RooftopSocial

Appendix B: NSW Post-MBCP Accountability and Safety Support Model

Prepared for NSW Department of Communities and Justice

Acknowledgement

The development of the Post-MBCP Accountability and Safety Support Model has been informed by the expertise, experience and generosity of a wide range of practitioners, subject matter experts, peak bodies and service leaders across New South Wales and nationally.

We acknowledge the practitioners working in men's behaviour change programs, victim-survivor advocacy services, Aboriginal Community Controlled Organisations, and allied domestic and family violence services who contributed their time, insight and practice wisdom through consultations, written submissions and peer dialogue. Their grounded expertise and commitment to survivor and child safety have been central to shaping a model that is practical, culturally governed and responsive to system realities.

We also acknowledge the contribution of subject matter experts and peak organisations who shared evidence, policy insight and critical reflection to strengthen the model's integrity, safety scaffolding and alignment with best practice and standards. Their guidance has helped ensure the framework is evidence-informed, survivor-centred and attentive to the risks of program drift and unintended harm.

This work reflects a collective investment in strengthening accountability, safety and system coherence beyond program completion. We thank all contributors for their leadership, rigour and ongoing commitment to improving outcomes for women, children and communities.

Executive Summary

The Post Men's Behaviour Change Program (MBCP) Accountability and Support model provides a consistent, survivor-centred structure for supporting men after completion of an MBCP in New South Wales (NSW). It addresses current gaps in accountability, risk visibility and system coordination during the period when instability and harm can increase and when survivors often carry the monitoring burden.

The model introduces a tapered, risk-scaled approach that integrates case management, structured facilitator check-ins, Risk Safety and Support Framework (RSSF)–aligned risk monitoring, survivor advocacy pathways and criminogenic goal setting. Where relevant, the model embeds Aboriginal Community Controlled Organisation (ACCO)-led pathways, cultural supervision, cultural healing and on-Country elements as core mechanisms that strengthen accountability and uphold cultural authority.

The model recognises the structural, cultural and geographic barriers faced by Aboriginal communities, culturally and linguistically diverse men, people in regional and remote areas, LGBTQIA+ participants, people with disability and those experiencing socio-economic disadvantage. It positions cultural safety, language access, accessibility and strong survivor pathways as features of safe, equitable practice.

The model is delivered in alignment with the NSW Practice Standards for MBCPs, which apply in full to the post-MBCP phase, including supervision, workforce capability, cultural safety and survivor-advocacy requirements.

A three-year pilot will test the model, examining feasibility, acceptability, safety, fidelity and early behavioural and system indicators. Recidivism is treated as contextual information rather than evidence of program effectiveness. Future funding may allow additional pilots to test alternative eligibility pathways, varied case management intensity and ACCO-led delivery streams in different regions.

The model's theory of change centres survivor and child safety as its primary outcome, with expected early shifts in men's accountability, stability and responsibility-taking, and improved system coherence and cultural safety. The accompanying Monitoring, Evaluation and Learning framework adopts survivor-informed, culturally governed indicators and mixed-method evidence to guide refinement throughout the pilot.

1 Overview

Across NSW there is currently no unified model for sustaining men's accountability and safe behaviour after completion of a Men's Behaviour Change Program (MBCP). Existing post-program responses are localised and vary in structure, intensity and linkage to survivor advocacy.

This Post-MBCP Accountability and Safety Support responds to this gap by establishing a consistent, survivor-centred framework that integrates behaviour-change maintenance, case management, and ongoing risk review. It recognises that sustained change requires structured contact, clear accountability mechanisms and professional supervision rather than ad hoc or time-limited follow-up.

The problem is most acute where men disengage from services following group completion, leaving victim-survivors without ongoing visibility of risk and systems without coordinated responses. The model therefore positions post-MBCP work asa distinct service phase within the continuum of perpetrator intervention, directly linked to the Risk Safety and Support Framework (RSSF).

The model comprises several integrated components:

- risk-scaled case management that follows a default taper with step-up capacity
- facilitator 1:1 check-ins focused on behavioural accountability
- RSSF-aligned risk assessment and review
- survivor advocacy pathways that maintain safe, voluntary contact
- criminogenic and DFV-specific goal-setting
- structured pro-social activities delivered only with DFV-competent partners
- clear workforce and supervision requirements
- culturally governed pathways for Aboriginal men, including Aboriginal Community-Controlled Organisations (ACCO)-led delivery, cultural supervision, cultural healing and on-Country mechanisms.

