use of QOL assessments and other victim-centred measures in the outcome evaluations of MPIs.

Our standpoint is in favour of measuring MPIs on the basis of improvements for victims/survivors. The WHOQOL-BREF and the proposed QOL-IPV items, however, do not account for interactions between individuals and the state, or the judicial and welfare service systems, such as those associated with IPV or MPIs. Understanding of this is crucial, in particular how the power of the state may impact services that are central to improving the QOL of IPV victims/survivors. Sufficient funding is needed for both victim/survivor and perpetrator services, service and judicial systems that are easy for women to navigate, and programs that provide evidenced interventions to stop the violence, keep women safe and, at the same time, are responsive to improving victims'/survivors' QOL. Further research is needed, as these have not been considered in the development of additional IPV-QOL items in this study due to being outside the scope of what can be considered as a measurable program outcome.

# References

- Alderson, S. (2015). An investigation into the impact of domestic violence perpetrator programmes on children and young people (Doctoral dissertation, Durham University). Retrieved from <http://etheses.dur.ac.uk/11277/>
- Alsaker, K., Moen, B. E., Baste, V., & Morken, T. (2016). How has living with intimate partner violence affected the work situation? A qualitative study among abused women in Norway. *Journal of Family Violence*, 31(4), 479–487. <http://doi.org/10.1007/s10896-016-9806-2>
- Alsaker, K., Moen, B. E., & Kristoffersen, K. (2007). Comparing quality of life instruments in a population of abused women. *Applied Research in Quality of Life*, 2(2), 125–139. <http://doi.org/10.1007/s11482-007-9034-2>
- Alsaker, K., Moen, B. E., Morken, T., & Baste, V. (2018). Intimate partner violence associated with low quality of life—a cross-sectional study. *BMC Women's Health*, 18(1). <http://doi.org/10.1186/s12905-018-0638-5>
- Alsaker, K., Moen, B. E., Nortvedt, M. W., & Baste, V. (2006). Low health-related quality of life among abused women. *Quality of Life Research*, 15(6). <http://doi.org/10.1007/s11136-006-0046-4>
- Anderson, K. L. (2013). Why do we fail to ask “why” about gender and intimate partner violence? *Journal of Marriage and Family*, 75(2), 314–318. <http://doi.org/10.1111/jomf.12001>
- Andrews, F. M., & Withey, S. B. (2012). *Social indicators of well-being: Americans' perceptions of life quality* [Ebook]. <http://doi.org/10.1007/978-1-4684-2253-5>
- Apers, S., Luyckx, K., & Moons, P. (2013). Is quality of life the ultimate outcome parameter? *European Journal of Cardiovascular Nursing*, 12(6), 502–504. <http://doi.org/10.1177/1474515113512735>
- Arias, E., Arce, R., & Vilariño, M. (2013). Batterer intervention programmes: A meta-analytic review of effectiveness. *Psychosocial Intervention*, 22(2), 153–160. <http://doi.org/10.5093/in2013a18>
- Asadi-Lari, M., Tamburini, M., & Gray, D. (2004). Patients' needs, satisfaction, and health related quality of life: Towards a comprehensive model. *Health and Quality of Life Outcomes*, 2. <http://doi.org/10.1186/1477-7525-2-32>
- Austin, J. B., & Dankwort, J. (1999). The impact of a batterers' program on battered women. *Violence Against Women*, 5(1), 25–42. <http://doi.org/10.1177/10778019922181130>
- Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse*, 7(4), 355–460. <http://doi.org/10.1891/1946-6560.7.4.355>
- Bates, E. A., Graham-Kevan, N., Bolam, L. T., & Thornton, A. J. (2017). A review of domestic violence perpetrator programs in the United Kingdom. *Partner Abuse*, 8(1), 3–46. <http://doi.org/10.1891/1946-6560.8.1.3>
- Bengtsson-Tops, A., & Hansson, L. (1999). Clinical and social needs of schizophrenic outpatients living in the community: The relationship between needs and subjective quality of life. *Social Psychiatry and Psychiatric Epidemiology*, 34(10), 513–518. <http://doi.org/10.1007/s001270050169>
- Bickman, L., & Reich, S. M. (2015). Randomized controlled trials: A gold standard or gold plated? In S. I. Donaldson, C. A. Christie, & M. M. Mark (Eds.), *Credible and actionable evidence: The foundation for rigorous and influential evaluations* (pp. 83–113). Los Angeles: Sage publications.
- Blanc, J., Boyer, L., Le Coz, P., & Auquier, P. (2014). Metacognition: Towards a new approach to quality of life. *Quality of Life Research*, 23(2), 467–475. <http://doi.org/10.1007/s11136-013-0485-7>
- Bonevski, B., Sanson-Fisher, R., Hersey, P., Paul, C., & Foot, G. (2000). Assessing the perceived needs of patients attending an outpatient melanoma clinic. *Journal of Psychosocial Oncology*, 17(3–4), 101–118. [http://doi.org/10.1300/J077v17n03\\_06](http://doi.org/10.1300/J077v17n03_06)
- Bonomi, A. E., Patrick, D. L., Bushnell, D. M., & Martin, M. (2000). Validation of the United States' version of the World Health Organization Quality of Life (WHOQOL) instrument. *Journal of Clinical Epidemiology*, 53(1), 1–12. [http://doi.org/10.1016/S0895-4356\(99\)00123-7](http://doi.org/10.1016/S0895-4356(99)00123-7)
- Bowland, S., Hensley, M., Johnson, B., & Fleming, A. (2010). Consumer focus groups: A key to transforming behavioral health systems? *International Journal of Mental Health*, 39(1), 16–28. <http://doi.org/10.2753/IMH0020-7411390102>

- Bowling, A. (2005a). *Ageing well: Quality of life in old age*. London: McGraw-Hill Education.
- Bowling, A. (2005b). *Measuring health—A review of quality of life measurement scales* (3<sup>rd</sup> ed.). Berkshire: Open University Press.
- Bowling, A. (2009). The psychometric properties of the older people's quality of life questionnaire, compared with the CASP-19 and the WHOQOL-OLD. *Current Gerontology and Geriatrics Research*, 2009, 1687–7063. <http://doi.org/10.1155/2009/298950>
- Bowling, A., Gabriel, Z., Dykes, J., Dowding, L. M., Evans, O., Fleissig, A., . . . Sutton, S. (2003). Let's ask them: A national survey of definitions of quality of life and its enhancement among people aged 65 and over. *The International Journal of Aging and Human Development*, 56(4), 269–306. <http://doi.org/10.2190/BF8G-5J8L-YTRF-6404>
- Bramston, P., Chipuer, H., & Pretty, G. (2005). Conceptual principles of quality of life: An empirical exploration. *Journal of Intellectual Disability Research*, 49(10), 728–733. <http://doi.org/10.1111/j.1365-2788.2005.00741.x>
- Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2019). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health social sciences* (pp. 843–860). Springer: Singapore.
- Brierley, G., Agnew-Davies, R., Bailey, J., Evans, M., Fackrell, M., Ferrari, G., . . . Feder, G. S. (2013). Psychological advocacy toward healing (PATH): Study protocol for a randomized controlled trial. *Trials*, 14(1). <http://doi.org/10.1186/1745-6215-14-221>
- Brown, R. I., & Brown, I. (2005). The application of quality of life. *Journal of Intellectual Disability Research*, 49(10), 718–727. <http://doi.org/10.1111/j.1365-2788.2005.00740.x>
- Bullinger, M., & Quitmann, J. (2014). Quality of life as patient-reported outcomes: principles of assessment. *Dialogues in Clinical Neuroscience*, 16(2), 137–145. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4140508/>
- Camfield, L., & Skevington, S. M. (2008). On subjective well-being and quality of life. *Journal of Health Psychology*, 13(6), 764–775. <https://doi.org/10.1177/1359105308093860>
- Campbell, A., Converse, P., & Rodgers, W. (1976). *The quality of American life: Perceptions, evaluations and satisfactions*. New York: Russell Sage Foundation.
- Cannon, C., Hamel, J., Buttell, F., & Fefreira, R. J. (2016). A survey of domestic violence perpetrator programs in the United States and Canada: Findings and implications for policy and intervention. *Partner Abuse*, 7(3), 226–276. <http://doi.org/10.1891/1946-6560.7.3.226>
- Chang, J. C., Cluss, P. A., Ranieri, L., Hawker, L., Buranosky, R., Dado, D., . . . Scholle, S. H. (2005). Health care interventions for intimate partner violence: What women want. *Women's Health Issues*, 15(1), 21–30. <http://doi.org/10.1016/j.whi.2004.08.007>
- Connell, J. P., & Kubisch, A. C. (1998). Applying a theory of change approach to the evaluation of comprehensive community initiatives: Progress, prospects, and problems. In K. Fullbright-Anderson, A. C. Kubisch, & J. P. Connell (Eds.), *New approaches to evaluating community initiatives: Theory, measurement, and analysis* (pp. 1–13). Washington: Aspen Institute.
- Coulter, M., & Van de Weerd, C. (2009). Reducing domestic violence and other criminal recidivism: Effectiveness of a multilevel batterers intervention program. *Violence and Victims*, 24(2), 139–152. <http://doi.org/10.1891/0886-6708.24.2.139>
- Council of Australian Governments. (2011). *The national plan to reduce violence against women and their children: Including the first three-year action plan*. Retrieved from [https://www.dss.gov.au/sites/default/files/documents/08\\_2014/national\\_plan1.pdf](https://www.dss.gov.au/sites/default/files/documents/08_2014/national_plan1.pdf)
- Crane, C. A., & Easton, C. J. (2017). Integrated treatment options for male perpetrators of intimate partner violence. *Drug and Alcohol Review*, 36(1), 24–33. <http://doi.org/10.1111/dar.12496>
- Creswell, J. W. (2015). *A concise introduction to mixed methods research*. Thousand Oaks: Sage Publications.
- Creswell, J. W., Shope, R., Plano Clark, V. L., & Green, D. O. (2006). How interpretive qualitative research extends mixed methods research. *Research in the Schools*, 13(1), 1–11.