These components work together to create a risk-responsive continuum that reinforces responsibility-taking, strengthens system visibility and minimises reliance on survivors to monitor risk.

The model also acknowledges intersectional barriers to engagement. Aboriginal and Torres Strait Islander, culturally and linguistically diverse (CALD), regional, disability and LGBTQIA+ communities experience unique access and trust challenges. Aboriginal community-controlled organisations will lead program design and delivery for Aboriginal men, supported by culturally governed data and evaluation processes.

Hours are flexible and risk-responsive,ensuring that men with higher volatility or escalating risk receive more intensive engagement while maintaining clear boundaries and safety safeguards for victim- survivors.

The accompanying monitoring, evaluation and learning framework prioritises survivor-reported safety, reductions in coercive control, emotional abuse, and parenting-related harm as primary outcomes.

1.1 What the evidence and consultations tell us

Evidence drawn from the 2025 statewide consultations and program evaluations indicates that:

- survivor-centred accountability must anchor all post-MBCP activity. Use of the RSSF provides a consistent, lawful mechanism for information-sharing and risk assessment.
- integrated, risk-scaled case management with professional supervision and clear behavioural goals is critical for sustaining change. Where case management is optional or time-limited, risk visibility declines
- structured engagement patterns, including tapered contact and defined re-entry mechanisms, increase men's accountability and maintain service oversight
- parenting and family-safety programs are effective only when DFV-competent, survivor-informed and clearly separated from any contact-entitlement processes
- cultural governance and Aboriginal community-controlled delivery strengthen program legitimacy, engagement and safety for Aboriginal men, women and children
- evaluation must measure reduction in coercive control and survivor burden, rather than relying solely on criminal recidivism data
- cross-agency collaboration, external supervision and communities of practice are essential to workforce sustainability and program fidelity.

The evidence base for post-MBCP supports is limited but provides useful guidance:

- **change is non-linear**: relapse and re-engagement are expected, not exceptional
- **program dose matters**: light-touch interventions are associated with poor outcomes and increased risk
- **continuity strengthens accountability**: long-term therapeutic relationships improve motivation and reduce disengagement
- **flexibility aids retention**: rolling entry, modular content, and tapered intensity support longer engagement
- **risks must be managed**: poorly governed or under-resourced models can drift, collude, or increase risks for survivors.

These findings establish the empirical and practice foundation for the model and inform the hypotheses to be tested through the pilot implementation phase.

2 The Post-MBCP Accountability and Safety Support model

2.1 Aim

The Post-MBCP Accountability and Safety Support model sets out a structured, evidence-informed framework for supporting men to sustain accountability and non-violence following completion of a MBCP. It defines the key components, workforce requirements and governance structures that will be piloted and evaluated across selected sites.

The model is informed by practice evidence gathered through statewide consultation and program review undertaken in 2025, and it positions post-MBCP work as a distinct, formal phase within the continuum of perpetrator intervention.

The model aims to:

- strengthen men's sustained accountability and support positive changes in reducing their use of violence following completion of an NSW-registered MBCP
- maintain survivor and child safety as the central indicator of program effectiveness
- test components including integrated case-management structures
- establish clear workforce, supervision and cultural governance arrangements to support program integrity
- generate empirical and practice-based evidence to inform statewide post-MBCP standards and long-term service design.

This aim aligns with the objectives of the NSW Domestic and Family Violence Plan 2022-2027, ensuring continuity of risk management and coordinated accountability beyond the core program stage.

2.2 Problem definition

Across NSW there is currently no consistent framework for supporting men to sustain accountability and make positive changes to reduce their use of violence after completing an MBCP. Existing post-program responses vary significantly in duration, intensity, cultural relevance, and their connection to survivor advocacy. This fragmentation creates gaps in risk visibility and limits the system's capacity to maintain safe, coordinated oversight once core group programs conclude. In the absence of a defined post-MBCP phase, the burden of monitoring often falls back onto victim-survivors, creating both inequity and avoidable risk.

A further challenge is the limited continuity between MBCP completion and the broader DFV system. Without structured transition points, tapered engagement, or clear accountability pathways, men may disengage or destabilise at precisely the point when risk can increase. Current arrangements do not reliably embed the RSSF as a mechanism for ongoing assessment, information-sharing and coordinated system responses.

These systemic gaps are experienced unevenly across communities. Engagement, access and safety outcomes vary according to cultural, social, geographic, linguistic and economic factors. Aboriginal and Torres Strait Islander participants face the compounded impacts of colonisation, historical and intergenerational trauma, racism, mistrust of statutory systems, and the ongoing erosion of cultural authority. For many Aboriginal men, healing, accountability, identity and connection to culture are inseparable. Without culturally governed pathways, on-Country elements and ACCO-led delivery, post-MBCP supports do not adequately address the cultural determinants that underpin engagement, responsibility-taking and safety for Aboriginal women and children.

CALD participants also experience barriers to trust, communication and safety. Language access, interpreter quality, migration status, and experiences of discrimination or exclusion can impede understanding of program expectations and limit safe disclosure of risk. For some, family or community dynamics can constrain help-seeking or create risks when interpreting cultural norms. Without active measures to address language and cultural safety, post-MBCP responses can reproduce system-level inequities.

People living in regional and remote areas face further challenges, including limited service availability, workforce shortages, transport barriers and inconsistent access to DFV-competent practitioners. These barriers can undermine continuity, restrict pathways to stabilising supports, and reduce system oversight at key points of risk.

People with disability, LGBTQIA+ participants, and those experiencing socio-economic marginalisation also encounter distinctive forms of exclusion and risk. Services are not always equipped to respond to these intersecting needs, leading to reduced access, reduced trust, and inconsistent safety outcomes.

The model addresses these gaps by establishing a structured, survivor-centred post-program phase that integrates ongoing risk assessment, behavioural maintenance, and DFV-informed case management. Where relevant, it embeds Aboriginal community governance and ACCO-led delivery for Aboriginal men, ensures cultural supervision and on-Country pathways where appropriate, and mandates culturally safe and accessible practice for all participants. By formalising survivor advocacy, culturally governed pathways, and structured risk-responsive engagement, the model provides a consistent mechanism for maintaining safety, accountability and visibility across the DFV system.

2.3 Guiding principles

The post-MBCP model is grounded in a set of guiding principles that express the values and assumptions underpinning all aspects of program design, delivery and

evaluation. They translate practice evidence and stakeholder insights into a shared foundation for consistent, survivor-centred delivery across NSW.

They draw on practice evidence, survivor expertise and Aboriginal community leadership to ensure the model strengthens accountability, safety and trust across the domestic and family violence service system.

Safety and accountability: survivor and child safety, achieved through centring survivor voices and sustained accountability of men who use violence, is the model's core purpose.

Survivor-centred practice: all decisions, processes and measures of success prioritise the experiences, autonomy and safety of victim-survivors and children.

Aboriginal governance and cultural authority: ACCOs lead design, delivery and evaluation of programs tailored for Aboriginal participants. Aboriginal cultural governance is embedded at every level of implementation.

Equity, access and inclusion: the model recognises the diversity of participants and communities, ensuring culturally safe, disability-inclusive, and gender-affirming practice across all settings.

Collaboration and shared responsibility: safety and change are collective outcomes requiring coordination between perpetrator, survivor, community and justice services.

System integrity: strong governance, DFV-informed supervision, and survivor-informed evaluation safeguard against program drift and collusion.

Continuous learning and accountability: the model embeds reflective supervision, practitioner learning, and system review to ensure adaptive improvement.

Evidence-informed learning: the pilot embeds longitudinal, mixed-methods evaluation to generate reliable knowledge about safe and effective practice.

These principles provide the conceptual foundation for the operational model that follows. They define the ethical and systemic conditions under which all program components must operate.

2.4 Hypotheses to be tested

This pilot will test this series of hypotheses to assess feasibility, effectiveness, and safety:

- eligibility: multi-source assessment reduces unsafe admissions, and proxies can substitute effectively when survivor input is unsafe
- retention: integrated case management increases men's retention in post-MBCP program and reduces risks for survivors compared with groups-only models
- dosage: sustained engagement of approximately 40 hours (noting current MBCPs deliver between 30 and 60 hours) with tapered intensity supports long-term change more effectively than short or abrupt models

- motivation: child-centred parenting programs (child-centred, trauma-aware parenting programs) and structured pro-social activities increase retention, positive engagement and outcomes
- system integrity: survivor-informed governance and DFV-informed supervision reduce collusion and program drift
- evaluation: longitudinal and survivor-informed approaches capture reductions in coercive control, emotional abuse, and parenting-related harm more effectively than recidivism data alone.

This pilot will test the post-MBCP model over a three-year period, focusing on feasibility, safety, fidelity and early outcomes.

Future funding may enable additional pilots to test variations, including different eligibility pathways, sequencing and intensity of case management, and ACCO-led delivery streams. These comparative pilots would support more rigorous testing of model components and strengthen the evidence base for statewide scale-up.