- Cripe, S. M., Sanchez, S. E., Sanchez, E., Ayala Quintanilla, B., Hernández Alarcon, C., Gelaye, B., & Williams, M. A. (2010). Intimate partner violence during pregnancy: A pilot intervention program in Lima, Peru. *Journal of Interpersonal Violence, 25*(11), 2054–2076. <http://doi.org/10.1177/0886260509354517>
- Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16*(3), 297–334. <http://doi.org/10.1007/bf02310555>
- Cui, M., Ueno, K., Gordon, M., & Fincham, F. D. (2013). The continuation of intimate partner violence from adolescence to young adulthood. *Journal of Marriage and Family, 75*(2), 300–313. <http://doi.org/10.1111/jomf.12016>
- Cummins, R. A. (2005). Moving from the quality of life concept to a theory. *Journal of Intellectual disability research, 49*(10), 699–706. <http://doi.org/10.1111/j.1365-2788.2005.00738.x>
- Cunha, O. S., & Goncalves, R. A. (2016). Severe and less severe intimate partner violence: From characterization to prediction. *Violence and Victims, 31*(2), 235–250. <http://doi.org/10.1891/0886-6708.VV-D-14-00033>
- Davis, S., & Madden, S. (2006). The international classification of function and health. In S. Davis (Ed.), *Rehabilitation: The use of theories and models in practice* (pp. 23–45). Edinburgh: Elsevier.
- Day, A., & Bowen, E. (2015). Offending competency and coercive control in intimate partner violence. *Aggression and Violent Behavior, 20*(Jan-Feb), 62–71. <http://doi.org/10.1016/j.avb.2014.12.004>
- De Maeyer, J., Vanderplasschen, W., & Broekaert, E. (2010). Quality of life among opiate-dependent individuals: A review of the literature. *International Journal of Drug Policy, 21*(5), 364–380. <http://doi.org/10.1016/j.drugpo.2010.01.010>
- Devries, K. M., Mak, J. Y. T., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., . . . Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science, 340*(6140), 1527–1528. <http://doi.org/10.1126/science.1240937>
- Dijkers, M. P. (2003). Individualization in quality of life measurement: Instruments and approaches. *Archives of Physical Medicine and Rehabilitation, 84*(2), S3–S14. <http://doi.org/10.1053/apmr.2003.50241>
- Eckhardt, C. I., Murphy, C. M., Whitaker, D. J., Sprunger, J., Dykstra, R., & Woodard, K. (2013). The effectiveness of intervention programs for perpetrators and victims of intimate partner violence. *Partner Abuse, 4*(2), 196–231. <http://doi.org/10.1891/1946-6560.4.2.196>
- Eckhardt, C. I., & Utschig, A. C. (2007). Assessing readiness to change among perpetrators of intimate partner violence: Analysis of two self-report measures. *Journal of Family Violence, 22*(5), 319–330. <http://doi.org/10.1007/s10896-007-9088-9>
- Evans, M. A., & Feder, G. S. (2016). Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support. *Health Expectations, 19*(1), 62–73. <http://doi.org/10.1111/hex.12330>
- Fakhoury, W. K., & Priebe, S. (2002). Subjective quality of life: Its association with other constructs. *International Review of Psychiatry, 14*(3), 219–224. <http://doi.org/10.1080/09540260220144957>
- Falb, K., Diaz-Olavarrieta, C., Campos, P. A., Valades, J., Cardenas, R., Carino, G., & Gupta, J. (2014). Evaluating a health care provider delivered intervention to reduce intimate partner violence and mitigate associated health risks: study protocol for a randomized controlled trial in Mexico City. *BMC Public Health, 14*(1), 772–781. <http://doi.org/10.1186/1471-2458-14-772>
- Farquhar, M. (1995). Definitions of quality of life: a taxonomy. *Journal of Advanced Nursing, 22*(3), 502–508. <http://doi.org/10.1046/j.1365-2648.1995.22030502.x>
- Feinleib M. (2001). A dictionary of epidemiology (fourth edition) [Review of the book *A dictionary of epidemiology (fourth edition)*, edited by J. M. Last, R. A. Spasoff, & S. G. Harris]. *American Journal of Epidemiology, 154*(1), 93–94. <http://doi.org/10.1093/aje/154.4.389>