2.5 Theory of change

MBCPs provide a critical intervention but cannot, in isolation, guarantee sustained behaviour change. A system that anticipates non-linear change, relapse, and cycles of recommitment is required.

The assumptions underpinning this framework are that:

- change is possible but uneven, and relapse is expected
- program dose matters: while 16 weeks may initiate change, consolidation requires sustained engagement over a longer period
- continuity of accountability is essential, ensuring that men remain connected to structured supports
- survivor safety and voice must remain central to all decisions and processes
- contextual stressors strongly influence relapse risk and must be addressed
- positive developmental pathways, such as resilience, pro-social identity, and safe parenting, reinforce accountability
- strong system safeguards – governance, supervision, and survivor-informed evaluation – are essential to maintaining integrity and safety.

The theory of change sets out the conceptual foundation of the model. Using an "if – because – then – so that" structure (see Table 1 on page) it explains why specific strategies, such as triangulated eligibility, integrated case management, and survivor-informed governance, are expected to contribute to safer and more accountable outcomes. It highlights the causal assumptions behind the framework and makes transparent the evidence and logic that connect activities to impacts.

The model positions post-MBCP support as a continuum of survivor-centred, risk-responsive pathways. It integrates participant case management, balances flexibility

with accountability, and embeds survivor advocacy, cultural safety, and robust governance.

2.6 Model components

Approximately 40 hours of structured intervention per participant is available. The hours include tapered, risk-scaled case management; facilitator accountability check-ins; survivor-advocacy input; criminogenic goal setting; and, where relevant, culturally governed supports and on-Country elements.

The model offers a layered set of supports, working together as a tapered, risk-responsive continuum:

1. Post-program groups with rolling/modular formats that revisit MBCP themes in greater depth, with tapering intensity planned with each participant (weekly - fortnightly - monthly).
2. Integrated case management from DFV-informed specialists addressing practical participant stressors (housing, employment, AOD, mental health) as barriers to retention and or change, always tied to behaviour change goals.
3. Parenting pathways that may include referral to child-centred, DFV trauma-aware programs.
4. Individual counselling for men with complex needs, as pre-group preparation or a complement to group participation.
5. Pro-social low-barrier activities (shared meals, recreation, volunteering) that reinforce positive social identities linked to accountability goals.
6. Re-entry and booster options so men can return to MBCP modules or “booster” sessions if risk escalates or relapse occurs, using same eligibility criteria.

In addition:

7. Survivor-centred work, including advocacy, ongoing safety monitoring, and structured collaboration with survivor services to ensure that women’s and children’s safety, wellbeing, and perspectives remain central throughout the program.

All components of the post-MBCP model operate under the NSW Standards for Men’s Behaviour Change Programs, including requirements for risk-informed practice, cultural safety, supervision, survivor-advocacy involvement and governance. The standards apply equally to case management, facilitator check-ins, survivor pathways, pro-social activities and any ACCO-led delivery streams.

2.7 Intended outcomes

The outcomes set out below describe the intended safety, accountability and system impacts of the Post-MBCP Accountability and Safety Support model. They reflect the model’s core purpose: to strengthen survivor and child safety by maintaining

accountability, risk visibility and coordinated system oversight following completion of an accredited MBCP.

The outcomes are framed across men, women, children and the service system, recognising that post-MBCP supports do not operate in isolation and that safety is produced through sustained accountability and effective coordination rather than individual behaviour change alone. Outcomes are sequenced to reflect early, medium and longer-term shifts, acknowledging that change is non-linear and that relapse, re- engagement and stepped responses are expected within safe and governed practice.

The outcomes should be read alongside the model's theory of change. Achievement of outcomes will be assessed using survivor-informed, culturally governed and mixed-method indicators, with recidivism treated as contextual information rather than a sole measure of effectiveness.

Table 1: Post-MBCP Accountability and Safety Support outcomes

Stakeholder group	Outcomes
Men	• Demonstrate sustained reductions in the use of violence and control through ongoing accountability and system oversight • Strengthen emotional regulation, resilience, safe parenting, pro-social identity, and help-seeking
Women	• increased safety • reduced burden of monitoring men • greater agency and trust in systems • improved emotional wellbeing and recovery opportunities • improved cultural connections
Children	• increased safety and stability • improved emotional wellbeing • positive parenting experiences • stronger relationships with non-violent caregiver
System	• survivor voices embedded in monitoring and evaluation • strengthened workforce, governance, and supervision • expanded evidence base for future system design

Outcomes reflect intended impacts to which the Post-MBCP Accountability and Safety Support model contribute, as part of a broader system response and are not presented as sole or attributable effects of the service.

Figure 1 overleaf illustrates the pathway through the model. The theory of change underpinning the model follows in Tables 2 and 3 sets out the program logic.

Figure 1: Post-MBCP Accountability and Safety Support pathway

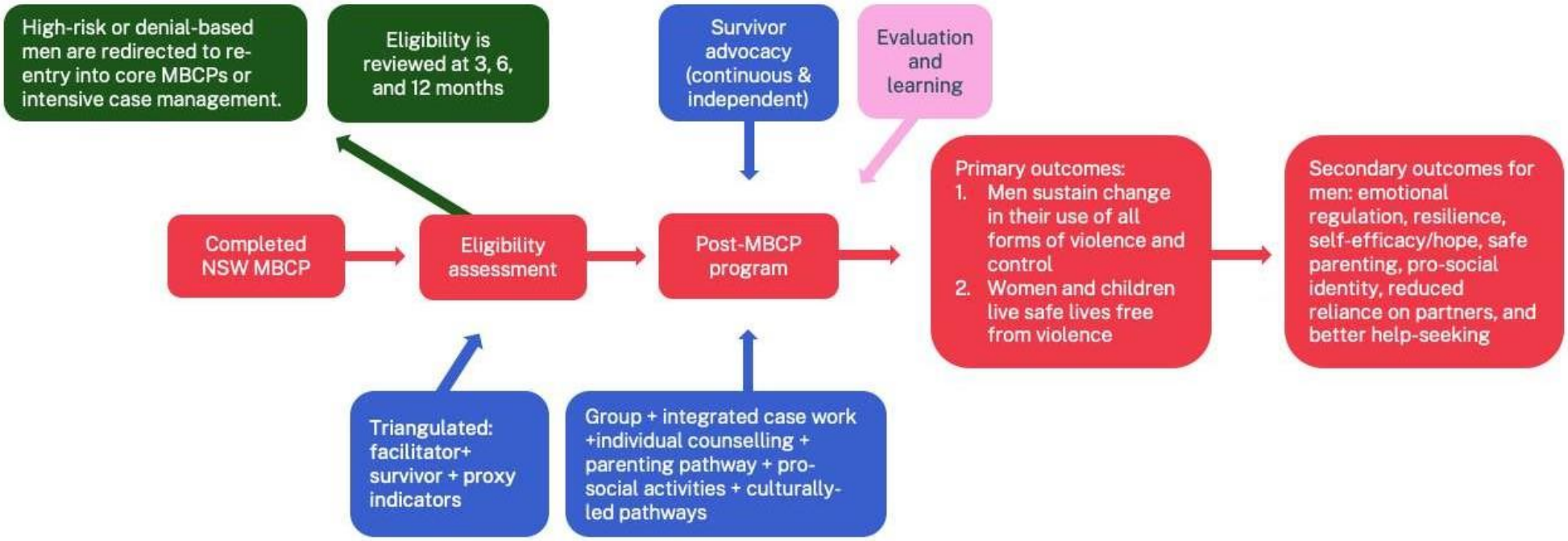

Table 2: Post-MBCP Accountability and Safety Support theory of change

If..	Because..	Then..	So that..
Men who complete an MBCP are provided with structured, survivor-centred post-program supports	Behaviour change is non-linear, relapse is common, and a single MBCP is insufficient for sustained change	Men remain connected to groups, case management, parenting pathways (child-centred, trauma-aware parenting programs), counselling, and pro-social activities	They sustain gains made in behaviour change and continue to reduce their use of violence over time
Eligibility is determined through a triangulated process (facilitator judgement, survivor input where safe, proxy indicators when not)	Single-source assessments miss risks; survivor voices are vital but cannot always be sought safely	Only men who demonstrate readiness are admitted, with survivors' perspectives protected	Risks of unsafe referrals are reduced and women and children remain safer
Integrated case management is embedded alongside behavioural interventions	Men's instability (housing, employment, AOD, mental health, parenting disputes) undermines program retention and accountability	Case management stabilises practical barriers while reinforcing accountability to change goals	Men are less likely to disengage or relapse, reducing risks for survivors, and more likely to achieve the stability that sustains behaviour change
Parenting pathways and pro-social activities are offered as motivators	Men are more likely to stay engaged when change connects to identity, relationships, and children's wellbeing	Men voluntarily sustain participation in supports	Safer parenting, stronger pro-social identity, and accountability are reinforced
Aboriginal men engage in ACCO-led cultural healing, on-Country work and Elder-led supervision	Cultural identity, belonging, and community accountability structures strengthen behavioural anchors	Men develop accountability grounded in cultural obligations and relational accountability	So that safety improves for Aboriginal women and children, and intergenerational healing is supported.