- Felce, D. (1997). Defining and applying the concept of quality of life. *Journal of Intellectual Disability Research*, 41(2), 126–135. <http://doi.org/10.1111/j.1365-2788.1997.tb00689.x>
- Felce, D., & Perry, J. (1995). Quality of life: Its definition and measurement. *Research in developmental disabilities*, 16(1), 51–74. [http://doi.org/10.1016/0891-4222\(94\)00028-8](http://doi.org/10.1016/0891-4222(94)00028-8)
- Fischer, J. A., Clavarino, A. M., Plotnikova, M., & Najman, J. M. (2015a). Cannabis use and quality of life of adolescents and young adults: Findings from an Australian birth cohort. *Journal of Psychoactive Drugs*, 47(2), 107–116. <http://doi.org/10.1080/02791072.2015.1014121>
- Fischer, J. A., Conrad, S., Clavarino, A. M., Kemp, R., & Najman, J. M. (2013). Quality of life of people who inject drugs: Characteristics and comparisons with other population samples. *Quality of Life Research*, 22(8), 2113–2121. <http://doi.org/10.1007/s11136-013-0350-8>
- Fischer, J. A., Najman, J. M., Plotnikova, M., & Clavarino, A. M. (2015b). Quality of life, age of onset of alcohol use and alcohol use disorders in adolescence and young adulthood: Findings from an Australian birth cohort. *Drug and Alcohol Review*, 34(4), 388–396. <http://doi.org/10.1111/dar.12227>
- Fitzgerald, R., & Graham, T. (2016). *Assessing the risk of domestic violence recidivism* (Crime and Justice Bulletin no. 189). Sydney: NSW Bureau of Crime Statistics and Research.
- Ford-Gilboe, M., Wathen, C. N., Varcoe, C., MacMillan, H. L., Scott-Storey, K., Mantler, T., . . . Perrin, N. (2016). Development of a brief measure of intimate partner violence experiences: The Composite Abuse Scale (Revised)—Short Form (CAS<sub>R</sub>-SF). *BMJ Open*, 6(12), 1–13. <http://doi.org/10.1136/bmjopen-2016-012824>
- Frost, N., Abbott, S., & Race, T. (2015). *Family support: Prevention, early intervention and early help*. New Jersey: John Wiley & Sons.
- Galushko, M., Golla, H., Strupp, J., Karbach, U., Kaiser, C., Ernstmann, N., . . . Voltz, R. (2014). Unmet needs of patients feeling severely affected by multiple sclerosis in Germany: A qualitative study. *Journal of Palliative Medicine*, 17(3), 274–281. <http://doi.org/10.1089/jpm.2013.0497>
- Galvani, S. A. (2007). Safety in numbers? Tackling domestic abuse in couples and network therapies. *Drug and Alcohol Review*, 26(2), 175–181. <http://doi.org/10.1080/09595230601146694>
- García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., . . . Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet*, 385(9978), 1685–1695. [http://doi.org/10.1016/S0140-6736\(14\)61830-4](http://doi.org/10.1016/S0140-6736(14)61830-4)
- Gavrielides, T., & Loseby, G. (2014). *The wind of change: Comparative lessons for restorative justice in South Africa and United Kingdom*. London: Restorative Justice for All Publications.
- Gehart, D. R. (2012a). The Mental Health Recovery Movement and Family Therapy, Part I: Consumer-Led Reform of Services to Persons Diagnosed with Severe Mental Illness. *Journal of Marital and Family Therapy*, 38(3), 429–442. <http://doi.org/10.1111/j.1752-0606.2011.00230.x>
- Gehart, D. R. (2012b). The mental health recovery movement and family therapy, part II: A collaborative, appreciative approach for supporting mental health recovery. *Journal of Marital and Family Therapy*, 38(3), 443–457. <http://doi.org/10.1111/j.1752-0606.2011.00229.x>
- Gilchrist, G., Canfield, M., Radcliffe, P., & d'Oliveira, A. F. (2017). Controlling behaviours and technology-facilitated abuse perpetrated by men receiving substance use treatment in England and Brazil: Prevalence and risk factors. *Drug and Alcohol Review*, 36(1), 52–63. <http://doi.org/10.1111/dar.12521>
- Gondolf, E. W. (1999). A comparison of four batterer intervention systems: Do court referral, program length, and services matter? *Journal of Interpersonal Violence*, 14(1), 41–61. <http://doi.org/10.1177/088626099014001003>
- Greenberg, D. H., & Morris, S. (2005). Large-scale social experimentation in Britain: What can and cannot be learnt from the employment retention and advancement demonstration? *Evaluation*, 11(2), 223–242. <http://doi.org/10.1177/1356389005055529>

- Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*, 82(4), 581–629. <http://doi.org/10.1111/j.0887-378X.2004.00325.x>
- Gugiu, P. C., & Ristei Gugiu, M. R. (2010). A critical appraisal of standard guidelines for grading levels of evidence. *Evaluation & the Health Professions*, 33(3), 233–255. <http://doi.org/10.1177/0163278710373980>
- Haggård, U., Freij, I., Danielsson, M., Wenander, D., & Långström, N. (2015). Effectiveness of the IDAP treatment program for male perpetrators of intimate partner violence: A controlled study of criminal recidivism. *Journal of Interpersonal Violence*, 37(7), 1027–1043. <http://doi.org/10.1177/0886260515586377>
- Halford, W. K., & Doss, B. D. (2016). New frontiers in the treatment of couples. *International Journal of Cognitive Therapy*, 9(2), 124–139. <http://doi.org/10.1521/ijct.2016.9.2.124>
- Halket, M. M., Gormley, K., Mello, N., Rosenthal, L., & Mirkin, M. P. (2014). Stay with or leave the abuser? The effects of domestic violence victim's decision on attributions made by young adults. *Journal of Family Violence*, 29(1), 35–49. <http://doi.org/10.1007/s10896-013-9555-4>
- Hamby, S. (2016). Self-report measures that do not produce gender parity in intimate partner violence: A multi-study investigation. *Psychology of Violence*, 6(2), 323–335. <http://doi.org/10.1037/a0038207>
- Hawthorne, G., Herrman, H., & Murphy, B. (2006). Interpreting the WHOQOL-BREF: Preliminary population norms and effect sizes. *Social Indicators Research*, 77(1), 37–59. <http://doi.org/10.1007/s11205-005-5552-1>
- Hegarty, K., & Leung, T. P.-Y. (2017). Interventions to support the identification of domestic violence, response and healing in mental health care settings. *Australian Clinical Psychologist*, 3(1), 5–18. Retrieved from <https://acp.scholasticahq.com/article/1740-interventions-to-support-the-identification-of-domestic-violence-response-and-healing-in-mental-health-care-settings>
- Hegarty, K., O'Doherty, L., Taft, A., Chondros, P., Brown, S., Valpied, J., . . . Gunn, J. (2013). Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): a cluster randomised controlled trial. *The Lancet*, 382(9888), 249–258. [http://doi.org/10.1016/S0140-6736\(13\)60052-5](http://doi.org/10.1016/S0140-6736(13)60052-5)
- Hegarty, K., Tarzia, L., Hooker, L., & Taft, A. (2016). Interventions to support recovery after domestic and sexual violence in primary care. *International Review of Psychiatry*, 28(5), 519–532. <http://doi.org/10.1080/09540261.2016.1210103>
- Hegarty, K., Tarzia, L., Murray, E., Valpied, J., Humphreys, C., Taft, A., . . . Glass, N. (2015). Protocol for a randomised controlled trial of a web-based healthy relationship tool and safety decision aid for women experiencing domestic violence (I-DECIDE). *BMC Public Health*, 15(1). <http://doi.org/10.1186/s12889-015-2072-z>
- Helfritz, L. E., Stanford, M. S., Conklin, S. M., & Greve, K. W. (2006). Usefulness of self-report instruments in assessing men accused of domestic violence. *The Psychological Record*, 56(2), 171–180. <http://doi.org/10.1007/BF03395542>
- Hester, M., & Westmarland, N. (2006). *Service provision for perpetrators of domestic violence*. Bristol: University of Bristol.
- Higginson, I. J., & Carr, A. J. (2001). Measuring quality of life: Using quality of life measures in the clinical setting. *BMJ*, 322(7297), 1297–1300. <http://doi.org/10.1136/bmj.322.7297.1297>
- Humphreys, C., & Campo, M. (2017). *Fathers who use violence: Options for safe practice where there is ongoing contact with children* (CFCA paper no. 43). Canberra: Australian Institute of Family Studies.
- Hunter, T., Botfield, J. R., Estoesta, J., Markham, P., Robertson, S., & McGeechan, K. (2016). Experience of domestic violence routine screening in family planning NSW clinics. *Sexual Health*, 14(2), 155–163. <http://doi.org/10.1071/SH16143>
- Jewkes, R. (2013). Intimate partner violence: The end of routine screening. *The Lancet*, 382(9888), 190–191. [http://doi.org/10.1016/S0140-6736\(13\)60584-X](http://doi.org/10.1016/S0140-6736(13)60584-X)

- Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls. *The Lancet*, 385(9977), 1580–1589. [http://doi.org/10.1016/S0140-6736\(14\)61683-4](http://doi.org/10.1016/S0140-6736(14)61683-4)
- Kamenov, K., Twomey, C., Cabello, M., Prina, A., & Ayuso-Mateos, J. (2017). The efficacy of psychotherapy, pharmacotherapy and their combination on functioning and quality of life in depression: A meta-analysis. *Psychological Medicine*, 47(3), 414–425. <http://doi.org/10.1017/S0033291716002774>
- Karimi, M., & Brazier, J. (2016). Health, health-related quality of life, and quality of life: What is the difference? *PharmacoEconomics*, 34(7), 645–649. <http://doi.org/10.1007/s40273-016-0389-9>
- Keam, G., & Cook, K. (2016). *The framing of federal domestic violence policy responses*. Paper presented at the Refereed Proceedings of TASA 2016 Conference. Retrieved from <https://apo.org.au/node/193896>
- Kelly, L. (1998). *Surviving sexual violence*. Cambridge: Polity Press.
- Kelly, L., & Westmarland, N. (2014). New approaches to assessing effectiveness and outcomes of domestic violence perpetrator programs. In H. Johnson, B. S. Fisher, & V. Jaquier (Eds.), *Critical issues on violence against women: International perspectives and promising strategies* (pp. 183–194). New York: Routledge.
- Kelly, L., & Westmarland, N. (2015). *Domestic violence perpetrator programmes: Steps towards change (Project Mirabal final report)*. Retrieved from <http://repository.londonmet.ac.uk/1458/>
- Klassen, A. C., Creswell, J., Clark, V. L. P., Smith, K. C., & Meissner, H. I. (2012). Best practices in mixed methods for quality of life research. *Quality of Life Research*, 21(3), 377–380. <http://doi.org/10.1007/s11136-012-0122-x>
- Klevens, J., Kee, R., Trick, W., Garcia, D., Angulo, F. R., Jones, R., & Sadowski, L. S. (2012). Effect of screening for partner violence on women's quality of life: A randomized controlled trial. *JAMA*, 308(7), 681–689. <http://doi.org/10.1001/jama.2012.6434>
- Krishnan, S., Subbiah, K., Chandra, P., & Srinivasan, K. (2012). Minimizing risks and monitoring safety of an antenatal care intervention to mitigate domestic violence among young Indian women: The Dil Mil trial. *BMC Public Health*, 12(1), 943–956. <http://doi.org/10.1186/1471-2458-12-943>
- Kulkarni, S. J., Mennicke, A. M., & Woods, S. J. (2018). Intimate partner violence in the workplace: Exploring gender differences in current health-related quality of life. *Violence and Victims*, 33(3), 519–532. <http://doi.org/10.1891/0886-6708.v33.i3.519>
- Leung, T. W., Leung, W. C., Ng, E. H., & Ho, P. C. (2005). Quality of life of victims of intimate partner violence. *International Journal of Gynecology & Obstetrics*, 90(3), 258–262. <http://doi.org/10.1016/j.ijgo.2005.05.010>
- Lilley-Walker, S.-J., Hester, M., & Turner, W. (2016). Evaluation of European domestic violence perpetrator programs: Toward a model for designing and reporting evaluations related to perpetrator treatment interventions. *International Journal of Offender Therapy and Comparative Criminology*, 62(4), 868–884. <http://doi.org/10.1177/0306624X16673853>
- Lysova, A. (2018). A violent event perspective on women's involvement in incidents of severe partner violence. *Violence and Victims*, 33(5), 813–829. <http://doi.org/10.1891/0886-6708.VV-D-17-00094>
- Maciuszek, D., & Shahmehri, N. (2003). *A framework for the specification of multifunctional, adaptive, and realistic virtual companions for later life*. Paper presented at the Proceedings of the International Conference on Aging, Disability and Independence, St. Petersburg, Florida.
- Mackay, E., Gibson, A., Lam, H., & Beecham, D. (2015a). *Perpetrator interventions in Australia: Key findings and future directions*. Sydney: ANROWS.
- Mackay, E., Gibson, A., Lam, H., & Beecham, D. (2015b). *Perpetrator interventions in Australia: Part one—Literature review*. Sydney: ANROWS.
- MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M., . . . Campbell, J. C. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *JAMA*, 302(5), 493–501. <http://doi.org/10.1001/jama.2009.1089>

- Maremmani, I., Pani, P. P., Pacini, M., & Perugi, G. (2007). Substance use and quality of life over 12 months among buprenorphine maintenance-treated and methadone maintenance-treated heroin-addicted patients. *Journal of Substance Abuse Treatment*, 33(1), 91–98. <http://doi.org/10.1016/j.jsat.2006.11.009>
- Matheson, F. I., Daoud, N., Hamilton-Wright, S., Borenstein, H., Pedersen, C., & O'Campo, P. (2015). Where did she go? The transformation of self-esteem, self-identity, and mental well-being among women who have experienced intimate partner violence. *Women's Health Issues*, 25(5), 561–569. <http://doi.org/10.1016/j.whi.2015.04.006>
- Matjasko, J. L., Niolon, P. H., & Valle, L. A. (2013). The role of economic factors and economic support in preventing and escaping from intimate partner violence. *Journal of Policy Analysis and Management*, 32(1), 122–128. <http://doi.org/10.1002/pam.21666>
- McCleary-Sills, J., Crockett, C., & Cooper, B. (2018). Invisible survivors: Causes and consequences of violence against older women and promising solutions. In S. Choudhury, J. T. Erausquin, & M. Withers (Eds.), *Global perspectives on women's sexual and reproductive health across the lifecourse* (pp. 255–271). Cham: Springer.
- McClimans, L., Bickenbach, J., Westerman, M., Carlson, L., Wasserman, D., & Schwartz, C. (2013). Philosophical perspectives on response shift. *Quality of Life Research*, 22(7), 1871–1878. <http://doi.org/10.1007/s11136-012-0300-x>
- McGinn, T., McColgan, M., & Taylor, B. (2017). Male IPV perpetrator's perspectives on intervention and change: A systematic synthesis of qualitative studies. *Trauma, Violence, & Abuse*, 1–16. <http://doi.org/10.1177/1524838017742167>
- McGinn, T., Taylor, B., McColgan, M., & Lagdon, S. (2016). Survivor perspectives on IPV perpetrator interventions: A systematic narrative review. *Trauma, Violence, & Abuse*, 17(3), 239–255. <http://doi.org/10.1177/1524838015584358>
- McIntosh, J. E., & Tan, E. S. (2017). Young children in divorce and separation: Pilot study of a mediation-based co-parenting intervention. *Family Court Review*, 55(3), 329–344. <http://doi.org/10.1111/fcre.12291>
- McLaren, H. J. (2013a). Domestic violence, housing and employment: Workers' perspectives on employment assistance in supported accommodation. *The Australian Journal of Social Issues*, 48(4), 415–433. Retrieved from <https://search.informit.com.au/documentSummary;dn=877988161235598;res=IELHSS>
- McLaren, H. J. (2013b). (Un)-blaming mothers whose partners sexually abuse children: In view of heteronormative myths, pressures and authorities. *Child & Family Social Work*, 18(4), 439–448. <http://doi.org/10.1111/j.1365-2206.2012.00863.x>
- McLaren, H. J. (2016a). Adult women groomed by child molesters' heteronormative dating scripts. *Women's Studies International forum*, 56, 66–73. <http://doi.org/10.1016/j.wsif.2016.02.016>
- McLaren, H. J. (2016b). Falling in love with romantic ideals: Women in relationships with child molesters. *Culture, Health & Sexuality*, 18(2), 143–155. <http://doi.org/10.1080/13691058.2015.1066857>
- McLaren, H. J., Gibson, C., Arney, F., Scott, D., & Brown, L. (2008). *Sowing the seeds of innovation: exploring the utility of diffusion of innovation theory*. Paper presented at the The History & Future of Social Innovation Conference, The Hawke Centre, Adelaide.
- McLaren, H. J., & Goodwin-Smith, I. C. (2016). Hearing their voices: Perceptions of women and men on reducing men's perpetration of domestic violence. Adelaide: Australian Centre for Community Services Research.
- McLaren, H. J., & Kenny, P. L. (2015). Motivating change from lecture-tutorial modes to less traditional forms of teaching. *Australian Universities' Review*, 57(1), 28–33. Retrieved from <https://files.eric.ed.gov/fulltext/EJ1053515.pdf>
- Mendez, M., Horst, K., Stith, S. M., & McCollum, E. E. (2014). Couples treatment for intimate partner violence: Clients' reports of changes during therapy. *Partner Abuse*, 5(1), 21–40. <http://doi.org/10.1891/1946-6560.5.1.21>
- Messing, J. T., & Thaller, J. (2015). Intimate partner violence risk assessment: A primer for social workers. *The British Journal of Social Work*, 45(6), 1804–1820. <http://doi.org/10.1093/bjsw/bcu012>