If..	Because..	Then..	So that..
Survivor advocacy, DFV-informed supervision, and independent governance are embedded as system safeguards	Without strong oversight, programs risk collusion, drift, or minimising survivor voices	Safeguards keep accountability central and ensure survivor perspectives guide decisions	Women's and children's safety remains the highest priority at all times
Longitudinal, survivor-informed evaluation is conducted	Recidivism data alone fails to capture coercive control, emotional abuse, and parenting harms.	Evaluation measures sustained behavioural change and survivor safety over 12–24 months	The evidence base grows, guiding safe system design and scaling
If survivor voices continue to inform decisions	They are the primary source of risk visibility and early warning signs	Decision-making is more responsive to risk	Women and children experience increased safety, reduced burden, and fewer risk escalations.

The program logic operationalises the theory of change. It maps the inputs and activities of the model to a sequence of short-, medium-, and long-term outcomes for men, women, children, and the system as a whole. While the theory of change explains why the model is designed in a particular way, the program logic shows how its components are intended to function in practice and how progress will be measured over time.
Together, these tools demonstrate that the framework is both conceptually sound and practically robust. They show that the model is not only guided by survivor-centred accountability but also structured in ways that allow for rigorous evaluation, system learning, and the safe scaling of effective practices.

Table 3: Post-MBCP Accountability and Safety Support program logic

Inputs	Activities	Short-term outcomes (0–6 months)	Medium-term outcomes (6–18 months)	Long-term outcomes (18–36 months+)
Accredited MBCP completers identified as eligible	Triangulated eligibility and assessment (facilitator judgement, survivor input where safe, proxy indicators)	Only men demonstrating readiness enter post-program supports	Survivors report greater trust that men remain accountable	Consistent eligibility pathways reduce unsafe admissions system-wide
Specialist DFV-informed facilitators and case managers, experienced or qualified to work with men who use DFV	Post-program groups (rolling, tapered, booster)	Men maintain connection to structured support after MBCP completion	Men demonstrate improved emotional regulation and responsibility-taking	Men sustain change across all forms of violence and control
DFV-informed case management workforce, experienced or qualified to work with men who use DFV	Integrated case management addressing destabilising stressors (housing, employment, AOD, mental health, parenting disputes)	Men engage more consistently with groups and services	Men stabilise life stressors without relying on partners/ex-partners	Men's accountability and capability is reinforced, reducing relapse risk
Parenting program practitioners and cultural mentors	Parenting pathways (child-centred, trauma-aware programs such as Caring Dads, Circle of Security)	Men show initial motivation to engage through focus on children's needs	Safer, more accountable parenting practices reported by survivors	Children experience safety, within relationship with father or without relationship with father

Inputs	Activities	Short-term outcomes (0–6 months)	Medium-term outcomes (6–18 months)	Long-term outcomes (18–36 months+)
Counsellors and therapeutic supports	Individual counselling for men with complex needs	Men address barriers to participation (trauma, mental health, AOD)	Counselling reinforces behaviour change goals and accountability	Men sustain long-term wellbeing supports, strengthening safety outcomes
Community organisations and pro-social partners	Structured pro-social activities linked to accountability	Men participate in safe, structured activities outside the home	Men develop pro-social identity and networks that reduce isolation	Pro-social identities are sustained, reducing likelihood of coercive or violent behaviours
Aboriginal Community Controlled Organisations and Elders	ACCO-led, culturally safe pathways	Aboriginal men engage with culturally relevant supports	Men strengthen accountability through healing grounded in culture Greater safety for Aboriginal women and children	Cultural healing and accountability contribute to intergenerational safety
Survivor advocacy and independent monitoring	Ongoing survivor advocacy and safety monitoring	Survivors feel heard and supported, without increased risk or burden	Survivors report reduced exposure to risk escalation post-program	Women and children experience sustained safety, stability, and healing and recovery opportunities
Governance, DFV-informed supervision, and independent evaluation	Strong governance structures and longitudinal, survivor-informed evaluation (12–24 months)	Program fidelity safeguarded; early lessons identified	Evidence builds about what works safely and effectively	System design evolves with a stronger evidence base, governance, and workforce capacity

3 Components of the model

3.1 Eligibility and assessment

Eligibility is determined through a triangulated process: facilitator judgement, survivor input (where safe), proxy indicators (validated tools, records, advocate perspectives), ACCO practitioner/elder input for Aboriginal participants, and structured risk assessments using the NSW RSSF.