- Migliore, C., Ziersch, E., & Marshall, J. (2014). *Intervention orders and the intervention response model: Evaluation report 3 (Statistical overview and outcome evaluation)*. Adelaide: Office of Crime Statistics and Research, Attorney-General's Department, Government of South Australia.
- Miller, E. (2017). [Review of the book *Evaluating outcomes in health and social care*, by Helen Dickinson and Janine O'Flynn]. *Medical History*, 61(2), 316–318. <http://doi.org/10.1017/mdh.2017.9>
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*, 151(4), 264–269. <http://doi.org/10.7326/0003-4819-151-4-200908180-00135>
- Morgan, A., Boxall, H., & Brown, R. (2018). Targeting repeat domestic violence: Assessing short term risk of reoffending. *Trends & issues in crime and criminal justice*. No. 552. Canberra: Australian Institute of Criminology.
- Morrison, P. K., Cluss, P. A., Miller, E. P., Fleming, R., Hawker, L., Bicehouse, T., . . . Chang, J. C. (2016). Elements needed for quality batterer intervention programs: Perspectives of professionals who deal with intimate partner violence. *Journal of Family Violence*, 32(5), 481–491. <http://doi.org/10.1007/s10896-016-9835-x>
- Moss, D. (2016). De-centered and influential practice in men's behavior change programs: Possibilities and challenges. *Journal of Systemic Therapies*, 35(3), 1–14. <http://doi.org/10.1521/jsyt.2016.35.3.1>
- Muldoon, M. F., Barger, S. D., Flory, J. D., & Manuck, S. B. (1998). What are quality of life measurements measuring? *British Medical Journal*, 316(7130), 542–545. <http://doi.org/10.1136/bmj.316.7130.542>
- Murphy, B., Herrman, H., Hawthorne, G., Pinzone, T., & Evert, H. (2000). The World Health Organization Quality of Life (WHOQOL) Study: Australian WHOQOL-100, WHOQOL-BREF and CA-WHOQOL instruments user's manual and interpretation guide. Melbourne: WHOQOL Field Study Centre, Department of Psychiatry, University of Melbourne and St Vincent's Mental Health Service.
- Najman, J. M., & Levine, S. (1981). Evaluating the impact of medical care and technologies on the quality of life: A review and critique. *Social Science & Medicine. Part F: Medical and Social Ethics*, 15(2–3), 107–115. [http://doi.org/10.1016/0271-5392\(81\)90012-5](http://doi.org/10.1016/0271-5392(81)90012-5)
- Nyström, M. E., Strehlenert, H., Hansson, J., & Hasson, H. (2014). Strategies to facilitate implementation and sustainability of large system transformations: A case study of a national program for improving quality of care for elderly people. *BMC Health Services Research*, 14(1). <http://doi.org/10.1186/1472-6963-14-401>
- O'Doherty, L. J., MacMillan, H., Feder, G., Taft, A., Taket, A., & Hegarty, K. (2014). Selecting outcomes for intimate partner violence intervention trials: Overview and recommendations. *Aggression and Violent Behavior*, 19(6), 663–672. <http://doi.org/10.1016/j.avb.2014.09.010>
- Patrick, D. L., Burke, L. B., Gwaltney, C. J., Leidy, N. K., Martin, M. L., Molsen, E., & Ring, L. (2011). Content validity—establishing and reporting the evidence in newly developed patient-reported outcomes (PRO) instruments for medical product evaluation: ISPOR PRO good research practices task force report: Part 1—eliciting concepts for a new PRO instrument. *Value in Health*, 14(8), 967–977. <http://doi.org/10.1016/j.jval.2011.06.014>
- Patrick, D. L., & Erickson, P. (1993). Assessing health-related quality of life for clinical decision-making. In S. R. Walker, & R. M. Rosser (Eds.), *Quality of life assessment: Key issues in the 1990s* (pp. 11–63). Dordrecht: Springer.
- Patrick, D. L., Guyatt, G. H., & Acquadro, C. J. (2008). Patient-reported outcomes. In P. T. Higgins, & S. Green (Eds.), *Cochrane handbook for systematic reviews of interventions* (pp. 531–546). Chichester: Cochrane Collaboration and Wiley-Blackwell.
- Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York: Springer Publishing Company.
- Phillips, D. (2006). *Quality of life: Concept, policy and practice*. Milton Park: Routledge.

- Ramsay, J., Carter, Y., Davidson, L., Dunne, D., Eldridge, S., Hegarty, K., . . . Feder, G. (2009). Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *The Cochrane Database of Systematic Reviews*, 8(3). <http://doi.org/10.1002/14651858.CD005043.pub2>
- Reeve, B. B., Wyrwich, K. W., Wu, A. W., Velikova, G., Terwee, C. B., Snyder, C. F., . . . Butt, Z. (2013). ISOQOL recommends minimum standards for patient-reported outcome measures used in patient-centered outcomes and comparative effectiveness research. *Quality of Life Research*, 22(8), 1889–1905. <http://doi.org/10.1007/s11136-012-0344-y>
- Ridgeway, J. L., Beebe, T. J., Chute, C. G., Eton, D. T., Hart, L. A., Frost, M. H., . . . Sloan, J. A. (2013). A brief patient-reported outcomes quality of life (PROQOL) instrument to improve patient care. *PLoS Medicine*, 10(11), e1001548. <http://doi.org/10.1371/journal.pmed.1001548>
- Rivas, C., Ramsay, J., Sadowski, L., Davidson, L. L., Dunne, D., Eldridge, S., . . . Feder, G. (2015). *Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review)*. *The Cochrane Database of Systematic Reviews*, 12. <http://doi.org/10.1002/14651858.CD005043.pub3>
- Rivett, M., & Rees, A. (2013). Working with perpetrators and victims of domestic violence. In S. Green, E. Lancaster, & S. Feasey (Eds.), *Addressing offending behaviour: Context, practice and value* (pp. 344–364). Milton Park: Routledge.
- Robbins, R., & Cook, K. (2017). ‘Don’t even get us started on social workers’: Domestic violence, social work and trust—An anecdote from research. *The British Journal of Social Work*, 48(6), 1664–1681. <http://doi.org/10.1093/bjsw/bcx125>
- Roberts, D., Chamberlain, P., & Delfabbro, P. (2015). Women’s experiences of the processes associated with the family court of Australia in the context of domestic violence: A thematic analysis. *Psychiatry, Psychology and Law*, 22(4), 599–615. <http://doi.org/10.1080/13218719.2014.960132>
- Robinson, A., & Payton, J. (2016). Independent advocacy and multi-agency responses to domestic violence. In S. Hilder & V. Bettinson (Eds.), *Domestic violence: Interdisciplinary perspectives on protection, prevention and intervention* (pp. 249–271). London: Palgrave Macmillan UK.
- Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52(1), 141–166. <http://doi.org/10.1146/annurev.psych.52.1.141>
- Ryff, C. D., & Singer, B. H. (2013). Know thyself and become what you are: A eudaimonic approach to psychological well-being. In A. Delle Fave (Ed.), *The exploration of happiness: Present and future perspectives* (pp. 97–116). Dordrecht: Springer Netherlands.
- Saletti-Cuesta, L., Aizenberg, L., & Ricci-Cabello, I. (2018). Opinions and experiences of primary healthcare providers regarding violence against women: A systematic review of qualitative studies. *Journal of Family Violence*, 33(6), 405–420. <http://doi.org/10.1007/s10896-018-9971-6>
- Sansoni, J. (2016). *Health outcomes: An overview from an Australian perspective*. Sydney: Australian Health Outcomes Collaboration, Australian Health Services Research Institute, University of Wollongong.
- Schallock, R. L., & Verdugo, M. A. (2012). A conceptual and measurement framework to guide policy development and systems change. *Journal of Policy and Practice in Intellectual Disabilities*, 9(1), 63–72. <http://doi.org/10.1111/j.1741-1130.2012.00329.x>
- Schlenk, E. A., Erlen, J. A., Dunbar-Jacob, J., McDowell, J., Engberg, S., Sereika, S. M., . . . Bernier, M. J. (1997). Health-related quality of life in chronic disorders: A comparison across studies using the MOS SF-36. *Quality of Life Research*, 7(1), 57–65. <http://doi.org/10.1023/A:1008836922089>
- Schwarz, N., & Strack, F. (1999). Reports of subjective well-being: Judgmental processes and their methodological implications. In D. Kahneman, E. Diener, & N. Schwarz (Eds.), *Well-being: The foundations of hedonic psychology* (pp. 61–84). New York: Russel Sage Foundation.