As an established framework across NSW services, the RSSF ensures that assessments use a consistent language and approach to risk, reducing duplication and supporting coordinated responses across agencies. It complements facilitator judgement and survivor input, and offers a reliable proxy when direct survivor engagement is unsafe or not possible.

Eligibility is not static – assessments should be reviewed at regular intervals, and eligibility can be withdrawn if risk escalates, survivor safety is compromised, or accountability is not sustained. This ensures that participation remains appropriate, safe, and consistent with program goals.

High-risk or denial-based men are redirected to core MBCP or an intensive case management pathway.

Evidence shows that single-source assessments miss risks, and survivor voices are crucial but cannot always be safely sought. By embedding the RSSF into a triangulated process, the framework strengthens its risk-responsive design. Only men who demonstrate readiness are admitted, with survivors' perspectives protected. Risks of unsafe referrals are reduced, and women and children remain safer.

3.2 Integrated case management

Case management is included as an integrated support alongside behavioural work, not as a standalone intervention. The purpose of a case manager is to address destabilising stressors while reinforcing accountability. This may include criminogenic goal setting. A nominal allocation of 15 hours is available per participant, with flexibility to reallocate unutilised time. See the annex for further detail.

Evidence from adjacent sectors shows case management improves retention and stability. Practitioners warn of role drift if boundaries are unclear, the need for case management to be DFV informed, and designed to address destabilising stressors while reinforcing men's accountability and engagement in change. Practitioners also highlight the importance of reducing reliance on partners/ex-partners for men's stability.

3.3 Program dosage and continuity

This model adopts approximately 40 hours, tapered over time. Program tapering will be individually planned and documented to ensure continuity and safe exit.

Evidence supports longer engagement as critical to sustained outcomes. Tapered intensity prevents abrupt endings, while allowing flexibility for relapse re -entry or booster sessions.

3.4 Parenting pathways

Parenting can be a motivator for engagement by some men, with pathways to child-centred and trauma-aware programs such as Caring Dads or Circle of Security, with links to accountability goals.

Evidence shows parenting is a strong motivator, but risks exist if framed around entitlement to contact or custody. Survivor and child safety must remain paramount.

3.5 Pro-social activities

Structured pro-social activities are included to strengthen men's positive social identities and reduce isolation, while remaining linked to accountability structures. Pro-social activities are used only where they reinforce behavioural goals and cannot proceed without DFV-competent partners, clear risk screening, and documented accountability linkages.

Evidence warns that unstructured or social activities delivered without DFV competence can collude with minimisation

3.6 Survivor safeguards

Survivor safety and voice are central to the model. A dedicated survivor advocacy and support component ensures that women and children remain visible, protected, and heard without added burden or risk.

Core functions of survivor advocacy:

- act as a conduit for survivor voices in program decisions
- provide clear, accessible information on eligibility, safety, and program processes
- support women to identify and articulate risks while protecting safety and confidentiality
- offer survivors independent avenues for feedback and accountability monitoring
- connect survivors including children with DFV, legal, and social supports to strengthen safety and recovery.

These safeguards are monitored through the program's governance structure and survivor-informed evaluation processes.

Evidence shows that embedding survivor advocacy not only strengthens safety and support for women and children, but also increases the accountability of men by ensuring survivor perspectives remain central to monitoring and decision-making.

Embedding survivor advocacy in this way balances the risks of engaging men post-MBCP, ensuring accountability to survivors is never diluted by programmatic focus on men's participation.

3.7 Cultural pathways

The framework includes ACCO-led, co-designed pathways for Aboriginal and Torres Strait Islander men, grounded in healing, accountability, and cultural safety. Where delivery occurs within community settings governance will be Elder-led, with cultural supervision for Indigenous and non-Indigenous staff.

3.8 Professional practice

Strong professional practice is critical to the safety and effectiveness of post-MBCP supports. Practitioners must have appropriate qualifications, skills, and supervision to deliver safe, survivor-centred interventions while sustaining workforce wellbeing.