- Shorey, R. C., Zucosky, H., Brasfield, H., Febres, J., Cornelius, T. L., Sage, C., & Stuart, G. L. (2012). Dating violence prevention programming: Directions for future interventions. *Aggression and Violent Behavior, 17*(4), 289–296. <http://doi.org/10.1016/j.avb.2012.03.001>
- Skevington, S. M., Lotfy, M., & O’Connell, K. A. (2004). The World Health Organization’s WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A report from the WHOQOL Group. *Quality of Life Research, 13*(2), 299–310. <http://doi.org/10.1023/B:QURE.0000018486.91360.00>
- Skevington, S. M., & McCrate, F. M. (2012). Expecting a good quality of life in health: assessing people with diverse diseases and conditions using the WHOQOL-BREF. *Health expectations, 15*(1), 49–62. <http://doi.org/10.1111/j.1369-7625.2010.00650.x>
- Sorde Marti, T., & Mertens, D. M. (2014). Mixed methods research with groups at risk: New developments and key debates. *Journal of Mixed Methods Research, 8*(3), 207–211. <http://doi.org/10.1177/1558689814527916>
- Spencer, P. (2016). Strengthening the web of accountability: Criminal courts and family violence offenders. *Alternative Law Journal, 41*(4), 225–229. <http://doi.org/10.1177/1037969X1604100402>
- Strada, L., Vanderplasschen, W., Buchholz, A., Schulte, B., Muller, A. E., Verthein, U., & Reimer, J. (2017). Measuring quality of life in opioid-dependent people: A systematic review of assessment instruments. *Quality of Life Research, 26*(12), 3187–3200. <http://doi.org/10.1007/s11136-017-1674-6>
- Sullivan, C. M., Bybee, D. I., & Allen, N. E. (2002). Findings from a community-based program for battered women and their children. *Journal of Interpersonal Violence, 17*(9), 915–936. <http://doi.org/10.1177/0886260502017009001>
- Sullivan, C. M., Tan, C., Basta, J., Rumptz, M., & Davidson, W. S. (1992). An advocacy intervention program for women with abusive partners: Initial evaluation. *American Journal of Community Psychology, 20*(3), 309–332. <http://doi.org/10.1007/BF00937912>
- Taft, A. J., O’Doherty, L., Hegarty, K., Ramsay, J., Davidson, L., & Feder, G. (2013). Screening women for intimate partner violence in healthcare settings (Review). *The Cochrane Database of Systematic Reviews, 4*. <https://doi.org/10.1002/14651858.CD007007.pub2>
- Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach’s alpha. *International Journal of Medical Education, 2*, 53–55. <http://doi.org/10.5116/ijme.4dfb.8dfd>
- Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., & Rivara, F. P. (2006). Intimate partner violence: Prevalence, types, and chronicity in adult women. *American Journal of Preventive Medicine, 30*(6), 447–457. <http://doi.org/10.1016/j.amepre.2006.01.016>
- Tiwari, A., Fong, D. Y. T., Yuen, K. H., Yuk, H., Pang, P., Humphreys, J., & Bullock, L. (2010). Effect of an advocacy intervention on mental health in Chinese women survivors of intimate partner violence: A randomized controlled trial. *JAMA, 304*(5), 536–543. <http://doi.org/10.1001/jama.2010.1052>
- Tiwari, A., Leung, W., Leung, T., Humphreys, J., Parker, B., & Ho, P. (2005). A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG: An International Journal of Obstetrics & Gynaecology, 112*(9), 1249–1256. <http://doi.org/10.1111/j.1471-0528.2005.00709.x>
- Tollefson, D. R., Webb, K., Shumway, D., Block, S. H., & Nakamura, Y. (2009). A mind-body approach to domestic violence perpetrator treatment: Program overview and preliminary outcomes. *Journal of Aggression, Maltreatment & Trauma, 18*(1), 17–45. <http://doi.org/10.1080/10926770802610657>
- United Nations General Assembly. (1948). *The universal declaration of human rights*. Geneva: United Nations.
- United Nations General Assembly. (1993). *Declaration on the elimination of violence against women*. Geneva: United Nations.
- Vall, B. (2017). *Nordic countries overview of work with perpetrators of intimate partner violence*. Copenhagen: Nordic Council of Ministers.



- Vaughan, C., Murdolo, A., Murray, L., Davis, E., Chen, J., Block, K., . . . Warr, D. (2015). ASPIRE: A multi-site community-based participatory research project to increase understanding of the dynamics of violence against immigrant and refugee women in Australia. *BMC Public Health*, 15(1), 8–10. <http://doi.org/10.1186/s12889-015-2634-0>
- Verdugo, M. A., Schalock, R. L., Keith, K. D., & Stancliffe, R. J. (2005). Quality of life and its measurement: Important principles and guidelines. *Journal of Intellectual Disability Research*, 49(10), 707–717. <http://doi.org/10.1111/j.1365-2788.2005.00739.x>
- Vlais, R., Ridley, S., Green, D., & Chung, D. (2017). *Family and domestic violence perpetrator programs: Issues paper of current and emerging trends, developments and expectations*. Perth: Stopping Family Violence.
- Von Ah, D. M., Russell, K. M., Carpenter, J., Monahan, P. O., Zhao, Q., Tallman, E., . . . Champion V. L. (2012). Health-related quality of life of African American breast cancer survivors compared to healthy African American women. *Cancer Nursing*, 35(5), 337–346. <http://doi.org/10.1097/NCC.0b013e3182393de3>
- Walsh, J., Spangaro, J., & Soldatic, K. (2015). Global understandings of domestic violence. *Nursing & Health Sciences*, 17(1), 1–4. <http://doi.org/10.1111/nhs.12197>
- Wendt, S., & Zannettino, L. (2014). *Domestic violence in diverse contexts: A re-examination of gender*. New York: Routledge.
- Westmarland, N., & Kelly, L. (2012). Why extending measurements of ‘success’ in domestic violence perpetrator programmes matters for social work. *British Journal of Social Work*, 43(6), 1092–1110. <http://doi.org/10.1093/bjsw/bcs049>
- Westmarland, N., McGlynn, C., & Humphreys, C. (2018). Using restorative justice approaches to police domestic violence and abuse. *Journal of Gender-Based Violence*, 2(2), 339–358. <http://doi.org/10.1332/239868018X15266373253417>
- Whitaker, D. J., Murphy, C. M., Eckhardt, C. I., Hodges, A. E., & Cowart, M. (2013). Effectiveness of primary prevention efforts for intimate partner violence. *Partner Abuse*, 4(2), 175–195. <http://doi.org/10.1891/1946-6560.4.2.175>
- Williams, K., Sansoni, J., Morris, D., Grootemaat, P., & Thompson, C. (2016). *Patient-reported outcome measures: Literature review*. Sydney: Australian Commission on Safety and Quality in Health Care.
- Wittenberg, E., Joshi, M., Thomas, K. A., & McCloskey, L. A. (2007). Measuring the effect of intimate partner violence on health-related quality of life: A qualitative focus group study. *Health and Quality of Life Outcomes*, 5(67), 1–7. <http://doi.org/10.1186/1477-7525-5-67>
- Wonders, N. A. (2018). Climate change, the production of gendered insecurity and slow intimate partner violence. In K. Fitz-Gibbon, S. Walklate, J. McCulloch, & J. M. Maher (Eds.), *Intimate partner violence, risk and security: Securing women’s lives in a global world* (pp. 34–52). London: Routledge.
- Wood-Dauphinee, S. (1999). Assessing quality of life in clinical research: From where have we come and where are we going? *Journal of Clinical Epidemiology*, 52(4), 355–363. [https://doi.org/10.1016/S0895-4356\(98\)00179-6](https://doi.org/10.1016/S0895-4356(98)00179-6)
- World Health Organization Quality of Life Group. (1998a). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), 551–558. <http://doi.org/10.1017/s0033291798006667>
- World Health Organization Quality of Life Group. (1998b). The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties. *Social Science & Medicine*, 46(12), 1569–1585. [https://doi.org/10.1016/S0277-9536\(98\)00009-4](https://doi.org/10.1016/S0277-9536(98)00009-4)
- World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: WHO.
- Wozniak, D. F. (2009). Rites of passage and healing efficacy: an ethnographic study of an intimate partner violence intervention. *Global Public Health*, 4(5), 453–463. <http://doi.org/10.1080/17441690902815488>
- Zollfrank, A. A., Trevino, K. M., Cadge, W., Balboni, M. J., Thiel, M. M., Fitchett, G., . . . Balboni, T. A. (2015). Teaching health care providers to provide spiritual care: A pilot study. *Journal of Palliative Medicine*, 18(5), 408–414. <http://doi.org/10.1089/jpm.2014.0306>

Zosky, D. (2016). Changing hostile beliefs towards women through partner abuse intervention programs. *Open Journal of Social Sciences*, 4(2), 99–107. <http://doi.org/10.4236/jss.2016.42014>

Zubaran, C., & Foresti, K. (2009). Quality of life and substance use: Concepts and recent tendencies. *Current Opinion in Psychiatry*, 22(3), 281–286. <http://doi.org/10.1097/YCO.0b013e328328d154>

# Appendix A:

## Overview of the interview schedule

### Part 1–Demographic questions

1. How old are you? Age in years (*put "0" if prefer not to say*)
  
2. Who do you live with? (*select all that apply*)
  1. I live alone
  2. With my spouse or partner or boyfriend
  3. My children
  4. My parents or siblings or extended relatives
  5. Friends or housemates
  6. Homeless
  7. Other (please specify \_\_\_\_\_)
  
3. What is your current accommodation? (*select one response only*)
  1. Paying off a mortgage or own home
  2. Private or public renting
  3. Boarding with parents or siblings or extended relatives
  4. Boarding with friends
  5. Caravan park or hostel or boarding house
  6. Sheltered accommodation or refuge
  7. Homeless
  8. Other (please specify \_\_\_\_\_)
  
4. Do you currently undertake paid work? (*select one response only*)
  1. Yes, full-time
  2. Yes, part-time
  3. Yes, casual
  4. No, I do not undertake any paid work
  5. No, I am a student
  6. No, I receive government support
  7. Other (please specify \_\_\_\_\_)

5. What is the highest level of education you have completed? *(select one response only)*

1. Primary school
2. Year 10
3. Year 12
4. Certificate or diploma
5. Degree
6. Other (please specify \_\_\_\_\_)

## Part 2—Qualitative question on the women’s definition for QOL

6. When anyone mentions the term “quality of life”, what does QOL mean to you?

## Part 3—Administer the WHOQOL-BREF

The WHOQOL-BREF (WHOQOL Group, 1998a) instrument comprises two global items: global QOL and satisfaction with health.

This is followed by the remaining 24 items to measure QOL across four QOL domains—physical health (seven items), psychological health (six items), social relationships (three items) and environment (eight items) (see Appendix D) (Skevington et al., 2004). Items are measured via 5-point Likert scales.

## Part 4—Qualitative questions about the women’s QOL

7. Thinking about your life as a whole, what is it that makes your life good—that is, the things that give your life quality?

Prompts:

- You may mention as many things as you like.
- Can you please provide an example of what you mean by ...?

8. What is it that makes your life bad—that is, the things that reduce the quality in your life?

Prompt:

- You may mention as many things as you like.

## Part 5—Administer the CAS<sub>R</sub>-SF

The CAS<sub>R</sub>-SF (Ford-Gilboe et al., 2016) asks women about their relationship status, including whether they have been in an adult intimate relationship, whether currently in a relationship, and if they are currently or have ever been afraid of their current or any partner.

In relation to any partner, women are asked to identify if they have ever experienced any IPV type per the 15 composite abuse items and, if in the last 12 months, to indicate frequency on a 6-point Likert scale:

- blamed me for causing their violent behaviour;
- shook, pushed, grabbed or threw me;
- tried to convince my family, children or friends that I am crazy or tried to turn them against me;
- used or threatened to use a knife or gun or other weapon to harm me;
- made me perform sex acts that I did not want to perform;
- followed me or hung around outside my home or work;
- threatened to harm or kill me or someone close to me;
- choked me;
- forced or tried to force me to have sex;
- harassed me by phone, text, email or using social media;
- told me I was crazy, stupid or not good enough;
- hit me with a fist or object, kicked or bit me;
- kept me from seeing or talking to my family or friends;
- confined or locked me in a room or other space; and
- kept me from having access to a job, money or financial resources (Ford-Gilboe et al., 2016, pp. 12-13).

9. How have you responded to the CAS<sub>R</sub>-SF questions?

1. In relation to current relationship/s
2. In relation to former relationship/s
3. Combination of both

## Part 6—Partner’s MPI involvement

10. Has your current/ex-partner ever been involved in a men’s perpetrator intervention program? (*select one response only*)

1. Currently, 1-3 months
2. Currently, 3-6 months
3. Currently, 6-12 months
4. Currently, 1-2 years
5. Ever (2 years or more ago)
6. Never

11. Prior to his commencement of the program, how would you have rated your quality of life? *(Select one response only)*

1. Very poor
2. Poor
3. Neither poor nor good
4. Good
5. Very good

12. How satisfied are/were you with the program? *(select one response only)*

1. Very dissatisfied
2. Dissatisfied
3. Neither dissatisfied nor satisfied
4. Satisfied
5. Very satisfied

13. What are some of the things the MPIs could change that would make life better for you?

Prompts:

- You may mention as many things as you like.
- Can you please provide an example of what you mean by ...?

14. Is there anything else you would like to add?

Thank you for your time.

# Appendix B:

## Coding of qualitative data

The tables in this appendix represent the broad QOL themes identified from the thematic analysis of qualitative data. As analytical spreadsheets, they show the coding of words, short phrases and descriptive labels (generated by the researchers to represent segments of the transcripts). These were consolidated as QOL themes.

**Table 7** Fear and violence theme

Concepts	Codes	Sub-totals	Totals
<b>Safety from IPV</b>	Feeling and being safe/having and feeling a sense of security	52	
	Physical safety/physical abuse/free from physical abuse	13	
	Emotional safety/emotional abuse/emotional blackmail/emotional manipulation/held captive emotionally (or psychologically) during the relationship	6	
	Continuation of emotional abuse after MPI/after relationship ends	2	
	Verbal abuse/put downs/criticism	13	<b>86</b>
<b>Fear</b>	Living in fear/feeling scared/being scared/feeling vulnerable	6	
	Fear is ongoing/no safe place/walking on eggshells	22	
	Not worried about getting into trouble/not having to watch my back all the time/not scared to come home	7	<b>35</b>
<b>Isolation</b>	Isolation instigated by partner (current or former)	7	
	Isolation consequence of abuse/unable to socialise/isolation from friends/isolation from family	27	<b>34</b>
<b>Theme total</b>		155	<b>155</b>

**Table 8** Self-determination theme

Concepts	Codes	Sub-totals	Totals
<b>Autonomy</b>	Own identity/a life with self-agency/make decisions/do what I want when I want/come home when I want/choose who I go out with and where/not having to answer to others/not being free	25	
	Living without hindrances/not hiding friendships/going out without monitoring/work without monitoring	14	
	Independence/live independently/being myself/having my own space/manage own finances/not answering to anyone/being in control	23	
	Freedom/no freedom/not hiding what is going on/speak without consequences/going out and being herself/freedom and access to external supports/free of him	26	
	Courage to leave/able to leave/helpless/self-respect/morals/being a good person/living true to one's values and beliefs/being at ease with herself and choices/life measuring up to expectations/inner peace with self/being thankful/faith	29	<b>117</b>
<b>Meaningful life</b>	Having a sense of purpose/able to plan/goals/life with meaning/goals, planning and future	22	
	Moving from survival to growth/thriving/motivation for self-care/meeting own expectations/getting in touch with own growth and maturity/achieving	13	
	Hope/having hope/something to live for	14	<b>49</b>
<b>Theme total</b>		166	<b>166</b>



Table 9 Basic needs theme

Concepts	Codes	Sub-totals	Totals
<b>Money</b>	Financial security/enough to enjoy social life/financial freedom/being comfortable/enough plenty	26	
	Financial survival/worse off than partner/enough for basic needs	29	<b>55</b>
<b>Employment</b>	Having a job/able to get a job/employment flexibility	31	
	Job satisfaction/work life balance	27	<b>58</b>
<b>Food</b>	Enough food to eat	17	
	Good food to eat	6	<b>23</b>
<b>Transport</b>	Transport with no restrictions	2	
	Having a car/run my own car/access to vehicle	6	<b>8</b>
<b>Education</b>	Access to study/studying/university	10	<b>10</b>
<b>Housing</b>	Somewhere to sleep/social housing/wanted a safe place/not community housing with drug addicts/stable housing/long term lease	12	
	Warm/nice home/clean house/my own house	9	<b>21</b>
<b>Clothing</b>	Enough clothing/warm clothing	3	<b>3</b>
<b>Theme total</b>		178	<b>178</b>