Key elements:

- qualifications and competencies: practitioners are required to meet NSW Practice Standards for MBCPs, with additional skills in cultural safety, integrated case management, and child-centred parenting
- supervision: both DFV-informed and clinical supervision are essential, with consistent, formalised structures embedded in governance
- cultural safety: ongoing training and ACCO-led guidance should support culturally safe practice, especially for Aboriginal and Torres Strait Islander men
- parenting practice: practitioners delivering child-centred programs (e.g. Caring Dads, Circle of Security) require specialist training and supervision to maintain accountability and prioritise women's and children's safety
- ethical practice: clear boundaries and ongoing training are needed to prevent role drift, collusion, or minimisation of violence.

3.9 System design and sustainability

The resource framework must explicitly fund cultural governance, supervision, Aboriginal delivery, women's and children's advocacy capacity, interpreter and translation services, and small participant brokerages to support safe engagement.

Annex

Integrated case management

Integrated case management is a core, non-optional component of the post-MBCP model and operates as a risk-scaled, accountability-focused function that maintains system visibility and stabilising support during the post-program period. Case management is delivered alongside group or individual behaviour-change work.

Case management provides structured, DFV-informed contact that supports ongoing assessment, reinforces responsibility-taking, and coordinates system responses using RSSF guidance. It does not replace group work or therapeutic counselling, and it must not drift into welfare-oriented casework, emotional support, or unbounded problem-solving. All case management interactions are anchored in risk, safety and criminogenic/DFV-specific goals.

Risk-scaled case management dosage

The model sets a **default tapered schedule** to ensure consistency across sites, while allowing risk-responsive variation. The standard taper is:

- weekly for four weeks
- fortnightly for six sessions
- monthly for two sessions.

Facilitators and case managers can **step up** intensity at any point in response to RSSF reassessment, instability indicators, or survivor/she informs of increased risk. Step-up can include a return to weekly contact, additional structured check-ins, or collaborative work with partner agencies.

A **minimum total duration of 4–6 months** of case management is expected unless withdrawal is warranted due to risk or non-engagement.

Clear role differentiation

To prevent drift and maintain fidelity, the model distinguishes between:

- facilitator 1:1 check-ins
- minimum 1 hour per fortnight.

Facilitator check-ins

The purpose of these facilitator check-ins is accountability, progress review, behavioural reflection, reinforcement of group content. These check-ins:

- must maintain a behavioural, risk-focused frame
- are documented in the same structure as group content (skills, accountability, risk indicators)
- are not case management
- are not for problem-solving or emotional support

Case management sessions

These are structured, risk-responsive appointments. The purpose is stabilisation, coordination, criminogenic goal setting, risk monitoring, escalation. These sessions:

- follow a defined case management template (RSSF review, goal progress, system linkages, actions and consequences)
- may include collaboration with external agencies
- never replace group contact or facilitators' behavioural work.

This dual structure increases clarity, prevents scope creep, and reduces safety risks associated with unstructured or unsupported 1:1 contact.

Workforce and supervision requirements

To support safe, high-quality case management delivery, the model requires:

- monthly external supervision for practitioners, delivered by a DFV specialist and documented using a structured supervisory template
- cultural supervision when working with Aboriginal participants delivered by ACCO governance or cultural knowledge-holders
- internal reflective practice at least monthly, linked to RSSF updates
- case discussion protocols where any risk escalation, minimisation, or boundary drift triggers supervision review within 72 hours.

Criminogenic and accountability-focused goal setting

Case management uses a **structured goal-setting framework** grounded in DFV and criminogenic needs. Goals must:

- focus on risk drivers (e.g., coercive control, entitlement, emotional dysregulation, substance-related volatility, financial instability)
- be behavioural, observable and measurable
- be linked to consequences for non-progress
- avoid broad wellbeing or welfare goals that, if pursued without accountability, can increase collusion risk.

Examples include:

- reduce controlling behaviours in financial decision-making
- use agreed de-escalation strategies during conflict
- attend mandated appointments reliably
- implement parenting boundaries in line with child-safety advice.

RSSF alignment and risk escalation

Every case management session includes:

- a brief RSSF-aligned review
- documentation of risk indicators
- survivor-informed insights (via advocates, never via direct contact)
- stability and volatility markers
- immediate escalation steps if required.

This ensures case management remains the structured backbone of accountability during the post-MBCP period.

Communities and Justice

6 Parramatta Square
10 Darcy Street
Parramatta NSW 2150

Locked Bag 5000
Parramatta 2124

Office hours:
Monday to Friday
9:00am – 5:00pm

E: Grantdesignandsupport@dcj.nsw.gov.au
and
DFVStrategy@dcj.nsw.gov.au

NSW GOVERNMENT