Table 10 Wellbeing theme

Concepts	Codes	Sub-totals	Totals
Physical health	Being healthy/good health	31	<b>43</b>
	Ill health/disability/no health	7	
	Being alive/feeling alive/pain free days	5	
Mental health	Stress/anxiety/able or unable to relax/stressful home environment/worrying/no stress/not having hassles in life/activities that are relaxing/relaxation/me time	36	<b>74</b>
	Depression/depression related lack of energy/negative thinking/being able to taste my food	14	
	Psychological wellbeing generally/feeling loved/feeling good about self/emotional wellness/stable mental health/spiritual wellbeing	20	
	Feeling alone/sense of not belonging	3	
	Stability/consistency/routine/quality self-reflection	1	
Emotional health	Shame/hiding the abuse from family and friends/being honest to others about the IPV/couldn't talk/shame is enormous	5	<b>94</b>
	Stigma/being judged/feeling judged/he pulls faces	6	
	Happiness general/being able to laugh/happy life.	35	
	Able to enjoy life/able to undertake interests (e.g. music, jogging, yoga, travelling, beach walks etc.)/happy life	31	
	Feeling content/at peace/peace and quiet	17	
<b>Theme total</b>		<b>211</b>	<b>211</b>

Table 11 Social systems theme

Concepts	Codes	Sub-totals	Totals
Informal supports	Family/having family contact/access to family	36	<b>101</b>
	Friends/friendships/being able to trust friends	51	
	Intimate partner/loving intimate partner/not having hassles with him/communication/time together/no betrayal	14	
Children and pets	Caring for children/a life with children/time with children/happy times/pleasing and meaningful activities/a balanced life with children/good relationships/togetherness	26	<b>82</b>
	Ensuring children's needs are met/are comfortable/welfare of children/attending school/developing routine and structure/have routine and structure/stability/caring for them/provide/nurture	25	
	Being part of keeping the children safe/family safety/parenting children safely	14	
	Caring for pets/animals/pets are part of the family	17	
Community engagement	Participation in the community/involved in the community/helping the community/give back to the community/good neighbours/social status among peers	21	<b>25</b>
	Able to stay in own community	4	
Formal supports	Court system/trusting courts/custody matters/coping with the system/lack of understanding of IPV/authoritative mess/system failure/minimisation of IPV in divorce contexts	29	<b>40</b>
	Institutions/supportive services/free counselling/safety with authorities/access to appropriate counselling/appropriate responding to perpetrators' breaching of court orders	11	
Theme total		248	<b>248</b>

# Appendix C:

## Quantitative data

**Table 12** Demographic characteristics of women participants (N=100)

Demographic characteristic		Total N=100	
		n	%
Living arrangements <sup>a</sup>	With children	61	61
	With a spouse/partner/boyfriend	31	31
	Alone	17	17
	With relatives	11	11
	With friends/house mates	4	4
	Homeless	2	2
	Other	1	1
Accommodation	Renting	52	52
	Mortgage/own home	35	35
	Other	13	13
Work	Yes, casual	16	16
	Yes, part-time	25	25
	Yes, full-time	18	18
	No paid work	18	18
	Student	8	8
	Government support	12	12
	Other	3	3
Education	Completed Year 12 or equivalent	85	85
	Did not complete Year 12 or equivalent	15	15
Currently in a relationship	Yes	44	44
	No	56	56

Note: <sup>a</sup> This characteristic does not sum to 100 as multiple responses were possible.

Table 13 IPV experiences (ever) of women participants (N=100)

Demographic characteristic	Total N=100	
	<i>n</i>	%
Current	28	28
Former	64	64
Both	8	8

Table 14 IPV experiences (last 12 months) of women participants (N=70)

Recent IPV experience	Total N=70	
	<i>n</i>	%
Current	27	39
Former	36	51
Both	7	10

Table 15 IPV forms experienced (last 12 months) by women participants (N=70)

IPV forms experienced	Not recent		Recent	
	<i>n</i>	%	<i>n</i>	%
Blamed for causing violent behaviour	13	19	57	81
Shook, pushed, grabbed or threw person	27	39	42	60
Tried to convince others that participant was crazy	17	24	52	74
Used or threatened to use a weapon to harm them	54	77	16	23
Made to perform unwanted sex acts	43	61	27	39
Followed or hung around outside work	38	54	32	46
Threatened to harm or kill someone close to participant	41	59	29	41
Choked participant	49	70	20	29
Forced or tried to force having sex	45	64	25	36
Harassed by phone, text, email or social media	20	29	50	71
Told was crazy, stupid or not good enough	10	14	59	84
Hit, kicked or been bit	35	50	35	50
Stopped from seeing family or friends	32	46	36	51
Confined or locked in a room or other space	46	66	23	33
Kept from accessing a job, money or financial resources	25	36	44	63

**Table 16** IPV perpetrator's participation (ever) in MPI (N=100)

MPI participation	Total N=100	
	n	%
Recent	27	27
Ever	45	45
Never	27	27
Missing	1	1

**Table 17** QOL of women participants (N=100)

MPI participation	Total N=100	
	n	%
Very good	14	14
Good	33	33
Neither good nor poor	27	27
Poor	22	22
Very poor	4	4

**Table 18** QOL of women participants, WHOQOL-BREF domains (N=100)

WHOQOL-BREF domain	N=100		
	Mean	Median	Standard deviation
Physical health	58	61	22
Psychological health	50	50	21
Social relationships	49	50	27
Environment	60	63	22

**Table 19** Fear and QOL amongst women who responded to the question “are you currently afraid of your partner?” (N=63)

WHOQOL-BREF domain	Yes n=36			No n= 27			Total N= 63		
	Mean	Median	Standard deviation	Mean	Median	Standard deviation	Mean	Median	Standard deviation
Physical health	47	43	22	66	72	21	56	54	23
Psychological health	38	38	19	58	58	17	47	46	21
Social relationships	36	33	26	60	58	24	46	42	27
Environment	43	41	20	73	75	15	56	56	23

**Table 20** Fear and QOL amongst women who responded in the affirmative to the question “are you currently afraid of your partner?” (N=36)

WHOQOL-BREF domain	In the last 12 months n=18			12 months or more/never n=18		
	Mean	Median	Standard deviation	Mean	Median	Standard deviation
Physical health	42	39	19	55	48	24
Psychological health	33	29	15	44	42	22
Social relationships	32	29	17	41	33	32
Environment	36	34	17	51	45	21

# Appendix D:

## WHOQOL-BREF domains and items

Table 6 WHOQOL-BREF domains and items

Domain	Items
Global QOL	How would you rate your quality of life?
Global health satisfaction	How satisfied are you with your health?
Physical health	To what extent do you feel that physical <i>pain</i> prevents you from doing what you need to do? How much do you need any <i>medical treatment</i> to function in your daily life? Do you have enough <i>energy</i> for everyday life? How well are you able to <i>get around</i> ? How satisfied are you with your <i>sleep</i> ? How satisfied are you with your ability to perform your <i>daily living</i> activities? How satisfied are you with your capacity for <i>work</i> ?
Psychological health	How much do you <i>enjoy</i> life? To what extent do you feel your life to be <i>meaningful</i> ? How well are you able to <i>concentrate</i> ? Are you able to accept your <i>bodily appearance</i> ? How often do you have negative feelings such as <i>blue mood, despair, anxiety, depression</i> ? How satisfied are you with <i>yourself</i> ?
Social relations	How satisfied are you with your <i>personal relationships</i> ? How satisfied are you with your <i>sex life</i> ? How satisfied are with the support you get from your <i>friends</i> ?
Environment	How <i>safe</i> do you feel in your daily life? How healthy is your <i>physical environment</i> ? Have you enough <i>money</i> to meet your needs? How available to you is the <i>information</i> that you need in your daily-to-day life? To what extent do you have the opportunity for <i>leisure</i> activities? How satisfied are you with the conditions of your <i>living place</i> ? How satisfied are you with your <i>access to health services</i> ? How satisfied are you with <i>transport</i> ?

Source: Skevington et al. (2004)



This page has intentionally been left blank.

This page has intentionally been left blank.

ANROWS

# ANROWS

AUSTRALIA'S NATIONAL RESEARCH  
ORGANISATION FOR WOMEN'S SAFETY

*to Reduce Violence against Women & their Children*

